



Nepal Safer Motherhood Project a part of HMGN Safe Motherhood Programme

The Nepal Safer Motherhood Project (NSMP): A Model for Change

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NSMP has been justifiably recognized as a leader within Nepal in the use of change management processes with which to facilitate sustainable improvements in maternal health. Many people have been involved in the provision of support and technical inputs, but perhaps equally important to acknowledge are those whose understanding and belief in the importance of such a need in the beginning. Among these are Jean Marion Aitken, Sandra MacDonagh, Joyce Abbatt, Hazel Simpson, Hom Nath Subedi, and Ravi Pradhan who wrote so boldly about Ke Garne in the Kathmandu Post in 1993.

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In terms of implementing and supporting these change processes, all of the NSMP staff must be acknowledged for believing in change and sharing this enthusiastically with the communities they work with. Equally, acknowledgement must go to all those who embraced change and are continuing to battle against negative attitudes and unsupportive systems.

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ACRONYMS & ABBREVIATIONS

AHW	Auxiliary Health Worker
ANM	Auxiliary Nurse Midwife
BEOC	Basic Essential Obstetric Care
CEOC	Comprehensive Essential Obstetric Care
CINA	Commitment in Action
COPE	Client Oriented Provider Efficient
CQI	Continuous Quality Improvement
DDC	District Development Committee
DFID	Department for International Development
DHSP	District Health Strengthening Project
EmOC	Emergency Obstetric Care
EOC	Essential Obstetric Care
FCHV	Female Community Health Volunteer
FFC	Foundations for Change Programme
FHD	Family Health Division
HMGN	His Majesty's Government of Nepal
HRDO	Human Resource Development Officer
HSC	Hospital Support Committee
IEC	Information, Education and Communication
INGO	International Non Governmental Organisation
LFP	Livelihoods & Forestry Programme
ODA	Overseas Development Administration
OPR	Output to Purpose Review
MCHW	Maternal Child Health Worker
MMR	Maternal Mortality Ratio
MMRD	Maternal Mortality Reduction
MO	Medical Officer
NGO	Non Governmental Organisation
NHTC	National Health Training Centre
NSMP	Nepal Safer Motherhood Project
QOC	Quality of Care
RHCC	Reproductive Health Coordination Committee
SM	Safe Motherhood
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organisation

1. EXECUTIVE SUMMARY

The Nepal Safer Motherhood Project (NSMP) has successfully demonstrated that innovative change management can deliver positive changes in attitudes, behaviours and working practices. Key to the success of the project was a genuine commitment to fostering local ownership, and to participatory approaches to problem-solving. Change has been secured by the use of extensive capacity building and on-going support. Most importantly, many attitudinal barriers to change have been overcome through the utilisation of management techniques adapted for the Nepali context, particularly to counter *ke garne*¹ - the negative fatalism that pervades Nepali culture. This paper explores the change processes and highlights the project achievements, and attempts to relate these to key elements of successful change.

Using participatory approaches, NSMP developed a **clear, easy-to-articulate and shared vision** of the project outcomes. Project-appointed Human Resource Development Officers acted as change agents and helped to ensure an **effective communication strategy** within and outside the project. An **appropriate overall strategy** – “changing hearts and minds” – was adopted, and key elements were implemented using **tried-and-tested approaches**. The project identified and **strategically addressed critical points of resistance**, including the prevailing *ke garne* mindset. The project also **fostered ownership and involvement of key stakeholders** using the “whole hospital approach”, and by training entire teams of staff ensured that there was a **body of people committed to making the change sustainable**.

¹ Roughly translated as: “what to do?” and implying “don’t give yourself a headache, because nothing can change”

2. BACKGROUND AND INTRODUCTION

NSMP, funded by DFID and managed by Options, began its inception phase in 1997. This initiative was a major component of the national safe motherhood programme that was established in the same year. NSMP was one of the first major international projects to operationalise the paradigm shift in safe motherhood programming - from a focus on prevention (eg ANC) to one of improving access to essential life saving obstetric care.

The inception phase ran from March to December 1997. Phase I – establishing the project in three districts - was completed in 2000, and Phase II – expansion to seven other districts (representing 15% of Nepal's population) - is currently in progress and due to finish in March 2004. In addition to the district level implementation support, NSMP is a major contributor to national level policy and programme development. By basing proposed programmatic and policy changes on NSMP's own experience and work within the Nepali reality, the project is able to influence government understanding of, and commitment to, good practice, including process indicators, monitoring, and QOC related to maternal health.

NSMP has two main components:

- **Service Provision**, under which the capacity to provide quality essential obstetric care (EOC), both Basic (BEOC) and Comprehensive Emergency Obstetric Care (CEOC) in rural areas is increased. This includes improvements to the "hardware" aspect, including support to appropriately upgrading the physical infrastructure of health care facilities, the provision of safe and adequate blood supplies, provision of essential equipment, establishment of infection prevention and waste management as well as "software", aspects -improved performance of personnel, both technically and managerially.
- **Increasing Access**, under which awareness of, and demand for, EOC services is promoted through a range of interventions broadly categorised as (a) behaviour change communication interventions (radio, street drama, printed materials etc) and (b) practical interventions such as emergency transport schemes and emergency fund schemes. These interventions are provided through the programmes of 56 partners, including government line ministries and non-government organisations, and overseen by government district level reproductive health coordination committees (RHCC).

