Strengthening Quality of Essential Day-of-Birth Care Services at Health Centers in Ethiopia

Abeba Bekele Ayele[1], Yordanos Molla[1], Asayehegn Tekeste[1] and Atrie Fkadu[2]
[1]MCSP/Jhpiego, Johns Hopkins University Affiliate; [2]Newborn in Ethiopia Gaining Attention (NEGA) Project

Background and Rationale

- In Ethiopia, despite significant improvements in access to maternal, and newborn health (MNH) services, the quality of care provided remains a challenge, affecting the attainment of effective MNH coverage at scale.
- The Federal Ministry of Health (FMOH) developed a National Health Care Quality Strategy that prioritizes MNH.
- This Strategy employs a phased approach to address quality of care, starting with hospitals and gradually reaching primary health care units (health centers and health posts).
- In the past few years, an increasing proportion of women are delivering at health centers—from 10% in 2011 to 28% in 2016 (based on demographic and health survey data), with considerable regional variation—though with poor readiness on the part of health centers to provide basic MNH care. Therefore, the Maternal and Child Survival Program (MCSP) supported 11 zonal and two special *woreda* health offices to improve the quality of MNH care in selected health centers that have high-delivery loads.

Purpose and Tools

- Purpose—support public health centers identify and address critical gaps in the service standards that address the quality of MNH care provided to mothers and newborns on the day of birth.
- Tools—adapted FMOH's MNH quality improvement self-assessment tool for use with health centers.

Methods

- Jointly by zonal health offices and MCSP, thirteen health centers—in the regional states of Tigray; Amhara; Oromia; and Southern Nations, Nationalities, and People's Region (SNNPR)— were purposively selected based on their high-volume delivery rates.
- MCSP NEGA revitalized health center quality improvement teams (QITs) and oriented on the tool and its process, the scoring method, and roles and responsibilities of the different actors (*woreda* health office, zonal health office, MCSP, and health centers).
- QITs conducted baseline self-assessments to determine the percentage of standards the health center achieved the 80% minimum target score.
- QITs identified gaps in standards, prioritized the gaps, and developed a time-bound action plan for each gap.
- A regular review of action plans was integrated into the health center's management meetings; a follow-up full self-assessment was done every 2 months.
- On average, each health center did three internal self-assessments and a final verification assessment involving external managers and program support (QITs with MCSP staff and representatives from woreda and zonal health offices).
- For their baseline and subsequent self-assessments, health center QITs used a self assessment tool with 206 quality verification criteria that were organized into 28 standards.
- A health center's achievement was measured by the standards it met. To meet a standard, a health center needed to report 'yes' or a 'not applicable' for each of the standard's criterion. The cut-off point for an acceptable quality of service was 80%.

Methods, continued

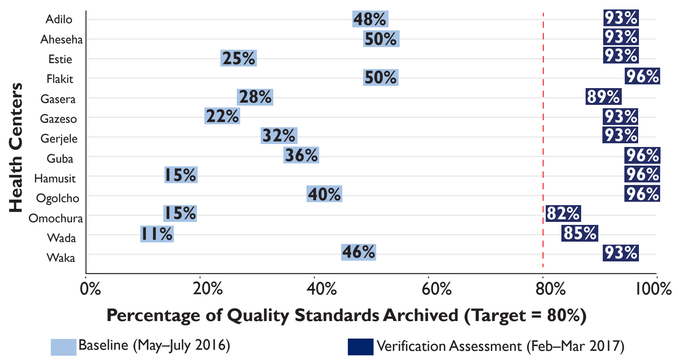
Table 1: Quality Improvement Self-Assessment Criteria for Health Centers

Area Number	Area Description	Number of Standards	Number of Verification Criteria	Major Self-Assessment Method Used
1	Human and Physical Resources			
	1.1 Being layout & Infrastructure	2	12	Observation, Document Review
	1.2 Staffing Pattern	1	10	Document Review
3	Management of labor and delivery	9	107	Observation
4	Postpartum care and Newborn care			
	4.1 Postpartum care	3	18	Observation
	4.2 Newborn care	2	17	Observation
5	Management of newborn complications	2	9	Observation
7	Pharmacy services	3	6	Observation, Document Review
8	Quality improvement monitoring & auditing system	4	18	Document Review
9	Community Involvement	2	9	Interviews
	Total	28	206	

Results

A baseline assessment was done between May–July 2016, and a final verification assessment was done between February and April 2017. On average, a health center had implemented quality improvement activities for an average of 8 months using the plan-do-study-act cycle.

