

EVALUATION OF APPRECIATIVE INQUIRY PROCESS FOR HEALTH FACILITY MANAGEMENT COMMITTEES

Final Evaluation Report

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Submitted by:

Madhusudan Subedi
Ashok Kumar Paudel

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Madhusudan Subedi
Ashok Kumar Paudel

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ABBREVIATIONS

AI	Appreciative Inquiry
ANC	Ante Natal Care
ANM	Assistant Nurse Midwife
BC	Birthing Center
BEOC	Basic Emergency Obstetric Care
CEOC	Comprehensive Emergency Obstetric Care
CS	Cesarean Section
DFID	Department for International Development
DHO	District Health Office
DPHO	District Public Health Office
EOC	Emergency Obstetric Care
FHD	Family Health Division
FPA	Family Planning Assistant
HF	Health Facility
HFMC	Health Facility Management Committee
IP	Infection Prevention
NSMP	Nepal Safer Motherhood Project
OPD	Out Patient Department
OT	Operation Theatre
PAC	Post Abortion Care
PHCC	Primary Health Care Centre
PHN	Public Health Nurse
PNC	Postnatal Care
RC	Regional Coordinator
SBA	Skill Birth Attendance
SMNH	Safe Motherhood and Newborn Health
SN	Staff Nurse
SSMP	Support to the Safe Motherhood Programme
VDC	Village Development Committee

EXECUTIVE SUMMARY

The Context and Background

The National Safe Motherhood Programme is a priority within the Government of Nepal's (GoN) Health Sector Strategy, which works towards meeting the Tenth Five-Year Development Plan and the health sector targets set out in the Millennium Development Goals (MDG). Nepal's maternal mortality ratio of 281 maternal deaths per 100,000 live births is equivalent to a woman dying every four hours, and it is widely accepted that many of these deaths are direct consequences of under utilisation of maternal health services and low quality of care, especially in rural areas.

Achieving the MDG targets for reducing maternal and newborn deaths depends upon improving utilization and quality of maternal and newborn health services at all levels of care, in particular ensuring 24-hour delivery services are available at local facilities. While inputs such as infrastructure development, staff training and demand generation initiatives are the essential part of national efforts to meet the MDGs, it is increasingly recognized that strengthening Health Facility Management Committees (HFMC) at the local level is a critical complementary need. Experience from across the country has shown that supporting HFMCs has resulted in improved management of facilities, improved community relations, fostered local ownership and commitment to health facilities, and mobilized community resources.

Appreciative Inquiry (AI) is a management tool which focuses on positive features and achievements, rather than gaps and failings and builds self esteem and a belief in the ability to change. Introduced to support HFMCs, AI planning and review aims to empower HFMCs and communities to take responsibility for improving local services; build the capacity of HFMCs to positively review the past, envision an improved future and identify areas for immediate change.

As part of DFID's Support to the Safe Motherhood Programme (SSMP), Genesis Management was contracted to conduct participatory planning workshops using the AI approach in selected Basic and Comprehensive Emergency Obstetric Care (B/CEOC) facilities, and to train teams of district based

facilitators to roll this out to peripheral facilities. A total of 50 health facilities from 28 districts, including health posts (HP), Primary Health Care Centres (PHCC) and hospitals were selected. In August and November 2008, 82 persons received training as AI facilitators and were provided with checklists and guidelines for conducting AI workshops in the district. The main purpose of the AI planning process was to enable HFMCs to plan and establish improved and regular maternal health services, especially 24-hour delivery and B/CEOC, as appropriate. Various implementation modalities for taking AI planning down to facility level were used including the provision of support to the district AI facilitation team from external consultants, and Regional Coordinators, as well as the district team acting alone.

Purpose and Objectives of Evaluation

The purpose of the consultancy is to evaluate the current model of implementing the participatory AI process through a master AI facilitator and trainer with roll-out to lower level facilities through AI trained district health teams. The evaluation reviews evidence of how the AI process has made a difference in the functioning and utilisation of facilities for maternal health services, and in light of prevailing financial constraints makes recommendations on how to take this initiative to scale, and sustain positive change.

Evaluation Methodology

A number of methods were used to gather information and to identify and triangulate reported changes, including: interviews with health facility in-charge, interview with chairperson of health facility management committee; review and analysis of facility records; focus group discussion (FGD) with breakthrough team; FGD with mothers to understand public perception of changes in the functioning of the facility. A total of 12 health facilities representing different development regions, types of facilities and modality of facilitation were selected for the evaluation.

Given that the AI workshops only began in December 2008, this evaluation comes at a relatively early stage in implementation but nevertheless is felt to be an important pointer to the Government. Secondly, this study takes a qualitative and operational approach to assessing the affect of AI. Interpretation of the study's findings needs to bear in mind that various enabling initiatives have been introduced by government of late, such as the "free primary health care policy" and incentives for

institutional delivery, which may account for the changes witnessed in the management, delivery, and use of maternal services pre and post introduction of AI. While AI may have contributed to improvements in management and services, it is not possible to attribute change to AI.

Major Findings

Availability of trained female staff is essential for delivering maternal and newborn services and is a critical gap across the country. One of the strongest indications of the impact of AI has been both the local hiring of ANMs by HFMCs, and the invigorated pressure HFMCs have placed on District Health Officers to fill ANM gaps. Following the AI planning workshops, HFMCs in 4 facilities (Dauda Health Post, Parasan Health Post, Aurohi Primary Health Care Centre (PHCC) and Rajapur PHCC) took responsibility to hire local ANMs using their own resources, with Parasan Health Post hiring two ANMs. Following pressure from the HFMC, the DHO for Sankhuwsabha District resourced an additional ANM for Mamling Health Post.

Infrastructure deficiencies have been eased in some facilities due to the construction of birthing centres. While infrastructure gaps remain commonplace across the facilities, comparing pre and post AI status, and from discussions with key informants, the AI process has stimulated HFMCs to construct placenta and burning pits, provide water in toilets, and construct separate delivery rooms.

Although accurate records of Essential Obstetric Care *drug availability* prior to AI are not available, reports from staff and facility in charges suggest that there has been an improvement in drug supply after AI workshops were held. Reportedly none of the facilities had earlier availed of all nine essential drug items while currently 4 facilities do so. The AI review and planning process may have contributed to improved drug distribution from the district and availability of drugs to the public within the facility, but it is most likely that the “free primary health” policy is the main driver of this improved situation. This is similar for the status of equipment and supplies which also improved over the period under study, and benefitted from the free primary health care initiative.

With increased staffing, availability of *ANC and delivery services* improved between the pre and post AI period. The number of facilities providing daily ANC services increased from 9 to 11. While the number

of facilities providing 24 hour delivery services increased from 5 to 9. Lack of trained staff (Safrubusi Health Post), lack of incentives for undertaking additional working hours (Madhuwan PHC) and perceived insecurity of staff staying at the facility (Madhuwan PHC and Dubarkot HP) were common reasons why facilities were unable to offer 24 hour delivery care.

Reports from the HF Incharge in Mamling HP, Parasan HP and Letang PHC mentioned that the AI workshops increased their sense of responsibility to display the names of women who received delivery incentives in a visible place, and to promote *transparency*. They further cited that incentives had been given to the mothers immediately after delivery.

Infection prevention practices reportedly improved after the AI workshops, especially in Mamling HP, Parasan HP, Letang PHC, Rajapur PHC, and Madhuwan PHC. This is in part the result of increased availability of placenta and burning pits. Cleanliness within and around the facility reportedly improved generally following the AI workshops according to both staff, managers, mothers and community respondents.

Recording and reporting status improved in almost all HFs after the AI workshops with a strong shift to completing new maternity registers and monthly maternity reports. Health staff mentioned that they knew the importance of complete recording and proper reporting for planning and evaluation of the programme.

Drawing on *service utilisation* records we found that normal institutional deliveries increased by 54.61 percent between the 6 month period prior to AI and the 6 month period after its introduction; contributing factors are likely to include the institutional delivery incentives, and the facility level improvements in part stimulated through the AI planning process. Complicated deliveries increased by 28.99 percent.

One of the main weaknesses of the AI approach has been insufficient *monitoring and technical support* and follow-up to the HFMCs following the initial AI planning workshop. Lack of follow-up was inhibited

by delays in budget approval and poor security in some places, but as a critical force for sustaining motivation and momentum, needs to be rectified with urgency.

A number of systemic problems undermine the provision of accessible and quality maternal and newborn health services, and the management of resources. Critical staff shortages and the frequent turnover of staff requires policy level resolution through the filling of sanctioned posts, and the introduction of a clear transfer policy that rewards providers prepared to work in remote districts. The lack of an elected local government body hampers the management committee's authority and domain of influence.

Contributing to Change, Making a Difference

One objective of the evaluation was to examine the extent to which the AI process has made a difference in the way health facilities function. Comparison of the conditions of facilities before and after the AI participatory planning process was introduced show improvements in the physical condition and quality of services provided. One of the most significant changes has been the mobilisation of facility management and external stakeholders such as VDCs, to hire additional ANMs to increase the availability of delivery services. Reinforcing this move has been the introduction of free primary services and incentives to pregnant women to deliver with a skilled birth attendant, such demand generating policies, in hand with supply side strengthening initiatives (and social mobilisation efforts in some districts), have raised the stakes and potential for HFMCs to respond with improved services. In this context, the AI process has supported health facility managers take leadership and mobilise local stakeholder support to respond to the changing sector environment.

While isolating the effect of AI on facility improvements is not scientifically possible, consultations with stakeholders provides insight into their perceptions of how facilities have changed and the motivating forces behind it. Key factors at the local level appear to be the level of commitment of the members of the HFMCs, political parties, and health staff to change, and their capacity to mobilise and bring on board other key actors, such as VDCs, DDCs, and local community based organisations and NGOs. Stronger team spirit, more joined action, and collaboration was reported by many of the respondents to have been one of the most significant outcomes of the AI workshops, though mediated by the quality of

the leadership of the facility. This is also reflected by reports of increased interaction between facilities and DHOs, both in terms of improved coordination and support, and advocacy.

Differences in the way facilities performed post AI illustrate the fact that AI is a management change process that is mediated and shaped by local actors and conditions, achieving varied rather than standardised outputs; capable of inspiring and mobilising for change in some places, such as Rajapur PHC, but not in others. Comparison of the different modalities used showed no strong advantage of one approach, although discussions with key informants underlined the importance of using external consultants to lead AI at district and CEOC level.

Lessons Learned

AI as a positive step for change: AI workshops have led to a variety of innovations in health facilities to support the quality of services and infrastructure improvement, and to mobilise a wide range of stakeholders within and outside of the health service to work together to improve maternal health. The workshop has been a positive step for change. However, it is a long-term management change process which needs intensive and on-going supervision and monitoring if momentum and commitment are to be sustained.

