**Field and Interview Note**

Field workers: RA and OC

Interviewee: KB

Note Taker: OC

Note Checked and Edited by: JS

Language of Interview: Nepali/English

Note Transcribed by: OC

Place: In front of office room, Marajgung Nursing Campus, IOM

Time: 10:30 -11:30 AM

Date: 23 December 2015

***Context***

*This is a second meeting with Kiran Bajracharya, prof. of Nursing at Marajgunj Nursing Campus. Indeed, this is a follow up meeting of the one which held in July 2015. The primary purpose of this meeting is to develop further understanding on the MIDSON’s works/activities in the post-earth situation in Nepal in relation to non-governmental organizations (NGO’s) response to support pregnant women and delivery mothers at the communities. This attempt is helpful in knowing further on the impact of earth-quake on maternal child health sector of Nepal.*

*With the arrival of Radha Adhikari in Nepal, meeting with Prof. Kiran is set up for 23rd December, 2015 at 10:00 in the morning. As per the time given RA and OC reached to the Marajgungj Nursing Campus in the premise of Tribhuvan University Teaching Hospital (TUTH).*

*As we went there, we found that her office room was closed as we were waiting to Prof. Kiran to be arrived at her office, a lady informed to RA that Prof. Kiran was in Vice-chief’s room. And she asked us to visit that room. We went there, we greeted each other, and I introduced Radha Adhikari to Prof. Kiran and Radha Adhikari is known to Vice -chief from a long ago.*

*After a while Prof. Kiran asked us to move to her office room and we then moved to her office room for talk but we discussed outside of the her office room at open space.*

*As all three of us sat on stools at open space, RA began talk with she visits in Nepal and Malawi and Nepal partner is Social Science Baha where Obindra is based on, and Kamazu College of Nursing is our Malawi partner, where we work with Address Maltra, Vice president of global nurse confederation.*

 *The Kiran explained about the logistic of MIDSON, it has been receiving support from UNICEF from its beginning at 2010 for the office management. MIDSON is located in Kupondol in three rooms of the quarter of Maternity hospital. She further argued that as there is no separate midwives cadres in Nepal, maternal mortality rate is not reduced. She also talked about the recent statistic of mortality rate as revealed by Population Monograph as 428 something (480) is correct one. And she also mentioned this statistics differs with the sources. There is not just a controversy on the maternal and mortality rate but also it could be conspiracy for receiving foreign aid from donor continuously, she added.*

RA: This research project is simultaneously going on in Malawi and Nepal. Right Obindra, Obindra might have already explained to you all about the project, perhaps I may be repeating it.

KB: good rapporteur, [laughing….]

RA: we began our research project by focusing on MDGs and these are going to be ended.

KB: now onwards, we should move on to Sustainable (Development) Goals, SDGs,

RA: we should move on to SDGs and we are focusing on how foreign aid is supporting, we look foreign aid funded projects. Mostly foreign aid funded projects and their relationships with government, implementing partners, local NGOs and INGOs, and how these are functioning, we are looking on that. Our project is going to be completed,

KB: right, it is good. Are you going to disseminate the findings of the research?

RA: yes, it will be organized, we will invite you on that occasion, and we actually missed you in our inception workshop. As we had to engage in several tasks at once, such as; set up the project in Nepal, set up for Obindra’s post and other works including inception workshop. We were doing the mapping of the projects, we invited almost all stakeholders on our inception workshop, but we missed the MIDSON.

KB: oh, when did it take place?

OC: it was held on July 2014,

RA: yes, July 2014, one and half years ago.

KB: right,

RA: Ishwori didi was participated from the ministry of health and population (MOHP).

KB: sometimes it happens,

RA: after that I felt *dhak dhak*, I knew about MIDSON at that time. We will invite MIDSON on our dissemination.

[*In between our talk, a middle aged woman, brought a glass of tea for Prof. Kiran and we asked her to take her tea but Kiran asked her staff to bring/prepare tea for us too, and she brought tea for us in a while*]

RA: you know Merry Roseberry, right.

KB: obliviously, I do know her. She is a brilliant person, she has done her PhD. She is an academician at there.

KB: what does Merry say then? Which college does she teach?

RA: now she is in Scotland. I knew her in Scotland. Merry’s daughter Eva and my daughter Tara are friends since they were in grade one. Now, they are in grade twelve.

KB: oh…

RA: I knew her from that time,

KB: Merry Roseberry,

RA: Yes, It has been twelve years I have known her. She has been to Nepal right,

KB: yes, she has been here twice, she was here for training at first as a volunteer. It is fascinating, there are so many compatible matters among us.

RA: yes, there are,

KB: haven’t you felt such things, while you discuss at UK,

RA: yes, I do.

KB: you do not have professional midwives yet, there is no human resource called midwives.

RA: yes, it does take place, and my working area is same one. What has happened to midwifery education? Quite earlier there was diploma in midwifery right? Does it still exist? BN midwifery?

KB: no, Prubanchal University has course on BN midwifery, private universities do have that course. It is not in our university (TU). As our understanding goes, there is no such course BN midwifery rather there is two district professions (a) nursing and (b) midwifery if we look at it at global level.

There is no professional midwives in Nepal rather there is Auxiliary Nurse Midmidwive (ANM). It is completed in eighteen months training which is not in line with the global standard.

RA: yes, the standard ANM does not match with the global standard and next and ANMs study many things not just midwifery.

KB: they study all diseases, communities which are necessary things as well. But, we could have made it as professional midwives at least community midwives, if we could be able to modify content matters with standard with ICM. Community midwives, right there is difference between institutional midwives and community midwives, at the first level we could convert current ANMs into community midwives. This could be professional title for them (ANMs) as well. This could also save the dignity of our country too. Do you have the midwives in your country? Everyone who visits here ask this question right, which is difficult for us.

We should have to tell, no, we do not have, nurses are working as midwives. Whoever I have to speak with about it, don’t you have separate preparation? No, not yet. We do not have separate preparation, midwifery is a part of the nursing and nurses also pose some degree of midwifery skills, nurses also deal with the problems regarding to mothers and children. If a mother and child arrive at the health facility, they cannot say this not my work. They (nurses) must have some skills of midwives too. Nurses also pose some skills of midwives but midwife is midwife. Isn’t it? Who can save the lives, she is empowered, she has separate preparation, she has a wider scope of practicing, perhaps, knowing these things by government, until there is no reduction of mortality at community, doctor, nurse do not reach to the village rather an ANM is responsible for providing first level health facility at the community. They are not well prepared, that is why maternal mortality rate is not reduced yet, and there is very less institutional delivery rate in the community, even pregnant women receive (delivery/travel) incentive not all pregnant women visit health facility for institutional delivery until there is no availability of a professional with skill, attitude and communication skill, in case of UK there is clients, rights; maintain of privacy, I was surprised when I visited to the midwife’s clinic in UK. Oh…

RA: you had visited to even the rural areas of Scotland, right?

KB: we had visited to all the rural areas of Scotland, and did observation, there were really empowered midwives, they do all the works including ultrasound, they themselves prescribed and then referred, and then unlike in our country, all the details of client is sent to the referral hospital immediately and get admitted and then outcome of the baby and mother at the referral hospital is immediately informed in rural health center.

