The Nepal Safer Motherhood Project: A Model for Change

Authors: David Wilkinson[a], Melissa Cole[a], Susan Clapham[b1], Dr Yasho Vardhan Pradhan[c]

Contributor: Antoinette Pirie[a]

[a] International Health Consultants, Options; [b] Department for International Development, [c] His Majesty's Government of Nepal, Family Health Division

ABSTRACT

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*[2] - the negative fatalism that pervades Nepali culture. This paper explores the change processes and highlights the project achievements, and relates these to nine 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 an appropriate combination of tried-and-tested and innovative 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.

Keywords: Safe Motherhood; Change Management; Quality of Care; Nepal; Developing Countries, Emergency Obstetric Care; Foundation for Change.

1. BACKGROUND AND CONTEXT: THE NEED FOR 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).

---

[1] The opinions expressed are those of the author not DFID

[2] Roughly translated as: "what to do?" and implying "don't give yourself a headache, because nothing can change"

In 1997, the Nepal Safer Motherhood Project (NSMP), funded by DFID and managed by Options Consultancy Services, began with the explicit purpose of promoting access to emergency obstetric care (EmOC) through the development of a District EmOC Model, addressing the availability and quality of care, and also the complex barriers to EmOC-seeking behaviour in project communities. During Phase One of the project (1997-2000), NSMP operated in three districts expanding to a total of ten districts in Phase Two (2001-2004), representing 15% of Nepal's (2001) population.

DFID's Identification Mission in 1995 recognized the infrastructural 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. Aitken (1994) describes the range of cultural and institutional features operating in the Public Health System in Nepal that have impeded so many external interventions [*1*]. She questions whether agencies should 'try and change that culture or simply adjust interventions to improve services in order to take account of its likely effects.' Brown (1989) argues that many interventions have failed through taking the second option [*2*].

The baseline picture at the inception of NSMP was not encouraging: 24-hour EmOC was not available at any of the units; clinical practice was poor, and in some cases was judged to contribute to, rather than reduce, morbidity; all elements of obstetric care were judged to be sub-standard, despite extensive staff training which was considered merely as an opportunity to supplement salaries; and 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 [3].

Shortly after the commencement of the project, a participatory needs assessment identified the range of inputs required to address the objective of "increased quantity and improved quality of EmOC". These included technical and infrastructural inputs but, almost more importantly, a clear acknowledgement of the need to address the prevailing mindset of service providers and transform the institutional culture from apathy to activity. The needs assessment findings clearly showed that health staff resisted emerging from their "comfort zone" and preferred to blame others for their poor performance [4].

2. MANAGING THE CHANGE PROCESS

Change management research conducted in several countries has identified a number of key elements that occur in successful change processes [5*, 6, 7, 8*]. In this section, the management approaches and lessons learned from NSMP will be examined in the context of the key elements of successful change management.

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

Kotter (1996) identifies a number of key steps in developing a clear and shared vision [5]. 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 *peons*[3] 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 (1996) [5] 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 set out an achievable picture of the future.

NSMP's vision in its first phase was that:

> *District Hospitals should be able to offer 24-hour comprehensive emergency obstetric care (CEmOC) 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.*

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

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

A project dissemination strategy was established which included 6-monthly reports with a set of annexes devoted to lessons-learned, processes to disseminate written research and evaluations, and informal and opportunistic mechanisms to communicate the project vision. NSMP's documentation and presentation of process and impact has been critical in ensuring "home grown" learning is translated into policy and practice.

[3] Peon – local term for a cleaner/housekeeper

2.3 STRATEGY – Choosing an appropriate strategy to foster change

The choice of an overall change strategy was directed by a number of factors. Kotter & Schlesinger (1979) developed a "strategic continuum" [9] along which a strategy for change might be plotted (see Fig 1 below).

FACTORS	
Minimal or recent resistance to change	Entrenched resistance to change
Less influential change agents	More influential change agents
Commitment from others not needed	Commitment from others needed
◄────────────────	────────────────►
Faster change	Slower change
Clearly planned	Planning evolves
Little involvement of others	Others heavily involved
Resistance is overcome	Attempt to minimise resistance
STRATEGY	

Fig 1.

The Project team assessed that the factors affecting the proposed change all lay to the right of the above spectrum, and from this NSMP identified an appropriate strategic approach to manage the change.

Thurley & Wirdenius (1973), identify five different approaches to strategy development [10]:

Directive – where change is largely imposed by management, with little involvement of other stakeholders (generally used where the pace of change needs to be rapid and where resistance is minimal);
Negotiating – which allows for bargaining and concessions on implementation (e.g. productivity bargaining);
Analytical – which often uses experts to solve clearly defined problems (generally management-led without much consideration of its acceptability to those affected);
Action-centred – the approach is to start with a general idea of the problem, try out solutions and modify these in the light of effects;
Normative (hearts and minds) – this approach often uses external change agents, and an attempt is made to capture the commitment of those affected, not just to specific changes, but to the overall vision (hence "hearts & minds"). Often used in changing the quality of a product or service, the aim is to get staff committed to the concept of high quality and to constantly strive towards it.

