

Deploying Roving Auxiliary Nurse Midwives in Nepal:

Guidance and Lessons Learned from the FACT Project



USAID
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Fertility Awareness
for Community
Transformation



Government of Nepal
Ministry of Health
Family Health Division

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Recommended Citation:

Deploying Roving Auxiliary Nurse Midwives in Nepal: Guidance and Lessons Learned from the FACT Project. May 2018. Washington, D.C.: Save the Children and the Institute for Reproductive Health, Georgetown University for the U.S. Agency for International Development (USAID).

This guidance manual was prepared by IRH and Save the Children under the Fertility Awareness for Community Transformation (FACT) Project. This manual and the FACT Project are made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement No. AID-OAA-A-13-00083. The contents are the responsibility of IRH and Save the Children and do not necessarily reflect the views of Georgetown University, USAID or the United States Government.

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Acknowledgments

This guidance manual was prepared by the Institute for Reproductive Health, Georgetown University in collaboration with Save the Children under the Fertility Awareness for Community Transformation (FACT) project. This manual will not be possible without the contribution of many collaborators. IRH and Save the Children wish to thank the Nepali Family Health Division, the National Health Education, Information, and Communication Centre, district health officials, service providers, and promoters for piloting Pragati in conjunction with the FACT team.

Finally, we would like to thank the FACT team in Rupandehi.

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LIST OF ACRONYMS AND KEY PHRASES

ANC	Antenatal Care
COFP	Comprehensive Family Planning
CPR	Contraceptive Prevalence Rate
DPHO	District Public Health Office
FACT Project	Fertility Awareness for Community Transformation Project
FCHV	Female Community Health Volunteer
FHD	Family Health Division
HFIC	Health Facility In-Charge
HMIS	Health Management Information System
HMG	Health Mothers Group
LAM	Lactational Amenorrhea Method
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
MUAC	Middle upper arm circumference
NDHS	Nepal Demographic and Health Survey
NGO	Non-Governmental Organization
PHC-ORC	Primary Health Care – Outreach Clinic
PNC	Postnatal Care
PPFP	Postpartum Family Planning
RANM	Roving Auxiliary Nurse Midwife
SDM	Standard Days Method
VDC	Village Development Committee

Summary

Roving Auxiliary Nurse Midwives (RANMs) are a cadre of health workers in Nepal who provide home and community-based health services. In the Rupandehi District, the USAID-funded Fertility Awareness for Community Transformation (FACT) Project, working with the Family Health Division (FHD) and Rupandehi District Public Health Office (DPHO), implemented an approach to deliver family planning services to marginalized communities by deploying RANMs over a 15-month period. While enhancing family planning services was the primary purpose of the project, services provided by RANMs also included other maternal and child health services, particularly antenatal (ANC) and postnatal care (PNC).

The RANM intervention was successful in reaching marginalized households, or those not accessing health services, with family planning and pregnancy-related services and linking community members to the health system. This was done through a combination of home visits, community activities, and mobilizing influential people and community members to expand conversations around social norms and reproductive health.

The RANM intervention was implemented as part of an integrated package of activities which included the integration of the Standard Days Method (SDM) into the Ministry of Health's (MOH) family planning program and the community-based Pragati intervention, which are detailed in separate reports. This guide focuses on the RANM intervention alone, providing guidance on the implementation process, challenges, and lessons learned from the FACT Project.

Background

In the past ten years, the Government of Nepal has made significant strides in improving service quality and access to reproductive health services, resulting in reduced maternal mortality and unmet need for family planning. Today, 57% of deliveries occur in a health facility – a significant increase from 18% in 2006 (NDHS, 2016). Additionally, though the contraceptive prevalence rate (CPR) among currently married women using a modern method in Nepal increased from 26% in 1996 to 43% in 2016, there has been no change in the modern CPR since 2006 (NDHS, 2016). Furthermore, CPR and rates of met need for family planning are lower among certain caste/ethnic and religious groups (NDHS, 2011).

Despite overall improvements in reproductive health outcomes in Nepal, the existing health system faces challenges in improving access to quality services among these marginalized groups. Some of these challenges include geographic barriers due to distance and rough terrain, limited qualified staff – particularly in rural areas – and social barriers to accessing the health system. These barriers have also been exacerbated by the large percentage of migrating workers leading to increased spousal separation.

In Nepal, female community health volunteers (FCHVs) are trained as a cadre of community health volunteers to promote maternal and child health, manage childhood illnesses, and provide short acting contraceptive methods at the community level. While FCHVs may have initially been able to expand knowledge and demand for family planning and primary care services, limited capacity and motivation made it difficult for them to adequately address the unmet need for family planning among marginalized ethnic groups (i.e. Dalit, Janajati, Madhesi, and Muslim). A household survey across five districts of Nepal found that only 17% of current family planning users seek family planning services from FCHVs and that only one-fifth of married women are currently using a family planning method. Recognizing this gap in service delivery, the Government of Nepal is supporting the

introduction of more qualified health service providers at the community level to address barriers to family planning use, especially among marginalized communities.