[*Fellow* *staff of Kiran has brought tea for us, they make tea for limited people, it was awkward for me, thank you Mira, Kiran said to her staff*]

As I have seen all these changed there I felt shame, we also need this sort of services, more like an individualized, and women centered care. Women centered, a woman with me, for instance, Radha visits to me, right there will be no one around me, woman there trust their own midwife and talk very openly and provide history which is in our context lacking. In our country there is a serpentine queue one after another. Every other person is waiting for her turn in our country. Woman issue is quite different, even history is sensitive. There is secret matter, maintenance of privacy, we should discuss on child birth, private part as I saw such environment there, I approached to see their clinics at UK and Scotland NHS approved institutes, they told us that please wait, we should not disturb to them as midwife is working in the room. A red bulb is on outside of the room which indicates that a midwife and a client are interacting each other. If things are in our case, all things are remained open. And, I told that, it does not requires a lot of cost for it, rather it is just a matter of an attitude. We can also run such clinic. What I say is we can bring change even at minimal cost, we do not need budget. At first we should develop trust, rather maternal incentive scheme of Rs. 1000 or Rs. 1500 alone does not make sense until trust among we two has not developed. And, complete information is not provided.

RA: right,

KB: I do not like that particular component. Quality education, quality service are [lacking] I would like to be a role model for providing quality education and service in Nepal. Why should not we start it from a very small clinic? We are planning to run a clinic through MIDSON, Radhaji.

RA: yes, yes. [*RA giving her business card to KB*]

KB: you are working for mother and child, and doing a research project, I would like to bring some [positive] changes,

RA: you are right, changes should be brought. For that we are doing research.

KB: low cost high tech. Technical part is ours. We have studied a lot but are not able to apply it.

OC: yes,

KB: I feel very sad, how many more years am I going to work further? If I work actively, I will work 4/5 more years from now. I feel like, we have not been able to bring changes, today, I spoke with Chandra at counselling too, Chandra Kala is now working at council.

I asked her about the status of education, because it is in the mandate of ministry. Ministry has to endorse it.

[*A student came to KB and inform her about an exhibition that is going to take place tomorrow at 12:00 noon*]

RA: this project is going to be completed soon, and then we will invite you in dissemination then we can discuss what could we do next, right.

KB: are you at Social Science Baha?

OC: yes, it is a research partner for Nepal for this project.

KB: and, who supports you for this research project then?

RA: This research project is funded by DfID/ESRC. Obindra might have already mentioned you, Nepal partner for this research is Social Science Baha, and University of Edinburgh is leading this research and I am research fellow there.

KB: so you work there.

RA: yes,

KB: so good,

RA: I am a research fellow and three other team members are there also based on Edinburgh, and two colleagues are based on Nepal. Do you know? Deepak Thapa,

OC: he is a director of Social Science Baha, Deepak Thapa and Obindra work in Nepal for this project. Address Maltra, is our research partner in Maliwi and like Obindra, there is a research associate in Malawi too. There are two colleagues in Malawi, two in Nepal and four in Edinburgh so altogether, we are eight persons in our research team.

And, basically we are trying to see under this project is, how maternal child health sector in two is moving ahead in two counties? What sorts of projects are supporting in this sector? And, how foreign aid has supported the sector? And, what sort of changes have been occurred at the discourse level? How people view foreign aid? All in all, how can we make foreign aid to meet maternal child health goals?

We will talk it further in our planning to conduct dissemination, we should say next year right?

KB: you mean in 20016.

RA: we are planning to have it in the summer of 2016, we even finalized the date right?

OC: you are right, we are planning to organize one in end of July and another in the first week of August. We will inform you accordingly for this time.

RA: what we were discussing was we will develop mailing list, on that list, you could add her address as well.

OC: yes, I do have her business card.

RA: did mapping exercise of almost all the projects related to maternal and child health in Nepal and we selected four projects out the mapping of all, for the further/detail study. All of these four case studies (projects) should be foreign aid funded, we have selected one programme implemented by Care-Nepal another one programme by ADRA-Nepal and next is *Aama Surakchhya Programme* under the Ministry of Health and Population (MoHP) and then final one is Suaahara programme, we are studying these four programmes for detail study. And then, what MIDSON has been doing all these going to fall under our method, for developing greater understanding of what is happening in the country?

As Obindra has already spoken to you, I have read all the notes he has developed and that was helpful in making my understanding broader.

KB: If so, how can I be further helpful?

RA: we will discuss on clarifying a couple of issues. By then, we you were talking about MIDSON and its history and also spoke on Skill Birth Attendance. I read an article on something, somebody KC had written about it, I do not remember it correctly.

KB: was that on MIDSON?

RA: no, it was on SBA. It was about Skill Birth Attendance. It was on something journal, on which government has planned to provide training to *seven thousands* SBA. While he was writing that article, target was not met? Has it achieved by now?

KB: by now it is almost there, I heard that number crossed six thousands already.

RA: Is it SBA training going on these days too?

KB: yes, this is ongoing programme and the SBA package is revised now, learning package is being revised now. Advanced SBA training has initiated now. Advanced SBA training is provided to doctors, gynecologic obstetricians, as they are involved in fistula, cesarean section and surgery. So, advanced SBA is only for doctors,

RA: so it includes physicians.

KB: it is for OBGYN. It does not include physician, in our context as we say physician it takes internal medicine only.

Advanced SBA is running now. Training package is revised now. And, all the health professional are provided an update on MNH. Maternal and New Born Health update. It provides update on the basis of the evidence in relation to the current scenario. Government of Nepal via NHTC has run a training for health workers.

RA: who does funding for this programme?

KB: there are multiple donors are there for funding this programme, DfID, KfW.

RA: does KfW provide funding in Nepal too?

KB: yes,

RA: It was DfID before KfW.

KB: KfW has spent money on,

RA: KfW has also spent money on Nepal too, it has spent money on Malawi. It is a bank, I think it is like German bank.

KB: anyhow, KfW has spent a lot of money in Nepal.

RA: oh really, so KfW has provided funding for training on updating the MNH programme.

KB: no, it has not only provided funding for MNH update training but also supported on Skill Birth Attendance, also in the sector of maternal and new born health, and to the government of Nepal, Aama Surakchhya Programme, what we call Maternity Incentive Scheme which is given for a mother, Rs. 500, Rs. 1000 and Rs. 1500 as she gives birth at the health facility. This money also comes from KfW that is why it is a strong partner of government of Nepal.

RA: to meet and speak at KfW, whom should we contact? Do you know, any person there?

KB: you will know from it from ministry of health and population as KfW is the main partner of MoHP to work in maternal and child health. You will get contact detail of the KfW contact person from ministry itself, either from Ishowari mam or from Dr. Lohani, [Gunaraj].

And, NHSP is the one which introduces any new health strategies, form policies in the sector of newborn and child health sector of Nepal. Have you visited there? If you make visit to NHSP? You will then, develop better understanding regarding these issues. This is National Health Sector Programme and then to support this programme, there is NHSSP, National Health Sector Support Programme. NHSP and NHSSP.

Sometimes, we ourselves become confused. One after another, we are gradually developing understanding. I should teach some part of these components here (IOM) too. While teaching national policies and strategies, many of our fellow teachers even do not know. Very complicated. Complex networking of Nepal.

RA: so to support Nepal Health Sector Programme, there is Nepal Health Sector Support Programme then.

KB: to support NHSP there is NHSSP, which has one more S.

OC: former is the programme of government and later is the project of donor to support the government’s programme.

KB: and these projects have strongly supported to the SBA. How long they (donors) will be supported to SBA and our advocacy is they should also support to midwifery too. (our voice) because if you see the policy of SBA, government of Nepal has set up three folds goals: (a) short term (b) midterm and (c) long term.

Under short term goal, all health workers will be provided with SBA training. It is a like blanket method. Training will be given to doctors, nurses all. As providing training on longer period of time on pre-services are costly and less feasible so under the midterm goal is to introduce SBA training on pre-services at curriculum at professional schools so that once they graduate, they will be skillful, with that vision SBA was incorporated in curriculum. And, on the basis of that curriculum we have been teaching. This was introduced back in 2007.

