**Field and Interview Note**

Field worker: OC

Interviewee: KB

Note Taker: OC

Note Checked and Edited by: JS

Language of Interview: Nepali/English

Note Transcribed by: OC

Place: Ground floor, Marajgung Nursing Campus, IOM

Time: 10:30 -11:30 AM

Date: 29 July 2015

***Context:***

*After couple months of the earthquake hit the county, I arranged meeting with Kiran Bajrachharya, professor of Nursing and president of Midwife Society of Nepal (MIDSON) as per the recommendation from research team, especially from Radha Adhikari and Jeevan Shrama. The primary purpose of this meeting was to have better understanding on impact of earthquake on maternal child health sector. Furthermore, we were more curious to know what sort of initiatives/actions MIDSON was taking to tackle with the problems, who does it collaborates with, how it has been collaborating with Government Organizations (GOs) and Non-Government Organizations (NGOs), what are learnings, as well as the practical challenges and difficulties to move ahead in such catastrophic situation mostly by focusing on maternal and child health especially on rural Nepal.*

*This interview was arranged with prior appointment with Prof. Kiran through phone and Radha Adhikari provided cell number of Prof. to Obindra, and he made contact with Prof. Kiran. Interview was taking place in her office room and was recorded with her due permission, however it was verbal. The conversation was lasted for about an hour. There was slight interruption once/twice as her staff and students came to visit her for admistratve and logistic works to get done during conversation.*

*Although, meeting was scheduled for 10:00 AM, it did not take about half an hour later. Conversation went well.*

I reached to the Marajgung Nursing Campus, with help of location Prof. Kiran Bajrachharya, had provided me when I had telephone conversation with her in previous day. As I reached to the campus, a male security guard with uniform, asked me, why are you here? Who are you looking for? I answered to him that, I have a meeting with Kiran mam, she has asked to me to come to her office by 10:00 AM this morning, so I am here to attend meeting.

Write your name and address in the register placed there, indicating the registered placed in the table near the main gate. I did accordingly. The guard then, told further Kiran mam has not arrived to office yet, perhaps will arrive after 10:00 o’clock, you could wait her somewhere around. I asked him where her office is. He showed to me her office, i.e. located at the ground floor. The name of Prof. written in the door was helpful to know it. About 10:30 a middle aged woman with sun glass came through gate and guard inform that the same person herself as ‘Kiran Mam’. I followed her and greeted her and we went to her office.

As we reached to her office, she asked me to take sit on one side of chair put near the table in her room. Two chairs are placed in either sides of the table. She sat another side and we began to talk.

KB: Perhaps you have already collected/known the information about our organization through its website, in our country there is no midwife cadre, because nurses as working as midwives and of state has not provided the protected title but in other countries there are midwives. As you have come from Edinburgh (she thought I am from Edinburgh although I explained her that I am actually based in Nepal and work from Social Science Baha) there are midwives to deal with pregnant women and women issues. In Nepal neither there are midwife cadres nor is there separate midwifery education. So I, as a professional of midwife and professor of Institute of Medicine (IOM) I teach midwifery here, as my experiences in other countries visits, it (midwife) is a global need and nurses are working as midwives in Nepal.

OC: why do you think it (midwife) system has not happened in Nepal?

KB: right from the beginning, 2013 VS, (1956 AD) from the history of Nepal, traditionally we have only two health cadres either nurses or doctors, we do not have midwife cadres, although we have assistant midwife, known as auxiliary nursing midwife (ANM) that is why we have met the bench mark. We do have midwives who have not met the international bench mark, now this a right time and it has already been late to address this issue. As we have felt that we need midwives in the country so we initiated/established association of midwives MIDSON back at 2010.

As I am a midwife professional/teacher and my colleagues who are nurses, working in maternity ward, labor room, antenatal care unit, they are supposed to be midwives, they must have the protected title of midwife, which state has not provided yet, nurses also work some of the work of the midwife but they are not fully midwives.

OC: if so, what is the difference between nurses and midwives?

KB: it is different, totally different, nurses are the nurses who carry out all the orders and treatments from the doctors and midwives are independent practitioners.

OC: so midwives are more independent than those of nurses,

KB: midwives are independent practitioners and they hold as friends of women during the reproductive period and midwives are expert for the normal birth.

OC: so the provision of skill birth attendance (SBA) training going on in Nepal is inclined toward midwife then?

KB: not, skill birth attendance training is life saving skill, it is an additional skills and it is actually a task shifting. Globally, doctors, human resources are very less, so that it is for task shifting of doctors to the nurses. Some of the skills or authorities of doctors have transferred to the nurses, so that mothers and new borns could be saved under safe motherhood programme that is why this SBA training has provided to health workers.

Although, our colleagues have received SBA training and have been working a lot, state has not been able to called them (SBA trainers) as midwives.

OC: should there be separate provision?

KB: what should we do from now onwards is, as we know, nursing and midwife are separate professions, nurses deal with the other clients and midwives deal only with girls and women’s issues and special focus is on pregnancy and during and after the child birth. Also care new-born and counsel on family planning. As we came to about all this information regarding duties and responsibilities of midwives, we initiated MIDSON in Nepal so that we can raise our voices for the need of midwives in the country.

OC: and then, perhaps in long run you can establish midwives.

KB: yea, in the long run we are going to start the midwifery education and in the long run the midwives carders will be developed for the country, and we will be focused on developing cadres. This is global agenda and issue too. Midwifery preparation is different, this category is put within the nursing also try to develop as separate category as well. In this regard, we are behind than other countries among Asian. If we see it in the context of Asian countries, lesson learn from European countries and other developed countries, where maternal mortality is very low, in such places, how they have achieved? Some countries like Shri-Lanka, even in the Asia, we can imagine, there is very low maternal mortality rate (MMR) because they (Shri-Lanka) do have community midwives and *rammro* good referral mechanism.