Mobilising for change: The very thrust of the programme has been to enable the community to realize that the problem of maternal mortality and the responsibility to address the problem is theirs, and that the community and local government have important roles to play in improving maternal health. This has generated local commitment and encouraged local actors to volunteer to support service strengthening, and start advocating for better services and the critical inputs needed for them.

The importance of leadership in Health Facility Management: Establishing and/or expanding availability of 24 hrs delivery services requires an effective management team. When the members of HFMC are not willing to invest in management change, it is extremely difficult to move forward. On the other hand, when the HFMC is committed to making quality changes in the health facility remarkable progress is possible. The commitment of the HF Incharge, HF staff and HFMC is the key to success. Technical support and coaching to develop the team spirit and motivation of this core group is essential.

Provision of human resources, supply and monitoring: The capacity of the AI process to nurture the leadership qualities of providers, VDCs, DDCs, political parties and community members needs to be backed up by the increased provision of trained SBAs, essential supply and equipment, and intensive monitoring from the health service if gains are to be maximised.

Follow-up visits by the facilitators: Regular follow-up visits are important for continued learning, motivation, and behaviour change. The follow-up visits should be organized informally.

Recommendations

Scaling up of the AI Planning Process: Overall, AI has made a positive contribution to improved management and delivery of maternal and newborn services. For scaling up this process, both the issue of competent facilitators and financial sustainability are important. In this context, it is recommended that district level AI coaching should be facilitated by qualified external consultants and DHO. At the peripheral level (PHC, HP, SHP), AI workshops should be conducted by trained district facilitation teams under the authority of the DHO, drawing on Regional Coordinators for support where they are available. The existing facilitator guide should be expanded and distributed; containing all the resources and tools used in district level workshop as well as a complete set of facilitators' notes. This guide will serve as a resource and a confidence builder for the facilitators at the peripheral level.

Planned Monitoring/Review Visit and Technical Back Up: Regular follow up technical support to HFMCs, and monitoring of progress against action plans should be undertaken by the District AI Facilitation Team. This is essential to sustain interest, motivation, and address bottlenecks.

Motivating Providers: Consideration should be given to the provision of appreciation certificates and rewards at an institutional as well as at the individual level. Similarly, experience sharing visits to successful HFs are recommended to stimulate and encourage the staff of HFs, as well as members of HFMCs.

Maximising AI Gains: AI workshops have mobilised communities and health providers to support, advocate and deliver better quality services, and raised funds to meet service shortfalls. Maximising the potential contribution of AI calls for filling supply side gaps in infrastructure, drugs, equipment and staff and strengthening social mobilisation to generate demand for services; underlining the importance of well-coordinated, sector wide development.

CHAPTER I: INTRODUCTION

1.1 The Context

The National Safe Motherhood Programme is a priority within the Government of Nepal's (GoN) Health Sector Strategy, which works towards meeting the Tenth Five-Year Development Plan and the health sector targets set out in the Millennium Development Goals (MDG). The goal for maternal health is reduction of the maternal mortality ratio by three quarters between 1990 and 2015. The framework for implementation of the safe motherhood programme is the National Safe Motherhood and Newborn Health Plan, 2006-2017, the goal of which is, "improved maternal and neonatal health and survival especially of the poor and vulnerable" and the purpose, "increased healthy practices and utilisation of maternal and neonatal health services, especially by the poor and vulnerable, delivered by a well managed health sector".

In 2004, the UK Department for International Development (DfID) committed £20 million through the five-year Support to the Safe Motherhood Programme (SSMP) to support the Nepal government in implementing the National Safe Motherhood Programme. Technical assistance is managed by the UK based Options Consultancy, with a core team of central level advisers in Nepal, based in the Department of Health Services, working closely with government colleagues and other safe motherhood stakeholders to support the needs of the national programme. Some of the major areas of SSMP/Options' technical assistance are:

- Policy development and planning
- Equity and access (increasing access to services)
- Strengthening and expanding services
- Human resource development
- Improving infrastructure and equipment
- Monitoring and information management

Complementing the work of the core team at central level, SSMP funding supports contracted partners who manage implementation of different components of the programme in a total of 19 selected

districts. The partners work through district based NGO partners, local government, line agencies, community stakeholders and Health Facility Management Committees (HFMC) to provide holistic support for strengthening services and increasing access.

1.2 Strengthening Health Facility Management through Appreciative Inquiry

Strengthening Health Facility Management Committees (HFMC) is recognized as critical to maximise gains from supply side inputs such as provision of equipment and infrastructure and staff capacity building/ training, and from inputs to increase demand for and access to services. The HFMCs are central to decision-making at facility level, and experience from across the country shows that supporting them has resulted in improved management of facilities. Well-functioning HFMCs has also led to improved community relations, fostering of local ownership and commitment to supporting health facilities, mobilizing community resources to fund physical improvements, and recruitment of additional staff to support 24 hour services.

Appreciative Inquiry (AI) is a management tool that has been applied in various forms of safe motherhood efforts in Nepal for some years. It inspires people to explore their own strengths by focusing on development of self-potential and belief in the ability to change. AI seeks to identify what went right in order to replicate and further develop the experience. Unlike traditional approaches that focus on problem identification and solution, AI seeks to nurture positive attitudes and harness surrounding (external and internal) enabling factors to generate improvements.

Family Health Division recognises the potential of AI as a management strengthening tool to augment traditional service development inputs at facility level. Under SSMP, Genesis Management was contracted to conduct participatory planning workshops using the AI approach in selected Basic and Comprehensive Emergency Obstetric Care (B/CEOC) facilities, and to train teams of district based facilitators to roll this out to peripheral facilities. The district AI facilitation teams included Public Health Nurses, Family Planning Assistants and Public Health Officers. In addition, Safe Motherhood Regional Coordinators (RC), and staff from district based safe motherhood support agencies (United Mission to Nepal (UMN) and Action Aid Nepal (AAN)) were trained to support the district AI facilitation teams. A total of 82 persons received training in August and November 2008 to prepare them to take on district

AI facilitation, with checklists and guidelines provided for conducting AI workshops at peripheral facilities.

The district facilitators then implemented an AI participatory planning and review process in selected health facilities in their own districts and supported the facilities in sustaining the resulting benefits. A total of 50 health facilities have so far been selected from 28 districts, including Health Posts (HPs), Primary Health Care Centres (PHCC) and hospitals. The main purpose of the AI process was to enable HFMCs to plan and establish improved and regular maternal health services, especially 24-hour delivery and BEOC or CEOC, as appropriate.

AI participatory planning was introduced through workshops which were implemented via various modalities including:

- Facilitation by Genesis Management at 4 CEOC sites.
- District AI facilitation teams with backstopping from Genesis Management at 5 BEOC and 32 birthing centres.
- District AI facilitation teams with support from regional coordinators at 6 birthing centres.
- District AI facilitation teams without backstopping from either Genesis Management or regional coordinators at 3 birthing centres.
- UMN and AAN provided support in mobilising communities in 3 districts.

1.3 Rationale of the Evaluation Study

SSMP/ Options proposed an external evaluation of the effectiveness of the AI participatory process in generating real and lasting improvements in the maternal health services provided by the selected facilities. Although this evaluation comes at a relatively early stage in implementation it is expected that the findings will inform GoN and partners in making decisions about scaling up AI as a management strengthening initiative. It will also provide information about the level of input required by different stakeholders (district facilitators, DPHO, regional coordinators and local civil society organisations) to effectively support and sustain the positive changes initiated by the AI process in service delivery and collaborative working with communities. Consideration will also be given to the effectiveness of the training for facilitators and whether adjustments are needed.

1.4 Purpose and Objectives of the Evaluation

The purpose of the study is to evaluate the current model of implementing the participatory AI process through a master AI facilitator and trainer with roll-out to lower level facilities through AI trained district facilitation teams. SSMP/ Options wishes to specifically explore whether training district teams to implement the process with no back up from a specialist agency is a viable model for the future. The evaluation compares the effectiveness of the various implementation approaches used, as outlined above, and makes recommendations on how positive change can be sustained at reasonable cost, given prevailing financial constraints. The output of this evaluation will inform a strategy for scaling up and sustaining the AI process.

Objectives of the Evaluation

The specific objectives of the evaluation were to:

1. Examine the extent to which the AI process has made a difference in the health facilities by identifying evidence of change, such as increased service availability (24-hour delivery or extended opening hours) and service utilisation; improved physical working environment and quality of services; team work and positive problem solving among health staff and management; improved attitudes among health staff towards clients and each other; increased functionality of HFMCs and their support and management oversight of health staff; improved frequency and effectiveness of communications between facilities and communities.
2. Assess the extent to which the facility has been able to establish and maintain functional 24-hour delivery or B/CEOC services, in line with the objectives of the participatory workshop and as appropriate to the type of facility. Assess the level of support required and received from Genesis, district facilitators, the community and local civil society organisations. A matrix/ timeline should be developed to illustrate progress over time against the baseline and identify the physical and technical inputs that enabled the improvements.
3. Examine the extent to which HFMCs have increased their utilisation of the funds at their disposal and raised further local funding for service improvements. Document how this has contributed to achieving the objectives of the facility improvement plan.
4. Participate in scheduled follow on review and planning workshops where possible or organise meeting of HFMC members and upto seven breakthrough team members in each selected health

facility, to gain insight into progress and constraints and the level of cohesion and understanding amongst the broader stakeholder group. At facilities where it is not possible to attend a scheduled workshop, the consultant team is expected to facilitate its own participatory review of progress against the breakthrough plans developed at the initial AI planning workshop.

5. Investigate and document the positive experiences and barriers experienced by the facility staff, HFMC members, district teams and community representatives in implementing the facility breakthrough plans developed. This covers strengthening and delivering of services, improving working environments, strengthening working relationships within the facility and between the facility and community.
6. Assess the implementation of the participatory workshops by the facilitators, including whether they were able to use all the tools provided, whether the training they received effectively prepared them for the challenges they encountered and whether the workshops were successful in achieving their aims.
7. Identify any areas in which the AI approach and training could be modified to better equip prospective AI facilitators to achieve their objectives, and assess whether further training or supervision might be required. In particular, identify the level of on-going support required for sustaining positive change and motivation.
8. Use the findings to explore the potential of other models for scaling up, to increase effectiveness and reduce costs. Comparison of the cost of the AI process under each of the implementation approaches weighed against outputs will be necessary to inform recommendations made for scaling up, bearing in mind the management and mobilization challenges at higher level facilities. The resource implications of using an agency to support this process are considerable, and other approaches could be considered, such as using particularly successful district teams to support or deliver AI in neighboring districts or districts where the teams are not strong.

CHAPTER II: EVALUATION METHODS

2.1 General Approach

The consultant team used a mix of quantitative, qualitative, and participatory methods for the evaluation. A number of methods were used to gather information and to identify and triangulate reported changes, including: interviews with health facility incharge, interview with chairperson of health facility management committee; review and analysis of facility records; focus group discussion (FGD) with breakthrough teams, and FGDs with mothers to understand public perception of changes in functioning of the facility. Comparisons of current (post AI) with base line data for each facility are done as far as possible.

