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ACCOUNTABILITY FOR HEALTH EQUITY: GALVANISING A MOVEMENT FOR UNIVERSAL HEALTH COVERAGE

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Notes on Article Contributors	v
Notes on Multimedia Contributors	xi
Foreword	
The International Health Partnership for UHC 2030 (UHC2030) Core Team	xiii
Introduction: Accountability for Health Equity: Galvanising a Movement for Universal Health Coverage	
Erica Nelson, Gerald Bloom and Alex Shankland	1
Introduction to Multimedia	
Sophie Marsden, Karine Gatellier and Sarah King Vaishali Zararia, Renu Khanna and Sophie Marsden Denise Namburete and Erica Nelson	17
Health Accountability for Indigenous Populations: Confronting Power through Adaptive Action Cycles	
Walter Flores and Alison Hernández	19
Inverted State and Citizens' Roles in the Mozambican Health Sector	
Jose Dias and Tassiana Tomé	35
<u>Accountability and Generating Evidence for Global Health: Misoprostol in Nepal</u>	
Jeevan Raj Sharma, Rekha Khatri and Ian Harper	49
The Political Construction of Accountability Keywords	
Jonathan Fox	65
Key Considerations for Accountability and Gender in Health Systems in Low- and Middle-Income Countries	
Linda Waldman, Sally Theobald and Rosemary Morgan	81
Gendered Dimensions of Accountability to Address Health Workforce Shortages in Northern Nigeria	
Fatima Lamishi Adamu, Zainab Abdul Moukarim and Nasiru Sa'adu Fakai	95
Reducing Health Inequalities in Brazil's Universal Health-Care System: Accountability Politics in São Paulo	
Vera Schattan Coelho	109
Making Private Health Care Accountable: Mobilising Civil Society and Ethical Doctors in India	
Abhay Shukla, Abhijit More and Shweta Marathe	129
Neglected Tropical Diseases and Equity in the Post-2015 Health Agenda	
Emma Michelle Taylor and James Smith	147
Glossary	159

Accountability and Generating Evidence for Global Health: Misoprostol in Nepal*

Jeevan Raj Sharma, Rekha Khatri and Ian Harper

Abstract Postpartum haemorrhage (PPH) is a major cause of maternal morbidity and mortality in Nepal. Compounded by the remote terrain, endemic poverty, and a lack of access to health facilities, the use of misoprostol has advantages over the standard use of oxytocin for PPH management. Drawing on our qualitative study of a pilot intervention managed by the Nepal Family Health Programme, we map the institutional relationships involved in the design, implementation, and practices for bringing misoprostol into national policy. In the intense and competitive global and national policy arena, sustained lobbying and getting the ‘right people’ on board were as powerful drivers as the quality of the intervention itself. The case study takes us to the heart of the debate around the politics of generation of evidence for interventions in global health programmes, and ultimately the question of accountability for health policy and practice.

Keywords: maternal health, accountability, evidence, health policy, Nepal, misoprostol, development.

1 Introduction

Postpartum haemorrhage (PPH) is a major cause of maternal morbidity and mortality in Nepal and in the global South. It is estimated that about a quarter of maternal deaths are caused by PPH (Rushwan 2011; Say *et al.* 2014). Misoprostol is a drug that causes the uterus to contract and thus stop PPH (Allen and O’Brien 2009). In May 2011, the World Health Organization (WHO) 18th Expert Committee on the Selection and Use of Essential Medicines approved the inclusion of misoprostol for the prevention of PPH in settings where injectable uterotonics,¹ mainly oxytocin, are not available or feasible (Chu, Brhlikova and Pollock 2012). In this article we explore, in the context of Nepal, a programmatic intervention set up to demonstrate the feasibility of misoprostol distribution by female community health volunteers (FCHVs) run prior to WHO approval. As a part of the Biomedical and Health Experimentation in South Asia (BHESA) research project conducted in Nepal, India, and Sri Lanka between

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2010 and 2013, we investigated a pilot intervention carried out under a bilateral programme of the United States Agency for International Development (USAID) and the Government of Nepal that took place in Nepal's Banke District between 2005 and 2007. At the time of our field research, this had already been incorporated into national policy.