The USAID-funded FACT Project, implemented by the Institute for Reproductive Health at Georgetown University (IRH) and Save the Children, was a five-year project (2013-2018) that aimed to foster an environment where women and men can take actions to protect their reproductive health throughout the life-course. FACT tested interventions for increasing fertility awareness and expanding access to fertility awareness-based methods (FAM) to improve use of family planning methods and improve reproductive health outcomes. In Nepal, where access to and use of family planning services are influenced by both geographic and social barriers to the health system, FACT tested an approach to address unmet need for family planning among marginalized ethnic groups through household delivery of family planning services. In partnership with the FHD and DPHO within the MOH, FACT and the DPHO deployed RANMs in select communities of the Rupandehi District to provide family planning services at the household level.

FACT and the DPHO deployed nine total RANMs who were assigned to work in identified clusters of marginalized households across six Village Development Committees (VDCs) and two municipalities in the Rupandehi District. The intervention was implemented during a 15-month pilot period to test this service delivery modality as a possible approach to address the unmet need of family planning among marginalized communities in Nepal.

The FACT Project's introduction of RANMs is consistent with the Government of Nepal's policies around expanding equitable access to and quality of community level health services under the Nepal Health Sector Strategy 2015-2020 (NHSS 2015-20). Such a strategy also contributes to the "Reaching the Unreached Strategy" (RTU 2016-2030). The addition of qualified RANMs at the community level offers a significant opportunity to expand access to family planning and broader primary care services. Understanding how these RANMs contribute to universal health coverage will continue to provide important policy-level information.

How to Use This Guide

This guide describes the services provided by RANMs in the community and the process FACT undertook to implement the RANM intervention. The experience from the FACT Project, documented in this guide is intended to inform program designers and implementers who wish to deliver household-level services through RANMs in Nepal.

Specifically, this guide describes the package of services that was provided by the RANMs at both household and community levels. The guide also describes the implementation steps to achieve these activities, including hiring and training RANMs, conducting community assessments, and creating linkages with health facilities. Finally, additional orientation and implementation tools are available in the Annotated Resource List in the annex.

RANM Model Overview

FACT based the RANM intervention model on a community-nursing approach, where nurses define and address health needs at both individual and community levels. Each RANM was from the community where she was stationed to carry her functions. The RANMs received the same training that ANMs based at the health facility receive in Nepal. To begin their work in the community, each RANM conducted an initial household needs assessment as part of a larger community assessment. The assessment helped to identify households not currently being reached by the health system for

health services and helped to introduce each RANM to her community, thereby developing trust and engaging community leaders to help assure the community's health needs were met. The household needs assessment was critical in helping the RANMs prioritize and monitor the needs of her clients, including the direct services she could provide to them and referrals to the health facility.

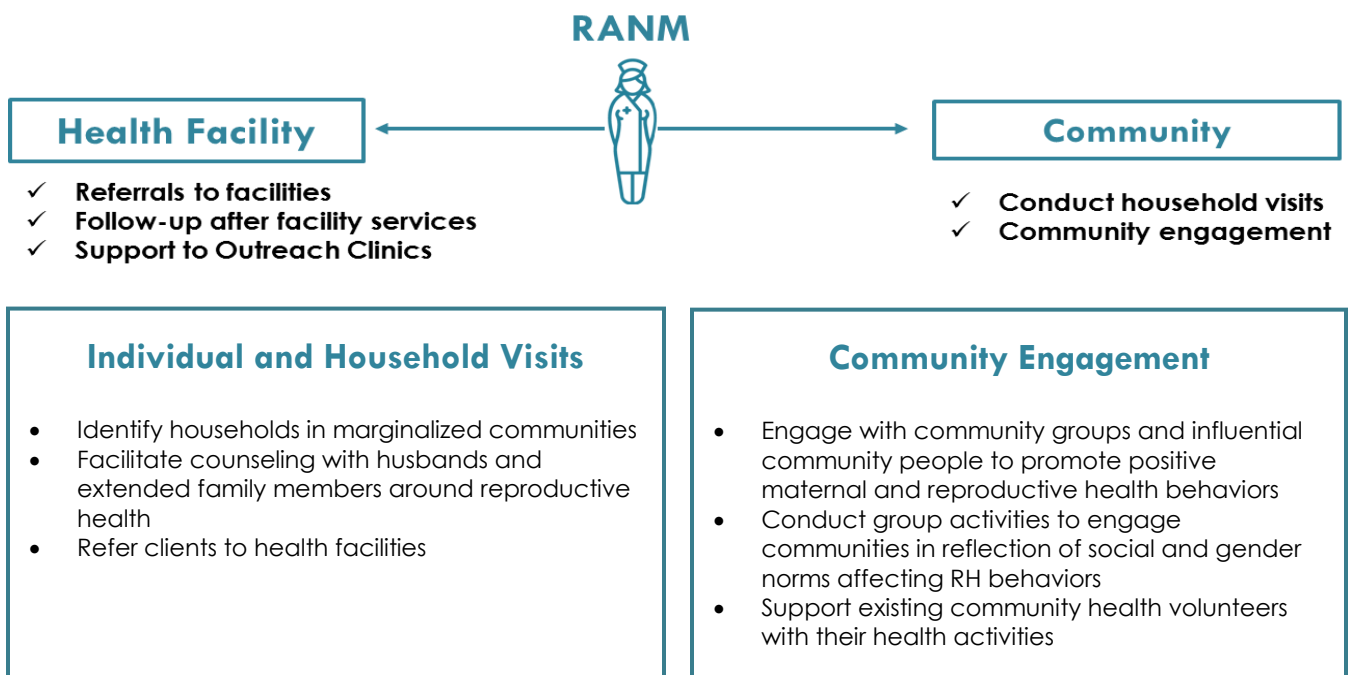
By providing a range of individual services in the home, as described in Table 1, the RANMs were able to expand access to routine health services for marginalized households and provide a link to the health system through providing referrals to the health facility where needed. The RANMs were also able to involve spouses and extended family members – where appropriate – in education and counseling discussions. This was particularly helpful in addressing some of the social and gender barriers that women in these marginalized communities face in accessing and utilizing services.