RA: how it is incorporated in the curriculum?

KB: all the SBA skills are put under the midwifery.

RA: How many hours, has it been taught?

KB: it is more like additional, as we do not have adequate hours for it, we have fund difficulties in making adjustment. It is like more than fifty hours. What has mentioned in the policy was after completing short term and term goals, the vision of the long term goal is professional midwives will be developed, that has been written. Professional midwives will be developed, and also mentioned that this policy will be worked only for five years from its implementation. And, this policy appeared in 2006, and it has been implemented from 2007. And, by 2012 all the goals of SBA should be achieved and government of Nepal had to work for professional midwives and it is already 2015 and we are behind because not government does not work on it but because there is lack of negotiation among professional organizations like ourselves. There was a controversy. While initiating midwifery education in the country and doing ground work. Whom do they do consult with? Do they consult with us or with Obindraji? They consult with us right, they consult with those people who are involving in teaching midwifery in nursing. They consult with us. When they consult with nursing association, that created sort of difficulty for them and they thought like once midwives come in the ground ten what will we nurses be going to do then? To the some extent, security (job) issue then that result in why should we need midwives, nurses are doing the jobs?

In fact, nurses do not even know that who are midwives? Why they are needed? As I mentioned earlier, there is no such provision for reach to unreached people. Nurses do not have international skills, ICM has provided global standard, who is midwife? And what are the scope of practices? Nursing is the dependent profession, they carry out the doctor’s prescription and midwifery is the independent profession and midwives are the experts for normal birth only. By handling low risk and normal births if there comes any complications then midwives refer to the doctor and then expanded role of the midwives is collaborative work with the team of doctors and midwives. In that manner, ICM has categorized in a global standard.

This idea has not understood in Nepal by our colleagues, what our colleagues in Nepal usually do is express their own personal views and life experiences and mentioned that, we do not need midwives. So far, nurses are working well, why do we need midwives? These sort of irrational ideas are actually not based on evidence, what I mean here.

These days evidence-based discussion has been come into play. What has happened at the global level? For instance, why (child) mortality has reduced in Shirilanka and Thailand? Even though these are Asian countries. It is because, they have mobilized midwives, this lesion should learn by doctors who work for government of Nepal, our high level officials of government *hakimharu*, admin staff should go for raising voice for need of midwives in our country too as this is a global voice. Because Nepal has to bear the pressure from the high level as various conferences organized by UN agencies like women delivery conference, ICPD conference in those conferences it was mentioned that no woman should die because of the child birth and skilled human resources are needed. Who is skilled human resource is a midwife because doctors are not reachable anywhere right, in every nook and cranny (*kunaa kaapchaa*) of the country.

In these matters, minister, secretary level staff have made signature on international conventions then they submit the action plan to work further. They then, provide tentative budget for the programmes while returning to Nepal, they remain silent. Apart from this, Nepal is very political and once political bodies give pressure to the professional associations, then political appointed ministers will follow it. This is in fact the existing problem in Nepal, otherwise, midwifery education in Nepal would began in 2012/13 and by now one batch would be graduated.

And, to begin the midwifery education, what sort of education model should be adopted in Nepal? On that, we could also learn from the success stories of other countries in the world too. We can go to midwives from nurses as well.

RA: same had done in UK previously.

KB: in some countries, there is direct entry for the course, in others one can go to the midwife from nurse. Those who are interested to be a midwife, work with mothers and newborns and who are currently work in maternity unit, to give them protected title, if we give them additional skills and knowledge then they get protected title as ‘midwife’. What nurses, tell irrationally is if so all the nurses should be midwives then? All nurses should be midwives then, the current 22,000 nurses of the country should all be midwives then, nurses mention.

I am actually surprise with the knowledge of politicians, first not all nurses like to be midwives, if this is a voice of nurses, not all nurses want to be midwives. Nurses who work in ICU orthopedic, renal wards do not likely to transfer to the labor room to be midwives, they do not come.
RA: they do not come.

KB: they do not come, I suggest, we should not discuss on that line. So, those who are currently working in the maternity wards, and who are working in the safe abortion, family planning, and working in the communities for mother and child, they are eligible for the midwives. And, we can provide them additional course so that they will get the protected title from the state. Right, Radhaji, if I am wrong then please correct me and also provide me suggestions.

RA: no, I got your point. I understood the intention.

KB: so how do we produce? We can learn from the other countries’ practices? We do not want direct/fresh entry, for instance come through ISC, after twelve years of education, we do not conduct midwifery education. In the context of Nepal, there are lot of unemployed nurses, there are lot of private colleges, so there are so many nursing graduates, and they are not getting the jobs, if we provide them additional course on midwives then they will easily be midwives, such as bridge courses for them. What is lacking with reference to the international standard? What is deficit there? How many hours of teaching is needed yet? What about the curriculum? If analyze all these stuff, and move ahead. We have done gap analyze as well, what portion of midwifery education has been taught to current nurses? What portion should we taught them to meet the global bench mark? And then they will get the title? MIDSON has done works on all these aspects.

RA: in the case of UK, how many years or how much time they spend in that area? For instance, professionals who work in the maternity ward of Nepal, they are very experienced, they do not need a lot of classes on midwifery,

KB: they do not a lot of classes, what they need is, classes on communication, respectful maternity care, how to do total woman centered care? Different positions during the labors? These are some of the areas we have identified, along with clinical practices to the some extent with mentor, with a mentor. For instance, Merry Rose Davis and there is a person called Hillary in Scotland. I do not know, whether you have met her or not?

RA: Hillary, what is her last name?

KB: Hillary something, she looks a bit fat.

RA: has she worked in Nepal before?

KB: not, she came here to volunteer in our organization. GMTP (Global Midwifery Training Project) RCM, (Royal College of Midwifery) I do have her photographs. If we can bring such persons and provide orientation/training that helps to bring changes in Nepal. Political influence and attitudes are the major challenges in Nepal. This profession (midwifery) is ultimately going to help the nurses so why nurses (nursing association) are against it?

RA: did nursing association also against midwifery?

KB: yes, it was and now it was convinced and association has understood it matter from 2015. Because World Health Organization (WHO) has invited them in the meeting of midwifery frequently in the global forum so they came to know and realize then we have begun to work collectively on it.

We and Chandra are working together, who was not that happy in the beginning to initiate midwifery education in Nepal but she now is asking for organizing midwifery meeting now, this is from the president of nursing council.

Definitely, it takes time for changes to happen because people have to have understanding at certain level. So I do not blame to anyone, if we are planning to introduce midwifery education in Nepal should not do delay in it rather our colleagues should involve in doing literature review at the some extent. We should not express our views based on only our experience, I asked our colleagues a question, are we midwives? They said, yes, we are all midwives, because we have studied and worked on it at the greater extent so we are all midwives.

And then asked another question, if you are midwives then what kind of license government of Nepal has provided to you? License is a registered nurse not a registered midwife. They keep on saying that, we are midwives even though government has not provided us a license. I told them that if the land certificate*, laalpurja* of your house is not in your name then how do you validate it? If government has not provided a license to a driver, he/she is not allow to drive a vehicle. I had to remind those ordinary stuff to colleagues, many of them were against me.

