Remote Areas Access to MNH service Pilot (RAMP) Briefing Paper

A study on access to maternal neonatal and child health (MNCH) services in remote areas of Nepal (Regmi et al 2013) found that remoteness strongly affects access to and the use of MNCH services both within and between districts.

Based on this study, a Remote Areas Access to MNH services Pilot (RAMP)[1] was designed to improve core MNH service delivery and provide a demand-side package of interventions to overcome barriers to access in remote Nepal. It was piloted in Taplejung district from May 2014 to September 2015. The pilot implemented different intervention packages which were then compared.

Intervention	Package		
District wide interventions: • District wide coordination for resource mobilisation and drugs distribution • District hospital services • Obstetric first aid to paramedics • FCHV based interventions	1	2	3
Supply side health facility interventions: • District level earmarked MNH fund for human resources, equipment, supplies. • ANM skill enhancement • HFOMC strengthening.		2	3
Demand side interventions: Equity and Access Programme (EAP) interventions: • Behaviour change communication • Emergency fund and transport arrangements • Stakeholder mobilisation and advocacy.			3

The District Health Office (DHO) in Taplejung was the main implementer of the pilot supported by Family Health Division and the Nepal Health Sector Support Programme (NHSSP).

An independent evaluation found that service delivery expansion and improvements in quality could be achieved through the capacity building of service providers and health facility management and operation committees (HFOMC), and by district health offices responding to health facilities' critical needs. Higher service use among communities across the majority of indicators was found in **package three** (see insert) which included an additional element of community mobilisation and behaviour change communication inputs compared to the other two packages. A value for money study undertaken as part of the assessment showed package three also to be most cost effective. Whilst acknowledging a few limitations when implementing and evaluating the pilot, it is proposed that this model provides the foundation for improving access to and use of MNH services in the rest of Taplejung and in other remote districts.

Increased service availability, improved health facility management and quality of care

Service expansion and quality improvement were possible when coordinated inputs and intensive support were provided for staff capacity building, critical equipment and supplies were made

[1] For the full report on RAMP please see www.nhssp.org/resources

available, HFOMCs were strengthened and the DHO's ability to respond to critical needs of health facilities was improved.

Improved access to and use of services, and improved care at home

The study results clearly show that combining supply and demand side interventions (package 3), leads to the most significant positive changes. Details can be seen in the table below.

Increased service utilisation of:	Best results:		
	1	2	3
Use of modern contraceptive methods			✔
Four ANC visits attendance			✔
Institutional deliveries			✔
Early initiation of breastfeeding			✔
Delayed bathing of newborns until 24hrs post-birth	✔		
Decline of diarrhea and pneumonia incidences in last 12 weeks		✔	

LESSONS LEARNED & RECOMMENDATIONS: improving availability and quality of MNH services in remote areas.

1. **Small flexible grants** managed by the district health office can fill key facility level gaps and motivate providers and HFOMCs.

   Recommendation: DHOs should be provided with a flexible earmarked fund for birthing centres to bridge human resource (HR) gaps related to late budget release and single year contracting until permanent staff can be secured (e.g. midwives).

2. **Placement of auxiliary nurse midwives (ANMs)/skilled birth attendants (SBAs) at the district hospital** helps these staff retain skills and improves motivation. In remote areas where the volume of deliveries is low at birthing centres, it is important to regularly update ANMs'/SBAs' knowledge, skills and confidence.

   Recommendation: Regular placement at district hospitals or training sites (i.e. for two weeks every two to three years) should be arranged for ANMs and SBAs.

3. **Birthing centres can be successfully upgraded to basic emergency obstetric and neonatal care (BEONC) centres.**

   Recommendation: Review the distinction made between birthing centres (BCs) and BEONCs and provide trained staff with the necessary equipment and training to non-BEONC facilities in order to provide all BEONC signal functions.

4. **Capacity building and support to HFOMCs is essential to create an enabling environment** at health facilities for improved functioning and quality of care. HFOMC training and regular support activities are needed for these, frequently dormant, committees.

Recommendation**:** Provide more regular support and expand the range of subjects offered by the National Health Training Centre (NHTC) on HFOMCs to include leveraging village development committee (VDC) and district development committee (DDC) resources and guidance on the use of funds generated by facilities.

5. **Displaying facility performance in traffic light colours** inside and outside facilities serves as a continuous reminder to staff to improve services and encourages the responsiveness of HFOMCs.

   Recommendation**:** Include the health facility self-assessment tool used to assess availability, readiness and quality of MNH services in on-site mentoring tools in order to improve service provision.

6. **Whole site infection prevention training** contributed to significantly improved infection prevention practices at health facilities.

