



Nepal Safer Motherhood Project
a part of HMGN Safe Motherhood Programme

**Synthesis of Final Evaluation Findings from the
Nepal Safer Motherhood Project**

By Jean-Marion Aitken and Deborah Thomas

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

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Contents

Acronyms, Abbreviations and Nepali Terms	iii
Introduction	1
The Challenge of Maternal Mortality in Nepal.....	1
Nepal Safer Motherhood Project	2
NSMP’s goal, purpose and outputs	2
External Processes Influencing NSMP	3
NSMP Evaluation and the Purpose of this Paper	5
Increasing Access	6
Barriers to Increasing Access	6
The Complexity of Enabling Increased Access.....	7
Approach Taken by NSMP	8
Progress and Achievements.....	9
Key issues	14
Comparative approaches: UNICEF’s and NSMP’s Safe Motherhood IA interventions	14
Sustainability.....	15
Improving Service Delivery	16
Barriers to Improving Service Quality	16
The Complexity of Improving Service Delivery	17
Approach Taken by NSMP	17
Progress and Achievements.....	19
Key Issues.....	21
Constraints to Further Improvements in QoC	24
Influencing Policy	28
Barriers to Achieving Policy Change	28
Approach Taken by NSMP	28
Progress and Achievements.....	29
The Change Process Summarised.....	31
Increasing EOC (BEOC and CEOC) Utilisation.....	33
NSMP’s Approach to Increasing Utilisation	33
Key Constraints to a Greater Increase in Utilisation	34
Progress and Achievements.....	36
Key Issues.....	37
Is the Increase in Utilisation Reasonable?.....	38
Is the Increase in Utilisation Likely to be Sustained?	38
Conclusions and Key Recommendations for Nepal National Safe Motherhood Programme	40
Who has the project reached/not reached?	40
The Evidence and Challenges Remaining for the Future SM Programme and National Scale-up	41
Wider Benefits from Support to Safe Motherhood	45
Challenges Remaining for National Scale-up	47

Annexes

Annex 1:	Project Logical Framework for the Nepal Safer Motherhood Project (Phase II) – Final Revision: September 2002	1/1
Annex 2:	Framework for Synthesis Evaluation of NSMP.....	2/1
Annex 3:	Reports and Papers Documented in this Report.....	3/1
Annex 4:	Increasing Access	4/1

Tables

Table 1:	Nsmp Coverage By Regions, Districts, Vdcs, Municipalities And Partners	3
Table 2:	Average Hardware Cost By Ecological Belt	26
Table 3:	Aggregate Cost Of Service Provision By Ecological Belt And Service Facility ...	26

Acronyms, Abbreviations and Nepali Terms

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
BCC	Behaviour Change Communication (replaces IEC)
BEOC	Basic Essential Obstetric Care
BPP	Birth Preparedness Package
BYC	An NGO in Baglung District
C/S	Caesarean Section (surgery)
CBEF	Community Based Emergency Fund
CBO	Community-Based Organization
CDO	Chief District Officer
CEDAW	Convention on Elimination of Discrimination Against Women
CEOC	Comprehensive Emergency Obstetric Care (includes BEOC + C/S and B/T)
CRC	Citizen Report Card
DACAW	Decentralized Action for Children and Women (UNICEF)
DDC	District Development Committee
DFID	Department for International Development (UK)
DHCC	District Health Co-ordinating Committee
DHO	District Health Office/Officer
DHS	Department of Health Services (Ministry of Health)
DPHO	District Public Health Office/Officer
EDP	External Development Partner
EMOC	Emergency Obstetric Care (includes BEOC and CEOC)
EOC	Essential Obstetric Services
FCHV	Female Community Health Volunteer
FFC	Foundation for Change
FHD	Family Health Division (of DOH)
HA	Health Assistant
HICODEF	Himalayan Community Development Forum (an NGO in Nawalparasi District)
HMB	Hospital Management Board
HMC	Hospital Management Committee
HMGN	His Majesty's Government of Nepal
HRD	Human Resource Development
HRDO	Human Resource Development Officer
HW	Health Worker
IEC	Information, Education, Communication
INGO	International Non-Government Organization
KIM	Key Informant Monitoring
LDF	Local Development Fund
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker

MLD	Ministry of Local Development
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NFE	Non-Formal Education
NGO	Non-Government Organization
NHEICC	National Health Education, Information and Communication Centre
NSMP	Nepal Safer Motherhood Project
ODC	Organizational Development Centre
OPR	Outputs to Purpose Review
OVI	Objectively Verifiable Indicator
PHC	Primary Health Centre
PHN	Public Health Nurse
QoC	Quality of Care
RH	Reproductive Health
RHCC	Reproductive Health Coordinating Committee
SDO	Social Development Officer
SHP	Sub-Health Post
SM	Safer Motherhood
SMF	Safer Motherhood Forum
SMSC	Safe Motherhood Sub-Committee
SMWG	Safer Motherhood Working Group
TBA	Traditional Birth Attendant
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VHW	Village Health Worker
WDO	Women's Development Office/Officer
WRLHP	Women's Right to Life and Health Project

Nepali Terms and Concepts

<i>bandh</i>	strike
<i>charpai</i>	wood frame cot
<i>Dalit</i>	disadvantaged/underprivileged caste (artisan, formerly called 'Untouchable')
<i>dhami-jhankri</i>	faith healer
<i>jagir</i>	government service
<i>Janajati</i>	ethnic groups
<i>jutho</i>	ritual pollution
<i>karma</i>	fate
<i>ke garne</i>	Literally 'what to do?' (implies 'nothing can be done about it; expresses fatalism)
<i>kwak doktor</i>	quack doctor
<i>laj</i>	shame, modesty, shyness, embarrassment; the result of lack of empowerment
<i>thulo manché</i>	big man, important person (source force)

Introduction

The Challenge of Maternal Mortality in Nepal

Nepal has one of the highest maternal mortality ratios in the world¹, estimated at 539 per 100,000 live births (HMGN 1996) though more recent modelled estimates by WHO/UNICEF/UNFPA (2000) put this even higher at 740 per 100,000 (range 440 – 1100). At the root of such high maternal mortality is women's low social status, played out through early marriage, poor nutrition, low female literacy, poor reproductive health (high parity, short birth intervals, high unmet demand for family planning), and social norms that leave women out of family decision-making, undervalued and disempowered.

Added to this scenario, is the inadequate availability of accessible, affordable and client-oriented health services that women and their families trust, want and can afford to use. The majority of women continue to have home births, with 89% of all deliveries taking place in the home, of which only 13% are assisted by trained health workers. Nearly 25% are attended by traditional birth attendants, more than 50% are assisted only by relatives, friends or other non-health personnel, and 10% are not assisted at all (Demographic and Health Survey, HMGN, 2001).

All the above factors combine to influence the 'three delays' (described in Thaddeus and Maine 1994) which determine the utilisation of and success of Essential Obstetric Care (EOC).

Delay	Influenced by
Delay 1: Decision to seek care	Social and cultural norms Awareness of services Expectation of cost
Delay 2: Identifying and reaching a health facility	Availability of services Perception of quality of service Distance and transport problems
Delay 3: Receipt of adequate and appropriate treatment	Presence of trained staff Staff attitude and motivation Availability of necessary equipment and supplies

The Ministry of Health's (MoH) current strategy as set out in the National Safe Motherhood Programme (2002-2017) is to increase access to services through the establishment of basic and comprehensive essential obstetric care (BEOC and CEOC) at hospitals and primary health care centres (PHCC), and skilled attendance at the community level through the services of trained maternal and child health workers (MCHW).

¹ Placed after some African countries where the impact of very high HIV/AIDS prevalence is now being felt.

Nepal Safer Motherhood Project

The Nepal Safer Motherhood Project (NSMP) was initiated in 1997 to support HMG/N's Family Health Division to improve maternal health in selected districts. NSMP (a DFID funded project managed by Options UK) is being phased out in September 2004, to be followed by a programme of DFID funded direct support to the National Nepal Safe Motherhood Programme of HMGN.

NSMP is implementing a range of interventions designed to address the three delays. The full project logframe is included in Annex 1 and its objectives are summarized below:

NSMP's goal, purpose and outputs

Goal: To contribute to His Majesty's Government of Nepal (HMGN) SM programme's objective of reducing maternal mortality

Purpose: Sustained increase in utilisation of quality midwifery and obstetric (BEOC and CEOC) services

The above objectives are to be achieved through interventions in 3 output areas:

Output 1

NSMP contributes to safe motherhood policy and programme development (including feeding into global lesson-learning)

Output 2

NSMP supported facilities (hospitals and PHCs) provide good quality midwifery and obstetric services

Output 3

The social context for and access to midwifery and obstetric services within NSMP-supported districts improved

In Phase 1, the Project focused mainly on improving the midwifery and emergency obstetric care services of selected health facilities in 3 districts (Baglung, Kailali and Surkhet). Project inputs have followed two main components: **service provision** under which systems to manage services for women of reproductive age were established – including improvements to the physical infrastructure of hospitals, equipment and supplies, and training of personnel; and **increasing access** which sought to improve the social context for, and access to, midwifery and obstetric services in order to enable women to utilize services.

Following a mid-term review in 2000, Phase 2 of NSMP was extended to six more districts (Parbat, Myagdi, Rupendehi, Nawalparasi, Jumla and Dailekh). In addition the increasing access component was extended to more VDCs in the Phase 1 districts.

Table 1: NSMP Coverage by Regions, Districts, VDCs, Municipalities and Partners

Regions	Districts	VDCs			Municipalities (urban) (2004)	Partners (2004)
		Start: Phase-1 (1997-2000)	End: Phase-2 (2004)	% VDCs (rural) in District Covered		
Western hills	Baglung	4	22	36.5%	1 of 1	6
	Myagdi		16	40%	–	4
	Parbat		23	42%	–	6
terai	Rupandehi		22	31%	1 of 2	5
	Nawalparasi		24	32.5%	–	3
Mid-West hills	Surkhet	4	16	31%	1 of 1	6
	Dailekh		9	16%	1 of 1	2
	Jumla		18	60%	–	4
Far West terai	Kailali	4	19	43%	2 of 2	5
Totals:	9 (6 hill, 3 terai)	12	169	35%	6	41

Source: NSMP data

External Processes Influencing NSMP

A number of events and processes in the project's external environment have had a significant impact on NSMP's approach and achievements.

Health Sector Reform: Lack of clarity about the final form and pace of health sector reform changes has made development of project strategy difficult. SM services will be included in the proposed Essential Health Care Services Package (EHCSPP) to be funded through a health sector support programme. Sustainable models for training, logistics, support and supervision for SM services must all take account of the integrated systems that will be required to deliver the EHCSPP, and as yet these are not well developed. This has hindered planning for the sustainability of project inputs.

Decentralisation The Local Self-Governance Act 1999 (LSGA) has made provisions for local participation in development and decision-making processes through the devolution of power and responsibility to the local governments. District Development Committees (DDCs), Municipalities and Village Development Committees (VDCs) are now responsible for their own development. To date, Sub-Health Posts (SHPs) in 26 of Nepal's 75 districts have all been handed over to local bodies. This process of handover is being accelerated to include health facilities beyond SHPs. The issue of the pace and form of decentralisation and its sustainability is therefore of crucial concern to all stakeholders in determining appropriate strategies at the district level.

Conflict has introduced further uncertainty and hindered planning and implementation, particularly at district and VDC levels. The conflict in Nepal is a result of the Maoist insurgency and the response of the government security forces (the police and more recently the Royal Nepalese Army) to this. The insurgency began in February 1996 and developed in scale and scope. By 2000-2001, the Maoists were actively operating in a significant proportion of districts across the country. A cease-fire and talks, which took place during the summer of 2001, broke down by November and since then the Maoists launched several new attacks, and the government declared a State of Emergency. The conflict then intensified. A subsequent ceasefire in 2003 also broke down and disruption continues. The wide-ranging effects of conflict are discussed in more detail below and throughout the report.

Conflict is a key confounding variable and has disrupted all project processes and the context in which the project worked. It has also affected the work of project partners and the institutional context in which NSMP worked. Conflict is leading to demographic trends which are affecting utilisation. Those who can are migrating to the towns leading to increasing urbanisation and easier physical access to health facilities.

Conflict has also hampered the evaluation process. It is difficult to disaggregate the effect of conflict from the achievements of NSMP and to postulate what the achievements might have been in the non-conflict scenario the project was originally designed for.

Dissolution of elected bodies at all levels is one of many consequences of the conflict and State of Emergency. The lack of elected peoples' representatives in the local governments has led to uncertainty about who to work with at district level and has raised questions about the mandate and accountability of different local bodies. Groups which are supposed to be elected, such as Village Development Committees (VDCs) and District Development Committees (DDCs) are currently staffed by employees and appointed representatives of the central government (which is also appointed by the King, not elected). This has led to an increased reliance on non-government partners.

Emphasis on poverty and marginalized populations in international development policy has heightened since the original project was designed. Poverty is currently reflected as a priority in DFID's global policies, DFID's Country Assistance Plan (CAP) for Nepal and Nepal's Poverty Reduction Strategy Paper (PRSP) on which the CAP is based. Although the project was aware of equity issues from the beginning, it is important to recognise that its goal and purpose reflect overall reductions in maternal mortality and increases in utilisation of services without distinction between types of user. The project was designed to take a public health approach to saving lives and has had subsequently to adjust its access strategies to take account of increasing policy emphasis on the poorest and most marginal populations. The contradictions and consequences arising from public health as opposed to social inclusion aims are discussed later in this paper.

NSMP Evaluation and the Purpose of this Paper

NSMP is an exceptionally well-monitored and well-documented project and over its 7 year life has undertaken a huge range of studies and reviews to learn from project experience and to inform policymaking. As the project closes, the intention is to capitalise on this resource, drawing out lessons for the Nepal National Safe Motherhood Programme development and identifying and prioritising early actions for support to the National SM Programme.

In addition to the existing body of reports, a number of specific evaluations covering EOC utilisation, Quality of Care and Increasing Access were commissioned. This paper aims to synthesise the findings of all these works and is therefore a combination of internal and external evaluation. It concentrates on the immediate lessons available from NSMP experience and seeks to answer the questions in the evaluation framework (Annex 2). The lessons from NSMP are also considered in the context of learning from other safe motherhood programmes, within Nepal and internationally, which may be useful for programme implementation.

Key NSMP achievements and findings summarised in this evaluation document are also posted on the NSMP website² as an integral part of NSMP's overall dissemination strategy, both in Nepal and globally. See also Annex 3 for a detailed list of all of the reviews and reports included here.

This paper is structured around the three output areas of NSMP (increasing access, improving services and influencing policy) which are followed by a discussion of its purpose (increasing utilisation). In each case the major barriers are described, together with the project's approach and achievements, and then further challenges of sustainability and key issues for the future are discussed. The paper continues with a discussion of who the project has reached and the wider benefits of support to safe motherhood. It concludes by identifying the challenges remaining and some key recommendations for the National SM programme. This paper will be accompanied by a separate paper which discusses the achievements and learning from NSMP in the light of global debates on Essential Obstetric Care (EOC).

Limitations of this paper

This is **not a formal evaluation** against the log frame because it is based on several specific studies over time. NSMP commissioned work in areas where issues or questions needed to be answered. The studies do not constitute a resource which is exhaustive or comprehensive in covering all the project aspects.

This is also **not an impact evaluation** as at this point we can only review immediate changes and it is therefore too early to assess impact. Sustained change in utilisation can only be assessed some time after project completion although this may be further influenced by new planned interventions.

² The NSMP website can be found at www.nsmmp.org. All key documents can be accessed through this site (see also Annex 3 for a detailed list of documents included in this report).

Increasing Access

NSMP Logframe Output 3 Statement:

The social context for and access to midwifery and obstetric services within NSMP-supported districts improved.

Barriers to Increasing Access

The barriers to accessing essential obstetric care (EOC) in Nepal are extreme and diverse, embedded as they are in the social, cultural, political, economic and geographical context of the country. The barriers can be broken down into a range of factors:

- *Low status of women* and the low worth attributed to them, leads to the low prioritisation of their health needs and rights within the family, community and broader society.