2.2 Health Facility Selection Process

The AI participatory planning workshops were implemented in the following different ways:

- Genesis Management at 4 CEOC sites.
- District AI facilitation teams with backstopping from Genesis Management at 5 BEOC and 32 birthing centres.
- District AI facilitation teams with support from regional coordinators at 6 birthing centres.
- District AI facilitation teams without backstopping from either Genesis Management or regional coordinators at 3 Birthing Centres.
- In 3 districts, UMN and AAN provided support in mobilising communities.

The Participatory AI workshops were completed in all 28 planned districts between 24th December 2008 and 15th July 2009. During this period 4 workshops were conducted at CEOC, 7 at BEOC and 39 Birthing Centers (BC). Total 50 AI workshops were conducted throughout the country (Annex: II).

Study districts were selected based on representation from all five development regions and ecological Zones; and facilities were selected to cover a range of implementation modalities, and levels of care. A series of consultation were held with technical advisers from SSMP/Options to finalise the districts and health facilities for study. The details of districts, health facility and types are presented in Table 1.

Table: 1 District, Types of Facility and Facilitators

Development Regions	Districts	AI Approach	Type of Facility	Name of HF
Eastern Development Region	Siraha	District AI Facilitation Team + Genesis Management	BC	Aurohi PHCC
	Shankhuwasabha	District AI Facilitation Team	BC	Mamling HP
	Sunsari	District AI Facilitation Team + Regional Coordinator (RC)	BC	Madhuwan PHCC
	Morang	District AI Facilitation Team + Regional Coordinator (RC)	BEOC	Letang PHCC
Central Development Region	Dhanusa	District AI Facilitation Team	BC	Dubarkot HP
	Rasuwa	District AI Facilitation Team + Genesis Management	BC	Safrubesi HP
	Nuwakot	SSMP + Genesis Management	CEOC	District Hospital, Nuwakot
Western Development Region	Nawalparasi	District AI Facilitation Team + Regional Coordinator (RC)	BC	Bulingtar PHCC
Mid Western Development Region	Bardiya	District AI Facilitation Team + Genesis Management	BEOC	Rajapur PHCC
Far Western Development Region	Doti	District AI Facilitation Team	BC	Dankot HP
	Doti	District AI Facilitation Team+ RC	BC	Daud HP
	Kanchanpur	District AI Facilitation Team+ Genesis Management	BC	Parashan HP

2.3 Nature of Data

Both primary and secondary data have been used. A substantial amount of the primary data has been collected from different sites through the use of quantitative and qualitative research techniques.

Secondary data has been drawn from health facility utilisation records, project documents and progress reports.

2.4 Data Collection Techniques and Tools

2.4.1 Key Informants Interviews (KIIs)

KII was one of the main techniques of data collection. A detailed checklist was developed with pertinent questions to assess the different aspects covered by the AI participatory planning workshops and the current situation of health facilities. Separate interview guides were prepared for chairperson of HFMC, HF In-charge, Family Health Nurse/Family Planning Officer, and Genesis Management and community members (see Annex III).

2.4.2 Focus Group Discussion (FGD)

In each facility site, at least one FGD was conducted with mothers having at least one child. Emphasis was given to those mothers who had delivered in the health institutions. Mothers were invited from different wards to participate in the discussion. Another FGD was conducted with the breakthrough group and members of HFMC, to gain insight into progress and constraints and level of cohesion and understanding amongst the broader stakeholder group.

2.4.3 Participation in Review and Planning Workshop

As per ToR, consultants were expected to take part in the follow up review and planning workshop where possible. Due to political instability, the national budget was passed from the parliament only in November 2009 after the field work had been completed. Thus, observation of detail budget planning by HFMCs and how this was implemented could not be explored in each of the health facilities. However, the consultant team was able to participate in a review and planning exercise facilitated by Genesis Management in Rajapur BEOC.

2.4.4 Interactive Dialogue with DHO

Since DHO is the concerned authority for the overall planning, monitoring and supervision of the health facilities in the district, interactive dialogue with DHO was another tool for information collection. The key issues discussed with DHO were awareness about AI workshop, information about the health facility

and how AI has made a difference, possible ways in making the programme successful, need and importance of scaling up AI in other facilities.

2.4.5 Observation of Supply, Facilities, Recording and Reporting

The consultants also undertook field observation and discussion as an important technique with staffs of health facilities during the review of health records. Observation was made of ANC/PNC room, delivery room, toilet with water source, placenta pit, burning pit, other back up light source, emergency drugs, equipment and supplies, recording and reporting and use of new maternity register. Similarly, display of monthly notice, and the name of women who had received maternity incentives was also verified by observation.

2.5 Limitation of the Study

Since the AI workshop only began in December 2008, this evaluation comes at a relatively early stage in implementation, with only the initial planning and review meeting so far held at each site. Secondly, some of the quantitative information was not gathered before the initial AI workshop and so could not be clearly compared with the existing facilities and supply available post AI. Third, there are other confounding variables which have influenced service use over the past year, such as the introduction of free health services and the provision of incentives for institutional delivery. Thus, the increase in institutional deliveries and improvement in service utilisation are the result of many factors, including but not limited to the AI workshops.

CHAPTER III: KEY FINDINGS AND DISCUSSION

Findings of this evaluation of AI participatory planning workshops is based on primary and secondary data. Primary data are derived by using FGDs, KIIs, interactive dialogue with DHO, observation of supply, and facilities, while secondary data was collected from respective health facilities and record review. Comparisons on various quantitative as well as qualitative information are done for the six months before the AI workshop period from October/November 2008 to April/May,2009(Mangasir, 2065 to Baisakh, 2066 BS) and six months from May/Jun, 2009 – Oct/Nov,2009 (Jestha to Kartik, 2066 BS) after the AI workshop period.

3.1 AI Workshop Brief

The goal of the AI workshops was to ensure 24-hour safe motherhood and neonatal health (SMNH) services, including BEOC in PHCs and CEOC services in some hospitals. This involved firstly carrying out an assessment to establish baseline information on the status of maternal and neonatal health services in the selected facilities, and secondly facilitating planning and review workshops for establishing and strengthening 24-hour services (BEOC and BC).

The AI workshops were designed to increase understanding of participants of why women die in pregnancy and childbirth, what is required to avert avoidable deaths and disabilities, and how it is possible to bring about change by working together towards the common goal of maternal mortality reduction. The workshops also brought stakeholders together to review information for programme planning in the health facilities. The planning and review process aimed to create an enabling environment in health facilities to support the provision of 24-hour quality SMNH services. The workshop focused on general district information, such as accessibility of health facilities to communities, availability of the prerequisites for SMNH service provision, utilisation of services and facility level management. At the workshops facility based change agents were identified to lead and sustain the process.

A three day AI workshop was conducted in each health facility by respective AI facilitators. Generally there were three AI facilitators in each workshop implemented by district facilitation team comprising of

DHO, PHN and FPS. If the workshop was facilitated by RC, two persons (out of DHO, PHN, FPS) from the district also facilitated. The Genesis Management implemented AI workshop had at least one facilitator as a consultant, with participation of PHN, FPS and DHO from the respective districts. The number of participants in each workshop varied from 25 to 50. The participants of the workshop were staffs of the concerned health facility, representatives of the political parties, members of the HFMC, FCHVs, representatives of local NGOs and CBOs. In some workshops, representatives of line agencies, including police also participated. It was also found that the district hospital (CEOC) under study invited the AI workshop participants from PHCs, HPs and SHPs to spread exposure and raise awareness and support for AI. The number of participants at CEOC sites was relatively higher compared to BC and BEOC.

Various session plans were organised for the planning workshop. Each session had specific objectives, this included the situation of maternal mortality and morbidity in Nepal, effective management and accountable governance, leadership and teamwork, women's right to life and development, time as a resource, success stories of the hospitals and other peripheral health facilities. The interrelationship between vision, mission and commitment to becoming successful at the personal as well as the organisational level were also discussed.

The workshop participants were divided into three to four groups to develop a plan of action to improve the facility. Major issues discussed among the teams were: provision of 24-hour delivery services in the health facility; management of medicine and equipments; management of human resources; emergency funds in the health facility; management of emergency transport; community contribution; quality of services including water supply, toilet facility and facility garden; management meeting and review plan. The plan of action included the allocation of responsibilities to individuals ranging from the health facility staff to VDC authority for target activities.

During the study team's interaction with the PHN and FPS they reported that they had followed the facilitation methods they had been taught in their AI training. They mentioned that they had followed the 4-D cycle; discovery, dream, design and destiny. Instead of starting from 'what does not work' or 'what is wrong' or 'whose fault is it', they started the from 'what works' or 'what are other possibilities' or 'what can we do'. From interaction with district facilitators, variation was found in their capacity to

facilitate the AI approach and share lived stories, and as to be expected, external consultants from Genesis Management had deeper skills in AI facilitation.

Almost all interviewed AI workshop participants mentioned that the workshop was new to them. They noted that it created awareness about the importance of quality management and built positive understanding between health staff and patients, and health facility managers and staff. Some participants also mentioned that the AI workshop had helped them develop a more positive understanding towards people and their activities, improved control of their emotions such as anger and impatience, and strengthened their willingness to listen, be more accessible to others, and humble.

“I have been able to control anger and impatience, and develop willingness to listen. Previously, I used to interpret many people and their voices negatively. Now, I start to interpret those views and voices positively. The AI has helped in my family and party life.”

- Party Representative in Rajapur PHC, Bardiya

“The major impression of AI workshop was positive thinking. Willingness to listen others, successful stories of the people and organisations, and capacity of local people to change health facility as a stepwise process were other important lessons. Though it is not an easy task to apply all the issues discussed in personal life as well as in the organisational one, it helps us to work in a team for the betterment of health facility.”

- Member of HFMC, Mamling HP, Sankhuwasabha

“I have taken various trainings like immunisations, vitamin A, management of ARI but AI workshop was very different one. We neither handled expensive equipments nor went to various wards, we discussed about our unlimited capacity to make our health facility better.”

- FCHV of Letang PHC, Morang.

It was reported that the AI workshops helped participants discover their many potentialities and opportunities to establish 24 hour delivery services in their health facility. Additionally, AI workshop participants were empowered to envision the future of the health facility by using maximal local resources.

The training facilitators mentioned that the number of days for the training was sufficient and they had managed almost all issues that had been planned for the workshop. Almost all participants mentioned that they had very positive feeling and commitment for the betterment of their health facilities during AI workshop. However, follow up and guidance after the workshops was not undertaken as planned by the facilitation teams, and many of the commitments could not be completed due to lack of continuous encouragement and support from the HFMCs and various breakthrough teams. Details of changes in various factors before and after the AI workshop is described in the following sections.