It was clear that the last of these strategies, ("hearts and minds") is the one that best met the needs of NSMP, and was consequently the approach adopted by the project.

2.4 IMPLEMENTATION PLAN – achieving a balance between innovation, and tried & tested models for implementation

While allowing scope for innovation, a guiding principle for successful change management is to employ implementation models that are tried & tested, and engage implementers that are well-accepted and respected in their fields.

NSMP adopted two complementary approaches for implementing their change management strategy – Quality of Care (QoC) – largely based on international and evidence-based best practice, and Foundation for Change (FFC) - already used in

Nepal (although not in health) to good effect. The key elements of these two approaches are outlined below.

2.4.1 Quality of Care

The NSMP Quality of Care (QoC) model follows the well-known Continuous Quality Improvement (CQI) approach, and was originally adapted from COPE[4], a methodology that utilizes a step-by-step approach to help staff analyse, plan, improve and monitor their services. The focus is on improving overall service delivery systems, rather than on individual staff performance [10]. The QoC approach developed by the team consisted of three steps: 1) setting local standards for quality of EmOC services, 2) taking actions to achieve the agreed standards, and 3) monitoring changes over time.

All members of the teams received training in maternal care and/or infection prevention, after which they set their own standards in these areas. Each hospital reviewed QoC issues through a monthly assessment, using checklists that identified and analyzed barriers to quality health care. The QoC teams then developed action plans to identify areas for improvement using local resources 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. Periodic review meetings brought together staff from all the hospitals to share experiences and lessons learned.

2.4.2 Foundation for Change

The QoC process described above was complemented by an innovative organisational development programme**,** Foundation for Change (FFC), introduced in 1998. It was clear at the start of the project that there was an urgent need to strengthen the management, accountability, and decision-making capacity as well as address the sense of apathy that prevailed at the hospitals. FFC helps participants analyse personal and institutional barriers to change, determine system strengths and weaknesses, and develop individual and team-based change management skills.

The FFC package is based on the framework of “Appreciative Inquiry” [*12, 13, 14, 15, 16*]. Used to complement the traditional problem-solving approach, Appreciative Inquiry seeks out what is “right” in an organization and builds upon this. Such an approach requires an organization to make a commitment to continuous learning, growth, and generative change.

The FFC process consisted of a programme (spread over 12 months) that included confidential interviews with participants, workshops, team follow-up coaching sessions, and meetings with senior staff. In Phase Two of the project, NSMP staff were trained to take over the responsibility for coaching and hospital staff and Hospital Support Committee members were trained together. Change agents from within the hospital staff were also trained as facilitators of the FFC process. In the other component, increasing access, NSMP is training district level facilitators drawn from local NGOs and District Health staff, who then take the programme to the community level.

---

[4] 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

Evaluations indicate that the QoC model would have had less success without the enabling environment created by FFC *[*17, 18, 19*].* QoC teams began to think more positively - critical to using existing resources more effectively, taking a more independent approach to external resourcing and even finding personal 'resources' not previously utilized. Using FFC ensured easier implementation of project plans and meant that the project could function as "catalyst" rather than a "carthorse".

2.5 ADDRESSING POINTS OF RESISTANCE – Developing effective mechanisms for identifying and addressing cultural, institutional and personal points of resistance

There is a common understanding amongst the Nepalese that "your future is already written down for you - it is your karma". 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) [10]. It was clear to the project team that the prevailing *ke garne* attitude was a major point of resistance.

By involving staff at a number of levels in the design of the change process NSMP empowered them to create new visions and possibilities, and take responsibility for managing the change. Using FFC, staff created "breakthrough projects" which helped develop a commitment to changing the *approach to caring* - for the facilities and equipment, and in regard to client interactions. In addition, staff felt the changes brought about by FFC were sustainable because of the increased teamwork, respect, role clarity, work sharing and positive thinking, and staff now note that *"Ke garne is declining" [18].*

A further point of resistance stemmed from the prevailing *social* culture in Nepal whereby certain casts and ethnic groups are socially excluded, and gender-related dynamics influence the functioning of society. Initially, senior staff (such as doctors - who are generally male, and from a higher caste) resisted the notion of joint meetings with support staff. NSMP used infection prevention (IP) training to foster a team approach, as this was an intervention in which all staff could, and should, play an important role. Administrators, storekeepers, peons and sweepers became part of the hospital team working towards achieving a shared vision. The project included all cadres in training, and staff who had never previously received training were motivated by acquiring new knowledge and skills, and by a recognition of the importance of everyone's 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 social structures remain a challenge, but key successes, such as the cohesiveness of the IP teams, and the measurable reduction in infection in the units, give rise to optimism that these barriers can be overcome.

2.6 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.

The improvement of infection prevention (IP) measures and waste management was an early successful intervention. 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 better knowledge of and interest in midwifery. Nursing staff appreciated their new skills and confidence in identifying problems during delivery.

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

2.7 ENABLING ENVIRONMENT – Fostering an enabling political and policy environment, 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, high maternal mortality rates remain invisible and un-tackled (De Brouwere et al, 1998) [21].