Socio-cultural, for example traditional beliefs in 'jutto' (ritual pollution) classify women during menstruation, delivery and other obstetric bleeding as polluted. This discourages contact with pregnant, labouring and postnatal women and the provision of the special care and attention they need (Social Research Report³ 2000).

- *Economic*, for example, the high cost of facility based EOC and high transportation costs (which account for more than 50% of total costs for normal deliveries) means that more than 50% of women who deliver in a hospital have to borrow money to pay for expenses (Cost Study 2004).

International evidence shows that the **cost of EOC** is one of several important barriers to use, especially for the poor and ultra-poor (Koblinsky 2003). Within the Nepalese context of widespread poverty, and a poorly financed public health system, the Cost Study found EOC to make significant and often times impoverishing financial demands on families.

The study found that:

- 41% of households surveyed reported difficulty in raising funds for hospital care
- 51% of those delivering in hospitals borrowed money
- 32% of the poorest income cohort (i.e. the bottom 20%) reported the sale of land and livestock to pay for care in a health facility

Home deliveries are not without cost. The study reports that:

- The cost of a home delivery is on average 36% of the poorest household's monthly income (compared to only 1% of that of the wealthiest)
- Savings and daily wages cover the costs of only 42% of home deliveries

Cost Study 2004

- *Geographical*, the physical environment, particularly in the hills and mountains, with poor roads, trails and bridges, leaves communities without

³ All NSMP reports are referred to by title (shortened) are fully referenced in Annex 3 and can be found on the NSMP Website. All external reports are referred to by author/date with references in Annex 3.

motorable transport. Labouring women may have to be carried for up to 8 hours or longer to reach hospital (Cost Study 2004⁴).

- *Political*, the Maoist insurgency is affecting the delivery of health services across the country and impacting on people's ability to reach care. Beun and Neupane (Conflict Study 2003) estimate that the conflict has added an additional 10% to the total delay that women experience from deciding to seek care to receiving EOC.

The effect of conflict on access to maternal health services

Travel at night in most areas is now almost impossible; vehicles are prohibited from remaining overnight at road heads; and public transport is significantly reduced, partly due to delays caused by security checks. Moreover, the conflict has reduced the availability of money in villages: banks have closed; the better-off and potential money-lenders have moved to urban areas in fear of the Maoists; and many local savings and credit groups that could have provided emergency funds have become dysfunctional. While health workers do not appear to be targeted by either side, their movement in the community has been severely restricted. In the most heavily-affected areas, staff absenteeism and the restricted availability of supplies is impacting on services at primary health centres and sub-health posts.⁵ The few district hospitals that have been attacked or had water and electricity cut-off, are likewise facing staff shortages.

Conflict Study 2003

- *Legal*, until recently (2002) Nepal had a highly restrictive abortion law that pushed abortion underground and encouraged unsafe practices. Some estimates suggest abortion accounts for 15-30% of maternal mortality in the country. Newly created comprehensive abortion care services aim to reduce the toll of abortion related maternal deaths.
- *Perceptions* held by women and their families about the poor quality of care at health facilities, including poor attitudes of health care providers, discourages use of these facilities. In the same way, uncertainty about treatment costs, and the perception that treatment will be expensive, deters potential clients even if 'poor boxes' and exemption mechanisms have been established at the facility.
- *Nature of services and institutions* themselves, such as the limited availability of doctors, particularly female doctors, lack of privacy, and uncleanliness of hospitals.

Annex 4 contains two figures taken from the IA Review (2004) which present the barriers to access diagrammatically, and the interventions under NSMP that have been used to enable access.

The Complexity of Enabling Increased Access

International experience shows that actions to enable access need to work at multiple levels (policy, district, community). These actions must employ a variety of

⁴ See Annex 3 for a detailed list of all the documents included in this report.

⁵ Though in some places staff at SHPs are pressured by Maoists to stay – reportedly increasing availability of services.

approaches (advocacy, social mobilisation, finance and transport, service and institutional improvements) targeting a broad spectrum of political and service stakeholders (political leaders, district public service managers, NGOs, CBOs, informal leaders, traditional practitioners, health service providers) and the women and their families that need to be empowered to use EOC. Moreover, these myriad levels of action, ways of working, and actors are embedded in the diverse social, cultural, economic, geographic and political fabric of Nepal. Clearly there is no simple solution for enabling access in this complicated scenario.

Barriers to access and enabling opportunities vary tremendously by location in Nepal. They alter according to the local political and economic context, the severity of the armed conflict, the physical terrain, the social diversity of the population and the social capital, cohesion and assets of individual communities, and by the availability and quality of local EOC provision. The complexity and variability of the barriers to EOC across the country underlines the importance of local analysis and responses that all need to be nested in local opportunities and capacities, and underwritten by national commitment and priority.

Access to EOC Defined

Access is enabled in an environment that encourages people to utilize health services, within any given social context. At its best it is a dynamic, participatory process based on good practice. Access advantageously uses local knowledge, perceptions and values, relevant traditional practices, preferences and beliefs, to enhance knowledge and awareness. Access encourages self-confidence, voice and agency especially amongst women. Access embraces financial, institutional and infrastructure factors, including but not limited to funding, transportation and education. Access relies upon good provider attitudes, trust, honesty, responsiveness, accountability, and quality service delivery both at established facilities and through outreach programmes. Access engages socially marginalized and vulnerable communities, is inclusive and is empowering.

IA Review 2004

Approach Taken by NSMP

In recognition of the diverse social contexts existing across Nepal, NSMP's approach to improving access has rightly embraced principles of participation, ownership and sustainability and applied them to safe motherhood at the district and local level. NSMP has worked to engage the political and institutional structures in each of the districts, and has fostered partnerships and networks with key actors and organisations that can mobilise the public and leverage the political support and ownership necessary for directing and sustaining resources to safe motherhood. The project's **district partnership approach** is the cornerstone of its IA initiatives and fundamental to mobilising the resources and commitment of the multiple actors and interests that need to be involved in improving maternal health. The package of IA inputs channelled through district partnerships have primarily focused on 4 key areas of work:

- **Community level awareness raising and social mobilisation** to increase knowledge and importance of safe motherhood, reinforce positive cultural preferences and norms around pregnancy and birthing, and to empower women and their families to make timely decisions to seek appropriate EOC.

- **Community based emergency funds and transport schemes** to enable women and their families to overcome the financial and transport barriers to accessing EOC.
- Strengthened **links between communities and the health system** through community health workers to reduce the social and cultural distance between women and health facilities, to encourage more culturally acceptable provider practices, and to promote timely referrals.
- **District level advocacy and mobilisation** to build political and institutional commitment to tackle safe motherhood as a district development priority.

NSMP has a well developed Increasing Access monitoring system that tracks both partner progress against agreed activity plans, and involves RHCCs in the collective self-assessment of progress against strategic increasing access objectives including mapping of the operational environment and how this changes over time.

Progress and Achievements

The district partnership approach and the package of IA inputs delivered by NSMP have stimulated and enabled improved access for many communities and families. NSMP's experiences, its achievements and weaknesses provide a firm basis upon which the SM programme can now strengthen the design and implementation of strategies and activities to promote access. The main findings and recommendations for the National Safe Motherhood Programme as it moves into implementation are summarised below:

The District Partnership Approach

The District Partnership Approach was the means through which political commitment and multi-sectoral support was mobilised at district and sub-district levels, and it provided the vehicle for working with communities and implementing activities. The approach builds on the existing institutional structures and capacities of each District rather than creating parallel structures. Based on the lessons from NSMP we recommend that the approach be strengthened to become more inclusive, more pro-poor, and more institutionally sustainable, and taken to scale under the National Safe Motherhood Programme.

- **Institutionalising SM in the district:**
 - District level advocacy, networking and cohesion-building was essential for facilitating a multi-sectoral response to SM, and this important role that was filled by NSMP staff will need to be factored into the SM programme. Good practices from the Women's Right to Life and Health Project (as discussed below) are also relevant and need to be considered.
 - Safe Motherhood Forums (SMFs) and Reproductive Health Co-ordinating Committees (RHCCs) have served as a platform for co-ordination of activities of the institutions working in the reproductive health sector and encouraged district co-ordination across sectors, including reducing traditional antipathies between government and non-state actors. These bodies need to be strengthened and sustained under the new programme.

- In the current political situation and with reduced levels of DDC budget, funds for supporting SM outside of health will be essential for sustaining multi-sectoral interest in SM, and need to be continued.
- NGO and civil society partnerships will be critical for success. To pursue a more inclusive and institutionally sustainable approach a longer-term and more developmental approach to partnership is required that will support the institutional development of NGOs and CBOs to enable them to become long-term change agents. This implies greater initial investment in capacity building of groups who have their roots in marginalised communities but have weak organisational and management skills.
- **Transparency**
 - NSMP gave high importance to the rapid scaling up of IA activities through NGOs with perceived existing capacity and networking strengths, identified through district Reproductive Health Coordination Committees. This decision was in the context of a time-bound project under pressure to achieve its purpose of increased utilisation. However, the cost of not pursuing a fully transparent and open competitive system for selecting district partners was non-inclusion of remote geographical areas within the district, and a process that left project staff and management open to claims of favouritism at the local level. The lesson for the national SM programme is to use transparent and competitive procedures in selecting future partners. Transparency creates trust amongst district stakeholders. Open competitive practices, though more administratively demanding and host to a range of political pressures, are ultimately fairer and will be more effective in opening up a broader pool of qualified partners. Selection criteria will need to be carefully constructed to ensure that civil society organisations from, and working in, vulnerable communities, that have weak organisational and management skills are not marginalised during competitive processes.
- **Prioritising inclusion of remote and vulnerable communities**
 - The parameters of future partnerships need to be based on prioritising the inclusion of remote and vulnerable communities and geographical areas with additional investments made for capacity building of these partners.
 - Transparent, fair and evidence-based criteria need to be used for allocating SM resources to populations within districts based on poverty and vulnerability.
 - District poverty maps based on data from the PDDP/LGP database on inclusion/exclusion, and data from the Poverty Alleviation Fund are evidence bases that could be used more systematically for prioritising allocation of IA resources.
- **Working in conflict**
 - NSMP and most NGO partners continued to work in conflict-affected areas despite serious implementation difficulties, and developed positive responses to the Maoist insurgency.

- NSMP also developed a monitoring tool to track the impact of the conflict on access to safe motherhood services. This marked a major advance in both SM and the broader development sector as a whole.
- Even more proactive and positive approaches to the conflict will be beneficial for the SM programme, such as: strengthening the focus on disadvantaged populations, decentralising and devolving service delivery, engaging local staff, working with and through local groups to spread information and awareness, and developing financing and transport schemes that better respond to the very poor.

Community awareness-raising and social mobilisation

The project used various methodologies for increasing knowledge of the risks of pregnancy, informing families, traditional practitioners, informal and formal leaders of where to go in an emergency, raising the importance of women's health and mobilising communities to support SM action. It also used a participatory tool called Key Informant Monitoring (KIM) which aims to gain an in-depth understanding of perceptions and behaviours related to reduced barriers to EOC, quality of care and improvements in the social status and mobility of women. This technique involves community members interviewing their peers with the findings analysed and synthesised at community level and used to inform local advocacy work and improve programme inputs.

Key experiences and lessons for the SM programme are:

- Women's empowerment is fundamental to improving maternal health. SM contributes to, and benefits from women's increased voice, agency and inclusion. Synergies and opportunities for the SM programme to promote women's empowerment need to be seized.
- The whole community approach taken by NSMP, rather than the targeting of specific community actors, needs to be continued because of the complex web and myriad influences on family decision-making around pregnancy and childbirth.
- Critical knowledge of the dangers of pregnancy and childbirth among key family decision-makers has improved in those areas of project districts where partners are working. Local NGOs are effective conduits of information.
- The benefits and fit of the different IEC approaches is poorly understood and much more systematic learning and sharing of experiences is needed to promote positive and proactive behaviour change. We believe this calls for:
 - Collecting and sharing good practices being implemented by NSMP partners to feed into the design of localised IEC under the future programme. Examples could include Cross Flow Nepal Trust's remembrance sessions with mothers-in-law targeted at engaging their compassion; and the power of local group action in Rupendehi to contest poor provider practices.
 - Greater IEC technical support to local partners implementing IEC activities under the SM programme.
 - Strengthened systems for monitoring, learning and adapting IEC approaches.
- Working with and through community groups is a powerful approach for introducing and reinforcing information. NSMP has shown that groups enable women to build their confidence to share SM information with family and

peers, and build the confidence of members to use that information in proactive SM behaviour and responses to emergencies. The lessons for the SM programme are:

- To consider community institutions and social capital as the platform and framework for mobilising the community behind SM.
- To strengthen the use of existing community groups to raise awareness and mobilise the community for SM.
- To promote local responses to ensuring the inclusion of disadvantaged groups (Dalits, Janajatis, ultra-poor of all caste and ethnic groups) in group development according to the social cohesion and assets of the community.

Community based emergency transport and funding schemes

Community based emergency transport and funding schemes have had a positive and direct influence on family decision-making to seek facility based EOC and need to be strengthened, continued and expanded under the SM programme. Key areas for the future programme are:

- Transport
 - To develop local incentives (e.g. vouchers financed by the programme) to assist Dalits and other marginalised groups overcome the discrimination and difficulties they continue to experience in organising transportation.
 - Develop practical links between transport and funding schemes to improve the availability and pricing of transport and promote transport workers cooperation in conveying pregnant women.
 - Continue to develop creative solutions to overcoming the limited availability of emergency transport during curfews and bandhs (strikes), such as NSMP's SM awareness-raising work with security forces in the Baglung cluster.
- Community based emergency finance schemes (CBEF) (also see below)
 - Explore links between CBEFs and hospital payment procedures to improve targeting of hospital exemptions to the poor.
 - Improve links between hospitals and transport workers to avoid the need for exchange of cash at hospitals, or to transport workers if a patient is covered by a CBEF.
 - Strengthen the legal status of CBEFs.
 - Support the capacity development of CBEF management.

Strengthened links between the community and the health service

A variety of inputs have been used to increase the acceptability and perceived quality of services in order to encourage EOC use with variable effectiveness, and critical issues remain:

- Uncertainty of the cost of facility based EOC has not been reduced and remains a barrier to use. The SM programme needs to continue to develop ways of packaging the cost of specific treatment episodes to reduce uncertainty, and to consider means of reducing the actual costs to women and their families.
- Where exemption schemes or SM funds exist in facilities these need to be well publicised so that potential clients are aware of them when making their decision about care-seeking.
- Management reforms are needed to control costs and reduce the shadow practices (such as rent-seeking between pharmacists and doctors) that keep costs to the client artificially high.
- Foundation for Change training has boosted skills and motivated staff (see 'Improving Service Delivery'). Further evaluation is required to assess the level of input required for scaling up and extending such appreciative inquiry training into an on-going programme of supported transformation.
- NSMP's constructive relationships with traditional practitioners have assisted in early referrals and need to be continued and expanded.
- Clients continue to feel disempowered and vulnerable in health facilities (Quality of Care Study 2004). More needs to be done to empower clients through for example: familiarity visits; the setting, dissemination and monitoring of client rights; greater efforts to find out what clients want and need to feel more confident in asking providers questions and making demands; monitoring of provider attitudes and interactions with clients, and use of incentives to reward respectful and positive behaviour.

District level advocacy and mobilisation

- This has taken place principally through RHCCs and SMFs which include senior officials from local government, line agencies and implementing NGOs and through partner exchange visits and mass media activities including radio programming.
- An important outcome is that all RHCCs have made district safe motherhood plans which have been integrated into District Periodic Health Plans in 8 out of 9 districts, and which include discrete budget allocations in the yearly plan in the majority of cases.
- Another important outcome is that around 70% of partner NGOs have revised their constitutions to include safe motherhood as a priority concern and committed to maintaining the structures and activities created during their partnership with NSMP.
- VDCs have also responded to community mobilisation/education initiatives including feedback from Key Informant Monitoring, by contributing in cash and kind to local safe motherhood initiatives (e.g. contributions to emergency funds, provision of stretchers, funding additional awareness raising sessions).

