Nepal Safer Motherhood Project

a part of HMGN Safe Motherhood Programme

Project Progress Report

Reporting Period:
January - June 2002

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Family Health Division
Department of Health Services
Ministry of Health, HMGN

Options

DFID Department for International Development

Nepal Safer Motherhood Project
(A part of HMGN Safe Motherhood Programme)

General Information

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ABBREVIATIONS

AI	Appreciative Inquiry
ANC	Ante-Natal Care
A&M	Assessment and Monitoring
ANM	Auxiliary Nurse Midwife
AOR	Activity to Output Review
BAMS	Batchelor of Ayurvedic Medicine
BCC	Behaviour Change and Communication
BEmOC	Basic Emergency Obstetric Care
BEOC	Basic Essential Obstetric Care
BTS	Blood Transfusion Service
CB	Capacity Building
CEmOC	Comprehensive Emergency Obstetric Care
CEOC	Comprehensive Essential Obstetric Care
COPE	Client-Orientated Provider-Efficient
DALYs	Disability Adjusted Life Years
DDC	District Development Committee
DFIDN	Department for International Development in Nepal
DHO	District Health Officer
DHSP	District Health Strengthening Project
DOHS	Department of Health Services
DPHO	District Public Health Officer
EOC	Essential Obstetric Care
EmOC	Emergency Obstetric Care
FAO	Financial Adviser's Office
FCH	Female Community Health
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FFC	Foundation for Change
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit (German Technical Cooperation Agency)
HIMDD	Health Institutions and Manpower Development Division
HICODEF	Himalaya Community Development Forum
HMC	Hospital Management Committee
HMGN	His Majesty's Government of Nepal
HP	Health Post
HRD	Human Resources Development
HRDO	Human Resources Development Officer (NSMP)
HSC	Hospital Support Committee
IA	Increasing Access
IEC	Information, Education, Communication
INF	International Nepal Fellowship
INGO	International Non Government Organisation
IP	Infection Prevention
IPR	Inception Phase Report (NSMP)
KIMT	Key Informant Monitoring Tool
MBBS	Batchelor of Medicine, Batchelor of Surgery
MCHW	Mother and Child Health Worker
MIRA	Mother Infant Research Activities
MDGP	Medical Doctors General Practitioners
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MoU	Memo of Understanding

MSD	Medical Supplies Department
NESOG	National Association of Obstetricians and Gynaecologists
NFCC	Nepal Fertility Care Centre
NFE	Non Formal Education
NGO	Non Governmental Organisation
NHEICC	National Health Information Communication Centre
NHTC	National Health Training Centre
NRCBTS	Nepal Red Cross Blood Transfusion Services
NSMP	Nepal Safer Motherhood Project
OPR	Output to Purpose Review
OVI	Objectively Verifiable Indicator
PAC	Post Abortion Care
PFAD	Planning and Foreign Aid Division
PHC	Primary Health Care
PHCC	Primary Health Care Committee
PHN	Primary Health Care Nurse
PPH	Post Partum Haemorrhage
PPR	Project Progress Report
QoC	Quality of Care
RH	Reproductive Health
RHCC	Reproductive Health Co-ordination Committee
SDA	Social Development Adviser (NSMP)
SDF	Social Development Facilitators
SDO	Social Development Officer (NSMP)
SHP	Sub Health Post
SM	Safe Motherhood
SMSC	Safe Motherhood Sub Committee
SMWG	Safe Motherhood Working Groups
SWAP	Sector Wide Approach
TA	Technical Assistance
TAP	Technical Assistance Programme
TOR	Terms of Reference
TUTH	Tribhuvan University Teaching Hospital
UMN	United Mission to Nepal
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
WHO	World Health Organisation
WRTLH	Women's Right to Life and Health (UNICEF)

1. INTRODUCTION AND SUMMARY

This reporting period has witnessed some exciting new initiatives in both the increasing access and service provision components and in the project contribution to national policy and programme development.

However, a major factor influencing development of project programming has been the continued deterioration in the security situation during the period which has significantly impacted upon project progress to Output, and in particular on increasing access activities. The project has responded with a programme of carefully researched alternative activities, both in Service Provision - in less volatile areas, and in Increasing Access – of broader brush inputs. It is important to note that if the security situation should improve, work will continue in the allotted districts, with new activities complementing, and not detracting from, the project's original focus. This alternative approach is further outlined in Appendix 1.

Contribution to Safe Motherhood Programme and Policy Development (Output 1)

NSMP has been an active member of a Family Health Division (FHD) led Abortion taskforce, since its establishment in January 2002, for the purpose of supporting new legislation to legalise abortion (still to be finalised). The taskforce has to date overseen the production of a draft abortion policy document and the process has been supported by two major inputs: a NSMP supported international consultant (Nepal-based) put together an extensive review of international lesson learning on the development and implementation of new abortion policies with which to support the Nepali policy development process, followed by a GTZ-supported senior national consultant who developed the initial abortion policy document. The taskforce is now addressing the need to develop an Abortion Services Implementation Plan and accompanying guidelines, which NSMP will support by providing further technical assistance inputs.

FHD also established a working group to develop a neonatal strategy, of which NSMP is a member.

NSMP's continuing influencing role has been in evidence, particularly in the increasing number of requests from organisations (DoHS and others) to utilise senior staff as resource people, particularly in the areas of physical upgrading and Quality of Care (QOC) support. In addition NSMP, together with UNICEF, were influential of the increased public health perspective on safe motherhood taken by the 2002 NESOG conference.

NSMP completed a project dissemination strategy in April. During this period formal dissemination events included:-

- a joint NSMP/MOH presentation on midwifery in Nepal at the International Confederation of Midwives - Vienna
- five papers drawn from NSMP's learning, presented at the above NESOG conference

UNICEF and NSMP have continued to collaborate on supporting the establishment of a national essential obstetric care (EOC) monitoring system. The work is nearing completion and the system will come on stream from July 2002, ensuring that all districts use the same process for the provision of data to FHD/HMIS required to monitor EOC progress against the standard *UN process indicators*, which the Government also utilises for their own 15-year Safe Motherhood Plan's Purpose level indicators, as does NSMP.

During this period NSMP contracted NESOG, together with a national consultant, to institutionalise the revised monitoring process into the health systems of the 13 NSMP/UNICEF supported districts, utilising the recommendations made by the previous year's international consultancy.

NSMP continues to support the national skilled attendance strategy using MCHWs for out-of-facility care (see Appendix 2). In June a multi-partner collaborative venture commenced which will both evaluate the performance of the MCHWs to date, and will create a long-term monitoring system. As part of that venture NSMP initiated a self-reported review of MCHWs in NSMP supported districts, the findings of which will be analysed soon.

Service Provision (Output 2)

This period saw the initiation of an exciting new venture – the BEOC training programme for doctors. NSMP, UMN, FHD, NHTC and the Maternity hospital collaborated in the design, piloting and management of the programme intended for general MBBS doctors whose skill levels in BEOC need enhancing (see Appendix 2). The final week of training includes a week on PAC, during which time nurses from the doctors own facilities join them for the training.

Five districts (8 facilities) have received an onsite QOC refresher course in which the draft FHD QOC guidelines were introduced. All facilities now have functioning QOC committees with identified key change agents supported by the project HRDOs.

Both anaesthetic training and midwifery training continue as planned, in a climate of greater recognition of the urgent need to take a more strategic approach to the critical issue of human resource responses to maternal mortality reduction. This includes debates on the appropriate cadre of staff for out-of-facility skilled attendants, as well as the parallel debate over the appropriate balance between professional midwives, smaller numbers with greater skill levels, verses lower skill levels amongst greater numbers (ANMs and staff nurses). A summary of NSMP's human resource development support and a discussion of national strategic human resource issues are presented in Appendix 2.

Interesting variations in the service provision strategy are emerging in response to local district needs. Jumla are concentrating on the establishment an airborne referral service for all serious cases (until it has a CEOC facility) and is giving greater attention to safer and clean home care whilst establishing its BEOC care. Generally progress is faster in achieving BEOC and CEOC (particularly in the Terai) than was the case in Phase One. This is partially due to NSMP's maximising its learning from Phase One but also due to some committed local individuals. One district originally designated to achieve BEOC now has the human resources and commitment to move to CEOC level, for which NSMP 's continuing supportive inputs can be relatively small.

Four district hospitals are now under going renovation/ construction following agreements on the construction process brokered between NSMP, FHD and DFID. Competitive tendering resulted in the award of two contracts – one to manage the work in Parasi (Nawalaparisa) and Bhim (Rupandehi) hospitals and the other to manage the work in Parbat and Myagdi hospitals. All work is due for completion by December 2002. An exception to the agreed contractual process was made for Jumla hospital due to its unique and remote position, with the use of a negotiated tendering process. NSMP's construction work is presented in Appendix 5.

Increasing Access (Output 3)

Security has significantly impacted upon progress although the degree to which this is so varies considerably, with Dailekh and Jumla being the worst affected districts resulting in NSMP being unable to place staff at local level throughout this reporting period. As mentioned above, this is further discussed in Appendix 1.

Safe Motherhood working groups (SMWGs) have now been established in all nine districts. They report to the RHCC where operational, and where not the SMWGs form 'accountability relationships' with other district health coordination mechanisms, where they exist (see Appendix 8). Most SMWGs have demonstrated real progress in maturing their working mechanisms and many hold a more strategic view of safe motherhood interventions within their districts.

Having established the groups, attention was given to supporting them in the development of their monitoring frameworks (identifying indicators and this means to measure progress against them). Within this framework the use of the key information tool (KIMT) is positioned (see Appendix 6 for further details). All SMWGs are now working to six monthly plans, and some have instigated a review process within that period.

Within the SMWG 42 partnerships are in existence – 50% are supported through long-term MOUs and the other 50% by direct activity based support by the project. These partnerships enable NSMP to provide input into 119 VDCs, representing 27% of the population of the project's 9 districts.

District Development Committees (DDCs) are demonstrating a greater interest in addressing safe motherhood – and in six districts safe motherhood initiatives have been incorporated into their seven-year strategic plans with many DDC bodies working directly on safe motherhood activities, in partnership with other organisations. The Women's Development Office and the Ministry of Education are becoming increasingly active partners at district level.

Ongoing and critical orientation work at community level continues to ensure a critical mass of support for safe motherhood issues. This is working both as an output in itself and also as a platform from which many other more immediate needs are addressed, for example more than 400 emergency funds and 100 transport schemes have been established. Alongside this, NSMP provides essential capacity building support to a range of partners, according to their needs and existing strengths.

NSMP's significant support to the development of the draft national IEC strategy continues. The experience of supporting the formation of eight district safe motherhood IEC strategies provided valuable "reality checks" that have proved critical in finalising the draft strategy.

District-wide IEC strategies are integrated into the SMWG's six-monthly plans. In addition, NSMP partners incorporate their BCC/IEC activities into their own work plans which in turn also feed into the district SMWG's six monthly plans, thus ensuring a good overview is maintained.

BCC activities have greatly increased in number and scope during this period, utilising innovative mechanisms such as accessing women through the well established non-formal education (NFE) systems and regional radio programmes. Anecdotal evidence from implementers of NFE classes and letters from radio listeners prove that these inputs have become very popular.

Both IA and SP components work together on supporting the MCHW pilot as skilled attendants. The refresher training continues, in 7 district workshops, to initiate support for MCHWs in their working place with commitments being made by both communities and DPHOs to give further or additional support.

General Programme Related Issues

During this period the Family Health Director was promoted to Director General of Health Services. His long tenure with FHD and his consistency, innovation and energetic approach to safe motherhood has played a significant a role in the strength of the national programme today. His personal day-to-day support, vision and great interest in NSMP have been hugely valued by the team.

NSMP's ongoing partnerships with UNICEF's WRTLH, DHSP and MNH continue to work well. During this period NSMP also appreciated the opportunity to work more closely with GTZ, and look forward to a continuing collaboration in the future.

Constraints to Achieving Project Outputs

Previously, Project Progress Reports have included a separate section on Constraints to Achieving Project Outputs. However, it is deemed that as any constraints are always well documented in both the Introduction and Report to LogFrame sections, that this resulted in unnecessary duplication. Also if additional information is required – such as updates on the impact of insecurity on project progress – that this is covered in detail in a separate and specific Appendix.

For this Project Progress Report, therefore, constraints have been detailed throughout the narrative. In addition, and in response to the worsening security situation and the serious impact of this on project progress, a separate report is attached at Appendix 1: a Programmatic Response to Working in Politically Insecure Environments.

2. REPORT ON PROGRESS TOWARDS ACHIEVEMENT OF PROJECT OUTPUTS

2.1 Head LogFrame

Purpose: Sustained Increase in Utilisation of Quality Midwifery and Obstetric (BEOC and CEOC) Service

Output	Major Activities	Status	Comments
Output 1: NSMP contributes to safe motherhood policy and programme development (including feeding into global lesson-learning)	1.1 Develop and promote ways of working programmatically 1.2 Participate on SM subcommittee and TWGs 1.3 Participate in SM network 1.4 Develop and maintain effective working partnerships with key agencies 1.5 Develop and implement a dissemination strategy		Contributed to the SMSC's furthering maturity in moving towards joint working (e.g. on policy support documents). **Policy support:-** NSMP is an active player in the FHD-led **abortion taskforce** which has in the light of legislative change, steered the process of abortion policy development and planned an ongoing abortion programme. **Programme support:-** NSMP's senior staff have increasingly been viewed as **resource people** both by MoH (eg service provision support to an FHD supported EOC district) and by other SM EDP (eg GTZ for physical infrastructure advice). NSMP continues to support the **national SM IEC strategy** finalisation by incorporating critical district learning. **Dissemination of learning: –** NSMP has now developed a dissemination strategy. Dissemination activities in this period include:- • presentation of a paper by the Special Secretary, Health on midwifery at the International Confederation of Midwives, Vienna in April 2002 • presentation of 5 NSMP papers at the annual NESOG conference Joint working with FHD & NHTC on evaluation and on-going monitoring of refreshers trained **MCHWs as a cadre of skilled attendants** has been initiated. This work will be jointly funded by

Output	Major Activities	Status	Comments
			NSMP and USAID and an agreement is being finalised on the modalities for this. NSMP and UNICEF jointly collaborated on the process of institutionalising **EOC monitoring** into FHD/HMIS. Two national consultants undertook the process of ensuring that the 13 safe motherhood districts now monitor using the UN process indicators and this is managed by the DoHS.
Output 2: NSMP-supported facilities (hospitals & PHCs) provide good quality midwifery and obstetrics services	2.1 Needs assessment of facilities and equipment 2.2 Develop and undertake participatory planning and dissemination process for upgrading facilities 2.3 Construct and renovate facilities; deliver equipment; quality inspect buildings and equipment before handover to HMGN; develop facility and equipment support system for maintenance, arrange for user training 2.4 Strengthen local blood transfusion services	2.1 Completed 2.2 Completed 2.3 Ongoing 2.4 Ongoing	NSMP has received two **proposals for procurement** of equipments from UNICEF and Crown Agents. Both proposals are being evaluated by a consultant and NSMP will proceed based on the consultant's recommendation. NSMP's **construction/renovation** work is divided into two stages. Stage 1 covers work for Myagdi, Parbat, Nawalparasi, and Rupendehi. HIMDD approved the proposed design for these sites in January 2002. Contracts for construction were awarded through a competitive tendering process agreed by FHD, DFID and NSMP. Construction started in March and is scheduled for completion by December. Stage 2 shall cover construction/renovation work for Jumla and Dailekh. Jumla's design work commenced in April and the construction contract was awarded in July. Dailekh construction work process is still to be addressed. NSMP continues to advocate for the **development of national standards for operating blood transfusion services (BTS)** (defining the role and responsibilities of Nepal Red Cross Society (NRCS) and the MoH at central and district levels. Findings from the NSMP supported BTS evaluation study were disseminated at

Output	Major Activities	Status	Comments
			the National AIDS Strategy Development forum and at the NESOG conference. NSMP's support to **district Chapters of the NRCS:** • Agreement was reached with NRCS in Dailekh on NSMP's support for construction of a blood bank (a MoU will be signed) • A MoU was signed with NRCS in Surkhet to share the cost of construction of a shop, the revenue from which will sustain the NRCS's local BTS All three blood banks in Phase One districts have started screening for Hepatitis C and, as agreed, NSMP is providing testing kits for at lease six months.
	2.5 Needs assessment of human resources 2.6 Develop and implement a participatory planning and dissemination process for capacity building 2.7 Develop basic skills to support QoC model 2.8 Update and monitor QoC model	2.5 Completed 2.6 Completed 2.7 Ongoing	An on-site **Quality of Care (QoC) orientation** was held for entire teams at eight NSMP supported health facilities (six hospitals and two PHCs). A change agent has been selected at each site who is responsible for implementing a six monthly QoC plan and for monitoring changes in QoC. QoC committees in all eight facilities are active. FHD's **revised draft QoC Guide** (based on NSMP's extensive experience of QoC) is in use at the eight health facilities mentioned above. The remaining seven NSMP supported facilities will be oriented to the Guide within the next six months.

