

Using Key Informant Monitoring in safe motherhood programming in Nepal

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This article discusses the methodology and application of the Key Informant Monitoring (KIM) tool as used by the Nepal Safer Motherhood Project (NSMP). NSMP aims to achieve a sustained increase in the uptake of midwifery and essential obstetric care services by addressing, among other things, constraints on access to such services. Data collected by community-based Key Informant Researchers (KIRs) are synthesised and used by NSMP and key project partners for monitoring and planning purposes. NSMP has used KIM findings to modify its main interventions at the local level. International and Nepali NGOs have adopted KIM in their safe motherhood and other development programmes. Village Development Committees, with support from NGOs and NSMP, have responded to issues raised by KIM by running maternal health awareness-raising campaigns, working with traditional healers, improving the quality of care, and facilitating local emergency transport and funding schemes. KIRs have proved effective as sources of information and as change agents, spreading safe motherhood messages to promote behaviour change.

Background

The Nepal Safer Motherhood Project (NSMP)—funded by DIFD and implemented by Options Consultancy Services—has supported the Government of Nepal’s National Safe Motherhood Programme since 1997 by seeking to contribute to improved maternal health in selected districts and to policy and programme development at national level. The purpose of the project is to bring about a sustained increase in the uptake of midwifery and essential obstetric care (EOC) services as part of an effort to reduce maternal morbidity and mortality. During phase one (which ran until December 2000), the project concentrated on service provision and increasing access to care in three districts. Since January 2001, when NSMP entered its second phase, there has been a greater emphasis on national policy development, and a scaling-up of the service provision and access work into an additional six districts.

The uptake of obstetric and midwifery services in rural Nepal is extremely low. The unmet need for obstetric care is estimated at 95 per cent (New ERA 2000:10), and only 13 per cent of births nationally are attended by a health professional (ORC Macro 2002:149). One of the objectives of NSMP is to improve access to midwifery and obstetric services within NSMP-supported districts. A key indicator for measuring progress against this objective relates to reducing barriers to quality midwifery and obstetric care services, and increasing the ability

of women to make informed and independent decisions regarding health-seeking behaviour. This indicator is monitored through Key Informant Monitoring (KIM). Using KIM, in combination with routine data collection and periodic reviews by partner agencies, such as local community-based organisations (CBOs) and NGOs, NSMP aims to gain an understanding of the socio-cultural, economic, and political environment (henceforth referred to as 'social context') within which maternal health, pregnancy, and childbirth are experienced, and specifically to monitor progress in improving access.

Methodological origins of KIM

KIM is an adapted version of the peer ethnographic research method (see Hawkins and Price 2000; Price and Hawkins 2002) that was developed in response to the need for an actor-centred development research method that enables a more rigorous engagement with the realities of the everyday lives of poor and marginalised people, and which recognises that far from being a static set of norms and expectations, culture is continually constructed and negotiated in social interactions and everyday practice. The recognition by development agencies and practitioners of the limitations of methods such as population-based sample surveys for generating valid and appropriate information on social behaviour, and of the time required to conduct in-depth ethnographic research, has led to an increased interest in employing rapid assessment methods (see Manderson and Aaby 1992 for a review). These methods, such as Participatory Rural (or Rapid) Appraisal (PRA) and Participatory Learning for Action (PLA) have been used effectively by development agencies to conduct community-based analyses from an actor-centred perspective; but far from being rapid, their effective use often requires an extensive initial input of time and resources into building relations of trust, and to generate an understanding of local social contexts. Without this initial understanding of community dynamics, PRA/PLA may unwittingly favour the discourses of the powerful and elite, and promote the production of consensus views and normative discourses (Mosse 1994:508ff.). The peer ethnographic method was designed to be less costly and quicker to use than sample surveys and large-scale participatory exercises, and is aimed at generating data that are not easily produced by these and other methods that dominate much of development research and monitoring.