Key issues

Comparative approaches: UNICEF's and NSMP's Safe Motherhood IA interventions

UNICEF's Women's Right to Life and Health Project (WRLHP) provides a useful comparison to NSMP, and offers experiences and lessons that need to be fed into the national SM programme. WRLHP is one component of UNICEF's national Decentralised Action for Women and Children (DACAW) programme, an integrated development programme working with national and local government, line agencies and civil society. NSMP and WRLHP are crucially very different in that WRLHP is supported and nested in the much broader institutional context of DACAW and can benefit from its institutional links to community based organisations and groups, stronger leverage across line agencies at the district level, and the large human resources it employs.

Hence, where NSMP has worked closely with NGOs and line agencies to mobilise communities and implement its IA package, WRLHP has used the broader DACAW structures and resources. One result is that the WRLHP appears to have been more effective in its social mobilisation activities than NSMP, drawing on a wider range of stakeholders and relying more heavily on influential interpersonal communication than NSMP's partners (this may in part be due to the enhanced opportunity for person-to-person communication created through the network of community groups supported under the much larger DACAW).

NSMP has worked closely with the government IEC Centre to improve the quality of IEC materials produced for the entire SM programme. Both NSMP and UNICEF have good pictorial materials, though UNICEF's IEC materials and tools are of a particularly high standard. UNICEF's materials are particularly appropriate for reaching non-literate communities and need to be more widely and efficiently distributed to organisations that can use them. NSMP's radio programming is innovative and widely listened to and in future this communication tool could be combined with use of UNICEF's pictorial materials.

In terms of increasing financial and transport access, NSMP's approach appears to be stronger. WRLHP does not address the barriers to accessing transport due to cost and non-availability, although in some areas DACAW is providing funds to poor and needy women who need a caesarean section. WRLHP has stimulated emergency funds at VDC level and through more local women's groups, as under NSMP. The findings from the Conflict Study on NSMP's community based emergency funds will also be relevant for those fostered under UNICEF. Neither UNICEF nor NSMP have effectively strengthened the management and use of hospital exemptions or facility emergency funds, although both have tried, and this is an important area for future attention.

Possibly due to UNICEF's use of DACAW's community health workers, WRLHP has not strengthened the skills of MCHWs, and here NSMP's training and support provides important experience. Both NSMP and WRLHP have adopted appreciative inquiry methodologies for building team spirit and motivation although with differing levels of intensity and input. An evaluation of both overall methodologies to assess relative cost effectiveness and to draw out lessons for the national programme is

required. UNICEF does appear to have put even more emphasis on district networking and coordination led by the DPHO, and the IA Review suggests that UNICEF's integrated team approach - in which actors from district to community, and across sectors - meet to discuss problems, successes and plan for the future is a major strength of WRLHP: good practice that needs to be factored into the design of future district support for networking and team building.

NSMP has invested heavily in external reviews of elements of the project and filled critical information gaps on SM of value to the country, such as the financial Cost Study (2004). NSMP has also pioneered the use of Key Informant Monitoring (KIM) in the community, an in-depth participatory tool designed to elicit information on changes in the perceptions and behaviour of specific social groups in a community. However, NSMP's internal use of monitoring data, including its use of KIM findings, has been weak. In contrast, WRLHP's use of data and its graphic representation has produced materials that have facilitated internal communication, encouraged attention to monitoring, and nurtured ownership and pride in the results. Graphic, easy to understand, snapshots of project progress are useful materials that the national programme should include, but more importantly, they contain information that needs further analysis and the results factored into programme management.

Overall, the two projects have clear areas of comparative strength, and both have developed approaches and innovations that, with further refinement, are ready for scaling up.

Sustainability

NSMP has made progress in improving the social context for EOC in those areas where its increasing access approach through district partnerships has been implemented. There has inevitably been some positive spill over onto communities not reached directly by NSMP partners. However, the magnitude of the barriers to access and the scale of social mobilisation and innovations necessary to promote EOC use, suggest that the district partnership approach needs to cover a much larger proportion of a district population than the current optimistic estimate of a third of the district - and particularly the more remote and vulnerable communities - if it is to enable equitable access to SM in target districts.

An example is difficulties in sustaining the work of some of the district level Reproductive Health Coordination Committees (RHCCs), which has been noted in some districts after NSMP withdrawal.

Improving Service Delivery

NSMP Logframe Output 2 Statement:

NSMP supported facilities (hospitals and PHCCs) provide good quality midwifery and obstetric services.

Barriers to Improving Service Quality

Quality of care (QoC)⁶ includes both the technical aspects of care (correct procedures, treatments, hygiene etc) and also the quality of the interaction between the Service Provider (SP) and the patient (respect, provision of information, gentleness etc). Evidence shows that poor quality of care can contribute to high maternal mortality through inappropriate and ineffective treatment and it is one of the major reasons given by potential clients for not using the services that many facilities in Nepal provide.

Inappropriate deployment and use of trained staff, frequent transfers, poor logistics and lack of supervision have all been noted as constraints to development interventions in HMGN health services (QoC Study 2004). Many training-based attempts to improve service quality have been undermined by these aspects of Nepal's health service management. Further, the evaluation showed that the following retard quality improvement initiatives:

- **Staff shortages** due to loss to private practice, civil service cuts, the conflict etc. are a major and constant constraint to all the QoC work. 'On average only 1/3 of the Medical Officer posts are filled' (QoC study 2004).
- **Inappropriate deployment of staff**, where staff with special skills are not in a position to apply them, is another widespread problem. For example, overburdening MCHWs with unclear job responsibilities at the Sub-Health Post (SHP), together with the difficulties of travelling to the field, reduces the amount of time they can spend out in the community delivering SM messages and attending births.
- **Frequent transfers** undermine the application of skills training and threaten the sustainability of NSMP inputs. An evaluation of the Foundation For Change (FFC) training noted: 'The transfer of hospital staff and district officers is also a concern. Due to high turnover in Kailali, more than half of the current nurses have not received FFC training.' (Foundation for Change Review 2003)
- The MCHW Assessment (2003) and the review of the performance of those who received the post-basic midwifery training (2002) both stress the importance of an improved **enabling environment** in contributing to staff performance. Training is not effective unless it is combined with an enabling environment which supplies the necessary staff time, equipment, support, drugs etc. Lack of supplies to replenish their kit box and the lack of supportive supervision are already proving to be problems, reducing the performance of the MCHWs (MCHW Assessment 2003).

⁶ See Annex 3 for a detailed list of all the documents included in this report, which can be downloaded from www.nsmmp.org

- Similarly both the MCHW Assessment and the report on the post-basic midwifery training mention the low value given to MCHW services and post-basic training in some DPHOs. This, combined with **little supportive supervision**, undermines the continuing application of what has been learnt and the general performance of service providers.
- Traditional expectations of **patronage** also undermine the QOC. Patients mention Service Providers treating ‘*affno manchhe*’ (their own family and friends) better than others. This perception by users clearly needs to be countered if confidence in service quality - and hence utilisation rates - are to grow.
- Safe motherhood services are a challenge to health systems in that they require so many different interventions and players to be co-ordinated. **Prompt referral** is critical in the management of obstetric emergencies since most cannot be predicted in advance. Lack of referral slips (most MCHWs were found not to have them) makes it hard to assess how much MCHWs and ANMs are referring patients. The absence of hospital ID for MCHWs means that they are not allowed to enter with patients they are referring. This both undermines the MCHW status in the eyes of their clients and their linkage with hospitals. Both of these in turn, negatively impact on referrals.

The Complexity of Improving Service Delivery

One of the key challenges to reducing maternal mortality in any setting is that the complex range of interventions needed (identification of risk, referral, appropriate and timely treatment) require that the entire health system be functioning at all levels. This is very challenging to any project as it requires working on all aspects of health service delivery in order to improve quality of care (e.g. human resource management, infrastructure/supplies management, functioning support units and financial management).

Bureaucracies are hard to change and the Nepalese one is no exception. Although current plans for decentralisation offer the possibility of greater local freedom of action for health service managers, as discussed earlier, the current political situation has reduced the pace of these changes and also raised doubts about the accountability of local bodies.

In addition, NSMP has been working in a Nepali **organisational culture** that has been well-documented (Aitken 1994, Abbatt 1999, Wilkinson 2003 etc) as an area that can be very resistant to change. The culture of ‘*ke garne*’, characterised by a sense of disempowerment and apathy where the individual feels no responsibility or capacity to change things, produces minimally functioning services where workers feel no incentive to work harder. This culture permits the constraints to service delivery described above and has proved very resistant to previous attempts to improve services.

Approach Taken by NSMP

NSMP has approached Quality of Care as part of a **package of inputs** to districts, including those addressing the social context of, and access to, SM services (as described in the section on Increasing Access) as well as those supporting service delivery.

In Phase 1 (initiated in 1997), the Project focused mainly on improving the midwifery and emergency obstetric care services of selected health facilities in 3 districts, using a locally appropriate model based on the broad concept of Quality of Care (QoC), including case management standards and client / provider satisfaction. During Phase 1, NSMP Human Resource Development Officers (HRDOs) provided intensive support in individual facilities to improve the quality of care. Using an iterative learning process, this model was developed, refined and extended to six more districts in Phase 2 of NMSP (from 2001). This required HRDOs to cover more than one district and several facilities supporting internal 'Change Agents' (a staff member who was expected to lead change from within the facility). Some health facilities have received a comprehensive "package of inputs" whereas in others the support was in variable combinations, according to need.

NSMP support included improvements to the "hardware" aspects of quality, including support to appropriately upgrading the physical infrastructure of health care facilities, the provision of safe and adequate blood supplies, provision of essential equipment, and the establishment of infection prevention and waste management. NSMP also provided support to the "software" aspects, which included:

- Capacity building training to hospital staff (clinical and non clinical and at all levels)
- Strengthening the management capacity of the local hospital management committee (HMC) (using an appreciative inquiry approach to successfully develop their support for the change process)

The appreciative inquiry approach employed was a training package called "**Foundation for Change**" (FFC). An integral part of the package is focused on developing an individual's self-potential and belief in their ability to change, as a means of motivating people and building a sense of collective responsibility. The package focuses on people's attitudes to each other and their work, and on tools for improving their relationships and for organising and executing their work.

NSMP adapted COPE (a Client-Oriented Provider Efficiency concept) as a tool to initiate QoC change. Rather than a blueprint approach with absolute standards, the COPE methodology sees quality as something which can be continuously improved, from whatever starting point. The process involves 1) identifying, describing, and analysing the areas for improvement using standard checklists, 2) planning local solutions, 3) implementing the plan, and 4) monitoring the plan.

Two teams (Maternity and Infection Prevention) were charged to take responsibility for leading the process, facilitated by the HRDO. A local level support mechanism (a Quality of Care committee including members from NSMP and the Hospital Management Committee) was established to ensure monitoring of the process as well as to support the teams to implement their plans.

A series of review meetings took place at the central level as well as district level to develop the **QoC monitoring system**. Major recommendations made were then incorporated in the planning process and carried over in phase two health facilities as well. The key change brought in was the reduction of the reliance on project staff (the HRDO), by developing the capacity of the "change agent" as a facilitator within the health facility to ensure local level support, and to maintain recording/reporting.

The QOC Committee and Health Management Committee both received FFC inputs to develop their vision, mission, goal and action plan towards improving the quality of care.

In 2001, FHD and NSMP jointly reviewed NSMP's implementation experiences of the QoC approach in the light of new international evidence. As a result, a "**Guide for Quality Obstetric Care**" was published in March 2002 in the Nepali language (now translated into English). The guide includes tools to measure QoC outcomes (qualitative and quantitative indicators) from the service providers' perspective as well as from the users' perspective. The tools in the guide have been adopted by a number of EDPs working in safe motherhood (WHO, UNICEF, GTZ, MNH, and NFCC/QoC unit). To date, the tools have been implemented at 16 health facilities including in the non-project supported district of Janakpur.

In 2003, following revision (in the context of international evidenced based learning) and testing by NSMP of both the maternal death and the perinatal death review forms, the Nepali QoC guide was updated to include these (QoC Approach Paper 2004).

In recognition of the fact that all parts of the local health system need to be functioning well if SM services are to be effective, NSMP has worked increasingly with different district level bodies (Line Agencies, DDC bodies and NGOs) as the **district partnership** approach has evolved (see previous section). The "Foundation for Change" (FFC) training package was used to improve the management and implementation activities of key Safer Motherhood (SM) organisations and stakeholder groups - district level government, line agencies and NGOs, and communities at the village level.

Progress and Achievements

Provision of Midwifery and Obstetric Services

By the end of Phase II, all supported facilities were functionally operational, including buildings, equipment, waste disposal, stores, maintenance etc. Although physical resources were, in principle, adequate for providing essential BEOC/CEOC services, they were found to be insufficient to cope with an increasing client flow (QoC Study 2004).

However, improved availability of services has been achieved (QoC Study 2004) and this included the availability of 24-hour BEOC services where previously there had been only limited hours. In some CEOC facilities the operating theatre (OT) was not open all hours, which results in delays while staff were called and the theatre opened. This is clearly linked to understaffing at the facility.

In terms of the 24 hour supply of safe blood transfusion services, all sites showed improved availability of blood and the functioning of the Blood Transfusion Service although blood was not always available 24 hours a day. The availability of blood free of charge to the poor is another significant achievement of NSMP.

Quality of midwifery & obstetric care (as defined by FHD/NSMP's QoC framework)

The QoC Study (2004) states that the most significant improvement resulting from use of the QoC model is in the technical competence of the staff. For example, improvement of post abortion care (PAC) quality was noted. This was achieved through the introduction of evidence based clinical techniques (such as Manual Vacuum Aspiration), the development of protocols and the training of nurses in PAC. In NSMP supported health facilities, nurses' roles were significantly expanded to address the acute shortage of physicians. Nurses can now manage obstetric complications up to the level of BEOC, and in addition to this some are also trained as *anaesthetic assistants* in order to provide safe anaesthetic care.

Nurses in NSMP supported facilities have also been trained to manage normal and complicated newborn care. The QoC evaluation found a high level of competency for newborn resuscitation (score 86.1%) in NSMP supported facilities whereas this essential life saving skill was not being practiced in the control facilities observed by the study team. There is increasing international attention given to ensuring integration of newborn care into safer motherhood and NSMP recognised the importance of this early on and has made efforts to promote integration. However the QoC study also found that counselling of families for postnatal care including care of the mother and baby is still weak.

The QoC Study also suggested that despite improvements in communication with clients after FFC and communication training, the client-provider relationship is still generally one-way and limited, with many clients afraid to ask questions. Poor feedback to accompanying relatives is a particular area where communication is still weak.

Sustainability of the quality of midwifery and obstetric care

QoC has been sustained but to varying degrees in the Phase 1 facilities. The MCHW Assessment showed that 60% of trained MCHWs in project supported districts demonstrate skills in care (inc. skilled attendance) and referrals that are in accordance with HMGN RH Protocol. This assessment also showed that the number of births attended by MCHWs was very low compared to the expected births in their catchment populations. Referrals from MCHWs have been hard to monitor due to the lack of referral forms. However, the recent trend from the HMIS data shows a slow but steady increase in home deliveries by health workers. The HMIS data shows the increase in home deliveries by health workers is 3.6% between 2001/02 in NSMP hill districts compared with 2.1% in all hill districts. The contribution of MCHW refresher training and promotion of an enabling environment in NSMP districts is likely to have been important.

Transparency and Accountability in Management

Improvements in team working at facility level have been shown. This is difficult to achieve in Nepal's very hierarchical culture and the involvement of all from Hospital Superintendent to cleaners in improving infection prevention is a good example of quite significant achievement in this area. Improved co-ordination between departments (e.g. lab services and ANC) is another and the integration of related service provision (e.g. ANC, FP, TT and PAC) has improved services from the

client's perspective as they do not have to return on another day for a related service.

However, the link between the QoC Committee and the Hospital Management Committee was found to still be rather weak (QoC Study 2004) and linkages between the IA and SP components of NSMP's work and the institutions involved could be further improved.

Key Issues

A package of inputs

NSMP's approaches have been much more successful than many previous attempts to improve the quality of Nepal's health services. Key to this appears to have been changing the organisational culture in facilities and empowering service providers to improve quality. NSMP has succeeded in both motivating staff to *want* to improve quality and in *empowering* them to do so.