While NSMP has engaged in change management approaches in both components, this paper will focus on the change management approach used in the service provision component.

3. CONTEXT: WHY CHANGE?

Nepal has one of the highest Maternal Mortality Ratios (MMR) in the world, with an estimated national average of 539 per 100,000 live births – with significantly higher figures for MMR in remote mountain areas (FHD, 1996). Influenced by the 1987 Safe Motherhood Conference in Nairobi, His Majesty's Government of Nepal (HMGN) decided to design and implement a National Safe Motherhood Programme in the same year. HMGN requested DFID (then ODA) to provide financial and technical assistance to help implement the programme in ten government-selected, districts.

Although much has been achieved in projects at district level, reduction in MMR remains a key Ministry of Health (MoH) objective. The National Safe Motherhood Plan (2002 – 2017) outlines the approach to be adopted at a national level, developed from proven models of service delivery and management (FHD/HMGN, 2002). This approach draws on national evidence of effective interventions – many of which were developed from NSMP's experiences as the largest and most mature safe motherhood project in the country. In addition, the Plan draws from the latest international knowledge of what is known to lead to Maternal Mortality Reduction (MMRD). Key issues include:

- Survival of the estimated 15% of all pregnant women developing serious complications (UN, 1995), is largely decided by whether or not they have access to treatment, specifically Essential Obstetric Care (Maine, 1999).
- The major causes of maternal death can neither be detected nor averted during pregnancy (for example through antenatal screening, Rooney, 1992).
- Avoidance of the three delays (in seeking, reaching and receiving care) is an imperative to achieve the goal of maternal mortality reduction.
- Assistance at delivery by skilled staff reduces MMR (Graham et al, 2000).

The recent Nepal Demographic and Health Survey (MoH et al, 2002) reveals that less than one in ten births in the five years preceding the survey took place in a health facility. Only 13% of births were attended at delivery by a doctor, nurse, midwife or Auxiliary Nurse Midwife (ANM), whilst nearly one in four were attended by a traditional birth attendant (TBA). Though these national indices show a slight improvement since the 1996 Nepal Family Health Survey (MoH et al, 1997), the 2002 DHS highlights the critical lack of emergency obstetric care. Only 5% of the estimated need for emergency obstetric care is being met, and only 0.7% of deliveries are by caesarean section, (c.f. the lowest acceptable rate of 5% - UNICEF, 2000). Although HMGN has made major strides in policy development (and NSMP's learning has been significant in this respect), there is still a huge unmet need for EOC and the programme's challenges are one of the major concerns of His Majesty's Government of Nepal.

NSMP's Project Identification Mission in 1995 identified the infrastructure and technical weaknesses in Nepal that contributed to the very high MMR, but did not highlight the inherent socio-cultural dynamics that act as barriers to change (Lenton et al, 1995). Thus the original project design did not fully take in to account the low capacity and poor morale of health service staff, nor the widespread cynicism about the impact of donor projects. Aitken (1994) describes the range of cultural and institutional features operating in the Public Health System in Nepal that have impeded so many interventions by outside bodies. She questions whether agencies 'try and change that culture or simply adjust interventions to improve services in order to take account of its likely effects.' It can be argued that many interventions in Nepal, and elsewhere, have failed, by virtue of taking the second option (Brown, 1989).

Shortly after the commencement of the project, a participatory needs assessment (DFID, 1997) identified the range of inputs required to address the service provision component's

objective of “increased quantity and improved quality of EOC”. This included improvements to the hardware and software inputs (as described above) and, most importantly, an acknowledgement of the need to address the prevailing mindset of service providers and transform the institutional culture from apathy to activity.

4. KEY ELEMENTS OF SUCCESSFUL CHANGE

In ‘Improving Quality of Care in Maternity Services: a description of processes for change’ MacDonagh and Pownall argue that the change process, or the way that the product is delivered, is of equal importance to the product itself’ (MacDonagh, 2000).

Change management research conducted in several countries has identified a number of key elements that occur in successful change processes². These can be summarised as:

- **VISION**
Having a clear and shared vision of the outcome of the change, and ensuring that key stakeholders understand this vision. The vision may evolve as the change process unfolds.
- **COMMUNICATION**
Developing and maintaining effective internal and external communication and feedback systems
- **STRATEGY**
Choosing an appropriate strategy to foster change
- **IMPLEMENTATION PLAN**
Using tried & tested models for implementation
- **ADDRESSING POINTS OF RESISTANCE**
Developing an effective mechanism for identifying and addressing cultural, institutional and personal points of resistance to change
- **QUICK WINS**
Systematically planning for early and easy successes
- **ENABLING ENVIRONMENT**
Fostering an enabling political and policy environment in which to operate
Identifying powerful and visible leader(s) who will sponsor the change
- **OWNERSHIP**
Fostering ownership and involvement of the key stakeholders
Having a body of people committed to making the change happen
- **SUSTAINABILITY**
Institutionalising and sustaining the change, based on the realisation that change generally takes longer than anticipated.

² See Kotter’s work on ‘Leading Change’ (Kotter, 1996), Maslow’s work on motivation (Maslow, 1954), Beckhard on ‘Managing Complex Change’ (Beckhard, 1987) and Senge’s work on ‘The Learning Organization’ (Senge, 1990).