We began by researching the individuals, organisations, and institutional arrangements that were responsible for bringing the idea of misoprostol to Nepal, managing this pilot intervention and lobbying for its scaling up into national policy. This included mapping the role of organisations and individuals and their key relationships and networks in this process. We looked through the webpages of all the organisations involved in the bilateral programme managing the pilot intervention, and collated their publications including reports, technical briefs, and two academic articles that were published in 2006 and 2010 in the *International Journal of Gynecology & Obstetrics*. We carried out interviews with staff members and consultants involved in this initiative, and government staff who were directly involved in the pilot and its scaling up into policy. We also conducted ethnographic fieldwork in Banke District where the pilot intervention took place, and interviewed staff at the District Health Office, health workers in sub-health posts, as well as FCHVs who were involved.

Our aim was to chart the considerable work done by the individuals and organisations, and understand their relationships and networks during the process of getting misoprostol into national policy. We reveal how in the intense and competitive policy arena, sustained lobbying and getting the 'right people' on board were as powerful drivers as the quality of the intervention itself. Underlying the intervention were strong ideological drivers and the vested interests of USAID, WHO, and international research organisations, and complex national and international organisational politics.

Central to these relationships and their configurations is the question of accountability. In our view, there are two ways to think about accountability in the context of this empirical research. First, the global health landscape and associated accountability structures is increasingly complex, with the entanglement of public and private actors (Horton 2014; Bruen *et al.* 2014). The involvement of chains of private actors that mediate the relationship between global health policies and local populations raises critical questions on overlapping and competing mandates (Sharma *et al.* 2017) as well as risks involved with diluting responsibility across a broadening set of actors (Bruen *et al.* 2014). Who should be accountable for global health programmes that involve a large number of actors with varying degrees of power and influence? How should the relationships of accountabilities be worked out amongst different actors, including funding agencies, host governments and their ministries, the implementing agencies (be that primary health-care providers from government and/or non-governmental organisations (NGOs)), and the recipient populations?

Second, accountability concerns within global health programmes are being informed by new norms such as value for money and measurable results as a way to address accountability (Fan and Uretsky 2017). There is increased economic and political pressure to demonstrate the impact of projects and programmes in terms of demonstrating that the disbursement of resources is tied to measurable results (Horton 2014; Valters and Whitty 2017). This has given rise to new institutional forms including monitoring and evaluation and the critical importance of generating evidence within programmes. Not only are programmes increasingly organised as a set of measurable results, with costs directly linked to the achievement of those measurable results, they are also increasingly organised around ‘pilot’ interventions. Essentially, these shifting norms shape the very idea of health and how health programmes should be designed and implemented. In this sense, the ideas associated with accountability are shaping the way we define the problem, prioritise the interventions, and measure their outcomes.

Thus, this case study takes us to the heart of the debate around the politics of generation of evidence for interventions in global health programmes, and ultimately the question of accountability for health policy and practice. It is an example of but one programmatic intervention being undertaken in Nepal, reflecting the increasing complexity of constellations of organisations involved in the provision of health services. A final caveat is methodological. We do not make normative claims or suggestions for change to accountability mechanisms, or ascribe normative judgements (be these ideological, ethical, or political). Our approach is ethnographic, and we provide this case study as a way to think where we place the primacy of responsibility: either at the level of the state, or with bilaterals that fund, or with NGOs in this context.

2 Background

PPH is defined as loss of greater than 500ml of blood following within 24 hours of vaginal delivery (WHO 2009). Given widespread poverty, anaemia, unequal gender relations, remote terrain, and limited access to health facilities resulting in high numbers of home deliveries without skilled birth attendants (SBAs), PPH is a major cause of maternal death in Nepal and much of the developing world (Rushwan 2011; Say *et al.* 2014; Suvedi *et al.* 2009).

Endorsed by WHO, oxytocin is the preferred option for the management of postnatal care but it needs to be administered by injection by a health professional, and requires a cold chain for storage (Chu *et al.* 2012). Thus, whilst effective, this limits its use practically (Prata, Bell and Weidert 2013). Despite considerable efforts to increase institutional delivery in Nepal, including new innovations such as maternity incentive programmes,² the institutional delivery rate stood at 35 per cent in 2011 (MOHP, New ERA and ICF International 2012).