Thailand is also lies in Asia, and maternal mortality rate is very low in Thailand too, why such things happen there is, because midwives are there in Thailand but in Nepal we do not have midwives, in India there are midwives, what they called ‘nurse midwives’. Maternal mortality rate is still high in India because they do not have separate midwifery cadres. And, Bangladesh, Afghanistan, Pakistan learnt the lesson and they already have started separate midwifery education and they have already produced these cadres. So, Nepal still, it is behind, so MIDSON is raising the voice and lobbying with the government for the separate cadres of midwives in the country. So, this is what we are doing. The board of the MIDSON is to bring the midwifery cadres in the country. So right now, we are working with the government of Nepal because the government has already mentioned, they has been endorse the policy, ‘Safe Motherhood Policy in 2006’ via under the Skill Birth Attendance (SBA) policy, the government of Nepal has adopted three categories of policies i.e. short term, midterm and long term. These things, we all should know. Under the short term policy, all the doctors and nurses should be provided with SBA training.

OC: which is last for ten months,

KB: no, not for ten months, it is last for two months.

OC: oh yes, it is last only for two months instead.

KB: yea, it is two months long training and it has been started from the 2007. So that nurses and doctors, could work to reduce maternal mortality and morbidities especially at peripheral level, that is why it is task shifting for short term. Still, this training is ongoing. Under midterm, government of Nepal is planned to…SBA is started from 2006, and ongoing training is not a joke, associated cost is obviously higher,

OC: it is going on across the country.

KB: across the country it is quite difficult, so that produced human cadres, for instance, doctors and nurses, if the SBA training course is designed under the syllabus of nursing and medical education it will be helpful in producing SBAs in parallel way and later we could phase out the SBA training. Therefore, midterm policy is more focused on introducing SBA in nursing and MBBS syllabus, but it has not significantly been successful as expected.

OC: Since when it (SBA) was incorporated in syllabuses?

KB: It was introduced from 2007,

OC: no, SBA,

KB: SBA training was introduced from 2006 in Nepal and from 2007 this training was introduced to doctors and nurses as in-service training.

OC: what I mean here is, since when SBA was introduced in syllabuses?

KB: It was introduced from 2007, also it went in parallel way both in training and courses (syllabuses), like you mentioned, but curriculum is now implementing, although students study the course on SBA they cannot use of learnt skills at practice, so aim of the curriculum is only met partially. After short term and long term policies, government of Nepal has also adopted long term policy, under this policy, government of Nepal has announced ‘to reduce maternal mortality and morbidities professional midwives are needed, so separate midwifery education will be started’ so that these midwives can take the leadership in the field of midwifery.

OC: has government said, from when it will start separate midwifery education in the country?

KB: yea, they mentioned that, once they have started the in-service education for the two months and they said that this education short term skill birth attendance training will run till 5 years. Five years from 2006. It is only for 5 years. The SBA policy was formulated in 2006 and training was begun from 2007 and should be over in 2012. By 2011 or 2012 it (SBA) should be stopped.

OC: but it is still going on,

KB: but it is still going on, and then what it has been mentioned in the policy is that this skill birth attendance will be replaced by the midwifery education. In long term strategy, it is written that SBA training is only run for five years and then it will be replaced by midwifery education, but still we are behind, slow.

OC: we are already three years behind right,

KB: yea, we are in 2015 now right, it is already three years delay. We are not been able to introduce midwifery education in Nepal so far. There are many issues and challenges behind, so this is why the MIDSON is here for working together with the government.

OC: what sort of role you will play from now onwards to work with government?

KB: that is why, our role is working together with government and we are the technical experts to bring midwifery education in the country.

OC: actually, what MIDSON does to provide technical support to the government?

KB: because the government do not (does not) know, what is midwifery? How the midwives will be prepared? Because we have been prepared midwives, we are untitled midwives, because we are studying, practicing, we have seen in the other countries how the midwives are developing? I have seen in Edinburgh/Scotland Royal College of Midwives, Gillian Smith, the president of college there, we are twin with the Royal College of Midwives UK, so I have visited all the countries, we know better, what is midwives; we are technically supporting to the government to bring the midwifery education in Nepal.

OC: so what sort of things are included in technical support?

KB: technical support is full of technical, developing the curriculum, developing teaching-learning models, developing guidelines, developing the regulatory mechanism, agitation for the council, regulatory mechanism is the council, who are eligible to provide the title? Who are not eligible? What is the gap with these nurses? How we can bring midwives cadres with these nurses? Whether we should convert these nurses into the midwives providing the additional training and skills? Like in the Sweden and UK they have these types of cadres, those who are interested to be midwives, the nurses can also go for the midwives with additional training and additional preparation. So, can it be replicated in Nepal? We have already seen the possibilities?

OC: did you do feasibility study then?

KB: we have done everything, everything,

OC: if so, what sort of result you are come up with?

KB: we have finished the feasibility, we have finished the draft curriculum for the separate cadres of midwifery, we have already finished teaching learning guidelines, we have already developed models, and we have worked out with Nepal Nursing Council (NNC), which is the regulatory body, located in Dhumbarahi. They are also, examining, how should midwifery be accredited? What are the guidelines? Who are eligible? Minimum requirement? Although, we have written everything.

Now we are waiting for the endorsement of it (midwifery curriculum) from the government of Nepal/Ministry of Health and Population (MoHP).