3.2 Availability of Maternal and New Born Services

3.2.1 Availability of Infrastructures

Availability of infrastructure is one of the necessary conditions for maternal and new born services. Essential infrastructure includes: separate ANC/PNC room, delivery room, toilet with water source, placenta pit, burning pit, regular electricity supply, back up light source, and regular water supply in labour room. Out of twelve HFs, this evaluation found that only two health facilities had all seven types of infrastructure post the AI workshops, the Nuwakot CEOC, and the BC at Parasan Health Post. As we see from Table 2 the facilities that received AI facilitation by the District Team alone appear to have started from a lower infrastructure base than those receiving AI through other modalities. However, all the facilities studied regardless of the AI modality saw an improvement in infrastructure post AI workshops (See Table:2).

Table: 2 Health Facility-wise Availability of Infrastructures

AI Approach	Name of HF	Availability of Infrastructures								Total	
		Separate ANC/PNC room	Delivery room	Toilet with water	Placenta pit	Burning pit	Regular electric supply/light	Regular water supply in labor room	Before AI	After AI	
AI Approach	Mamling HP	✓	✓	✓	✓	✓	✓	x	4	6	
	Dankot HP	x	✓	x	x	x	✓	x	0	2	
	Dubarkot HP	x	x	✓	x	x	x	x	0	1	
District Team + Genesis Management	Aurohi PHCC	x	✓	✓	x	x	✓	x	2	3	
	Safrubesi HP	x	✓	✓	x	✓	✓	✓	3	5	
	Rajapur PHCC	✓	✓	✓	x	✓	✓	✓	4	6	
	Parasan HP	✓	✓	✓	✓	✓	✓	✓	4	7	
District Team + RC	Letang PHCC	✓	✓	✓	✓	✓	x	✓	4	6	
	Madhuwan PHCC	✓	✓	✓	x	✓	✓	✓	5	6	
	Bulingtar PHCC	x	✓	✓	x	x	✓	x	2	3	
SSMP+ Genesis	Dauda HP	x	✓	✓	x	x	✓	x	3	3	
	District Hospital	✓	✓	✓	✓	✓	✓	✓	6	7	
Total		6	11	11	4	7	10	6	37	55	

✓ = Available, x= Not available

Information about the facility-wise infrastructure before AI was gathered from various sources; facility assessment documents, interviews with HFMC, HF Incharge and interaction with the local people. The pattern we find is that after the AI workshops, improvements in infrastructure have mainly taken place around the construction of placenta pits and burning pits, the provision of water in toilets, and the availability of delivery rooms. New buildings for Birthing Centres created separate rooms for delivery, ANC and PNC services at some facilities and enabled availability and delivery of services.

3.2.2 Availability of Drugs

GoN recommends nine essential drugs (Oxytocin, Mg So₄, IV Canula, Ringer Lactate/ Normal Saline, Calcium Gluconate, Ampicillin, Metronidazole, Gentamycin, Nifedepin) for use during and after delivery . Out of twelve HFs, only five have all nine items of drugs. There is no record of the availability of each of the nine drugs before AI was introduced at each facility, and without this baseline data it is difficult to accurately measure changes in EOC drug availability pre and post AI. However, it was reported by the HF Incharges and other staff in the health facilities that none of the health facilities had the complete nine items of essential drugs before AI, so some improvement does seem to have taken place.

From Table 3 we see that there is little difference in the availability of drugs at health facilities according to the AI facilitation modality applied, except for the CEOC at Nuwakot District Hospital; where we would expect drug availability to be better. Availability of drugs in District Team facilitated HFs ranges from 3-9, Genesis Management and District Team facilitated HFs ranges from 4-8, and District Team and RC facilitated HFs ranges from 7-9 items. SSMP and Genesis Management facilitated District Hospital (CEOC) has all nine items of drugs. The details of HF-wise availability of drugs is given in Table: 3.

Table: 3 Health Facility-wise Availability of Drugs

AI Approach	Name of HF	Availability of Drugs											Before AI	After AI
		Oxytocin	MgSO4	IV canula	Ringer lactate/NS	Calcium gluconate	Ampicillin	Metronoda	Gentamycin	Nephadefin				
District Team	Mamling HP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	9
	Dankot HP	✓	x	✓	x		x	✓				x	NC	3
	Dubarkot HP	x	x	✓			x	✓				x	NC	3
District Team + Genesis	Aurohi PHCC	✓	x	✓	✓	x	x	✓			x	✓	NC	6
	Safrubesi HP	✓	x	✓	✓	x	x	✓			x	✓	NC	4
	Rajapur PHCC	✓	✓	✓	✓	✓	x	✓			✓	✓	NC	8
	Parasan HP	✓	x	✓	✓	x	✓	✓			✓	✓	NC	6
	Letang PHCC	✓	✓	✓	✓	✓		✓				x	NC	7
RC	Madhuwan PHCC	✓	✓	✓	✓			✓				✓	NC	9
	Bullingar PHCC	✓	x	✓	✓	x	x	✓			✓	✓	NC	9
	Dauda HP	✓	x	✓	✓	x	x	✓			x	✓	NC	9
SSMP+ Genesis	District Hospital	✓	✓	✓	✓			✓				✓	NC	9
Total		11	5	12	11	5	4	11	8	3	NC	108		

NC= Not complete of all nine items of essential drugs

✓ = Available, x= Not available

HF Incharges reported that lack of essential medicine was not currently a problem for management of 24-hour delivery in their health facilities. In almost all health facilities the supply of medicine has increased due to the 24-hour delivery provision at the respective health facilities, and the policy of 'free health services' implemented by GoN.

3.2.3 Availability of Equipment and Supply

Out of nine BCs studied, one third had all eight types of supply and equipments post AI (Delivery bed, Delivery set, Suture set, Autoclave or Momo-cooker, Ambubag, MVA Set, Vacuum set, Virex), required for a BC. The results for where District Teams facilitated AI were 2-8 types of supply and equipments, whereas it was 4-7 and 5-8 for facilities in which the District Team and Genesis Management, and the District Team and the RC facilitated respectively (Table: 4 of Annex-1).

Out of 11 types of supplies and equipments expected at BEOCs, both of the BEOCs have all 11 types of supplies and equipments (Table: 5 of Annex-1). A CEOC needs additional supply and equipment (Operation theatre, C/S set, Laparatomy set, Spinal anesthesia set). The one CEOC studied had all 15 types of supplies and equipments provisioned by the government protocol.

During interviews with HF Incharges and breakthrough teams, equipment and supply was not perceived as a problem to providing quality services and management of the health facility. While there is no record of the supply and equipment status prior to the launching of the AI process, it was cited by most of the HF Incharges that the supply and equipment situation improved after the AI workshop. They further mentioned that this was the result of the cumulative efforts of the AI workshop, and implementation of the free health care policy, including maternal health by GoN.

3.2.4 Availability of ANC Services

Eleven out of twelve health facilities surveyed provide daily ANC check up for pregnant mothers with the exception of Safrubesi HP. Safrubesi birthing centre is not functioning due to the transfer of female health staff to the district headquarters. Most health workers advise women to attend for ANC on a fixed day of the week for regular ANC check ups, though they do also provide ANC services on demand. Detail of availability of ANC is given in Table: 6 below.

Table: 6 Availability of ANC Services

AI Approach	Name of HF	Availability ANC Services	
		Before AI	After AI
District Team	Mamling HP(BC)	daily	daily
	Dankot HP(BC)	weekly	daily
	Dubarkot HP(BC)	weekly	daily
District Team +Genesis	Aurohi PHCC(BC)	No ANC service	daily
	Safrubesi HP(BC)	daily	No ANC service
	Rajapur PHCC(BEOC)	daily	daily
	Parasan HP(BC)	daily	daily
District Team + RC	Letang PHCC(BEOC)	daily	daily
	Madhuwan PHCC(BC)	daily	daily
	Bulingtar PHCC(BC)	daily	daily
	Dauda HP(BC)	daily	daily
SSMP+Genesis	District Hospital(CEOC)	daily	daily
Total		9 daily & 2 weekly	11 daily

Comparing the situation before and after the AI workshops we see several improvements both in terms of increased numbers of facilities delivering ANC as well as the shift towards daily rather than weekly services. Dankot and Dubarkot HFs had weekly ANC services before AI and currently they are providing daily ANC services. Aurohi did not have ANC services before AI but now this has been regularized to a daily basis. The hiring of additional staff has contributed significantly to expanding ANC services in the HFs.

3.2.5 Availability of 24 hours Delivery Services

The provision of 24 hour delivery services is dependent on the availability of a sufficient number nursing staff. Out of a total of 21 nursing staff currently involved in delivery services across the 12 facilities under study. Before AI workshop 5 nursing staff had received SBA training while 3 have received SBA

training after AI by GoN. Safrubesi HP doesn't have nursing staff at all. Though Dankot HP, and Daud HP each have only one nursing staff, during the interaction with the local community people, HFMC and HF staff, it was found that they are living quite near (about 20 minutes walking distance from the health facility) and providing 24 hour delivery services as per requirement during the off hours of office time. It is also to be noted that the delivery services are provided not only by the trained SBAs but also by other nursing staff, especially by locally hired ANMs on contract basis. Details of availability of 24 hours delivery services is given in Table:7

AI Approach	Type of Facility	Name of HF	Availability of 24 hrs Delivery Services		
			Before AI	After AI	Number of Nursing Staff
District Team	BC	Mamling HP	x	✓	2
	BC	Dankot HP	x	✓	1
	BC	Dubarkot HP	X	x	1
District Team +Genesis	BC	Aurohi PHCC	✓	✓	3
	BC	Safrubesi HP	✓	x	0
	BEOC	Rajapur PHCC	x	✓	3
	BC	Parasan HP	x	✓	3
District Team +RC	BEOC	Letang PHCC	✓	✓	3
	BC	Madhuwan PHCC	x	x	1
	BC	Bulingtar PHCC	x	✓	2
	BC	Dauda HP	✓	✓	1
SSMP+Genesis	CEOC	District Hospital	✓	✓	4
Total			5	9	24

✓ = Available, x= Not available

Out of 12 HFs, only 5 HFs had 24-hour delivery services before AI workshop. Currently, 9 HFs are providing 24-hours delivery services. Despite notable improvements in availability of 24 hour delivery care, challenges remain in extending this to other facilities. The major reasons mentioned for not having 24 hour delivery services were unavailability of female health staff at the health facility (e.g.Safrubesi HP), and lack of provision of extra incentives for additional working hours (e.g. Madhuwan PHC) and

feeling of insecurity by the female staff at the health facility during night duty (e.g.Madhuwan PHC and Dubarkot HP) . The HFMC, HF staff and breakthrough team do not have specific plans to address these problems. They are, however, expecting support from respective DHOs.