Misoprostol was developed by SEARLE (now Pfizer) in 1973. The US Food and Drug Administration (FDA) first registered it in 1988 for

the treatment of gastric ulcers (Millard, Brhlikova and Pollock 2015). It was also found to cause the uterus to contract, which is why it is considered as an option to stop PPH, and was increasingly used 'off-label' for different purposes (*ibid.*). More importantly, unlike oxytocin, it can be taken orally, sublingually, or vaginally, and does not require a cold chain for its storage, and thus it is considered by some to be a suitable option in the absence of skilled medical professionals. For these reasons, it is thought to be a suitable solution for the management of PPH in low-income settings (*ibid.*). In the last two decades, there have been a large number of pilot interventions in low-income countries such as Nepal that assess misoprostol's efficacy and the feasibility of distribution by community health volunteers (*ibid.*).

Jhpiego conducted the first study on community-based distribution of misoprostol in Indonesia (Sanghvi *et al.* 2004). The purpose of this study was 'to demonstrate the safety, acceptability, feasibility, and program effectiveness (SAFE) of community-based distribution and use of oral misoprostol to reduce PPH in areas where a large proportion of births are not attended by skilled providers' (Sanghvi *et al.* 2004: viii). As we were told by a senior official at Jhpiego, they wanted to take 'misoprostol treatment outside of the formal system'. It showed dramatic impact. Although interestingly this was never published, the results were widely disseminated at a meeting in 2004, and were widely cited, and – we were informed – therefore 'didn't really need publication'.³

As is apparent from cautionary statements put out by WHO, their resistance to the use of misoprostol was mainly threefold: first, against the ideas of self-administering; second, concern with the as-of-yet unreported side effects of the drug (for example, uterine rupture if taken too early). One of the publications advocating WHO's cautionary approach quoted Sir Iain Chalmers: 'Because professionals sometimes do more harm than good when they intervene in the lives of other people, their policies and practices should be informed by rigorous, transparent, up-to-date evaluations.'⁴ And third, as reiterated in the interviews we conducted, that it would detract from the use of SBAs. The subsequent approval of misoprostol by WHO in May 2011 has increased promotion for community-based distribution in low-income countries, although the scientific evidence has been contested.⁵

Called '*matrisurakchya chakki*' in Nepali (literally translated as 'safety tablet for mothers'), the push for its widespread use was directly stimulated by targets for Millennium Development Goal 5, and is embedded in the rise of metrics and measurement in global health programmes (Adams 2016). This discourse is driven by 'magic bullet' solutions to complex global health challenges. In addition, scholars have commented on the role of networks of organisations and individuals with substantial financial and political backing from major foundations, in influencing WHO's decision to include misoprostol in its Essential Medicines List (Millard *et al.* 2015), and the role of civil society organisations in Uganda (Atukunda *et al.* 2015). In this article, we offer an ethnography

of how misoprostol made it into Nepal's national health policy as a part of a pilot intervention despite resistance from WHO. We offer an analysis of how sustained lobbying and getting the right people on board were critical in this process.

3 Evidence generation in the health sector in Nepal

Elsewhere we have charted the history of scientific research in the health sector in Nepal and its close ties to development aid (Sharma, Khatri and Harper 2016). Much of this research activity in the health sector is sponsored by bilateral aid agencies such as USAID and/or carried out by development institutions, often in collaboration with universities and research institutions. Not only have the discourses on evidence become central in proposing solutions to health challenges, health programme interventions are increasingly designed to generate evidence. With organisations like the Global Fund, for example, demanding that the resources are now dispersed based on performance linked to indicators, this increasingly drives how organisations design their programmes.⁶ Thus, the accountability and results agenda in global development and health debates have directly shaped these forms of interventions (Adams 2016; Valters and Whitty 2017).

This form of generation of evidence around programmatic interventions has been sustained by assemblages of local and international organisations and universities, and supported and funded by aid institutions. These assemblages and institutional forms involving donors and their advisors (bilaterals; international non-governmental organisations (INGOs)), government policymakers, programme managers working for governments, INGOs, and NGOs, and researchers are not only critical in the generation of evidence but also provide much-needed networks of support for the successful up-scaling of pilot projects (Sharma *et al.* 2016; Harper 2014). In Nepal, several NGOs and a few private research firms specialising in health systems research have emerged that mainly work on short-term sub-contractual agreements with the government, bilateral, multilateral, and private philanthropic organisations.⁷

Given the small number of these institutions, reflecting the limited research capacity in-country, they are often oversubscribed by the sponsors. The short-term nature of the contracts mean that they are constantly busy in simultaneously handling multiple projects while moving to the next one (*ibid.*). These evidence generation activities are dispersed and hidden under various programmatic interventions and it is almost impossible to map all the ongoing activities (Sharma *et al.* 2016). There is no clear definition as to what is regarded as health research activity and thus what needs approval from the Nepal Health Research Council (NHRC) and what does not. The misoprostol pilot intervention that this article reflects on did secure NHRC approval.