'In Kailali an important part of the improvements in hospital management can be ascribed to the COPE/QoC system that NSMP introduced. It has helped staff and management address their needs and issues, and get support from the QoC committee and the HSC, when needed. It has also improved communication and collaboration among staff, and encourages them to be client friendly and to seek to satisfy the client's needs. Staff have observed a lot of positive energy through the QoC approach, and the system has given the HSC a more active role and better links to the staff.'

Foundation for Change Review 2003

The QoC Study (2004) suggests that including QoC interventions as part of the package of improvements has given service providers self-confidence and this has significantly contributed to their technical performance.

The success of UNICEF's WRLHP (whose service delivery approach was modelled on NSMP's) in also creating the necessary empowerment and sense of responsibility for significant change in the quality of services to occur, suggests that the 'team approach' and the appreciative enquiry methodology used in the FFC training have been critical inputs. In Nawalparasi and Surkhet, when asked what would have happened if there had been no FFC programme, the respondents were categorical that the impact of NSMP's other inputs would have been much less (Foundation for Change Review 2003).

Key to NSMP's success in improving quality seems to have been the combination of a variety of inputs into a synergistic package so that different interventions were mutually supporting. Thus Hodgson et al note:

'FFC is strongly supported by the rest of the NSMP programme, which provides hospital staff and other stakeholders with incentives or benefits for participating. Incentives like training and the potential for advancement, improved facilities, responsiveness to requests for support, and recognition and appreciation.'

District level focus

As discussed above, safe motherhood services are a challenge to health systems in that they require so many different interventions and players to be co-ordinated. NSMP has been very successful in working with a whole range of stakeholders, political, institutional, community etc. Once again the critical factor in NSMP's success appears to have been its highly integrated approach which co-ordinated work with and support to local political and government organisations as well as work with local NGOs and community-based organisations. Thus issues of both access and service quality were addressed at the district level and through a wide variety of fora, acknowledging the close links between the two components.

Sustainability of improvements in QoC

NSMP's approach, and its success, has been due to the careful co-ordination of a wide variety of inputs at every level. It will be hard to sustain all the different types of NSMP inputs (training, mentoring, supplies etc) through HMGN systems, which have been weak, particularly in terms of supportive supervision and logistic supplies.

However, initial signs are encouraging: health management committees have been budgeting for Infection Prevention materials (mostly unavailable prior to NSMP's arrival) over the last 2 years (QoC Approach Paper 2004). These teams continue to meet even though HRDO support and expenses from NSMP have been withdrawn (QoC Study 2004). Respondents in the QoC Study, questioned how long this can be sustained in the longer term however. It is an achievement that facilities are sustaining the purchase of their own materials, but their potential for income generation to support this is linked to deployment and access issues (see below). The QoC Study also mentions that some facilities are having problems maintaining Infection Prevention activities.

Transfer of responsibility from HRDO to the facility Change Agent (CA, usually a senior nurse) has encountered various difficulties to do with the CA's position within the management structure, their lack of budget authority to manage emergency purchase of essential drugs/supplies, frequent transfers with no handovers etc., although this was seen in some hospitals. Many of those interviewed expected problems when the HRDO had gone (QoC Study 2004).

NSMP's approaches have been tailored to address the problem of frequent transfers, which is not new to the Nepali health system and which constitutes a critical constraint to any development intervention. The team approach to all the QoC work has reduced the project's vulnerability to the effects of the transfers of individuals and has proved successful in sustaining QoC improvements so far. The move from posting an HRDO (Phase 1) to covering more facilities by supporting Change Agents in each one (Phase 2) should make the scaling up of QoC interventions more sustainable in the National SM programme.

Another response to frequent transfers is to support and encourage the hiring of staff from the locality:

‘Some HSCs and RHCCs are seeking to increase the number of staff who are from the local area so that their knowledge and expertise are not lost to the district. In Baglung and Surkhet older nurses from the local area are helping new nurses learn about FFC and practise it. This is possible because turnover is relatively low, as existing nurses are local and want to remain in the district, and therefore the number of new nurses is less than in other places. It illustrates the value of hiring local staff.’

Foundation for Change Review 2003

As part of the whole site capacity building process, data recording and reporting systems have been significantly improved. NSMP’s contribution to the development and common use of UN Process indicators will strengthen the HMGN Monitoring and Evaluation systems and should ensure that staff trained by the project can apply their M&E skills in any HMGN facility. Thus NSMP’s work should contribute to strengthening other facilities as staff are transferred. The standardising of national protocols and training curricula are also very important contributions to maintaining quality standards nationwide when staff move so frequently.

The sustainability of the effects of the FFC has been questioned by Wilkinson in the Model for Change Report (2003). Hodgson et al (2003) in their review of the FFC training comment that, unlike NSMP’s more technical inputs, there has been no organised follow up of FFC to institutionalise it:

‘Most of the breakthrough projects set during the FFC training have been achieved, but few new breakthrough projects have been generated after the FFC training was completed. This suggests that the practice of taking on new initiatives and achieving them has been reliant on the support provide by the workshops and the trainer. Also, perhaps the practice of breakthrough projects has not been incorporated into the QOC system.’

This raises questions about the sustainability of the QoC improvements after the NSMP withdraws. It seems that changes brought about by FFC (and the breakthrough projects which were a part of this) are declining slowly, and the way to sustain them is to ensure continuing support from the health system. *FFC has shown what is possible, but unless the health system can institutionalise these changes, they may not be sustainable.* This requires changes in the way government works, in particular staffing practices, supervision and levels of reward and remuneration. As the FFC evaluation concluded: ‘Perhaps those working at the grassroots can help bring this about through their increased awareness of what is possible, as demonstrated by NSMP and FFC, and their growing self-confidence to express the need for changes.’ (Foundation for Change Review 2003).

Constraints to Further Improvements in QoC

Conflict is a major constraint to improving further the quality of care, although its effects are hard to determine. It appears to be impacting on the availability of staffing, although conflicting reports on availability of staff have been received (Conflict Study 2003). Out of hours and home visiting services have certainly been reduced as workers fear to move at night. On a more positive note, the Conflict Study documents an improvement in timekeeping at facilities because staff fear Maoist action if the facility is not open for the full hours.

Some District hospitals have suffered attacks and cuts in their electricity and water supplies – deterring staff and patients from going there and impacting on the quality of services. Supplies of all kinds (drugs, equipment, building materials) have been delayed and disrupted, hindering all SM activities. PHCCs and SHPs have also faced absent staff and restricted drug supplies. Unreliable logistics for supplies were noted as hindering MCHWs in their work (MCHW Assessment 2003).

Referral must be strengthened if met need for BEOC and CEOC is to increase and more women are to receive the care that they need. This requires the focus of the nature of ANC to be moved away from an emphasis on clinical measurements and towards informing women of their options and discussing the need to make plans for the birth and potential complications. As such the role of MCHW and ANMs (who carry out Ante-Natal Care at Health Posts) needs to expand from simply performing clinical tasks to act as a community educator and motivator for planning for the birth. This will require MCHWs and ANMs to have the skills and confidence to educate men as well as women – an area in which they are currently lacking (MCHW Assessment).

Lack of clarity on the **governance arrangements** of health facilities, Hospital Development Committees (HDCs), Health Management Committees (HMCs) etc is hampering their effectiveness. Their membership, roles and responsibilities need to be clearly understood by all stakeholders if they are to be effective and accountable. This is partly related to the **dissolution of elected local bodies** which has undermined local structures and management accountability. This has led to an over emphasis in the membership of representatives from HMGN institutions. It has also made these bodies more vulnerable to the problems of HMGN, for instance frequent transfers of HMGN staff affecting continuity in these groups.

Although the NSMP model has shown success in improving facility management, particularly around local resource mobilisation, and this in turn has been able to improve staff motivation by providing them with what they need to do their jobs, this model could not address the larger constraints of the health system such as better management of drug/supplies, quality of lab services, staff transfer and understaffing etc. To increase the efficiency of this model there is a real need to implement the sub health sector reform (safe motherhood programme) process, and by combining the two together this will strengthen the health system.

Facilities are now empowered to raise income from fees and to hire their own staff and purchase some supplies. This should allow them much more scope to improve

the quality of care, however **resource availability** is a constraint to service quality in many facilities. Staff employed by the HMC (usually support staff rather than highly trained cadres) are on different Terms and Conditions to those employed by HMGN. Since they lack the security and pensions of HMGN staff they are generally less motivated. The QoC Study (2004) comments that whereas hospitals can give staff incentives, PHCCs cannot. This is largely because most PHCCs have no doctor and since this limits the services they can offer, it also limits the income they can generate as in general the services for which people will pay are those offered by doctors. Thus the availability of doctors affects health facility income-generation and in consequence, the incentives the facility can offer its staff and the extras it can provide. The tendency for doctors to work in urban facilities could also reinforce inequity in service provision.

Resources are also key in terms of the **total cost** of project inputs. Scaling up to achieve a national SM programme will require a massive financial commitment. An analysis of NSMP costs over the life of the project showed that management costs averaged 21.4% of the total (this percentage was greater at the start of Phases 1 and 2 reflecting the costs of establishing new systems and capacity and had reduced to 6.6% by the last year of the project). The cost per district was greater in Phase 2 districts (GBP 258,898 as opposed to GBP 221,318) due to increasing prices and investment in more facilities per district. The proportion of management costs went down however from 27.6 per cent to 18.7 per cent . This was probably due to economies of scale. Nonetheless it is important to recognise that the strengths of NSMP already identified: co-ordination of inputs, well-integrated approaches etc do not come without management costs.

Hardware costs varied greatly by ecological zone as shown in Table 2 on the following page. This reflects the widely differing transport costs between the mountain, hill and terai districts. Once again it can be seen that to target the mountainous districts where populations are more remote will require much greater resources.

Table 2: Average Hardware Cost by Ecological Belt

NRs. in Million

1.	Building Construction	No.	Average cost per district by Ecological Belt						Overall Average
			n.	Mountain	n.	Hill	n.	Terai	
a.	New Extension	8	1	6.17	5	2.79	3	2.86	3.19
b.	Existing Building Alteration	5	1	0.86	2	0.41	2	1.44	0.91
c.	Others	6	1	1.07	2	0.46	3	0.60	0.62
	Total			8.10		3.66		4.90	4.72
2.	Equipment Supplies	8	1	1.76	4	1.94	3	2.32	2.06
3.	Blood Transfusion	5	1	0.34	3	0.71	1	0.77	0.73
Overall Average				10.20		6.31		7.99	7.51

Note: n denotes number of districts.

* Consultant's cost of NRs. 0.40 million is not shown in belt-wise cost but is included in the overall average.

The average cost of training per district is NRs. 3.57 million including the cost of consultants and management. These costs when associated with training remain more or less unchanged irrespective of the number of districts and so again, economies of scale could be achieved. Training costs are greater for CEOC (NRs. 2.22 million per site) than BEOC facilities (NRs. 1.44 million per site excluding consultant and management costs).

Table 3: Aggregate Cost of Service Provision by Ecological Belt and Service Facility

NRs. in Million

Component	Overall Average	Ecological Belt			Service Facility	
		Mountain	Hill	Terai	CEOC	BEOC
Hardware	7.51	10.20	6.31	7.99	7.81	6.02
Software	3.57	2.55	3.74	4.06	3.82	3.05
Aggregate	11.08	12.75	10.05	12.05	11.63	9.07

Per head project costs also ranged from NRs 761 in the mountains to NRs 87 in the terai with an average of NRs 138. Basic training is carried out by many institutions with little quality control or standardisation over the content of the training.

Lack of **practical training** is a weakness affecting the quality of the work of many staff. This problem is hard to address given the small number of deliveries in most training units. Increasing utilisation is therefore a means to improve quality as well as an end in itself. In training units, students and on the job trainees require supervision and this can be a problem in some units which are busy and understaffed. In these cases the requirement to deliver practical training can hamper service delivery and its quality (QoC Study 2004).

Use of information is still a problem. NSMP has made great progress with facilities in improving the quality of reporting, but even where record keeping is good, the information is still not used for health facility management, rather it is sent up to the

centre for compilation. There is therefore no direct link at the facility level between the services provided and any recognition of progress or improvements still needed. It is suggested that the future programme avoid too much reliance on written reporting and concentrate on the use of information for facility management purposes.

Influencing Policy

NSMP Logframe Output 1 Statement:

NSMP contributes to safe motherhood policy and programme development (including feeding into global lesson-learning)

Barriers to Achieving Policy Change

NSMP, from its onset, played an active role in policy development. This contribution was recognised in 2000⁷ at the Output to Purpose Review which recommended that influencing policy should become an explicit objective if the impact of learning from NSMP was to be maximised and NSMP's ongoing work in this area recognised.

Influencing safe motherhood policy and programme development in Nepal was potentially difficult as the Reproductive Health sub-sector was and still is, characterised by a multiplicity of external development partners (EDPs) and implementing agencies. With such a wide stakeholder group pursuing a variety of objectives and agendas, developing consensus and common approaches could have been extremely difficult.

NSMP developed a highly successful approach to policy development which was largely borne from two streams of influence: First, from 'home grown' knowledge – well monitored field experience that produced critical learning; secondly, the appropriate application of international experience. The weaving on these two was delivered in a manner which embedded the process into the Family Health Division and resulted in good quality policy influence.

Approach Taken by NSMP

NSMP's approach was strategic from the beginning. The project office's position in the same building as the **Family Health Division** (FHD) and the willingness of NSMP staff to respond to requests for advice and assistance, combined with the presence of a very active and supportive Director of FHD, meant that communications with FHD were excellent from the start. Regular discussion and dialogue has taken place with FHD and other divisions of the Department of Health Services on policy issues such as abortion, skilled attendance, increasing access and costs of obstetric care.

At the national level, NSMP has actively participated in the **Safe Motherhood Sub-Committee** where lessons from NSMP are shared and debated. The RH policy stakeholder group in Nepal, while large and diverse, is characterised by unusually good co-operation and co-ordination. Although NSMP cannot claim all the credit for this, the project has certainly been a strong supporter of these processes.

The project's **district focus** and the presence of strong staff in the field has allowed assessment and close observation at NSMP sites, which have fed into the

⁷ All documents can be accessed on www.nsmo.org and are included in a detailed list at Annex 3.

development of national policies and guidelines. Thus the national QoC standards and tools were developed and refined in light of feedback from NSMP sites. From 1997 NSMP piloted the post-basic course for Registered Nurses and subsequently assessed their performance in post.

The project has attempted to respond and reposition itself in the light of emerging debates. It has produced **papers** on the role of Safe Motherhood in the context of SWAps and Health Sector Reform and responded to the shift in policy from a focus on EOC only to normal and complicated deliveries at home. Although not working at the home delivery level, the project has sought to contribute to the emerging debate (both internationally and within Nepal) around skilled attendance at birth. This has focused on the levels of skills and training required for skilled attendants and what support they need to be effective in the community.

Progress and Achievements

Feeding district learning into central level policy & programme development

At district and VDC level, findings from the Key Informant Monitoring (KIM) results seem to have influenced local officials (VDC and DDC), as they provide valuable qualitative insights. Also at district level, partnerships with HMGN line agencies have resulted in SM being integrated into the planning and priorities of the line agencies. For instance, SM features in the DDC plans of all 9 districts that NSMP works in, (even though the plans have been somewhat undermined by budget cuts due to the conflict).

Feeding district evidence into central level policy and planning has been a key feature of NSMP's work. In order to influence government support for NSMP's work, the original QoC evaluations were able to demonstrate that BEOC was not available 24 hours in many facilities. Similarly, NSMP was central to the piloting of the MCHW cadres as community based skilled attendants from the onset of the FHD pilot in 2001. NSMP supported the pilot in a range of practical ways, ensured the learning was well documented and the topic was tabled at several national policy forums. NSMP then co-funded a national evaluation of the MCHW's performance. During this period, NSMP liaised with the Dugald Baird Centre at the University of Aberdeen (the SAFE project) thereby ensuring international learning on the degree to which life saving care can be decentralised was fed into policy development. Although the debate over community based skilled attendance has still to be finalised in Nepal, NSMP's role has been critical in its further development.