   Recommendation**:** one-day orientations and practical demonstrations should be included in on-site mentoring tools and provided by NHTC to all new clinical staff joining the public health service during induction training.

7. **Sustaining the RAMP model of facility level capacity enhancement requires extra support** to the DHO and the public health nurse. DHOs in remote districts tend to have fewer capable and less well motivated staff than those in non-remote areas and frequent staff transfers are the norm.

   Recommendation**:** Provide extra support to the DHO and the public health nurse in order to sustain the RAMP model of facility level capacity enhancement in Taplejung.

8. **Enhancing the capacity of health workers to maintain the new Health Management Information System (HMIS)** needs to be incorporated in on-site coaching for staff.

   Recommendation**:** Incorporate HMIS training in on-site coaching.

9. **Lack of accommodation for accompanying family members** travelling with a pregnant woman from a remote area to a birthing centre is a major barrier for institutional delivery for women that live particularly far from a BC.

   Recommendation**:** Explore viable options for accommodating family members, including in waiting homes, to enable better access to services for families from remote locations.

LESSONS LEARNED & RECOMMENDATIONS: Social and community mobilisation for behaviour change and enhanced service use

1. Social mobilisation programmes need to **invest in NGO partner capacity building** as a prerequisite for implementation. Similarly, capacity building of local staff and the development of community based social mobilisers is critical for programme success and takes time.

***Recommendation*:** Providing support, capacity building, and monitoring to social mobilisers is critical for programme success and health social mobilisation programmes need to take this into account by providing an adequate timeframe and the resources needed to achieve this.

2. **Encouraging poor women** with heavy work burdens **to attend regular meetings** requires considerable motivation building.

   ***Recommendation*:** In very poor areas, the provision of small incentives linked to existing entitlement programmes such as the four antenatal care (ANC) entitlements needs to be considered. Various social mobilisation programmes need to be consistent in the incentives they offer to incentivise people.

3. **Additional social mobilisation groups may need to be formed and individual households targeted** to reach the poorest and most vulnerable women. *S*ocial mobilisation programmes in Nepal are built on existing women's groups; however in remote areas additional groups may need to be formed to overcome the difficulties remoter hamlets face reaching existing groups. Targeting of individual households was also an essential component of social mobilisation and behaviour change activities in RAMP.

   ***Recommendation*:** Tailor social mobilisation to the local context, include strategies to reach the poorest and most vulnerable women, and factor these into the design as additional time and resources are likely to be required for these essential components.

4. **Mobile phone technology** can be used to send voice messages and reminders to low literate women and improve linkages between women and service providers.

   ***Recommendation*:** Explore mobile phone technology to target women and families to improve health service usage.

5. **Emergency transport is essential** in remote areas

   ***Recommendation*:** Form community groups to take responsibility for emergency transport and support agreements with transport agents to establish communication mechanisms and costs for transporting emergency cases.

6. **Social mobilisation** is a medium term investment for long-term sustainable behaviour change. The low cost funding of equity and access programme (EAP) activities in Taplejung was justifiable given the short term nature of the project; but as government prepares to develop longer term plans for remote areas, the investment envelope for behaviour change and demand generation needs to be results oriented and more realistic to ensure quality implementation.

   ***Recommendation*:** A medium term investment is required for social mobilisation programmes to achieve sustainable behaviour change and this is an essential component of MNH programming in remote areas.

Scaling Up and Next Steps

RAMP has demonstrated that improved MNH outcomes can be achieved in remote areas for a modest investment. However, although RAMP has shown that service expansion and quality can be increased in remote areas in a relatively short period of time, a longer term investment is needed to strengthen its health system, generate demand for services and change family behaviour.

An economic assessment of the likely costs of scaling up the package of services in additional remote VDCs and districts based on different coverage levels, showed a decreasing trend in scale up costs as coverage levels increased.

Based on lessons learned from the Taplejung remote areas MNH pilot, we recommend:

At programme level:

- District level planning and replicating the Taplejung approach in remote districts in order to better reach women and children in these areas (HFOMC, SBA placement, onsite mentoring using QIP tool, earmarked fund)
- Long term support by partners in remote districts
- A focus on inter-sectoral coordination and creating opportunities for synergies with social mobilisation and governance programmes - including transport, communication systems and education line agencies.

At system level:

- MoH to develop a staff retention strategy specifically for remote areas
- In extreme remote areas alternative service providers should be explored.

The next step is for NHSSP to work with the FHD to identify how the government can build on RAMP's experience, sustain momentum in Taplejung, and inform strategies for improving MNH outcomes in remote districts as part of the Nepal Health Sector Strategy (2015-20).