In the following section, the management approaches and lessons learned from the service provision component of NSMP will be examined in the context of the key elements of successful change management outlined above.

5. MANAGING THE CHANGE PROCESS

5.1 VISION - Having a clear and shared vision of the outcome of the change and ensuring that key stakeholders understand this vision.

Kotter (1996) identified a number of key steps in developing a clear and shared vision. These include:

- Creating a feeling that change is needed
- Creating a vision that is easy to communicate
- Communicating the vision so that others share it

Before commencing work in any of the hospitals or primary health care centres, NSMP held participatory workshops to analyse the working environment and generate an awareness of the need for change. All staff, from peons³ to medical superintendents – were fully involved in the consultations. This process resulted in a consensual agreement of a vision and a plan to attain it.

Kotter recommends developing a vision that can be communicated by anyone in 5 minutes or less, and NSMP, together with hospital staff, developed the five-minute vision that was understandable and easily articulated outside and within hospitals. This clear vision challenged the perceived powerlessness of both clients and providers, and provided an achievable picture of the future.

Vision of NSMP in its first phase

The district hospitals will be able to offer 24-hour Comprehensive Emergency Obstetric Care in an environment that is:

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

5.2 COMMUNICATION - Developing and maintaining effective internal and external communication and feedback systems

5.2.1 Internal Communication

NSMP's main strategy for communicating the vision within the project was to post Human Resource Development Officers (HRDOs), in each of the hospitals⁴. The HRDOs supported district-level service provider staff in implementing the new processes and procedures that would help achieve the vision. These 'change-agents' acted as communication channels between the centralised project management, Department of Health Services and the implementing districts, and as such were critical elements in 'capturing the hearts and minds' of hospital staff.

³ Peon – local term for a messenger

⁴ In Phase 2, each HRDO was able to cover between two and four hospitals

In the first phase of NSMP the team was relatively small, with 10 professional staff and the spirit of "one and all" was relatively easy to maintain. In the second phase, the project scaled up quickly to a total of 36 staff. In order to encompass this rapid expansion, the management culture needed to evolve from that of an "extended family" to a culture that embodied more formal information exchange, accounting and reporting structures. In order to maintain motivation, loyalty, and security this change process had to be managed with tact and sensitivity. Given that only three professional staff have left NSMP to date, it seems that they are striking the balance between appropriate structure and a sense of belonging to a body.

5.2.2 External Communication

NSMP has developed excellent relationships with the Department of Health Services, and other organisations in Nepal, and with partners from the international safe motherhood community. Relationships are fundamentally based on communication leading to trust, influence and ultimately in the ability to ensure that NSMP's learning is utilised to maximize effect.

NSMP is physically located in the Department of Health Services Family Health Division, which facilitates daily contact and support between these organisations.

The Project has been instrumental in the development of the National Safe Motherhood Plan (2002 – 2017), and lessons learnt from the Project guide the further input required to influence maternal mortality reduction MMRD in Nepal.

A project dissemination strategy is well established, with a number of mechanisms for disseminating written material. NSMP is the only safe motherhood project to produce 6 monthly public reports with a set of annexes devoted to lessons-learned. Carefully designed and appropriate presentation of these lessons-learned has proved effective in ensuring that research is translated into policy and practice. NSMP has presented its work at a number of national conferences, including NESOG (2003), SMN (2002), MNH/NSMP (2001). Internationally, NSMP has been proactive in disseminating its learning at workshops and conferences, including the White Ribbon Alliance: Delhi (2002), Kenya (2003), and is in the process of publishing papers for peer-reviewed journals.

Since Nepali society has a strong oral tradition, NSMP took the appropriate and innovative step of producing three videos outlining the project processes and achievements⁵. The first video recorded the situation in one community prior to project intervention and a follow-up video was made three years later with the same community, in order to document change. This video has exerted a powerful influence on policy makers – many of whom are too busy to travel to remote areas. The third video was televised nationally, and is an important advocacy tool in demonstrating that every community member can be a valuable asset in preventing maternal deaths.

⁵ These are largely focused on the component of the project devoted to improving access

5.4.1 Quality Improvement

The NSMP Quality of Care (QoC) model follows the well-known Continuous Quality Improvement (CQI) approach, and was originally adapted from COPE⁶, a methodology that utilizes a step-by-step approach to help staff analyse, plan, improve and monitor their services and thereby make incremental changes. The focus is on improving overall service delivery systems, rather than on individual staff performance. The project staff believed that using an appropriate QOC approach would encourage providers to participate in a meaningful way in overcoming the barriers to good-quality services. The QOC approach developed by the team consisted of three steps: 1) setting local standards for quality of EOC services, 2) taking actions to achieve the agreed-upon standards, and 3) monitoring changes over time.

The process proved to be one of trial and error, and staff needed to be flexible in developing local standards and local solutions to address barriers to quality improvement. All members of the teams received technical training in maternal care and/or infection prevention, after which they set their own standards for maternal care and infection prevention practices. Each hospital reviewed QOC issues on a continuous basis, through a monthly assessment using checklists that identified barriers to quality health care, and analysed their causes. The QOC teams then developed local action plans and worked to implement these plans over the following month. Copies of the plans were posted in the maternity unit to encourage all staff members to participate in the assessment process. The action plans were reviewed quarterly and the teams made efforts to solve problems using local resources. Periodic review meetings brought together staff from all the hospitals to share experiences and lessons learned.