The peer ethnographic method is derived from the participant-observation approach characteristic of anthropology fieldwork, which emphasises the need for trust and rapport between the researcher and the researched. Data collection in the peer ethnographic method is carried out by peer¹ researchers, who are established members of the community or the research target group. The initial identification and selection of the peer researchers is thus crucial, and to date has been usually undertaken by civil society organisation partners, with knowledge of and working relations with the target group (see Hawkins and Price 2000:7, 22; Price and Hawkins forthcoming 2005). In most applications of the peer ethnographic approach the research target group has been relatively homogeneous (e.g. youth, sex workers, men who have sex with men (MSMs)), making the selection of representative peer researchers unproblematic. However, the adaptation of the peer approach in Nepal, discussed below, is taking place in a highly stratified and differentiated social context, which has significant implications for the identification of peer researchers.

The peer researchers conduct in-depth and unstructured interviews with individuals selected from their own social networks. Rather than a large sample of people being interviewed once only, a series of in-depth interviews is conducted with a small sample of individuals, selected from the same social network, on the basis that data produced by intensively examining a small

number of cases produce a more thorough understanding of social life than the 'superficial exploration of many' (Hammel 1990:471).

As the peer researchers have established relationships of trust with the people they are interviewing (by the very fact that they are members of the same network or social group), the fieldwork does not require the time for rapport building typified by conventional anthropological ethnography or some PRA/PLA exercises. The approach also recognises that social networks are not made up of consensus groups but include relationships of conflict and distrust. The interviews aim to elicit the meanings that actors attribute to the social behaviour of their peers. All interviews are conducted in the third person (interviewees are asked not to talk directly about themselves, but about 'others like them') in an attempt to elicit narrative accounts of how interviewees conceptualise the social behaviour of 'others' in their networks, not accounts of their own behaviour, or normative statements about how people 'ought' to behave. Consequently, differing and conflicting perspectives emerge in the narratives.

Data collection in the peer ethnographic method recognises that it is not possible to observe the behaviour or record the narratives of others without filtering the data through an analytical framework, involving some level of meta-analysis. The peer ethnographic method is therefore structured around analytical issues identified by the peer researchers as their peers' central concerns. Conversational interview prompts for each of a number of interviews assist the peer researchers to initiate conversations and to follow up on key issues. The prompts are developed by the peer researchers in an initial participatory training workshop, and are intended as guides to help frame their conversational interviews, rather than as interview scripts. During training, the peer researchers refine and modify the prompts, so that they translate easily into appropriate local language and context. The peer researchers field test different ways to raise the same issue with different interviewees, in recognition that the way something is talked about varies even within one social context, according to the age, sex, class, etc. of the respondent. Following the field testing, the prompts are refined further, so that the tools that the peer researchers finally take to the field are locally specific.

A further key element of the peer researcher training centres on issues of confidentiality. During training it is necessary to emphasise repeatedly that the researchers should not record personal details of their interviewees beyond the necessary social classification (e.g. age, sex, ethnicity). Indeed, peer researchers do not record a detailed script of their conversations or produce conversational narratives. The data-collection prompts are designed to assist the researcher to record phrases and/or events given most importance by the interviewee during the course of the conversation. The interviewee participates in the data-recording process through confirming that phrases and events recorded are the most important ones in their narratives and explanations. The peer researchers record findings from each interview on a single sheet of paper, and during data analysis these sheets are used to show how different themes emerge in different conversational contexts.

Data analysis is carried out on two levels. The first is at the level of 'meta-analysis', in which the peer researchers' narratives are drawn on as a primary source of ethnographic data. In-depth interviews are carried out with the peer researchers by an experienced social researcher, over a short period at the end of the data-collection process. The peer researchers become the key informants to the social researcher, and their conversational narratives provide the data for a detailed social analysis. During this process the social researcher necessarily filters these data through an analytical framework, the theoretical background to which is made explicit in the social analysis. The second level involves the peer researchers conducting their own data analysis through a participatory workshop, facilitated by the social researcher, during which the peer researchers work as a group to identify key issues emerging from the interviews, lessons learned, and any changes to the interview frameworks for further research

and monitoring. At this level of analysis the peer researchers bring their own perspectives to bear on the interpretation of the interview narratives.

