



# **Nepal Safer Motherhood Project**

**a part of HMGN Safe Motherhood Programme**

## **Challenging 'Ke Garne': Experiences of the Nepal Safer Motherhood Project**

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Finally, a word of thanks to the staff of the project-supported hospitals who rose to the challenge of defeating 'ke garne' and, in so doing, have shown that a different and better future is possible for Nepal.

## ABBREVIATIONS

BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
COPE	Client Orientated Provider Efficient
DFID	Department for International Development
DHO	District Health Office
HMGN	His Majesty's Government of Nepal
HRDO	Human Resource Development Officer
NSMP	Nepal Safer Motherhood Project
ODA	Overseas Development Administration (now DFID)
QoC	Quality of Care

## WHAT IS MEANT BY 'KE GARNE'?

The common understanding amongst the Nepalese is that 'your future is already written down for you - it is your karma or your fate'. Consequently many employees in government organisations in Nepal are immersed in a mood of cynicism and apathy - 'ke garne' which roughly translates as 'don't give yourself a headache because nothing can change'.

Writing in The Kathmandu Post in 1993 Ravi Pradhan<sup>1</sup> boldly described the situation in Nepal and laid the blame squarely on the perpetuation of the Jagir management culture:

***'Over the last 30 years, Nepal has received billions of dollars in aid and loans, employed thousands of foreign experts, and the best and most educated minds in the country. Yet, in the assessment of many Nepalese and Westerners, Nepali state organisations and institutions are very ineffective, unproductive, impervious to improvements, autocratic, rigid and unresponsive to customer needs and satisfaction..'***

***'...Probably the most devastating effect of the Jagir culture is that it has disabled people in their capacity to create new possibilities, new visions, and to take responsibility for creating and initiating changes.'***

The historical roots of the Jagir culture lie somewhere in the 16<sup>th</sup> and 17<sup>th</sup> Moghul regimes. In this system the ruler appointed loyal subjects as jagirdhars (feudal lords) over a jagir (fiefdom). The jagirdhar was the absolute ruler of his fiefdom in which productivity, efficiency, quality of product or service, innovation or creativity, merit and hard work were not rewarded but suppressed. This system is still evident today in current management practices in many institutions and organisations and is a major obstacle to the improvement of services.

This paper describes the efforts of the Nepal Safer Motherhood Project to challenge 'ke garne' and the Jagir culture by assisting staff in project-supported hospitals to '**create new possibilities, new visions, and to take responsibility for creating and initiating changes,**' - in effect, to transform the institutional culture from one of apathy to one of activity.

## WHAT IS THE NEPAL SAFER MOTHERHOOD PROJECT?

The Nepal Safer Motherhood Project is funded by the UK Department for International Development (DFID) and is being implemented by Options Consultancy Services Limited, a UK-based consultancy and project management company specialising in reproductive, sexual and maternal health. NSMP supports His Majesty's Government of Nepal's (HMGN) Safe Motherhood Programme. The goal of NSMP is to contribute to HMGN's objective of reducing maternal mortality in Nepal. The specific purpose of NSMP is to 'increase utilisation of and access to quality emergency obstetric life saving care.' The focus of NSMP's work is in the three districts in the west of Nepal - Baglung, Kailali and Surkhet.

The project has two main components:

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<sup>1</sup> Ravi Pradhan, 1993: *The Jagir Culture in Nepali Organisations: An Essay*, The Kathmandu Post

1. **SERVICE PROVISION** under which the capacity to provide quality emergency obstetric care within rural areas is increased. This includes improvements to the physical infrastructure of hospitals, provision of equipment and supplies, and improved performance of personnel.
- **INCREASING ACCESS** under which awareness of and demand for services is promoted through community participation so that women whose health may be at risk as a result of complications which occur during pregnancy, childbirth, or the post natal period, have the capacity to use the available services.

This paper is based on the experiences drawn from the implementation of the first component of the project, **service provision**.