In 2001, as NSMP was preparing to scale up from 3 to 10 districts for the second phase of the project, three critical issues accelerated the evolution of the QOC process. Firstly, the Infection Prevention and Maternity Care teams in each hospital merged into a general QOC team. Secondly, the hospital management committees assumed full responsibility for providing essential supplies and services that had previously been supported by NSMP, thus increasing local involvement and ownership. At the same time, a series of documents were published⁷ that helped to better define QOC and how to monitor its progress in the context of maternity services. NSMP's learning "home grown" knowledge continued to influence policy.

5.4.2 Organisational Development

The QOC process described above is underpinned by an organisational development programme, Foundation for Change (FFC), introduced in 1998. Though not initially a priority for NSMP, it quickly became clear at the start of the project that there was an urgent need to strengthen the management and decision-making capacity at both hospital and community levels. Piecemeal coaching was taking place on issues such as communication skills and facilities management, but integration of these initiatives was needed for maximum impact and to reach all levels of the Project.

⁶ COPE: Client Oriented, Provider Efficient. A quality improvement tool originally developed by EngenderHealth (formerly AVSC International) in Africa for improving service delivery in family planning facilities

⁷ Pittrof R. and Campbell O, 2000; Hulton L, Matthews Z, Stones R, 2000. Graham W et al. 2000

Since late 1998 this strategy has been supplemented with the locally developed Foundation for Change (FFC) programme. Strongly rooted in the Asian tradition, as well as drawing on Western learning where appropriate, FFC helps participants analyse personal and institutional barriers to change, determine system strengths and weaknesses, and develop individual and team-based change management skills.

FFC seeks to bring about changes in the motivation and attitudes of people towards each other, and in the way they take responsibility for their actions; it also seeks to develop skills to organize, manage and lead. It is a combination of appreciative inquiry and other simple management tools, and has been implemented as one component of a spectrum of capacity-building inputs to NSMP.

The FFC package addresses two important aspects of a change model, namely human and technical qualities. Technical quality is concerned with what is done to improve services, know-how, and support systems, whereas human quality addresses how it is done, in terms of client focus, provider attitudes, and team spirit, which in a hospital setting translates into improved quality of care, more positive and open attitudes and behaviour, improved teamwork, better communications, and customer service.

While FFC provides some technical management skills, it mainly supports the development of the human qualities within organizations - the part that generates willingness, commitment, and individual leadership. The FFC package is based on the framework of "Appreciative Inquiry"⁸. Used in place of the traditional problem-solving approach (i.e. finding what is wrong, and forging solutions to fix the problems), Appreciative Inquiry seeks what is "right" in an organization and builds upon this. This approach requires an organization to make a commitment to continuous learning, growth, and generative change.

Starting in 1998 the FFC process consisted of a year-long programme including confidential interviews with participants, workshops, team follow-up coaching sessions, and meetings with senior staff. In Phase One of NSMP the FFC process consisted of four workshops held over a period of one year, combined with coaching by the trainers on assignments given to participants between workshops. At first the training was given only to hospital staff and to VDC-level representatives and health workers. Later in Phase One it was decided to provide the training to the hospital support committee (HSC), because NSMP came to recognize the important role the HSC plays in management of the hospital.

In Phase Two, for reasons of economy, the FFC process was shortened, while retaining its effectiveness. There are now three workshops of three days each, over a nine-month period, with coaching by NSMP staff instead of by the FFC trainers. Hospital staff and HSC members are trained together, and change agents from within the hospital staff are being trained as facilitators of the FFC process. VDC training is no longer conducted by external trainers, and NSMP is developing district level facilitators from among local NGOs and DPHO staff to train the VDCs in the future.

At district level NSMP identified the need for greater coordination and collaboration among stakeholders, and FFC training is now being provided to the Reproductive health Coordination Committee (RHCCs) and the SM Sub-committees (SMSC) in both Phase One districts and Phase Two districts.

Evaluations of the FFC process⁹, conducted in both phases of NSMP, assert that the QOC model (described above in section 4.4.1) would have had less success without the input of FFC. Quality improvement is a problem-based approach, and the "appreciative approach" of

⁸ Watkins & Mohr, 2001; Cooperrider & Srivastva, 1987; Bushe, 1998; Bushe & Coetzer, 1995

⁹ Hodgson R, et al, 2003; Hodgson, 2001; Kafle & Subedi, 2001

FFC has helped to bring about a shift from focusing on problems to generating a commitment to make the QOC model work, and to bring about the results that staff desired.

5.5 ADDRESSING POINTS OF RESISTANCE – Developing an effective mechanism for identifying and addressing cultural, institutional and personal points of resistance

The baseline picture at the inception of NSMP was not encouraging. Neither BEOC nor CEOC was available at any of the units on a 24-hour basis. Clinical practice was poor, and in some cases judged to contribute to, rather than reduce, morbidity. Despite the large amount of training attended by staff, all elements of obstetric care were judged to be sub-standard. Training was considered as an opportunity to supplement salary, by earning allowances paid for participation, and was not resulting in improved practice. Untrained staff were undertaking much of the patient care and all elements of infection prevention. There was a complete absence of teamwork and interdepartmental communication. Furthermore, a ‘them-and-us’ attitude prevailed between health staff and the community. This was frequently manifested in hostile scenes in which clients and staff were openly aggressive to each other. Not surprisingly, hospital staff at all levels appeared overwhelmed by the problems they faced. In addition, there was tension and ambivalence in the way the Project team were received. Antagonism and scepticism to outsiders was only just tempered by the status and financial benefits associated with being part of a project.