Accreditation of NSMP piloted training courses

A significant contribution to national debates on the required cadres and curricula for health staff has been NSMP's work in piloting and providing *home grown* evidence for the best balance between skill levels and coverage of service providers. Influence, for example, from experience of developing and testing curricula for Post Abortion Care (by nurses), was then combined with lobbying of the medical establishment to enable the inclusion of PAC in the RH clinical protocols and the training of nurses in PAC.

Legalisation and Implementation of Abortion Services

Unlike all other examples, this topic did not develop from field based experience but NSMP acted upon and contributed to changing the social and political climate surrounding abortion. NSMP's role in the years prior to the change in legislation was one of a group of players lobbying for change but its role became more significant in the immediate pre-legislation period and during the elaborate and lengthy legislation period. NSMP was a founding member of the influential national technical committee for abortion (and funded its Secretariat), commissioned policy informing briefs and literature reviews (see the NSMP Website) and has continued to fund the majority of the implementation of the initial national two year plan.

Institutionalisation of NSMP initiatives

Partnerships with NGOs for Increasing Access have also raised the partners' awareness of safe motherhood issues and have influenced the NGOs' internal policies and best practice in areas such as improving their own maternity leave. RHCCs and other safe motherhood forums have become more popular with NSMP support and have gained more influential membership, with DDC officials in particular becoming increasingly involved.

Successes

A presence at all levels appears to have been key to NSMP's success:

- The project's physical position in FHD (combined with the enabling environment provided by the Director FHD) seems crucial to the development of influence at the central level based on good relationships with key stakeholders.
- At the facility level the HRDO was able to provide technical on the job coaching as well as facilitation, mentoring and limited financial support. This was appreciated by facility staff and has been highlighted by the QoC Study as key to the success of QoC interventions.
- NSMP's strong district level presence allowed the project to develop networks and relationships and ensure co-ordination of a package of inputs.
- Its solid technical presence in the field has allowed NSMP to contribute direct field experience to policy making discussions. This, together with demonstrated successes, has gained the NSMP credibility at every level.
- Presence has also been important in relations with district level partners. Those which were more remote were less frequently visited by NSMP staff and consequently communication and interpersonal relationships were less good. In these cases NSMP visits tended to be seen by partners as monitoring rather than supportive (Partnership Review 2003).
- NSMP also had a strong organisation culture and a shared vision of its purpose and goals. These were articulated to partners clearly, and a change management approach, through FFC and other initiatives, was used to underpin service delivery and increasing access activities. See the box on the following page.

The Change Process Summarised

NSMP is now regarded as a model for successful implementation of Safer Motherhood initiatives and is influential at both national and international levels. Flexible, pragmatic project sequencing has enabled the Project to focus on tangible improvements, such as renovation of hospital buildings and improvements in infection control and waste management, leading to an early improvement in staff morale. Once the 'basic' needs had been met, the focus was shifted to improving organisational development and the quality of care, through competency based training.

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

Model for Change Report 2004

Sustainability

As mentioned above, presence seems key to success. NSMP had very **competent staff** at the district level who were able to facilitate and sustain the project supported interventions. This will be a problem for scaling up, given HMGN's well-documented problems with keeping well-qualified staff in remote districts and with the lack of supportive supervision generally.

NSMP also created **strong communication** between district and centre so that learning from the districts informed policy making. This is another often noted weakness in HMGN services. The QoC Study notes that staff felt that in the HMGN system, the centre was not supportive of, or responsive to, activity in the districts.

While the **Reproductive Health Co-ordinating Committees and Safe Motherhood Forums** have demonstrated success in creating a platform and interest among local officials in RH and SM, there are questions of ownership and sustainability after NSMP ends (because of the strong support NSMP staff were able to give to these bodies in the district). To capitalise on success so far and to try to ensure greater local ownership and sustainability, the RHCCs should be positioned under the DDC Health and Social Welfare Committee and not under FHD.

Central level ownership

While NSMP's work on QoC and IA has been successful in creating local ownership (particularly strikingly in the health facilities, given the organisational constraints), it is reported that most of the line agencies in the District see NSMP as a donor not as a catalyst acting for FHD (Partnership Review 2003). Thus ownership by the central policy level is not perceived in the districts. It must be a priority for the National SM Programme to clarify and demonstrate that this is a national government-led programme (with EDP support) and not a donor-driven initiative.

Increasing EOC (BEOC and CEOC) Utilisation

NSMP Logframe Purpose: Sustained increase in utilisation of quality midwifery and obstetric (BEOC and CEOC) services

In 1991, deliveries attended by health care providers in Nepal stood at 7.4% (HMG/N, 1991) of all expected deliveries. By 2001 this indicator had gone up to 10.8 percent (MoH, 2001) and in 2002/3 HMIS data gave a figure of 16.1%. The challenge is to have 90% women delivered by a skilled birth attendant by 2015.

NSMP's Approach to Increasing Utilisation

NSMP has sought to increase utilisation of EOC services through its inputs into increasing access, improving service quality in hospitals and PHCCs and influencing SM policy in Nepal.

In assessing the success of NSMP's attempts to increase utilisation of services two points concerning the project design must be noted. Firstly, in Phase 1 the project worked only in CEOC facilities. Following the mid-term review recommendations, Phase 2 extended support to some BEOC facilities (PHCCs). NSMP has not worked directly on home births attended by a skilled attendant.

Secondly, the project's purpose and indicators initially concerned general (population-wide) increases in utilisation. There were no specific targets or objectives concerning the utilisation by different groups. The policy demand to focus on the most marginalized came after the project was already designed and running. The project has however attempted to adjust its strategies to take the needs of these groups into account.

Measuring utilisation

NSMP worked in 9 districts, namely, Kailali, Surkhet, Baglung, Rupandehi, Nawalparasi, Parbat, Myagdi, Jumla and Dailekh. UNICEF's Women's Right to Life and Health Project (WRLHP) is working in another 4 districts: Saptari, Kapilvastu, Dang and Panchthar. Both projects contain a service component, under which systems to improve the quality of essential obstetric services are incorporated. The system of monitoring EOC, developed by NSMP and partners and, endorsed by FHD, currently covers these 13 safe motherhood districts and as the number of safer motherhood (SM) districts increases, the monitoring system will be expanded.

The EOC monitoring system has been rigorously developed and is considered reasonably well managed and reliable. It only gathers data from the public facilities in the district however, while using the district population as its denominator in calculating met need. Thus if there is any private facility activity in the district the met need figures will be an underestimate. Changes in utilisation of other facilities and services, private for profit and private not-for profit, are not currently measured by the system. Similarly the HMGN HMIS system measures institutional and home births attended by HMGN staff but does not take all private facilities into account. It is therefore necessary to assess the total utilisation (public and private facilities), particularly in view of the expanding services being provided by the private sector.

As part of the final evaluation, therefore, a study was conducted in six selected districts (including 3 NSMP and 2 UNICEF-supported and one without project support) to assess whether there has been any increasing trend in EOC utilisation, in public and private health facilities (Utilisation Study 2004⁸). This study is useful in adding depth to the data from the HMIS and EOC monitoring systems as, in addition to covering activity in private facilities, it also includes more information about the origin (ethnic, religious and geographical) of those using the health services.

Key Constraints to a Greater Increase in Utilisation

Health service infrastructure is major constraint. 'There is a tendency towards a shortage of BEOC facilities even in districts where there are adequate numbers of CEOC facilities' (Utilisation Study 2004). 'The facilities in all districts are clustered around the urban and peri urban areas, adjacent to the roads, while large parts of population in the rural and remote areas remain virtually without services. This was true for both private as well as the public facilities.' For this reason it remains easier to increase met need in the terai where physical access is less of a problem (PPR July-December 2003).

Coverage of increasing access activities

One of the key constraints to a greater increase in utilisation has been the limited coverage of the increasing access activities, both the proportion of the population in a district covered, but also the lower reach to geographically remote and socially vulnerable communities. However, given the social context and the deepening conflict situation in the country, plus the fact that partners have only been providing support for 3 years, the pace of social and behavioural change behind EOC utilisation could not have realistically been expected to be much faster (for example conflict related delays to project plans in the far western districts of Jumla and Dailekh).

In general, both broader and more targeted coverage of activities that enable access is required. This in itself raises challenges for the future. First there is the cost of expanding an IA package. The NSMP IA package cost approximately NRs 6 million per district, covering approximately a third of the population in a district, and this was the more accessible population. Given that poorer, more remote, less organised communities will require a more intensive package of support, one can see that the cost of expanding the coverage of the IA package to new districts will be significantly more than under NSMP, though this will vary by district and area according to the social context. In addition to the cost of expansion, another important factor will be the existence of district partners that have the capacity to deliver the IA package. In communities where community development is weak, where NGOs and CBOs are not present, or where they are too weak, additional resources and time will be required to develop capacity and the mechanism through which SM can be promoted. Thirdly, the political context in which resource-related decisions are made will present challenges to ensuring resources and energy are directed to poorer and needier communities, who tend to be less powerful and less politically influential. Targeting resources according to poverty benchmarks based on reliable poverty data will be essential for reducing the risk of concentrating inputs in better-off, more

⁸ See Annex 3 for a detailed list of documents referred to within this report.

accessible, and more powerful areas. Fourth, while the continuing conflict places even more stress on the need for pro-poor, inclusive development, it also poses practical difficulties in working in heavily-affected communities.

Even in areas where NSMP partners have been active, and progress has undoubtedly been made in enabling access, constraints and delays persist in deciding to seek EOC and reaching that care.

Delay in deciding to seek EOC

From the evidence available, the project appears to have increased knowledge and awareness among communities of the dangers of pregnancy and childbirth, and where to go in an emergency, but decision-making continues to account for the longest delay in accessing EOC (Conflict Study 2003). Dependent as decision making is on a wide range of conditions in addition to knowledge, such as: attitudes towards and value given to women's health and well-being; presence of male family members who are the traditional decision-makers; perception of the cost and appropriateness of EOC, inevitably mean this will be the most complex and challenging domain to influence. Experiences from NSMP partners do suggest that social mobilisers, peers, and traditional practitioners are becoming more influential in helping families make more timely decisions to seek EOC when an emergency is suspected. Such a "community watch" function needs to be institutionalised at this level for all pregnant women so that informed and influential members of the community can support the decision to seek EOC, helping to organise money, transport, childcare and reassurance as required.

Referral

The evidence is that MCHWs are not reaching beyond SHPs in part because of their other duties (in particular deputising for absent colleagues). Calling the MCHW late in the delivery after there are problems reduces her effectiveness and hence her standing in the community. 'One of the problems hindering the utilisation of EOC was the lack of a functioning referral system with two-way linkage and communication between different levels of health facilities.' (Utilisation Study 2004). The loss of phones (due to conflict) in many places reduces referrals and makes it much harder to arrange transport.

Delay in reaching EOC

The total cost a family has to bear for using facility based EOC, including transport and other opportunity costs (as well as the physical availability of transport) remains a significant barrier to timely care (Cost Study 2004.). Even in areas where project partners are active not all communities have established or sustained community emergency funds and transport schemes. In addition, facility based exemptions and emergency funds are poorly targeted and little known about in the community. The exemption system currently fails to assure poor women and their families that they will receive appropriate care at a cost they can afford. Without fuller protection from the costs of EOC, or flexibility in payment scheduling, delays in seeking care are likely to persist. Likewise, the uncertainty of the cost of care at a facility remains a serious obstacle and discourages prompt decision-making to seek EOC. Transparent and clearly understood pricing policies need to be developed so that families know in advance the total cost of EOC care, packaged appropriately, without the cost uncertainties and informal fees that currently exist.

Conflict

The armed conflict is having a serious negative impact on both care seeking and the provision of EOC. Beun and Neupane (Conflict Study 2003) have estimated that the conflict is adding an extra 10% to the normal delays related to deciding to seek, reach and receive EOC. The greatest impact of the conflict on EOC utilisation appears to be the resulting lack of transport in rural areas, particularly in remote and heavily-affected areas. The higher cost of living in rural areas resulting from the conflict, and the reduced availability of daily wage jobs are adding to the financial burden of EOC. Given these conditions, decision-making was also found by the Conflict Study to have been further delayed, as families factor into the equation the added difficulties of accessing EOC due to the conflict. Once again, lack of awareness is a constraint: women and their families often do not know about curfew exemption agreements which may have been negotiated with the security forces and hence do not take advantage of them (Conflict Study 2003).

For project partners, the conflict is having a mixed but generally significant impact on their programmes. Social mobilisation is severely constrained in heavily-affected areas as villagers are restricted from gathering together by both security forces and the Maoists. Some emergency funds have been dissolved by the Maoists or become dysfunctional for conflict and non-conflict related reasons. NGOs are finding it difficult to operate in communities, and have generally withdrawn non-local staff. In some areas, NGO partners have been forced to stop working altogether. On a more positive note, the conflict has spurred innovative responses, such as the use of radio to help fill the gap in interpersonal IEC activities although the impact of radio on behaviour is likely to be less. The conflict has also forced a repositioning of development priorities and ways of working, much stronger focus on inclusion, tackling discrimination, and targeting the most vulnerable: a shift that will ultimately benefit the entire nation.

Progress and Achievements

Increase in meet need for CEOC and BEOC in NSMP districts

Analysis of project data shows that NSMP and UNICEF have both effected an increase in utilisation in project areas, despite the conflict. Based on this data, the average annual increase in Met Need for EOC⁹ is 1.3% for phase 1 districts over 7 years and 1.2% for phase 2 districts over 4 years implementation.¹⁰ The results of the Utilisation Study (2004) indicated that in none of the surveyed districts was the UN recommended level of met need achieved, the proportion of all births at a facility for the year being well below the recommended level of 15% in all districts. Caesarean sections as a percentage of all births was also still below the minimum 5% in all but one district.

⁹ Met Need for EOC is calculated as the percentage of complications managed to total complications expected. [Complications expected are calculated using the formula 15% of all pregnancies will have complications.]

¹⁰ In UNICEF districts the average is 2.5% in 4 districts over 4 years. However, if Saptari, a district which had a more rapid increase in EOC use, is excluded from the analysis, the remaining 3 districts show an average increase in Met Need for EOC of 1.2%.

Increase in appropriate referrals to obstetric facilities

Whilst monitoring appropriate referrals is difficult, information on changes in the proportion of institutional and home deliveries by health workers is readily available from the national HMIS. This data shows an increase in deliveries at home by health workers from 4.3% in 2001/2 to 5.7% in 2002/3 nationally. The rate of increase is higher in NSMP supported hill districts (3.6% increase from 2001/2 to 2002/3) than non-NSMP hill districts (2.1% increase in the same year) which suggests training, enabling environment workshops and promotion of MCHWs among the community have helped increase the demand for MCHWs at deliveries (PPR January-June 2004).

As discussed above, there is some evidence that women are choosing to go directly to CEOC hospitals rather than wasting time and money in going to a lower level facility first (PPR July – December 2003). However, if women perceive a high quality of service at BEOC sites and they are nearer to their homes which might lower transport costs, they may not by-pass them.

Increase by poor and marginal groups of midwifery and obstetric services in project supported facilities (using proxies)

See section on 'who has the project reached?' below.

Key Issues

MCHWs and 'skilled attendance'

A key part of the district safe motherhood system should be the MCHWs. There has been much debate in Nepal about what service should be available for those without complications to ensure that they have a safe delivery and to make sure women who experience complications during home delivery receive obstetric first aid and prompt referral to a health facility with C/BEOC services. To inform this debate NSMP commissioned an evaluation of the performance of MCHWs to assess what they are currently achieving.

The study found that MCHWs appear to have acquired the necessary skills in their 3 months basic plus 6 weeks additional skill training (commonly referred to as 'refresher training'). This is an encouraging result as this means the cadre could be scaled up quickly. In addition, HMGN has already embarked on a policy of upgrading MCHWs to Auxiliary Nurse Midwives with the intention of posting better trained staff to Sub health posts (SHPs).

MCHWs were found to be attending far fewer births than expected however (this is discussed further in the section on 'utilisation'). This was partly due to the fact that they became overburdened deputising for other absent staff at the SHPs but also to a reluctance to travel, particularly at night. The study recommended that their job description be reviewed to emphasise the priority tasks (MCHW Assessment 2003).