Given this background, Section 4 examines the specific institutional arrangements around the introduction of misoprostol.

4 Institutional arrangements

In Nepal, the network to introduce misoprostol into the government's national programme coalesced around the Nepal Family Health Program (NFHP). It has broad aims, particularly to support the Government of Nepal's goals of decreasing fertility and under-five mortality, through providing basic family planning, and maternal and child health services.

This has involved the following partners, for phase 1 (2002–07): John Snow Inc. (JSI); EngenderHealth; Johns Hopkins University/Center for Communication Program (JHU/CCP); Jhpiego; CARE; Save the Children Federation/US (SCF/US); the Nepal Fertility Care Center (NFCC); the Nepali Technical Assistance Group (NTAG); Management Support Services (MASS); and the Adventist Development and Relief Agency (ADRA).⁸ And for phase 2 (2007–12): JSI Research and Training Institute (RTI), and its partners – Save the Children; EngenderHealth; Jhpiego; World Education; NTAG; NFCC; MASS; the Nepal Red Cross Society; the United Mission to Nepal; the BBC World Service Trust; the Digital Broadcast Initiative Equal Access Nepal; and the Family Planning Association of Nepal.⁹

This ostensibly bilateral programme funded by USAID had its own office, separate from the Ministry of Health. Its well-furnished offices and staffing conditions by far exceeded the budget of government departments. One senior member in NFHP described it as 'a consortium of different parties' – not registered as a different organisation, and staff are paid by different partners.¹⁰ Thus NFHP was not an NGO, government department, or a unit of USAID; it was essentially a consortium of several key organisations that brought together different expertise on technical knowledge on maternal health, logistics, and communications. It had significant leverage in health systems development in Nepal.

Accountability fell to both USAID and the Government of Nepal. NFHP management had to report to USAID. As a bilateral programme, NFHP had the authority of the Government of Nepal, although it sat outside of the government structure. Although the activities of NFHP were carried out through the government structure and with the engagement of government staff, these staff did not have leading roles in shaping the programme. In other words, the government was accountable for the programme, although NFHP project staff largely carried out its activities. NFHP had a budget of about US\$25m. It had hired a number of highly experienced expatriates as well as Nepali professionals with deep knowledge of the health system and service provision in Nepal. Many of the employees were former employees of the government, or had been employees in phased-out USAID-funded projects with the required skills and relationships for navigating the health system. At the time of our fieldwork, the team leader of NFHP was hired under EngenderHealth, a New York-based organisation. Some of the key organisations have headquarters in the US (Jhpiego in Baltimore, JSI in Boston, SCF/US in Connecticut with project offices in Nepal, Venture Strategies in California). The others are based in Nepal.

Table 1 Key organisations in the NFHP consortium

Organisation	Main objectives	Role in NFHP
Jhpiego ¹¹	Promotes practical, low-cost innovations to improve the health of women and their families	Technical support and training
EngenderHealth ¹²	Develops private sector involvement, particularly around sexual and reproductive health, and promotes social franchise	'Nepalising' the training materials
John Snow Inc. (JSI) ¹³	Improves the health of underserved people and communities	Management of logistics
Johns Hopkins University/Center for Communication Program (JHU/CCP) ¹⁴	Mobilises health communications to save lives and transform public health system	Development of communications strategy and materials
CARE Nepal ¹⁵	Empowerment of poor, vulnerable, and socially excluded people to fulfil their basic needs and achieve social justice	Support in the formal handover of health facilities to local communities in 17 districts
Save the Children (SCF/US) ¹⁶	Improves the lives of children worldwide	Support in the formal handover of health facilities to local communities in 17 districts
Nepal Fertility Care Center (NFCC) ¹⁷	Provides standardised reproductive health services across Nepal as well as supporting the government by training direct and indirect government and NGO health personnel	Technical support on family planning and reproductive health services
Adventist Development and Relief Agency – Nepal (ADRA) ¹⁸	Creates just and positive change through empowering partnerships and responsible action	Implementation of the programme in selected districts
Valley Research Group (VaRG) ¹⁹	Conducts applied socioeconomic research including action research, and offers training and consultancy services	Carries out operational study with a baseline and endline survey
Management Support Services (MASS) ²⁰	Delivers innovative and customised management services which include logistics planning, supply chain management, HR management, organisation development, and research studies	Financial and organisational management
Nepali Technical Assistance Group (NTAG) ²¹	Enhances technical and management capabilities of health personnel working in various health programmes	Technical support on the delivery of community-based approaches to the programme
Venture Strategies for Health and Development (VSHD) ²²	Stabilise global population by securing women's freedom to choose their family size	Lobbying for misoprostol to be registered as an essential medicine ^{23,24}