The peer ethnographic method has been field tested and applied successfully in a number of geographical and programme settings, including an urban adolescent health project in Zambia, sex worker HIV/AIDS behaviour change programmes in Cambodia and Myanmar (Burma), a public-sector health services development programme in Brazil, and an MSM regional HIV/AIDS programme in the Balkan states (see Hawkins and Price 2000; Longfield et al. 2004; Price and Hawkins 2002, forthcoming 2005; Richter 2002 for details).

The Key Informant Monitoring tool in NSMP

In line with the generic peer ethnographic method from which it is adapted, KIM takes as its starting point that social context is important in shaping maternal health outcomes and maternal health-seeking behaviour. KIM is being used to gain an in-depth understanding of how women of childbearing age perceive wider changes in the social context in which pregnancy and childbirth are experienced, and to monitor progress towards creating an enabling environment, from the perspective of these women.

The principles of the generic peer ethnographic method which made it attractive for use in NSMP included:

- The method recognises divisions within society and associated differences in perceptions of acceptable and appropriate behaviours.
- Respondents are from the same social groups or networks as the data collectors; such relationships of relative equality mean that the respondents are more trusting and open in their interviews.
- The method's emphasis on respondents not talking about themselves but about people 'who are like them' allows sensitive topics to be discussed without risk of causing embarrassment, and ensures that ethical and confidential dimensions of research are not transgressed.
- The data collection, analysis, and dissemination process is built on partnerships with local community-based organisations and structures.
- The method facilitates dialogue and communication between a programme and the communities with which it is working. The conversational interviews serve as a basis for this process of dialogue.

Communities in rural Nepal are highly stratified by ethnicity/caste, gender, kinship, and age, which together militate against public social interaction, especially among women. Younger women have little power or autonomy, and their behaviour in relation to pregnancy and childbirth is influenced strongly by men and senior kinsfolk. Hierarchical power relationships further discourage open communication between generations and between the sexes. Such a social structure makes it necessary to recognise and give emphasis to social divisions (notably those based on sex, age, and ethnicity/caste) when exploring community perceptions. This context has significant implications for the way in which the peer ethnographic method had to be adapted for use in rural Nepal, as the following short discussion illustrates.

Although KIM focuses exclusively upon the perceptions of change among women of childbearing age, it seeks to find ways of ensuring representation of significant social categories within this group—notably by identifying female researchers from a range of reproductive age groups and from representative ethnic groups and castes.

Constraints to women's social and geographical mobility in rural Nepal mean that there are no clearly developed peer groups. KIM has, however, adhered to the principle of training women to interview other women of similar age and social background and characteristics.

Likewise, concepts of anonymity (which form the basis of the peer ethnographic conversational interview techniques, such as ‘tell me about others like yourself’) have less meaning in rural Nepal, where communities are so small. To address these constraints KIM avoids any reference to the concept of peer in its conversational interviews: the prompts encouraged respondents to talk about ‘people they know’ and ‘events they have heard about or know of’. Such prompts clearly encourage responses based upon gossip. However, gossip in KIM (as in peer ethnography) is viewed as a valid and important source of data.

One final key difference between KIM and the peer method relates to the data-analysis process. Whereas social (ethnographic) analysis is integral to the data-analysis process in the generic peer ethnographic method (whereby peer researchers are interviewed by an experienced social researcher at the end of data collection), in KIM this social analysis is subsumed within phases one and two of the data-analysis and review process.

Development and organisation of KIM

The division of labour for implementing KIM was refined following a pilot phase conducted in 2000/01 in three Village Development Committees (VDCs) in one NSMP district. The VDC is the lowest level of government administration in Nepal. The pilot assessed the validity and appropriateness of different data-collection configurations, and experimented with three models. In one VDC, the data collectors (Key Informant Researchers or KIRs) were drawn exclusively from the local community, and represented a range of social categories of women of reproductive age. In the second VDC, NSMP field staff served as the data collectors, while in the third VDC, KIRs interviewed people from their own social category, while staff from NSMP and local NGOs interviewed members of social groups not represented by the KIRs. The pilot revealed that model one produced the highest quality of data; and thus it was decided that Nepali NGOs, in conjunction with VDC members and NSMP staff, would be responsible for identifying and recruiting representative KIRs from within each VDC.