OC: it sounds like, MIDSON will take lead on technical aspect? Then what will be the role of government here then?

KB: the role of the government is to make endorsement of the syllabus, facilitating, and creating enabling environment creation. Creating conducive environment for things to get done, and lobbying and advocating with the other donor agencies such as UNFPA, WHO and GIZ, they are working with the government for midwife cadres.

OC: what their role is in this initiation?

KB: their role is to provide financial support, UN agencies, besides ICM, international confederation of midwives, it is in Netherland that is the president of 116 countries. ICM is also proving the guideline and everything that includes financial and technical support for Nepal, even though we are somewhat late. And, still the process is going on, we are moving very fast but unfortunately we faced the earthquake.

OC: yes,

KB: on 25th of April, (2015) so by this time we have stopped all the stuff of midwifery education and we have been involved in the relief, response, reestablishing and rehabilitation of the vulnerable groups, they are pregnant women, child bearing women and those who have already given birth, and those who are the neonates, and those of the women who are not at the age of child bearing but they also do have potentiality to bear child in the future in the society and the community also they have some reproductive problems. From right now we are focusing on them (reproductive age and problems group)

OC: what sort of things you are actually initiating to response or address these sort of problems of the groups?

KB: after the earthquake, immediately; after 72 hours, we just wait and watch (till 72 hours of earth quake) because we are not only health professionals but also victims of the earthquake, isn’t it?

OC: yea, we all collectively been through the same problem.

KB: yes, we were affected in a minor way in compare to those who lost their lives and homes, isn’t it? And after 72 hours of earthquake we felt somewhat secured then immediately we (MIDSON) started our relief camps.

OC: what did you do at first?

KB: We started the ‘Help Desk’ at maternity hospital, Thapathali,

OC: ‘Help Desk’ and then what did you do from there?

 KB: we counselled to all the pregnant women and their families.

OC: who counselled actually?

KB: we midwives, we ourselves, we ourselves sat on the premises of hospital by setting ‘Help Desk’. We had a meeting the director of maternity hospital.

OC: was it before starting your ‘Help Desk’?

KB: yes, it was before starting our ‘Help Desk’.

OC: what sort of things we discussed in the meeting there?

KB: and then we discussed about, we are going to give quality care to the pregnant women and delivery mothers, those who are helpless, those who have given the births, may have gone through many problems, in going to the homes, in this context, MIDSON counselled to those who are going to give birth but very scared of vising to hospital due to earthquake, so they are staying back at home, and their husbands have sent to the hospitals to get some advices, when do they should visit to the hospital? What should they do? Instead of pregnant women coming to the hospitals, by themselves, they send their husbands, family members and companion to the hospital and asked several questions to us. When should we visit to the hospital? What should we do? Although, my wife’s delivery date is still to come but she is complaining pain, and husband asked should we bring my wife to the hospital or not? They were afraid of bringing pregnant woman to the hospital. After listening to them, we did calculation and tried to find out whether she was in actual labor pain and or in false labor pain? Because of psychology or earthquake, these things also induced pain, so that we critically analyzed what was the exact cause of all the problems and then we counselled the husbands, their family members, and then we assured that if they need, we could visit to their homes, by knowing the locations, where is the locations?

OC: what were the things you commonly focused on while counselling to them?

KB: at the help desk, at first we tried to address their own curiosities and queries.

OC: what sort of curiosities they were coming up?

KB: as I mentioned earlier, they complained that, they are having pain, although their delivery dates are due and what should we do? in such case, Should we bring pregnant women to the hospital or not? Some other complained that, they gave birth to the child but they have problem after discharge from the hospital as their rented rooms are destroyed and homes are far away from the Kathmandu and they request, if they could find any possible options to stay after delivery from the hospital.

In another cases, pregnant women who are living in the (temporary) shelter homes mentioned that, they not only do not have any required medicine such as iron tablets as their houses were destroyed by earthquake but also not been able to make regular pregnancy checkup. And, we should distribute iron, calcium to them.

OC: did you do the distribution of all these medicines?

KB: yes, we did all these things.

OC: where did you get them?

KB: we brought on our won.

OC: MIDSON, bought them on its own,

KB: MIDSON bought them on its own because it has its own money, as society or an organization. We usually get money from membership, also we put our own money to do humanitarian service. We bought, some medicine, gloves and other basic equipment. And then, we distributed medicine to pregnant women for 15 days or a month, so that things will be gradually stable, and we just did educate them, counselled them and we reassured them, psychological aspect is very important. ……………………………her student came in between with file on her hand. I thought it was for approval of something. And she returned shortly.

KB: and psychosocial counselling to pregnant women is very important. Then, someone told us that we live far from the hospital and he waited for a long so we also arranged vehicle for those who had to travel along way. Some other told us that they were food having food from morning and feel morning we provided biscuits and juice for them.

OC: you mean, you tried to address the contextual problems emerged in that context, right.

KB: it was more like need based, it is like what was their actual need? We identified the need and intervened accordingly. We set up the ‘Help Desk’ at maternity hospital.

OC: how many days did ‘Help Desk’ last for?

KB: probably it was lasted for 15/20 days. We parallely run ‘Help Desk’ in the hospital and we thought of mobilizing rescue team immediately. As day to day newspapers reported that pregnant women and delivery mothers spending time on cold at *Tundikhel,* an open space in center Kathmandu mainly vulnerable group is having hard time there. As we came to about the poor condition of women from news, we went to the *Tundikhel,* with essential rescue team with first aid kit/bag.

OC: how did you form the essential team?

KB: we did not have any problem to form that essential team because we all of us are technical group. We formed the essential group out of our own colleagues, professionals then divided ourselves into different groups.