The low productivity of MCHWs is also 'due to a range of factors' (MCHW Assessment 2003) many of which relate to community support for their efforts and how they are perceived by the community. It seems that cultural beliefs are still an important factor in the low demand for MCHWs. Most MCHWs are not from the

lowest castes and it is likely that the access of the low caste groups to their services will be limited. 'Out of 51 MCHWs interviewed, majority (76%) belonged to Brahmin/Chhetri, and the rest from hill and terai ethnicities. None of them came from the Dalit community. Most (42%) were above 45 years and 35% were between the ages of 25 and 28 years of age.' (Utilisation Study 2004). Lack of hospital ID cards means that the MCHWs cannot accompany their patients into hospital which discourages accompanied referral and reduces the status of the MCHW in the eyes of her clients.

The decision to recruit MCHWs into the Public Service so that they can be posted anywhere has been shown to undermine the local accountability of MCHWs. It was clear that locally recruited MCHWs were better received by their clients and that the local recruits were more satisfied with their work. The process of selecting MCHWs will be key to ensuring: their acceptability to communities, keeping skills in communities, ensuring MCHW services are effectively utilised and building links between services in the community and the referral centres.

Is the Increase in Utilisation Reasonable?

The range of annual growth in Met Need for EOC for the project period is from 0% in Rupendehi to 6% in Saptari. Out of the 13 EOC monitored districts only 3 have an annual increase in Met Need for EOC outside 1% to 2%. This experience suggests 1% to 2% could be a reasonable target for government under the National Safe Motherhood Programme. This will be further discussed in a future paper, proposed for November 2004 (see NSMP Website).

Is the Increase in Utilisation Likely to be Sustained?

The social context for increased use of EOC in some areas of project districts has started to shift, but will require ongoing reinforcement and promotion if it is to be sustained, and broadened out. Key to sustaining the gains will be continuing political commitment to SM in the districts. This will be essential for attracting district development resources and motivating the multiple actors and sectors critical to enabling access. In short, this means sustaining commitment to the district partnership approach. Changes in the social context for better maternal health are still new and shallow. Women's empowerment generally has not made major strides during NSMP, and though the project has encouraged the valuing of pregnancy and childbirth and assisted in enabling access, these project-stimulated changes require continuing nurturing and reinforcement. In the context of the conflict and the shrinking development support for NGOs, they are having to scale back activities and, without NSMP support, are unlikely to be in a financial position to sustain SM mobilisation. Continued support to partners enabling community level change will be essential, though based on the evidence from the various studies and evaluations, this support needs to be better targeted to include vulnerable groups that have so far been largely excluded.

Increased client numbers have been noted at almost all NSMP-supported facilities (QoC Study 2004). This increase in uptake of services is partly due to changes in infrastructure (some facilities have been upgraded by HMGN during the period of NSMP support and their catchment areas extended) and also due to increasing urbanisation as a result of the conflict and insecurity in rural areas. Nonetheless, the

QoC inputs appear to have contributed to increased demand. Unfortunately the effects of the conflict and on-going poor HR deployment has meant that increasing demand has been combined with decreasing staff numbers in many facilities, making the QoC improvements (particularly those relating to the quality of the client – provider interaction) very hard to sustain.

In part the constraints are organisational and cultural eg. when an ANC clinic started opening earlier (ie on time) the staff were able to accommodate more clients without compromising the quality of interactions (QoC Study 2004). Also, if the conflict further reduces the presence of trained staff in rural areas this will affect the sustainability of further increases in utilisation.

Conclusions and Key Recommendations for Nepal National Safe Motherhood Programme

Who has the project reached/not reached?

This section of the report reviews evidence of who the project has reached and excluded by looking at inclusion of those disadvantaged by caste and poverty, geographical remoteness, religion, age, and language. Although these various social conditions are often inter-related, they are broken down here to increase transferability of experience and good practice to the future SM programme. Strengths and weaknesses of project approaches are drawn out, and recommendations made for the national SM programme.

Overall, the project has reached a large proportion of the Nepal population, but in different ways and at different levels of intensity. At the broadest level, project-related lesson learning and experience has influenced national reproductive and maternal health policy, the development and design of the forthcoming national SM programme, and led to changes in maternal health service provision and provider practices outside of project districts. More directly, the project's main focus and site of implementation has been in 9 out of the country's 75 districts, covering 13% of the country's female population of reproductive age (15-49) (HMGN 2003/4 data). This consisted of 6 districts in the hills (Baglung, Myagdi, Parbat, Surkhet, Dailekh, Jumla) and 3 districts in the terai (Rupendehi, Nawalparasi, Kailali) plus an additional terai district (Banke) where the FHD has adopted NSMP's methodologies without significant project inputs: see Table 1.

Service provision improvements in each of these districts have potentially reached the entire district populations, an estimated 15% of the national population (QoC Approach paper 2004), and those from neighbouring districts that have chosen to use health facilities strengthened by the project. Most intensively, the project has reached those populations that have had the benefit of available service improvements and increased access to services resulting from the project's increasing access activities. By the end of the project, these increasing access activities covered approximately a third of the VDCs in each of the project districts, some 169 VDCs out of the nearly 3,000 VDCs in the country, plus 6 municipalities, approximately 5% of the Nepalese population.

Beneath these statistical estimates the Increasing Access Review and the EOC Utilisation Study provide a clearer picture of who has been reached by the project and who has not. In order to understand why and how some social groups have been included while others not, we need to understand how Nepalese society works to block some social groups from accessing development opportunities, and how this condition has been played out in the context of NSMP.

Definitions of Social Inclusion and Social Exclusion

Poverty in Nepal is widespread, complex and multi-dimensional. Poverty is deeper in rural areas compared to urban areas, and more concentrated in physically remote and isolated areas, in the hills and mountains and in the Western and Far Western regions. Poverty is greater among women, ethnic groups (Janajatis) and Dalits (PRSP, 2003).

The definition of social inclusion is the removal of institutional barriers and the enhancement of incentives to increase the access of diverse individuals and groups to development opportunities (World Bank 2003). Social exclusion is also the social, economic and political processes or institutions that create and reproduce poverty outcomes persistently over time for certain social groups (IA Review 2004).

In the Nepalese context, inclusion and exclusion are based on the relative position of individuals or groups in society based on power and privilege, social positioning that is rooted in gender, caste, ethnicity, wealth, language, religion, age, geo-political identity and citizenship, and the complex interaction of these social conditions that results in multiple disadvantage.

The Evidence and Challenges Remaining for the Future SM Programme and National Scale-up

Inclusion of the Ultra-Poor, Dalits and Janajatis

As described in 'Barriers to increasing access' section of this report, cost is a significant factor determining access to obstetric services. The Utilisation Study (2004) recorded the caste of women treated for obstetric complications in 2060/61 in Rupendehi, Nawalparasi and Baglung districts. Overwhelmingly the study found that Janajati women made up a significantly smaller proportion of emergency obstetric users than the proportion of Janajati women of reproductive age in the respective districts. In Rupendehi District although 61.3% of women of reproductive age are Janajatis (based on 2001 Census data), they constituted only 28.3% of emergency obstetric care users in 2060/61. Likewise in Nawalparasi, 60.1% of women of reproductive age were classified as Janajati in the 2001 Census, but they made up only 34.4% of emergency obstetric users in 2060/61. The proportion of Dalit EOC users is also less than the proportion of Dalit women in the respective districts, although the differences are less marked than for Janajatis, though this may be due to the smaller numbers involved. For example, in Rupendehi District, Dalit EOC users make up 8.1% of users but are 12.8% of the population. In Nawalparasi District, Dalit women constituted 12% of EOC users but are 14% of the female reproductive age population.

The Utilisation Study (2004) therefore shows large inequalities in the use of emergency obstetric services with higher status Brahmin/Chhetri castes accounting for a much larger proportion of users than their proportion of the population. The findings confirm the continuing disadvantage and barriers that vulnerable groups face in accessing services. In mountain areas where women need to be carried to hospital it is still difficult to find higher caste men prepared to carry a Dalit woman, and such deep social discrimination may take generations to change. Such

discrimination raises the need for a targeted programme response to enable Dalit women to overcome this barrier.

To increase financial access to EOC NSMP supported the creation of **community based emergency funds**, and less directly the implementation of facility based exemption schemes and emergency funds for the poor. Both community based and facility based financing mechanisms hold the potential for addressing the financial barriers that the poor and poorest face in using EOC. However, the Neupane (2004) evaluation of community based SM emergency funds found:

- Dalit membership varied according to the social make-up of the community. In communities with a high proportion of Dalits (Dalit majority), they were well-represented in groups; in communities where Dalits live alongside a large number of other caste groups (Dalit minority), their membership was low; and in communities where Dalits were about an equal proportion of the community, separate caste groups tended to be formed. Where Dalits are not group members they lack entitlement to emergency loans.
- Many high caste people are not willing to allow Dalits to be members of the group or, if members, to be engaged in leadership roles, similar conditions are true for other groups, especially Muslims and the ultra-poor in general.

Local **community groups** have been the main vehicle through which NSMP partners have worked to empower women and their families to take timely and informed decisions about obstetric care, and mobilise the wider community's support to reinforce positive EOC seeking behaviour. The IA Review has documented a broad spectrum of group approaches with varying degrees of, and innovative approaches to, Dalit and ultra-poor inclusion. Overall they found that "although some local groups are exceptional in their inclusiveness, this cannot be assumed the norm, and in some social contexts, targeted approaches to reaching marginal peoples are essential if they are to participate in, and benefit from the project." (2004)

- The NGO HICODEF (the Himalayan Community Development Forum) provides a good example of an organisation applying different models for promoting SM tailored to the social capital and cohesion of the community. In the Churia Hills of Nawalparasi, HICODEF integrated the project's package of SM interventions into its long-standing community development programme. Groups in the Churia Hills include people of multiple caste, ethnicity and poverty status. In contrast, in the adjacent terai lowlands, HICODEF are working specifically with several poor Dalit groups, highly vulnerable communities that depend on daily wages as fishermen, and are at the very bottom of the social hierarchy.
- The Village Development Programme (VDP) in Nawalparasi provides a good example of programme learning and adaptation (Increasing Access Review 2004).
- NSMP's KIM tool has documented the power of group membership to empower poor Dalit women to approach FCHVs and MCHWs (typically young, literate and privileged caste women) to assist them in delivery, a practice previously unheard of. The willingness of health workers to assist Dalit women during labour, and in some cases to cut the cord, is a marker of significant social change and breaking down of traditional beliefs of pollution and hierarchy.

Health facility based emergency funds are available as per government directive, at least in theory if not practice. In reality, the Cost Study found little variation in the cost of EOC hospital care across income groups, and concluded that hospital exemption systems are failing to protect the poor and poorest. To begin with, hospital exemption schemes subsidise only the direct hospital costs of those able to access them, which is a relatively small proportion of the total costs incurred for an EOC case at a facility. Moreover, as the IA Review found, exemption systems are not based on transparent and objective criteria for determining eligibility, and families are generally dependent on the “good will” of doctors on duty with no recourse to arbitration. It was further reported to the IA Review team that Poor Funds tended to be used more by well-connected and better-off middle class clients who have the social power to demand exemptions, than by less privileged but more deserving clients. From focus group discussions in the terai, the IA Review team also found that MCHWs, as well as many NGO partners of NSMP, were unaware of the existence of the hospital funds.

Recommendations

The evidence reviewed illustrates the strength of prevailing power structures to exclude socially vulnerable groups from participating in SM activities and the need for locally designed innovative strategies to enable their inclusion in the programme. Below are specific recommendations on enhancing inclusion of vulnerable social groups (Dalits, Janajatis and the ultra poor of all castes and ethnic groups) in access-related interventions.

On group participation: To encourage Dalit inclusion in areas where they are a minority group and typically outside of group structures, the programme could consider the creation of Dalit-only groups, as per HICODEF’s experience, or create incentives for existing groups to encourage Dalit membership.

On community based emergency funds: Safeguards and mechanisms for including Dalits, the ultra-poor and other vulnerable groups in emergency funds should be negotiated by the SM programme with local communities through district partners to ensure inclusiveness. A uniform, top-down approach is unlikely to work and care will be needed to ensure that safeguards are developed with the full participation and commitment of groups, building on existing social solidarity and tailored to the social context. To enable the ultra-poor to join emergency fund groups, the programme will need to explore how it can cover the cost of membership, possibly through vouchers financed by the programme.

On transport schemes: Targeted incentives for carrying Dalit and other vulnerable groups need to be developed to overcome the added barriers Dalit women face in organising transport in an emergency.

On facility based exemptions: the FHD should work with hospitals to develop transparent and efficient systems for managing and administering hospital exemptions, to ensure that funds for the poor reach the poor. This will mean tackling shadow practices that keep EOC costs to the patient high, including commonly known rent-seeking behaviours and bribery. We suggest exploration of the feasibility of joining up community based schemes which are better positioned to identify the ultra-poor and vulnerable, with hospital exemptions to improve hospital targeting.

Attention also needs to be given to the attitudes and rationale behind local pricing policies that discourage use and equity, such as the extremely high price of manual vacuum aspiration (MVA) in some places (e.g. NRs. 700 at Bir Hospital in Taulihawa, Kapilbastu) while it is free in others (e.g. Lumbini Zonal Hospital, a few miles away from Taulihawa, in neighbouring Rupandehi District).

On provider behaviour. The Quality of Care Study (2004) found poor people lacked the confidence to speak out and request attention from providers. Building on NSMP's work, more innovative approaches are needed to reduce the cultural divide between providers and clients, and to empower clients in the hospital environment, particularly those from vulnerable social groups. Such approaches may include the introduction of client rights and measures to enforce them, client satisfaction surveys, dignity audits, and citizen report cards to monitor public perceptions and experiences of health services.

Reaching the Geographically Isolated

The Utilisation Study (2004) found that around two-thirds of EOC users in Rupendehi and Nawalparasi districts lived less than 2 hours from the facility, and over 80% of users in both districts lived within 4 hours travelling time. In addition, the study found that users were more likely to live close to the main roads than in remoter, less accessible areas. The study concluded however, '... it is encouraging to see that over the years, utilisation from VDCs distant from the roads is also gradually increasing, as is the overall pattern of utilisation.' (Utilisation Study 2004)

The IA Review mapped the working areas of NSMP partners in Nawalparasi District against the DDC's GIS based poverty-map and found that only HICODEF out of NSMP's NGO partners worked in very remote VDCs (1.5 days walk to Bharatpur hospital in an adjoining district). In Rupendehi District, NSMP partners are predominantly working in VDCs along the main roads and not in the remoter and less accessible parts of the District although two partners (PAPWT and Cross Flow Nepal Trust) are attempting to cover a few remote VDCs.

NSMP's decision to work with NGO partners that had the capacity to absorb SM inputs, without needing significant institutional strengthening or support to extend their programmes into new areas (which it could not afford), had the effect of limiting the project's coverage to VDCs where some established NGOs were working. As a consequence, the more remote and socially vulnerable communities in a district were typically not included; areas and communities that Whiteside (Partnership Review 2003) suggests are not typically targeted by elite-led NGOs.

Recommendations

The lesson for the national programme is that the objectives and parameters of partnerships (partners being the primary vehicle for improving access to EOC) must include and prioritise working with remote communities and vulnerable populations who are the most disadvantaged, and often multiply disadvantaged, in accessing EOC, even though organisations working with disadvantaged groups and more isolated communities may require more intense support than others.

Implications of targeting marginal or other excluded groups

The Increasing Access Review also reviews evidence around access for other specific groups such as religious minorities, young people and non-Nepali speakers. While the barriers are different for each, the recommendation in every case is for approaches tailored to the specific social and cultural context. This will require planning and programme development at the district level rather than standardised approaches for the whole country.

A key strategic and highly political decision that will need to be taken at the district level, is where to place the emphasis on generating demand – i.e. is it to encourage the ‘early takers’, or to strive to reach the most underserved, or to do both at the same time? Given the government’s pro-poor policies and commitment to promoting equitable development (both under the PRSP of 2002 and the LSGA of 1999), the SM national programme is obliged to prioritise the poorest and most marginal areas, and to invest in enabling EOC use among these populations. However, given the high maternal risk all women in Nepal face and the persistent poor availability and low use of EOC, high investment in improving access to, and the availability of, EOC services will be required to reach even the more socially, physically, and financially accessible. To translate government policies into implementation it will be important that transparent, fair and evidence-based criteria are used for allocating resources based on disadvantage.

