

# Study on Quality of Care Approach in Selected Health Facilities of Nepal

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## Executive Summary

Prepared for Nepal Safer Motherhood Project,  
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## Executive Summary<sup>1</sup>

### 1. Introduction

#### 1.1 Background

The DFID-funded Nepal Safer Motherhood Project (NSMP) was implemented since 1997 in support of the HMG/N National Safe Motherhood Programme. The first phase focused on improving midwifery & emergency obstetric care services of selected health facilities in 3 districts (Baglung, Kailali and Surkhet) through a Quality of Care (QoC) approach. In the second phase (2001-2004) the project expanded to seven more districts and aimed at increasing access next to improving service provision.

The “hardware” interventions included upgrading of infrastructure, provision of equipment and supplies, essential drugs, safe blood supply, Infection Prevention and waste management measures. The “software” interventions included capacity building of the service providers and others in clinical and non clinical skills and strengthening management support for QOC approach through Change Agent, QOC committees and Hospital Management Committees (HMCs). The Human Resource Development Officer (HRDO), project staff, provided technical assistance to the health facilities and facilitated the QOC process.

##### 1.1.1 QoC Approach

A locally appropriate QOC model was adopted and adapted over time on the basis of an iterative learning process, including the international experience. The QOC model aims to promote accountability and motivation among all staff through an appreciative approach, involving them as equals and enabling them to develop their potential through technical training. It also entails the formation of QOC teams to identify barriers and develop local action plans; and directly address problems that do not require funds or use locally available funds and make available resources for larger requirements.

A “Guide for Quality Obstetric Care” was developed in 2002 (in Nepali as well) by NSMP/FHD and revised in 2003. The guide includes a tool for measuring QOC outcomes, based on the QOC framework consisting of 13 core elements falling under the broad categories of Provision of Care by health facilities and Experience of Care by clients/family members. Each element describes the criteria and indicators for required level of standard<sup>2</sup>.

Table: QOC Framework – The Elements

Part 1: Provision of Care	Part 2: Experience of Care
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<sup>1</sup>The full document and other related documents can be found on web: [www.nsmpp.org](http://www.nsmpp.org)

<sup>2</sup> Monitoring of Quality of Care of Maternity Services, FHD/DOHS/MOH, 2004

Element 1: Human resources Element 2: Physical resources Element 3: Maternity Information Systems Element 4: Availability of essential services 24 hours a day Element 5: Appropriate Technologies Element 6: Good Practice Element 7: Comprehensiveness of care Element 8: client-provider relationship Element 9: referral system	Element 10: Respect, dignity and equity Element 11: Emotional support Element 12: Competent Prompt services, accurate information, and cleanliness facility Element 13 Acceptability of services
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The QOC approach entails enlisting support of all sections/units including store for drugs and supplies, laboratory, medical record, administration and accounts for staff co-ordination and management, all involved for up keeping infection prevention and waste management measures. It further enlists support of the blood transfusion centre (BTC) managed by Red Cross and ambulance services managed by Red Cross or other institutions.

## 1.2 Scope of Study

This study presents the key findings of the assessment study on Quality of Care (QOC) approach in midwifery and emergency obstetric care services conducted in 10<sup>3</sup> selected health facilities of different levels – Zonal Hospital (ZH), District Hospitals (DH) and Primary Health Care (PHC) centres. In total eight health facilities with full support of Nepal Safer Motherhood Project (NSMP) and two control health facilities across six districts were assessed during June - August 2004.

The study was conducted as of one of three studies evaluating the NSMP with regards to quality of care, increasing access to and utilisation of Safe Motherhood (SM) services respectively, with the aim to draw lessons for further enhancing the approach and provide input for the national safer motherhood programme of His Majesties Government of Nepal (HMG/N).

## 1.3 Objective of the Study

The study aimed to assess the QOC approach adopted by NSMP/FHD for improving the quality of midwifery, including newborn care and BEOC/CEOC services provided by the various health facilities. The assessment focused on two aspects; 1) technical competency of service providers in reference to the QOC framework<sup>4</sup>, and 2) management support for institutionalising the QOC approach. It aimed to identify the facilitating and constraining factors that need to be taken into consideration by FHD and other stakeholders in scaling up the national safer motherhood programme. Based on outcomes of the study a tool was to be developed outlining the essential inputs for establishment of BEOC/CEOC site for improved midwifery and obstetric services in health facilities.