OC: if so, what sort of members were included in the essential team then?

KB: the essential team was formed out of the people like myself, a teacher. We as a teacher, involves in clinical with students so that we do have our skills, how to examine pregnant women? Plus, our members are from maternity hospital, we invite colleagues who work on clinical side and also to those who work in public health as well.

OC: how many people were there tentatively in an essential group?

KB: it was form out of five people. A team of five people visited to *Tundikhel* and we took permission from Nepal Army, as camp site were controlled by army. Behind Mahankaal, *Tundikhel,* right

OC: did you have to get permission from army?

KB: yes, we had to get permission from army and explained everything including our purpose of visiting the camp site. With due permission from army and their security support, we visited each and every tent set up there.

OC: to find out the condition of the pregnant and delivery women?

KB: to find how many women are there? How many newborns are there? And how many pregnant women are there? And how they are suffering? How many delivery mothers are there? While visiting each and every tent, some women were came to tent directly from hospital after giving birth to the child, some women said that they have been living under the tent from the last ten days without having proper bathing they also showed us discharge slip. See, neither mother received basic care nor did a child was bathe. That was the problem of the time. A mother and a child were stinky.

OC: bad smell came from them.

KB: yes, personal hygiene has not maintained there. They did not get chance to change. In that situation what we did was, immediately, this baby needs bath, because there was a chance of infection, we should examine all the things, we did new born examination, we bathe the baby and the we cured the umbilical cord of the baby by putting antiseptic. I have all the pictures of that in my laptop. If you like to see them, I can show them to you.

OC: OK. That would be nice.

KB: and then we also freely examined to mother as well. Also, we provided necessary drugs to mother as well such as antibiotic, when we talked about women, we analyzed all things after the birth. We know very well, what are their problems are, how is vaginal discharge? We also ask, what sort of water is coming? While we are asking those questions, if they were telling us stinking water is coming? What happen? Temperature should be examined? We called it puerperal infection, post-partum infection. After examining the temperature of her body as it was 101 F we referred that case. Then we came to know this is the pure infection, we then referred immediately because maternity hospital is nearby, and it is not far from the camp. And then another pregnant woman, who has expected delivery date in 2/3 days later. We examined her, fetal heart sound (FHS) is Ok, we told them, mothers felt happy as their baby is fine. There is machine called Doppler which helps in hearing the sound of FHS, when the sound of fetal heart comes from machine, we could see their happiness in their facial expression as well. The we counselled them about what should they do during delivery,

OC: you mean, going for institutional delivery?

KB: of course, institutional delivery is our priority. Because it is not nearby, from *Tundikhel* to maternity hospital. At the time we met such kind of women (pregnant and delivery) in 33 tents set out in *Tundikhel.*

OC: tentatively how many women were there?

KB: 33 tents means equal number women, i.e. 33.

OC: how many of them were pregnant/delivery?

KB: pregnant women, post-natal women, new born altogether, we found 33 women. Then, single visit is not enough for such condition. We came to about the needs of the women in our first visit/need assessment one which helped us to know which additional equipment should we need to carry with us then we did follow up visit.

OC: was it in the next day of your first visit?

KB: we did it next day. We did it continuously.

OC: how long did you continue for?

KB: we continued it for 5/6 to one week. As we thought it is going to be stable and we started similar work in next site immediately in MIDSON’s own capacity and logistic. We did it in Bhaktapur, Patan and various places of Kathmandu. And, we were busy doing such work for pregnant/delivery women at post-quake situation, government of Nepal invited (MIDSON) us in Reproductive Health (RH) sub cluster meeting held at Family Health Division (FHD) Teku.

OC: Dr. Pushpa Chaudhari is currently director of it.

KB: with Dr. Pushpa and Dr. Shilu. Then, we were engaged with government staff too.

OC: again we were doing lobbying with government.

KB: we had to lobby with government for collaborative work.

OC: what was your role there?

KB: As we were attending each and every meeting of government and UN agencies were willing to support. To implement the support of UN agencies we need local NGOs as partners. Then, we were invited.

OC: MIDSON was invited.

KB: yes, MIDSON was invited, and MIDSON was working with UNFPA right from the beginning of MIDSON, since 2010. UNFPA is our partner. And, UNICEF was also approached us after this earthquake to work collaboratively on mother and child situation. Doctors and focal persons of UNICEF asked us to ensure quality care for maternal and child health also deploy the staff as mothers and children are suffering in post-quake situation particularly in 14 affected districts.

In such situation, we did not want to decline the collaborative approach although it was challenging. And, we were working after 72 hours of earth-quake. As it was similar task, we immediately accepted the UNICEF’s collaboration.

OC: what kind of deployments did you begin then?

KB: As we agreed to work, we did formal agreement and submit proposal. Then, we did ‘onsite coaching’ on the staff of birthing centers, primary health care centers (PHCs) and districts hospitals especially, focusing on maternity care across 14 affected districts.

OC: what were the things that included in ‘onsite coaching?’

KB: ‘On site coaching’ included present emergency situation. How to deal with women? Psychosocial counselling, life saving skills, normal birth, anti-natal care, newborn care, how to do respectful women care? By including all above mentioned things, we prepared a package and we sent out our mentors to the affect area/communities.

OC: who were the mentors?

KB: all the mentors were SBA trainers, like us.

OC: you mean, teachers and health practitioners?

KB: yes, practitioners and teachers. We sent them to ‘on site coaching’. One group has just arrived to Kathmandu yesterday. They came to Rumjaatar from Okhaldhunga, they just arrived 11 o’clock last night. They suffered a lot. They were complaining like, the trail was too long, and it was rainy season, the road access was not good, they suffered. This is how things are moving ahead. It is very challenging, I appreciate my team.