Output	Major Activities	Status	Comments
	2.9 Develop specific technical skills in midwifery and obstetric care through short term and long term training	2.8 Ongoing 2.9 Ongoing	Once feedback is received from the fifteen facilities (comprising of ten hospitals and five PHCs) and from one non-NSMP-supported hospital, it is expected that this draft of the QoC Guide will be finalised. Initiating a six-week **BEOC Refresher course for MBBS doctors:-** • NHTC and the FHD are leading this new area of HR development. NSMP financed the course development and provided the technical input (through contracting the services of UMN's RH advisor) • Five doctors have successfully completed this course to date • In this period NSMP commenced actively supporting the Maternity Hospital is being developed into a training site for this course and potentially for other courses **Midwifery refresher training** was provided to 29 nurses from 14 health facilities. The midwifery refresher course provided by Patan hospital was evaluated by assessing the performance of 11 of the 29 graduates in their workplaces. The evaluation report shows improvement in practice immediately after training. In terms of a sustained change over time, the report of the **Post-Basic Diploma Midwifery course** was presented at a central HMGN meeting and findings showed that graduates working in positive environments retained their competency longer and were better motivated to provide quality care than those who lacked an enabling environment. Four individuals (nurses and paramedics) from four CEOC facilities successfully completed a six-month **anaesthetic assistant** course

Output	Major Activities	Status	Comments
	2.10 Develop and monitor referral systems among NSMP-supported facilities 2.11 Onsite support for changes in clinical practice (including one-off support for essential drugs to OT/labour ward)	2.10 Ongoing	at Patan hospital. **Scholarships** were awarded to: • Three nurses for the Post-Basic Diploma in Midwifery course, and • Six nurses for the Bachelor in Nursing course Under the leadership of NHTC, NSMP supported an on-site programme on **clinical standardisation and clinical teaching skill**s was provided at Tansen Hospital for the ten trainers involved in the Post-Basic Diploma in Midwifery course. **A referral strategy** has now been developed for Jumla. It includes innovative ways of galvanising district-level resources for emergency funds, emergency transport, and more effective communications with the facility where women with complications are being referred. NSMP continues to work on developing long-term measures to ensure **availability of essential drugs and supplies** (such as magnesium sulphate). One out of three Phase One hospitals is in the process of establishing a Sajha medical shop inside the hospital complex to ensure the continuing supply of affordable drugs. All Phase One **Hospital Support Committees** (HSC) have been actively supporting hospital needs, and provide inputs such as the cost of essential drugs, IP supplies, and salaries of additional staff. **NSMP has successfully withdrawn support** for two out of three Phase One hospitals. With only 25 percent of HRDO time provided, management support and technical standards are now self-.sustaining. It is believe that combining the QoC model with HSC

Output	Major Activities	Status	Comments
	2.12 Develop and implement exit strategy for Phase One facilities 2.13 Support for improved and efficient facility management 2.14 Monitor effectiveness of the MCHW cadre in safe motherhood	2.11 Ongoing 2.12 Initiated 2.13 Ongoing 2.14 Ongoing	support increases the chance of a successful planned + well managed exit. Inputs from the **Foundation for Change** has been given to five Phase Two hospitals. These facilities have begun selecting different "breakthrough" tasks (eg establishing an emergency fund and improving communication among different hospital units; increased commitment from the HSCs etc.) Fifty-three percent of the 382 MCHWs from nine NSMP-supported districts have completed the **MCHW refresher course**. A self-assessment tool was distributed to them, and 50 percent have responded. The information is now being analysed to explore the difference, if any, in performance of MCHW's who have received enabling environment support and those who have not. Findings will contribute to the development of Nepal's skilled attendance pilot programme (see output 1), initially by informing the strategy development process of district health teams.

Output	Major Activities	Status	Comments
Output 3: The social context for, and access to, midwifery and obstetric services within NSMP-supported districts is improved	3.1 Undertake NSMP Phase Two needs assessment 3.2 Develop and undertake a participatory planning and dissemination process 3.3 Establish/engage with district-level fora for safe motherhood	3.1 Completed 3.2 Completed VDC level 3.3 For a establish-ed and interaction ongoing	NSMP partners have incorporated a variety of **participatory planning processes** into their work. The district SM for a, or **safe motherhood working groups (SMWGs)**, have been established in all nine NSMP supported districts. Except for Dailekh and Jumla (see below), the SMWGs are becoming more proactive and strategic. Achievements include:- • effective collaboration among members • continually increasing the profile of safe motherhood within districts (demonstrated by increasing interest in membership) • increased level of commitment and implementation by members Recent new involvement includes active programming by District Education Offices, Women's Development Offices, District Development Committees, and Municipal Offices. Due to security reasons **NSMP withdrew district-based staff** from Jumla and Dailekh between January and May 02. The districts were supported by a long distance management arrangement from Surkhet. These SMWGs are therefore less developed than those of the other districts. In this period, the seven active SMWGs developed and implemented their **second six-monthly safe motherhood plan**, with technical and financial support from NSMP.

Output	Major Activities	Status	Comments
	3.4 Facilitate development of districts' SM strategy/approach 3.5 Undertake advocacy and capacity-building with partners (government and I/NGO) and communities 3.6 Social mobilisation	3.4 Ongoing 3.5 Ongoing 3.6 Ongoing	Safe motherhood concerns have now been included in the DDC's **seven-year strategic plans** in six districts. Two districts are in the process of gaining inclusion for these concerns. **The number of working partnerships** has increased to 42 active partnerships at present with government and non-governmental organisations. MoUs have been signed with 21 partners for intense SM input in selected working VDCs or Municipalities. Partners' implementation is well underway in all districts except Dailekh (due to the security situation). To date, NSMP's partnership work covers a total of 119 VDCs out of 470, and five out of 8 municipalities ie a coverage of approximately 27 % of the population. NSMP provides **continuous capacity** building inputs to partners' district and field level staff. This includes training, orientation processes, skills building, coaching, management training etc. To date, approximately **400 emergency funds** have been established and are functioning. About 100 groups are currently initiating **transport schemes**. Partnerships with the DPHO, specifically to support the creation of and to sustain an **enabling environment for trained MCHWs,** now exist in seven districts and are at varying degrees of implementation. Based on the **draft National Safe Motherhood IEC Strategy,** eight districts (all except Dailekh) have developed district-specific IEC implementation plans linked to the SMWG's six monthly plans. These plans include **behaviour change communications (BCC)**

Output	Major Activities	Status	Comments
	3.7 Facilitate full implementation of district approach (e.g. transport schemes, emergency funds, IEC, group formation)	3.7. Ongoing	activities. Examples of district level SM BCC activities include: • Sixteen groups trained in performing arts, using theatre skills to disseminate SM and other health messages in culturally appropriate manner • Integration of danger sign awareness through counselling, street dramas and puppet shows at the ANC/PNC clinics • Publication of newsletters on safe motherhood, articles in national and local newspapers • Integration of SM messages into non-formal education classes covering one entire district • Initiation of regional radio programming to publicise SM Seven districts included SM events for International Women's Day, combining the national level theme regarding good nutrition for pregnant and post-partum women and the promotion of family responsibility at this time. In all districts except Jumla and Dailekh, national and local level events are celebrated jointly with a range of stakeholders, requiring joint planning, implementation and resource sharing thus maximising the impact of a district-wide approach. The **impact of insecurity** has affected progress to date and the degree to which planned activities have taken place. Although this differs form district to district, the lack of security prevents partners and NSMP staff from travelling to certain areas. In districts that are particularly insecure, the project has adapted new ways of working and shifted relative weighting between activities for example, increased its work in municipal areas, incorporating SM issues into non-formal education programmes, supporting the broadcasting of a safe motherhood regional radio programmes. Four SMWGs initiated **district strategy reviews** to refine and

Output	Major Activities	Status	Comments
	3.8 Regular reviews of strategy/approach	3.8. Initiated	ensure the appropriateness of their six-monthly plans. Three other SMWGs and their implementing partners came together to **review past activities** and formulate their six-monthly plans (in the past, plans were prepared independently and submitted to the SMWG for approval.) This process was found to be very useful for all concerned. Six out of nine district SMWGs have now established their own increasing access **monitoring system through support from NSMP.** The district's monitoring systems are an integral part of the IA monitoring framework and their establishment has allowed the framework to be finalised. Incorporated in that system is the **key informant monitoring (KIM) tool** (to monitor progress in creating an enabling environment, from the women of RH age's perspective) which has now been implemented in two VDCs of five districts. The process was facilitated by HICODEF (a local NGO), who had originally piloted the tool.

APPENDIX 1: PROGRAMMATIC RESPONSE TO WORKING IN POLITICALLY INSECURE ENVIRONMENTS

This document was issued in May 2002 in response to a worsening security situation and its actual and potential impact on project activities.

BACKGROUND

NSMP operates a duel approach to ensuring that the Project Purpose of *increased utilisation of essential obstetric care* is met: firstly, the **Service Provision** component operates in health facilities to enhance their quality of service. The component is sited primarily in designated district hospitals and, to a lesser extent, in Primary Health Care Centres (PHCCs). Secondly, the **Increasing Access** component operates to identify and challenge the barriers to accessing care by supporting district level safe motherhood forums in addressing their local access needs.

Since November 2001, the rising insecurity within Nepal has engendered more regular reviews of project progress, and has forced the project team to re-evaluate some of the planned activities now at risk due to the project's inability to work in certain geographical areas. These are set out below, together with the alternative strategies proposed. It will also be seen that the impact of insecurity has been much greater on the Increasing Access component than for Service Provision.

1. Quantification of Insurgency Impact on NSMP's District Level Operations

An approximated level of negative impact on increasing access activities is shown in Table 1 below. It covers the period October 2001 to April 2002 and is calculated on the proportion of planned activities not undertaken during the period by the project or the project partners for reasons of increased insecurity. The majority of activities that went ahead as planned were those based in municipal areas. This does not take into account the negative effect this has on general programme planning.

Table 1: Approximated % of planned activities *not* undertaken due to insecurity, by district

District	Percentage Negative Effect
Dailekh	Due to insecurity no plans made[1]
Jumla	90-95%
Myagdi	50-60%
Surkhet	40%
Baglung	30%
Parbat	20%
Kailali	40%
Rupendehi	0%
Nawalparasi	0%

2. Ways in Which Insecurity Negatively Affects Programmed Activities

Service Provision Component

- HMGN facility staff are largely in place but are de-motivated and distracted, making it difficult for NSMP to support long term planning
- Only 3 of the 5 PHCCs are accessible, making support patchy and insufficient for sustained change. 2 PHCCs are in remote, rural areas of mid-hill districts, and are heavily affected by the insurgency

Increasing Access Component

- Compromised (to varying degrees) partner's ability and interest in operating planned safe motherhood work

[1] Although 1 local women's network is partnering NSMP in working in 6 VDCs.

- An increasing reluctance amongst villagers and VDCs to host outsiders or attend group gatherings has resulted in curtailing of activities
- Living with a degree of insecurity impacts on staff and partners morale and motivation
- The Maoists have established some form of local government at VDC level in most NSMP districts during the last six months and this uncertainty of local governance creates an unstable state in which to work, especially in the more remote districts
- HMGN public health staff are increasingly unwilling to visit interior areas of the districts thus impeding project work. This also results in the weakening of the health sector generally
- In the most heavily affected districts, Dailekh and Jumla, even municipality-based activities have been affected

3. Responding to an Increasingly Insecure Working Environment

Phase Two strategies are based on three years experience, with a comprehensive needs assessment, analysis and strategic design. The strategies developed are deemed to be the most effective means of meeting the project's purpose. However they were designed prior to the escalation of violence, which has severely impacted on their effectiveness.

Through its ongoing evaluation of the ongoing situation within Nepal, NSMP is convinced that its purpose *will* be impacted upon by the current level of insecurity. Over the last 18 months, NSMP has been actively responding to the changing context by adapting strategies to ensure that the project continues to contribute to its purpose, without exposing project staff to unreasonable risk. The revised *ways of working* detailed in this paper respond to this challenge and although some strategies are new, this is represented to a much greater extent rather by a change in weighting in planned inputs. However, it is important to make clear that this change in emphasis to the project's ways of working may *not have the same results* as those originally planned for Phase Two.

Although NSMP remains committed to its nine priority districts, NSMP's currently compromised ability to deliver in all of these districts at this time is resulting in a significant under utilisation of resources – both financial and human. NSMP proposes to redeploy these resources to other appropriate areas of work whilst ensuring that any new commitments will not compromise the project's ability to re-engage fully in affected districts, whenever the situation allows for this within the project's lifetime.

4. Revised Weighting of Component Activities

<u>Service Provision</u>

4.1 Support to Bheri Zonal Hospital, Banke District (not currently a NSMP supported district)

Support to Bheri Zonal hospital can be provided in response to NSMP's policy of redeploying under-utilised staff and anticipated under spend of the service provision budget (Output 2).

<u>Rationale</u>: adding support to this facility was determined by its service as an important referral hospital for two of NSMP's remoter districts. Strengthening its ability to respond appropriately as a referral unit will benefit the communities of NSMP supported districts, when the previously planned project inputs are constrained due to security.

The hospital staff have expressed a genuine willingness to enhance the quality of the care they provide. NSMP propose to provide "software" inputs that will enhance the quality of care available through support to the areas of human resource development, appropriate equipment provision, and management support. Additionally, this will supplement other inputs as GTZ is currently in the process of planning the construction of a maternity unit in the hospital.

4.2 Support to Bharaputur Districts hospitals

Rationale: Support to Bharaputur hospital is proposed in response to NSMP's policy of redeploying under-utilised staff. In terms of funding for this, half will be provided from the (anticipated under-utilisation of) service provision budget (Output 2).

Support will be provided in the same manner as described above.

Increasing Access

4.3 Further efforts to build referral links

To complement support to Bheri Zonal hospital (4.1) support shall be provided to improve referral links from the marginalised districts to Bheri Zonal hospital, building upon the inputs above. This also complements work already underway to strengthen the link from Jumla to both Surkhet district and Bheri Zonal hospitals, and from Dailekh to Surkhet district hospital.

This intervention will involve establishing subsidised transport systems and facility-based funds, as well as improving co-ordination and communication between the hospitals. It will involve working with a variety of stakeholders, including the police and the private sector - in particular the airlines and other transport companies and unions – and it is expected that this may also motivate political and other leaders to support the schemes and promote the services within their area. Utilisation of radio and other media inputs will support this intervention (see below).

Whilst the work will initially focus on Jumla and Dailekh districts, it is likely to also positively impact upon other marginalised mid-west districts.

4.4 Greater support to the utilisation of the media to profile the safe motherhood agenda

Radio
There are now a number of local FM radio stations functioning across the country in addition to the national Radio Nepal Regional[2] and radio listenership continues to increase. USAID's MNH and UNICEF are both interested in moving into radio drama production to disseminate safe motherhood messages, and discussions are currently underway at national level to explore the ways of integrating this work into the national Safe Motherhood IEC strategy. Productions aired will be utilised as the core of a campaign structure, supplemented by other activities. NHEICC/MNH have developed some prototyped spots and dramas, targeting mothers-in-law and husbands, which can be localised and translated.

Radio can be a powerful medium where it is dovetailed with other interventions which maximise discussion and localisation (for example, community group leaders may be supported to facilitate small group discussion and consideration of the issues raised). Local radio also allows for the promotion of newly upgraded health facilities and details of how care may be accessed. In addition, communities and providers can be involved in productions as can local groups, trained for street drama activities.

This initiative has already started in Baglung and services at Baglung and Pokhara hospitals have already been highlighted. Surkhet and Rupendehi safe motherhood forums are also interested in utilising this medium and various partners have expressed an interest in cost sharing. It is anticipated that lesson learning may be shared between the districts.

Newsletters
This intervention has already been initiated in Surkhet district where the first issue targeting community leaders and other influential has been developed and circulated. Production was a joint effort between the DDC, NSMP and SAC, a local NGO. Baglung district is now interested in adapting and localising the intervention for their own use and area.

[2] Coverage: Regional Radio, based in Surkhet covers Surkhet, Jumla, Dailekh, Kailali, Dang and other nearby districts. There is also a FM radio station in Bhairahawa, which covers Rupandehi and Nawalparasi district and the Pokhara Regional Radio covers Baglung, Parbat, Myagdi, Kaski and nearby districts.

Newspapers
As safe motherhood and the legalisation of abortion gain national profiles, opportunities begin to arise for the involvement of local journalists in targeting local leaders and literate men through this medium.

Local cinemas and cable networks
Opportunity exists for the occasional use of local cinemas and cable networks to air prepared films or short discussion programmes to access the municipal community. This is particularly true in Jumla where these media are still original and of interest to the community. Local cable networks have previously been used by the project in four districts to access people within the municipalities and this area of support can be scaled up.

4.5 Greater support to the health sector in the promotion of safe motherhood

Greater use of hospitals for health promotion
During NSMP's first phase, training in use of puppets and other low resource communication methods were given to the hospital and DPHO staff in the three districts supported. The staff have used these skills during festivals and profiled events but low staffing levels restrict their use during work hours. In Baglung and Surkhet local NGOs with performing arts skills now also exist and many are currently prevented from undertaking their normal work due to insecurity. Opportunities therefore exist to fund them to use drama and other performing arts, as well as interpersonal communication, with out- and in-patients and their families within the hospital compound. A campaign structure similar to that of the child-to-child campaigns could be initiated, and FHD's Birth Preparedness Package could also be used following the completion of its pilot.

Further investment in the DPHO and greater use of the DPHO ink to peripheral health workers
Immunisation (routine and pulse programmes) and Family Planning Campaigns still continue despite insecurity and are always preceded by an orientation programme for the health workers. Greater use could be made of these orientation periods and other health worker review meetings for capacity building of DPHO staff and health workers, increasing their technical knowledge of safe motherhood and improving communication skills. As well as for immediate effect, this intervention may be employed as a longer-term investment.