<sup>3</sup>NSMP supported HFs (Districts): Baglung DH (Baglung), Seti ZH & Tikapur PHC (Kailali), Surkhet DH (Surkhet), Lumbini ZH & Lumbini PHC (Rupandehi), Nawalparasi DH & Chormara PHC (Nawalparasi)  
 Control HFs (partially supported through FHD and non-supported respectively): Janakpur ZH (Dhanusha) and Basantapur PHC (Rupandehi)  
 A rapid assessment of Bheri ZH (Banke) partially supported by NSMP

<sup>4</sup> [Family Health Division, DOHS/MOH, Monitoring quality of care in maternity services"2004](#)

#### **1.4 Study Methodologies**

The QOC framework served as basis for the assessment. Research methods and tools were agreed upon in consultation with NSMP staff and the Study Management Group comprising of RH and SM experts after a documentary review.

A cross sectional sample of 10 health facilities was taken ensuring cross coverage of phase 1 and 2 project supported districts, different HF levels (zonal, district and PHC), and direct and indirect (through the FHD) interventions. The study covered over 300 individuals representing various stakeholders and employed a variety of tools including technical assessment of knowledge and skills of staff using the “Follow-up of Healthcare Providers Trained in Maternal and Neonatal Health” of The Maternal and Neonatal Health Assessment Package, (JHPEIGO, 2002). Further to these individual and group discussions using semi structured questionnaires, exit interviews, direct observations and record reviews were carried out.

The field visit to PHC in Surkhet district – additional control PHC - could not be carried out due to security reasons, resulting in limited data for comparison of project supported and control PHCs.

#### **Stakeholders Interviewed**

- QOC Committees and local Health Management Committees,
- Service Providers (SPs) – nurses and doctors, support staff, paramedics, technicians, administrative staff (medical recorder, store, accounts)
- District Public Health Officer, Public Health Nurse, MCHW personnel
- Reproductive Health Coordination Committee members
- Community members – mainly women clients & their families
- Blood Transfusion Centre, Ambulance personnel & Red Cross representatives
- Sajha Medical representatives and staff of local drug stores
- NSMP staff

#### **1.5 KEY FINDINGS**

The QOC approach introduced in NSMP supported health facilities has resulted in considerable improvement in service provision in midwifery including newborn care and emergency obstetric services, although evidence based internationally accepted standards are yet to be met<sup>5</sup>. QOC of maternity services entailed a new concept within health facilities and its introduction a process of change, which is still underway. The process of bringing change in staff’ attitudes and to overcome resistance in order to adopt the improved practices has been gradual requiring frequent support, regular follow-up and monitoring for adopting and sustaining the practices.

The process of institutionalising the QOC approach in NSMP supported health facilities are on going while it is very nominal in the control health facility partially supported and non-existent in the non supported health facilities.

The key achievements and constraints/challenges have been presented below.

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<sup>5</sup> Monitoring of Quality of Care of Maternity Services, FHD/DOHS/MOH, 2004

### **1.5.1 Achievements - QOC of Midwifery and Obstetric Service Provision**

The key achievements of the QOC approach institutionalisation process for improving midwifery and obstetric service provision are summarised as follows:

*Increase in range of services including availability of 24 hours BEOC/CEOC services:* Significant achievement is seen in the availability of 24 hour BEOC and CEOC services in the health facilities supported by NSMP – even at PHC level (Chormara and Tikapur PHCs). Other, related services such as laboratory services, blood transfusion services, drugs supply (Sajha or private medical stores) have also significantly increased, leading to improved provision of care.

*Improved infrastructure, equipment and supplies including waste management measures:* Physical facility has been considerably upgraded under NSMP support. Construction and/or rehabilitation of Operation Theatre and maternity wards enabling the service provision are in principle adequate for providing essential BEOC/CEOC services. Equipment and supplies, improved waste management practices (e.g. use of incinerator and placenta pit), have resulted in better service provision. However an increasing client flow in recent years complicates managing space and maintaining cleanliness.

*Improved competencies, confidence and application of the practices among service providers:* Human resources development interventions have improved the skills, knowledge and understanding of providing enhanced maternity services among clinical and non clinical staff. It has considerably enhanced confidence and motivation, particularly among nursing staff. This resulted in the establishment and maintenance of evidence based clinical procedures for midwifery and B/CEOC services, standardising the clinical skills, improved client-provider relations and team cooperation, increased internal transfer of skills and knowledge and better record keeping.