By providing services in the home, the RANM has an opportunity to provide maternal and child health services as an “entry point” for providing comprehensive family planning services in the “unreached” households. Addressing these other health needs builds trust; thus, allowing the RANM to address the more sensitive family planning and reproductive health service needs. The RANMs were also able to expand their reach and influence by building relationships with local community groups, community stakeholders, and influential community members to create an enabling environment for behavior change.

Figure 1: Map of Nepal



Figure 2: RANM Service Delivery Model



The RANM Service Delivery Package

The RANMs delivered a package of services that included individual and family services at the household level, complemented by health promotion and community engagement activities in the community where she was working.

Table 1: RANM Household and Community-Level Activities

Individual / Household Services*	Community Activities
<ul style="list-style-type: none"> • Family planning counseling, referral, and family planning method provision (condoms, oral contraceptive pills, injectables, SDM, and LAM) • ANC counseling, postnatal, and newborn care • Child nutrition assessment and counseling • First-aid treatment and referral • Referrals to health facilities as needed <p><i>(All counseling included spouses and extended family members when appropriate)</i></p>	<ul style="list-style-type: none"> • Collaborate with and support FCHV • Conduct outreach to informal and formal groups with Pragati games and health promotion discussions particularly targeting men and youth • Engage influential people to promote and support RANM activities

Household Services

The RANM intervention initially prioritized the doorstep delivery of family planning services as part of the RANMs' services, including counseling and provision of family planning methods (condoms, oral contraceptive pills, injectables, and SDM). RANMs also provided health information regarding fertility, menstruation, and maternal, newborn, and child health (MNCH). After the RANMs started to conduct their household visits to provide family planning services, families began requesting additional services, particularly for sick children and first aid services. They recognized the benefit of having a skilled provider in the community and appreciated the access to services closer to home.

Recognizing the significant unmet need among marginalized households for all health services in general, the FACT Project, working with the FHD & the DPHO, expanded the scope of the RANM service delivery package to include additional MNCH services. In all cases, referral to the health facility for services and treatment was emphasized, especially referrals to promote facility deliveries. The details for each individual service are listed in Table 2 below.



Additional resources used by RANMs as part of their toolkit are available in the Annotated Resource List in the annex, including guidance for MNCH, providers and picture codes used during interpersonal communication activities.

Table 2: RANM Service Delivery Package

<p>Family planning</p>	<ul style="list-style-type: none"> ▪ Counseling on and providing pills, condoms, SDM, LAM and injectables, based on the balanced counseling approach ▪ Supplying management and waste disposal, as agreed with the health facility ▪ Engaging with husbands and in-laws and conducting couple counseling, when possible and as appropriate ▪ Referring for long-acting and permanent methods, and/or side effects management at the health facility ▪ Following up with discontinued clients
<p>ANC</p>	<ul style="list-style-type: none"> ▪ Conducting at least two ANC visits to pregnant women, with husbands and extended family present when possible, to provide counseling and education on: <ul style="list-style-type: none"> ○ What to expect during pregnancy, healthy behaviors during pregnancy, and education on danger signs throughout pregnancy and post-partum ○ Maternal nutrition ○ Birth preparedness ○ Breastfeeding and essential newborn care ○ Family planning ▪ Conducting physical exams: including blood pressure, fetal heart tones, and checking for danger signs ▪ Referring to health facility for complications, ANC checkups, and for delivery ▪ Discussing how social and gender norms can influence pregnancy and newborn care outcomes
<p>PNC & newborn care</p>	<ul style="list-style-type: none"> ▪ Conducting home visits for the second and third PNC visits and provide care, including physical examination and counseling on postpartum danger signs, including fathers when possible ▪ Promoting postpartum family planning (PPFP) ▪ Providing and counseling on essential newborn care and breastfeeding ▪ Identifying postnatal and neonatal danger signs and timely referral for newborn or maternal illnesses
<p>Nutrition Counseling</p>	<ul style="list-style-type: none"> ▪ Measuring middle upper arm circumference (MUAC) measurements for under-five children ▪ Providing nutrition education ▪ Referring to the health facility for additional follow up when concerned
<p>First Aid / Illness consultation</p>	<ul style="list-style-type: none"> ▪ Being the first point of contact with acute first aid or illness concerns ▪ Assessing and making referrals to health facility as needed

Community Activities

Community engagement (including male engagement) in reproductive health can leverage shifts in reproductive health behavior by enhancing diffusion beyond the points of direct contact between the RANM and individuals, as well as by encouraging shifts in social and gender norms through public reflection at the community level. The RANMs used four principal strategies to achieve broader engagement and diffusion in the communities where they worked.