4.6 Further work with other line ministries/sectors

Non-formal education
This initiative has already started in Surkhet district at the request of the District Education Office (DEO). DEOs have a network of non-formal education (NFE) classes, covering most VDCs and utilised mainly by women. The classes provide not only the skills to read and write, but also an opportunity for women to share and discuss their concerns and issues.

In Surkhet district, NSMP together with DHSP and one of NSMP's partner NGOs, is supporting the DEO to disseminate health messages through their 390 NFE groups, involving curriculum development and facilitator training inputs.

Whilst recognising that government run NFE classes are often poorly managed and didactic, their large reach and use of locally based facilitators make them a potentially sustainable channel with which to influence women within the community with safe motherhood messages. This may be further supported by co-ordination with radio programmes and other interventions. NSMP hopes to utilise the work in Surkhet as a 'pilot' and adapt it to other districts as appropriate. Baglung DEO has already shown interest in this.

Forestry (working with LFP)
Within Baglung, Myagdi and Parbat, LFP plan to train 30 animators in each district over the next three years. These volunteers will work in their own communities supporting the forest user groups. NSMP hopes to work with LFP and the DFO to integrate knowledge and understanding of safe motherhood into their training.

4.7 Greater inputs to municipalities

A shift to municipalities has already started to take place with partners unable to implement regularly in many VDCs and a subsequent increase in attention to working areas closer to or within the municipalities. In addition this builds on the work initiated in Surkhet and with the Municipalities themselves. Met need for EOC is low, even within these areas, where women are less likely to be restricted from accessing the hospital due to a fear of travelling (although there is substantial anecdotal evidence of the impact on the curfews on night travel to hospitals even within the Municipalities resulting in maternal deaths).

4.8 Working with the private sector and utilising trade links

Efforts are currently being made to explore the possibility of using trading links between Surkhet and Dailekh as an opportunity to distribute supplies (such as clean home delivery kits) and information. The possibilities of working with local drug shop owners are also currently being investigated and ideas include the production of paper packets for medicines with safe motherhood messages.

All the work proposed above under the increasing access section of part 4 will be meet within the existing increasing access budget.

APPENDIX 2: HUMAN RESOURCES – NSMP'S CONTRIBUTION AT A STRATEGIC LEVEL

KEY ISSUES

As stated in the Ministry of Health's (MOH) 15 year Safe Motherhood Plan (Output 2, activity 12), in order to address maternal mortality reduction (MMR), Nepal requires the development and implementation of a comprehensive human resource strategy. This needs to cover:-

- the out-of-facility community care skilled attendants
- the number and skill levels of required per cadre of nurses
- the number and skill levels of required per cadres of doctors

This annex covers the current status of human resource issues relating to MMR and presents a discussion of the major strategic issues that the safe motherhood community is currently addressing in order to improve this. It begins with an overview of the status of midwifery in Nepal.

1. The Current Positioning of Professional Midwifery

In order to achieve its stated purpose of a sustained increase in the utilisation of quality maternal health services, the 15-year Safe Motherhood plan prioritises the development of EOC facilities, and in particular BEOC[1] (ratio of 6:1 BEOC/CEOC). By 2017, there will be 63 CEOC sites and BEOC in all district hospitals and 137 PHCCs across the country. This plan feeds into HMGN's tenth five-year development plan which also identifies the need to implement a strategy for midwifery[2] in order to actualise EOC availability.

1.1 The background to midwifery in Nepal

In 1976 the Institute of Medicine ran a two-year 'Bachelor in Midwifery' course. There were 24 graduates but it is not known how many are still practising or in what capacity.

In order to develop the capacity of in-country resources the MOH, with support from NSMP and in collaboration with UMN Tansen hospital, designed, piloted and have continuously supported a twelve-month Post-Basic Diploma in Midwifery course at UMNT. To date there have been 11 graduates[3] with a further 5 HMGN staff nurses currently under training. The Diploma course has now been approved by the MOH but accreditation in terms of defining the appropriate career/promotional aspects of this new cadre have yet to be finalised. In 2001, MOH and NSMP conducted an evaluation[4] of the graduates' performance. The findings demonstrated that the course equipped the midwives well in terms of knowledge and skills but it is the degree to which their working environment provides the support needed for their work that principally determines their ongoing level of performance. It is evident that the entire healthcare system needs to be strengthened in order for the midwives to fully utilise their skills.

NSMP was again central to the development of a second midwifery course - the six-week refresher course although, having completed this, graduates are not actually termed professional midwives. The course was developed and approved by MOH and NSMP and managed by the UMN/HMGN Patan hospital in 1998. The course was subsequently expanded and moved to Tansen hospital in 1999 where it has been running continuously since then. To date, 82 nurses from NSMP's supported districts have undertaken the course, funded by the project.

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[1] A survey of EOC availability revealed that the gap in EOC provision as assessed against the UN standards is 8 CEOC and very significantly 97 BEOC, thus establishing BEOC sites is more important than increasing CEOC sites (HMGN/UNICEF 2000).
[2] Professional midwives are defined as those staff nurses with additional postgraduate training (diploma level) in midwifery.
[3] 8 UMN nurses and 3 HMGN nurses.
[4] HMGN, NSMP 2001 Performance Evaluation of Graduates of the Post Basic Diploma Midwifery Course

In 2000-1 JHPIEPGO/MNH supported the UMN/HMGN Patan hospital to establish a training site for midwifery. This coincided with a review of the refresher course at Tansen, which in turn fed into the development of a MOH midwifery course (2001), aligned to the 1997 Reproductive Health protocols, for ANMs and staff nurses. Thus, the MOH course is now provided at Tansen and Patan hospitals and at 11 other NHTC approved training sites.

1.2 Strategic issues

A key question is the most appropriate strategic direction in which to scale up midwifery skills (which in Nepal include some BEOC skills). Should investment of scarce resources be deployed to a larger number of nursing staff through the refresher course (at an approximate cost of US$ 485/participant[5]) or should government prioritise resources to train a smaller number of - but more highly skilled - professional midwives (diploma level, at a cost of US$ 1,310/participant). The answer may lie in an appropriate ratio between the two.

To address this issue, as a consequence of the dissemination of the Diploma course evaluation results, the MOH formed a taskforce to develop a long-term sustainable midwifery strategy (this need is also stipulated in Output 2 of the 15 Year Safe Motherhood plan and in the National Safe Motherhood Training Strategy). This will consists of appraising and contrasting both midwifery courses in terms of both the range of skills acquired and the degree of sustained clinical skill, in order to assess the "added value" of one course over another, and then feeding the results in to the sustainable midwifery strategy.

NSMP has committed funding support to MOH for this initiative and is seeking partners to work with - WHO, Institute of Medicine and the (UK) Royal College of Midwives have all shown interest.

Whatever the outcome of the above issue, Nepal is in critical need of national training centres and trainers, there being currently no certified midwifery trainers available. The MOH therefore urgently needs to develop a strategy to scale up and institutionalise midwifery into HMGN teaching hospitals, as to obtain one professional midwife per PHC will, at the current rate of three graduates a year, take 60 years to achieve!

One key factor is the significant finding from the Diploma evaluation that training in itself does not result in skills being sustained. Midwives must have the back up of a supportive and functioning decentralised health care system and the active promotion of their role to their communities.

2. Addressing Out of Facility Skilled Attendance

Given that nearly 90% of Nepal's women deliver at home, that only 13% have a skilled attendant present and that less than 5% of the estimated met need for EOC is indeed met, then the availability of home-based midwifery and obstetric first aid - linked to quality EOC availability - is urgent.

Based on this assessment and emerging international evidence that midwifery linked to EOC *can* reduce maternal mortality, in 1999 the MOH decided to pilot a programme of community based skilled attendants by investing in the Maternal and Child Health Worker (MCHW) cadre. NSMP, UNFPA, and JHPIEGO assisted the MOH in this venture, with NSMP and JHPIEGO collaborating in developing a competency based curriculum and three district learning centres. Concurrently, UNFPA supported NHTC with scaling up a refresher course for MCHWs and providing them (with WHO support) with EOC kit boxes. In 2001, drawing from NSMP/JHPIEGO's and UNFPA/NHTC's experiences, a final MCHW refresher course was approved by the MOH. The course competency level is not that stipulated in the 1997 Reproductive Health protocols which are widely accepted now as too ambitious and need revising. To date over 33% (1048) of Nepal's 3123 employed MCHWs[6] have received the refresher course.

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[5] Based on costs at Patan and Tansen hospitals.
[6] 4,100 MCHWs have actually been trained (ie basic training)

In addition to supporting the development of the course NSMP has:-

- provided on-site technical support to three training centres
- provided EOC kits boxes to over 250 MCHWs (after contributing to FHD's revision of the EOC kit box contents)
- facilitated the DPHOs in the nine NSMP supported districts to hold workshops with MCHWs, together with the SHP in-charges and VDC chairmen in their receptive VDCs, with the purpose of advocating for a more enabling environment for the MCHWs

2.1 Strategic questions

Will MCHWs attain and retain a level of skill that will impact on maternal mortality? The skill level that the MCHWs are currently being trained to is not that which would enable them to be termed "skilled attendants" in international terms.

Relevant to this are four key issues:
i) The lack of consensus on whether MCHWs can attain the skill level currently being taught. This involves care to a reasonably sophisticated level given that their current basic training course is only for a three-month period.
ii) Given the weak health sector will MCHWs realistically receive the support they require?
iii) Will MCHWs be acceptable to rural communities (only 0.4% of deliveries in the previous 5 years were conducted by MCHWs)?
iv) Whilst home care midwifery linked to EOC is a proven strategy, in the absence of adequate EOC, will MCHWs alone make a difference?

In order to begin to address these key points, it is critical that this pilot programme is monitored, and NSMP has been advocating for this since 2001. The FHD has now established a MCHW taskforce and USAID and NSMP agreed to support the monitoring process. A concept paper was developed in mid 2002 and NSMP (through the services of UMN's Reproductive Health Advisor) commenced the first two stages[7] which will subsequently lead to the MCHW performance evaluation study, supported collaboratively by USAID and NSMP.

3. Expanding the Role of Nurses

Since 1997, the MOH has been expanding the role of nurses in EOC. The national Reproductive Health protocols detail the level of skill that a nurse - trained appropriately - can now deliver. Since 1999, 36 nurses have been trained and are performing post abortion care[8] to a competent standard. In addition, the midwifery courses discussed above have enabled nurses to perform EOC skills hitherto excluded from their mandate (such as vacuum extractions and management of retained placentas). NSMP's monitoring and substantive evaluation study[9], confirms that nurses are retaining these life saving skills when operating in a conducive environment. It is also encouraging to witness the commitment shown by nurses who, even in the absence of doctors, are striving to deliver all six functions of BEOC.[10]

A further development in the scope of nursing skills is in the area of anaesthesia. In 2000 FHD, NHTC, NSMP and INF undertook a pilot course for nurses in anaesthesia. In 2001 the course was assessed, revised and approved by the MOH. To date, 5 nurses and 2 AHWs have graduated from the six-month competency based anaesthetic assistant course. These nurses will work under the supervision of a MDGP or surgeon in district hospitals. Their performance will be closely monitored by all concerned.

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[7] A review of the available data and literature to date on the programme - including an evaluation of over 100 self-reported forms completed by MCHWs in NSMP supported districts.
[8] FHD 2001: An Assessment of the Quality of Post Abortion Care in Nepal - The Training and Service Provider Delivery Perspective
[9] HMGN, NSMP 2001 Performance Evaluation of Graduates of the Post Basic Diploma Midwifery Course
[10] Intravenous (I/V) and Intramuscular (I/M) antibiotics, I/V & I/M Oxytocics, I/V & I/M sedatives, manual removal of placenta, manual aspiration of retained placenta, assisted vaginal delivery (vacuum)

4. Supporting Doctors in their Contribution to EOC

In 1999, NSMP supported one MBBS doctor and one Bachelor of Ayurvedic Medicine and Surgery (BAMS) doctor to be trained in CEOC. However, training the MBBS doctors to this level was not found to be satisfactory for a range of policy related reasons. In 2000, the MOH and NSMP reassessed the situation and agreed that MDGPs were the critical and the most appropriate provider of CEOC given their skill levels, tendency towards district service and the fact that the MDGP programme is firmly established in Nepal. NSMP has been advocating for the promotion of more MDGPs and has provided four MDGP scholarships for HMGN MBBS doctors, although unfortunately in 2002 no doctor has yet passed the entrance exam.

Clearly MBBS doctors have the potential to save lives. However, many doctors are under confident and not sufficiently competent in obstetric care. Thus in 2001, MOH, NHTC and NSMP (through the technical services of UMN's RH advisor) agreed to instigate a BEOC course for MBBS and BAMS doctors. The Maternity hospital was receptive to the technical and management support provided by the project and is to be commended for their commitment to this venture. The course has been piloted in three batches with the curriculum soon be finalised. By September 2002, nine doctors will have undertaken the course.

APPENDIX 3: COURSES NSMP HAS BEEN INSTRUMENTAL IN DEVELOPING AND SUPPORTING

SN	Training Programmes	Commencement Dates and Approach	NSMP's Role	Approximate Numbers of Staff Trained	Comments/ Issues
1.	**Infection Prevention (IP)** Clinical staff 5 days; non-clinical 7 days, follow-up 2 days each quarter for one year	• Piloted in 1998 • Final programme commenced from 2000 • Approach: on-site training with entire hospital team	• NSMP contracted training to Nepal Fertility Care Centre (NFCC) and provided technical input to the development of the training strategy. • NSMP funds the total cost for training (both the NFCC's fee and participants' costs). • NSMP ensures the availability of supplies for IP 18 months post the training programme, after which hospital support committees (HSC) provide supplies. • At the district level, HRDOs monitor the quality of training, encourage the team to monitor changes, and provide onsite technical and management support.	216 staff from phase (three) districts 260 staff from Phase Two (six) districts	The challenge now is to integrate IP training into NHTC's programme
2.	**Essential Newborn Care** Initial training 4 days, follow-up 2 days biannually for one year	• Piloted in 1998 • Final programme commenced from 2000 • Approach: on-site training with entire clinical team	• NSMP contracted training to MIRA, provided technical input in developing the training strategy, fund and all necessary neonatal equipment and supplies. • NSMP funds the total cost for training (both MIRA'a fee and participants' costs). • At the district level, HRDOs monitor the quality of training, encourage the onsite team to monitor changes in care, and provide onsite technical or management support.	163 staff from Phase One districts 120 staff from Phase Two districts	As above The challenge now is to integrate newborn care into NHTC's programme
3.	**MCHW Refresher Course** Training of 45 days without any follow-up	• Piloted in 2000 • Finalised in 2002 • Approach: Competency-based training in designated training sites.	• NSMP provided technical support to NHTC to design the course, and supported the cost of the training programme in NSMP districts for one year. • NSMP actively supported MoH's approval process. • At the district level, HRDOs ensure the quality of the training, encourage the PHN or DPHO supervisors to provide onsite support to the MCHWs, and work with the SHP committee members on mechanisms to provide an enabling environment for MCHWs.	National wide approximately 1,000 MCHWs trained (out of 3123). NSMP funded the training cost for 35 MCHWs from Phase One districts	Monitoring and onsite supervision support to the MCHWs is not prioritised by district health management teams. The challenge is to find ways for the team to initiate an effective monitoring system
4.	**Midwifery Refresher**	• Piloted in 1998 • Finalised in 2000 • Approach: Competency-	• NSMP contracted training to Patan and Tansen UMN hospitals, provided technical support to the NHTC to pilot, design, and finalise the midwifery refresher-training curriculum.	40 nurses from Phase One districts 42 nurses from Phase	The performance of graduates requires evaluating

SN	Training Programmes	Commencement Dates and Approach	NSMP's Role	Approximate Numbers of Staff Trained	Comments/ Issues
	For ANMs and staff nurses 6 weeks course	based training in designated • Training NSMP support Patan and Tansen UMN training hospitals	• NSMP funds the total cost for training (both the institutional fee and participants costs) for NSMP staff from supported districts. • At the district level, HRDOs encourage the onsite team to monitor changes in midwifery care and provide technical and management support for staff.	Two districts	See Appendix 2 regarding strategic issues related to midwifery
5.	**BEOC In-Service** MBBS/ MDGP Doctors 45 days -includes one week of post abortion care	• Piloted in 2002 • Approach: Competency-based training at Maternity Hospital	• NSMP contracted training to maternity hospital, provided technical support to NHTC (both direct and by contracting the services of the UMN RH Advisor) to design, pilot, and implement the course. • NSMP funds the total cost for training (both the institutional fee and participants' costs) • At the district level, HRDOs encourage the onsite team to monitor changes in BEOC care and provides technical and management support to the doctors.	2 medical doctors (MBBS) from Phase One districts 7 medical doctors (MBBS) from Phase Two districts	Before finalising the BEOC curriculum, the performance of BEOC-trained doctors needs to be evaluated
6.	**Foundation For Change (FFC) programme** 10 days over a one-year period	• Piloted in 1998 • Finalised in 1999 • Revised in 2001 • Approach: (since 2001) managed in two teams 1. Hospital staff and HSC[1] 2. district stakeholders-VDC2[2] team and SMWG3[3]	• NSMP contracted training to Pragya management team. • NSMP influenced the structure and content of the course for use in Phase Two. • NSMP funds the total cost for training (both the Pragya's fee and participants' costs) • At the district level, HRDOs monitor the quality of training and support health facility staff in implementing innovations that bring about change.	246 from Phase One districts (hospital and HSC team) 1000 from Phase One districts (VDC team) 200 hospital & HSC team members, and 150 SMWG members in Phase Two districts	Anecdotal evidence shows that FFC makes a difference: (for example HSCs now proactively support the cost of essential drugs, supplies, HR, and the cost of treatment for needy women FFC programme shall be evaluated in second half of 2002
7.	**Equipment User Training** 2 days	• Piloted in 1998 • Finalised in 1999 • Approach: on-site training of the entire hospital team	• NSMP contracted training to INF/TAP • NSMP funds the total cost for training (both INF's fee and participants' costs) • At the district level, HRDOs provide follow up support	200 staff from Phase One districts 200 staff from Phase Two districts	The challenge is to integrate training for use of equipment into MoH