There is a common understanding amongst the Nepalese that “your future is already written down for you - it is your karma or your fate. Consequently many employees in government organisations in Nepal are immersed in a mood of cynicism and apathy - ‘*ke garne*’, which roughly translates as ‘don’t give yourself a headache because nothing can change’. (Abbatt, 1999).

Ke garne manifested itself in the belief that “*Women die as a result of childbirth and there is nothing we can do about it*”. It was clear to the Project team that the *ke garne* attitude was a major point of resistance.

A related point of resistance stemmed from what Joyce Abbatt describes as the Jagir management culture, which is prevalent in Nepal. Writing in *The Kathmandu Post* in 1993 Ravi Pradhan¹⁰ noted:

“Over the last 30 years, Nepal has received billions of dollars in aid and loans, employed thousands of foreign experts, and the best and most educated minds in the country. Yet, in the assessment of many Nepalese and Westerners, Nepali state organisations and institutions are very ineffective, unproductive, impervious to improvements, autocratic, rigid and unresponsive to customer needs and satisfaction ... Probably the most devastating effect of the Jagir culture is that it has disabled people in their capacity to create new possibilities, new visions, and to take responsibility for creating and initiating changes”.

This system is still evident today in current management practices in many institutions and organisations, and is a major obstacle to the improvement of services. By involving staff at a number of levels in the design of the change process, rather than merely delivering the change, NSMP empowered stakeholders to create the new visions and possibilities and to take responsibility for managing the change.

NSMP addressed further possible points of resistance by including all cadres of staff in training. Cadres who had never previously received training now enjoyed the benefits of learning new knowledge and skills. Administrators, store-keepers, peons and sweepers

¹⁰ Ravi Pradhan, 1993: *The Jagir Culture in Nepali Organisations: An Essay*, *The Kathmandu Post*

became part of the hospital team working towards achieving the shared vision. Initially, senior staff (such as doctors - who are generally from a higher caste) resisted the notion of joint meetings with support staff such as the peons. This attitude reflects the prevailing caste culture. Sensitive and imaginative strategies to gradually address this issue were required. The project used infection prevention (IP) training as its first pragmatic opportunity, as this is an intervention in which all staff can, and should, play an important role. Improved communication and mutual respect for all staff were fostered in IP meetings, through an understanding of everyone's respective roles in a critical technical area. The entrenched dynamics of the hierarchical and caste systems remain a challenge, but key successes, such as the cohesiveness of the IP teams, give rise to optimism that these barriers can be overcome.

Building upon lessons learned in the first phase, NSMP focused attention on hospital management committees in the second phase. Committee members have all been through the FFC process, have been on study tours to other districts, and have received on-the-job training. Managers who embraced the positive change process have been encouraged and rewarded with greater responsibility. However, managers who were unwilling to change found their roles as leaders diminished, as an empowered staff increasingly took responsibility for bringing about change.

5.6 QUICK WINS – Systematically planning for early and easy successes

A critical technique for changing fatalistic attitudes is to demonstrate quick successes in a change programme, and consequently NSMP planned for short-term wins and created opportunities to celebrate successes.

An early successful intervention was the improvement of infection prevention (IP) measures and waste management (outlined in Section 4.5 above). NSMP provided on-site training in IP for all cadres of staff, procured essential supplies, and constructed large concrete waste-pits. Infection Prevention Committees were quickly established, with representation of all cadres, to monitor the hospital situation and identify solutions to problems. Staff immediately saw the benefits of the new measures, especially the cleaner hospital grounds and buildings, and the increased protection for themselves.

NSMP facilitated the introduction of the partograph (a device for monitoring progress during labour) into all hospital delivery rooms, and trained staff in its use. This was a tangible tool that was quickly understood, and it encouraged new skills and interest in midwifery. Nursing staff appreciated their new skills and confidence in identifying problems during delivery.

There are some location-specific examples of "quick wins. In one remote mountainous district a planned piece of major construction work was delayed – and the severe climate meant that commencement would not be possible until April of the following year. The project ameliorated the natural disappointment of the staff by quickly establishing a temporary hot-water system. Since having a hot shower was a luxury that was greatly appreciated by staff and clients, this initiative helped to encourage women to attend the hospital for care, and helped to restore the morale of the staff.

Training needs, identified by the staff themselves, have removed the need for financial incentives to attend training, and staff are motivated by the immediate benefits for themselves and their patients.

5.7 ENABLING ENVIRONMENT – Fostering an enabling political and policy environment in which to operate, and identifying powerful and visible leader(s) who will sponsor the change

Research data from a number of countries has demonstrated that strong political commitment is essential to achieving a reduction in maternal mortality, and that where this has been delayed maternal mortality rate remains invisible and un-tackled (De Brouwere et al, 1998).