The training and refresher courses proved particularly effective with internal follow-up. The NSMP HRDO<sup>6</sup> functioned as supporter and monitor in the application of the skills and knowledge acquired by the service providers.

*Improved Infection Prevention Practices:* The Infection prevention (IP) training – a whole site intervention - has greatly improved the understanding of and need for IP among staffs. As one of the most sustained interventions it has led to improved infection prevention practices, cleanliness of premises and continuity of IP practices; also resulted in decreasing the infection rates. The practice however is found less functioning in control health facilities.

*Provisions for the Poor:* Services are mostly provided without demanding prior payment. Emergency funds for financing transport & treatment of poor clients have been established both within the health facilities (initiated by project support and also the HMG/N policy of allocating budget for poor patients) and by various community groups. Management, linkages and allocation are not coordinated hampering the utilisation of the fund.

### **1.5.2 Strengths in Management Support for QOC Approach**

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<sup>6</sup> Human Resource Development Officer, appointed by NSMP

*QOC Committee:* Establishment of QOC committees (representation of all sections/units of the health facilities) proved effective for improving inter-sectional co-ordination and co-operation in view of introducing and institutionalising QOC approach for improved maternity service provision. The Committee in particular led by an active Change Agent<sup>7</sup> and supported by the Medical Superintendent played a significant role in improving and maintaining IP practices including cleanliness of the facility, staff behaviour towards clients, staff competencies, and availability of emergency drugs and range of services. The Committee engagement has facilitated promotion of adoption of standard IP practices; upgrading health facilities infrastructure; establishing emergency funds and internal staff management system to address understaffing.

#### *Change Agent and HRDOs*

The Change Agent supported by the HRDOs have started taking up their role of facilitating the institutionalisation process of QOC approach, during which overcoming resistance against change among staffs have been a major challenge. The HRDOs have been instrumental in QOC institutionalisation process, promoting and educating staffs of the new practices, bridging gaps between staff, QOC Committee and HMCs. They provide technical support, coaching the nursing staff, back-stopping the Change Agent and the QOC Committees and also providing limited but essential financial resources (NSMP) for QOC initiatives.

*HMCs:* There is increased awareness among HMCs to contribute for improving maternity services provision. The contribution has mainly been financial by purchasing low-cost equipment and supplies, employing additional staff mainly support staffs and few technical staffs and in some cases providing incentives to staffs. HMCs most lobby towards the central level authorities for fulfillment of vacancies, physical facility upgrading and supply of larger equipment and other materials.

### **1.5.3 Constraints and Challenges for QOC of Maternity Services Provision**

*Understaffing:* Most health facilities are understaffed with respect to doctors, nurses and paramedics. Hence understaffing represents a major constraint and a challenge for effective SM service provision. The HMG/N established positions (ANMs) are insufficient in the face of an increasing client flow, and many critical HMG/N sanctioned posts are vacant or staff are absent for prolonged period of time, with no system of replacement to minimise the effect of understaffing. Many medical officers and other service providers do not report to their duty station; due to limited opportunities for private practice and learning, and the isolated locations of many health facilities.

HMCs mainly recruited extra support staff while the need is for nursing and medical staff. Involvement of volunteers and on-job-trainees (OJTs), albeit helpful for day-to-day work, puts an additional burden on nursing staff due to strict supervision being required.

Scarcity of competent human resources represents a major constraint for putting the QOC approach into practice. The staff shortages result in pressures preventing service providers to respond to clients' requests and practice proper client-provider communication. It reduces staff motivation and also put clients at risk in case of parallel demands for services /emergencies. This further constitutes a major constraint for providing 24 hours CEOC and blood transfusion services.

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<sup>7</sup> Sr. Nursing personnel of the HF selected to support the QOC approach in midwifery and obstetric care provision.

Waiting times remain within set standards during working hours but entail major delays at other times.