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, providing the experience and reality checks needed, and the second at policy level to engender the trust and confidence of senior managers and policy-makers.

NSMP was skilful in identifying national champions for maternal mortality and working alongside them. Establishing respectful and trusting relationship was critical. The project also utilised “home grown” knowledge gained though evaluations and research to inform and shape policy – and built on this using evidence based practice such as the QoC process described earlier. The demonstrable success of some of the models used led to their adoption by the Ministry of Health’s Family Health Division.

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

An ongoing participatory transformation process supported the development of the “whole hospital approach” and the Quality of Care initiative. Conventional power relations were challenged by ensuring the inclusion of all hospital staff and management in transformation activities. This approach has been time consuming, but has fostered local ownership and control of activities, and the prospect of sustainable change.

In Phase One, the HRDOs - all experienced and skilled midwives - operated as key change agents. The HRDOs supported staff training and development and worked with the local hospital teams to sustain quality improvement. In Phase Two, the role of each HRDO evolved from being direct change agents to transferring their skills to nurses, who in turn became the QoC change agents. These nurses were identified and appointed by colleagues, and the role of the HRDOs changed to supporting and empowering these second-generation change agents. NSMP has witnessed the rising confidence of these new change agents, not only in their work related to QoC, but also in their interaction with the hospital management committee.

2.9 SUSTAINABILITY - Institutionalising and sustaining the change

Developing sustainable improvement has been at the core of the Project's transformation process. From the outset, NSMP worked with local staff and communities to help them take responsibility for diagnosing and solving 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. 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. In addition, provision of training to all staff moderates the detrimental effect of the high staff transfer rate.

NSMP fosters a team mentality, where support staff and service providers are learning to work together, resulting in improved motivation, communication and management skills. Building on FFC inputs, other organizational enabling factors were also more *visible* (e.g. use of evidenced-base practices, ability to meet client demand, increases in supplies and staff availability), helping the team to sustain change.

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 responding by allocating additional resources for essential drugs and replacement supplies, and for expansion of staff numbers.

HMIS data for the project areas indicate an average annual increase of met need for EmOC of 1.0% for phase 1 districts and 1.4% for phase 2 districts [*22*], which respectively meet and exceed the National Safe Motherhood Plan's target of 1% increase per annum [*23*]. NSMP is now regarded, at both national and international levels, as a model of successful implementation for Safer Motherhood. UNICEF (a partner in the Averting Deaths and Disability programme) drew heavily from NSMP in designing their safe motherhood project and the two projects work very closely ensuring they both inform policy and work to the national 15 year Safe Motherhood Plan.

3. THE CHANGE PROCESS SUMMARIZED

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 a **balance between tried-and-tested approaches, and innovative 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** – encouraging *adaptability*, significant within Nepali culture because resistance to change was so high.

REFERENCES

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

2. Brown D. Bureaucracy as an issue in the Third World: an African case study. 1989, *Public Administration and Development*, 9: 369-380.

3. Nepal Safer Motherhood Project-Hospital Needs Assessments –1997 & 2000. NSMP/Options Consultancy Services.

4. NSMP Need Assessment Reports 1998 & 2000. Nepal Safer Motherhood Project. NSMP/Options Consultancy Services.

5. Kotter J.P. Leading Change. 1996, Harvard Business School Press.

6. Maslow A. Motivation and Personality. 1954, Harper.

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

8. Senge P. The Fifth Discipline: The Art and Practice of The Learning Organization. 1990, Doubleday.

9. Kotter J.P. and Schlesinger L.A. Choosing Strategies for Change. 1979, Harvard Business Review. Mar-Apr; 57(2):106-114.

10. Thurley K. and Wirdenius H. Supervision: A Reappraisal. 1973, Heinemann.

11. EngenderHealth. COPE: Client-Oriented Provider-Efficient Services. 1995, EngenderHealth.

12. Watkins J.M. and Mohr B.J. Appreciative Inquiry: change at the speed of imagination. 2001, Jossey-Bass/Pfeiffer.

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

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

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

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

17. Hodgson R., Badu K., Kati C. and Parajuli M. Artistry of the Invisible: Evaluation of ‘Foundation for Change’ - a change management process. 2003, NSMP/Options Consultancy Services.

18. Hodgson R. NSMP: A Report on a Review of ‘Foundation for Change’. 2001, NSMP/Options Consultancy Services.

19. Kafle G. and Subedi H.N. Review of the 'Foundations for Change' tools used in Phase I and an approach for Phase II. 2001, NSMP/Options Consultancy Services.

20. Abbatt J. Challenging 'Ke Garne': Experiences of the NSMP. 1999, NSMP/Options Consultancy Services.

21. 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? 1998, *Tropical Medicine and International Health*; 3(10): 771-82.

22. Ministry of Health: Family Health Division. EmOC Monitoring Data 2003. HMGN.

23. Ministry of Health: Family Health Division. National Safe Motherhood Plan 2002-17. HMGN.

For more information on NSMP and access to NSMP/Options reports visit: www.nsmp.org