3.2.6 Complication Management Services in CEOC & BEOC

Both Rajapur PHCC and Letang PHCC (BEOC)have availability of all eight complication management services for pregnant mothers (Table: 8 of Annex-1).

Nuwakot District Hospital (CEOC), has availability of nine complication management services out of ten; lacking blood transfusion services for pregnant women (Table: 9 of Annex-1). The situation prior to AI was not found to be recorded properly. During the interaction with DHO and other staff at CEOC, it was cited that 24 hours CS/Laparotomy and vacuum delivery were made available after AI workshop.

3.2.7 Display the Name of Women who Received Delivery Incentives

In total, post AI, 7 out of 12 HFs (58.3%) displayed the name of mothers who received delivery incentives, this is a significant increase from only 2 out of 12 HFs prior to the AI intervention. The details of HF-wise information is given in the Table: 10

Table: 10 Displayed the Name of Women who Received Delivery Incentives				
AI Approach	Type of Facility	Name of HF	Total	
			Before AI	After AI
District Team	BC	Mamling HP	x	✓
	BC	Dankot HP	x	0
	BC	Dubarkot HP	x	0
District Team +Genesis	BC	Aurohi PHCC	x	0
	BC	Safrubesi HP	x	0
	BEOC	Rajapur PHCC	✓	✓
	BC	Parasan HP	x	✓
District Team + RC SSMP+Genesis	BEOC	Letang PHCC	x	✓
	BC	Maduban PHCC	x	x
	BC	Bulingtar PHCC	x	✓
	BC	Dauda HP	x	✓
	CEOC	District Hospital	✓	✓
Total			2	7

✓ = Available, x= Not available

The AI workshops appear to have encouraged Incharges to display the names of women who received incentives from the health facility. The HF Incharge in Mamling HP, Parasan HP and Letang PHC mentioned that they felt more aware and responsible for increasing transparency after the workshops and displaying names in a visible place. They further cited that the delivery incentives have been given to the mothers immediately after delivery.

Comparing change in the displaying of names according to the facilitation modality it seems that those facilities which received facilitation by the District Team and Regional Coordinator were more likely to introduce name displays; this may reflect the focus of the RCs responsibility and possible emphasis in the planning workshops. It suggests that with a stronger push towards name displays this could be replicated in other facilities.

3.3 Quality of MNH services

3.3.1 Infection Prevention Practices

Infection prevention practices have sustainably improved after the AI workshop, especially in Mamling HP, Parasan HP, Letang PHC, Rajapur PHC and Madhuwan PHC.

AI Approach	Name of HF	Infection Prevention Practices					Total	
		Use of Autoclave/ Momo Cooker	Use of Chlorine	Proper Waste Disposal	Use of Placenta Pit	Use of Burning Pit	Before AI	After AI
District Team	Mamling HP	✓	✓	✓	✓	✓	3	5
	Dankot HP	✓	x	x	x	x	0	1
	Dubarkot HP	✓	x	x	x	x	0	1
District Team +Genesis	Aurohi PHCC	✓	x	✓	x	x	1	2
	Safrubesi HP	✓	x	x	x	x	0	1
	Rajapur PHCC	✓	✓	✓	x	✓	3	4
	Parasan HP	✓	✓	✓	✓	✓	3	5
District Team + RC	Letang PHCC)	✓	✓	✓	✓	✓	3	5
	Madhuwan PHC	✓	✓	✓	x	✓	2	4
	Bulingtar PHCC	✓	✓	✓	x	x	1	3
	Dauda HP	✓	x	x	x	x	1	1
SSMP+Genesis	District Hospital	✓	✓	x	✓	✓	3	4
Total		12	7	7	4	6	20	36

✓ = Available, x= Not available

Only Dauda Health Post saw no improvement in infection prevention practices after AI was introduced. The activeness of the HFMC and HF staff are key drivers of these important changes that appear to have been stimulated by the AI planning process. There appears to be no major difference in the level of improvement in infection prevention practices by AI facilitation modality other than slightly stronger progress made by facilities that were facilitated by the District Team and RC.

3.3.2 Services provided by SBA during Delivery

Out of a total 12 HFs, Safrubesi HP doesn't have SBA for delivery. There are seven different categories of service which are supposed to be provided by SBAs during delivery services. The range of service provided by SBAs varied by facility, with the district hospital providing all 7 categories and other types of facilities offering between 2 and 6. There is little variation in results between the different AI modalities. The information about the types of services provided by SBA during the delivery before AI workshop were not available in almost all health facilities. Without such baseline data relative change could not be drawn properly. (please see Table: 12 of Annex-1 in detailed).

3.4 Recording and Reporting Status

Recording and reporting status was assessed by using three indicators namely; completeness/ accuracy, preparation of monthly report, and use of new maternity register. Equal weightage was given for each indicator and has been compared before and after AI workshop. Eleven out of twelve (91.7%) HFs have prepared monthly maternity reports, less than half (45.4%) of the HFs have complete/accurate records. Whereas, nine of them are using new maternity registers to keep daily records related to maternity services.

As seen in Table 13, recording and reporting status has improved in almost all HFs after the AI workshop. Health staff mentioned that they knew the importance of complete recording and proper reporting for planning and evaluation of the programme. They mentioned that the issues of appropriate reporting and recording system were also briefly discussed during AI workshop. There has been a strong shift to using the new maternity register and staff report that they can now provide various information as per need.

Table: 13 Recording and Reporting Status						
AI Approach	Name of HF	Recording and Reporting Status			Total	
		Complete/ Accurate Recording	Prepare/ Report Monthly	Use of New Maternity Register	Before AI	After AI
District Team	Mamling HP	✓	✓	✓	2	3
	Dankot HP	X	✓	x	0	1
	Dubarkot HP	X	x	✓	0	1
District Team +Genesis	Aurohi PHCC	X	✓	x	0	1
	Safrubesi HP	X	✓	x	0	1
	Rajapur PHCC	✓	✓	✓	2	3
	Parasan HP	X	✓	✓	1	2
District Team + RC	Letang PHCC	✓	✓	✓	2	3
	Madhwan PHCC	✓	✓	✓	2	3
	Bulingtar PHCC	✓	✓	✓	2	3
	Dauda HP	X	✓	✓	1	2
SSMP+Genesis	District Hospital	X	✓	✓	1	2
Total		5	11	9	13	25

✓ = Available, x= Not available

No difference in improved reporting based on the AI facilitation modality could be observed.

3.5 Utilisation of MNH Services

Change in utilisation of Maternal and Neonate Health Services (MNHS) before and after the AI workshops draws from secondary data from respective health facilities, and requires a degree of caution in interpretation given reliability concerns.

3.5.1 First ANC Visits

In totality across the 12 facilities under study, the number of ANC visits decreased by 1.2 percent in the 6 months after the AI workshop compared to a 6 month period before the workshop. The sharpest decline was found in Dankot HP. According to the HP In-charge this decline was due to the irregularity and absence of the ANM in the health facility. Similarly, transfer of the ANM from Dauda HP resulted in a decline in service availability and use. (Table:14).

Table: 14 First ANC Visit				
AI Approach	Name of HF	First ANC Visit (in numbers)		% Change
		Before AI	After AI	
District Team	Mamling HP	70	50	-28.6
	Dankot HP	101	31	-69.3
	Dubarkot HP	70	67	-4.3
District Team +Genesis	Aurohi PHCC	136	139	2.2
	Safrubesi HP	34	36	5.9
	Rajapur PHCC	367	429	16.9
	Parasan HP	207	238	15.0
District Team + RC	Letang PHCC	214	178	-16.8
	Madhuwan PHCC	39	39	0.0
	Bulingtar PHCC	56	59	5.4
	Dauda HP	237	201	-15.2
SSMP+Genesis	District Hospital	515	554	7.6
Total		2046	2021	-1.2

Following the AI workshops several HFMCs locally hired SBAs (ANM) from their own resources, this happened in Dauda HP (one ANM), Parasan HP (two ANM), Aurohi and Rajapur PHCCs (one ANM each). Similarly DHO has supported one ANM in Mamling HP. AI triggered the HFMC to hire ANMs from their local resources and stimulated them to put pressure on the DHO of their respective districts for MNH resources. VDCs have also been supportive of such activity after AI workshops, especially in Rajapur PHC, Mamling HP, Daud HP, Parasan HP and Aurahi PHC.

It does not appear that the AI modality has been a contributing factor to the hiring of additional ANMs. Overall, the activeness of the HFMCs has increased in many health facilities and there is now a strong sense of responsibility towards providing 24 hour delivery services.

3.5.2 Fourth ANC Visits

In totality, the number of women receiving a Fourth ANC visit after the AI workshop has increased by 4.2 percent overall.

Table: 15 Fourth ANC Visit					
AI Approach	Type of Facility	Name of HF	Fourth ANC Visit (in numbers)		% Change
			Before AI	After AI	
District Team	BC	Mamling HP	25	32	28.0
	BC	Dankot HP	32	70	118.8
	BC	Dubarkot HP	70	60	-14.3
District Team +Genesis	BC	Aurohi PHCC	84	97	15.5
	BC	Safrubesi HP	40	33	-17.5
	BEOC	Rajapur PHCC	182	177	-2.7
	BC	Parasan HP	196	153	-21.9
District Team + RC	BEOC	Letang PHCC	105	140	33.3
	BC	Madhuwan PHCC	34	38	11.8
	BC	Bulingtar PHCC	9	24	166.7
	BC	Dauda HP	152	134	-11.8
SSMP+Genesis	CEOC	District Hospital	227	246	8.4
Total			1156	1204	4.2

3.5.3. First PNC Visits

The first PNC visit has increased by 5.49% overall after AI workshop. No pattern according to AI modality is visible. PNC Visits in Safrubesi, Madhuwan and Dauda have decreased after AI workshop. This may be due to the decrease in institutional delivery after AI workshop in the respective HFs. Mothers might have visited the health facility or private clinic where they had given birth.

Table: 16 First PNC Visits					
AI Approach	Type of Facility	Name of HF	First PNC Visit (in numbers)		% Change
			Before AI	After AI	
District Team	BC	Mamling HP	33	39	18.18
	BC	Dankot HP	156	112	-28.21
	BC	Dubarkot HP	43	60	39.53
District Team +Genesis	BC	Aurohi PHCC	53	74	39.62
	BC	Safrubesi HP	38	20	-47.37
	BEOC	Rajapur PHCC	301	346	14.95
	BC	Parasan HP	179	209	16.76
District Team + RC	BEOC	Letang PHCC	54	64	18.52
	BC	Maduban PHCC	102	12	-88.24
	BC	Bulingtar PHCC	46	80	73.91
	BC	Dauda HP	212	198	-6.60
SSMP+Genesis	CEOC	District Hospital	294	380	29.25
Total			1511	1594	5.49

3.5.4 Institutional and Home Delivery Status

Institutional and home delivery status draws on the available records and data from respective health facilities.