[1] HSC-hospital support committee members
[2] VDC-village development team members are (VDC committee, volunteers & Mother's group)
[3] SMWG-safe motherhood working group members

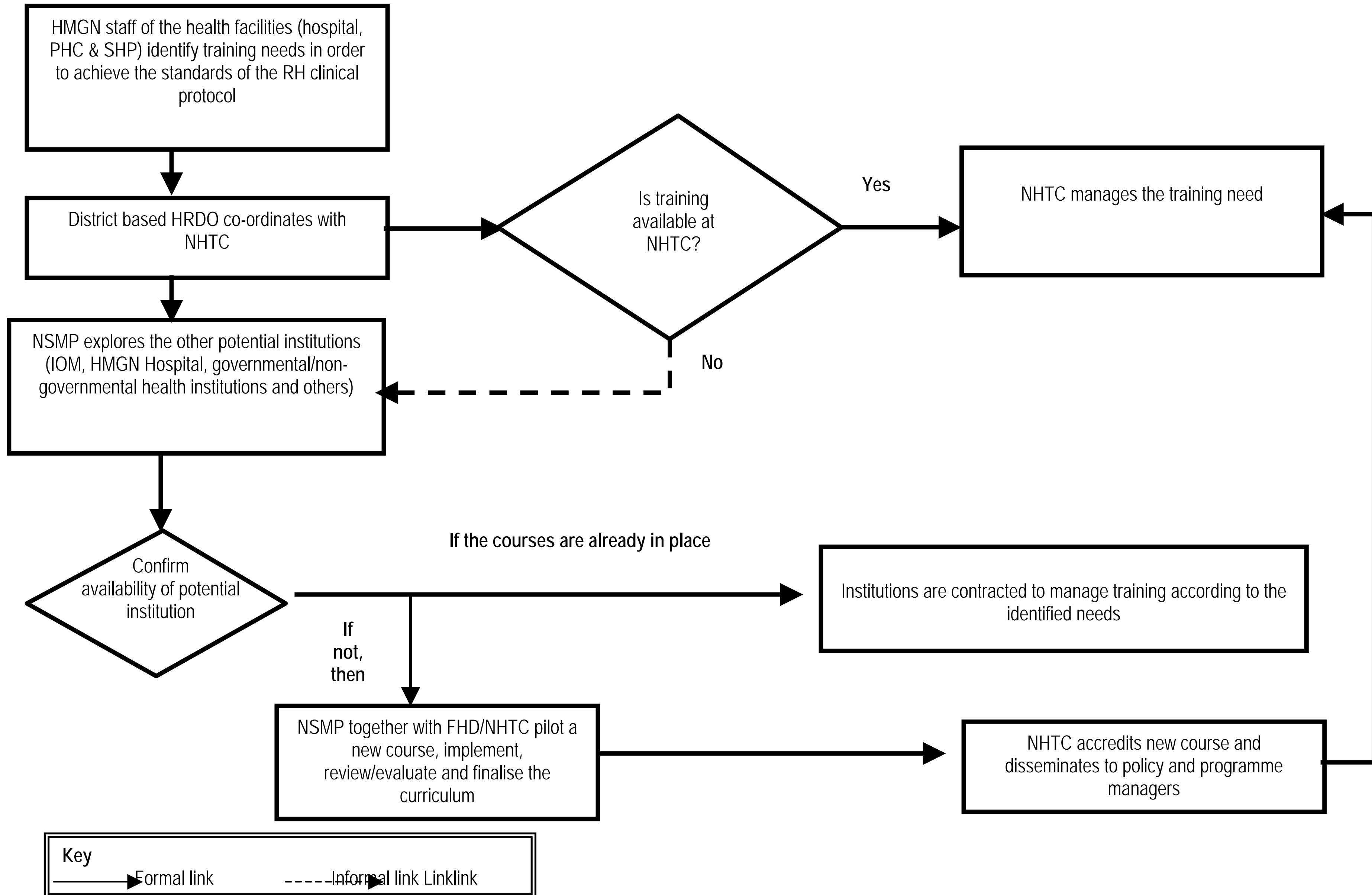
SN	Training Programmes	Commencement Dates and Approach	NSMP's Role	Approximate Numbers of Staff Trained	Comments/ Issues
8.	**Maintenance training** 3 weeks	• Adopted INF six weeks course package in 1998 • Approach: hands on training at INF workshop in Pokhara	• NSMP contracted training to INF/TAP • NSMP funds the total cost for training (both INF's fee and participants' costs) • At the district level, HRDO provides follow up support	8 support staff from Phase One districts	As above
9.	**Anaesthetic Assistant (AA) Training** 6 months	• Piloted in 2000 • Finalised in 2001 • Approach: Competency-based at Patan Hospital	• NSMP contracted training to Patan hospital and provided some technical input to the curriculum. • NSMP facilitated MOU between Dr. Paul Foster of INF and FHD for the service of anaesthetic assistant training. He is now the national AA Coordinator. • NSMP funds the total cost for training (both the institutional fee and participants' costs). • NSMP is actively involved in dissemination of learning from the AA programme and facilitated the approval process for the six-month AA training course at MoH.	7 (nurses and paramedics) from four CEOC sites of both Phase One and Phase Two districts	A separate cadre of anaesthetic assistants needs to be recognised by the MoH
10.	**Post-Basic Diploma Course in Midwifery** 1 year Scholarship	• Piloted in 1997 • Finalised in 2000 Approach: competency based training at Tansen UMN hospital	• NSMP contributed technical support in the development of the course and provided management support in establishing a midwifery training site in Tansen UMN hospital. • NSMP funds the total cost for this course (both the institutional fee and participants' costs). • At the district level, HRDOs monitor graduate performance and support them. • NSMP developed a scholarship strategy and drew up a MoU between itself, FHD, HMIDD, and the DoHS in 2001.	3 staff nurses completed and 3 are currently taking this course	
11.	**Proficiency Certificate in Nursing** 3 years	• Scholarship award commenced in 2000	• NSMP has made available six scholarships to HMIDD for ANMs, yet to be awarded.	1 ANM from Phase One is currently taking this course	According to MoH the entrance exam is a barrier for staff working in remote areas

SN	Training Programmes	Commencement Dates and Approach	NSMP's Role	Approximate Numbers of Staff Trained	Comments/ Issues
12.	**Bachelor in Nursing** 2 years	• Scholarship award commenced in 2000	• NSMP has awarded seven scholarships to date.	1 staff nurse completed and 6 are currently taking this course	
13.	**MDGP post graduate degree** 3 years	• Scholarship award commenced in 2002	• NSMP has made available four scholarships to HMIDD for medical officers, yet to be awarded.	None	These scholarships have not been awarded as no MoH candidate passed the entrance exam this year
14.	**ANM course** 18 months	• Scholarship award commenced in 1999	• NSMP awarded three scholarships for ANM course to date.	3 ANMs had completed this course	

KEY TO ACRONYMS

AA; Anaesthetic Assistants	HRDO: Human Resource Dev. Officer	PHN: Public Health Nurse
ANM: Auxiliary Nurse Midwives	HSC: Hospital Support Committee members	SHP: Sub Health Post
DoHS: Dept of Health Services	INF: International Nepal Fellowship	SMWG: Safe Motherhood Working Group members
DPHO: District Public Health Officer	MCHW: Mother Child Health Worker	SN: Staff Nurse
FFC: Foundation for Change	NFCC: Nepal Fertility Care Centre	TAP: Technical Assistant Programme
MD: Management Division	NHTC: Nepal Health Training Centre	VDC: Village Development team members are VDC committees, volunteers & Mothers' Group members

APPENDIX 4: FLOW CHART DEMONSTRATING TRAINING PROCESS



APPENDIX 5: NSMP'S PHYSICAL FACILITY IMPROVEMENT PROCESS FOR C/BEOC

1. Background

During the project planning process, it was determined that in order for healthcare sites to provide full essential obstetric care (EOC), physical infrastructure improvements were also needed alongside capacity building of service providers. Although needs assessments of the three Phase One project hospitals were performed during the project's inception phase, these were by necessity, rather narrow in scope. When detailed assessments of the physical infrastructure were made at a later date, it became apparent that more improvements were needed than had originally been thought. Key issues were:

- The amount of space was found to be inadequate, resulting in overcrowding, impediments to staff and client movement, and lack of privacy for women clients.
- The physical spaces were laid out without thought to unit functions. Movement did not flow logically from labour areas, through delivery rooms, to postnatal spaces. Hygiene issues became apparent—people entered and exited through the same door without infection prevention precautions, and clinical waste travelled through the same course as clean equipment.
- The conditions at some facilities were potentially dangerous and upgrading would require hospital-wide work. There were structural defects that could have major consequences in event of an earthquake (Nepal is in a major seismic zone). Dampness and deterioration caused by water leaks from improperly designed or poorly maintained roofs and plumbing was widespread. The existing electrical systems posed threats to human life, water distribution systems were poor, and systems required for the disposal of biomedical waste were nonexistent.
- Wall and floor finishes could not be cleaned properly with strong disinfectants such as chlorine

2. Policies and Approaches

NSMP has adopted an integrated approach to all its operations, interventions to the improvement of physical facilities were deemed necessary. NSMP aimed to upgrade physical facilities so that they are structurally sound, sensibly laid out, easily cleaned, well lit and reasonably secure against vermin.

2.1. Approach to improvement of physical facilities

Laid out in the table below, are the variety of approaches NSMP considered for improvements to the condition of physical facilities. A combination of refurbishment and new construction was decided upon.

Table 1: Approaches to the Improvement of Physical Facilities

Approaches	Feasible/ Not Feasible	Reasons
Refurbishment only	NF	Refurbishing existing facilities would not bring about the desired results as there was not enough space to re-create functional layouts for quality EOC.
All new construction	NF	Although the functioning of departments would have been excellent using this approach, it would have far exceeded the Project's budget. As one consideration had been to provide MoH with an affordable model for possible replication, new construction would not have been appropriate. Further, an overemphasis on obstetric care could have upset the balance of hospital operation to the detriment of other services, and therefore would have provided very little input into general hospital upgrading.
Western building approach	NF	Using imported materials with direct western involvement in the construction could certainly have produced high quality

		building work, but costs would have increased drastically. In addition there was the question of whether a facility built with western technology could be adequately and properly maintained in the Nepali context. Further, this option would not have produced the desired cost-affordable model for replication.
Combination of refurbishment and new construction	F	A degree of new work together with building alterations and/or renovations in existing adjoining buildings seemed to be the most appropriate approach.

2.2. Combination of refurbishment and new construction

The "combination" approach involved complex alterations and/or renovations. A high standard of work and a good quality works supervisor were felt necessary to ensure quality construction, to increase durability, and to lessen future maintenance (building maintenance takes very low priority in Nepal, and the recurrent budget for such activities is nearly nonexistent). Local materials and construction techniques were used to ensure the work was appropriate to the local context in terms of style, maintenance and cost.

This approach made it possible to incorporate desirable features into the design, such as logical layouts for inter-departmental activities, clean-dirty flow patterns, and functional space relationships. Hospital-wide benefits include the installation and upgrading of electrical distribution systems, water supply systems, and waste disposal systems.

2.3. Participatory process of consultation

Extensive consultation took place between the Project staff and site staff/users. All cadres were given the opportunity to discuss and input into the design. Initially, the cleaning and ancillary staff were rather surprised to be consulted on building construction as this was a new experience for them. However, they quickly became enthusiastic participants although this participatory process was very time-consuming, it produced very dramatic results in the high degree of pride and site ownership that resulted. These factors are contributing to the extra effort staff spend to maintain the high level of quality provided.

3. Processes

The processes used to manage whole physical facility upgrading work were divided into three stages: needs assessment, design & acceptance, and construction management. Tables 2a, 2b and 2c outline these processes as followed in the project's Phases One and Two.

Table 2a: Needs Assessment Process

Phase One	Phase Two	Remarks
1. Determined appropriate nature, scale, and quality of obstetric accommodation. 2. Set the minimum level of operation and facilities required. 3. Involved both visual and measured surveys. 4. Discussed and consulted with all concerned authorities.	1. Same processes applied except for step two (determining and setting minimal levels), which had already been agreed during the Phase One assessment.	WHO Safe Motherhood Practical Guidelines were used as the basis for the minimum level of facility upgrade required for effective service. Next, consideration was given to providing facilities that were appropriate in the local context and to determining the appropriate nature, scale, and quality of obstetric accommodations to be provided. These were compared with the standards of existing obstetric facilities through thorough needs assessment involving both visual and measured (engineering) surveys. Extensive discussions and consultations with all parties concerned formed part of the assessment. Experiences gained in Phase One were utilised in Phase Two which made this process faster.

Table 2b: Design and Acceptance Process

Phase One	Phase Two	Remarks
1. The same architectural consultant who did the assessment provided the building design. 2. Proposals were discussed at district level workshops, and general agreements reached. 3. Agreed proposals were presented and discussed at a central level workshop. 4. Designs and drawings were developed based on agreed proposals. 5. The Department of Health Services (DoHS) approved the designs.	1. The Phase One architect provided the building design. 2. Proposals were discussed with hospital support committees (HSC) and healthcare providers. 3. Proposals were revised and designs developed based on discussions. 4. Designs were presented to and discussed with HSCs and hospital staff, and approval obtained. 5. Designs and costs were discussed with FHD and were submitted for approval to HIMDD along with estimated costs. 6. The proposed designs and estimated costs were approved by DoHS.	The same architect was selected for both Phases because he had: • Experience of the extent of the work due to of his involvement in the assessment process. • An excellent reputation for achieving high-quality work, completion on time and within budget. • Great experience, both in UK and in Nepal, of renovating, repairing and improving existing buildings. • Produced extensive and comprehensive drawings and specifications, thereby reducing the possible add-on costs by claiming work had been missed in the original plans. • Produced highly informative progress reports that enabled all HIMDD, NSMP and hospital staff to be kept informed of how the work was proceeding.

Table 2c: Construction Management Process

Phase One	Phase Two	Remarks/Progress to date
1. The same architectural consultant who provided the assessment, design, and costing was used for construction management. 2. Contracts for Surkhet and Kailali were awarded through direct negotiation on fixed-cost basis. 3. The contract for Baglung was awarded through closed	1. NSMP consulted with DFID and FHD about using the assessment and design consultant for construction management. 2. NSMP notified FHD and DFID of preliminary cost estimates for construction and consultancy. 3. DFID and FHD agreed to the use of the assessment and	**Phase One** • Due to the remoteness of the districts and low priced/high complexity of the work, Kailali and Surkhet construction contracts were negotiated with a single contractor. Baglung, being near to Pokhara/ Kathmandu was the most accessible district and therefore a competitive bidding process was used. **Phase Two** • The construction process in Phase Two was even more participatory and transparent than in Phase One. In Phase One NSMP informed FHD and HIMDD of construction costs only after they were incurred and did not inform on the consultancy fees. In Phase Two, FHD and HIMDD were provided with detailed cost

competitive bidding. 4. The consultant carried out all processes (such as selection of contractors, site supervision and certifying the payments).	design consultant for construction management. 4. The consultant was not allowed to independently select contractors. 5. Contracts for construction work at four group-one hospitals were awarded through closed competitive bidding. • The consultant prepared the bidding documents. • NSMP distributed the documents to the bidders. • Bids were opened publicly. • The consultant evaluated the bids and made recommendations for award of contracts. • Final selections were made by NSMP, FHD and DFID jointly. 6. In agreement with DFID and FHD, the construction contract for Jumla was awarded through direct negotiation on a fixed-cost basis.	estimates early in the approval stage. • Due to the conflict situation, NSMP separated the six hospital sites into two groups, the first group managed being Rupendehi, Nawalparasi, Myagdi and Parbat, as they were least affected by conflict. • Dailekh and Jumla were placed in the second group, to be completed as the security situation allows. • The local communities in Dailekh and Jumla want to see construction underway. The continued delays are having a negative impact on the way the NSMP is viewed in these districts and unless work begins soon, there will be little support in future. • By March 2002, it was felt that the conflict was having less impact on the NSMP in Jumla than in Dailekh and as it is relatively easy to fly directly into Jumla from Nepalgunj, DFID and NSMP have agreed that despite security problems there is still value in proceeding with construction and decided to proceed before the monsoon. • Managing complex work and achieving high quality in a remote place like Jumla is difficult, especially in the existing conflict situation. The architect is unable to provide full-site supervision, and therefore a reliable contractor with previous experience in performing high quality work in remote locations was needed hence the award of the contract on a fixed cost basis rather than open tender.