### BRIEF HISTORY OF THE PROJECT

The scope for a substantial involvement in the health sector in Nepal was identified by DFID (then ODA) as early as 1993. A subsequent health sector strategy mission identified reproductive health services as a priority area with emphasis on promoting safer motherhood. This mission was followed by a detailed inventory of the safe motherhood capacity in proposed districts, a feasibility study (January 1995) and an appraisal mission (September 1995). The project design was based on these studies.

The proposed project duration was six years including an inception phase from March to December 1997. This would be followed by two phases: Phase One (two years) in three districts; and Phase Two, expansion to other districts, the number to be determined following review of the first phase.

The project had been fully operational for approximately sixteen months at the time of writing this paper.

### WHAT SITUATION WAS FACED BY NSMP?

Following a detailed hospital needs assessment carried out during NSMP's inception phase, many weaknesses were identified. These included low capacity in:

- Infection prevention and waste management
- Basic midwifery care
- Antenatal care and the referral system
- Neo-natal care
- Post-abortion care
- Basic and Comprehensive Emergency Obstetric Care
- Attitude to communication
- Management systems and skills

- Provision of safe and adequate blood supplies
- Management and maintenance of stores

NSMP developed a comprehensive approach in which many of the weaknesses of the system would be addressed, not merely the lack of skills to provide emergency obstetric care. This approach encompassed:

- Physical improvements, such as renovation of buildings for maternity use, including operating theatres;
- The provision of appropriate supplies and equipment, and;
- Re-building the morale, confidence and competence of hospital staff in order to provide Emergency Obstetric Care (EmOC) services of high quality.

Of these three elements in the approach the third provided the greatest challenge. The project realised that it would not be sufficient to provide training, supplies and new buildings and hope that staff would respond with enthusiasm. The cynicism, apathy and 'ke garne' attitude so prevalent in hospitals was rooted in a much deeper malaise and required a more radical and innovative remedy if the project was to succeed. Transformation of the staff and the hospital would be required at an early stage in NSMP's life.

### **EFFORTS AND LESSONS IN CHALLENGING 'KE GARNE'**

NSMP was aware that attempts to bring about change and transformation often fail. In order to minimise the risk of failure NSMP based its change-strategy on the results of an analysis by John Kotter<sup>2</sup> of the most common reasons for the failure of efforts to transform institutions. This paper takes the reasons for failure described by Kotter and, using the experience of NSMP, re-presents them as key lessons for those attempting to bring about fundamental change within Nepali institutions.

The following is a summary of these key lessons. Each lesson is briefly explained and some experiences are drawn from the project to demonstrate the application of the lesson.

- 1. Create a feeling that change is needed**
- 2. Create a sense of urgency of the need for change**
- 3. Create a vision which is easy to communicate**
- 4. Communicate the vision vigorously**
- 5. Remove obstacles to the vision**
- 6. Involve a critical mass in the transformation process**
- 7. Systematically plan for easy and early wins**
- 8. Do not declare victory too soon**

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<sup>2</sup> John Kotter, 1995, 'Leading Change: Why Transformation Efforts Fail', *Harvard Business Review*, March/April

### 1. Create a feeling that change is needed

*"Efforts to bring about change will fail if we try to **deliver** changes to an institution rather than working out how to **involve** people in the creation of change."*

NSMP assisted hospital staff to recognise the **need** for change by involving **all** staff in analysing the hospital needs analysis carried out in the Inception Phase.

Participation in the **design of the change** was encouraged by holding workshops at district level to discuss the results of the needs assessment and to identify with staff what changes would be needed. Ownership of the change process by hospital staff was established at the beginning. This, along with transparent procedures (no hidden agendas), facilitated the implementation of activities.