- **Collaborating with FCHVs:** In each VDC, the FCHVs and RANMs formed a health team in the community to create demand for services and meet the immediate health needs of community members. The FCHVs assisted with introducing the RANMs in the community, identifying priority households, conducting group education sessions, particularly through their Health Mothers' Groups (HMG) meetings, conducting health promotion activities, and referring clients to the RANMs. The RANMs, in turn were able to provide health technical support and credibility for FCHV activities.
- **Conducting education sessions at outreach clinics:** As part of their routine outreach services, facility-based health providers often conducted primary health care-outreach (PHC-ORC) and immunization clinics in communities where RANMs worked. These outreach clinics offered an opportunity for the RANM to provide health education and to conduct Pragati games, resulting in increased visibility and integration of health activities at the community level. The success of this integration depended on active partnership between the health facility management and staff, and the RANMs in their area.
- **Organizing formal and informal group education sessions:** While the FCHVs focused on conducting health activities through their HMG meetings, the RANMs took opportunities to provide health education wherever people gathered to play games to encourage discussion about maternal and reproductive health. This enabled them to reach youth and men who participated in community groups.
- **Engaging influential people:** Influential community people, when effectively identified and engaged, can facilitate access to marginalized households and can promote desired attitudes and behaviors by using their social influence to role model and encourage change. The RANMs were encouraged to engage influential people in their activities to facilitate their assimilation into the community and to garner support for their community activities. It was difficult to implement this strategy consistently across contexts and with different RANMs, but it was possible when RANMs were supported by FCHVs or staff from health facilities whom the community trusted.



Additional resources, including guidance for male engagement and for engaging influential people, are available in the Annotated Resource List in the annex.

Pragati and RANMs

This RANM intervention was implemented in select VDCs and municipalities in the Rupandehi District. Six of the VDCs had a simultaneous fertility awareness and family planning intervention called Pragati occurring under the FACT Project. The Pragati intervention consisted of the implementation of community games to improve fertility awareness, to address family planning information gaps – particularly around misconceptions and side effects - and to encourage discussion around social and gender norms that influence family planning behaviors. The Pragati games offered a platform for interactive learning and reflection, encouraging youth, men, and women to participate. As part of their work, many RANMs implemented Pragati games to promote family planning use, to engage with community members, to build rapport, and to provide health information to the community. Although an important tool for RANMs under FACT, the games are not an integral part of services for future RANM interventions.



More information on Pragati is available at:

irh.org/pragati-fertility-awareness-games

Implementation and Deployment of RANMs

This section covers the essential program implementation components of the RANM intervention and describes how activities were tailored to the requirements of the RANM job:

- Hiring and training
- Carrying out a community assessment
- Expanding services
- Linking with community stakeholders
- Linking with health facilities
- Reporting

Hiring and Training

Prior to the actual hiring process, the FHD and the DPHO worked with FACT to agree on a job description, to share the expected scope with the family planning sub-committee, and to develop a funding mechanism for the DPHO to hire the RANMs with FACT funds. These were outlined in a Memorandum of Understanding (MoU) that all parties agreed to.



Additional resources, including job descriptions, orientation and training materials, and counseling tools are available in the Annotated Resource List in the annex.

The hiring of the RANMs by the DPHO was part of an effort to integrate RANMs into the health system as specified in the MoU. The RANMs' direct supervisors were the in-charges from their respective health posts. In addition to funding the positions, the FACT Project also provided technical support in defining the RANM role and activities, and in providing essential capacity building. However, this model led to the health facilities lacking ownership for the RANMs and the RANMs feeling that they did not belong to either the DPHO system or to Save the Children's organization. There was also a tendency for some health facilities to appropriate RANM availability to assist with facility service delivery – which was not part of their role. This was hard for the RANMs to resist because the health facilities were paying and supervising them. For future interventions, more engagement by the DPHO and the local government bodies, and/or a more direct funding stream might resolve some of this ambiguity.

From conception, the project sought to recruit trained Auxiliary Nurse Midwives to provide door-to-door family planning services for marginalized households in the project's intervention sites. As such, preference was given to candidates who were from the local area and spoke the local language. The RANMs were also expected to live in the communities where they would be working. This proved a challenge and exceptions (most often related to language) were made where there were no local ANMs. Priority was given to ANMs in nearby clusters, and in one case an RANM was to live outside her catchment area as she took responsibility for her own transportation to her community. Later on, the project also equipped RANMs with bicycles so that they could travel easily within their catchment areas to conduct their activities.

The FACT Project placed emphasis on developing the RANMs' capacity to function in expanded and more independent roles outside of the traditional facility structure. This required significant resources in trainings and supportive supervision. Other implementers may want to adjust and adapt the attached training materials according to their specific project needs.