The division of responsibilities for data collection and analysis thus became:

- The NSMP Social Development Officer (SDO)² for the specific NSMP district takes overall responsibility for supervising and managing the logistics of data collection and analysis.
- Local NGO staff (in collaboration with NSMP Local Facilitators) directly supervise data collection by the KIRs at field level and are responsible for periodic debriefing (data recording) sessions with them, and for facilitating the social analysis process at the end of the data-collection period.
- The KIRs collect data at community level, and NSMP’s Communications Officer oversees the data analysis in all the districts, and documents and disseminates the findings.

NSMP collects data using KIM at approximately 12 monthly intervals. The first round of data collection was in March 2002, the second in February/March 2003, with a third planned for mid-2004. Data from the first round were used to further refine project design and to establish a baseline against which to monitor subsequent change. KIRs were identified by local NGO field staff who were familiar with the communities and the social and ethnic categories and stratification within them. They were assisted in the identification and recruitment process by VDC officials and NSMP field staff (SDOs and Local Facilitators). KIR selection criteria included a basic level of literacy (necessary for recording written information), although a small number were illiterate. The frequency of KIR debriefing (described in the subsection below on data analysis and recording) facilitated information recall for those KIRs who were unable to record in writing the notes from their conversational interviews. KIRs were selected to represent each major ethnic group/caste and a range of age groups in the VDC.

A total of 72 KIRs were recruited and trained: six for each of two VDCs in the districts of Nawalparasi, Rupandehi, Kailali, Parbat, Surkhet, and Baglung. Training of the KIRs by NSMP’s partner NGO and NSMP female Local Facilitators began in January/February 2002 in the NSMP districts, with data collection taking place over a period of approximately five weeks.

Data collection

In each round of KIM data collection, KIRs select two women of childbearing age (whom they know and with whom they mix socially) to interview three times. The interviews focus on women’s perceptions of barriers to EOC services, quality of midwifery and obstetric care, and women’s decision-making capacity. Table 1 sets out the main focus of the three interviews in terms of the information they seek to elicit and the themes of the conversational interviews.

Interviews are carried out over approximately five weeks, during which time the KIRs receive regular support from and debriefing by Local Facilitators and NGO staff. In line with the peer ethnographic approach, conversational prompts guide each interview and assist KIRs to start conversations and to follow up on issues (during training, KIRs practise using these prompts, and revise them to make them appropriate to local context/language). The prompts (expressed in the third person) serve as the key issues to probe in the conversational interviews. As far as possible interviews are conducted in private, and at times when the respondent is not distracted by work or other activities. Data-collection sheets are provided for each of the interviews; the KIRs do not record a detailed script of the conversation—only key words, phrases, or events given most importance by the interviewee (discussed in more detail below). The KIRs confirm with respondents that the key phrases and events recorded were accurate, relevant, and important.

KIM—like the peer ethnographic method—is not designed to produce vast quantities of qualitative research data, but information that can be processed into a usable format by

Table 1: The KIM interviews

Interview	Information required to monitor change	Themes for questions
Barriers to midwifery and EOC services	Do women recognise the risks of pregnancy and the benefits of allopathic services? What economic and transport barriers do women perceive as restricting their access to these services?	Perceived roles of different care providers (traditional and allopathic) Perceived risks of pregnancy How women who need to get to hospital access finance and transport (including broader constraints to accessing these resources)
Quality of care	Is care perceived to be more widely available, acceptable, affordable, and effective?	Perceptions of specific changes in the availability, acceptability, affordability, and effectiveness of care
Women’s decision making and autonomy	Can women better express their needs, influence decision makers, and make decisions?	Perceptions of relationships with husband and mother-in-law, and of wider social pressures and acceptable practices

NSMP. As there are limitations to the amount of qualitative data that KIRs are able to record, the notes on the data-recording sheets serve only as a guide to the main issues that emerge during the interviews. KIM aims to develop an understanding over time of how women of childbearing age in NSMP-supported districts experience and perceive changes that are likely to affect their access to midwifery and obstetric services, and is thus a continual process of dialogue and reflection. One question asked by NSMP stakeholders during the initial development of KIM was whether KIRs would accurately report what is said to them, i.e. whether they would tell the 'truth' about their conversations. But the tool is not interested in collecting 'facts' about individual people, its function is to produce an understanding of the different ways in which people talk about and describe the social world they experience around them. However, a methodological issue which did need to be addressed related to KIR bias. NSMP field staff were surprised by the extent of the positive changes which were reported during the first sets of data emerging during the second round of KIM. Discussions with the KIRs revealed that some had become over-committed to the objectives of NSMP and overzealous in their conversational interviews in pursuit of evidence of improved access and service quality. This shortcoming was successfully addressed in subsequent KIR refresher training courses.