*Competency level:* The knowledge level of service providers on midwifery and EOC services remained low across all health facilities assessed; below the standard even in health facilities supported by NSMP while in the “control” health facilities it was very low. This the staff attributed to long gaps since the course undertaken and limited or no practice or updating on recent development. The competencies of service providers in specific clinical skills vary; the competencies were more acceptable in NSMP supported health facilities while it was very low in control health facilities. Technically, many appropriate technologies and evidence based practices were applied by staff in NSMP supported health facilities (such as partograph, active management of third stage, use of magnesium sulphate for severe pre-eclampsia and eclampsia, prophylactic antibiotics at time of an emergency caesarean section, and vacuum delivery as first choice for an instrumental deliveries). However flaws occurred in terms of understanding and practice of comprehensiveness of the care provision such as Ante Natal Care (ANC) and Post Natal Care (PNC). In the control health facilities skills for coping with emergencies were lacking. The gaps in competencies are negatively affecting QOC practices in midwifery and obstetric care provision.

*Staff Motivation:* An enabling environment in terms of incentives and other compensations, physical facilities and teamwork is partly ensured in the health facilities, adversely affecting staff motivation and performance. HMC employed staff work under relatively unattractive working conditions and tend to perform inadequately. Further to this the job descriptions of the service providers do not match with actual responsibilities and staff competencies, leading to unwillingness and limited accountability amongst staff.

*Internal Staff Management:* Inefficient staff allocation within the health facility adds to the effect of staff shortages, and results in underutilisation of specialised skills of the staffs leading to quality issue in maternity service provision. Transfer and “deputation” (*kaa*) of staff across health facilities and internally seriously hampered the introduction and continuation of QOC approach, as key staffs are replaced by untrained staff and mechanisms for proper handover/takeover of responsibilities do not exist. Transfer of staff is done without HMC involvement constraining the HMC to take any actions to minimise staff shortage.

*Operations & Maintenance of Infrastructure, Equipment and Supplies:* Physical upgrades and extensions lacked appropriate involvement of the concerned health facilities staffs by the central level HMG/N system, resulting in inadequate design and often poor construction quality. Health facilities lack budget for maintenance of the physical facility and larger equipment and supplies and depend on uncertain support from the central level (Management Support Division of Department of Health Services). The drinking water, hand washing and toilet facilities for clients and visitors are inadequate. For medical recorders equipment – inadequate computer/printer facility - and skills development has further complicated the record keeping practices.

*Ambulance Services:* The ambulance services though operate reasonably at the zonal level, remain unreliable at the lower health facilities levels.

*Experience of Care by Clients:* Major shortfalls in ensuring respect and emotional care for clients including allowing companionship, visual and auditory privacy, and attention in the event of death or disability. Service providers most are unaware of the “right of information of clients” and the communication is mostly one-way and the explanations of obstetric procedures and prescriptions tend to be incomplete. Communication and information provision with those accompanying clients is extremely poor.

#### **1.5.4 Weaknesses in Management Support for QOC Institutionalisation**

*Inadequate Status and Competency of Change Agent:* The internal Change Agents were envisaged to take over the role of HRDOs. The Change Agents are facing constraints to adequately take up their role as the change agent despite technical backstopping by HRDOs. However, due to the lack of external status, professional authority, access to NSMP resources and financial compensations, as well as adequate interpersonal skills and official authority the Change Agents will have difficulties to take up the functions of the NSMP HRDO.

*Sustainability of OOC Committees:* The sustainability of the QOC Committees is threatened by limited capacities of Change Agent, transfer of key health facilities staff without handover/takeover system, weak linkage of the Committee with the HMC, lack of adequate resources, and absence of effective backstopping mechanisms. The momentum gained through project support can fade away in absence of continued support putting the entire QOC approach institutionalisation at risk.

*HMCs functioning:* The standards and guidelines for HMC functioning is inadequate leading to differing practices by the HMCs for health facilities development. In particular the recruitment practices of many HMCs endanger them of increasing their financial liability. The HMCs are faced with the challenge of balancing income generation against provision of affordable services and responding to increased client flow. The composition of HMCs in itself raises the issue of sustaining ownership, commitment and accountability for health facility development. Transparency and decentralised decision making based on progress reviews and updated records is rarely practiced. Smaller health facilities and those located in less accessible areas have very limited options for resource generation and hence support the overall health facilities development. Many are unaware of the QOC approach and their role in supporting this initiative. The QOC Committee was to support the Medical Superintendent (MS) in the day-to-day operations, however due to lack of appropriate and adequate authority the MS seems overburdened. There are no long term strategies for health facilities development in view of QOC approach institutionalisation.