Figure 1: Percentage standards achieved at baseline and final verification assessment by health center



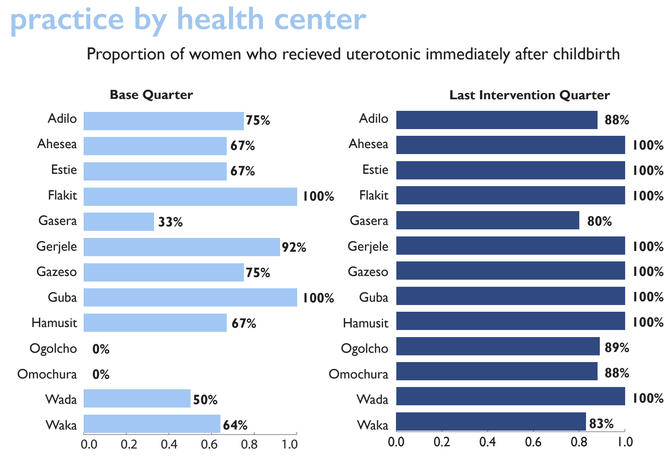
All health centers met less than 50% of the standards in their baseline self-assessments. Most gaps were in the area of labor and delivery care (55%), followed by postnatal care for mother and baby (20%). After 8 months, all health centers met at least 80% of the quality standards, as measured during the verification assessment.

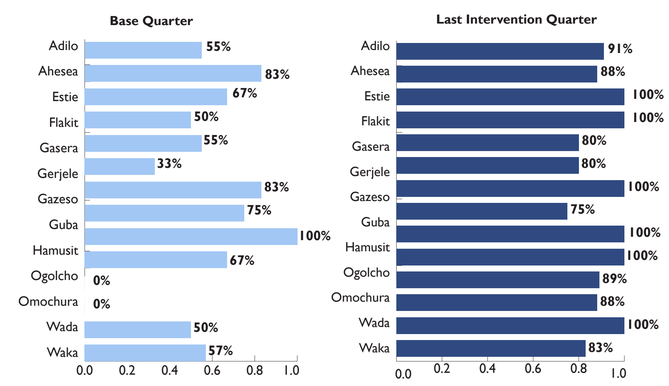
Main changes across majority of the health centers include the following: reorganization of rooms such that the first-stage labor, delivery, and postnatal rooms are separate from each other; screens separate delivery couches to maintain privacy; floors and walls of delivery rooms are washable for easy cleaning; 24-hour water supply; emergency drugs and supplies for mother and newborn are available and easily accessible at all times; buckets of different colors for equipment disinfection purposes; personal protective gear for health workers; improved lighting in and ventilation of labor and postnatal rooms; water and soap for mother to use to wash their hands; and improved content delivered during predischarge postnatal counseling.

Results, continued

Many best practices are increasingly being followed. For example, at baseline, only two (15%) out of 13 health centers provided immediate postpartum uterotonics to all women. At endline, however, eight (61%) out of 13 health centers were providing immediate postpartum uterotonics to all women—and all 13 health centers were providing immediate postpartum uterotonics to at least 80% of the women.

Figure 2: Change over time in service delivery practice by health center





Similarly, at baseline, none of the health centers had fully completed all partographs; however, at the final verification assessment, six (46%) out of 13 health centers had fully completed 100% of the partographs. At the final verification assessment, almost all health centers (12 out of 13, 92%) had fully completed at least 80% of the partographs, compared to three (23%) at baseline. Four out of 13 health centers increased their rate in successfully resuscitating neonates who were not crying at birth—from an average of 75% at baseline to 95% at the end of the intervention period.

Conclusions

Formation of QITs created ownership, strengthened team work, and improved accountability. Health Center QITs can use a self-assessment tool to identify critical quality gaps by using their own resources and can lead change to measurably improve day-of-birth services for mothers and newborns. The self-assessment tool helped to demystify quality standards and highlighted simple actions that health workers can relate to in their day-to-day work. Poor quality of data in delivery registers, especially for newborn health outcome measures, was a challenge that limited meaningful analysis and interpretation of newborn care indicators.

Recommendations

As quality improvement is an ongoing process that requires commitment and time, engaging subnational health managers from the outset is critical. Establishing learning sites to share experiences in person with other health center QITs facilitates replication and innovation. Local data management and use should be systematically integrated into all quality improvement initiatives. Many common quality gaps can be addressed by facility QITs' using local resources—looking internally before seeking external support.

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