Kiran mam always tell that there is no midwife in Nepal my colleagues complain to me. If there is please so me a license provided by the government. Many of our colleagues are now realized the need of midwifery in Nepal and donors (partners) also has come ahead with their helping hands because this a global voice, a global voice. Anyhow a mother and a child should be saved, skilled human resources should be there, each mother and new born has to have access to health care, access of skilled care during the birth, no mother should die during the process of the child birth because they are dying. If we see it in the context of Nepal, geographical terrain (difficulty) is the main problem, access is not there. A pregnant woman has to cross to the Koshi river to go for getting services like for ANC checkups and delivery at health facility. Also travel through *tuin,* a ropeway. There is no road access. We cannot predict on pregnancy, although I am safe during pregnancy, during my delivery if my uterus did not contract and I had PPH (post-partum hemorrhage). After giving birth to a child I had bleeding, it went like water flowing from a tap and the blood of human body 5.5 liters finishes within two hours. How should I reach to the district headquarter to search for skilled care? On the way to the hospital women are dying because of giving the birth.

For this reason, skilled human resources closer the door of the women is required, without addressing this, whatever amount government provides Rs. 500, Rs. 1000 and Rs. 1500 and if pregnant woman do the regular four times ANC visits then also get additional Rs. 400. Apart from this, whether it is an institutional birth or a home birth, every district has its own scheme on delivery mother and child, like *sutkeri bhetghaat*, meeting with a delivery mother, where delivery mothers are provided with foods, chicken, eggs and also promote family planning it is all there but there should be skilled assistance for safe birth. That is midwife, in the context of Nepal what sort of midwives should be developed? And should made current nurses as midwives, this is my idea.

At the community level for the time being, front line managers are ANMs. ANM course is not in line to the global standard, ANMs are not well-prepared and this course has been privatized ANMs lack skills. By providing them bridging course we can convert them into a first line community level midwives. This will benefit to the government to the greater extent easily and immediately because this training will over within a few months.

After this, we can go for certifying course of midwifery affiliated with universities. What we can do is, once completing PCL nursing/staff nurse candidates who like to be midwives has to join three years of midwifery course here according to the system of Nepal. At the international level, there is 18 months course after completing nursing but in the Nepali system, we candidates begin their intake from SLC (School Leaving Certificate), 18 months midwifery will not be adequate in Nepal so as higher education, we are planning to introduce 3 years bachelor in midwifery with affiliation to TU (Tribuvan University) even though I am an employee of IoM, TU.

I am planning to introduce this course from here (IoM). We have bachelor in nursing, community health, psychiatry, and adult. We have all these courses, why should not we introduce bachelor in midwifery? Many of our colleagues still argue that we should introduce bachelor in nursing/midwifery. Several colleagues are still confused even the same level colleagues.

RA: In the past?

KB: forget about the past. In the past there was a course on bachelor in nursing/midwifery during the tenure of Radha Ranabhat and Gomati didi but it was not in line with the global standard. Our (University’s) mistake is lie there. I am also a professor of university at IoM and now I have understood this subject matter in better way. There are two professions, this is a distinct and separate profession. Nursing and midwifery are two separate professions. These have been moved forward together from the beginning. And, the controversy even today is bachelor in nursing/midwifery. Specializing in midwifery if we say so, it is going to be a part of nursing and a dependent role not an independent one.

RA: that was at the time of 1970s right,

KB: whether you realized it or not?

RA: yes, did realize it. That was of the late 1970s, and now a lot advanced has made in the world. If we talk about ANM, when the idea of ANM came in Nepal and initiated the programme, what were the public health needs by then? And what are such needs now in the country?

KB: yes, now the awareness level among public is already higher, public also talk about their rights. If quality education is not provided? Or if person practice midwifery without having license? Then, it will be legal issue. How do you find about it? You could also provide me suggestions/comments. Whether I am right or not in doing advocacy event?

RA: advocacy is needed otherwise things do not move ahead.

KB: we are still working on traditional way, why nurses always do all the things? If there are midwives in all countries, why people are against on a matter of which in fact benefit to the entire country? Should not we safe to a mother and a child who are about to die during delivery? And, provide adequate training to produce to human resource to work on this sector? SBA training is rather an emergency management. This just give idea on how to handle PPH to a mother during delivery? Likewise, how to handle bridge case *ulto bachchha*? And, if complication of abortion then provide them MVA (manual vacuum aspiration) service. If a client with eclampsia then provide them magnesium sulfate (MgSo4). These are things taught under SBA training. This training has not taught about the woman centered care.

RA: you mentioned that, there is a provision for midwifery education in Nepal under long term goal.

KB: all the high level government officials (doctors, nurses, directors) do not involve in literature review rather move ahead with the surficial understanding then said new wine in old (same) bottle. I spoke at the health link, a talk programme of BNMT (British Nepal Medical Trust) and Dr. Hemang Dixit, ex-dean of IoM, he is now retired, participated in the event and I explained about the advocacy of midwifery, also mentioned about the government of Nepal deeds in midwifery so far. And he told that, what sort of thing you have brought forward, as ANMs have taken their responsibilities in the sector from long ago in the country, so why should we need midwives then? It is like filling new wine in an old bottle, he commented.

I responded him that, sir in the medical science too, a physician and a surgeon were enough in the past so why do you need endocrinology, neurology and orthopedic, nephrology, transplant surgery why do you all these? Transplant surgery that used take place in America now has begun in Nepal.

RA: right.

KB: you need all logy and ask nurses to carry the basket full of loads, I told him. We should learn success stories from others. And, high level officials like ministers, secretaries are asked to prepare action plan/provide budget to bring changes in your country Nepal and safe women then should not we work to safe for women. What the *papiharu* sinners. Why should we do delay in this? This is my question Obindraji.

As I asked my colleagues to initiate programme here (IoM) in the college. We should not initiate new one we should go as it is. My colleagues blame me that rather I am speaking of Euro/Dollar [she meant here *she is indicating the voice of donors than her own*] on it? [Laughing….] where am I going to receive dollar from? A professional advocating for the midwives, I am doing a voluntary job. I work here for my survival, *bhat khane kaam*. After completing my job here I go to there (MIDSON’s office) at three o’clock in the afternoon.

Now we are focusing on humanitarian services, it is more focused on maternal and child health only particularly on RH (reproductive health).

OC: how it has been moving on? We also discussed on it in our last meeting as well?

KB: we are going to organize a dissemination of it next week? Will you be able to participate on it? It is like to be happened on Sunday or Monday next week?

RA: which place does it going to take place?

KB: colleagues are working on the planning part of it.

RA: On Sunday we have our programme.

OC: If it is on Monday, maybe we could make it.

KB: we are organizing an event for dissemination on ‘MIDSON in Humanitarian Service’. We conducted camps, we provided services to about more than 10,000 in the places like Nuwakot. We also had deployed 25 nurses/midwives in the remote health facilities such as PHCC (primary health care center), HP (health post) where there is lack of doctors/human resources. Now we do not have midwives so that we called them nurse midwife. We paid them Rs. 40,000 per month per person and deployment was lasted for three months. It was for serving in acute condition. It was for relief.

RA: was that for three months? This was described in the note too,

KB: we had deployed 25 persons and financial support was from UNICEF, funding should be there from somewhere. As these were not midwives, how should we deploy them in the communities to serve mother and child? We then provided them three days quick training on what to do on midwifery? Then we, sent them to the most affected six districts such as Gorkha, Dhading, Nuwakot, Rasuwa,

Although there were frequent aftershocks, these young professionals completed their job nicely in the community. While reading their reports, we knew that, so we should not underestimate to anyone. Each and every one has their own potentialities, we came to know that. After we sent them with short training of three days, we were worried about them as something could happen to them in the field. Then, we, seniors like ourselves, went to the communities for ‘onsite coaching’ with the models, wherever they (nurses midwives) were deployed. Apart from ‘onsite coaching’ we did monitoring evaluation and very good results came out. Community people do not like to leave our deployed staff. You know Radhaji, what had happened latter?