NSMP was the first major Safer Motherhood Project to be initiated in Nepal. At an early stage, the Project Team adopted a two-pronged approach to fostering an enabling environment. The first operated at district implementation level to provide the experience and reality checks needed, and the second at policy level to engender the trust and confidence of senior managers and policy-makers.

A critical point that strengthened the policy environment occurred during the inception of the second phase of the project, when the Family Health Department (FHD) and NSMP held a joint review of the QOC approach. This review analysed the learning from 5 years of implementation of NSMP, plus new evidence-based learning from initiatives in other countries. Following this review the QOC approach was revised and a new version was produced in Nepal that included locally appropriate tools for monitoring quality of EOC. The tools, jointly developed with HMGN, have received approval from international agencies working in the arena of safe motherhood, including UNFPA, UNICEF, USAID and GTZ.

The two approaches described earlier – QOC and FFC – continue to create an enabling environment for change at district level, although there are indications that if the changes are to be sustained, FFC needs to be further institutionalised at national level (see section 4.9). NSMP's staff have learned from the empowering processes involved in QoC and FFC and, as a result, a very strong team has emerged. This is in large part why the project is so widely respected.

At national level the Project Team based in Kathmandu continues to network effectively with key DoH staff, and with local and international agencies, thus providing an enabling environment in which the project can operate. Being physically based in the Family Health Division encourages easy access by HMGN staff to the project team for advice and support, which is generally provided through an informal/drop-in arrangement that is effective in maintaining good personal and professional relationships.

NSMP are key players in a dynamic and productive HMGN-led safe motherhood committee at national level. There is clear dedication amongst the MOH senior staff to making this initiative succeed.

Finally, the project's extensive external communication strategy, described above in Section 4.2.2, has contributed to developing and maintaining an enabling policy environment.

5.8 OWNERSHIP - Fostering ownership and involvement of the key stakeholders, and having a body of people committed to making the change happen

A participatory transformation process was developed early in the Project, and this supported the development of the "whole hospital approach" (i.e. training, facilities improvement and the Quality of Care initiative). The Project Team used Pretty's typology of participation to guide their work with staff and community members at all levels (Pretty, 1994). Conventional and accepted power relations were challenged by ensuring the inclusion of all hospital staff and management, from medical superintendents to cleaners, in transformation activities. This

approach has been time consuming, but has enabled a solid foundation to be developed which is manifesting itself in the later stages of the Project by local ownership and control of activities and the prospect of sustainable change.

One of the biggest problems in the Nepal health service is the frequent transfer of skilled staff. To help ameliorate the adverse effects of this problem, NSMP has provided extensive training to entire teams, including those cadres who were not likely to be transferred - peons, sweepers, junior nurses, administrators etc. Now, when trained staff are moved by HMGN, there is still a critical mass of remaining staff who have the skills, knowledge, commitment and motivation to train and support new arrivals. For example, hospitals have established Infection Prevention Committees (IPC), which includes the medical superintendent, the sister-in-charge, a storekeeper an administrator, peons and sweepers. The IPC can therefore continue its work, even if a majority of the staff are transferred.

As mentioned earlier in this paper, in Phase One the Human Resource Development Officers (HRDOs) operated as key change agents. The HRDOs, who are all experienced, skilled midwives, supported staff training and development and worked with the local hospital teams to sustain quality improvement. In Phase Two, the HRDOs were each able to support between 2 and 4 hospitals. The change support strategy was revised, and the role of each HRDO evolved from being a change agent to transferring their skills to nurses, who in turn became the QOC change agents. Each of the nurses was identified and appointed by her colleagues, and the role of the HRDOs was to support and empower these second-generation change agents. Over the last year, NSMP has witnessed the rising confidence of these new change agents, not only in their work related to QOC in the hospitals, but also in their interaction with the hospital management committee.

5.9 SUSTAINABILITY - Institutionalising and sustaining the change.

From its early days NSMP has worked with local staff and communities to help them take responsibility for diagnosing and helping to solve their own health and development problems. Community participation has been used as a key empowerment tool, both to achieve the Project's overall objective and to support the longer-term work that will be required if reduction in MMR is to continue.

Developing sustainable improvements has been at the core of the Project's transformation process. Participation has not been viewed merely as an 'input' but rather as the basis on which the Project has operated. Training, quality improvement initiatives, team working and organisational development, (i.e. the 'package of inputs' provided by NSMP), have all been geared to future sustainability. Provision of training to all staff moderates the detrimental effect of the high staff transfer rate.

Due to the hierarchical nature of Nepali culture, the concept of real teamwork has been difficult to introduce and implement. Traditionally, staff have followed instructions without question, and abstained from expressing their concerns or opinions. The outcome of this institutional climate was apathy and a lack of motivation. However, a team mentality is evolving, where support staff and service providers are learning to work together. Management skills have improved, as has communication among colleagues.

As a result of the project's "package of inputs", service providers and managers have gained a degree of self-confidence that allows them to manage resources effectively, and to resolve local problems without external interventions. The hospital management committees have been impressed with the improvements they see, and are now responding by allocating additional resources for essential drugs and replacement supplies, and for expansion of staff

numbers.

The QOC approach and FFC interventions were designed to enhance sustained behaviour change. However, a recent evaluation of FFC¹¹ notes that FFC appears to have been “added on” to the SM programme, rather than integrated into it. While FFC training has been provided to a wide range of stakeholders, the follow up and support required to institutionalise skills gained during the training have not been fully incorporated into the SM systems. There is no manual or guidelines for practising the skills, nor organised reflection on the skills acquired during the training. While this makes the changes that FFC has brought about all the more remarkable, there are some concerns about their sustainability.