The trainings and orientations for the RANMs included:

- **National Comprehensive Family Planning (COFP) and Counseling Training** – The COFP/counseling is the national standard family planning training curriculum for MOH service providers. This is an eight-day competency-based training that emphasizes counseling, informed choice of all family planning methods in the MOH family planning program, and provision of quality family planning services. The curriculum also included the Standard Days Method, which was newly added to the COFP/counseling.
- **Two-day orientation on the RANM roles and responsibilities** – With the recognition that social and gender norms significantly influence reproductive health behaviors and family planning use, particularly among the target marginalized groups, it was important that the RANMs understand and be able to use the Pragati games as part of their community-level activities. In addition to learning about the Pragati games, this orientation also included a review of the RANM roles and responsibilities; how to collaborate with the DPHO structures and health system; how to mobilize and engage communities to improve reproductive health; and data reporting. Family planning logistics management and needle disposal were also important, since the RANMs were providing Depo-Provera injections at the household level. If the Pragati games were not included in the RANM role, the orientation schedule and content could be adapted.
- **Refresher Training on community MNCH services and social norms** – Once the FHD and the project decided to expand the scope of the RANM service delivery package to include additional health services beyond family planning, there was a need to provide additional refresher training, particularly for MNCH. Effective coordination of pregnancy care with the health facility was emphasized during the training as certain visits within the recommended routine series of ANC visits must be conducted in the facility, and mothers receive financial incentives for attending routine ANC visits. In addition to ANC, the training content also included the provision of pregnancy-related counseling, newborn care, nutrition assessment and counseling and PNC including postnatal family planning counseling. With respect to social norms, male engagement during pregnancy and with newborn care was encouraged by including husbands of clients during ANC and PNC counseling visits. The project developed picture cards that RANMs could use during counseling to spark conversation around gender roles and promote couple communication. As the decision to expand RANM services was made after RANMs had received their COFP/counseling training, this content had to be included in a separate training. For future implementers, this training could be integrated with the COFP/counseling training as one event.

Community Assessment and Development of Client Logbooks

The project's formative research and consultative meetings helped to identify the marginalized ethnic groups who were not accessing existing health services within the intervention area and where they were located. Project staff engaged local leaders, key stakeholders, and DPHO / health facility staff to map areas with the highest concentration, or "clusters" of marginalized communities. These suggested communities were validated by on-site visits and then finalized as "marginalized clusters." Based on the identified marginalized clusters, the number of households within a



Additional resources, including the household needs assessment tools, and client logbook and how to use them, are available in the Annotated Resource List in the annex.

cluster, and the distances between the clusters, the total number of RANMs was determined. In one VDC, it was possible for one RANM to cover two clusters while in the urban areas more than one RANM was needed (for example, in the Butwal Municipality). While the clusters needed further adjustment as the project proceeded, these clusters became the catchment areas assigned to the RANMs.

Before deployment in their household clusters to provide services, the RANMs conducted a community assessment, including a household needs assessment in their clusters. This facilitated their becoming familiar with the target community and developing trust within that community.

Community Assessment

After a community-level introduction from the local Health Facility In-Charge (HFIC), the RANMs conducted a household needs assessment – requiring them to visit all households within their identified clusters. The goal of this assessment was to identify the houses and groups with the highest need for family planning and health services so that the RANM could prioritize her services and other activities. The assessment process had the added benefit of allowing the RANM to become familiar with her target area and to build relationships with households.

The RANMs used a household needs assessment guide and tool to collect data on their beneficiaries, which included ethnicity, occupation, number of children, and source of health care. The assessment also included data on family planning use and barriers to use. Finally, the assessment also identified households with migrant husbands and the duration of time during the year when their husbands were away from home. The household needs assessment of pregnancy status and MNCH care-seeking was conducted at a later time, after the project expanded the scope of the RANM service delivery package.

As part of the wider community assessment, the RANMs also conducted meetings with the FCHVs in their cluster areas and began identifying influential people and groups in the community with whom they might collaborate. While engagement of these groups was central to the overall RANM model, it would have benefited from a more structured and purposeful assessment in this early assessment phase. These engagement activities were reinforced through coaching and supportive supervision of the RANMs, encouraging continued collaboration in the community.

Systematic Identification of Influential Groups and People

While untested in this project, the identification of influential community members and groups can be conducted through social network mapping.

Essential elements include:

- Identification of influential people through a “snowball” process, asking a range of community members who they consider to be influential in their lives and in their community, and asking the same question to those “referrals”. Eventually, certain individuals will be identified by multiple people.
- Identification of significant groups in the community through focus group discussions. Information can be validated through discussions with multiple groups of community members (women, men, youth, teachers, etc.). Care should be taken to avoid assuming that the largest or most formally recognized groups are the best groups for diffusion – although they may be.

Management of a Client Logbook

The individual household information collected through the household needs assessment led to the identification of priority households for follow-up, based on unmet need for family planning and health services.

The Client Logbook was developed as a tool for the RANMs to track:

- households and clients
- clients' health needs
- services provided
- plans for follow-up services

As new client or household needs were identified (such as new pregnancies), RANMs added these updates to the Client Logbook and service tracking. The RANMs' Client Logbook was designed to help RANMs monitor their clients through the continuum of care from household to facility-level referrals.

The Client Logbook was also used for work planning and community activity tracking. The RANMs used the Client Logbook to develop monthly work plans based on the health needs and priorities they identified, and tracked community and group activities. All RANM activity data was compiled monthly and submitted for the health facility and project monitoring staff. All service-delivery data (particularly MNCH and family planning) was integrated into the district health management information system (HMIS) through entry of their data into the health facility family planning and MNCH registers.