Basically, district officers sent us an official letter with great appreciation of our work and thanked us for our work at their respective districts then requested to extent their services for next three months. Now, how should we pay to those staff? [Laughing……] we would like to continue their deployment in the respective communities as people are receiving good services there. As there is a visible report is there, there is visible flow of patients there at the health facilities. The number of patients flow is increased as people heard that health workers from Kathmandu has to health facility to provide services, then that will increase patients flow.

Then I had shared this thing with JOY (Camp) and then JOY agreed to support 4/5 staff to deploy for six more months.

RA: oh really.

KB: yes, it has provided support for 4/5 staff for next six months. We need to get approval from Social Welfare Council. Now we are on the process of getting approval. [*She received her phone call]*

 RA: JOY Camp is representative of RCM UK. They receive some fund from the DfID.

KB: [*After the phone call was over*] a midwife from Holland has come to the Teaching Hospital here, and my colleague asked me whether I have time to meet and speak with her? I told her that I could meet and speak so I asked them to visit our campus/my office. She is right now, at the birthing center. We had made a birthing center at here [Tribhuvan University Teaching Hospital] in technical support of MIDSON in collaboration with the volunteers who came here from UK.

RA: oh really, at TUTH.

KB: yes at TUTH, doctor does not care there instead midwife does. When Merry Rose Davis and her colleagues were here in Nepal they provided midwifery training and volunteers also worked together. Now, women give birth at homely environment on floor on mattress. There no old tradition method or lithotomy position. Rather there is support, birthing balls are available here. When you have time, better visit there.

RA: sure, who is there these days?

KB: these days, you may not know them, Kalpana Piya, Prabati Siwakoti, and Sangita Thapa.

RA: I should have known to them if I see their faces.

KB: you know them. It was easy for us to establish birthing center here, it is difficult to work with doctors, they also find it good, and they are on board with us. [*KB’s phone rang and she answered her phone]*

RA: and, how many birthing centers does MIDSON have?

KB: MIDSON does not have its own birthing center. We built this one [at TUTH] in our technical support, we are planning to make it as a role model. And, we would like to build one birthing center of our own at our office at Kupandole. As I mentioned earlier, main problem is our space. We do not have our own space, we do not have our own building, and we operate through rented building.

 There are 3/4 rooms left inside one temple like building and we have hired that place, and from that place we are planning to initiate a midwife led clinic. Anti-natal care and parenting education will be lunched at the very beginning of the clinic. There is parenting class in UK, giving to husband and wife at one place. Counselling is provided to husband and wife together, so that they are ready for child birth so there is no fear of it among them. They are taught in counselling that how to cope? As I have seen such practices in countries outside of Nepal.

So, we even do not have to spend a lot of money for providing such services. I really like to begin one clinic of such kind but I do not have helping hands to initiate the venture. By now, almost all equipment of clinic is ready still we are not able to run the clinic. We have not run it although everything is ready for running it. Colleagues who like to volunteer also has provided their assurance for doing volunteering, that does not move the organization ahead for long run, we should also keep sustainability of it in the mind. Once organization is initiated then it should be moved ahead. So, I have not started it yet. I have been run one or two camps in a week so that local people will know what sort of services we are going to provide through our clinic. So now we are providing one camp in a week. Now we are trying to increase it as regular services or twice/thrice in a week then we can attract to those women who actually walk through Kopondole to reach to the maternity hospital at Thapathali.

Our services apparently can be seen there, always we do advocacy on midwifery then if we do not show one clinic as role model in practice then it will be like listening a story. I really like to run one such type of clinic in the town [She has stressed on this statement].

RA: last time, as per Department of Health Service (DoHS) reports there are around 17, 00 birthing centers across the country. How many are there do you think?

KB: these birthing centers are for the sake of name only. There is provision that every sub-health post will upgrade into health post then build birthing center on it right. We came to know this fact as we travel various districts outside of Kathmandu in post-earth quake situation. If you see the birthing centers outside Kathmandu valley there are in miserable condition. Can it be count as birthing center? As it keeps one bed, a table and some equipment. People even do not know the concept of birthing center. It means, homely atmosphere, stay with her own family, birth companion, delivery conducted by skilled service providers, and walk around, it should be like that.

Patient is restricted to the bed, should stay in very cold, visitors are not allowed to stay in surrounding, and it is like the same traditional method.

RA: so then, it sounds like how delivery takes place in the health post, even that facility was not there before, right. Added one is only a bed right.

KB: there is nothing.

RA: those 1700 birthing centers across the county.

KB: those places where there is follow up, there is a bit better services, skilled staff provide services, and it is like 24 hours and 7 days a week. If would ask a question like, is it birthing center? Then staff answers, yes it is. Then, if I ask another question on how many deliveries conducted in the center then they do not answer about the case load, because there is no case at all in the birthing centers. Pregnant women do not visit to the birthing because pregnant women have not trusted to them (health staff). It is also their (health staffs’) attitude and quality of services. Does providing incentive work alone? Client goes to the place wherever she/he feels safe. Delivery has not taken place in the birthing centers, how many deliveries take place in a month? They mention that 2/3 in entire month. In some other places, even less than that has occurred.

Few days back, near to the Kathmandu, I could bring you there for visit, we had gone to *Bane Gaun* of Lalitpur district for conducting camp. The camp was support by Direct Relief Support. This is a California, USA based NGO, which provides humanitarian support at the time of crisis.

I had sent out MIDSON’s works/activities/ accomplished and press release we made during post-earth in Nepal to everywhere then president of ICM was communicated this news to the Direct Relief Support as a result, Direct Relief Support announced $100 million for MIDSON immediately. Then, what do we do with it? And, Direct Relief Support asked us what your need is? As we mentioned them that we have been engaging in humanitarian services, organizing camps. Then, you continue work on to expand reproductive health (RH) camps, they told us. Another difficulty by then was, travelling to communities, as we had to pay a lot for vehicles at the post-earth-quake context and lately the fuel crisis due to ‘Nepal India Blocked’ had worsen the situation even more negatively. Then, they asked us that, what do you need now? It would be better if we have one vehicle we requested them.

OK, you phrase a vehicle for the camp and ultimately this car will be MIDSON’s car. See Radhaji,

RA: and then, which currency was that 100 million?

KB: that was their’ currency, dollar. US Dollar. If we do the work then fund comes in from unexpected direction. As they asked us to conduct camp in *Bane Gaun* we hand conducted camp with support from Direct Relief Support. See, that was primary health care center. If it is PHC then there is doctor but is it is health post then there will be not doctor. There are two doctors in that PHC but these doctors are positioning their as a part of scholarship of higher study. They have a bonding with government of Nepal so they are there but they will not stay even one day extra after they complete two years of service in that PHC.

As we have visited several communities, they are just counting days for completing their services as part of bonding with government so how could they provide quality care to the community people that is why they are present in the PHC on 2 days in a week. See, they give services only two days in a week.

RA: In Lalitpur... [Laughing]

KB: I will reveal here… and about the staff, if there are three staff with the SBA then they provide services on turn wise and one staff provide service in a day. It is like 24 hours 7 days a week but there is only one staff in the birthing center, because collaborative work with the colleagues and individual is different. There is no controlling and monitoring mechanism, no one can touch no one in Nepal. I feel very sad, we visited their birthing center as they came to about our visit, perhaps they had cleaned the surrounding, and it was all watery and wet. It was an information of just three weeks ago.

When we visited there, our arrival was quite earlier than expected then we witnessed all watery and wet surrounding of birthing center, it might have all dusty and dirty so they hand washed with the water. God had showed us the reality for eye opening [Laughing….]