**'This is the first time anyone has asked our concerns and ideas' - a peon in Seti Zonal Hospital, Kailali**

### 2. Create a sense of urgency of the need for change

*"A sense of urgency is needed to "drive people from their comfort zones". Without this sense of urgency, efforts will be paralysed and failure will be inevitable."*

Expectations in the project hospitals were that NSMP would hold an initial workshop and then not appear again for several months, as had happened frequently in the past with other donor projects. NSMP overcame this and instilled a sense of urgency by outlining the major milestones in the project's life and keeping to them. All promises made concerning timing of activities were strictly adhered to. Hospital staff began to trust NSMP and to enjoy the momentum created. Staff began arriving on time for work, stayed the whole day and volunteered for additional training on public holidays and rest days - without any financial incentive.

### 3. Create a vision which is easy to communicate

*Transformation efforts can fail when there are plenty of plans but no vision. Kotter<sup>3</sup> recommends a basic rule of thumb - "Learn to communicate the vision to someone in five minutes or less and get a reaction which signifies both understanding and interest."*

NSMP, together with hospital staff, developed the 'five minute vision' which was understandable and easily explained within and outside hospitals.

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<sup>3</sup> John Kotter, 1995, 'Leading Change: Why Transformation Efforts Fail', *Harvard Business Review*, March/April

### Vision of NSMP

*By the end of Phase One the three district hospitals will be able to offer 24-hour Comprehensive Emergency Obstetric Care in an environment which is:*

- *safe and clean*
- *adequately and appropriately equipped*
- *has a woman and family focus*
- *staffed by personnel who are committed to working as a team to improve maternal health*
- *managed by staff confident and competent to treat obstetric emergencies appropriately*

The vision provided the rationale for the transformation of the hospital and all the activities within the project: NSMP-supported hospitals created and understood this vision.

The vision-creating process was facilitated by a management input which used an approach known as 'Appreciative Inquiry',<sup>4</sup> or the art of creating a positive future.

In summary, Appreciative Inquiry involves taking participants through four stages:

**Appreciating** - valuing the best of what is at the moment

**Envisioning** - what might be

**Dialoguing** - what should be

**Innovating** - what will be

Appreciative Inquiry is a radical departure from the more usual problem-solving approach which focuses on identifying what is not working and is embedded in the language of deficiency and negativism.

Using the Appreciative Inquiry approach hospital staff were able to collectively examine their own organisation and to identify the positive factors and strengths within the working environment; develop a vision; discuss changes needed; and to create solutions through their own efforts in design, innovation and action.

In the context of the project, hospital staff together created and implemented 'breakthrough' projects to achieve their vision. These included the introduction of the partograph, the development of local reproductive health protocols, the formation of an intersectoral team for fund-raising to support vulnerable women, the establishment of all-cadre Infection Prevention Committees, and so on.

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<sup>4</sup>David Cooperrider, Appreciative Inquiry: Case Western University, Cleveland, USA

#### **4. Communicate the vision vigorously**

*"Transformation is not possible unless you capture the hearts and minds of those who are part of the process. This will not be achieved if the vision is communicated by holding a single meeting, or issuing a single communication, or if the supposed leaders of change behave in ways which contradict the vision".*

NSMP's main strategy for communicating the vision vigorously was to post 'change-agents' to each of the project hospitals. These 'change-agents', called Human Resource Development Officers (HRDOs), communicated regularly between project centre and district. They became the living embodiment of the vision and worked to support staff in implementing the new procedures and ways of working which would achieve the vision. Their role and activities were crucial in 'capturing the hearts and minds' of hospital staff.

In addition, NSMP staff communicated the vision regularly through their advocacy efforts with a wider group of donors, NGOs and government health services.

#### **5. Remove obstacles to the vision**

*"As transformation proceeds so obstacles emerge as people try new approaches and develop new ideas. Obstacles can be small and large and can range from inefficient procedures to performance appraisal systems. Perhaps the worst obstacle of all will be the "hakims", the managers, who refuse to change at all. Failure to remove obstacles will impede transformation efforts".*

NSMP reduced the impact which obstacles could have on the transformation process by including all cadres in training and other inputs. Cadres who had never previously received training now enjoyed the benefits of learning new knowledge and skills. Administrators, store-keepers, peons and sweepers became part of the hospital team attempting to achieve the vision.