OC: how was the combination of your team?

KB: teachers and practitioners are there in the team. Others are not allowed to involve in the team.

OC: are they all female in the team?

KB: all of them are female. There should be deployment of female to deal with the issues of female because of the cultural reason. And along with ‘on site mentoring/coaching’ we also deployed staff at most affected districts.

OC: what did those staff do? Or what sort of support did those staff provided at the place of deployment?

KB: we deployed the staff and their duty was to provide cure from the place of deployment, provide services, practice, as it was focused on disaster, we were more focused on psychosocial counseling and care and respectful care, and quality care to the women.

OC: can you please tell me about ‘respectful care’ briefly?

KB: respectful care is, the care that we have been providing so far is routine care. In the case Nepali practice, doctors and nurses are boss. As I learnt from aboard, the respectful maternity care means, any forms of violence should be not be there, such as physical and verbal. Instead, it involves good communication with women, women centered care, identify the need of women, touch to the women, to support, to counsel, to provide education. Women centered care, what are the problems of women? Such respectful maternity care, how to deal with women? How to do communication? All of these were included in ‘on site coaching’.

OC: Basically, these programmes were implemented only in 6 most vulnerable districts categorized by the government of Nepal.

 KB: we deployed staff/team in Dolkha, Rasuwa, Sindhupalchowk, Gorkha, place like Barkpak, epicenter of April 25 earthquake. Places of Sindhupalchowk like Chautara, Melamchi. We deployed 25 staff nurses in 6 districts.

OC: how many staff for per district?

KB: number of staff deployed in the districts was depends up the need of the district. District health officer (DHO) of particular district made call to MIDSON and request the number of staff as per the need of the district, DHO mentioned the number of staff he needs to provide services in the community. We then, deployed the staff with the coordination with government. Indeed, DHO or DPHO informed us for deploying staff as the need of districts/communities then we sent our staff accordingly. At minimum we had sent 3 persons in one team.

OC: how did these DHOs/DPHOs come to know that MIDSON has been doing work in maternity care in post-quake situation?

KB: we were in the meeting together at Family Health Division. FHD tells that MIDSON deploys the staff in these six most vulnerable districts. And focal person of every district attends the meeting and then they (focal persons) approach to us. We have very good communication and coordination with them. There is good mechanism, and then we also call to Melamchi, district health office of Sindhupalchowok to know, what our staff are doing there? Whether the number of staff sent out there was adequate or not? While doing such, they requested for two more staff as there was high case load. Then, we sent out staff who were in our list. Before sending out staff to the community, we provided them three days orientation so as to maintain quality care. This was predeparture training to camp.

OC: how was it?

KB: That was fantastic. We provided that training. That was the training of midwifery. How to provide care at the post disastrous situation because care providers are also vulnerable there. They also have to stay in temporary shelter, they have to spent whole night in such condition and also aftershocks were felt frequently given that context, how they survive there, we tried to include all these things in predeparture training.

OC: who provided predeparture training?

KB: we provided that training.

OC: what I mean, who were the trainers?

KB: trainers were our colleagues. SBA trainers. In midwifery training we are the experts. And, we ourselves designed the package of training, thinking that certain things should be included in the package.

OC: what were included in predeparture training package?

KB: that training included things like as mentioned earlier, normal birth, anti-natal care, respectful care, and how to manage in disastrous situation. And, there are several relief kits for disaster situation, provided from UN. Such as midwifery kit, dignity kit, hygienic kit, there are a lot of such kinds. And MIDSON has such type of kits and it has distributed them in 14 districts.

OC: whom did you coordinate with?

KB: we were supported by UNICEF. UNICEF purchased all the kits and we distributed them in all the places we have been visited and provided ‘on site coaching’ across the 14 districts. We also provided information to staff about all the kits that are used in the emergency situation and disastrous situation, it was a sort of orientation on kit. How to do disaster management? What sort of kits are used in relief situation? See, how all these things look like? We ourselves are learning from all these things. But what did we do is, we did quick management.

OC: this things are not only interesting to hear/listen to but also involve a lot of management skills to deal with situation as these are link with disaster and situation is not normal.

KB: it was not planned, we are not prepared, and nobody has done preparation.

 OC: how has your experiences been managing the situation and coordinating with various stakeholders even in such critical condition?

KB: oh, that was a fantastic experience. By now, I know everything.

OC: you mean,

KB: as you just heard of all those things, as all of us know, no any disaster occurs in a planned manner. Disaster occurred, we focused on immediate rescue, perhaps we have some experience in the sector or it is a humanitarian work, and went to the ground to help and support to the government as a professional association. We joined the hand with government. Then, UN agencies approached to us. I did not know about the midwifery kit before because we did not experience of such event. Kits usually design for disaster situation only, as I was informed about all these kits preparing for disaster situation in Nepal, the work load was over on me. What sort of kit was that? We do not have adequate space in our office to store these kits properly. Thousands of kits were coming to our office. At the same time they also asked for us to buses/motors to transport them to the affected communities. And I do not have experience on managing vehicles, I did not know what is DI or four wheelers?

OC: did you know now what is DI?

KB: it is also name of company and space of vehicle at the back where one can put goods and we need four wheels drive to travel to remote parts. And four wheelers could travel on muddy road as well and all of the four tires of the vehicle helps while traveling, see all these things remained my experiences.

After deploying the staff with predepartutre training, our mentors go for supervision, how they are performing in the work places.