On that wet situation it has kept one table in the delivery room. How they conduct delivery in such situation. And District Health Officer (DHO) of Lalitpur district was also along with us for monitoring. As we explained the situation to him then he requested us to provide support for the PHC. And then, I told him that, if this health facility agrees, we will provide technical support to it as we have received various equipment form UK such as one Doppler. Any pregnant woman who can listen the heart beats of her baby by herself that brings changes in their faces. See, have you listened your baby’s heart beats, see what a beautiful. As we did that, the facial expression of a mother is different. This is our evidence based practice. And we will provide such Doppler and he asked us to do that. As I asked him to visit me in Kathmandu and I will also show the birthing center here, he has not gotten back to me yet.

Until they have not sent us request letter, we cannot take action for it. Even though I will follow it up once and then ask what they think? What is the status? Also will request them to visit to MIDSON with the official letter.

So regarding birthing centers, whatever number of birthing centers are constructed by government of Nepal there is no quality service in them at all. There is vast, *dherai* difference between statistical data and the existing scenario we see with our naked eyes so that I do not trust on it (statistics). When I observe the situation then it tells me the reality because place like Nepal there is manipulation, everywhere is manipulation. In many of I/NGOs activities/programmes are limited in paper only.

As this is December, everyone is in hurry to prepare report and reporting, no any hotel has vacant room [Laughing……..]

RA: here I would like to follow up some queries which we had in our last meeting. As I spoke with Obindra, how this MIDSON established? How programmes have developed? You have mentioned that donors have also supported, we have done feasibility study as well. Donors like UNFPA, WHO, GTZ, are supporting in midwifery?

KB: these people call as GIZ,

RA: yes, GIZ

How did you approach to them (donors)?

KB: we do not have to approach them, as I mentioned earlier, it is a global voice. A pressure has come to them as well because their field of work is maternal and new born health. What has been there in maternal and new born health which is endorse by UN agencies, is skilled provider at birth. We again returned to the same thing, skilled provider at birth, no woman should die because of the child birth and each and every pregnant and laboring woman must have access of skilled care during the birth. And what type of skilled is a midwifery skilled and who will provide this skill is the midwife.

Is there midwife in Nepal? Searching has begun now in all countries particularly in low income countries. What about the midwife? While doing this, there is no midwife service in Nepal. Right. Only skilled mixed is found in Nepal so have you read the state of the world midwifery report?

 RA: is it published recently?

KB: It has reported on 73 low income courtiers out of 74 low income counties in the world with findings. State of the World Midwifery Report 2014. It was lunched in Prig, Chez Republic. We have been there. I have that report, I have ecopy of that as well. And, I also have presented in several other countries about midwifery of Nepal. Lately, I did presentation in Shri-Lanka as well. State of World Midwifery and status of Nepal, who are the providers? What percentage? What type of categories? In this way I have done assessment. As we have raised such voice globally, we do not have to approach anyone. And, UNFPA is the lead globally to bring the midwives in the country where there is no midwife for this reason, we do not have to find out them (donors) rather they come to us for these days.

RA: and

KB: these days we have been working jointly with ministry. UNFPA, WHO and GIZ are working for developing MOU these days on who does what? Because as we have worked already on various problems. We did assessment? Feasibility study? And we came to know there is no education on midwifery.

What should we do further to introduce midwifery in the country? For instance, people came to visit this institute (IoM) as well and then we reached to the conclusion that we do not have infrastructure, no trained teachers, lack of human resources, and no skilled lab. Now these working partners will help on providing training to the faculty, refining curriculum and support nursing council to maintain regulatory mechanism. Likewise, for quality care to provide support to the advocacy group like MIDSON so things are moving in this way.

We are working with UNFPA right from the beginning 2010. Our office is being run with the technical, logistic and financial support of UNFPA now. We have three staff who is paid by UNFPA and provided all the office equipment including chairs and tables for office. It is located in Kopondole.

As a professional, we should not dependent on donor always, we have to see our own sustainability part as well. So we are moving towards that part as well. We should not have to approach to the donors rather they approach us. They write email to us. Then we will sit for meeting and go for MOU and we will do the consultations of such kinds. For some groups, we do consultancy as well, for instance, UNFPA asked us to prepare a deployment plan of Nepal and I did it accordingly. I have done one of such work. In curriculum development I worked as consultant too. So I do lot of literature review.

Radhaji might have seen State of the World Midwifery Report 2014 and Lancet of Midwifery which is also published in 2014. I have a copy of Lancet at my office I can show it to you but cannot give it to you.

 RA: that is right, I can access it online through my university. I can do it tonight.

KB: so these are some milestones. There has been a lot progress in Nepal in regard to the midwifery. In the past, people did not anything but these days visibility has already been begun to see in midwifery and MIDSON.

RA: It has been 4/5 years since it has been initiated in Nepal right.

KB: 5 years. It was established in February 2010.

RA: so we have to say 5/6 years.

KB: in the coming February. It will be 6 years.

RA: so it has made a lot of progress. And, you do not have scarcity of funding if you can work.

KB: I have been kept telling you, we do not have funding.

RA: the money they give,

KB: they do not give money to the association rather they will give money to a certain package, for instance, as we have to make regulation mechanism for midwifery education in council then they will give money for that.

RA: yes,

KB: if we work on education, than they will give money to university.

RA: you mean, there is no sustainability.

KB: they do not give fund to the association. Association is a lobbying voice and a pressure group and quality care right. And, if you see the pillars of ICM. There are three pillars, they called it as ERA, meaning Education, Regulation and Association. And these three pillars are interdependent to each other. And, it has mentioned that if one pillar among three is weak then the whole system will be weak. Education, Regulation and Association. Education is University regulation is the Council [nursing council] association is MIDSON.

The role of association is more or less to sensitize to colleagues, do advocacy and to work for the capacity building and to work on CPD [continuous professional development] and to provide training and to make visit for quality control we do these kinds of activities. Apart from UNFPA, no other agency has provided funding for these kinds of activities. If fund is given then that will be for fragmented activities.

RA: If you like to work on contract basis then, you may likely to receive funding like package work.

KB: yes, so midwifery association should be made strong by global voices. I would like to repeat the same thing as earlier, we should be provided with working environment, a working space and an enabling environment……[an young nurse with dress came to her and talked for a while]

UNICEF had provided drugs during humanitarian time, we distributed them various health facilities of all 14 hard hit districts. There are still few boxes of drugs, we are planning to distribute them across. Lately, we sent two boxes of drugs to Patan Hospital. To what extent we should work, see.

KB: [would you like to move further towards sunny place or would you prefer to move inside the room]

RA: [if we like we could move further]

KB: are you done with conversation or do we still have something to discuss further?

RA: I have something to talk further, should I called it final or not? It is about statistics, as you mentioned earlier, what has been in the paper? What sort of result is present in December? What naked eyes see? I like to discuss a bit further on that topic.

KB: [Laughing…]

RA: [if we like to move further to sunny place, let’s move ahead]

KB: I have not explored about you.

RA: please do it [Laughing]

KB: I speak, in a one sited way. Haven’t I speaking a lot?

RA: no, it is good. You have not. In fact we have come here to listen you. I think, I came to know from the Facebook page of MIDSON itself, either you or someone else posted it. When new data was published on maternal mortality of Nepal, the official figure that is presented these days,

KB: There is variation in statistic of Population Monograph and other source?

RA: yes, the matter of variation of statistic in different sources wise? After that publication, there was an article in newspaper, which I reached a lot about that latter. What has happened in that regard? I know there is controversy in the statistics.