Evidence of which populations are the poorest and most marginalized is now more easily retrieved than ever: e.g. using district poverty maps (GIS) developed by the nation-wide PDDP/LGP initiative from the Ministry of Local Development and National Planning Commission, as well as the government’s PDDP/LGP extensive data base on inclusion/exclusion of disadvantaged peoples in mobilising groups in the districts. Other sources, such as the government’s Poverty Alleviation Fund (PAF), are also relevant and useful in this regard. The importance of such evidence-based resources on which to plan and implement greater equity under the national SM programme is clear.

Wider Benefits from Support to Safe Motherhood

There have been other benefits from NSMP which are external to its log frame and original objectives.

The projects IEC and social mobilisation inputs have contributed to the broader process of empowering women. For example, women’s participation in local groups has brought women out of the home, created the opportunity for women to share experiences and views and to develop their self-confidence and voice to question and challenge social norms and practices. The development and success of innovative tools such as the Key Informant Monitoring system can now be applied to raising women’s voice on other topics. Women’s involvement in the management of community based emergency funds has enhanced their leadership and organisation skills and status in the community, and challenged traditional male perceptions of women. Female social mobilisers are in many communities pushing the boundaries for women, receiving recognition and payment, participating in community affairs and decision-making, and are often young women who are respected and influential. The project’s whole community approach has also contributed to community

development efforts by reinforcing community institutions and including men and local leaders as key actors in SM. Respect for, and inclusion of traditional practitioners has paid off in terms of promoting early referrals, but has also helped to build a working relationship between traditional practitioners and community health workers, MCHWs and FCHVs.

Beyond the community, the project has strengthened the capacity of implementing partners to integrate safe motherhood into their programmes, as well as exposing them to good development practices such as participatory planning and monitoring. Development of partner capacity in more general areas (especially in financial reporting and management) is a further benefit of the project. Improved district level networking and coordination around SM has potentially benefited district coordination more generally, and specifically around health, and assisted in building broader relationships between Government and NGOs.

NSMP inputs have provided a focus for hospital change and a powerful example of what can be achieved. The increases in empowerment and awareness that have been achieved to ensure all concerned to take responsibility for improving quality are notable and could form the basis for many improvements in the future. Other aspects of Reproductive Health are now being integrated into QoC model, so the benefits of the QOC work should extend to other services. Already improvements in infection prevention can be seen throughout facilities in the form of improved waste disposal, cleaner wards etc. These improvements together with the improved availability of blood benefit all facility users not just obstetric cases.

As importantly, the FFC process and the work with the hospital management committees has succeeded in showing that facility management can become more accountable and responsive to local users. The NSMP approach used the service providers' voices to put pressure on health management committees to use local resources effectively and transparently. NSMP internal monitoring findings showed that out of 18 health facilities, service providers of 15 health facilities have felt that due to this model, their voices influenced the health management committee, resulting in improved transparency and effectiveness. While auditing their local resources it was found that more than 80% of their local budget was spent in purchasing drugs/supplies, and recruiting additional staff. In the past, health facilities staff were unaware about the facility's expenditure and that affected their morale and sense of accountability. In the context of a very weak health system, the NSMP model has shown that it is effective for mobilising the local resources towards improving the quality of midwifery & obstetric care, and the same model could be replicated to address the issues of overall health facilities management system.

Furthermore the NSMP district partnership approach has helped in developing relationships between facilities and communities /district structures. Once again this provides an example of what is possible and a basis for other work in the future. Tools such as the Key Informant Monitoring system have been shown to influence local officials and as such have proved a channel for the voice of ordinary women into the political process which was not available before.

Challenges Remaining for National Scale-up

If the successes of NSMP are to be extended to all of Nepal's people, then the project's model will have to be scaled up considerably. Constraints have been identified in all areas which will threaten the sustainability of present achievements or could impede further progress. In particular, the following constitute particular threats.

Conflict

Among the poor, conflict exacerbates the reasons for non-utilisation of SM services (poverty, lack of jobs increased costs, reduces transport etc). Because the impacts of conflict are greatest for the poorest, conflict is tending to exacerbate exclusion. Nonetheless, the study on the effect of conflict on access was careful to stress that curfews inhibited care seeking, but were not the key constraint (Conflict Study 2003) – other barriers such as finance and transport were greater.

Importantly the conflict has impacted on NSMP activities and those of project partners. The Conflict Study showed that higher level staff were not visiting the field because of the emergency. This impacts not only on supervision and field staff morale, but also on the possibility of monitoring their activities and ensuring quality in SM activities. Conflict has also impacted on the security of NGO funding and therefore the sustainability of partners, many of whom have become very dependent on funds for SM. The National SM Programme will have to ensure longer term funding, particularly of core costs rather than just additional activities, if these partners are to remain strong and viable. The Conflict Study noted a denial of the impact of conflict on their operations by many partners which could be due to their fear of losing funding if they admitted to problems. This does not allow realistic planning or true partnership and the National SM programme will need to monitor its partnership mechanisms very carefully.

As stated earlier, the effects of conflict are very diverse and complex. However, the study on the effect of conflict on access concluded that 'Health services have hardly suffered under conflict'. It went on to state 'staff not attending their postings are absent for other personal reasons'. It is too easy to blame all non-performance on conflict. The type of conflict monitoring tool developed by NSMP should continue to be used to monitor closely the local effects of conflict and ensure that it is not used to excuse lack of commitment to improving the health system.

Weakness of the HMGN health system

As described earlier, the HMGN system has many aspects which are not conducive to improving quality of care. NSMP's work on improving service delivery has been carefully designed to overcome, as far as is possible, many of these constraints. In the context of a very weak health system, this model has shown that it is effective for mobilising local resources towards improving the quality of midwifery and obstetric care, and the same model could be replicated to address the issues of overall health facilities management systems. However, the model cannot address the larger health system issues such as better management of drug/supplies, quality of lab services, staff transfer and understaffing. High transfer rates are undermining FFC and QoC while poor deployment and lack of EOC training sites are also constraints undermining service quality, which in turn undermines utilisation.

To increase the efficiency of this model there is an urgent need to implement health sector reforms as outlined in the NHSP-IP. If the wider systemic issues are addressed and combined with National Safe Motherhood Programme inputs, the two processes should synergistically strengthen the health system. A 'virtuous circle' is required in which improved quality leads to increasing caseload, which in turn will increase skills and confidence of service providers (as shown by the NSMP experience with post basic training and MCHW refresher training). Without the wider reforms however, the National SM programme will always be constrained in what it can achieve.

Scaling Up the District Partnership Approach

NSMP's Partnership Approach is recommended for scale up and will require investing in the capacity building of partners and the development of institutional development skills in SM programme staff – overall a longer term commitment in order to reduce partner dependence on project activities. Working through intermediary organisations gives a greater reach and likelihood of sustainability (as evidenced also by the UNICEF and DACAW experience). However, it does reduce the amount of direct control over activities and ways of working (for instance most NGOs have strong party affiliations) and is therefore more vulnerable, especially to the effects of conflict. Thus while NSMP has developed conflict monitoring tools and guidelines for its staff to protect them and ensure that the 'Do No Harm' approach is followed, it is harder to ensure that partner practises follow the same approach.

Clear proposals for future partnership strategy have been proposed in the Partnership Review (2003), including:

- Working through partners requires sophisticated administration. For instance, problems with funding channels from NSMP have led to delays in activities.
- Working with more established partners limits the reach of increasing access initiatives and can exclude some groups especially because most NGO workers are upper caste and male.
- NSMP has developed practical tools to monitor and manage partnerships and these should be scaled up.

Annex 1: Project Logical Framework for the Nepal Safer Motherhood Project (Phase II) – Final Revision: September 2002

Objectives	OVI	MoV	Assumptions
Goal: To contribute to HMGN SM programme's objective of reducing maternal mortality	Reduction in maternal mortality ratio	WHO and HMGN National estimates	To sustain improvements in maternal health, other health and development programmes in place
Purpose: Sustained increase in utilisation of quality midwifery and obstetric (BEOC and CEOC) services	<p>1.1 Increase in met need for CEOC in Baglung, Surkhet, Kailali, Rupandehi and Jumla districts, as a composite of:</p> <ul style="list-style-type: none"> - % increase in met need for EOC - district wide - % increase in met need for EOC - per project supported facilities - % increase in met need for c-sections <p>1.2 Increased in met need for BEOC in Nawalparasi, Parbat, Myagdi, Dailekh as a composite of</p> <ul style="list-style-type: none"> - % increase in met need for EOC - district wide - % increase in met need for EOC - per project supported facilities - % increase in referrals from BEOC facilities to CEOC facilities in project district <p>1.3 Increase # appropriate referrals by MCHWs to obstetric facilities</p> <p>1.4 Increased utilisation by poor and marginal groups of midwifery and obstetric services in project supported facilities (using proxies)</p>	<p>1.1-1.2 HMIS/FHS EOC monitoring system (established mid 2002)</p> <p>NSMP records, MCHW monitoring system (still to be developed by FHD, NSMP and other partners)</p> <p>1.4 periodic data collection and analysis - facility admissions register</p>	<p>HMGN adopts NSMP model and replicates</p> <p>HMGN continue to develop the national SM programme and harness additional resources</p> <p>Pregnancy Protection Bill promulgated and implemented</p> <p>Other RH interventions in place</p> <p>SM remains a priority under a SWAp</p> <p>Development workers not specifically targeted by either of the conflict parties</p> <p>Neither conflict party significantly restricts movement of people, services or commodities</p>

Outputs	OVIs	MoV	Assumptions
<p>Output 1: NSMP contributes to safe motherhood policy & programme development (including feeding into global lesson-learning)</p>	<p><u>By end of Phase II:</u> 1.1 At least three examples of influencing SM policy and programme development 1.2 NSMP training courses piloted for government accredited/institutionalised 1.3 At least 3 examples of NSMP initiatives being institutionalised</p>	<p>1.1-1.3 Govt policy and programme docs.; Development partners' docs.; Interviews with key gov. officials; national SM programme review</p>	<p>EOC model recognised as central to SM programme Govt. makes long-term commitment to human and financial resource allocation in support of SM.</p>
<p>Output 2: NSMP supported facilities (hospitals & PHCs) provide good quality midwifery & obstetrics services</p>	<p><u>By end of Phase II:</u> 2.1 All supported facilities are functionally operational (buildings, equipment, waste disposal, stores, maintenance etc). 2.2 Safe blood transfusion service available 24 hours at selected facilities. 2.3 Quality of midwifery & obstetric care, (as defined by FHD/NSMP's QoC framework) in place in all Phase II facilities 2.4 Quality of midwifery & obstetric care sustained in Phase I facilities as NSMP withdraws 2.5 60% of trained MCHWs in project supported districts demonstrate skills in care (inc. skilled attendance) & referrals in accordance with HMGN RH Protocol 2.6 Project supported PHCCs/hospital support/management committees demonstrate effective management (greater</p>	<p>2.1-2.4 National SM programme review 2.1 Inspection and surveillance reports by NSMP in partnership with government 2.2 Surveillance reports by NSMP in partnership with NRCBTS 2.3-2.4: Surveillance reports by NSMP & partners (FHD, JHPIEGO) 2.5 MCHW evaluation study, NSMP commissioned study of MCHWs, 2.6 Surveillance reports by NSMP</p>	<p>Outputs 2 & 3 Decentralisation impacts positively on health service delivery Output 2 DPHO continue to support peripheral health services to provide midwifery care The health sector is not specifically targeted by the insurgency</p>

<p>Output 3: The social context for and access to midwifery and obstetric services within NSMP - supported districts improved</p>	<p>transparency/accountability)</p> <p>In selected VDCs, by end Phase II:</p> <p>3.1 Communities know of the risks of pregnancy and potential benefits of allopathic/biomedical health service</p> <p>3.2 Emergency transport and funding schemes are established, with capacity for rapid access by the poor</p> <p>3.3 Women perceive:</p> <ul style="list-style-type: none"> · reduced barriers to EOC services (through transport schemes, access to finance etc) · improved quality of care · improved social status/ social mobility (e.g. - communication with mothers-in-law and husband, to reflect their ability to be able to make decisions regarding health-seeking behaviour) <p>3.4 Within partner institutions, in supported districts:</p> <ul style="list-style-type: none"> · Safe motherhood articulated as an issue in ongoing work by key partners · District SM forums functioning (e.g. SM district plans developed) · District SM forums become part of formal Gov. system at district-level; SM integrated into the District Health Plan by end of Phase II · Partner organisations (govt, INGOs) implement according to district safe motherhood plan · VDCs which receive TA demonstrate improvements in management approach 	<p>3.1 & 3.2: District Monitoring System (e.g. periodic small-scale surveys/group discussions and routine data collection)</p> <p>3.3: Report of women's perceptions of social change collected using Key Informant Monitoring Tool</p> <p>3.4: NSMP district staff reports, partner I/NGO reports, minutes of district forums for safe motherhood</p>	<p>Women who access obstetric care at district facilities as a result of project activities are satisfied that they receive quality care</p> <p>Coverage of VDCs is significant enough to impact on utilisation</p> <p>Partnerships develop to address barriers</p> <p>Ability of partners (HMGN and NGO) to operate not significantly compromised</p> <p>Communities not significantly restricted in movement to access services by either of the conflict parties</p>
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Activities

1. Policy Support

- 1.1 Develop and promote ways of working programmatically
- 1.2 Significantly contribute to the SM subcommittee and its partners
- 1.3 Significantly contribute in the SM network
- 1.4 Develop and maintain effective working partner-ships with key agencies
- 1.5 Develop and implement a dissemination strategy
- 1.6 Activity seek areas for policy development

2. Service Provision

Facility Improvement:

- 2.1 Needs assessment of facilities & equipment
- 2.2 Develop & undertake participatory planning & dissemination process for upgrading and procurement
- 2.3 Construct and renovate selected facilities; quality inspect buildings, handover to HMGN;
- 2.4 Provide quality appropriate equipment through an effective procurement process, develop equipment support/maintenance system and user training
- 2.5 Strengthen the technical and managerial capacities of selected blood transfusion services

Ensure activities are conducted in a conflict sensitive manner

Capacity Building:

- 2.6 Needs assessment of human resources
- 2.7 Develop and undertake planning and dissemination processes
- 2.8 Establish and sustain a QoC model in all facilities
- 2.9 Develop specific technical skills in midwifery & obstetric care through short term & long term training for a range of service providers
- 2.10 Develop & monitor referral system between NSMP supported facilities
- 2.11 Provide onsite support for changes in clinical practice
- 2.12 Develop and implement exit strategy for Phase I facilities
- 2.13 Support for improved and efficient facility management through effective HSCs and HMCs
- 2.14 Monitor effectiveness of the MCHW cadre in obstetric first aid

Ensure activities are conducted in a conflict sensitive manner

3. Increasing Access

- 3.1 Undertake Phase 2 needs assessment
- 3.2 Develop and undertake participatory planning and dissemination processes
- 3.3 Establish/engage with district level forums for safe motherhood
- 3.4 Facilitate the institutionalisation of the SM forums as appropriate to the district context
- 3.5 Facilitate development of districts' SM forum's strategy/ plans and the monitoring therein
- 3.6 Undertake advocacy and capacity-building with partners (government and I/NGO) and communities to enable a range of access interventions to take place
- 3.7 Facilitate full implementation of districts' increasing access plans
- 3.8 Facilitate partners ability to provide a range of BCC activities
- 3.9 Support the development of the national SM BCC/IEC strategy
- 3.9 Regular reviews of strategy/approach

Ensure activities are conducted in a conflict sensitive manner

4. Contribution to conflict mitigation where appropriate

- 4.1 NSMP shall, where appropriate, adopt approaches to outputs 2 and 3 that will maximise opportunities to facilitate a reduction in real or potential conflict enhancing factors

5. NSMP management systems/practices appropriately address working in insecure areas

- 5.1 All NSMP staff trained in security training and familiar with district level security management processes
- 5.3 NSMP security guidelines upgraded as required
- 5.4 NSMP maintains good quality security monitoring systems

Annex 2: Framework for Synthesis Evaluation of NSMP

Guiding Principles

- Objective and lesson learning for National Safe Motherhood Programme development and identification of early actions for the programme.
- Concentrates on immediate lessons from NSMP and 'holds-back' on new areas that the future programme could take forward more usefully.
- Lessons from NSMP considered in the context of learning from other safe motherhood programmes, nationally and internationally, which may be useful for programme implementation.