Table: 17 Institutional and Home Delivery Status

AI Approach	Name of HF	Institutional Delivery(in numbers)						Home Delivery by Trained HWs		
		Normal Delivery		% Change	Complicated Delivery		% Change	Before AI	After AI	% Change
		Before AI	After AI		Before AI	After AI				
DHO	Mamling HP	33	39	18.18	0	0	0	1	0	-100.00
	Dankot HP	10	16	60.00	3	5	66.67	2	12	500.00
	Dubarkot HP	0	24	100	0	0	0.00	35	9	-74.29
DHO+Genesis	Aurohi PHCC	16	61	281.25	0	1	0.00	36	45	25.00
	Safrubesi HP	2	0	-100.00	1	0	-100.00	2	1	-50.00
	Rajapur PHCC	148	284	91.89	23	42	82.61	13	5	-61.54
DHO + RC	Parasan HP	84	178	111.90	3	0	-100.00	3	2	-33.33
	Letang PHCC	49	52	6.12	0	0	0.00	0	0	0.00
	Maduban PHCC	13	0	-100.00	0	0	0.00	0	0	0.00
SSMP+Genesis	Bulingtar PHCC	9	26	188.89	9	0	-100.00	30	17	-43.33
	Dauda HP	66	54	-18.18	0	0	0.00	0	0	0.00
	District Hospital	264	339	28.41	30	41	36.67	0	0	0.00
Total		694	1073	54.61	69	89	28.99	122	91	-25.41

In total, normal institutional deliveries across the facilities increased by 54.61 percent and complicated delivery by 28.99 percent after the AI workshop. The number of cesarean Sections dropped from 3 to 1 in the six month comparison periods, and home delivery decreased from 122 to 91 (25.41%). . Likewise, the number of women with complications referred out increased from 15 to 49 (226.67%) after the AI workshop. In totality, institutional normal deliveries increased among nine health facilities after the AI workshops, and across all forms of AI facilitation; gains were particularly high at facilities where AI had been facilitated by District Teams with Genesis.

3.5.5 New Born Care Status

New born care services have increased in total by 20.79% after AI workshop and in nine (75%) health facilities out of twelve (Table: 18).

Table: 18 New Born Care Status					
AI Approach	Type of Facility	Name of HF	New Born Care Status(in numbers)		% Change
			Before AI	After AI	
District Team	BC	Mamling HP	33	39	18.18
	BC	Dankot HP	22	48	118.18
	BC	Dubarkot HP	43	60	39.53
District Team +Genesis	BC	Aurohi PHCC	53	106	100.00
	BC	Safrubesi HP	38	18	-52.63
	BEOC	Rajapur PHCC	270	320	18.52
	BC	Parasan HP	110	191	73.64
District Team + RC	BEOC	Letang PHCC	111	75	-32.43
	BC	Maduban PHCC	40	11	-72.50
	BC	Bulingtar PHCC	39	53	35.90
	BC	Dauda HP	136	139	2.21
SSMP+Genesis	CEOC	District Hospital	298	381	27.85
Total			1193	1441	20.79

3.6 Making a Difference to the Functioning of Health Facilities

One objective of the evaluation was to examine the extent to which the AI process has made a difference in the way health facilities function. Comparison of the conditions of facilities before and after the AI participatory planning process was introduced show improvements in the physical condition and quality of services provided. One of the most significant changes has been the mobilisation of facility management and external stakeholders such as VDCs, to hire additional ANMs to increase the availability of delivery services. Reinforcing this move has been the introduction of free primary services and incentives to pregnant women to deliver with a skilled birth attendant, such demand generating policies, in hand with supply side strengthening initiatives (and social mobilisation efforts in some districts), have raised the stakes and potential for HFMCs to respond with improved services. In this context, the AI process has supported health facility managers take leadership and mobilise local stakeholder support to respond to the changing sector environment. While isolating the effect of AI on facility improvements is not scientifically possible, consultations with stakeholders provides insight into their perceptions of how facilities have changed and the motivating forces behind it. Differences in the way facilities have performed post AI illustrate the fact that AI is a management change process that is mediated and shaped by local actors and conditions, achieving varied rather than standardised outputs; capable of inspiring and mobilising for change in some places, such as Rajapur PHC, but not in others. Below we look at some of the contributing factors that helped make a difference, and key areas of change.

3.6.1 Contributing Factors for Change

The Chairperson/members of HFMC, health facility incharge, and members of breakthrough team were asked in different interactions about the contributing factors to improvements in health facilities. Almost all participants mentioned that the AI workshop had facilitated change. The participants also underlined that the AI workshop was only one of the factors contributing to change. Provision of 'free health care', incentive to the mothers, availability of health staff, provision of incentive to health facility for each institutional delivery and incentive provision for FCHVs are other supporting factors for positive change. It was also observed by the participants that the differences in health facilities before and after the AI workshops was mainly due to the commitment of the members of the HFMC, political parties, HF staffs, and their negotiating capacity with other supporting organisations. For example, Rajapur PHC,

Mamling HP and Parasan HP have been able to get support from other organizations (e.g. VDC, DDC, Red Cross Society). The role of workshop facilitator (SSMP, Genesis, Regional Coordinator and District Team) can be considered as a catalyst to speed up the change. The observation findings, and quantitative data support these arguments. For example, Safrubesi birthing centre facilitated by Genesis Management and the District Team is not functioning as per their plan and activities, whereas BEOC of Rajapur, Bardiya facilitated by the same AI modality is one of the more successful cases. Similarly while the birthing centre facilitated by District Team in Mamling has made improvements this has not been the case in Dubarkot.

3.6.2 24-hour Delivery or Extended Opening Hours

The evaluation team observed that there were at least minimum levels of physical facilities for starting normal delivery in all HFs. Most of the facilities either have their own building and rooms to conduct delivery or have birthing centres under construction. Construction of birthing centres along with the support of medicine and equipments has helped the health facilities to run 24 hour delivery. However, while infrastructure and supplies are necessary for delivery care, it is the availability of trained human resources (Staff Nurse and/or ANM) that is fundamental. If a minimum two trained human resources are available in the facility, 24-hour delivery services can function. In the absence of such human resources, pregnant mothers have undergone long journeys for an institutional delivery or given birth at home.

“I know that the institutional delivery is very safe for mother as well as child. Female staffs (nurse) are not in our Health Post and we feel uncomfortable to discuss pregnancy issue with the male health worker. I really wanted to give birth at the Health Post. Due to the unavailability of female health staff in the health post, I gave birth at home.”

- Mother who had given third birth at home, Safrubesi HP, Rasuwa

“We are not enough to manage 24 hour delivery services in our health facility. We tried to manage it for few months but could not continue as per expectation. We have many regular programmes including new or refresher trainings. If the mothers come during the office hour for the delivery, we do our best but after office hour we go to our home.”

- ANM in Madhuwan PHC, Sunsari

We found that the mothers who had given birth at the health facility were satisfied with services and all of them had received incentive.

3.6.3 Physical Facilities and Environment

The HFMC and the staffs of the health facility reportedly discussed about the improvement of physical facilities and the surrounding environment of the HF during the planning session of AI workshop. Mothers, members of HFMC, health facility staff and the community people mentioned that cleanliness of the ANC/ PNC rooms and waiting areas; toilet and drinking water facilities for the patients and care takers; and the cleanliness of the surrounding environment have improved post the AI workshops, especially in Rajapur PHC, Mamling HP, Parasan HP and Aurahi PHC. Such impressions were also mentioned by the staff of the respective HFs. HFMC members and health facility staffs further mentioned that such activities have been managed by working voluntarily and requesting VDC for financial support. VDCs have supported the improvement of physical facilities by providing small financial support to the health facility. It is also to be noted that the changes in physical facilities and environment was not the same in all the sites. It was reported that physical facilities and environment are better, in Nuwakot Hospital (CEOC) and Rajapur PHC (BEOC) and Mamling HP (BC) compared to other BEOCs and BCs; this view is consistent with the study observations. The main reason behind this is the activeness of the respective management committees and the commitment of HF staffs in these facilities.

3.7 Team work

The HFMC and health facility staff in almost all health facilities mentioned that the AI process had promoted team building and facilitated better understanding of each other. They noted that they realised a lot of things can be done jointly and effectively and this is the major contribution of AI workshops. In some HFs the participants reported a stronger collaboration and commitment among themselves, including the formation of a support network through which they seek advice and feedback from one another. Breakthrough teams are using the network to make positive changes in the health system. The participants gave examples of how they actively collaborate, call each other, share information and resources, give each other advice, and band together to advocate common positions.

“We take advice and feedback from the person who is relatively well known about the specific issues.”

- Members HFMC, Mamling HP, Sankhuwasabha.

“The management committee is not active and we have not been able to make a difference in health facilities even after the AI workshop.”

- HF Incharge, Safrubesi HP, Rasuwa

“Most of the community members think that HF staffs are solely responsible for the betterment of health facility and quality improvement.”

- HF Incharge, Madhuwan PHC, Sunsari

“ After AI workshop we realised that a lot of work can be done at the local level if HFMC, HF staff and the local people have positive attitude towards HF and the better health of people. We have realised that a small effort from each individual can bring about positive change and quality of health services”

- HF Incharge, Tribhuvanbasti HP, Kailali

The commitment towards teamwork and their activities, however, were found to vary in strength depending on the leadership of HFMC and HF staff.

“We have started to give time voluntarily for the betterment of health facility because it is realized that the problems are ours and we are the one to solve them. Previously we were blaming the health facility staff but now we request to them to stay more hours in the health facility, request them to be regular, and we also understand their problem.”

- Members of HFMC, Mamling HP, Sankhuwasabha

“We have been requesting senior staff of the health facility to come regular and provide the quality of services to local people. We have seen them relatively regular after AI but we are still requesting them. AI workshop helped us to understand our role and responsibilities.”

- Representatives of political parties, Letang PHC, Morang

“Our PHC building was old and we did not have adequate room for managing 24-hour delivery services. Because of the team work between us and the health staffs we shifted into the current place as a temporary solution to manage 24 hour delivery services.”

- Members of HFMC, Bulingtar PHC, Nawalparasi

Less positively, in some health facilities, for example in Safrubesi HP and Madhuwan PHC, the staffs continue to do only their regular routine activities during office hours, and the HFMCs has not given adequate attention to enabling 24-hour delivery services.

3.8 Frequency and Effectiveness of the Communication

Regarding the frequency of communication between HFMC and HF staff, most of the members of HFMC (e.g. Parasan HP, Aurahi PHC, Mamling HP and Rajapur PHC) mentioned that the frequency of meetings has increased as stakeholders worked on various activities to improve facility functioning, and engaged with supporting organisations, especially VDCs (Rajapur BEOC, Mamling BC, Parasan BC), DDC (Parasan BC), Red Cross Society (Aurahi BC). It was also noticed that HFs had received such support immediately after AI workshops as the HFMC and HF staff were very actively involved.