KB: Government of Nepal does not provide authentic answer on that regard. That is our weakness. As people blame me as I speak in Euro and Dollar. It is like that. WHO come up with one set of data, and Population Monograph of government of Nepal reveals another set of data. What Nepali, we have to think is, we should not depend on the data provided by others right. Government of Nepal itself has to work on that our own HMIS [health information management system]. Department of Health Service (DoHS). They have to do with their own data, perhaps they have been kept doing it, I may be unaware of it. There is different in data. Government of Nepal shows that 229 according to DoHS report and WHO reports 190 and Population Monograph reveals 428 or something. So, this does not look good with such controversial report. Again, in my opinion, If Nepal would able to meet MDGs 4 and 5. There is no need of KWC [she might mean KfW], DFiD. No one is needed, goals have met according to the targets. Then Nepal has made significant progress, now it is time to receive the award.

After this, as Nepal Monograph report reveals 400 which I feel as a drama. If this is not a condition then no any donor will support to Nepal as it has already made progress and then donors think Nepal as well established one. The target of MDG is 134. Then it is on the way to meet the target, as current data is 190. Why do we need the support of foreign donors? We do not need support anymore. In such context, Population Monograph shows, 400 something,

RA: who has brought it in the front?

KB: It is all cleverness of government.

RA: where can we get all these statistical records?

KB: the office of Population Monograph should found once. And the inquired about their recent publication, media persons may know about it. I do not know the office as I accessed it from paper and online sources. It will be found immediately.

RA: I would like to find out that particularly.

KB: we will find that, we will also work for that. What has mentioned in international standard is that, if maternal mortality is reduced to specific number than does not need foreign aid if so then Nepal will be in problem. Again, showing the mortality rate in such height as disclosed by the Population Monograph is very shameful matter.

RA: It has happened suddenly, right. It has almost been settled, it was appreciated around 2010.

KB: It has shown in the report government of Nepal that even during the conflict period of moist movement in Nepal, the number of maternal mortality has reduced significantly from 2006-2012. RA: even though so many questions were raised by then, they claimed that the source of information was reliable.

KB: our country is like this.

RA: the recent statistics on maternal deaths 400 was revealed by Population Monograph. We should check it once. And, WHO has its own statistic.

KB: WHO shows 190.

RA: what about government of Nepal?

KB: 229 [Laughing……..] there are already three different types of data, see.

RA: on what basis government of Nepal produce such data?

KB: I feel, may be, it uses sisterhood method. There are various methods exist. It is all about sampling. A study is being conducted under the title of ‘Maternal Mortality and morbidity Studies’. There is a sisterhood method.

RA: and, what about Population Monograph?

KB: we have not gotten chance to understand, what method it uses for study? We are so busy, we thought that we will look into method local part (which method, sampling) of it? We have not been able to do so, please forward the information to me once you find it out?

RA: sure, we will do it. I have been searching for it quite a while, once I had found it in either *Kantipur,* national daily newspaper published in Nepali language or elsewhere, but it does not describe in detail.

KB: lately, like 2/4 days ago, there was a news on Himalayan Times, an English national daily newspaper published from Nepal about Nepal needs to take an immediate action to reduce newborn mortality in the country. It also talks about skilled human resource, we need midwives, have you read that piece?

RA: I have not seen that one,

KB: have I carried that newspaper with me or not? I made a copy of it and put that at MIDSON. [She searched in her bag but did not find it] Actually, I have not put it in my bag. I was thinking to carry a newspaper.

RA: until few years ago, it used to call, maternal and child health but now it is called as maternal, child and neo-natal health.

KB: In the past, mother health was treated separately, fragmented programme and new-born had also a fragmented programme. These days, it is called that mother and new born are not separable. These should not be separated because they are interdependent to each other.

RA: yes,

KB: for that reason, government of Nepal has even changed the name these days. Now it is called SR-MNH (Sexual Reproductive-Maternal Neo-natal Health). Now all is modified.

RA: what SR means here?

KB: SR-MNH (Sexual Reproductive-Maternal Neo-natal Health). Because, from the age of adolescent people sexual involvement, sexual education, family planning and the problems of adolescent. All these are included. Reproductive health comes only after sexual. Sexual and Reproductive Maternal Neo-natal Health (SR-MNH) these days.

RA: Child has separated now.

KB: yes, it has included in newborn. Child has separate fragmented programme. Only newborn is attached with mother health because until baby is having mother’s milk. Then, child has different programmes. It includes ARI, Diarrhea, pneumonia, and so forth.

RA: there are a lot of things?

KB: there has been a lot of changes.

RA: exactly, I have begun to work in the health sector from Primary Health Care in Nepal.

KB: right, Alma-Ata conference.

RA: we used to study a lot, it is here in the same campus, now all that has become like stories. People even do not understand them.

KB: yes, they do not. Even in our own faculty, many of our colleagues do not understand that concepts, one has to update himself/herself.

RA: This is all I would like to talk, I do not have any further things to discuss ahead.

KB: do you like have tea again? We have canteen nearby, I would ask them to bring here.

RA: we are fine. We have taken your greater amount of time.

KB: I have to go now. I need to go to MIDSON and I have some work here to be completed and I need to work on audit report of MIDSON, an auditor will visit to MIDSON today.

RA: you have been working hard.

KB: I go to MIDSON every day and work till 7 o’clock in the evening. In the winter as I leave office 7 o’clock in the evening there is no any single public vehicle available on the road. Then, I need to take a taxi for home.

RA: where do you live?

KB: I live in new road. It is accessible to the some extent.

RA: it is a center of the town.

KB: sometimes, I easily find public vehicle so it has made my mobility easier. So I have not been to outskirt. Once I will be retired from my position then I will be settled elsewhere. [Laughing...] I have been searching for it but not been able to find one.

RA: May be it has been long you have worked here. How long have you been working here? Where did you work before moving to this place?

KB: 38 years.

RA: since 038?

KB: No, it has been 38 years old, I have been working here. It has been long.

RA: Yes,

KB: I have been working in academia from the beginning of my job.

RA: haven’t you started your job from Mahabaudhha?

KB: actually not, I graduated from Mahabauddha. I did my bachelor in around 2042/43 vs. (1986).

RA: I also did in 1988/89.

KB: oh really. And I did master from south India, Madras. I have not done PhD. I was nominated for PhD from WHO. May be it was not in my luck. There was a family problem by then and I did not go for PhD (Laughing…)

RA: maybe that was fine by then.

KB: yes, that was fine then and I am fine until now. Now, what sort of vision do you have for future? How can we go ahead collaboratively? If you have such provision then please share me with us?

RA: we will share?

KB: these are our milestones. We work with education, regulation and consultant, international and national. ICM, UNFPA and UK have developed our capacity because three years training is not a joke, right. We worked three years with Joy.

RA: they are very positive. Joy camp was positive to Nepal. I have met her in Edinburgh recently. She mentioned that she had returned from Nepal just a week ago. They have a report, right?

KB: a report of a training.

RA: she gave me that report as well to read it.

KB: she loves a lot. While came to Nepal, she has brought laptops, as laptops might have been damaged during earth-quake, you might have problem in infrastructure. And, she has sent message and equipment with other people who are vising to Nepal. She has kept sending, such reports/leaflets, and birthing balls.

RA: she has taken it very positively.

KB: they are planning to conduct a workshop in Nepal six month from now. Their volunteers will also visit Nepal such as people like Marry Rose Davis and the like. Their training support is not in monetary term but in technical one. They visit Nepal in every six months and conduct a workshop. They provide 4/5 lakhs and then they conduct workshop on midwifery where participants from government and regulatory body. And, in every three months their volunteers visit to Nepal and the we provide them placement according to their backgrounds, if they are academic they we place them in the colleges to develop faculty and if they are from service side they are positioned in the birthing centers. We had located lately volunteers here in teaching hospital, they established and at the very day of their return a baby was delivered in the center. They then returned, in this way they have been contributing in our capacity building.