Sources See endnotes 11–24.

Table 1 details the key organisations, their objectives, and roles in the NFHP consortium.

Table 2 Misoprostol in Nepal: key developments

1973	SEARLE (later incorporated into Pfizer) develops misoprostol
1988	FDA registers it for off-label use
2001	NFHP (2001–06) starts in Nepal
2003	NFHP submits published evidence on misoprostol to FHD
2000–03	Jhpiego carries out first pilot of community distribution of misoprostol in Indonesia, which gets published in 2004
2004	Jhpiego organises PPH Bangkok meeting – attended by director of FHD from Nepal
2004	NESOG Scientific Meeting
2005	Department of Drug Administration (DDA) approval of drug for pilot
2005	NHRC approval for pilot study
2005	TAG (technical advisory group) meeting makes recommendation to National Safe Motherhood and Neonatal Sub-Committee
2005	Baseline study in Banke, training and pilot intervention starts
2006	Paper from baseline published in <i>International Journal of Gynecology & Obstetrics</i>
2007	Endline/follow-up survey in Banke
2007	A follow-up to NFHP, NFHP II (2007–12) starts in Nepal
2008	Misoprostol included in national Essential Drug List (EDL)
2008	Approved for national programme
2012	WHO approves the inclusion of misoprostol for the prevention of PPH in settings where parenteral uterotonics are not available or feasible

Source Chu *et al.* (2012); Hobday *et al.* (2017); and interviews in Nepal (see endnotes 25–45).

This constellation of organisations indicates that there is a complex relationship between them, their roles and responsibilities (frequently in the guise of ‘technical support’), and the state. Calls for proposals to implement programmes are now increasingly issued by USAID, and others such as the Department for International Development (DFID) (UK aid), and consortia such as these apply.

Having outlined the main organisational arrangements of NFHP, we now turn to the work involved in bringing misoprostol’s programmatic presence into Nepal and stabilising it.

5 Misoprostol enters Nepal

Under NFHP, there was considerable work undertaken to bring misoprostol to Nepal (see Table 2 for a chronology of the key dates in this process). Initially, the Ministry of Health was reluctant to start the

misoprostol pilot.²⁵ It took more than a year for NFHP to convince the government. In 2003–04, NFHP staff presented the concept of using misoprostol in various forums in Nepal. Its lobbying included giving presentations at the Nepal Society of Obstetricians and Gynaecologists (NESOG) and to other critical stakeholders on maternal health in Nepal.²⁶

In 2004, Jhpiego organised a conference in Bangkok to disseminate the results of its study on community-based distribution of misoprostol in Indonesia,²⁷ to which it had invited teams from 18–20 countries.²⁸ NFHP took a strong team from Nepal led by the director of the Family Health Division (FHD) who committed that Nepal would pilot the misoprostol study.²⁹

Following on from this, a senior staff member from Jhpiego shared the idea of using misoprostol in the National Safe Motherhood and Neonatal Sub-Committee meeting in September 2004.³⁰ Likewise, NFHP facilitated the visit of an expert on misoprostol from Indonesia, who shared the Indonesian experience in the sub-committee meeting.³¹ Presentations by these authorities at the FHD were an important part of the lobbying. NFHP worked with the Ministry of Health to ask for the opinion of NESOG and the Maternity Hospital regarding the use of misoprostol.³² A major constraint in bringing misoprostol to Nepal was that the drug was not licensed in Nepal at that time, plus there were fears that it could be used for abortion.³³ Resistance was an issue from the perspective of the programme director. There was widespread speculation that misoprostol use could also deskill SBAs.³⁴ Overcoming such resistance was also about having the right political weight behind the programme. Therefore, lobbying and networks of alliances of NFHP was critical. Hence, as one senior Nepali researcher argued, getting research into policy is about leadership:

I think it's the leadership. It depends on the leader how he thinks for the country. Our Director-General, Dr X is one of the best in public health and among those who understands what is needed for our country. In the beginning, he initiated... There were programmes like chlorhexidine and other programmes and we all voted for [this programme] and he also felt strongly [about] it. So, when the leader says it, it's not difficult.³⁵

When NFHP started this work, there was no legal provision for medical abortion in Nepal³⁶ and therefore the use of the drug was a sensitive issue. But there was a provision that the drug could be imported with specific instructions under the recommendation by NESOG. NFHP applied to the Department of Drug Administration (DDA) and also to the NHRC for ethical clearance. NFHP held a few meetings with the director of DDA, after which Cipla started dealing with the DDA.³⁷ It did not take much time at the NHRC to get the clearance because the pilot intervention was seen to be the 'FHD's work'.³⁸

6 Banke pilot intervention

Banke District in the western Terai region of Nepal was chosen for the pilot intervention. This district was regularly used for pilot interventions and trials, and so already had experience and an operational research infrastructure in place.³⁹

The research study was designed to test the feasibility of community-based delivery of misoprostol by existing public sector community health volunteers, with self-administration of three 200mcg tablets by women delivering at home (Rajbhandari *et al.* 2010).

This PPH-related work was one of a broader set of activities, intended to improve maternal and neonatal outcomes, implemented by the district public health system with support from the Nepal Family Health Program (NFHP) funded by the United States Agency for International Development (USAID) (Rajbhandari *et al.* 2010: 283).

In this sense, NFHP already had an infrastructure and relationships set up for this pilot intervention.

From USAID's perspective, it was important that the pilot intervention included distribution of misoprostol through FCHVs, a community-based unpaid cadre that it has been supporting over the years. As part of its focus on services for and by women, extending services beyond the health facilities and promoting maternal and child health, USAID has continued to provide technical and financial support for the FCHV programme's expansion (Justice *et al.* 2016).

Health posts in Banke were painted with the message to use misoprostol. A senior official said: 'We had to picturise shivering (a potential side effect) for the flip chart. This was very challenging. Transferring technical knowledge was very difficult and it was a turning point for me.'⁴⁰

Logistics was a major component of this work and JSI managed all the logistics as they had been managing it for the family planning programme. NFHP had set up a monitoring and evaluation system, and it used highly experienced staff who had served at a well-known research organisation – New ERA – for a long time. International consultants were hired to help with monitoring and evaluation work.⁴¹ The regional office of NFHP was fully dedicated to implementing the project in Banke, and provided oversight for misoprostol distribution and other community-based maternal–neonatal work.⁴² The District Public Health Office (DPHO) team in Banke was fully involved in supporting the implementation of the project and provided management oversight.

The USAID budget could not be used for buying the misoprostol tablets and therefore Plan International Nepal paid for the medicines.⁴³ When the tablets came from Cipla, there were four 200mcg tablets in one packet. NFHP repackaged them to contain three tablets in one packet as the required dose was 600mcg, and also relabelled the packet as '*Matri Surakscha Chakki*'.

Government staff trained FCHVs for seven days, of which three days were focused on misoprostol. In addition, as a part of the pilot intervention, household surveys (which included 30 clusters of 30 households each) were conducted at baseline and at endline. A Nepali private research organisation, Valley Research Group, was subcontracted to conduct the survey. Baseline fieldwork was done in May–June 2005, about six months prior to the implementation of the programme, and the endline survey was done in June–July 2007.

The study found that out of 840 post-intervention survey respondents, 73.2 per cent received misoprostol. The standardised proportion of vaginal deliveries protected by the uterotonic rose from 11.6 per cent to 74.2 per cent (Rajbhandari *et al.* 2010). The study concluded that community-based distribution of misoprostol for PPH prevention can be successfully implemented under government health services in a low-resource, geographically challenging setting, resulting in much increased population-level protection against PPH (Rajbhandari *et al.* 2010).