Data analysis and review

Data analysis and review in KIM is conducted in two stages. In stage one, the original plan was for each KIR to be interviewed weekly by an NSMP female Local Facilitator in the community in which the research was conducted. This approach had to be abandoned because security issues associated with Maoist activity restricted the movement of NSMP staff. Instead, all KIRs from each VDC attend the district or VDC headquarters. Three such debriefings take place in the course of each round of data collection. The NSMP female Local Facilitator³ leads the debriefing sessions, while a female NGO representative takes notes (which later in the debriefing session are synthesised for discussion). The Facilitator asks each KIR in turn to report on the information they have collected to date. After the NGO representative has synthesised the central issues emerging from the conversational interviews as reported and discussed by the KIRs, she feeds back the synthesis to the group of KIRs. The discussion then focuses on ratifying the synthesis and discussing significant similarities and differences in the KIR data. Many of the debriefing workshops, which were originally scheduled to last one day, extend to two days to allow synthesis, feedback, and in-depth discussions of the principal issues that the interviews are generating. For each VDC, KIM produces approximately 12 data-collection sheets for synthesis (each KIR carries out three interviews with each of two respondents). In addition to forming the basis for discussion with Facilitators and in debriefings, the sheets are kept by the KIRs as a record or diary of their observations and conversations. An important lesson learned early on in the development of KIM related to the amount of data collected by the KIRs. During the pilot stage, the enormous amount of information recorded on the data-collection sheets constrained analysis and synthesis. By designing the first stage of data analysis around regular debriefings, KIRs felt more comfortable recording only brief information on the sheets, which served as 'memory jogs' when discussing findings in the debriefing sessions.

The second stage of the data-analysis process involves VDC Data Review and Dissemination Workshops held at the VDC headquarters, led by the local NGO, and following a similar pattern to the workshops led by the Local Facilitators during phase one. The VDC workshops are designed to identify the main issues emerging from the interviews, to identify lessons learned for NSMP and wider Nepali safe motherhood programming, and to review and modify the tool for ongoing monitoring by NSMP and VDCs/districts. In addition to the

KIRs, Facilitators, and the NGO (which facilitates the workshop), a number of other representatives attend the VDC workshops, including NSMP team members, VDC staff and officials, and other key partners (at district and NGO level). VDCs develop plans to address issues raised by initial KIM findings, with subsequent rounds of KIM data collection used to review these activities and to look at any changes that have occurred as a result.

Findings from KIM

Findings from the first two rounds of KIM data collection and analysis in Baglung District are summarised in Table 2, and are broadly illustrative of findings from the other NSMP districts.⁴ These and other findings are reflected on in subsequent sections.

Utilisation of KIM findings

Data such as those from Baglung above have been used at a number of levels. NSMP, for instance, is using KIM findings not only for monitoring progress against its increasing access objective but also to modify some of its local interventions. Two short examples serve as illustration. First, as noted in Table 2, KIM revealed that many women of reproductive age are aware of obstetric danger signs, but cannot act on this awareness because they are constrained in their health-seeking decision making, and lack control over household finances, which is controlled by husbands and mothers-in-law (who were also shown to lack awareness about these danger signs). Consequently, NSMP has placed greater strategic emphasis on the interaction between mothers-in-law, husbands, and pregnant women, through activities such as meetings among mothers-in-law and daughters-in-law, and husbands and wives, which among other things emphasise the need for improved intra-family communications and the need to support the pregnant or postpartum mother at home. Second, KIM has clearly shown that health service providers' behaviour acts as a barrier to women and their families seeking care, as a result of which NSMP contracted a private consultancy firm with expertise in interpersonal communications to train staff in the district hospital and the primary healthcare centres in all NSMP districts. Evaluation by NSMP's human resource development officers reveals that the training has increased participants' self-realisation. Although it is too early to see direct effects in terms of staff behaviour, there is evidence that staff are reminding each other of issues learnt during the training and correcting colleagues who breach expected behaviour standards. These two issues—family members' role in health-seeking behaviour and the behaviour of service providers—are also now being addressed as key themes through the NSMP-supported district-level weekly radio programmes on safe motherhood transmitted through Radio Nepal and an FM radio station (the radio magazine programme episodes are scripted by staff from the District Health Office and local NGOs, with NSMP providing technical backup). The findings are also shared in the District Reproductive Health Coordination Committee, a forum that includes service providers and programme implementers, allowing them to hear women's voices.