Approach

- Not a single piece of work but draws on information from previous NSMP studies and commissions new studies for unanswered questions.
- Combination of internal and external evaluation.
- Findings summarised in an evaluation document and summary sheet (s) for an "NSMP Information Pack" and for the NSMP website.
- Integral to NSMP's dissemination strategy

Limitations

- Impact limited to immediate changes – sustained change in utilisation can only be assessed some time after project completion.

Key questions

1. Why have increases in utilisation occurred? What are the key constraints to a greater increase in utilisation?
2. Is the increase in utilisation reasonable given design, implementation, costs and constraints? (An external judgement based on evaluation documents).
3. Is the increase in utilisation likely to be sustained beyond the project period? (Note, judge now and can be tested later at future evaluation). What key factors may need to remain in place in order to ensure this?
4. Has the Quality of Care model contributed to increased utilisation of midwifery and obstetric services?
5. Who has the project reached/not reached?
6. How far has the district level focus of NSMP been able to improve midwifery and obstetric services? What are the key constraints to further improvement?
7. What are the relative magnitude of the barriers to access and the effectiveness of various IA inputs? Have they led to an improvement in the social context for and access to midwifery and obstetric services within NSMP districts? How does the effectiveness of NSMP's IA approach compare with other safe motherhood projects in Nepal.
8. Are there important external benefits from safe motherhood inputs? (eg. OT staff and facilities for other surgical care, infection prevention practices, empowered HSCs, implementing partners, communities etc)
9. How has NSMP influenced safe motherhood in Nepal, from community and district level work through to policy level work? What have been the enabling factors for influence to be effective and how can these be built-upon in the future?
10. What have been the most important interventions external to the project (other projects/policy changes) that have helped/hindered in producing the project outputs and purpose?
11. How have the management arrangements and work culture of NSMP, including district and central levels, contributed to producing the project outputs?

Completed/initiated studies which can contribute to the answers

- Cost of implementing SM
- Costs to users of accessing SM services
- Impact of Conflict on accessibility of EOC services
- MCHW assessment
- Evaluation of Increasing Access component
- Evaluation of Appreciative enquiry (Foundation for Change)
- Use of emergency funds and transport
- Partnerships Review

(+ other completed studies with relevant information)

Monitoring data

- KIM
- EOC
- Knowledge survey
- Zoning data

Additional studies

- QoC evaluation including evaluation of courses
- Study of utilisation and non-utilisation
- Policy and management

Consultant requirements and outputs

1. Consultants for each of the additional studies.
2. A consultant for a desk review of all studies and monitoring data to answer questions posed in the Evaluation Framework. Outputs will be an evaluation document and summary sheet (s) for an “NSMP Information Pack” and for the NSMP website.
3. A framework to capture key evaluation findings and data sources for monitoring future change
4. A consultant to place NSMP evaluation findings in the global Safe Motherhood context.
5. A consultant to support dissemination of the evaluation findings in Nepal and possibly the UK.

Annex 3: Reports and Papers Documented in this Report

All NSMP documents are available on www.nsmg.org

NSMP Reports & Evaluations

Abbatt Report 1999

Abbatt J.: Challenges to Reducing Maternal Mortality – Experiences from the Three Districts in Nepal Supported by the Nepal Safer Motherhood Project (Kailali, Surkhet & Baglung). NSMP/Options 1999

Conflict Study 2003

Beun M. & Neupane B. D.: Impact of Conflict on Accessibility of EOC Health Services. NSMP/Options 2003

Cost Study 2004

Borghji J., Ensor T., Neupane B.D. & Tiware S.: Coping with the Burden of Costs of Maternal Health. NSMP/Options 2004

Foundation for Change Review 2003

Hodgeson R., Badu K., Kati C. & Parajuli M.: “Artistry of the Invisible” – An Evaluation of Foundation for Change, a Change Management Process. NSMP/Options 2003

Increasing Access Review 2004

Thomas D., Messerschmidt D., Messerschmidt KC L., Devkota B.: Increasing Access to Essential Obstetric Care: A Review of Progress and Process. NSMP/Options 2004.

Key Informant Monitoring Tool 2004

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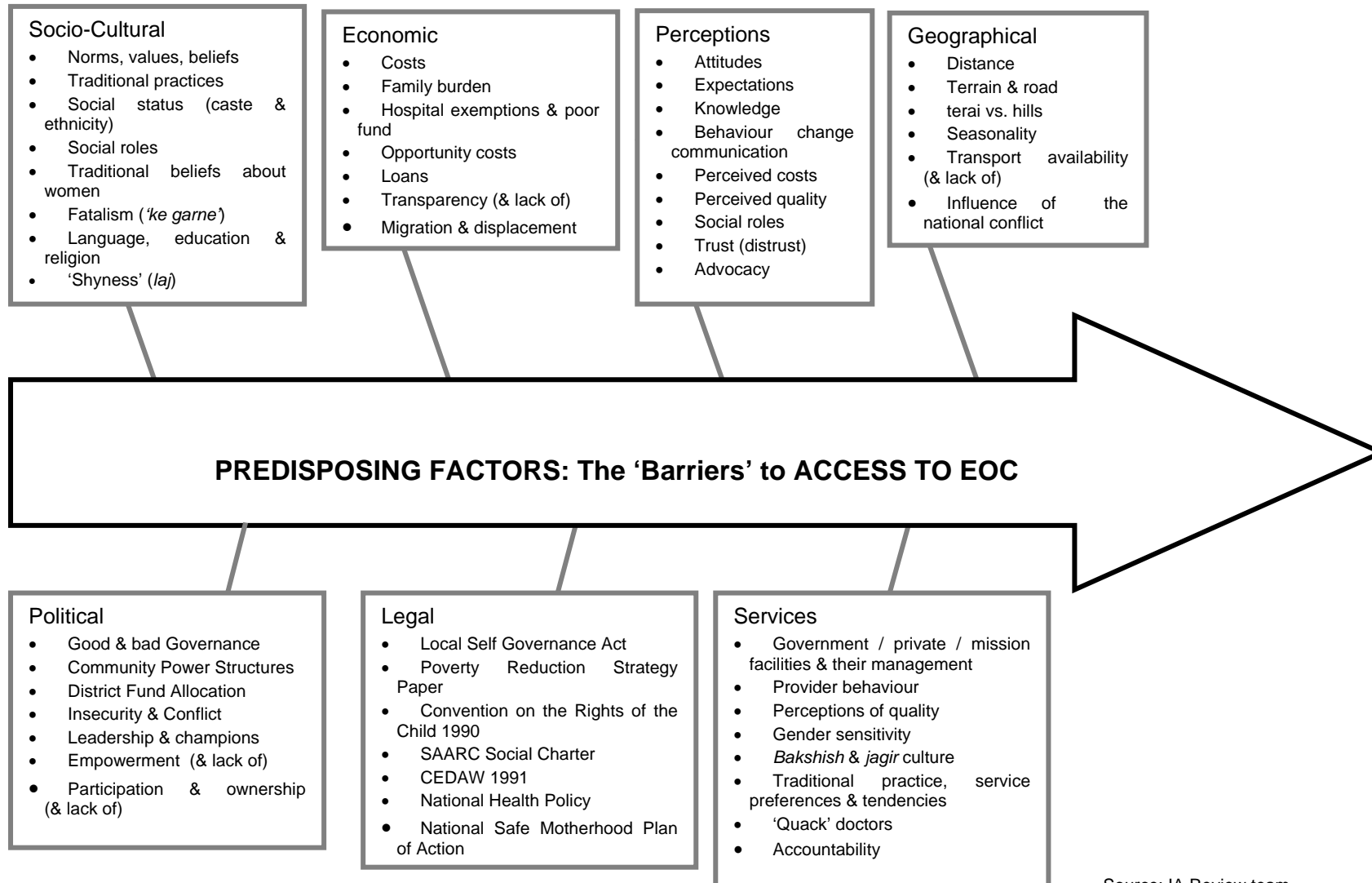
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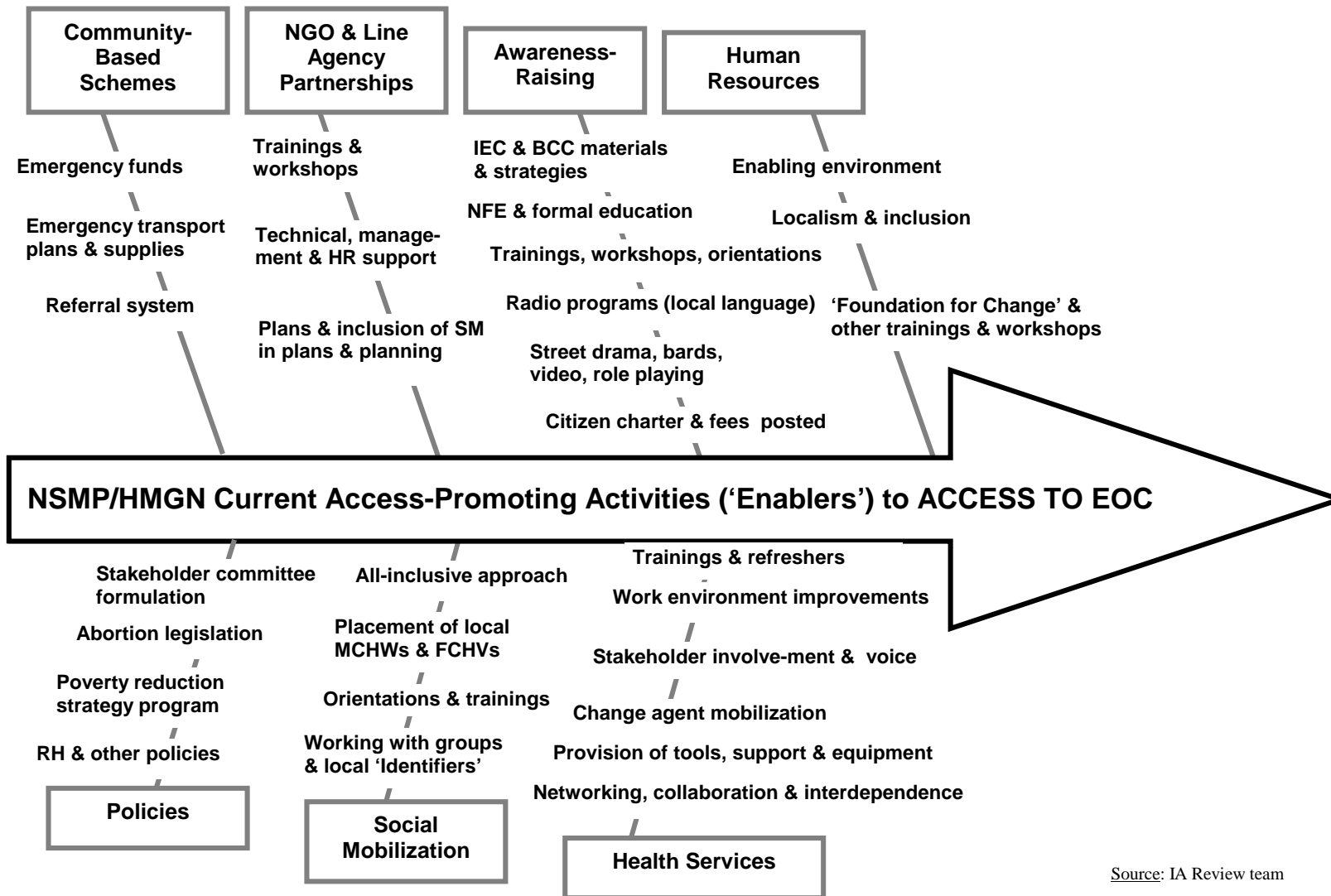
Annex 4: Increasing Access

Figure 1: Predisposing Factors to Access/Lack of Access to EOC



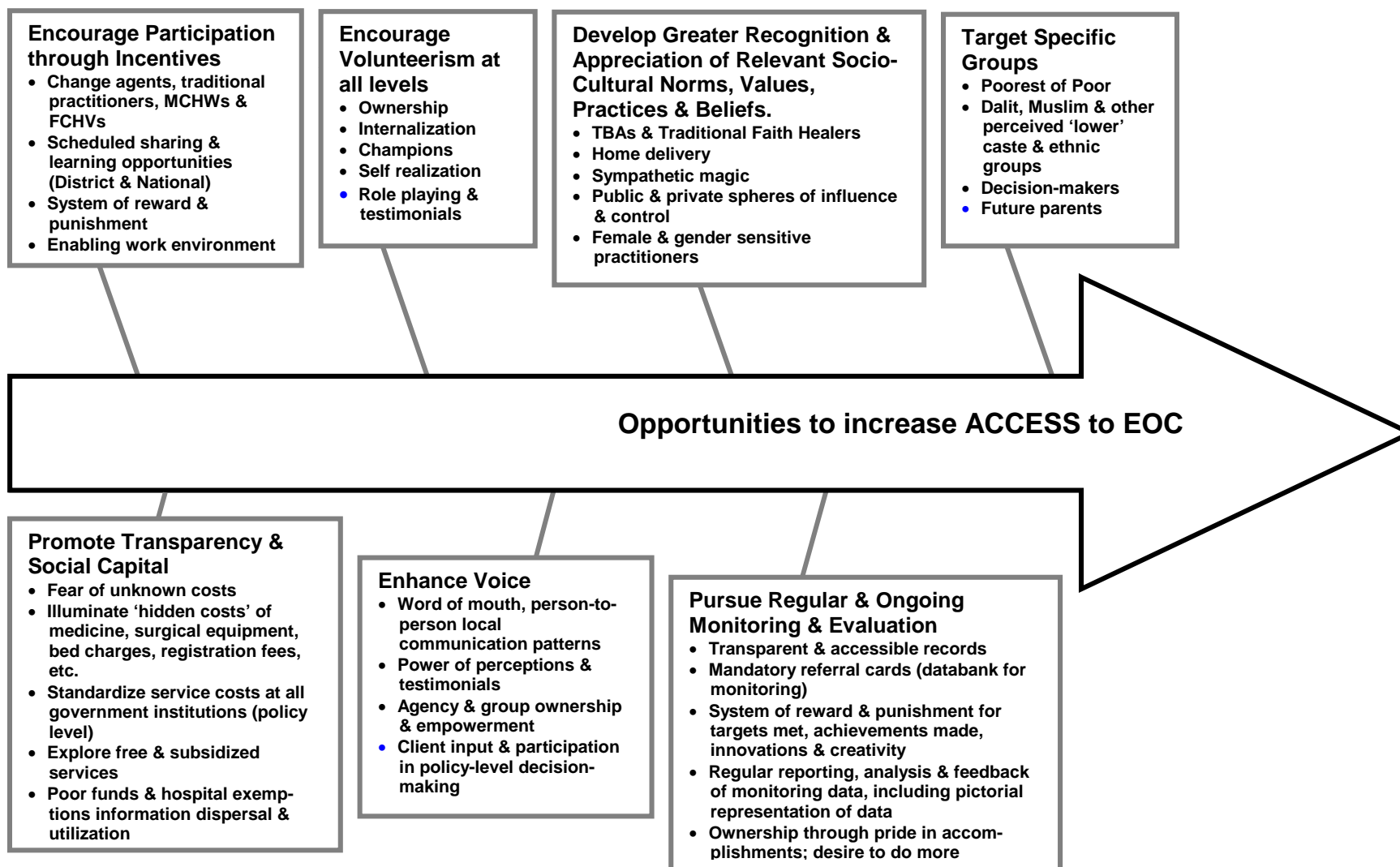
Source: IA Review team

Figure 2: Current Access-Promoting Activities Increasing Access to EOC



Source: IA Review team

Figure 3: Opportunities to Increase Access to EOC



Source: IA Review team