A recent evaluation of the impact of FFC recommends that NSMP must now capitalise on its successes by integrating FFC more thoroughly into the overall programme, systematizing it as part of the QOC system, and ensuring there is adequate follow up and support for the participants. The evaluation questions what will happen when NSMP withdraws, and notes that there is some indication that the positive changes that the project has brought about may not be sustained at their present level.

One indicator is that the QOC system of meetings has faltered with the transfer or departure of HRDOs in two of the districts. While a change agent has been appointed in each hospital to facilitate the QOC system and support the new behaviours, the evaluation notes that it is too early to say how well this will work

The transfer of hospital staff and district officers continues to be a major issue of concern. Due to high turnover in one district, more than half of the current nurses have not received FFC training. Some Hospital Support Committee (HSCs) and RHCCs are seeking to increase the number of staff who are from the local area, so that their knowledge and expertise are not lost to the district. In two of the districts, older nurses from the local area are helping new nurses learn about FFC and practise it.

The Maoist insurgency and associated political insecurity sometimes results in civil conflict in NSMP's working areas. In one of the affected districts, the RHCC and NSMP staff were concerned about the current political situation, with the DDC and VDC representatives having left their positions and the insurgency making it dangerous to visit communities and compelling men to leave their families. However, the nurses felt the changes brought about by FFC are sustainable, because there is teamwork, respect, work sharing and positive thinking. Even the paramedics feel the division of work, role clarity, and responsibility are increasing, and note that “*Ke garne* is declining”.

¹¹ Hodgson R, et all, 2003

6. THE CHANGE PROCESS SUMMARISED

NSMP is now regarded as a model for successful implementation of Safer Motherhood initiatives and is influential at both national and international levels.

Flexible, pragmatic project sequencing has enabled the Project to focus on tangible improvements, such as renovation of hospital buildings and improvements in infection control and waste management, leading to an early improvement in staff morale. Once the 'basic' needs had been met, the focus was shifted to improving organisational development and the quality of care, through competency based training.

Using participatory approaches, NSMP developed a **clear, easy-to-articulate and shared vision** of the project outcomes. Project-appointed Human Resource Development Officers acted as **change agents** and helped to ensure an **effective communication strategy** within and outside the project. An **appropriate overall strategy** – “changing hearts and minds” – was adopted, and key elements were implemented using **tried-and-tested approaches**, such as CQI and FFC. The project identified and **strategically addressed critical points of resistance**, including the prevailing *ke garne* mindset. The project also **fostered ownership and involvement of key stakeholders** using the “whole hospital approach”, and by training entire teams of staff ensured that there was a **body of people committed to making the change sustainable**. However, the changes brought about by NSMP are still dependent on appropriate political support and the maintenance of an enabling policy environment. Human resource allocation remains a precarious area, and inappropriate transfer of staff still has the potential to undermine some of the positive changes brought about by the project. Addressing these critical issues will be part of the challenge of the next phase.

7. BIBLIOGRAPHY

General references

Aitken JM. Voices from the inside: managing district health services in Nepal. *International Journal of Health Planning and Management* 1994; 9: 309-340.

Beckhard R and Harris RT. *Organizational Transitions: Managing Complex Change*. 1987, Addison-Wesley.

Brown D. Bureaucracy as an issue in Third World management: an African case study. *Public Administration and Development* 1989; 9: 379.

Bushe, G.R. (1998) Appreciative inquiry with teams. *Organization Development Journal*, 16:3, 41-50.

Bushe, G.R. (1995) "Advances in appreciative inquiry as an organization development intervention" .*Organization Development Journal* , 13:3, 14-22.

Bushe, G.R. & Coetzer, G. (1995) "Appreciative inquiry as a team development intervention: A controlled experiment". *Journal of Applied Behavioral Science*, 31:1, 13-30.

Clapham, S, I Basnet, L Pathak M. McCall, The evolution of a quality of care approach for improving essential obstetric care in rural hospitals in Nepal, Paper submitted to the International Journal of Gynaecology and Obstetrics, Averting Maternal Death and Disability section, 2003

Cooperrider, D. L., & Srivastva, S. (1987). Appreciative inquiry in organizational life. In W. Pasmore & R. Woodman (Eds.), *Research In Organization Change and Development* (Vol. 1, pp. 129-169). Greenwich, CT: JAI Press.

De Brouwere V, Tonglet R and Van Lerberghe W. Strategies for reducing maternal mortality in developing countries: what can we learn from the history of the industrialized West? *Tropical Medicine and International Health* 1998; 3(10): 771-82.

Family Health Division, Dept. of Health Services/HMGN. National Safer Motherhood Plan (July 2002 – July 2017). 2002, HMGN.

Graham WJ, Bell JS and Bullough CHW. Can skilled attendance at delivery reduce maternal mortality in developing countries? European Commission Expert Meeting, Nov. 2000.

Graham W et al. Criteria for clinical audit of the quality of hospital based obstetric care in developing countries. *Bull WHO* 2000; 78:614-620.