*Co-ordination, Supervision and Monitoring:* Co-ordination between health facilities is limited to Blood Transfusion Centre only. The co-ordination between HF and the District Public Health Office structure (under which the PHCs fall and are to provide BEOC services) and the various institutions represented in HMC is limited. The RHCC committees constituted a platform for institutions working in reproductive health with tangible successes in SM awareness raising and establishing Community Emergency Funds, but linkages between preventive and curative services remain weak. The supervision and monitoring by regional and central levels is poor, the directives often unclear or difficult to implement, and responses to requests for clarification or support are slow if not absent.

## **1.6 KEY RECOMMENDATIONS**

The recommendations for QOC approach initiation and institutionalisation in the health facilities are made for consideration by the stakeholder and authorities at various levels. These include programmatic considerations, policy level considerations including standards/guidelines, staffing, competency development and infrastructure upgrading. Recommendations are also made with regards to internal health facilities management and management support for QOC approach institutionalisation.

### **1.6.1 Programmatic Considerations**

While capacity development of health facilities has taken place it is reported as inadequate in terms of keeping in pace with the ever-growing demand for services. Client flow, catchment area and geographical location of health facilities determine probable number of deliveries and other services and need to be taken into consideration for assessing the developmental needs of the health facilities in terms of range of services, human and material resources and infrastructure.

The location of health facilities (remote / rural areas vs. accessible urban areas) determines the scope of opportunities for HMCs to generate income and support QOC approach, supplemented with the availability of alternative SM services for clients, and the shortage of competent technical service providers (doctors who can offer specialised and wider range of services which can generate income), and limited options for private practice as well as other opportunities to attract staff to remote areas.

### **1.6.2 Policy Level Considerations**

Various policy level actions by central level authorities are required for overcoming the key constraints in institutionalising the QOC approach for improved midwifery including newborn care and emergency obstetric services. These are as follows:

*Ensure Adequate Guidelines and Standards:* Refinement of the QOC Framework (FHD /NSMP 2003) to ensure adequate guidelines and standards are available for the health facilities and service providers on QOC of improved maternity services. In this regards focus should be given on quality improvement initiatives in the areas of drug supply, lab and blood transfusion aspects. The study team also felt the need of revising/updating national RH clinical protocol that was developed in 1998.

*Staffing and Competency Development:* Guidelines, standards and policies for staffing of sanctioned posts and to ensure adequate capacity of nursing and medical staff in remote, under-resourced health facilities is should be developed. The established positions, especially of medical and nursing staff, require to be updated to reflect the actual staffing needs (subject to # of deliveries at the health facility). The job descriptions of the nursing staffs is required to be updated to reflect the actual responsibilities (recent development in terms of clinical practice and responsibilities) along with performance appraisal system, based on which staff can be allocated and held accountable. A replacement system during prolonged absences of staffs is required to address periodic understaffing. HMCs should be consulted and informed in advance on transfer of staff and also to consider optimal use of specialised skills and continuity of knowledge and skills on QoC within health facilities.

To assess the competencies of the service providers the “Follow up of Health Care Providers Training in EOC” (JHPIEGO, Nov 2002) tool should be considered for usage. The competencies of staff should be developed in order to match the provision of services available at that health facility.

*Management Support and HMC Functioning:* The mandate and guidelines for functioning of HDCs and QoC committees should be revised in relation to QOC approach institutionalisation. The composition of the HDC needs to ensure increased local representation including representation from the maternity ward (e.g. CA). A generic operational guideline on HMC functioning including recruitment and performance appraisal policy with specifics for PHC, DH and ZH should be developed. A tool for assessing the HDCs in terms of their role/functioning, status and need for support with reference to supporting QOC approach of maternity service provision by health facility has to be developed and disseminated after piloting/refinement.

A policy for internal health facility management to allow maintaining core staff for maternity unit (competent ANMs) should be promoted. The HMCs should be supported to create conducive working conditions to attract staff in remote areas.

Physical Resources/ facility related: “Standards” for the physical facility of health facilities at various levels (BEOC /CEOC) – using the proposed list on essential inputs for B/CEOC sites along with brief guidelines to assess the physical facility and capacity in relation to increase in client flow/catchment area for EOC services provision (# of deliveries in health facility) should be developed.