Experience with developing and implementing KIM has led to a high level of recognition among implementing and other NGOs of its use in monitoring not only safe-motherhood activities but also other interventions associated with HIV, sexually transmitted diseases, and reproductive health. One implementing NGO is currently planning to use KIM in its other health and development programmes, including projects on HIV/AIDS and on girl trafficking. NSMP's dissemination at the national level (e.g. through the government's National Safe Motherhood Sub-Committee, which includes all the principal stakeholders involved in the promotion of safe motherhood) has already influenced others to use KIM as a central

Table 2: Findings from two rounds of KIM in Baglung District

Issue	KIM Round 1	KIM Round 2
Barriers to EOC and midwifery 1. Health-seeking behaviour	<p>Women prefer home delivery, with assistance from unskilled female family members or traditional healers, who rarely refer complications to health facilities</p> <p>When women have pregnancy-related problems, the first level of care is at home using local remedies. Only when the problem becomes life threatening do women seek care at health facility</p>	<p>Use of maternal and child health workers (MCHWs) to assist with births has increased, but many women still prefer to deliver at home using unskilled attendants</p> <p>More traditional healers refer difficult births to hospital immediately</p> <p>Increases in early decisions to seek care at health facility (due to improved level of knowledge about danger signs)</p>
Barriers to EOC and midwifery 2. Emergency transport and funding schemes	<p>Emergency transport is not kept readily available—being considered inauspicious. Referral often delayed while a <i>doko</i> (an open-sided bamboo basket) is constructed</p> <p>Distances from health facility and transport constraints mean women seek care from local healers. Poor road conditions deter care seeking at night and the use of motor vehicles for fear of prolapse</p> <p>When a high-caste woman is referred, low-caste men are asked to carry her. When a low-caste woman is referred, high-caste men find others to carry her. Women who are bleeding are considered ‘polluted’ and often forced to walk to hospital as men will not carry them</p> <p>Poor women cannot afford to seek care at hospital in emergencies. Time is required to locate a loan. Even when women have <i>pewa</i> (savings), they cannot spend it on their own treatment, as they may be accused of stealing by husband</p>	<p>Transport schemes established in every ward. A <i>doko</i> is kept ready in every ward and stretchers are available at the sub-health post</p> <p>Due to poor road conditions, women prefer to be carried in a <i>doko</i> than a jeep (women report jeeps are usually full anyway, and ‘drivers refuse to take sick people’)</p> <p>More men are carrying women to hospital in cases of emergency. But men from higher castes will not carry women of a lower caste</p> <p>Women more confident they will be able to access emergency funds (now available in every ward): ‘women will not have to die due to lack of money’. Funds also been used for other illness episodes and for food for poor postpartum mothers. However, women still need husbands’ permission to receive loans from funds</p>
Quality of care	<p>Women do not attend sub-health posts due to lack of beds, curtains, equipment, medicines, health staff; and because of high service charges, and lack of experience and discriminatory behaviour of health staff. Disaffection with</p>	<p>Women report: improved facilities in sub-health posts (separate examination room, bed, curtains); service providers more regularly at post; increased confidence in MCHWs who are available in community even at night, come</p>

(continued)