Lists of all households and their family planning status (users, non-users, or unmet need) were entered into the Client Logbook. Lists were later expanded to include information on pregnant and postnatal women, under-five children, and migrant spouses. When preparing their monthly work plans, the RANMs updated all of these lists. The Client Logbook, thus served as a tool to prioritize and guide client follow-up based on the needs identified.

Table 3: RANM Logbook Sections

The Client Logbook, maintained by each RANM, includes:	
Client Records <ul style="list-style-type: none">▪ Monthly Individual client follow-up and group activities plan (work plan)▪ Contacts with influential people▪ List of clients from household assessment and family planning use and marginalized status▪ Pregnant women record▪ Postpartum women record▪ Under-five Child Health record▪ Migrant household record	Service Delivery Records <ul style="list-style-type: none">▪ Individual activity sheet▪ Group activity sheet▪ Coaching & Mentoring with FCHVs and promoters▪ Contacts with influential people▪ RANM field activity list

Implementation of Expanded Services

While the package of RANM services at the household level has been elaborated in previous sections of this guide, there were several programmatic considerations in the delivery of these services that future program implementers should consider.

Maximizing the benefit of the RANMs through expanded services

As mentioned previously, it became clear early on that the community demanded more than family planning services. In addition to extending the reach of the health facility and facilitating access to services for the community, provision of these services also offered less sensitive “entry points” for introducing family planning discussions. Pregnancy care was a particularly useful platform for opening these conversations and allowed husbands or in-laws to learn about maternity and newborn care along with the mothers. The provision of preventive health and MNCH services in the community also helped build trust between RANMs and their beneficiaries, making it easier for them to enter homes and discuss sensitive reproductive health topics that are traditionally taboo topics to discuss with “strangers” among marginalized ethnic groups. By the end of the project, the majority of the services requested by the community from RANMs were family planning and pregnancy-related services.

One of the challenges, given the general appreciation for local service provision was to prioritize and justify the provision of these services for marginalized households that they would otherwise not have access to due to cultural or geographic barriers, without slipping into providing home services for everyone. More rigorous use of the Client Logbooks to monitor actual need and when needs may have been met would help guard against this risk.

Use of picture cards to encourage reflective discussion

An important component of household-level service delivery was the opportunity to talk with women, their husbands, and sometimes extended family members. The RANMs used these opportunities to discuss gender and family roles that influence reproductive health behaviors and maternal health outcomes. Particularly in relation to pregnancy-related care, the RANM used a series of picture cards to spark these discussions – identifying one or two picture cards or topics for each visit. Examples of picture cards that were developed are shown below.



Additional resources, including the ANC and pregnancy picture cards, along with guidance for their use, are available in the Annotated Resource List in the annex.

Figure 3: Husband attending birth



Figure 3: Husband helping with care of infant



For each figure, the following three questions were used to guide discussion:

- What do you see here?
- Is this something you might be able to do? Why or why not?
- What might the community think if they knew you or your husband were doing this?

Linkages with Community Stakeholders

Engaging Men

Recognizing that men are often key decision makers in the family, as well as key reference groups who uphold social norms more broadly, the FACT Project sought to include men in conversations about family planning and reproductive health with their wives, family members, and peers whenever possible. These discussions occurred most often through the RANMs' home visits, as well as during community and group activities. By engaging men, the project aimed to influence both family planning use and the social and gender norms associated with reproductive health behaviors. However, given the number of absent men and husbands in Nepal due to work migration, it may be important to better adjust the strategy to also reach migrant men.

A few parameters guided the project's male engagement strategy:

- The goal for involving men was to encourage more equal conversation and participation of couples together in decisions related to family planning use, not at the expense of women's participation and voice.
- Consistent with the "reflection and action" approach to social and behavior change, the Pragati games encourage men to explore and reflect on gender and social norms as well as reproductive health issues with their families, peers, and in their communities. While the Pragati games are not an essential component of an RANM service delivery model, the FACT Project found that the integration of the Pragati intervention into the RANMs' services helped expand their reach in communities.

Engaging influential community people

The primary role of influential community members was to enhance the acceptance and diffusion of new ideas and behaviors in their communities. Working with the RANMs, influential community members encouraged and modeled learning about and discussing reproductive health topics, and participated in community discussions around the social norms and acceptability of family planning use. They also helped the RANMs identify households or groups who needed their services, particularly among marginalized groups.



Additional resources, including guidance on male engagement and working with influential community people, are available in the Annotated Resource List in the annex.

It is important to note that influential people may have had positions of power or titles in the formal structure; but often, they were people with informal power or social influence. These were people who influence others through their charisma, leadership, or "who they are" without necessarily holding formal positions in society. The project made efforts to identify these informal leaders as allies and partners in the community to serve as champions of reproductive health. While the project served to spark their interest and enhance their capacity to advocate for positive reproductive health behaviors, they themselves developed their own roles in the community and dictated their own engagement with RANMs. In the spirit of social norms change through reflection, the project

did not recruit leaders to do prescribed activities, nor to transmit top down messages about reproductive health and family planning use.