4. Phase One Design and Construction Results

(Phase Two results are pending as construction is current and ongoing)

NSMP feels strongly that the construction process and choice of consultant have been fully justified by the construction results. Key results have included:

- The close consultation with hospital staff throughout design and construction phases has proved valuable as staff feel a real ownership of the new and renovated spaces and are motivated to work well and to maintain them.
- Hospital staff were appreciative of the opportunity to recommend modification to the architect during construction. The architect was flexible and the modifications should improve working conditions at a later date.
- The renovated areas are laid out logically with good flow patterns. Wall and floor surfaces are easily cleanable and the electrics are now safe.
- NSMP conclude that the construction component of the project has provided excellent value for money. The facilities are functioning well, users are satisfied, and recurring maintenance costs are kept to a minimum.

5. Overall Lessons Learned

The experience gained during Phase One provided several considerations which needed to be addressed, not only for Phase Two work but also in the upgrading of any existing HMGN hospitals in the future. All the concerns described in the Background section of this report are common to most existing HMGN hospitals and this was reinforced by the findings in the Phase Two needs assessment. The photographs in this report illustrate some of the existing conditions.
Practical experience gained by the NSMP staff is highly valued. Staff are now being used as resource persons by others working in the area of safe motherhood (e.g. UNICEF and GTZ).

Table 3 tabulates the major Phase One lessons that have been replicated or further modified during Phase Two.

Table 3: Lessons Learned from NSMP's Infrastructural Improvements Process

1.	Discussions with all hospital personnel (committee members, medical officers, nursing staff, and sweepers) provided practical suggestions. By incorporating these suggestions in to designs, staff morale is high and a sense of ownership has developed.
2.	In Phase One, designs were presented to central and district level authorities for approval after they had been completed. In Phase Two, district level stakeholders contributed to the development of designs. This participatory approach resulted in positive design modifications. Cost estimates and final design proposals were submitted to the Department of Health Services for approval and once approved, were directly passed back to district level and authorised to NSMP for implementation.
3.	Whereas construction management processes were not shared with the then ODA (DFID) and HMGN in Phase One, in Phase Two DFID Nepal and FHD have been involved in the decision making process from the beginning - from the hiring of the consultant to selecting the construction contractors. This has had a positive impact on NSMP as increased transparency at each of stage has resulted in a quicker response time, and counterparts are more aware of the project's good practices.
4.	Intra-hospital flow patterns are important in maintaining good hospital hygiene and infection prevention practices. Designs for modifications of five Phase Two hospitals reflect these "clean-in dirty-out" flow patterns.
5.	Mosaic finishes (marble chips in white cement matrix) are highly recommended on floors and lower-wall surfaces (from floor level up to 135 cm). Non-porous, free of joints, hard, and easy to keep clean with strong disinfectant chemicals, wall surfaces built. Electrical switches should be fixed above the mosaic demarcation so that cleaners can scrub walls safely and without interfering with electrical equipment.
6.	In Phase One NSMP addressed the need for adequate, safe and 24-hour uninterrupted supplies of water and electricity for obstetric care. An emergency lighting system was piloted which employed car headlights and a battery pack that was mounted on the ceiling and re-charged automatically. The design provided good lighting although it was expensive and complicated to build. Further, maintenance was a problem and the life span of the batteries was limited. In Phase Two, the Project is exploring alternative low-cost lighting.
7.	During Phase One, an underground chamber (with a lidded entrance chute) was constructed to ensure safe disposal of clinical waste. The pit has a five-year life span and is likely to be effective. However, there has been some concern that in the Terai area where the level of the groundwater rises during the monsoon, it may seep into the pit and cause the pit to overflow. While this has yet to happen, the project is exploring the use of low-cost incinerators in the Terai areas.

District Hospital, Jumla

Existing Delivery Room in operation

View of existing blocks and new construction site

Proposed architectural plan for new extension of OT, Delivery suit and upgrading of existing in-patient ward

District Hospital, Myagdi

Existing delivery room in operation

Construction site for new delivery suit

Proposed architectural plan for new extension of Delivery suit and upgrading of existing in-patient ward

District Hospital, Parbat

Construction site after demolishing of old toilets

Existing delivery room in operation

Proposed architectural plan for new extension of Delivery suit and upgrading of existing in-patient ward

Bhim Hospital, Bhairahawa, Rupandehi

Clockwise from top left: 1 East and north face of existing maternity unit; 2 South face of existing maternity unit with the west face of main hospital (where new delivery suit and link passage to main block will be constructed); 3 Delivery room in operation at existing maternity unit; 4 Labour and postnatal ward of existing maternity unit

Proposed architectural plan for new extension of delivery suit, internal alterations of existing unit and link passage to main block

Prithvi Chandra Hospital, Nawalparasi

Existing in-patient ward in operation

Building to be upgraded as new in-patient ward and maternity unit

Proposed architectural plan for new extension of delivery suit, internal alterations of building and link passage to emergency/out-patient unit

APPENDIX 6: NSMP INCREASING ACCESS MONITORING FRAMEWORK

Introduction

In 2001 (as reported in the last PPR) NSMP focused on the establishment of Safe Motherhood Working Groups in each district. This has now been achieved in all districts except Dailekh and Jumla (where insecurity has affected progress in this area). In the first quarter of 2002 NSMP focused attention on establishing a monitoring framework and system for increasing access work.

Process to Establish the Increasing Access (IA) Monitoring Framework

As detailed in the last PPR NSMP has further developed Output 3 monitoring to encompass a broader base of OVIs than was originally conceived. This allows for the institutionalisation of monitoring systems at district level to be transparent within the logframe. The IA monitoring framework allows for measurement of:-

- Levels of local knowledge and appropriate response linked to EOC warning signs plus changes in perceptions on the quality of services provided (OVI 3.1 to 3.3)
- Structural and institutional factors related to the profile of access and safe motherhood on the agenda of local government and implementing partners (ie OVI 3.4) This includes the provision of services such as transport and funding schemes

In 2002, increased support was provided to facilitate districts in developing their own sustainable monitoring systems. In doing so various principles were established and a set of tools developed to assess the process. Most districts have undertaken a workshop to support their development of indicators and local monitoring systems.

District stakeholders are responsible for the indicators and the use of this. To support this process NSMP has taken responsibility to co-ordinate the collection of grass-roots impact data (i.e. OVI 3.3) through use of the Key Informant Monitoring tool (KIMT) in 5 districts and to make this data available to the SMWGs and other partners to assist programming and to monitor progress.

The KIMT seeks to gain insights into the extent to which women of reproductive age (those who may be or become pregnant) perceive changes in the social context and in service access. In rural Nepal, young women have little decision-making power and their behaviour in relation to pregnancy and childbirth is influenced strongly by men and senior kinsfolk. As such, it is important to understand the pressures perceived by a woman and her family in making decisions to seek emergency obstetric care. The tool focuses exclusively upon women of reproductive age, as NSMP is interested in the extent to which this group is <u>perceiving</u> reduced constraints to accessing EOC and midwifery services, e.g. it matters little if men and older women are changing their attitudes towards pregnancy if women of childbearing age <u>do not perceive</u> them as having changed. Due to the time required for its collection and analysis the assumption is that the KIMT data will be collected only during the project lifespan, however a number of local partners have already shown interest in continuing this process and in such chases, the tool may be fully integrated into that district's monitoring system.

SMWGs will also have access, through the D(P)HO, to utilisation data from the EOC facilities, once this system is fully functioning. This is additional to NSMP's IA Monitoring frame-work as it is utilised by the project at purpose level.

Based on the work undertaken by the SMWGs, the component monitoring framework can now be finalised and is illustrated below. OVI's 3.1 to 3.3. reflect progress to Output whilst OVI 3.4 focuses on the institutionalisation of monitoring systems within each district.

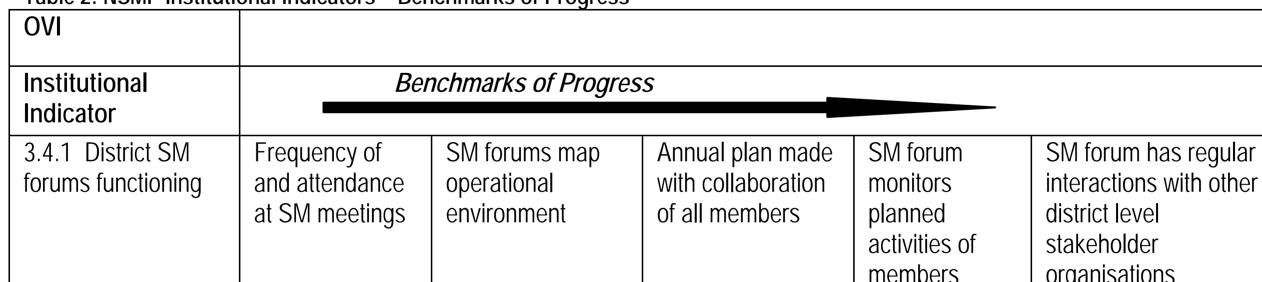
Table 1: NSMP Output 3 Monitoring Framework

Output	OVI	MOV	Sources of Monitoring information	Responsible Organisation	Freq'y
3. The social context for and access to midwifery and obstetric services within NSMP supported districts is improved	3.1 Communities appreciate risks of pregnancy and potential benefits of allopathic/ biomedical health services	District monitoring system	3.1 Knowledge surveys - checklist based	SMWG commissions local NGO/ DPHO	Every 9 months
	3.2 Numbers of transport schemes and funding schemes (with access by the poor)	As above	Reports from implementing partners	SM forum	Monthly
	3.3 Women perceive - Reduced physical barriers to EOC services (eg through transport schemes, funds) - Improved quality of care - Improvements in social status and mobility (eg communication with mothers in law and husbands) to reflect their ability to make decisions re. health seeking behaviour	Report of women's perceptions of social change collected using key informant monitoring tool	Key informant monitoring tool (KIMT)	NSMP with the SMWG through local partner NGO	Every 9 mnths 1 partner in 2 VDCs per district
	3.4 Safe motherhood articulated as an issue in ongoing work by key partners	NSMP district staff reports Partner I/NGO reports Minutes of district forums for SM	Local partners planning documents	SMWG	Yearly
	• District SM forums functioning (e.g. SM district plans developed)		SMWG minutes Maps SMWG plans	SMWG	Six monthly
	• District SM forums become part of Gov. system at district-level; SM integrated into the District Health Plan by end of Phase Two		DDC plans DPHO reports SMF reports	SMWG	Six monthly
	• Partner organisations (govt, INGOs) implement according to district safe motherhood plan		SMWG plans Partner plans & reports Agency plans SMWG co-ordination map District health plan	SMWG	Six monthly
	• VDCs which receive TA demonstrate improvements in management approach		Partner reports VDC plans VDC health plan	SMWG	Six monthly

NSMP's Benchmarks for Institutionalisation

The benchmarks developed by the stakeholders to assess their progress in reaching the outputs stipulated within OVI 3.4 vary between the districts according to locally perceived need. As such they cannot easily be used by the project to compare the progress between districts, nor overall progress towards the realisation of the OVI. Therefore, broad cross-district benchmarks have also been set by NSMP. These are designed to be simple and can be collected easily by the social development officers without additional work or interference in the SMWG's own monitoring system. These are detailed below and should be seen as cumulative although the order of their achievement may vary.

Table 2: NSMP Institutional Indicators – Benchmarks of Progress



OVI					
Institutional Indicator	*Benchmarks of Progress* →				
3.4.1 District SM forums functioning	Frequency of and attendance at SM meetings	SM forums map operational environment	Annual plan made with collaboration of all members	SM forum monitors planned activities of members	SM forum has regular interactions with other district level stakeholder organisations

3.4.2 District SM forums become part of Gov. system at district level	SM issues highlighted by forum feature in district health plan	Activities of SM forum included in DPHO's six monthly review	District health plan prepared with input from SM forum	RHCC accepted as member of Social Co-ordination Committee	DDC appoints representative to SM forum
3.4.3 Partner organisations implement according to district safer motherhood plan	Partner's report all SM activities to SM forum	Partner's plans consistent with SM plan	Partner's progress reports monitored by SM forum	All agencies working in SM in district report activities to SM forum	Comprehensive SM district health plan developed incorporating activities of all SM related activities
3.4.4 VDCs which receive TA demonstrate improvements in management approach	VDCs participate in SM activities	VDCs contribute funds for SM activities	SM issues included in VDC's plans	VDCs support training of own staff in SM	VDCs develop comprehensive health plans incorporating SM activities

APPENDIX 7: BEHAVIOUR CHANGE COMMUNICATION STRATEGY

This Appendix is written as a follow-up to Appendix 2 of the NSMP Project Progress Report of June 2001, which documented NSMP's partnership work with USAID's MNH project in support of FHD and NHEICC in the development of a national behaviour change communication strategy. The previous appendix detailed the process of strategy development culminating in the presentation of the Draft Strategy, by NHEICC, to the Safe Motherhood Sub-Committee.

Following the presentation, the strategy was disseminated to a broad cross-section of national level stakeholders and feedback taken. Once alternations were made, the process of translating and finalising the strategy for approval was taken forward by NHEICC, with technical and financial support from the MNH project.

A major theme of the strategy is an emphasis on decentralisation of activity and localisation of messages and materials, to ensure local appropriateness and relevance in terms of changes to behaviour promoted. Whilst the process of strategy approval was taking place NSMP, on behalf of NHEICC, piloted the strategy's localised approach in project-supported districts, both those with and those without EOC services.

This piloting process was taken forward by means of a district-level IEC workshop, facilitated jointly by NHEICC and NSMP and involving a broad group of district level stakeholders, including the safe motherhood working group and implementing partners as well as other line agencies and interested parties. The workshop sought to develop a broad implementation or campaign plan for district-led IEC strategy implementation including materials development and activity management. These plans included both IEC activities integrated into partners' ongoing work, and multi-partner led mass events and initiatives and these have now been incorporated into the Safe Motherhood Working Groups' 6-monthly plans (see Appendix 8).

As part of the workshop process, a briefing was given on the national strategy and the role of the districts within it. Through this process it became clear that the structure of the strategy was too complex for people to understand fully and additional work was undertaken by the facilitators to simplify the presentation of the strategy, gaining feedback from the participants. This process continued throughout the districts and much critical feedback was received. The focus was on helping people to understand the relevance of the strategy to them at district level, exploring in depth those areas which would directly help them to formulate their own IEC implementation plans, according to local context, availability of services, IEC media, resources etc. The strategy has provided a clear thematic framework and all campaigns have been structured within this, through the development of a cascade of district-specific messages.

This process and the follow-up support given, showed clearly that district stakeholders can take forward their own decentralised and strategic IEC activities with some skills building and support. However, it raised key issues for the documentation and dissemination of the IEC strategy and, as a result the decision was taken by NHEICC to delay the finalisation of the document in order to simplify the structure of the strategy and increase its accessibility. This process is currently under way with technical support from NSMP and the finalised document will be accompanied by a simplified and abridged flyer, and a district workshop manual.

Despite the strategy continuing in draft form, it has already been heavily influential in guiding national level safe motherhood IEC programming by MNH, UNICEF and NSMP. The three organisations meet regularly to review each other's materials and to ensure dovetailing of implementation prior to seeking HMGN approval.

MNH is currently leading this process, with the development of a campaign slogan (SUMATA), an accompanying jingle and a series of radio mini-dramas which will be aired nationally. Utilising the same slogan, UNICEF has committed to translating the mini-dramas to local languages and airing them through local radio. NSMP will also use both the slogan and the mini-dramas, incorporating them into radio magazine programmes produced by and in NSMP supported districts. In addition, together with other locally developed materials to be shared by all, MNH has

developed generic illustrations which can be adapted for use for any materials designed to promote care-seeking behaviours. There has been general approval for the strategy slogan to be used on all materials produced, no matter by whom.