Mechanisms for coping with obstacles were introduced into the hospitals, notably the COPE (Client-Orientated Provider-Efficient) approach, the establishment of all-cadre committees and 'breakthrough' projects. The COPE approach defines quality issues which need addressing, assists providers to identify obstacles (including their own performance), and helps to devise solutions. Breakthrough projects are the solutions to the identified obstacles.

Training and involvement was also extended to hospital managers - and this is beginning to have some impact. Managers who are unwilling to change are finding their roles as leaders diminished as an empowered staff increasingly take responsibility for bringing about change.

## 6. Involve a critical mass in the transformation process

*"Transformation efforts will fail if the process affects only a limited number of people. The commitment of many people will be needed to ensure that the transfer of key people will not lead to the collapse of the process".*

Change processes in Nepal are very vulnerable due to the frequent transfer of doctors and senior nurses. NSMP attempted to protect the change process by including in the transformation those cadres who were not likely to be transferred - peons, sweepers, junior nurses, administrators etc. In the event of the transfer of the senior staff the impact would be minimal on the change process since sufficient numbers would remain who were committed to bringing about change. For example, hospitals have set up Infection Prevention Committees which would continue their work even if the DHO was transferred.

## 7. Systematically plan for easy and early wins

*"Genuine transformation can take a long time and there is the risk that the momentum can be lost if there are no short-term results and improvements. Most people need to see compelling evidence (say within twelve months) before they commit themselves to the "long march"."*

NSMP planned for short-term wins and created opportunities to celebrate successes. For example, one of the earliest interventions was the improvement of infection prevention measures and waste management. Training for all cadres was provided on-site, essential supplies obtained and large concrete waste pits were constructed. Infection Prevention Committees were established with representation of all cadres to monitor the hospital situation and seek solutions. Staff immediately saw the benefits of the new measures, especially the increased protection for themselves and the cleaner hospital grounds and buildings.

The introduction of the partograph (a method of monitoring progress during labour) into the delivery room was another early win. Nursing staff appreciated their new skills and confidence in identifying problems during delivery.

Merit Award Schemes have been introduced by NSMP to be awarded to hospital teams (not individuals) for some aspect of the hospital's Quality of Care (QoC) programme. Awards are presented by a senior official from the Family Health Department - evidence to the staff that their improvements and commitment are noted at a high level.

All training carried out has been in response to needs identified **with** staff. Thus staff have seen immediate benefits for themselves and their patients. This has been achieved without the need for financial incentives.

**8. Do not declare victory too soon**

*In Kotter's words "While celebrating a win is fine, declaring the war won can be catastrophic".*

*"Until changes are firmly anchored into the hospital's culture then new approaches remain fragile and subject to regression. Short-term wins should build on the credibility achieved to enable people to go on to tackle even greater problems. Successful transformation is a long process and can take several years".*

At this point NSMP rests its case. Certainly it is timely to celebrate some wins but the war is not yet won. It is too early to judge whether the transformation efforts attempted by NSMP have succeeded and are anchored in the hospital culture. But the changes achieved so far are encouraging and the words of one senior nurse provide evidence of this:

***'We know we have to go on with what we have started - and now we feel strong enough to do it on our own.'***

NSMP and the three project hospitals have demonstrated that it is possible to challenge 'ke garne'. Whilst NSMP has been the catalyst for change, the real change has been made by the staff of the hospitals. The sense of shame felt by staff in the condition of the hospital and the poor quality of services offered has been transformed into a sense of pride and a determination to go further in the future.

This paper has concentrated on highlighting some of the experiences of NSMP in relation to challenging 'ke garne'. Anyone interested in reading more about the Nepal Safer Motherhood Project and its experiences in meeting the challenges to reducing maternal mortality can obtain the following booklet from the project or Options London:

***Challenges to Reducing Maternal Mortality: Experiences from the three districts in Nepal supported by the Nepal Safer Motherhood Project - Kailali, Surkhet and Baglung (1999)***

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