OC: how is supervision is done? Do mentors visit along with deployed staff?

KB: mentors go along with to drop deployed staff to the work sites because they are recent graduates just recently completed staff nurse course or BSc nursing course, as there is unemployment problem is rampant in Nepal we pay 35,000 as salary to per person.

OC: so did you provide money as well?

KB: you provided them their salary, UNICEF was supported us in providing salary to our deployed staff. Also, staff need to spend time in shelter, they were also given robber mat, sleeping bag, a packet of food, rain coat to keep themselves safe from rain, see, and we are making them well-equipped. All required logistic support plus salary 35,000 per month.

OC: So, in this way you were providing support/relief package to the needy women at the communities, how their responses were?

KB: they were quite happy with us. They were quite happy. We prepared well to deal with their situation.

OC: on the other hand, how their (deployed staff) needs were addressed or not in the communities?

KB: they do not have any problem. We mainly focused on anticipated realties the communities than that of being in Kathmandu. There could be totally different in actual realities of communities than what we assume here in Kathmandu.

OC: what sort of differences did they find then?

KB: patients, accommodation places, they have to sleep on the floor/robber mat, have to eat in the hotel, destroyed houses, health facility itself damaged, health facilities are delivered from open space, we mentioned this kind of expected situation to the staff before they leave which they found in the field sites. And we were not alone serving in the communities, team of GIZ, WHO, UNFPA, Public Health Society, and team to build temporary shelter there were several other team to work in the affected communities and our staff got all experiences, they are happy. But some of them felt that in such situation we (staff) ourselves struggle a lot to fulfil our own basic needs. They did get chance/facility for timely bath, as several persons are living under same tent, they had to compromise to the some extent on privacy and dignity. So that, our staff like to visit their own home in between, these were some challenges we were encountering. Some times in the weekend our staff visit to home without informing us and spend weekend with family then returned to the work places.

Although, we asked them to inform us in case they have to visit to Kathmandu, they did not inform us as they thought we would yelled to them if we would know of their visit during camp. And later we were informed from districts about their absent in the camp and if we made inquiry to our staff and they complained that as they need to take bath, change clothes and collect cash they visited to their home. And we sent money and our mentors to the field sites. These are the some challenges we faced during camps at the affected communities.
OC: how supervision was done? Would you mind explaining it a bit further?

KB: what we do is, we do supervision on the basis of need, because it is very costly to deploy our staff. It is not to work in hospital. They need to work on birthing centers, primary health care centers which are sparsely located. To reach from one PHC to another it takes 3/4 hours of walking. So, to reach from one PHC to another, we need to send a team of two persons, a person cannot travel alone. Our colleagues walked as long as 5 hours so that was very difficult for them. As I mentioned earlier, we have not planned or nor have we previous work experience, as our colleagues were having difficulty in walking, we sent vehicle to travel around, wherever travel in vehicle is possible only then walk I told them. And try to cover as many health facilities you could. If they can cover one health facility by walking five hours, they could cover two health facilities at least, if they travel by vehicle.

We sent vehicle to the field sites in reservation but we had to pay higher cost for travelling, this planned did not move ahead per we expected, we had to pay about 40,000/50,000 in travel for one trip so supervision and monitoring is costly. On top of that we have to pay TADA to mentors/supervisors along with remuneration that is why difficulty lies also in managing financial aspect, although we are managing it. We had to work in very rush way that we are not been able to do well budget plan, we cannot assume how much money will be spent? It depends on other as well, and sometimes some vehicle does humanitarian services but others asked higher amount than expected as they took it as opportunity to earn. This was the thing we found a bit challenging.

OC: what are the other challenges you have been through?

KB: but thank God, we were moving ahead. The next challenge is, our supervisors themselves been through challenges.

OC: you mean?

KB: we are working. Suppose, take my own case, I am the employee here (IOM) and my other obligation is there. I have to go there (MIDSON) at Kupondole.

OC: are you trying to tell they have constraint of time?

KB: time constraint, they do not get leave easily from their respective organizations, time constraint is one. And, we cannot work with other staff, we need experts, staff of admin cannot work in our field sites, because staff should be technically sound like us. If we send sound staff he/she identifies the gaps and make necessary corrections, and also does ‘on site coaching’ for supervision. She/he can work with along staff at hospital.

OC: so, what were the learnings then? Although, you keep mentioning that neither we were prepared nor was it well planned? We are dealing with situation in a pretty well manner?

KB: learning was maximum. In that disaster situation, in a quick decision, short decision, in any professional association we need to approve by calling meeting of board members to lunch any every activity and emergency decision is emergency. As colleagues came we immediately sending out them to the communities, because not all things go well in each direction. Some board members are attention seekers, and other are scared from earthquake and do not attend the meeting during that time. Also, we saw relevancy among our colleagues to be ready for going outside of Kathmandu in post-quake situation. So, one group of people are continuously working regardless of situation whereas other group is remained silent. That was also a challenge for us.

OC: even within executive members or board members, it was found that committed our non-committed ones.

KB: yea, even in board members too, we saw committed and to the some extent sleeping partners. Or non-committed. It is said that, one cannot make every one pleased.

OC: now, on the basis of your long work experience, how is the maternal child health sector aftermath of earth quake general in Nepal and particular in hard hit districts?

KB: as we sent out mentors and deployed staff at the communities, UN agencies and government of Nepal are very happy with us (our work). They are really happy with us. As we are attending on going meeting with government of Nepal. Now, as I said meeting, I just remembered, whether one of my colleagues gone to meeting or not. The meeting was scheduled for 11:00 o’clock today. I am here, I cannot run everywhere. I asked her to attend that meeting.