Community Platforms

Using their credibility as trained health professionals with a leadership position in the community, the RANMs served as catalysts for reflection and social change within their communities. Both the Pragati materials and the supplemental picture cards in the ANC materials enhanced the social and gender norms components of their work. Their strength was in their ability to reach across stakeholders, providers, clients, and community members with reproductive health knowledge, service provision, and discussion of social and gender norms.

As described earlier in this guide, the RANMs took responsibility for coordinating and supporting a variety of health activities in the community led by other community stakeholders, such as the FCHVs. The FCHVs referred clients with family planning and health needs to the RANMs and the RANMs often supported the FCHVs during Pragati game sessions or other group education sessions. Additionally, the outreach clinics conducted by the local health facility offered an opportunity to reinforce the links between the RANMs and the formal health system. In addition to their mobilization efforts with other community leaders and stakeholders, the RANMs also worked through other informal or formal groups that may not have otherwise been reached (such as adolescents or men) through existing community platforms.

Linkages with Health Facilities and Reporting

The RANMs under the FACT Project were hired and supervised by the DPHO health system that covered their cluster areas, even though RANMs' salaries were supplemented by the FACT Project. This structure had the advantage of having their position integrated within the formal health system for future sustainability, as well as reinforcing the links between the community service provision and services provided at the health facility.



Additional resources, including a RANM Supervision Checklist and guidance for effective supervision, are available in the Annotated Resource List in the annex.

Data collection and reporting was an important aspect of the project, as the DPHO wanted to ensure that the RANMs' services were incorporated into their data monitoring system. RANMs reported all of their activities through the Health Management Information System (HMIS) at the facility, and they referred clients with health problems, for deliveries, or for facility-based family planning methods (such as LAM or permanent methods) to the health facility for services. The RANMs reported at least twice a month to their respective health facilities to submit data from their Client Logbooks to the facilities and meet with the HFIC and participated in the monthly FCHV meetings coordinated by each health facility. To varying degrees, the HFIC also monitored the RANM Client Logbooks and work plans.

In addition to supervision and reporting, the health facilities were also part of the supply chain system for the RANMs' medical and family planning supplies. These included not only family planning methods, but also basic primary care and ANC care supplies. These commodity supplies were monitored on a monthly basis.

While it was challenging at the beginning, both health facility staff and RANMs themselves learned how their respective activities complemented each other to the benefit of the community. However,

there was a range in the level of mutual appreciation among health facilities and RANMs. Challenges the project faced included the ambiguity around whether the RANM “belonged” to Save the Children or the DPHO, a tendency for referrals to go towards the health facility but not from the health facility back to the RANMs, and clarification that, while the RANMs were part of the health facility “system,” they were not there as an additional human resource for facility-based services.

Adaptations and Learning

As previously mentioned, this RANM intervention was a pilot intervention that made various adjustments during the course of implementation. The most significant of these was the expansion of health services offered by the RANMs addressed in the Service Delivery section above.

Others included:

- Reinforcing the RANMs' Client Logbook as a case management tool
- Addressing needs at the household level
- Adjusting for an urban setting
- Recognizing the unique value added with the RANM role

Case Management

As the RANMs became more familiar with their role and priorities over the course of the project, they increasingly recognized the importance of the RANM Client Logbook as the primary tool to help them systematically prioritize and organize their work. The concepts of “caseload” and “case management” were relatively new and needed reinforcement to avoid slipping into offering services on an ad hoc basis without consideration for priority or resource allocation. Daily record keeping in the Client Logbook was emphasized to help their planning. RANM monthly “cluster meetings” were held to review the RANMs' activities, to review how their services and activities were reflected in the Client Logbooks, and to aggregate data for the project monitoring system from the RANMs' Client Logbooks.

Addressing Needs at the Household Level

As previously described, one of the RANMs' strategies to address social norms that influence reproductive health barriers was through playing Pragati games in communities and in smaller groups in homes. Beyond this, the set of picture cards used during ANC was key to opening similar gender role discussions at the household level. The RANMs' counseling on SDM also strengthened their “toolbox” for offering alternative ways to think about fertility and family planning. In addition to involving husbands and in-laws in reflection discussions with clients, home-visits were also an opportunity for RANMs to provide personalized, respectful care to women who may otherwise be discriminated against in facilities. The RANMs found that the ability to offer services at home addressed needs for confidentiality and privacy that might not be met when people have to publicly seek services. This was particularly true because some of the RANMs were not from the communities where they worked, so clients often felt that they could trust the RANMs with keeping their information confidential, compared to FCHVs who are from the community and know clients' family members.

Urban Strategy Adjustments

Based on the early marginalized identification, three of the RANMs in Rupandehi were assigned to two urban municipalities, specifically in slum areas. In the urban context, the RANMs found it necessary to be creative and flexible in their strategies for reaching people and groups since people spend less time at home and the majority are working for daily wages, making it more difficult to

mobilize them for either home visits or group activities. As alternatives to home visits, RANMs met people at work sites such as the river where people dig sand and the brick foundry. Conversely, during times when people were more often at home, such as in the winter, the geography facilitated rapid coverage through home visits since houses were close together and easy to access. In both cases, the concentration of people allowed for larger caseloads.