The central level should involve the health facility concerned in the design of the facility upgrading or extension to ensure adequate design and construction quality. The issue of lack of budget for maintenance of infrastructure and major equipment needs to be addressed.

### **1.7 Operational Level Considerations by Health Facility for Management and Support of Institutionalisation of QOC Approach**

QOC Committees, Change Agent and HMCs in close collaboration need to ensure adequate conditions for implementation and institutionalisation of QOC approach. Competency development of service providers should be carried out in a continual basis also in view of recent development and practices in midwifery and obstetric services provision along with fair development opportunities. Essential clinical and non-clinical training/courses should be provided to staff for quality EOC service provision. Promotion of staff should be accompanied with training enabling them to effectively carry out new responsibilities, especially management of ward/section/department and staff. For doctors BEOC/CEOC training are recommended.

The training interventions should emphasise the application of knowledge and skills acquired to ensure achievement of set standards in practices. A combination of on-site coaching and sending individual staff to participate in trainings /courses at the training sites along with regular mentoring and follow-up<sup>8</sup> has to be ensured for optimal upgrading of staff competencies. The refresher

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<sup>8</sup> [Using " follow up of health care providers training in EOC " \(JHPIEGO, Nov 2002\)](#)

courses should be complemented with internal follow-up through practice and knowledge revision to enhance effectiveness. The CME sessions should be continued to allow cross sharing between the service providers (nursing staff and doctors and others).

The infection prevention measures and practices need to be followed-up in order that the established practices are maintained and further strengthened.

*Change Agents (CAs):* In order for CA to take over the functions of the HRDO, the selection is critical and needs to be based on technical and interpersonal capacity. The CAs should be given necessary authority and support while frequent transfer of staff appointed as CA needs to be avoided. The CAs should be appointed from amongst internal HF staff to ensure the continuity of the QoC approach and should be represented in HDC. In order to keep their moral high there should be a provision of scholarship for long and short term course, exposure to national and international conferences.

*HRDO and regional level technical backstopping team:* In districts where intensive input for EOC service strengthening has already been provided (health facilities supported by NSMP and others) and where CEOC service are well functioning, quality enhancement and maintenance is required for which the HRDO with strong midwifery skills background can provide technical back stopping to a larger portfolio of health facilities across districts. In addition to a regional level technical backstopping team should be formed with the aim of back stopping the change agents in those districts where the mechanism and systems for QOC approach is well established. There should however be a provision to assess the level of support needed of HRDO. While in new districts where EOC will be introduced and established the HRDO's presence require intensely in order to facilitate the behaviour change process that takes 3-5 years and to provide technical backstopping.

*QOC Committees:* For securing the sustainability of QOC Committees, minimise the disruptions in the QOC Committee functioning e.g. care has to be taken in transfer of staff of the QOC committee along with proper handover of responsibilities. The linkage between QOC Committees and HMCs needs to be strengthened beyond the mere mediation of the Medical Superintendent, DHO and PHC In Charges mechanisms need to be established for internal and central level monitoring, follow-up and back-stopping.

A strategy should be developed in the long run to enable the QOC committees to function as the internal HF operation committee – with continued representation of all sections of health facility – encompass QOC of all services aspects provided by the health facility.

*Hospital Management Committees (HMCs):* The internal functioning of HMC needs to be improved and furthermore obtain the necessary external support in order to address key challenges. The HMC needs to emphasise appropriate recruitment and performance as per need of the HF, create conducive working condition to attract staff and enhance staff motivation and performance.

*Coordination, Supervision and Monitoring:* Linkages between health facilities providing curative services and District Public Health structures focusing on prevention need to be strengthened which the Reproductive Health Coordination Committees (RHCC) can provide the platform. The RHCC members suggest that at least one more year of NSMP backstopping and financial support

is required for ensuring better effect of the work on increasing access. There is a need to greatly strengthen the supervision and regular monitoring by regional and central levels to timely address constraints in resources availability, staff shortage, performance and internal management. In this regard the regional and central levels need to upgrade their supervision and monitoring functions, ensure that directives are clear and feasible, and speed up procedures for responding to requests by health facilities.

Based on the study findings a generic tool that lists the essential inputs (infrastructure, staffing requirements, equipments, essential drugs and supplies including waste management and infection prevention measures along with interventions in establishing BEOC/CEOC site for national safe motherhood programme to consider.