APPENDIX 8: PROJECT PARTNERSHIPS FOR IMPROVING THE SOCIAL CONTEXT OF, AND ACCESS TO, OBSTETRIC SERVICES

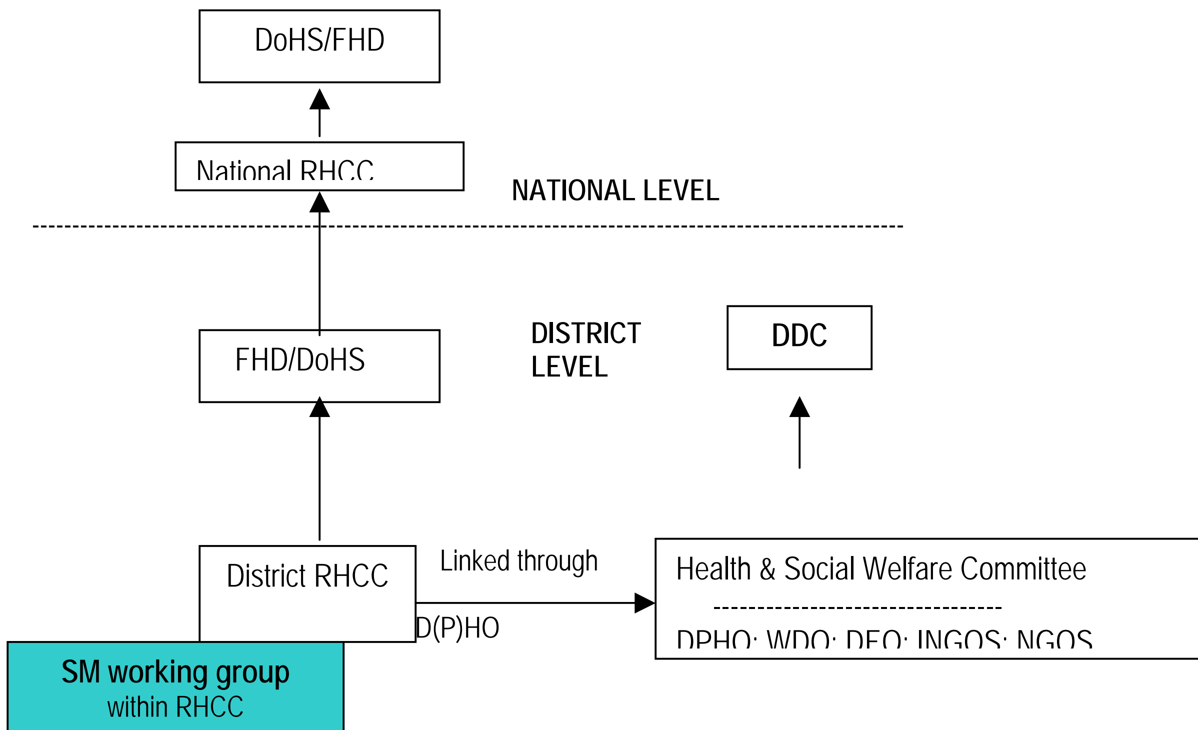
BACKGROUND

Appendix 3 of the Project Progress Report May to December 2000 detailed the strategic differences between the project's first and second phase working approaches. These included a shift in emphasis from small-scale piloting of interventions supported by project staff to the institutionalising of 'access' interventions at both district and community-level. This would be achieved through support to a cross-sectoral, district level working group or Reproductive Health Co-ordination Committee (RHCC) and through them, partnership-working with local government and non-government organisations with existing structures at VDC and sub-VDC level.

1. District Structures

The past 18 months have seen the establishment and support of a safe motherhood working group (SMWG) in each of the NSMP supported districts. These groups are similar in their membership and functions but differ in their name and reporting structures, in accordance with the local situation. It is envisaged that each of these groups, or at least their functions, will become fully institutionalised into the government structures at district level by the end of the project implementation period in March 2004.

The ideal model for institutionalisation is shown in the model below:



However, this model is not yet possible in all the districts, many of which do not have an RHCC and/or a motivated D(P)HO. Progress towards institutionalisation is further confused by the recent dissolution of local government (which could not have been foreseen when the strategy was designed).

2. Working Partnerships

Each of the district SMWGs has developed an implementation strategy to address access issues within their district. In line with this strategy, the group undertakes regular 6-monthly planning and budgeting. Much of the districts' 6-month plan details safe motherhood-focussed activities to be carried out under the regular programme of government and non-government organisations working within the districts. Limited financial support is given by NSMP. It is anticipated that by working through regular programmes and structures, safe motherhood related messages and activities will continue within the organisations' programmes, following the withdrawal of NSMP.

This 'partnership' working has taken different forms. Briefly summarised[1] these are:

- MoU based partnerships:
  Where an organisation is interested in an ongoing relationship with NSMP and is able to provide regular accounts to the project, a district-level MoU is signed outlining the activity areas and resource commitments of both partners
- Activity-based partnerships - Without MoUs:
  Where the above criteria is not the case, NSMP supports partners on an activity by activity basis

MoUs are not required by NSMP in working with government line ministries and local government. However, these have been constructed in some districts at the request of the government partner.

In addition to these bilateral partnerships, a number of multi-lateral partnerships have also begun to develop often incorporating both government and non-government organisations. Examples include activity partnerships to facilitate mass events: ongoing partnerships to support non-formal education; newsletter and radio programming; and ongoing partnerships to support municipality-based activities.

3. Current Partnership Status

NSMP is currently working in 42 different partnerships with government and non-government organisations, thereby supporting activities in 119 VDCs and 5 municipalities across the 9 districts, covering an average of 27% of each district[2]. In addition, NSMP works directly with the DPHOs to support the creation of an enabling environment for MCHWs.

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[1] More detail of working modalities and the approaches taken can be found in the *Summary of Proposed Working Principles and Guidelines*, Increasing Access Component, 2001

[2] Based on total VDC population.

The boxes below give case studies demonstrating different types of partnerships:

Box 1: An ongoing, MoU-based partnership with FPAN in Nawalparasi

This partnership has been formalised by means of an MoU and NSMP provides funding for FPAN-run safe motherhood activities. Work on safe motherhood has been integrated into FPAN's ongoing programming in 3 VDCs (with a population of 55,500). FPAN thinks that the per head of population covered by their activities is 60%, or 33,300. FPAN's working partners at VDC level include: VDCs officials and SHP staff; TBAs and FCHVs; CBOs; school teachers and students.

Activities are focused on establishing emergency funds, organising transportation schemes, supporting behaviour change and social context change, and promoting use of EOC services. For these activities, knowledge and skills building support has been given.

Results include enthusiastic, informed activity by FPAN staff and their partners, increased discussion on pregnancy and delivery with community members; active input by all VDC level working partners; establishment of emergency funds by 36 community groups and 2 VDC bodies; and the performance of regular safe motherhood related dramas by the local drama group.

Box 2: A multi-lateral, activity-based partnership for Chaite Dashain in Baglung

As part of their IEC campaign, Baglung district stakeholders decided to hold a communications mass event on Chaite Dashain (National festival – celebrated around a reputed Temple).

Chartare Yuba Club (CYC), a local NGO, took the leadership role and the event was organised jointly with the DDC, DPHO, AMK, WDO and NSMP. Street dramas, puppet shows and song competitions were some of the activities conducted on the day. The Health Education Technician was very actively involved in the planning and in conducting the activities. CYC took the responsibility of coordinating with the major stakeholders, developing and distributing pamphlets to the people beforehand to encourage participation in the event, worked with the local drama groups to disseminate SM messages based on the previously agreed theme, and took the lead role in organizing all the activities. AMK shared the cost by making some banners with SM messages written on them. DPHO contributed by providing technical input to the messages being disseminated throughout the various activities, and WDO helped to bring women from their groups for the song competition. DDC and other stakeholders actively participated in helping to organise and conduct activities on the day. Chaite Dashain was a good example of how much joint effort from different organisations can come together to help to conduct events in a smooth and easy way.

Box 3: An on-going, multi-lateral partnership in Birendrenagar municipality, Surkhet

This group partnership has grown from initial activities run by the NGO Social Awareness Centre (SAC) who facilitated public debates on safe motherhood within Birendrenagar Municipality, involving district leaders. From these debates, the need for more focus on safe motherhood within the municipality was raised both by the people and by the Mayor, and a group was formed to take this forward. Initial plans included developing female community health

volunteers and supporting community mobilisation and social context change through group mobilisation. The municipality office is supporting the use of existing groups developed by the Rural, Urban Partnership Programme, wishing to use these as cross-sectoral groups receiving support from the health sector through the FCHV and from other sectors via other workers. Safe motherhood has been integrated into this strategy, which will initially focus on health.

Interested members from the district have come together to take this forward forming a group partnership comprising of the Municipality Office, Canadian Health and Development Project, District Health Strengthening Project, SAC and NSMP.

The partnership is already resulting in stronger ownership of safe motherhood interventions by the Municipal Office, increased attention and financial investment by all group members, increased interest and technical support by the DHO and increased openness and interest in more collaborative work in the future. Examples of other collaborative work already initiated by some of the members includes preparing district safe motherhood advocacy newsletters: creating a regional safe motherhood magazine radio programme; and integrating safe motherhood into the district's non-formal education programme.

APPENDIX 9a:

Options

TERMS OF REFERENCE
ASSESSING EMERGENCY TRANSPORT SYSTEMS FOR THE NEPALESE CONTEXT

Background

The DFID-supported Nepal Safer Motherhood Project (NSMP) aims to support HMGN's National Safe Motherhood Programme by contributing to improved maternal health in selected districts. It has two components: *service provision* under which systems to manage services for women of reproductive age will be established - including improvements to the physical infrastructure of hospitals, equipment and supplies, and training of personnel; and *increasing access* which seeks to improve the social context for and access to midwifery and obstetric services within the supported districts in order to enable women to utilise services.

NSMP works to improve referral systems from community-level to the level of the required services. This may involve referral via community level health worker to a facility providing basic essential obstetric care (BEOC) services and, if this is not sufficient, from the BEOC centre refer to comprehensive obstetric care (CEOC) service. In line with international learning, NSMP works to support the provision of BEOC services, with links to CEOC services in some hospitals. Utilising this approach increases the availability of good quality services within limited resources.

Whilst the project has some experience in supporting the development of transport mechanisms to allow self or community referral to the hospital, less emphasis has so far been given to developing intra facility transport mechanisms (ie. vehicle transport) to transfer women in need of caesarean section or blood transfusion from a BEOC to a CEOC facility.

In June 2002 NSMP commissioned a Nepali consultant to head a small team to provide recommendations on ambulance services. The purpose of this currently ongoing consultancy is to explore the following:

- What is the most appropriate vehicle to be used as a referral ambulance in the hill districts of Western Nepal? (Taking in to account durability, local maintenance opportunities and topography, including seasonal landslides, exploring the different options of car, bus, motorcycle etc)
- How can the vehicle be efficiently managed and maintained?

This ambulance study will explore best practises and potential pitfalls in current ambulance management (management structure, maintenance practice, charging practice, exemption schemes for poor patients, alternative schemes when the ambulance is unavailable and ambulance replacement procedures) in Nepal. The study is due for completion by the end of July 2002.

To complement this ambulance-based study, NSMP wish to broaden its exploration of transportation schemes by deepening its understanding of non-ambulance systems drawing upon international learning of motorbike "ambulances" and other potential forms of emergency transportation.

NSMP require an international agency with expertise in transportation systems in other low resource countries to make recommendations to NSMP on transportation utilising the results of the current ambulance study and applying international learning to the Nepal context.

Purpose of the assignment

To recommend to NSMP the best transport system for the various topographical areas of Nepal.

Tasks

The consultant will:

1. Be given an overview of NSMP by the Options (the UK-based management agency) Project Manager.
2. Be briefed by NSMP's Project Director and the Social Development Manager (SDM) to ensure a comprehensive understanding of the project's approach regarding increasing access.
3. Provide a brief literature review on international experience of emergency transport mechanisms.
4. Lead a small team (interpreter, plus one/two of the following: a Social Development Officer, the consultant who undertook the Ambulance study, TBC) to visit one hill district and one terai district to assess transportation means and their suitability (and adaptation) for emergency medical transportation.
5. Address the particular need of Dailekh district (a hilly, remote and poor district which is difficult to access) through visiting a nearby district with the Ambulance study consultant (TBC).
6. Liase with relevant organisations in Kathmandu that address transportation (SDM will arrange appointments) where information additional to the Ambulance study is required.
7. Address the feasibility of motorcycle ambulances within the Nepal context
8. Prior to departure, present findings and recommendations to a small forum of interested stakeholders (NSMP to arrange).

Outputs

Produce a report that:-

- provides recommendations on appropriate emergency transport schemes developed from the ambulance study learning and from applying international knowledge contextualised to Nepal;
- Provides comments on a range of options for emergency transport vehicles, with clear arguments either for or against each option;
- Within this objective, to given particular attention to the feasibility of using motorbike ambulances.

Location

The consultant will ideally visit at least two districts including one hilly district. Due to the security situation in Nepal a decision on whether and where to visit will be made at the time of the consultancy upon advice from the British Embassy and DFID.

Timing

The consultancy will be for a total of 11 days and will take place as soon as possible

1.	International travel	= 2 days
2.	Project briefing and preparation	= 2 days
3.	Study time (including internal travel)	= 6 days
4.	Reporting	= 2 days

Total		**12 person days**

APPENDIX 9b:

Options

TERMS OF REFERENCE FOR AN INSTITUTIONAL REVIEW OF NSMP'S INCREASING ACCESS COMPONENT

Background

In this sixth year of the project, (and third year of the second phase), in the interests of furthering the sustainability of the work of NSMP's increasing access work, an institutional review of NSMP's increasing access component is now required.

NSMP"s current increasing access strategy commenced in early 2000 when NSMP made a strategic shift between the project's first and second phase working approaches. These included a shift in emphasis from small scale piloting of interventions through project staff to institutionalising 'access' interventions at both district and community-level. This would be achieved through support to a cross-sectoral district level working group or Reproductive Health Co-ordination Committee (RHCC) and through them, partnership-working with local government and non-government organisations with already existing structures at VDC and sub-VDC level.

District Structure

The past 18 months have seen the establishment and support of a safe motherhood working group (SMWGs) in each of the supported districts. These groups are similar in their membership and functions but differ in their name and reporting structures in accordance with the local situation. It is envisaged that each of these groups, or the functions of them, will become institutionalised into the government structures at district level by the end of the project implementation period in March 2004.

Progress towards institutionalisation is further confused by the recent dissolution of local government which could not be foreseen in the design of the strategy.

Working Partnerships

Each of the district's SMWGs has developed an implementation strategy to address access issues within their district. In line with this strategy the group undertakes regular 6-monthly planning and budgeting. Much of the districts' 6-month plan details safe motherhood-focussed activities to be carried out under the regular programme of government and non-government organisations working within the district. Limited financial support is given for these activities. It is anticipated that by working through regular programmes and structures safe motherhood related issues will continue within the organisations' programmes following the withdrawal of NSMP.
This 'partnership' working has taken different forms. Briefly summarised[1] these are:

- Ongoing partnerships – Generally with Memoranda of Understanding (MoU)[2]

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[1] More detail of these and the approaches taken can be found in 'Summary of Proposed Working Principles and Guidelines' Increasing Access Component, 2001

[2] MoUs are not required by NSMP in working with government line ministries and local government. However these have been constructed in some districts at the request of the government partner and NSMP is encouraging this trend as part of a capacity building input.

Where an organisation is interested in an ongoing relationship with NSMP and is able to provide regular accounts to the project, a district-level MoU is signed outlining the activity areas and resource commitments of both partners.

- Activity-based partnerships - Without MoUs.
  Where the above criteria is not the case, NSMP supports on an activity basis.

In addition to these bilateral partnerships a number of multi-lateral partnerships have also begun to develop often incorporating government and non-government organisations. Examples include partnerships to facilitate mass events, partnerships to support non-formal education, newsletter and radio programming and partnerships to support municipality based activities.

Current Partnership Status

NSMP is currently working in 42 different partnerships[3] with government and non-government organisations and supporting activities in 119 VDCs and 5 municipalities across the 9 districts, covering an average of 27% of each district[4]. In addition NSMP is working directly with the DPHOs to support creation of the enabling environment for MCHWs.

After nearly 18 months of the strategy's commencement, NSMP require a review of the strategy's working modalities (systems and structures) and policies in order to ensure clear documentation of learning and of actual practices in place and to thereafter refine the working modalities. Moreover, this review process presents an opportunity for NSMP to document its existing strategies currently in operation.

During the above process, it will be important to involve NSMP's Social Development Officers (SDOs), in a manner which enhances their understanding of the institutional issues involved, such as the continuing need to address the balance between demonstrating a degree of project impact and the creation of more long-term and sustainable modalities (which may show a lower impact, but sustained over a longer time period).

Purpose of Consultancy

- To review NSMP's partnership approach
- To document NSMP's increasing access's current actual modalities (systems, structures) and policies.
- To provide recommendations in order to strengthen the approach/strategy
- To develop NSMP IA institutional policy guidelines (which shall cover satisfactory practises in place and incorporate any issues relating to or resulting from this review)
- To review and advise on NSMP's exit strategy from district level operations
- To document the status quo of existing RHCCs

Tasks

1. Be briefed on the consultancy needs by the Project Director, Social Development Advisor and Social Development Manager.
2. Refine the tasks and methodology in light of issues/concerns raised by the above staff members
3. Undertake the consultancy in a manner that develops the capacity of the Social Development Officers (SDOs) and that takes account of the institutional concerns/issues that they identify.

Part 1: Review NSMP's IA Partnership Approach

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[3] Of which 21 have MoUs.

[4] Based on total VDC population.