RANM Appreciation of Their Role

Over the course of the project, the RANMs grew to appreciate the breadth and independence of their role. They appreciated the combination of theoretical and practical knowledge, and the systematic way of working that they learned from managing Client Logbooks. They appreciated the opportunity to adapt to different social and cultural settings, and to work at different levels, from the individual woman at the household level to collaboration with community leaders and health facility staff. As the RANMs felt increased appreciation for the role, the project was also able to encourage them to expand their responsibilities and reach.

Evaluation Results

Final evaluation results for this intervention have been analyzed and presented [in separate reports](#). However, routine monitoring data indicate that the RANMs were successful in:

- Identifying, targeting, and reaching marginalized people and households, or those not otherwise accessing health services, in their communities. Approximately 80% of their clients were among the marginalized groups of the area: Dalit, Madeshi, or Muslim.
- Collaborating with FCHVs and health facility staff to promote health activities at the community level. As the RANMs gained entry into the marginalized communities, the proportion of contacts among those individuals increased dramatically.
- Encouraging FP use. Women in the RANM sites were 2.6 times more likely to be using FP methods than women in the control communities, and 3.3 times more likely to intent to use an FP method in 3 months.
- Distributing a range of family planning methods, including SDM and Depo-Provera, which was especially important for those who face cultural barriers to seeking facility-based family planning services
- RANMs' "whole family" approach enveloped men and in-laws into the conversations, increasing fertility awareness and providing opportunities to reinforce accurate information in the communities. This approach was particularly relevant for antenatal and postnatal care visits that included specific methodologies for male engagement.
- Carrying out a combination of household and community activities in order to enhance their reach and impact. As RANMs worked longer in communities, their contacts became younger, suggesting an increased acceptance in the communities and a potential opportunity to reach adolescents.

Conclusions and Recommendations

The RANM intervention in the FACT Project was successful in reaching marginalized households – and those not accessing health services – with family planning and MNCH services. It did this through a combination of home visits prioritizing marginalized households and community activities mobilizing influential people and groups to expand conversations around social norms and reproductive health. There were, however, challenges and gaps that require more exploration.

Caseload Management

The identification and application of consistent criteria for identifying, prioritizing, and retaining marginalized households for caseload management and follow-up was challenging. Caseloads ranged from 150 to 440 households across RANMs, with larger caseloads in urban areas. Within these caseloads, the majority of RANMs managed to visit approximately 150 households per month. Where visit numbers were high, they tended to be group visits, often in the urban slum areas. RANMs generally acknowledged that there were households in their caseloads that they considered as not needing their services. A process for rotating households into or out of the RANMs' caseload based on changing needs also needs to be developed.

Maximizing Collaboration and Links between RANMs and Respective Health Facilities

As identified in the implementation section above, the different roles of Save the Children, MOH/health facilities, and the RANMs were problematic. This may resolve itself once an NGO entity is not between the RANM and the MOH; however, if outside support continues to be part of the strategy to expand RANM interventions in Nepal, further attention to the work planning and reporting, cross-referrals, and sense of mutual responsibility and teamwork will be needed. The health facilities are essential for the support of the RANM structure in the long term and their ownership over developing and maximizing the RANM role needs to be cultivated.

Another health facility element that needs further consideration is the inclusion of husbands in the provision of pregnancy and delivery care. If the RANMs are encouraging men to be more involved in the care of their wives and babies during pregnancy and the postpartum period, the health facilities also need to be welcoming of husbands' participation during pre-natal care and in labor wards. If male engagement in family planning and pregnancy care services is a priority, more consideration of a long-term strategy may be required.

Urban Strategy

While the municipality-based RANMs creatively explored different options to effectively reach and engage couples and households in accessing essential health care, there is still a lot to learn about using this model in urban settings. This exploration will benefit from joint problem-solving between the RANMs and their respective health facilities, as the health system structure in municipalities is different to that in the rural VDCs.

Understanding the Cost-Benefit of RANM Services

This project does not answer questions around the cost-benefit of these household-level services. As a rights-based approach, consistent with MOH policy, this model appears to be an effective intervention of reaching marginalized communities. However, it falls short of clarifying when RANM services may be essential for health, and when they may slip towards a “high-end model” for routine service delivery.

Annex – Annotated Resource List for RANM Implementation Guidance

The following resources can be found at:
irh.org/roving-auxiliary-nurse-midwives

The tools listed below were used in the RANM pilot program in Rupandehi. They include items to help plan an RANM intervention, implementation guidance and promotion.

Pre-implementation planning

- Example of RANM job description in Nepal
- Guidance for effective supervision
- Supervision checklist

Training

- Initial RANM orientation
- The Nepal Comprehensive Family Planning (COFP) curriculum
- RANM refresher orientation (includes sections on MNCH and social norms)

RANM caseload development

- Household assessment tool
- Using data from the household assessment
- Using household assessment data for programming
- Developing and using the RANM Client Logbook
- RANM Client Logbook

Guidance documentation and materials

- Guidance for Male Engagement
- Picture cards and their use during pregnancy care visits
- Strategy for Engaging Influential People
- Guideline for community maternal and newborn health services

RANM intervention results and promotional material

- RANM research brief
- SDM research brief
- RANM services infographic (previously displayed in target communities)