7 From evidence to policy

The findings from the Banke intervention were published in the *International Journal of Gynecology & Obstetrics* in 2006 and 2010 (Rajbhandari *et al.* 2006; Rajbhandari *et al.* 2010). However, as we show above, the decision that misoprostol and its community-based distribution was the right policy direction had already been made by a committed group of individuals and institutions prior to the publication of results. The key players – the FHD, NESOG, and the DDA – had all been involved from the beginning. The process was incremental. Not only was the pilot intervention implemented through the government system in Banke, but there was considerable work to engage decision makers in government offices through frequent working group meetings. The health minister had come to Banke to launch the programme. The Director-General was very supportive from the outset, and is one of the co-authors of the article, indicative of the support levered for the intervention.

As we have seen, the role of NFHP was central to this process. NFHP had created the necessary social and political networks to scale up the pilot into a national programme. After the successful result from the pilot, the programme was implemented in additional districts where further partner organisations could monitor and the government had begun to take responsibility to implement and monitor without external support.⁴⁴ In March 2010, there was a presentation on misoprostol at another conference in Bangkok. The government then committed to a national-level programme for misoprostol. An action plan was announced and the findings of the study were further discussed in the National Safe Motherhood and Neonatal Sub-Committee meeting, supported by the technical advisory group (TAG). The final ratified decision to make it a national programme was taken by the Ministry of Health.

8 Discussion

As shown above, the technical brief and the journal articles demonstrate that the narrative framing was set up to push debate within the health sector in Nepal. The intervention also fell firmly within the existing drive of USAID-funded programmes: that not only was it possible to run such a programme through the FCHVs, but they actively asked for more of this kind of work; that the programme reaches the disadvantaged segments of the community (hence hitting the right social inclusion discourses, pushed in particular by the World Bank); that this intervention is only *complementary* to the push (mainly by DFID) to attempt to increase the institutional delivery of babies, and where the drug sanctioned is the injectable oxytocin, thus attempting to allay these fears; and that the pilot intervention had demonstrated that it is possible to mobilise the resources and will of a range of partners so that rapid expansion could occur.

At stake here, we argue, was an ideological disagreement between WHO and Jhpiego, and its acolytes: WHO promoted the use of SBAs for delivery and were not on board with the use of misoprostol. We were informed by a senior member of NFHP that WHO also mentioned that if misoprostol has to be distributed, it must be through the health workers, not the community-based volunteers. The research participants felt that the difficulty was also because the Nepal government strongly adheres to WHO recommendations, and therefore it took quite some time to convince the authorities to pilot this study, which was an exercise solely intended for policy uptake.⁴⁵

While Millard *et al.* (2015) have pointed to the increasing role of networks in getting misoprostol onto the WHO Essential Medicines List, what they miss in our opinion is the underlying ideological struggle that misoprostol was able to lever: the relationship between the power of medical authorities and women; that is, ultimately, a question of who has control. We were informed that the first presentations of the SAFE study were to NESOG in Nepal and other professional societies, such as the Nepal Paediatric Society, for this very reason. It was the obstetricians and doctors that were particularly against this use of misoprostol on the grounds that the mode of delivery is crucial, and institutional support is a necessity, should anything go wrong, for identifying the side effects, etc. It is, however, this very lack of institutional support through much of rural Nepal that the pro-misoprostol lobby were using in arguing for its use. As one interviewee stated in lobbying the use of FCHVs, 'Every question was answered'. Thus it was able to show that here was a country 'reaching an MDG with less than 30 per cent skilled birth attendants, and it is community driven!'

Our conclusion from this work is that whether a study becomes policy or not ultimately depends on how well the researchers take part in the policymaking discourse. Researchers can work on their own and disseminate their findings, but successful scaling up depends on the strength and relevance of the political and policy networks of the

research group. Hence, we might argue, as Mosse (2004) has done more broadly for development interventions, that the outcome of policy or research is not as important as the generation of increasingly dense networks to sustain these relations and the flow of resources.

To conclude, the research delved into the interstices of development and health, but also the arena of where programmatic interventions and research intersect. We felt that we could make visible some interpretive dimensions on accountability that might have otherwise escaped us. This ethnography poses questions as to where to situate responsibility and accountability in the context of overlapping and competing mandates between different public and private, and national and international organisations, and the degree of programmatic evidence needed. Our work shows how accountability is dissipated across the organisations, each of which has a different role to play in the consortium, but is accountable financially to USAID, or their board which lies beyond the Nepalese state. In addition, the use of pilot projects such as the one we have described, and the increasingly evidence-based drive (to persuade at the level of national policy and for sceptics in powerful positions) makes it possible to lay broader claims for the model. If accountability is about laying claims to success and failure, then the programmatic pilot intervention mediates this task.