- Assess and refine the criteria used to assess and approve potential partners
- Clearly document, review and refine the two partnerships approaches (broadly categorised as" ongoing partnership" with MOUs and "activity based partnerships" without MOUs
- Review the contents/structure of current MOUs with partners
- Review and document the planning cycle process (issues to discuss may include:-
  - a review of the suitability of the 6 month cycle
  - how to manage competing planning needs
  - how to ensure maximum participation
- Review all management arrangements for multi partner activities
- Review the approach and principles embedded in NSMP's relationship with partner NGOs and the rationale for the approach to date, and compare this to other donor/NGOs arrangements in Nepal.
- From the review process above, recommend any refinements to current practice and suggest any areas of best practice from other projects that NSMP could adopt

Part 2: Review the Modalities of Working with Government and non government at District Level

- **Review SMWG's institutional arrangements**
  Document the range of the SMWG's:-
  - Role and effectiveness
  - Composition and management arrangements
  - Relationships with other district level health co-ordination committees
  - Potential for integration into other groups
  - Perceptions of members on ownership, sustainability and institutional accountability
  - Ability to adapt and operate under the current situation of none local governance
  - Potential to advance decentralised cross sectorally working in a manner that can be replicable

- **Review NSMP's management arrangement with the DPHO**
  - Review the extent to which SM partnership activities are integrated into existing DPHO work, and the degree to which DPHOs view this as supplementary 'project work' for which they require additional resources

- **Review the workings of the RHCCs in NSMP districts** (where they exist):
  - Membership and management arrangements
  - Relationship to SMWGs (where they exist)

Part 3: NSMP's Planned Exit Strategy

- Review the modalities of NSMP's Human Resource Development Officer's (HRDOs) withdrawal of support from Phase 1 hospitals eg:
  - How planned is this and how is it presented to stakeholders?
  - How do HRDOs monitor the level of withdrawal and manage this?
  - How do stakeholders perceive this process?
  - Identify any learning from this process and suggest any areas of documentation required
- Review how the withdrawal from Phase 1 VDCs is being management by the IA team
  - Review how this withdrawal was planned and is being managed
  - Review all relevant documentation to date
  - Identify any learning from this process and suggest any areas of further documentation required

Output

A report, which covers the issues, explored and meets the needs as expressed in the purpose of the consultancy. The report shall be an internal NSMP report though sections of it (RHCC review for example) will be utilised for other purposes.

Timing and Profile of Consultant

This consultancy is to be undertaken between September and December 2002. A locally based consultant is sought who has extensive experience of working with local partners at district and community level in Nepal.

APPENDIX 9c:

Options

DRAFT TERMS OF REFERENCE FOR 'FOUNDATION FOR CHANGE' REVIEW

Background

The DFID-supported Nepal Safer Motherhood Project (NSMP) aims to support the National Safer Motherhood Programme (SMP) of His Majesty's Government of Nepal (HMGN) by contributing to improved maternal health in selected districts. Options Consultancy Services Limited has overall management responsibility for the project.

The project has two main components: **service provision** which aims to improve the quality of emergency obstetric care available and **increasing access** which works with district stakeholders and local communities to promote awareness of and demand for services and to overcome the barriers to women's timely usage of emergency obstetric services.

During both its first and second phase of working NSMP has successfully used a set of tools called 'Foundation for Change', a combination of appreciative inquiry (see box below) and other simple management tools, with a wide variety of stakeholders at district and village development committee (VDC) level, including health facility staff. The purpose of using this package has been to improve the management and implementation of key organisations or stakeholder groups. It has been implemented as one component of a spectrum of capacity building inputs. An integral part of the package is focussed on developing individuals' self-potential and belief in their ability to change. The project feels that this is an essential component in motivating people to build their own sense of collective responsibility and the importance of skill building.

Appreciative Inquiry:- *Appreciative Inquiry (AI) is one of the arts of constructing a positive future. It focuses on the co-operative search for the best in people, their organization and relevant world around them. It inspires people to explore their own strengths and can be applied to leadership and management, team development, strategic planning, monitoring and evaluation etc. AI is a process applied to designing, planning and implementation through the individual and/or organizations' best experiences, positive attitude, and surrounding (external/internal) enabling factors as opposed to problem identification and solution. It can be applied both at individual and at organizations/group level.*

The package has been implemented in eight districts by two Kathmandu consultancy organisations, Pragya and Karuna Management Groups, over a period of four years. During this time the package has been further developed/adapted both in terms of its content and its position in the support strategy to district institutions. As part of this development process a review of the contents of the package was undertaken in July 2001 by project staff with the assistance of an external consultant. It was found that the package as utilised has differed between districts and stakeholder groups and over time has become more efficiently integrated with other elements of project support to these districts.

Stakeholders with whom the project has used the FCC 'package' include:

- District hospital and public health office staff
- Hospital management committees
- Members of the recently established multi-sectoral district safe motherhood fora, which include District Development Committee (DDC) members and senior NGO officers
- DDC bodies
- VDC committees, health facility support committees and health facility staff[1]

[1] First Phase only. The project intends to provide this in the second Phase by developing district level trainers.

Whilst NSMP has gathered a great deal of anecdotal evidence of the effectiveness of FFC, no formal evaluation has been undertaken. NSMP now requires a consultant to undertake an evaluation of the impact of FFC inputs on the functioning of the above groups. The consultancy will involve the establishment and management of a team to collect data in 3 Phase One NSMP-supported districts[2] (Baglung, Surkhet and Kailali) and 2 Phase Two NSMP-supported districts (Nawalparasi and Jumla); and the analysis of this data, drawing out the contribution of FFC to the change processes seen within these districts and the sustainability of the effect of FFC. The range of districts and VDCs chosen include those in which anecdotal information suggests FFC has had a major effect and those in which its effectiveness is in question.

Purpose of Consultancy

To design and conduct an evaluation of the impact of the FFC work undertaken by NSMP through Pragya and Karuna Management Groups.

Tasks

The consultant will:

- Through discussion with the project team, update his/herself on project experiences with FFC and expectations from the evaluation.
- Design an evaluation study and put together a team to undertake this. Essential elements of the study will include:
  - Study team visits to the five designated districts and three VDCs.
  - In-depth interviews and/or focus groups discussions with stakeholders representative of all groups involved in the FFC training, NSMP district staff and other organisations or individuals interacting with them on a regular basis
  - Development of 'case studies' of 3–4 change processes identified by stakeholders drawing out the role of FFC – as a training process, as a set of tools and as an ongoing approach - within these.
  - Areas of impact analysed should include impact on management processes, impact on level of focused activity and impact on equity/inclusiveness (e.g. With regard to hierarchy, gender etc) within each group.
  - The broader environment and modalities of FFC support should be noted and effort made to determine their effect on FFC impact with differences between districts drawn out.
- Manage (including if necessary training of) the study team, co-ordinate inputs with district project offices and ensure good quality data, analysis and reporting.
- Fully document the study.

NSMP Input

The NSMP programme support assistant will provide logistical and secretarial assistance in information collection and compilation. NSMP will source (in consultation with the consultant) a local organisation to provide staff with the required skill level for the study team.

Management Structure

The consultancy will be managed by the Project Director, NSMP.

Posting

The consultancy will involve field visits to at least 2 of the districts mentioned.

Timing

[2] Visits to Phase One supported districts should include 1 VDC visit each.

The total length of the consultancy will be dependant on the design of the study and number of personnel involved. The minimum length of the consultancy will be 10 days and the maximum 25 days. The consultancy will be undertaken during September 2002

Outputs
A study report fully documenting the study methodology, analysed data, case studies, conclusions and recommendations.

A hard and soft copy of the report should be submitted to the project director within 7 days of the end of the consultancy period.

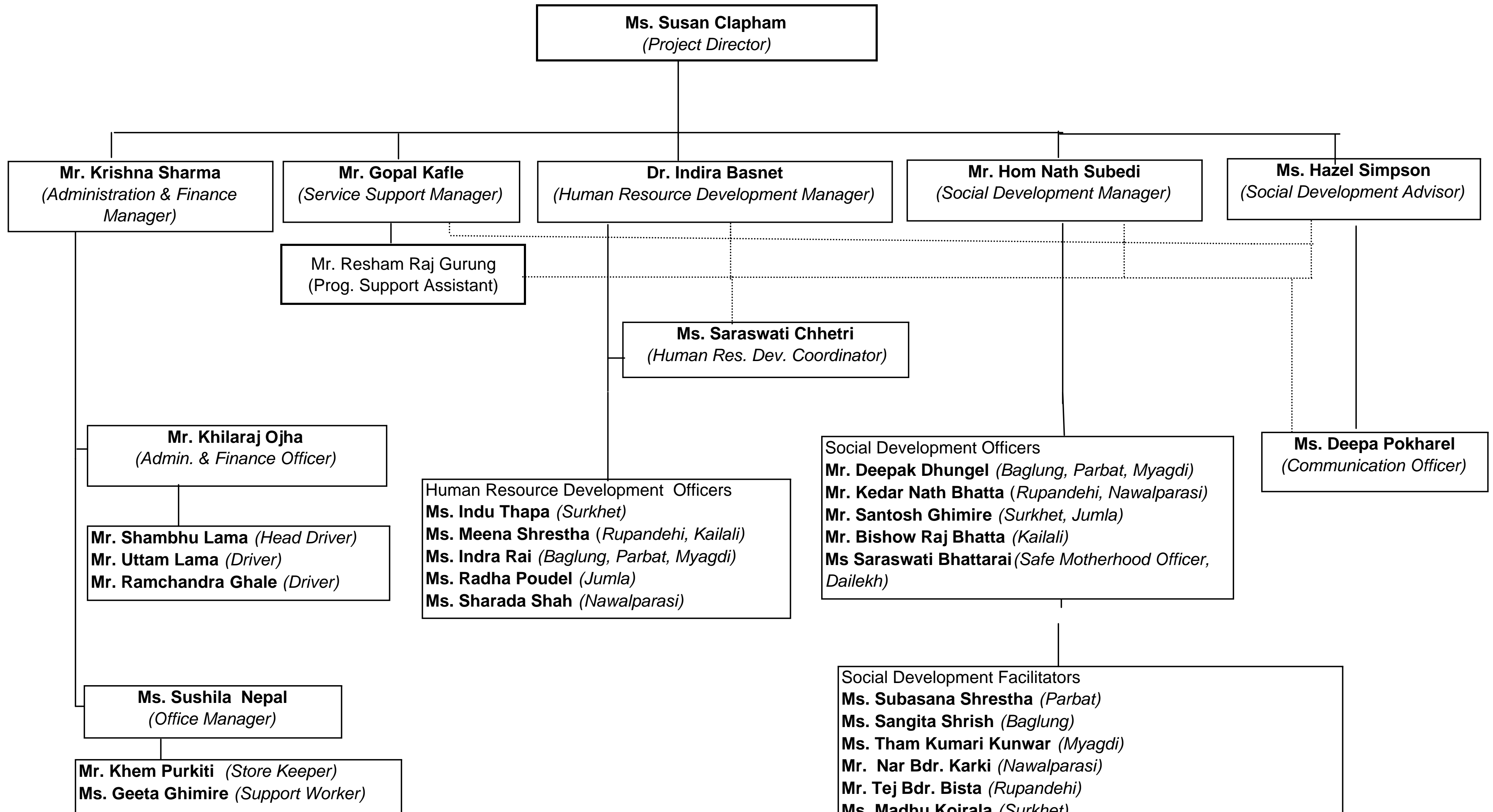
APPENDIX 10: NSMP SIX MONTH WORKPLAN: JULY-DECEMBER 2002	Jul	Aug	Sep	Oct	Nov	Dec
	2002					
Service Provision - A (Technical)						
Conduct QoC orientation in Kailali and Surkhet zonal and district hospitals						
Follow up of implementation of QoC action plan			ongoing			
Provide Midwifery Refresher Training to nurses (25)						
Provide BEOC in-service Training to Medical Officers (6)						
Complete Essential Newborn care training in Jumla district hospital						
Complete IP Training in Dailekh						
Complete Follow up of Neonatal training in Rupandehi, Nawalparasi,Parbat, Myagdi,Kailali and Surkhet						
Follow up of IP training in Parbat, Myagdi, Nawalparasi, Rupandehi and Jumla						
Organise a workshop to update knowledge and skill of HRDOs and nurses (who were trained 1999 and before) on Maternal and neonatal health advances						
Explore OT mangmt. training site and develop a draft OT mangmt. training for nurses						
Organise follow up training for Anesthetic Assistants for Baglung, Surkhet and Kailali						
Support districts in implementing EOC monitoring system		ongoing				
OT management training for Baglung, Nawalparasi and Bhim hospital						
Evaluation of MCHWs' performance as an skill attendants						
Study on Maternal Death Audits carried out in three districts						
Orientation to SM Officers of Dailekh district						
Conduct Need Assessment in Chitwan district hospital						
Support ot Chitwan hospital in implementing QoC model and HRD based on finding s of NA						
Support to Janakpur hospital in implementing QoC model and HRD based on findings of NA						
Support to Nepalgunj Hospital in implementing QoC model and HRD based on findings of NA				ongoing		
Participate in Regional Rev. planning workshop						
Organise a review palnning meeting with RHD team in western and midwestern						
Ultrasound training for two doctors Nawalparasi and Myagdi						
Clinical coaching on Vacuum application and MRP for nurses-Kailali and Surkhet						
Follow up of CSS training of UMN hospital, Tansen						
Award six scholarships for Proficiency certificate in Nursing						
Support Jumal district hospital to establish Emergency obstetric care services including emergency C/S						

Service Provision - B (Physical Facilities) Component						
Equipment						
Review of proposals received from UNICEF and Crown Agents						
MoU/Contract signed and final order placement to the selected Procurement Agent						
Equipment/Surgical instruments delivered to the hospitals						
PHCC's need of equipment finalised and incorporated into main package as appropriate						
Facility Improvement						
Construction continue at Myagdi, Parbat, Nawalparasi and Rupandehi			Continue			
Construction complete at Myagdi, Parbat, Nawalparasi and Rupandehi						Complete
Detailed construction draiwngs, Specifications, Bill of Quantity completed - Jumla hospital						
Contractor recommended, negotiated and contracted						
Construction starts on site - Jumla		Starts		continue		
Blood Transfussion Service						
Partnership for Dailekh blood bank - MoU developed and work start						
Partnership for Surkhet blood bank - MoU developed and work start						
Maintennace and Users' Training						
ToR developed						
Contract developed and signed						
Equipment setting & user training - Lumbini PHCC						
Janakpur visit - autoclave installation						
User training - Chormara PHCC and Tikapur PHCC			Tikapur			Chormara
Equipment setting & User Tarining (Parbat, Myagdi, Parasi & Rupandehi)						
Follow-up visits	Baglung		Kailali	Surkhet		Lumbini PHC
Maintenance Training (Initial)			9 Trainees			

Increasing Access Component						
General Access activities						
Prepare six-monthly plan for SM for all district						
Conduct Ambulance study						
Appoint and orient Safe Motherhood Officer in Dailekh and Social Development Facilitator for Jumla district						
District monitoring set up - Surkhet						
Consultancy on non vehicle transport system						
Institutional review of IA component						
Conduct facility based costing study						
Implementation of Key Informant tool for monitoring (except Jumla and Dailekh)						
Conduct FFC evaluation						
Gender followup with central and district level staff						
Development of ACCESS package						
Support to district level partners for SM plan implementation for all district (include technical capacity building)	Ongoing					
Support to district level forum for SM for all district	Ongoing					
Social mobilisation to facilitate finance and transport availability in selected VDCs	Ongoing					
BCC activities						
Radio programme input for district						
Produce Telefilm on EOC case						
Scaleup of the SM input in NFE classes						
Support SM network to hold regional level advocacy workshops						
Implementation of knowledge survey for baseline and monitoring (except Dailekh and Jumla)						
Other						
Implementation of NSMP FFC Strategy - Hospital roup		Parasi/Jumla				
Implementation of NSMP FFC Strategy - District Stakeholders GroupHospital roup	Kailali	Parasi/Jumla				
Trainers' Training			1st Grp.	2nd Grp.		