RA: when Marry first came to Nepal she was even not clear on how programme will move ahead? Then she came for second time and she has been more positive toward it. When she came for the first time, she was not clear, how programme will move ahead.

KB: that was even difficult for us too. We have been habituated in context, as they are coming here, where should we placed them? What should we do for them? What sort of process should we follow? In the initial days, we even do not know what training is? (Laughing…)

RA: has MIDSON conducted any project with receiving fund from international donor? Such as Helping Baby’s Breath in Nepal including trainings?

KB: we have received training on Helping Baby’s Breath? I received training as master trainer at the first batch. Then we have to transfer skills. We did it with our own capacity. We did not receive package from anyone. We disseminate among our own members. In some point of time, what we did was, we participated in the training as new ideas/concepts appeared, by collecting Rs. 1000 per person, and it was for our sustainability. The profile of trainees is also developed, they receive certificate as well. Master trainer, basically provides training.

Lately, we have been working on helping mother survive, have you heard of it?

RA: yes, I have heard of it.

KB: it is JHPAIGO’s innovation. And then respectful maternity care. We have conducting trainings incorporating these themes.

RA: so you have not run a fixed package of training.

KB: no, no. Now, after the earthquake, as we have seen/visited various health facilities in different districts, and found that ANMs who serve in those districts are not that much skillful. We are planning with the support from Direct Relief, as I mentioned earlier, 1 million, one corer rupees is how much? How many million is that?

RA: one million.

KB: Nepali one corer.

OC: May it is one million dollar.

KB: hundred million is really a lot. From that amount, as we have seen the actual capacity of ANMs working at different health facilities (birthing centers). Now we are planning to conduct a training for ANMs who are working at various health facilities. We are planning to develop a package for that training.

OC: what sort of training will you conduct then?

KB: It is midwifery update training. We are designing two weeks long training for them. They will in the class for a week and then they will work on clinical side at maternity hospital next week. Once they see with their own eye, if they have to refer the case, how they do it? How service is being provided, as not all of them chance to visit maternity hospital? So we want to make a week long exposure at maternity hospital and a week class room training. By focusing on these two aspects we are developing a training package. There is a lot of works to cover. As there is heavy workload, we have not been able to cover all the tasks. So we requests these students. They are master level students. As they are master level students they can take a leadership role. We have request them to participate also they have received membership form the MIDSON. We provide work to our members.

RA: and, a question was lost form my mind which came to mind earlier.

KB: sometimes it happens. You had asked me question on training.

RA: it was on SBA? I was about to ask question on SBA? As many as 7000 almost health workers have received this training, there are about 6500 or so? How is their effectiveness? In your opinion?

KB: its effectiveness is like plus and minus. 50/50. We cannot say 90%. Because a lot of studies on it have been done. Ministry has also done a study on it. Nick Simon Institute (NSI) had run a programme called FEP (fellow up enhancement programme). Do follow up on how SBA training has been moving ahead but enhancing in case any defect is found while doing follow up. MIDSON had conducted a study on follow up on SBA.

So, talking about SBA, there is wrong in selection process of SBA. Close persons are selected for the training and after graduated from training they have not done any work on maternal and child health, if a person runs a pharmacy then he/she is selected for SBA training. People who have received SBA training actually have not done work on maternal and child health. For this reason, SBA training has not been that much effective.

This has not even been implemented for example, a pantograph, and an important tool, not only a successful SBA graduate do not know how to fill it but also a trainer of SBA becomes confused while filling it up. If so then what is the quality of SBA training now you can imagine, things like this. At the level of ministry, secretary was Prabin Mishra, by then, about 2/3 years ago. And there was a sharing of SBA follow up once these things were revealed then secretary became so annoyed and asked to find out the defect immediately? Is it a defect of trainers or training? He had given an instruction, now you can imagine how effective the SBA training is? (Laughing…)

RA: the concept of it (SBA) had come into being actually?

KB: this concept was derived from Pakistan, skill birth attendance in the low income countries where human resource is lacking and any how the maternal and new born should be saved, with the lifesaving interventions.

RA: perhaps, a pilot study of it had done in Pakistan.

KB: It was initiated from Pakistan. The conference, itself on SBA was held in Islamabad. We called it here as Islamabad conference. From the Islamabad conference, the concept of SBA was derived it was for low and middle income resource countries and then it introduced in Nepal. It is very good one. In terms of skill birth attendance, who is the skill birth attendance? Doctor, nurse midwife. So it is an additional training to doctor, nurse and midwife. Lifesaving skills. We do not have midwife in our context, it become so as it has provided to doctor and nurse only. (Laughing…)

RA: suppose, you have abundance of money, in your opinion; there will not be any obstruction due to money, do you think Nepal needs SBA training anymore or not?

KB: Nepal still needs it. It has been mentioned in the policy that SBA training will be closed and substituted with midwives but it still needs to Nepal because SBA training is for the doctor, nurse and midwife. Who is SBA? SBA is a person accredited such as doctor, nurse, and midwife according to international definition.

RA: how it could be move ahead?

KB: so it can be taken as CPD [continuous professional development]. Skills should be enhanced continually for that reason, I have mentioned to you SBA is still needed in Nepal but it is not in replaced of midwife (Laughing…)

RA: and how should we make it effective? Like CPD, training should be provided to appropriate ones only. I feel these days it is more like blanket.

KB: it is more like blanket. Anyone who even apply to collages for teaching and they are asked that have they received SBA training?

RA: oh

KB: so people begin to run SBA training privately? And charges Rs. 35,000 per participant. If I am a leader then I encourage people to participate in SBA training conducted privately. Government of Nepal provides it in fee of cost to those candidates who are serving in different health facilities.

Then, at the time of budget closing; when there is no training from government of Nepal, people run this private SBA training. During Jestha/Aasar (May/June) government of Nepal does not release budget for SBA training. Right, Obindraji, are you getting it? During that time, these private institutes run private SBA training?

RA: who runs this kind of training?

KB: listed sites are formed for the training of SBA. Such as maternity hospital, Biratnagar, Chitwan. There are SBA sites in different districts about 50/55 SBA training sites across the country. As such training is conducted in a massive way, now one institute which runs SBA training massive is being under the investigation of CIAA. [Laughing……]

So we cannot say anything in Nepal is like game of give and take is happening here.

RA: interesting

KB: you came to know a lot from my side right.

RA: we came to know a lot.

KB: so if we have to make SBA package more effective, it should not be provided for two months long duration. It takes a staff from one health facility for two months. They should be invited to Kathmandu. MIDSON had run a modular SBA which means providing SBA training by going to the same working site. We have worked a lot for modular SBA. We conducted in the health facilities.

OC: how long does this training last for?

KB: It is also lasted for 2 months but we provided it on the fragmented basis so that staff from health facility does not have to leave the facility for training. We provided it at their door.

OC: do you have any closing question, she looks in a bit hurry.

RA: I will get contact to talk further. I will be around. I will see you again.

KB: how long are you staying here?

RA: I will stay 2/3 more weeks. We do not have to cover all today.

KB: and, you could put forward further question.

RA: if can be of help, please inform us accordingly.

*Reflection:*

*Unlike her constant advocacy for necessary of midwives in the country for the improvement of services for maternal and child health and their mortality and morbidly. A couples of more important and interesting things she highlighted in this conversation were: (a) there is a vast difference between the increasing number of birthing centers across the country and quality of services these centers actually provide for institutional delivery [which she mentioned that witnessed with her naked eyes] (b) controversy and conspiracy regarding to the different sets of different institutions have recently produced at the dusk of MDGs. (c) shifting of language in the maternal child health projects over the time such as MCH, MNCH, SR-MNH. These were some of the striking things of the conversation, think, we need to explore further.*