Table 2: Continued

Issue	KIM Round 1	KIM Round 2
	<p>health staff manifests itself in belief that if a baby dies, health staff 'have given medicine to cause this'</p>	<p>immediately, are well-liked because they counsel women and do not discriminate between rich and poor or by caste (resulting in more women attending antenatal care). Service providers in PHC and hospital liked for 'behaving politely and explaining things'. Women consider the district hospital provides 'good service' (24-hour surgery and blood, equipment, medicine is cheap). Most women believe that 'if a woman is taken to district or zonal hospital, she can be saved'</p>
<p>Women's decision making and autonomy</p>	<p>Women rarely discuss their obstetric problems openly, even those that are life threatening. They know danger signs in pregnancy, but cannot go for care as parents-in-law and husband do not consider these dangerous</p> <p>Women's involvement in household and community decision-making forums is symbolic only: their views are ignored and only men make decisions. Women are considered by men as unable to make decisions with regard to financial transactions, health-seeking actions, etc.</p> <p>Women's groups are encouraged by men to use funds (and their labour) to build temples or roads, not for safe-motherhood activities. When women's groups do not have money they are ignored by local men. When women try to influence economic decisions at household and community level, they are teased, accused of damaging household prestige, or sometimes physically beaten by husbands</p>	<p>Women increasingly report using antenatal care, and talking about problems with husbands (e.g. asking to be taken to health facility or to call MCHW for delivery). Most women prefer not to talk to mothers-in-law about pregnancy-related matters</p> <p>In nuclear families husbands support wives by doing heavy work like ploughing. In joint families, husbands are resistant to helping wives for fear of ridicule. Mothers-in-law are not thought to be very supportive. In poor families some pregnant women and new mothers are made to do heavy work and are given food only in the evening</p> <p>Women who devote their time to household work, spend <i>pewa</i> on household expenses, and rarely venture outside the household are listened to in family-level decision making. Those who exercise autonomy are not listened to</p> <p>Women (including KIRs) have influenced families to take pregnant women for check-ups and to health facilities in case of complications</p>

(continued)

Table 2: Continued

Issue	KIM Round 1	KIM Round 2
		Members of women-only local forums (mothers' groups, school management, forestry users, etc.) are able to make decisions regarding the operation of their funds (this is increasingly respected by wider community). If a local group also has male members, women are omitted from the decision-making process. Women still find it difficult to secure credit, as they do not own fixed assets (e.g. land)

monitoring tool in safe-motherhood and neonatal health programmes. For example, Save the Children (US), with training support from NSMP and the national NGO HICODEF, is using KIM in its new Saving Newborns' Lives Programme.

As illustrated in Table 3, VDCs have responded to the issues raised by KIM in a number of ways.

Table 3: Selected VDC responses to KIM findings

To improve <i>health-seeking behaviour</i> , VDCs have been actively involved in conducting awareness-raising campaigns, through Maternal and Child Health (MCH) clinics and in mothers' groups, on obstetric danger signs and the need to seek care immediately in the case of complications. In recognition of the fact that women often choose traditional healers as their first-service provider, NGOs (following requests from VDCs) have provided two-day training courses to traditional healers on the dangers of pregnancy and delivery, and the postpartum period, focusing on the need to refer quickly. KIM has already shown an increase in referrals from traditional healers following this training
To improve the <i>quality of care</i> , VDCs (with support from NSMP) have introduced curtains in health centre examination rooms so that pregnant women have privacy during antenatal check-ups; and are addressing service providers' poor behaviour towards patients and their carers by raising key quality of care issues at MCHW staff meetings
To improve <i>transportation</i> , VDCs are facilitating the establishment of community groups to construct <i>dokos</i> and stretchers (with voluntary contributions of bamboo/timber and labour)
To increase <i>economic access</i> , more emergency funds are being established. In recognition that poor women often cannot afford to seek care (because of transport, hospital costs, medicine, and other recurring costs), VDCs have provided budgets to the sub-health posts to contribute to emergency funds for the poorest
In an attempt to improve <i>women's decision making and autonomy</i> (a key factor in determining their access to EOC and midwifery care), some VDCs have set minimum female membership of 33 per cent in community groups such as water-user committees or forestry-user groups. In these and other community forums like mothers' groups, there is now evidence that women's voices are being heard in relation to key funding decisions about, for example, improving the physical infrastructure of the sub-health post, establishing microcredit schemes (including women having a say in who manages such schemes)

Conclusions and lessons learned

This short section highlights some of the main lessons learned from and wider implications for the application of the Key Informant Monitoring tool. Its use as a participatory monitoring tool has been illustrated above, including its role as a dynamic and flexible approach. This concluding section focuses on issues of local ownership, partnership, and methodology.