APPENDIX 11:

Nepal Safer Motherhood Project
Organogram (June 2002)



Note:

Accountable relationship

Functional relationship

APPENDIX 12: SHORT-TERM CONSULTANTS INPUTS

Assignments completed: January – June 2002
Assignments planned: July – December 2002

Name	Dates	Purpose	Report
Greg Whiteside	May 2002	Increasing monitoring and evaluation systems consultancy	Monitoring of NSMP's Increasing Access Component (internal report)
Antoinette Pirie	May 2002	Operations research	An Innovative Approach to Achieving Safe Motherhood
Sandra MacDonagh	May 2002	Monitoring & evaluation systems consultancy	MCHW Evaluation Framework
Neil Price	June 2002	Technical support consultancy (desk based)	The Key Informant Tool for Monitoring Improvements in Social Access to Midwifery and Obstetric Services
Greg Whiteside	June - December 2002	Support to demand creation	December 2003
Maureen McCall	August 2002	Operations research	Policy Support Paper - Implementation of Abortion Services Literature Review - Abortion Policy
David Potter	Ongoing during 2002-3	Civil engineering consultancy	None
Andy Barraclough	September 2002	Support to procurement	
IPAS	September - December 2002	Technical Assistance for the Planning of Abortion Services in Nepal	
Roger Hodgson	November 2002	Foundation for Change Review	
RFH/ITDG	November 2002	Emergency Transport Systems in Nepal	

APPENDIX 13: NSMP REPORTS

Name of Report	Year	Author	
IPR/PPR/OPR			
Nepal Safer Motherhood Project – Project Progress Report	June 2002	NSMP	Prepared by Options on Behalf of DFID and FHD (DOH)
Nepal Safer Motherhood Project – Project Progress Report	December 2001	NSMP	Prepared by Options on Behalf of DFID and FHD (DOH)
Nepal Safer Motherhood Project – Project Progress Report	June 2001	NSMP	Prepared by Options on Behalf of DFID and FHD (DOH)
Nepal Safer Motherhood Project – Project Progress Report	December 2000	NSMP	Prepared by Options on Behalf of DFID and FHD (DOH)
Nepal Safer Motherhood Project -Output to Purpose Review	June 2000	JSI	Undertaken by JSI (UK) on behalf of the Department for International Development
Nepal Safer Motherhood Project – Project Progress Report	April 2000	NSMP	Prepared by Options on Behalf of DFID and FHD (DOH)
Nepal Safer Motherhood Project – Project Progress Report	December 1999	NSMP	Prepared by Options on Behalf of DFID and FHD (DOH)
Nepal Safer Motherhood Project – Project Progress Report	June 1999	NSMP	Prepared by Options on Behalf of DFID and FHD (DOH)
Nepal Safer Motherhood Project - Project Progress Report	December 1998	NSMP	Prepared by Options on Behalf of DFID and FHD (DOH)
Nepal Safer Motherhood Project - Project Progress Report	June 1998	NSMP	Prepared by Options on Behalf of DFID and FHD (DOH)
Nepal Safer Motherhood Project- Inception Phase Report	January 1998	NSMP	Prepared by Options on Behalf of DFID
Nepal Safer Motherhood Project - Project Progress Report	July 1997	NSMP	Prepared by Options on Behalf of DFID and FHD (DOH)
Reports for OPR			
Critical Issues for Design of Phase 2 (Confidential)	May 2000	Susan Clapham	Prepared by NSMP on Behalf of FHD (DOH)
Increasing Access Component – A Review of Phase I	May 2000	Hazel Simpson	Prepared by NSMP on Behalf of FHD (DOH)
NSMP's Monitoring Systems	May 2000	Susan Clapham	Prepared by NSMP on Behalf of FHD (DOH)
NSMP's Dissemination Process	May 2000	Sandra MacDonagh	Prepared by NSMP on Behalf of FHD (DOH)
Quality of Care Approach – Results and Lessons Learnt	May 2000	Dr Indira Basnet	Prepared by NSMP on Behalf of FHD (DOH)

Name of Report	Year	Author	
The Contribution to the Nepal Safer Motherhood Project to the Sector Wide Health Policy (Confidential)	May 2000	Sandra MacDonagh	Prepared by NSMP on Behalf of FHD (DOH)
Stakeholder Analysis Report	May 2000	Gopal Kafle	Prepared by NSMP on Behalf of FHD
Consultants'and Staff Reports			
Policy Support Paper, Review of Global Lessons Learned and Recommendations to His Majestey's Government of Nepal on the Implementation of Abortion Services	July 2002	Dr Maureen McCall	Prepared by NSMP on Behalf of FHD
Literature Review and Global Lessons Learned on the Development and Implementation of Abortion Policy	July 2002	Dr Maureen McCall	Prepared by NSMP on Behalf of FHD
The Key Informant Tool for Monitoring Improvements in Social Access to Midwifery and Obstetric Services	May 2002	Neil Price	Prepared by Options on Behalf of FHD (DOH)
Monitoring of NSMP's Increasing Access Component (Internal report)	May 2002	Greg Whiteside	
Evaluation Report on NRCS Blood Transfusion Services in Kailali, Surkhet and Baglung	November 2001	Ms Indra Rai Dr Ram K.Neupane Mr Anil Maharan	Prepared by NSMP on Behalf of FHD
Sustainable Monitoring for the Nepal National Safe Motherhood Programme	October 2001	Dr Liz Goodburn, Dr Indira Basnet, Mr Sharad Sharma	Prepared by NSMP on Behalf of FHD
A report on the results of the first pilot of key information research and monitoring tool (KIRM-Tool)	September 2001	Drona KC Hazel Simpson	Prepared by NSMP on Behalf of FHD
Report on a Review of Foundation for Change for NSMP (Internal)	June 2001	Roger Hudson	
National Safe Motherhood IEC Strategy - draft	June 2001	Catrin Evans	Prepared by NSMP on Behalf of FHD and NHEICC (DOH)
Ethnographic Perspectives on Obstetric Health Issues in Nepal: A Literature Review	March 2000	Mary Manandhar	Prepared by Options on Behalf of FHD (DOH)
Obstetric Health Perspectives of Magar and Tharu Communities: A Social Research Report to Inform Nepal Safer Motherhood Project's IEC Strategy	March 2000	Mary Manandhar	Prepared by Options on Behalf of FHD (DOH)
Provision of Technical Support to the Capacity-Building, Team of he Nepal Safer Motherhood Project	December 19999	Joyce Abbatt	Prepared by Options on Behalf of FHD (DOH)
Support to the IEC strategy of the Nepal Safer Motherhood Project	December 1999	Gill Gordon	Undertaken by Options on Behalf of FHD (DOH)
Review Of NSMP's Procurement, Facility Improvement, Maintenance And Stores Management Inputs	December 1999	Andy Barraclough	Undertaken by Options on Behalf of FHD (DOH)

Name of Report	Year	Author	
Desk Review of Community Based Health and Social Finance Schemes	November 1999	Kirstan Hawkins	Undertaken by Options on Behalf of FHD (DOH)
Literature Review for IA Strategy Internal Draft report	October 1999	Mary Manandhar	Undertaken by Options on Behalf of FHD (DOH)
Challenging 'Ke Garne'	August 1999	Joyce Abbatt	Prepared by Options on Behalf of FHD (DOH)
Challenges to Reducing Maternal Mortality	August 1999	Joyce Abbatt	Prepared by Options on Behalf of FHD (DOH)
Review of Quality of Care Initiative Introduced by NSMP (Confidential Report)	May 1999	Joyce Abbatt	Prepared by Options
Review and Documentation of NSMP's Capacity Building Component (Assignment Report)	May 1999	Joyce Abbatt	Prepared by Options on Behalf of FHD (DOH)
Review and Documentation of the IEC Approach of the Nepal Safer Motherhood Project	January 1999	Joyce Abbatt	Prepared by Options on Behalf of FHD (DOH)
Review and Documentation of NSMP's Increasing Access Component	November 1998	Kirstan Hawkins	Prepared by Options on Behalf of DFID and FHD (DOH)
Assessment of Appropriate Communication Strategies in Safer Motherhood in Nepal	August 1998	Jennifer Peters	Prepared by Options on behalf of DFID and FHD (DOH)
Report of Pilot Activities in Capacity Building and Increasing Access to Emergency Obstetric Care at the Community and Peripheral Health Care Levels	July 1998	May Post Marion Gibbons	Undertaken by Options on Behalf of DFID
Report of a Consultancy for the Nepal Safer Motherhood Project	May 1997	Colin Thunhurst	Undertaken by Options on Behalf of DFID
Needs Assessment Reports			
Needs Assessment of Equipment and Surgical Instruments Requirements for Essential Obstetric Care in Phase II of NSMP	August 2001	Gopal Kafle	Prepared by NSMP on Behalf of FHD (DOH
Needs Assessment Report one report for each of the 6 new Phase 2 districts	June 2001	NSMP	Prepared by NSMP on Behalf of FHD (DOH)
Need Assessment Summary Report For phase 2 Design + Planning	December 2000	NSMP	Prepared by NSMP on Behalf of FHD (DOH)
Using Film Research for Community Needs Assessments	1998	NSMP	Prepared by NSMP on Behalf of FHD (DOH)
Community Needs Assessments: Key Findings Report: Baglung, Surkhet and Kailali District	February 1998	NSMP	Prepared by NSMP on Behalf of FHD (DOH)
Hospital Needs Assessment: Baglung, Surkhet and Kailali District	November 1997	NSMP	Prepared by NSMP on Behalf of FHD (DOH)

Name of Report	Year	Author	
Needs Assessment of Medical Equipment and Consumables Requirements	October 1997	Andy Barraclough	Undertaken by Options on Behalf of DFID
Report of a Construction Needs Assessment	September 1997	David Potter	Undertaken by Options on Behalf of DFID
DFID Reports			
Project Review: DHSP and NSMP (draft): Conflict Review	July 2002		
NSMP Monitoring Visit / Rupandehi and Nawal parasi Districts	October 2002	Michael O'Dwyer	
DFID Familiarisation Visits to Safer Motherhood Project	July 6th - 9th July 1999	Michael O'Dwyer Frances Winter	
NSMP Project Progress Report Jan-June 1999 Revised Comments	September 15th 1999	Michael O'Dwyer	
Activity to Output Report	December 1998	Carole Presern	
Report of an Activity to Output Review	December 1998	DFID	
Nepal Safer Motherhood Project: Inception Phase, DFID Review Mission	February 1998	SEADD	
Nepal Safer Motherhood Project: Activity to Output Monitoring and Comments on Inception Phase Progress	November 1997	DFID	
Miscellaneous and Project Produced reports			
Report on Performance Evaluation of Graduates of Post Basic Diploma Midwifery Course	April 2002	NSMP	Prepared by NSMP on Behalf of FHD (DOH)
Safe Motherhood in Nepal – video	2001	NSMP	Prepared by Options on Behalf of FHD (DOH)
District Planning Workshop Report for NSMP	May 2001	ODC	Prepared by Options on Behalf of FHD (DOH)
Strategic Support in Human Resource Management	September 2000	Henrietta Search	Prepared by Options on Behalf of FHD (DOH)
Nepal Safer Motherhood Project - World Health Day 1998, Activities Report	June 1998	NSMP	
Surkhet District Workshop	November 1997	HURDEC	Prepared by Human Resource Development Centre on Behalf of NSMP
Baglung District Workshop	November 1997	HURDEC	Prepared by Human Resource Development Centre on Behalf of NSMP
Kailali District Workshop	November	HURDEC	Prepared by Human

Name of Report	Year	Author	
	1997		Resource Development Centre on Behalf of NSMP
Appraisal Reports			
Project Memorandum	June 1996		Overseas Development Administration
Safe Motherhood at the District Hospital: Report of an Identification Mission	January 1995	Cliff Lenton et al	Prepared by Options on Behalf of ODA

APPENDIX 14: PROJECT LOGICAL FRAMEWORK FOR THE NEPAL SAFER MOTHERHOOD PROJECT (PHASE TWO REVISED)

Objectives	OVIs	MoV	Assumptions
Goal: To contribute to HMGN SM programme's objective of reducing maternal mortality	Reduction in maternal mortality ratio	WHO National estimates	To sustain improvements in maternal health, other health and development programmes in place
Purpose: Sustained increase in utilisation of quality midwifery and obstetric (BEOC and CEOC) services	1.1 Increased number attending CEOC facilities with an obstetric complication, as a composite of: - % increase in expected obstetric complications managed in CEOC facilities in project-supported catchment areas - % increase in c-sections as % all births in project-supported catchment areas - % increase in c-sections as % all hospital births (Baglung, Surkhet, Kailali, Rupandehi, Jumla) 1.2 Increased number obstetric complications managed in or referred from BEOC supported facilities to CEOC facilities - by year 3, BEOC cases managed in facilities in project districts reach c. 10% of all births in district. - by year 3, referrals from BEOC facilities to CEOC facilities in project districts as % all births in district (Nawalparasi, Parbat, Myagdi, Dailekh plus other districts where PHCs and BEOC are supported) 1.1 & 1.2 may be modified to fit with national SM programme process indicators currently being developed by FHD and NSMP 1.3 Increase number appropriate referrals by MCHWs to obstetric facilities: *to be designed as part of MCHW monitoring system being developed by FHD, NSMP and other partners* 1.4 Increased utilisation by poor and marginal groups of midwifery and obstetric services in project supported facilities (using proxies)	1.1-1.2 sentinel surveillance (using facility registers and HMGN reporting systems) 1.3 HMGN reporting system 1.4 periodic data collection and analysis - facility admissions register	HMGN adopts NSMP model and replicates HMGN continue to develop the national SM programme and harness additional resources Pregnancy Protection Bill promulgated and implemented Other RH interventions in place SM remains a priority under a SWAp

Outputs	OVIs	MoV	Assumptions
Output 1: NSMP contributes to safe motherhood policy & programme development (including feeding into global lesson-learning)	By end of Phase Two: 1.1 At least three examples of influencing SM policy and programme development 1.2 NSMP training courses piloted for government accredited/institutionalised 1.3 At least 3 examples of NSMP initiatives being institutionalised	1.1-1.3 Govt policy and programme docs.; Development partners' docs.; Interviews with key gov. officials; national SM programme review	EOC model recognised as central to SM programme Govt. makes long-term commitment to human and financial resource allocation in support of SM.
Output 2: NSMP supported facilities (hospitals & PHCs) provide good quality midwifery & obstetrics services	By end of Phase Two: 2.1 All supported facilities are functionally operational (buildings, equipment, waste disposal, stores, maintenance etc). 2.2 Safe blood transfusion service available 24 hours at selected facilities. 2.3 Quality of midwifery & obstetric care, as defined by NSMP's QoC framework – in place in all Phase Two facilities 2.4 Quality of midwifery & obstetric care sustained in Phase One facilities as NSMP withdraws 2.5 60% of trained MCHWs demonstrate skills in care (inc. skilled attendance) & referrals in accordance with HMGN RH Protocol	2.1-2.4 National SM programme review 2.1 Inspection and surveillance reports by NSMP in partnership with government 2.2 Surveillance reports by NSMP in partnership with NRCBTS 2.3-2.4: Surveillance reports by NSMP & partners (FHD, JHPIEGO 2.5 NSMP commissioned study of MCHWs using FHD endorsed WHO standards/ RH protocol	Outputs 2–3 Decentralisation impacts positively on health service delivery Output 2 DPHO continue to support peripheral health services to provide midwifery care No escalation of insurgency in NSMP districts
Output 3: The social context for and access to midwifery and obstetric services within NSMP -supported districts improved	In selected VDCs, by end Phase Two: 3.1 Communities appreciate risks of pregnancy and potential benefits of allopathic/biomedical health service 3.2 Perception of reduced barriers to EOC services (transport, financial etc) and of improved quality of care are evident	3.1 - 3.3 Report of community members' perceptions of social change collected using adapted key informant monitoring tool	Women who access obstetric care at district facilities as a result of project activities are satisfied that they receive quality care Coverage of VDCs is significant enough to impact on utilisation Partnerships develop to address geo-physical

	3.3 Women perceive improved social status/mobility, by eg: - being able to speak in male-dominated forums. - improvements in communication with mothers-in-law and husbands to reflect their ability to make decisions re health-seeking behaviour Within partner institutions, in supported districts: 3.4 Safe motherhood articulated as an issue in ongoing work by key partners 3.5 District SM forums functioning (eg SM district plans developed) 3.6 District SM forums become part of formal Gov. system at district-level; SM integrated into the District Health Plan by end of Phase Two 3.7 Partner organisations (govt, INGOs) implement according to district safe motherhood plan 3.8 VDCs which receive TA demonstrate improvements in management approach	3.4 - 3.8: NSMP district staff reports, partner I/NGO reports, minutes of district forums for safe motherhood	barriers

Activities	MoV	Assumptions
1. Policy Support 1.1 Develop and promote ways of working programmatically 1.2 Participate on SM subcommittee and TWGs 1.3 Participate in SM network 1.4 Develop and maintain effective working partner-ships with key agencies 1.5 Develop and implement a dissemination strategy	**1. Policy Support** 1.1-1.5: PPRs; committee reports; MOUs; subcommittee minutes; NSMP's dissemination strategy document	**1. Policy Support** Other SM development partners are collegial and collaborative Effective and consistent leadership in FHD continues
2. Services <u>Facility Improvement</u> 2.1 Needs assessment of facilities & equipment 2.2 Develop & undertake participatory planning & dissemination process for upgrading and procurement 2.3 Construct and renovate; deliver equipment; quality inspect buildings & equipment, handover to HMGN; develop facility & equipment support system - maintenance, user training 2.4 Strengthen local blood transfusion services <u>Capacity Building</u> 2.5 Needs assessment of human resources 2.6 Develop and undertake planning and dissemination process: capacity building 2.7 Develop basic skills to support QoC model 2.8 Develop specific technical skills in midwifery & obstetric care through short term & long term training (hospital, PHC staff, MCHWs, PHN) 2.9 Develop & monitor referral system between NSMP supported facilities 2.10 Update and monitor QoC model 2.11 Onsite support for changes in clinical practice (including one-off support for essential drugs to OT/ labour ward) 2.12 Develop and implement exit strategy for Phase One facilities 2.13 Support for improved and efficient facility management (IP supplies are managed within this) 2.14 Monitor effectiveness of the MCHW cadre in SM	**2. Services** 2.1-2.14: Needs assessment reports; MOUs; hospital surveillance reports; training reports; handover documents; consultants' reports (eg on NRCBTS, buildings); PPRs	**2. Services** <u>Facilities/Equipment</u> Process agreed for negotiation between development agencies and HMGN regarding construction Local procurement agent has proven capacity No escalation in insurgency <u>Capacity Building</u> No worsening staff transference levels MoH posts MDGPs to SM districts Hospital Support Committee effective Process agreed for awarding scholarships with HMGN MCHWs prove effective as skilled attendant cadre Other SM development partners are collegial and collaborative
3. Social		**3. Social**

3.1 Undertake NSMP Phase Two needs assessment 3.2 Develop and undertake participatory planning and dissemination process 3.3 Establish/ engage with district level forum for safe motherhood 3.4 Facilitate development of districts' SM strategy/ approach 3.5 Undertake advocacy and capacity-building with partners (government and I/NGO) and communities 3.6 Social mobilisation 3.7 Facilitate full implementation of districts' approach (eg transport schemes, emergency funds, IEC, group formation) 3.8 Regular reviews of strategy/approach	**3. Social** 3.1-3.8: Needs assessment reports; NSMP district staff reports; workshop reports; meeting minutes; MOUs; PPRs,	No escalation of insurgency Suitable partners are identifiable Patronage does not undermine project partnerships External influences do not significantly alter local partners' priorities Timeframe in change model is realistic Communities/social groups willing to embrace social change/changes in women's role