And, government congratulated us for doing very good job. In the dissemination meeting of government of Nepal, it explained about the deeds of MIDSON. It further stressed that MIDSON has done/conducted ‘on site coaching’ and monitoring in 14 affected districts and deployed staff in 6 districts. And that has helped in our publicity also has increased our visibility as well. That is one positive aspect of our professional association. And, next aspect is as we have been engaging in sector, people like you are come into contact with us. Suppose you are here today, other partners also come in contact with us and request to work collaborately and ask us for provision to follow for moving ahead.

After earth quake on May 5th was the international day of midwife, we were thinking to celebrate it heavily but aftermath of quake we were not able to do it as we were engage in relief work, as always, I wrote a press release, but this year we were working on Bhaktapur on day of May 5th we could not celebrate it but we were with women and children. I mentioned it in the press release of this year.

We are link with international organization ICM, our parent organization. As we sent our press release to the ICM, our publicity was went around, it was published in their news bulletin. The news of Nepal was published in their wall, it was a matter of global attention, and we were interviewed by the people like you, this news are also posted on the wall of UNFPA also posted in the wall of ICM.

Have you herd of ‘direct relief’ USAID it only works in disaster. And it announces $10,000 as immediate support with recommendation from ICM. Because, you keep up your work, we have done outreach camp on reproductive health, they asked us to expand that outreach clinics.

OC: outreach clinic on?

KB: one is deployment of staff and next is we are doing RH camps in a parallel way. Reproductive health camp.

OC: what have you done under RH camp?

KB: women who are suffering, we are providing services to them by organizing reproductive camps in their respective locations. These camps are organized in their own local location like in their won localities, VDC.

OC: who conduct this outreach camp?

KB: we ourselvelve conduct camp.

OC: who are the staff to conduct camp?

KB: our own colleagues, mainly those who are involved in ‘on site coaching’ and are involved in monitoring of staff conduct outreach camps. Because these colleagues are from maternity hospital, who are examine pregnant women, provide care to child and mother.

OC: you mean, from staff nurses to SBA trainers.

KB: from staff nurse to matron, sister in charge from hospital and from the college there are lecturers, professors. We divided colleagues into team, one goes to camp and another goes to the supervision. This has established good relationship among our colleagues and also has provided them an opportunity for outing. If people get membership from our professional association then they got some benefit as they are working with us. We select only capable persons, we list out the resources (name of persons), who is capable for what job? Who are capable in mentoring or who are capable in performing clinical jobs? We have developed that sort of list, we inform them accordingly and they arrange their leave from their office and go to the communities to work with us.

OC: what do they do in the outreach camp? (RH outreach camp)

KB: the outreach camp last for two days. It takes one day to reach to the community and spent two days on camp and another day to return to Kathmandu.

OC: so it sounds one camp takes 4 days of time including travel.

KB: we also do preparation and coordination. We sign on the proposal to conduct 10 camps in Nuwakot district only in collaboration with UNFPA.

OC: when do you begin to conduct outreach camp?

KB: right after earthquake hit the country.

OC: so it is going on.

KB: yea, it is ongoing. We have completed 6 camps and still 4 more camps to complete, only in Nuwakot district.

OC: when does other camp likely to take place?

KB: next camp will take place next week. We are communicating on this regard for selecting VDC to conduct camp, which VDC is most affected among others. Which communities women will be benefited? Also, access to the road to reach out the community in this monsoon reason, we should look that aspect as well and who are going to the camp? We need to purchase all the required drugs? We also need to rearrange the camp, we hire a nurse who is responsible for arranging camps one after another, because I will be here (IOM) and everyone else is in their own duty. We are volunteering in professional association, we go there after duty that is why I asked you to visit here. I will be available at MIDSON office only after 3 o’clock in the afternoon. Please do visit that office as well. It is in Kupondole. If I go there, I can to give you my time as I am proving here. People come to visit me one after another. These people include staff from Drug Company to driver, fellow staff who just returned from the camp. Then I need to deal with all these logistic and financial stuff as well. I cannot give time to the people, I will be really busy with a lot of works.

OC: I was about to ask query on RH camp? What do you do in RH camp?

KB: you know camp is camp. We provide treatment according to the problems. Besides, that we give especial focus on education, we have one education corner,

OC: is that health education corner?

KB: one health education corner,

OC: what components are included in that education corner?

KB: it deals with RH. All RH. It includes from hygiene to breast examination, anti-natal care, danger signs in mothers and newborns, when they should immediately visit to the hospital, breast feeding, we talk all these type of things. Also, health education, nutrition, family planning, all these are included in education corner. Then we have examination corner, we nurse midwives examine all women. We take in-depth history in one to one basis. As I mentioned earlier, women centered care, respectful care, it is not like hospital, and no one could listen to other. We deal on one to one basis, then I take entire history of single patient. Once one patient’s total examination is done then only we move to another patient, provide quality, dignified and with privacy maintained care, which we called it midwifery model of care.

After examining all the cases, if we feel doubt on anyone among them we then send that to the doctors who sit in the next room to us. So our team include obstetricians and gynecologists but we are the empower of the team.

 OC: where do you contact for them (obstetricians and gynecologists) to include in your team? How do you get them into your team?

KB: what do you mean there?

OC: I mean how do you do the coordination for including obstetricians and gynecologists in your team?