Hodgson, R, K Badu, C Kati, M Parajuli, Artistry of the Invisible- Evaluation of 'Foundation for Change' - a change management process, Options, 2003

Hulton L, Matthews Z, Stones R. A framework for the evaluation of quality of care in maternity services. University of Southampton. UK. 2000.

Kotter JP. *Leading Change*. 1996, Harvard Business School Press.

Kotter JP & Schlesinger LA, Choosing Strategies for Change. *Harvard Business Review*, March/April 1979

- MacDonagh S. Briefing paper for DFID Maternal Mortality Taskforce. 2002, DFID.
- Maine D. What's so special about maternal mortality? In: Berer & Ravindran eds. Safe Motherhood Initiatives: Critical Issues. 1999, Blackwell Science.
- Nepal Family Health Survey 1996. 1997, Ministry of Health (Nepal), New Era, and Macro International Inc.
- Maslow A. Motivation and Personality. 1954, Harper.
- Nepal Demographic and Health Survey 2001. 2002, FHD, Ministry of Health (Nepal), New Era and ORC Macro.
- Pittrof R. and Campbell O. Quality of Maternity Care – Silver Bullet or Red Herring? London School of Hygiene and Tropical Medicine, London. 2000
- Pretty J. Alternative systems of inquiry for sustainable agriculture. IDS Bulletin 1994; 25(2).
- Rooney C. Antenatal Care and Maternal Health: How effective is it? 1992, WHO Geneva.
- Senge P. The Fifth Discipline: The Art and Practice of The Learning Organization. 1990, Doubleday.
- Thurley K & Wirdenius H, Supervision: a Reappraisal, 1973, Heniiamann
- United Nations. Population Development, Vol 1: Programme of Action adopted at the ICPD, Cairo. 1995, UN.
- Watkins JM and Mohr BJ. Appreciative Inquiry. 2001, Jossey-Bass/Pfeiffer.
- WHO, Maternal and Safe Motherhood Programme. Obstetric and Contraceptive Surgery at the District Hospital: A Practical Guide. 1992, WHO.
- WHO, Maternal and Safe Motherhood Programme. Mother-Baby package: Implementing Safe Motherhood. 1994, WHO.

NSMP Materials:

Reports:

- Abbatt J. Review and Documentation of IEC Approach of the Nepal Safer Motherhood Project. Jan. 1999, DFID.
- Abbatt J. Review and documentation of Nepal Safer Motherhood Project's Capacity Building Component. May 1999, DFID.
- Abbatt J. Challenging 'Ke Garne': Experiences of the NSMP. Aug. 1999, DFID.
- Abbatt J. Challenges to Reducing Maternal Mortality. Aug. 1999, DFID.
- Anaesthetic Assistant Training Reference Manual & Course Guide. 2000, FHD/NHTC.

Barraclough A. Needs Assessment of Medical Equipment and Consumables Requirements. Oct. 1997, DFID.

Basic Essential Obstetric Care – In-service training for doctors: Participant Handbook & Log Book. April 2002, FHD/NHTC.

Basnet, I. Improving Quality of Care in Rural Hospitals in Nepal: The Process and Lessons Learned. May, 2002, NSMP.

District Planning Workshop Report for NSMP. November 2000, Organisation Development Centre.

Foster P. An interim report on the pilot training programme to increase the anaesthetic skills of nurses. Dec. 2000, NSMP/FHD.

Hodgson R. NSMP: A Report on a Review of 'Foundation for Change'. June 2001, NSMP.

Kafle G. Stakeholders Review. May 2000, NSMP/DFID.

Kafle G & Subedi HN. Review of the 'Foundations for Change' tools used in Phase I and an approach for Phase II. 2001, NSMP/DFID.

Lenton C. et al. Report of a Project Identification Mission: Safe Motherhood at the District Hospital. Jan. 1995, ODA.

Lenton C et al. A District Level Inventory for Safe Motherhood Planning in Nepal. Jan. 1995, MoH.

Lenton C et al. Nepal: Emergency Obstetric Care at the District Hospital. A Preliminary Draft Project Memorandum. Oct. 1995, ODA

MacDonagh S. The Contribution of NSMP to the sector-Wide Health Policy. May 2000, NSMP/DFID.

MacDonagh S. NSMP: Dissemination Processes and Lessons Learnt During Phase I. May 2000, DFID.

Nepal Safe Motherhood (NSMP). Needs Assessment Reports. 1997 and 2000, DFID.

NSMP. Inception Phase Report. Jan.1998, DFID.

NSMP. Report on Performance Evaluation of Graduates of Post Basic Diploma Midwifery Course. April 2002, DFID.

Simpson H. Increasing Access – a review of Phase I. May 2000, NSMP/DFID.

Summary of second phase strategy, working principles and guidelines: Increasing Access Component. 2001, NSMP.

Potter D. Report of a Construction Needs Assessment. Sept. 1997, DFID.

Project Memorandum: Safer Motherhood in Nepal. June 1996, ODA.

Slavin H. et al. Output to Purpose Review: Safer Motherhood Project Nepal. June 2000, JSI for DFID.

Videos:

'Save the Mothers'. 1997, Options,

'Breaking Barriers in Dhamja: Impressions – then and now'. 2000, Options.

'Improving the Quality of Services in the National Safe Motherhood Programme'. 2000, Options.

'Foundation for Change'. 2000, Options.