In terms of patient interaction, mothers in almost all facilities mentioned that politeness of the HF staff and their behaviour towards the patients and visitors at the HFs were the same as before AI. The frequently cited answers were, 'some have been very polite and friendly, whereas some are reserved'. However, none of the community participants mentioned that the HF staff behaved rudely. FGD participants (women as well as the members of HFMC and representatives of political parties) were happy with the way HF staff spoke to them and explained about the problems of individuals as well as the functioning of HFs.

Following the AI workshops, some HFMCs reported greater interaction with DHO. For example, HFMCs of Aurohi PHCC, Dauda and Parasan HPs have visited and coordinated with their respective DHOs for regular supply of drugs, and to fill ANM positions. HFMC of Parasan HP and Dauda HP also suggested to DHO that prior to ANMs taking part in training and other activities at district headquarters, substitutes need to be arranged so that the SBA service will not be hampered. HFMC of Aurohi PHCC requested the DHO to supply blankets and mattress for the delivery room and the DHO has taken up the request with Red Cross.

3.9 Emergency Funds

In almost all the health facilities, the AI workshops sensitised local leaders of political parties, members of HFMC, FCHVs and HF staff of the need and importance of emergency funds.. While it was generally accepted that the collection and management of emergency fund is an innovative idea for the emergency support of needy people, especially for poor and marginalised people in the community, no such funds have been established. During the AI workshops some of the participants had contributed cash as seed money for the fund but this has not been taken forward by the health facilities which continue to manage emergency issues on an ad hoc basis.

3.10 Monitoring and Technical Support Visit

During the AI workshop, the breakthrough teams prepared breakthrough action plan and programme activities to be implemented for the betterment of health facilities, though no plan was developed for facilitators to monitor/review the achievements of these activities . Except in Rajapur PHC, follow up of the breakthrough plan and site mentoring and monitoring of evidence based practices was not followed up by the facilitators in a systematic way During interaction with various facilitation members and focal person of SSMP, it was found that provision for follow up visits had been made, and follow up of the activities is reportedly being done by respective facilitators. Follow up visits and a review workshop would be helpful to accelerate achievement of proposed activities/breakthrough plan.

3.11 Cost of Various Modalities

The cost of the AI workshops varied according to the nature of health facility, and the type of facilitators. It was found that no single modality seemed particularly more effective in mobilising the health leadership; though the external consultants were better skilled in AI facilitation. Generally, the cost of AI workshop for BC level is about Rs. 55,000, for BEOC is about Rs. 95,000 , and for CEOC is about Rs. 175,000. The travel cost for FCHVs, hall rent, tea and snacks, office assistant, and incentive for the participants were found to be clearly mentioned in the guideline prepared and published by FHD. The other costs vary depending upon the distance from district headquarter, regional headquarters and number of facilitators involved in the workshops. Among the modalities implemented, Genesis Management was the most costly, followed by RC plus DHO, and DHO implemented. The importance of

engaging external consultants to facilitate CEOC workshops was recognised and demanded by the DHO and district team facilitators (FPS, PHN). Given financial considerations, roll out within districts are best undertaken by district AI facilitation teams that have received training from master trainers; support from Regional Coordinators is recommended.

3.12 Issue of Scaling Up

The HFMC, HF staff, FCHVs, representatives of the political parties mentioned that AI workshop had encouraged them to establish 24 hour delivery services, explore local resources and ideas of positive problem solving amongstakeholders. They have started to review their areas of strength and capacity to support the Health Facility. Almost all interviewed/discussed/interacted participants mentioned that the AI workshop should be scaled up in other facilities too.

“The AI workshop should be scaled up in as many health facilities as possible. More focus should be given to the political parties, VDC bodies, members HFMC and local NGOs to make them understand the need and importance of health facility including 24 delivery services. The programme should be included as one of the regular programmes of DHO. External consultant can be hired for the district level workshop. The PHC, HP, SHP level workshops should be conducted by PHN, FPO and the local person who participate in the district level workshop.”

- DHO, Sankhuwasabha

“To make AI workshop sustained and cost effective, external facilitation is needed only in district level workshop.”

- PHN, Sankhuwasabha

“I found AI workshop very innovative and helpful to encourage local people to improve physical working environment, regularity of the HF staff, team building and resource generation. This should be replicated in other health facilities also.”

- FPO, Morang

“The appreciative coaching should be given to many people so that the impact of the transfer of the HF staff would be minimal. It is a kind of exchange of experiences, guidance from more experienced colleagues, receiving feedback from someone external to their organisations and to improve skills. My personal experience is that the workshop facilitator should be able to cover the issues effectively and

responded the issues raised by the participants efficiently.”

- Managing Director, Genesis Management

“We have learned a lot of positive ideas from AI workshop. Such workshop should be conducted in other health facilities too.”

- Breakthrough Team, Rajapur PHC, Bardiya

District level authority (DHOs, FPO, and PHN) repeatedly mentioned that systematic follow-up visits by the facilitators should be conducted according to plans and should use pre-established indicators to measure participant progress in addressing their challenges, as well as providing informal advice and moral support to the health facilities.

They further mentioned that ‘A GUIDE FOR AI FACILITATORS’ should be developed and distributed, containing detailed resources and tools used in the AI workshops as well as complete facilitators’ notes. This guide will serve as a resource and a confidence builder for the concerned authority of DHO and local facilitators.

The members of HFMC and HF staff further mentioned that periodic follow-up visit would be important for continued learning and behaviour change. According to them, the follow-up visits should be informal, with participants able to ask questions, solicit advice and feedback, confide, or recount anecdotes about how their work is going. Most of the participants mentioned that such visits would be very useful, encouraging, and stimulating. Many of the participants consulted felt that follow-up of the activities has been insufficient to date.

3.13 Systemic bottlenecks to change

Critical staff shortage and the frequent turnover of staff is a systemic problem that requires policy level resolution through the filling of sanctioned posts, and the introduction of a clear transfer policy that rewards providers prepared to work in remote districts. Lack of well qualified and accessible human resources has long been a massive barrier to GoN’s objective to provide the safe delivery services required to reduce maternal mortality. The challenge now is to assure health staff who have safe

delivery skills (most specialists either work in the private sector or leave Nepal), are properly posted and in adequate numbers, and are retained by the government, particularly at geographically challenging posts.

Lack of locally elected bodies and their involvement in the management committee is another confounding variable which impacts on effectiveness. The VDC secretary, generally the chairperson of HP and SHP, has daily routine work along with other issues to take care. In such a situation continued monitoring of service availability, physical condition, service facility, drug availability and other updates for the quality of services at the health facility have not been their major priority. It can be expected that AI workshops could make more positive change if the HFMC were formed from elected local bodies. In future, effectiveness of the AI workshops is likely to increase as Nepal moves towards a federal republic state with devolution of power to the local level.

CHAPER IV: LESSONS LEARNED AND RECOMMENDATIONS

4.1 Lessons Learned

The following summarises lessons learned mentioned by health facility staff, health facility management committees, mother groups and observations from evaluation team members:

- **AI as a positive step for change:** Different management tools have different benefits. Technical know-how and individual readiness to contribute to change go together and is found to be one of the key guiding principles of AI approach. The AI workshop approach was found to be a new, exciting approach, a shift from conventional administrative management practices to a participatory learning approach grounded in a team building process. The AI workshop has led to a variety of innovations in the health facilities to support the quality of services and infrastructure improvement, including the hiring of additional ANMs, sourcing of drugs, and improvements in infection prevention practices. It has helped to identify gaps in knowledge, attitudes and practices at various level of health facility functioning and fostered a shared vision for the health facility based on a common understanding and the local situation. The power of AI is the way in which participants become engaged and inspired by focusing on their own positive experiences and capacity for positive change. HFMC and HF staff remembered and related personal and institutional experiences of success, identified the common elements of these experiences, and devised statements and action plans for enacting those positive experiences in their respective health facility. In most of the health facilities AI participants had a sense of commitment to make more of moments of success during the AI workshop. It has helped to bring change in staff attitudes and generate a feeling of collective responsibility among HFMC, facility staff and others members of the community. The workshop has been taken as a positive step for change. Overall we see that, the gap between 'saying ' and 'doing' varied due to various factors such as the commitment of the HFMC and breakthrough team, availability of health staff, as well as the quality of monitoring and supervision from district and central levels. Thus, AI is only a management tool which does not work mechanically without the commitment and activeness of the local people, especially HFMC, HF staff and the political parties.

- **Taking responsibility:** The very thrust of the programme has been to enable the community to realise that the problem is theirs and the responsibility to address the problem is also theirs so that they should volunteer and start advocating for support and services. In this way, the community people learn to address their issues on their own by advocating and accessing the available resources around.

The Importance of leadership in Health Facility Management: Establishing and/or expanding availability of 24 hour delivery services requires effective management to ensure adequate rooms for various services and for the staffs to stay within the premises of the health facility; availabilities of equipment, supply and drugs; information and monitoring system; and most importantly, to ensure sufficient skilled human resources. Without them women’s lives cannot be saved. When the members of HFMC are not willing to invest in management change it is extremely difficult to move forward. On the other hand, when the HFMC is committed to making quality changes in the health facility, remarkable progress has been possible.

- **Provision of human resources, supply and monitoring:** The AI workshop nurtures the leadership qualities of providers and the community members. Participatory planning, action and review make interdependence more apparent and stimulates local responsibility and action for saving women’s lives. However, this is not sufficient to guarantee 24 hours quality delivery, including BEOC and CEOC services. The management change process needs to be backed up by the increased provision of trained SBAs, essential supplies and equipment, and intensive monitoring thereby enabling AI to have stronger effect
- Follow-up visits by the facilitators:** Periodic follow-up visits *are* also important for continued learning and behaviour change. The follow-up visits should be organised informally, where participants would be able to ask questions, solicit advice and feedback, confide, or recount anecdotes about how their work is going. All participants were of view that these visits would be very useful, encouraging, and stimulating. Many of the participants interviewed, however, felt that follow-up visit had been insufficient to date.

Models for Scaling up: No major difference in outputs were observed among different AI implementation models which focused on effectively managing 24 hours delivery services,

increasing availability of health workers and stimulating the action of HFMCs. Furthermore, the issue of cost and sustainability need to be taken into consideration in any scale up plans. In this regard, while external consultant level support and facilitation is required at the district /CEOC level, facilitation by district teams is more appropriate for BEOCs and BCs . Additionally, RC can play important role to facilitate and monitor the ongoing progress of activities at the district as well as peripheral levels.