KB: we contact them through telephone because we are work in the team. Midwives and doctors always work together, I know doctors of here, (Teaching hospital) and maternity hospital at Thapathali, I would say, Dr. Kastub Malla, would you go with us in the camp? Or Dr. Pushpa would you go with us in our camp? I also say to Dr. Pushpa that, it is time to go joint monitoring with us, should involve in our team and provide us your suggestions. I also approach to Dr. Shilu Aryal, last Friday we along with Dr. Shilu Aryal from Family Health Davison went to joint monitoring at camp held in Ranipauwa, Nuwakot district. She also participated in the camp. We also ask her to participate in the similar camps in Sindupalchowok in next round soon.

OC: what was/is her (Dr. Aryal’s) responsibility at the joint monitoring?

KB: to monitor the aspects like how is camps are running? Whether quality of service is being delivered in the health camps not? Whether adequate equipment/goods are supplied in the camps or not? Whether camps have been women centered or not? Whether camp has conducted in coordination with local health facility of the locality? Whether such camps are necessary to conduct or not? All these tasks are seen by her.

OC: what is roles while conducting such camps then? What is the role of MIDSON?

KB: the role of the MIDSON is to the overall management of such camps because we are the team leader/manager.

OC: so it does everything then, as it is in the leading position of camp management.

KB: we lead the team and also get feedback and move ahead in a constructive way.

OC: what does that mean?

KB: to adopt best way in running back on the basis of the feedback. For instance, we need to put ringpesary for uterus and prolapse, whether there is prevention of infection or not? Because we do not find auto clip and not electricity, we need to conduct it under tarpaulin, *paal.*

OC: obviously when we go to the camp like that it has to be conducted under tarpaulin.

KB: so we need to conduct our camp accordingly. So we are learning our best, some people called earth quake as divesting but I also called it beneficial *kanyankaari*. We are serving to the certain section of people as well. It was so sad for those people who lost their lives in the event. As we have been providing door to door services right!

OC: would you mind sharing lessons learn during post disaster situation?

KB: we should move along team in disaster situation. And, as it is crisis, to manage crisis we should take quick decision, quick sort list and quick action. We should not do delay in such situation to take action.

OC: Is there any differences in doing coordination in normal time Vs disastrerious situation?

KB: obviously there is. In case of normal time, we could postpone the programmes/events we cannot do so in the disaster situation so each and every one is working in day and night, including UN agencies.

OC: so UN agencies not only provide logistic and financial support to NGOs but they also engage in other works as well. If so what sort work they involve in then?

KB: they do a lot. They reach to the office as early as 6:00 o’clock in the morning and work till 9:00 in the evening.

OC: what sort of responsibilities they take in conducting health camps?

KB: they do not go the field directly/physically. Sorry, they also make field visit as well. They work in mobilizing their own partners at most. Major part of their responsibilities lies in partner mobilization. Second, they involve in monitoring, on site coaching, and UN agencies have assign one staff as focal person of UN agencies in every district. For instance, x in Rasuwa district and y in Dolkha district.

OC: what does UN agencies’ focal person does/ (roles) in the assign district?

KB: roles of focal person are monitoring and supervision of work done by their partners in the district. In Dolkha district, the focal person of UNCEF is there and our staff is there too, and UNICEF has not only funded to MIDSON but also it has funded to Public Health Society, Women Rehabilitation Center (WOREC) so focal person of UN does monitoring and supervision all of its partners’ works. Also, focal person asks weekly report to its partners, how many people have been benefited? Pregnant women.

OC: so focal persons of MIDSON like organizations report to the focal person of UN agencies at the district.

KB: yes, they do so to us and UN focal person at the district as well.

OC: so focal person of UN agencies to UNICEF right,

KB: focal person of UN agencies does the overall reporting to UNICEF, ultimately report goes to the main body. And, the next challenge we have to face is, we cannot report to donor on weekly basis from such remote part. We do not allow our field staff to visit to Kathmandu and we cannot travel to such remote village timely. We report the field scenario on the telephone and photographs. They do reporting in the form of photographs, field staff send to us and we will see them to donors. In many place telephone/cellphone does not work/connect. And we inform to the donor that due to the network problem of communication reports of specific camps are due. As we should be obliged to the donors.

OC: obviously, there should be certain type/level of obligation.

KB: that is a kind of obligation.

OC: at the end, if you have to tell anything further on aftermath of earthquake and maternal child health (MCH). Please make your final/brief comment over them. Then we will conclude for today, in case, I have any further clarification I will obviously get back to you for that.

KB: As I have been working in the post-quake situation, each and every woman should be provided dignified care by skilled human resources, because health personal have to work independently in the rural setting where doctors are not available. Now we have sent nurses to the communities as midwives although government of Nepal has not given such title to them. Our mission will continue. I what tell to the government of Nepal and our working partners, midwives are urgently needed. We need this skilled human resources urgently in our country then only maternal mortality and morbidity will be reduced. We will not meet the targets only by setting MGD 4 and 5 because as you are research associate you know already than me.

You may be aware government of Nepal claim as 229 and WHO reports it is reduced to 190. Now we are reaching to MDG 4 and 5. Goal 5 has been up and down whereas MDG 4 is stagnant from 2006 till 2015 for new born death. It was recorded 33 in 2006 and it same today as well.

OC: some statistics shows 24?

KB: no, it is 34,

OC: you mean 33,

KB: yes, 33 as per the statistic of government of Nepal. And maternal mortality is still controversial what is being said just earth quake hit the country Population Monograph reveals 440 or so. That is why. These statics are not reliable, until government is not been able to deploy skilled human resources adequate human resources with proper rural retention policy maternal child health will not be improved. For this, our effort to lobby and advocate with government of Nepal will be continued. And we anticipate to work with UN agencies, regulatory body and ministry of Health is our core partner.

OC: Thank you so much for your time and information.

KB: thank you very much, (laughing…..)