Ownership of and control over the method and the data by local communities and other stakeholders has increased significantly in the course of KIM being used in the field. Local ownership was facilitated from the outset through the direct participation of the VDC and community in identifying the KIRs. As data collection and analysis proceeded over the first two phases, the sense of ownership over the method and the data has also become increasingly evident among local NGOs (who have enthusiastically embraced it and begun—or expressed interest in—using KIM in projects not supported by NSMP), and among VDCs (as evidenced by interventions aimed at addressing EOC and midwifery access constraints identified by KIM). Fostering local ownership and control has also increased the legitimacy of the findings. A number of VDCs expressed their commitment to acting on issues raised by KIM on the basis that such information has high credibility as the KIRs are drawn from the community, and the local NGOs identified as KIM partners were well known and trusted by the VDCs. The role of female facilitators in the debriefing sessions was also crucial to the credibility of the data, as women would not discuss sensitive issues about sexuality, pregnancy, etc. in the presence of men.

The discussion on how the findings are being used illustrated how KIM has facilitated participatory dialogue between NSMP, its key partners (at local and national level), and the community (especially the target population: women of childbearing age). Furthermore, the KIRs have emerged not only as sources of information to the project but also as change agents spreading safe-motherhood messages to promote behaviour change among families and communities. Through their interaction with women (and their husbands and family members) KIRs have raised awareness of issues identified in the interviews, thus acting as catalysts for dialogue and community-based behaviour change (there are cases where KIRs have managed to convince family members to take women with obstetric complications to the hospital, for example). This catalytic role has been enhanced as some KIRs are part of, and/or receive social support from, CBOs and local NGOs, who in turn are engaged in wider initiatives to promote behaviour change.

One of the principal lessons learned from the adaptation of the peer ethnographic method for use in rural Nepal relates to the nature of community and peer networks in such settings. The generic peer ethnographic method lends itself to use in urban and peri-urban settings, where peer networks are extensive and the population of communities sufficiently large and diverse to generate a sense of anonymity and hence allow the use of 'third-person' interviewing. In rural Nepal, where geographical communities are small in population size, and where power structures and social hierarchies limit women's social and physical mobility, the method had to be significantly adapted. The time required for adaptation and piloting the different data-collection configurations (and conversational interview techniques and prompts), along with the subsequent identification of local NGOs and further training of field staff and supervisors, delayed full implementation by around 15 months. The KIM experience to date in Nepal has, however, confirmed that with careful adaptation and sensitive piloting the fundamental principles and methodology of the peer ethnographic method can be applied effectively to both enhance participatory monitoring and to facilitate dialogue and behaviour change.

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Notes

1. The term 'peer' does not refer exclusively to young people, whose peers are often of the same age, but to members of the same social network or social group, such as friends, neighbours, workmates, and kinsfolk, with whom an individual shares relatively equal status.
2. The Social Development Officer (SDO) has overall responsibility for managing the increasing access work in NSMP-supported districts. The Local Facilitators are managed by the SDOs and their role is to work closely with the NGO partners, providing them with technical support. Along with NGO partners, they are responsible for the KIM training, debriefing, and VDC presentation.
3. It was recognised early in the KIM design process that having a female facilitator who was familiar with KIM and well known to the KIRs in a pivotal role in debriefing sessions was crucial to the success of KIM: pregnancy, childbirth, and associated issues concerning sexual behaviour would not be discussed—even by KIRs—in the presence of men.
4. The second round of KIM was undertaken in February/March 2003 in four of the six NSMP districts. Data analysis and presentation were delayed in the fifth (Kailali) because of the security situation during the first phase. Data collection was delayed by eight months in the sixth district (Surkhet) for security reasons as well.

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