4.2 Recommendations

- **Scaling up AI participatory planning and review:** Based on the changes stimulated by the AI process in the facilities studied we recommend the scaling up of AI participatory planning and review as a management change tool to support policy and programme implementation for safe motherhood. The potential of this management change tool is particularly strong in the current policy and programme environment which is generating demand for institutional deliveries through both access promoting initiatives, and supply side strengthening. For scaling up the AI process, the two issues of competent facilitators and sustainability are equally important. It requires training of trainers and their dedication to train others. Systematic follow-up visits, work plan and regular facilitation by the facilitators should be conducted according to plans. Facilitators need to use pre-established indicators to measure progress in addressing the challenges identified at each health facility, as well as provide informal advice and moral support during their regular visits. In this context, district level AI coaching should be facilitated by external consultants and master AI trainers and DHO. At least the HF Incharge and Chairperson of HFMC from each of the respective health facilities to be covered in the district should be invited to the district level AI workshop. If the workshop participants become more than 40, the group can be divided into two and such workshops should be organised either at the district headquarters or at the convenient place for the CEOC, BEOCs and BCs. Or alternatively, workshop for the CEOC and BEOC can be proposed together and the workshop for BCs separately. However, this situation varies upon the number of BEOCs and BCs in the district and the number of workshop participants. At the peripheral level (PHC, HP, SHP) the AI workshop should be conducted by concerned authorities of DHO (the PHN, Family Planning Assistant and Public Health Officer) and the participants who were involved in district level workshop. The

Regional Coordinators can play important role for facilitating the peripheral level workshops. The existing facilitator guide should be expanded and distributed, containing all the resources and tools used in district level workshop as well as complete facilitators' notes. This guide will serve as a resource and a confidence builder for the facilitators at the peripheral level.

- **Parallel provision of basic facilities, service site strengthening and social mobilization:** Strengthening HFMC is a critical complementary need to meet MDGs for improved management of facilities, improved community relations and accessing of local resources to fund improvement and recruit additional staff. However, inputs such as infrastructure development, provision of minimum required number of HF staff, medical supplies and equipments are the necessary conditions for functioning the HFs. Without such provision, 24-hour delivery services will remain a dream. AI workshop has helped demand creation in the community and service site strengthening. The provision of basic facilities as well as service site strengthening and social mobilization is needed to maximize the effectiveness of the AI approach.
- **Motivating providers:** Absenteeism and irregular attendance remains a problem in some facilities even after AI. Tackling this systemic issue will require a systems response. Some specific recommendations for consideration include the provision of appreciation and rewards at an institutional as well as an individual level; extra incentives for additional work to encourage the SBA to be regular and attentive for 24-hour delivery services; experience sharing visits at successful HFs to stimulate and encourage the staff of HFs as well as members of HFMCs.

Table: 8 Availability of Complication Management Services in BEOC

AI Approach	Name of HF	Availability of Complication Management Services in BEOC																Total			
		Management of PPH with Parenteral Oxytocin		Management of Eclampsia with MgSO4		Management of Sepsis with Parenteral Antibiotics		Management of Pre-eclampsia		MRP		MVA		Vacuum Delivery		Newborn Resuscitation		Before AI	After AI		
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		
DHO+Genesis	Rajapur PHCC	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	NR	8
DHO + RC	Letang PHCC	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	NR	8
Total		2	0	2	0	2	0	2	0	2	0	2	0	2	0	2	0	2	0	NR	16

Table: 9 Availability of Complication Management Services in CEOC		Availability of Complication Management Services in CEOC														Total											
		Management of PPH with Parenteral Oxytocin		Management of Eclampsia with MgSO4		Management of Sepsis with Parental Antibiotics		Management of Pre-eclampsia		MRP		MVA		Vacuum Delivery		Newborn Resuscitation		24 hrs CS/Laparotomy		24 hrs Blood Transfusion		Before AI		After AI			
AI Approach	Name of HF	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		
SSMP+Genesis	District																										
	Hospital	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	7
Total		1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	7	9

Table: 12 Services Provided by SBAs		Services Provided by SBAs																	
AI Approach	Name of HF	Use of Partograph		Allow Women to have Company during Labour		3rd Stage Labour Management		MgSO4 for Eclampsia		Antibiotics for Caesarean Section		Antibiotic for prolonged ruptured of membrane		MVA		Before AI		After AI	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
DHO	Mamling HP	1	0	1	0	1	0	1	0	0	1	1	0	0	1	0	1	NC	5
	Dankot HP	0	1	1	0	1	0	0	1	0	1	1	0	0	1	0	1	NC	3
	Dubarkot HP	0	1	1	0	0	1	0	1	0	1	1	0	0	1	0	1	NC	2
DHO+Genesis	Aurohi PHCC	1	0	1	0	1	0	0	1	0	1	1	0	0	1	0	1	1	3
	Safrubesi HP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	2	NA
	Rajapur PHCC	1	0	1	0	1	0	1	0	0	1	1	0	1	0	1	0		6
DHO + RC	Parasan HP	0	1	1	0	1	0	0	1	0	1	1	0	0	1	0	1	2	3
	Letang PHCC	1	0	1	0	1	0	1	0	0	1	1	0	1	0	1	0		6
	Maduban PHCC	0	1	1	0	1	0	0	1	0	1	1	0	0	1	0	1	2	
SSMP+Genesis	Bulingtar PHCC	1	0	1	0	1	0	0	1	1	0	1	0	0	1	0	1		5
	Dauda HP	0	1	1	0	1	0	0	1	0	1	1	0	0	1	0	1	3	3
	District Hospital	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	6	7
Total		6	5	9	2	10	1	4	7	2	9	11	0	3	8	0	3	8	45

NA= Not Applicable due to unavailability of SBA

NC= Not recorded by DHO before AI workshop

Table: 17 Institutional and Home Delivery Status

AI Approach	Name of HF	Institutional Delivery (in numbers)														Home Delivery by Trained HWs		Referred Out	
		Normal Delivery				% Change		Complicated Delivery		% Change		C.S.		Before AI	After AI	% Change	Before AI	After AI	% Change
		Before AI	After AI	AI	AI	Before AI	After AI	Before AI	After AI	Before AI	After AI	Before AI	After AI	Before AI	After AI	Before AI	After AI	Before AI	After AI
DHO	Mamling HP	33	39	0	0	18.18	0	0	0	0				1	0	-100.00	0	0	0
	Dankot HP	10	16	3	5	60.00	66.67							2	12	500.00	0	0	0
	Dubarkot HP	0	24	0	0	???	0.00							35	9	-74.29	0	0	0
DHO+Genesis	Aurohi PHCC	16	61	0	1	281.25	0.00							36	45	25.00	0	0	0
	Safrubesi HP	2	0	1	0	100.00	-100.00							2	1	-50.00	0	0	0
	Rajapur PHCC	148	284	23	42	91.89	82.61							13	5	-61.54	6	16	166.67
DHO + RC	Parasan HP	84	178	3	0	111.90	-100.00							3	2	-33.33	0	5	0.00
	Letang PHCC	49	52	0	0	6.12	0.00							0	0	0.00	0	0	0.00
	Maduban PHCC	13	0	0	0	100.00	0.00							0	0	0.00	0	0	0.00
SSMP+Genesis	Bulingtar PHCC	9	26	9	0	188.89	-100.00							30	17	-43.33	0	0	0.00
	Dauda HP	66	54	0	0	-18.18	0.00							0	0	0.00	0	0	0.00
	District Hospital	264	339	30	41	28.41	36.67							4	1	-300	9	28	211.11
Total		694	1073	69	89	54.61	28.99							122	91	-25.41	15	49	226.67

Annex II: Schedule of District AI Workshops for C/BEOC Sites and Birthing Centres

Districts	CEOC	BEOC	Birthing Centre	Name of Health Facility	Partners for DHO
Siraha			2	Aurohi PHCC (additional Golbajar) – 1	DHO+Genesis
Sankhuwsabha			1	Tumlingtar	DHO+Genesis
			1	Mamling	DHO
Solukhumbu			2	Nele & Chulakharka -2	DHO and Genesis
Sunsari			1	Madhuban PHCC (delivery) -1	DHO/RC/UMN
Morang		1		Letang PHCC(BEOC)	DHO, RC, and PHN of Saptari
		1		Bahuni PHCC(BEOC)	DHO, RC, and PHN of Saptari
Taplejung			2	Hampang and Sinam HP-2	DHO+Genesis
Dhanusha			1	Dhubarkot HP-1	DHO
Dolakha			3	Namdu, Fasku HPs and Charikot PHCC (delivery)-3	DHO+ RC+ Genesis RHDP
Rasuwa			4	Laharepauwa, Safrebesi, Thamhuche, Parchayang HPs -4	DHO+Genesis/Mehe ndi
Sindhupalchok		1	2	Jalbire, Dandapokhari HPs-2 and Barhabise PHCC (BEOC)	DHO+Genesis/MDM (France)
Nuwakot	1			District Hosital Nuwakot (CEOC)	Genesis +SSMP
Makawanpur	1			District Hospital Hetauda (CEOC)	Genesis+SSMP
Sarlahi	1			Sarlahi Hospital CEOC	Genesis+SSMP

Districts	CEOC	BEOC	Birthing Centre	Name of Health Facility	Partners for DHO
Mustang			1	Jarkot HPs -1	DHO+RC and Genesis
Palpa		1		Rampur PHCC (BEOC)	DHO+RC+Genesis
Gulmi	1			Gulmi Hospital CEOC	Genesis+SSMP
Nawalparasi			1	Bulingtar PHCC (BC)	DHO+RC+EAP
			1	Palhi PHCC(BC)	DHO+RC+EAP
Bardiya		1		Rajapur PHCC BEOC	DHO+Genesis
Salyan		1	2	Bajkot and Lekhpokhari HPs,- 2 Tharmare PHCC (BEOC)	DHO+Genesis+RC
Dolpa			1	Kaijan HP 1	DHO+Genesis
Jajarkot			2	Dalli and Sima HPs 2	DHO+Genesis
Surkhet			1	Lekhgaun HP -1	DHO+Genesis
Pyuthan		1	2	Okharkot, Kahawang HPs and -2 Pyuthan District Hosp.(BEOC) Extra	DHO+Genesis
Baitadi			2	Sreekot and Joshidhunga HPs -2	DHO+Genesis/
Bajura			2	Kolti and Tate HPs -2	DHO+Genesis
Bajhang			2	Khiratadi and Channa HPs- 2	DHO+Genesis/
Doti			2	Dankot HP	DHO
				Daud HPs	RC+DHO
Kanchanpur			1	Tribhuvanwasti -1	DHO+Genesis
28 Districts	4	7	39	4 CEOC, 7 BEOC and 39 birthing centres: Total 50 facilities	4 CEOC, 5 BEOC, 32 birthing centres, (total 41) in 26 districts completed by Genesis, 2PHCC(BEOC) and

Districts	CEOC	BEOC	Birthing Centre	Name of Health Facility	Partners for DHO
					3PHCC(BC) 1HP(BC) done by DHO and RC and 3HP by DHO only= total 50 facilities