Notes

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- 1 Uterotonics lessen blood loss during childbirth and are very important in the prevention and treatment of PPH.
- 2 These are financial incentive schemes aimed at assisting women and their families with regard to childbearing.
- 3 Interview with a senior official at Jhpiego, Kathmandu, 12 August 2011.
- 4 http://apps.who.int/iris/bitstream/10665/70328/1/WHO_RHR_10.11_eng.pdf.
- 5 For more on this evidential debate, see Chu *et al.* (2012).
- 6 See, for example: www.theglobalfund.org/media/5198/me_monitoring_andevaluation_brochure_en.pdf?u=63648896434000000.

- 7 The most active local research institutions include New ERA, the Valley Research Group, the Center for Research on Environment Health and Population Activities, the Health Research and Social Development Forum, and the Nepal Public Health Foundation. New ERA, for example, was established by three Peace Corps Volunteers in 1971, and was the first research firm established to work in Nepal.
- 8 www.jsi.com/JSIInternet/IntHealth/project/display.cfm?ctid=na&cid=na&tid=40&id=147.
- 9 http://nfhp.jsi.com/Docs/nfhp_flyer.pdf.
- 10 Interview with a senior NFHP staff, Kathmandu, 26 August 2011.
- 11 www.jhpiego.org/who-we-are/our-history/.
- 12 www.engenderhealth.org/our-countries/asia-near-east/nepal.php.
- 13 www.jsi.com/JSIInternet/.
- 14 <https://ccp.jhu.edu>.
- 15 www.carenepal.org/.
- 16 www.savethechildren.org/.
- 17 www.nfcc.org.np/.
- 18 www.adranepal.org/.
- 19 For details, see VaRG (2008).
- 20 <http://mass.com.np/>.
- 21 www.ntag.org.np/.
- 22 <http://venturestrategies.org/>. This organisation is a key 'node' in the international network involved in lobbying WHO to have the drug registered for PPH on the WHO Essential Medicines List (Millard *et al.* 2015).
- 23 www.venturestrategies.org/programs/womens-options/.
- 24 We received the following information from a VSHD representative via email about their lobbying activities in Nepal: 'In Nepal, my organization, VSHD, was investigating the status of the registration of misoprostol for PPH. We verified that it had been registered by the drug company Cipla (Bombay) via Yetichem for PPH very recently, perhaps in July. Two registrations, also by Cipla, of misoprostol for abortion preceded the PPH registration. Access to misoprostol is quite restricted, however'.
- 25 Interview A, NFHP staff, Kathmandu, 26 August 2011.
- 26 Interview B, NFHP staff, Kathmandu, 26 August 2011.
- 27 Interview A, NFHP staff, Kathmandu, 26 August; Interview, NFHP staff, Kathmandu, 12 August 2011.
- 28 Interview, NFHP staff, Kathmandu, 12 August 2011.
- 29 Interview A, NFHP staff, Kathmandu, 26 August 2011; Interview, NFHP staff, Kathmandu, 12 August 2011.
- 30 Interview B, NFHP staff, Kathmandu, 26 August 2011.
- 31 Interview B, NFHP staff, Kathmandu, 26 August 2011.
- 32 Interview B, NFHP staff, Kathmandu, 26 August 2011.
- 33 Interview A, NFHP staff, Kathmandu, 26 August 2011.
- 34 Interview A, NFHP staff, Kathmandu, 22 March 2011.
- 35 Interview A, NFHP staff, Kathmandu, 29 December 2011.
- 36 Abortion was made legal in Nepal in 2002.
- 37 Interview A, NFHP staff, Kathmandu, 26 August 2011.

- 38 Interview A, NFHP staff, Kathmandu, 26 August 2011.
 39 See, for example, Khanal *et al.* (2013); VaRG (2005).
 40 Interview A, NFHP staff, Kathmandu, 26 August 2011.
 41 Interview, NFHP staff, Kathmandu, 12 August 2011.
 42 Interview, NFHP staff, Kathmandu, 16 November 2011.
 43 Interview A, NFHP staff, Kathmandu, 26 August 2011.
 44 Interview, NFHP staff, Kathmandu, 12 August 2011.
 45 Interview A, NFHP staff, Kathmandu, 26 August 2011; Interview, NFHP staff, Kathmandu, 12 August 2011.

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