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Quality of Care Assessment Tool for maternal and newborn care in hospitals:

Learning experience from 25 countries & 133 hospitals across 5 regions

Quality, Equity, Dignity
A Network for Improving Quality of Care for Maternal, Newborn and Child Health

World Health Organization

INTRODUCTION

The **Integrated Maternal, Newborn & Paediatric quality of care assessment and improvement tool in hospitals** allows the use of a standard-based audit approach towards engaging hospitals in:

- Firstly, assessing all key domains relevant to quality of health care for maternal, newborn & child health
- Secondly, in developing action plans for quality improvement at hospital and national levels which can be incorporated into the quality improvement cycle, so as to ensure replicability and comparability of results over time and across facilities.

WELCOME

MODERATOR: DR. WILSON WERE, WHO HQ

Part 1: Presentations

The review of implementation features & observed gaps

Dr. Ornella Lincetto, WHO HQ

Results of quality cycles and factors influencing change

Dr. Maurice Bucagu, WHO HQ

Experience from Pakistan

Dr. Qudsia Uzma, WHO Country Office, Pakistan

Experience from WHO Africa Region

Dr. Nancy Kidula, WHO Regional Office for Africa

Part 2: Questions and Answers

The review of implementation features and observed gaps

World Health Organization

Dr. Ornella Lincetto, MCA Department, WHO

Geneva, 22 June 2021

What can be learnt after years of use of WHO hospital quality assessment tool?

Electronic supplementary material:
The online version of this article contains supplementary material.

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Use of a participatory quality assessment and improvement tool for maternal and neonatal hospital care. Part 1: Review of implementation features and observed quality gaps in 25 countrie

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PAPERS

Use of a participatory quality assessment and improvement tool for maternal and neonatal hospital care. Part 2: Review of the results of quality cycles and of factors influencing change

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over time and of the factors influencing change.

Background

Quality of care impacts on survival and health of women, newborns and burden of stillbirths.

MN hospital QA/QI tool published in 2009 (EURO MPS), updated in 2014 (EURO), and revised by HQ MCA.

Five sections: hospital support services; case management; hospital policies and organization of services; experience of care; templates for reporting the finding and action plan

A multidisciplinary participatory approach, from assessment to action plan

Used in my many countries upon request of MOH with UN agencies and partners support, and in few NGOs supported hospitals

Methods

- Publications from 2009 to 2017 and reports retrievable from WHO or partners websites; unpublished reports also searched.
- Inclusion criteria:

- analytical description of methods, including tool adaptation, composition of the international and national assessors' team and characteristics of the facilities being assessed;
- detailed information on the assessment process, including the involvement of staff and mothers, and of its results;
- summary description of recommended actions

- Only regional or district hospital assessments

Framework for analysis

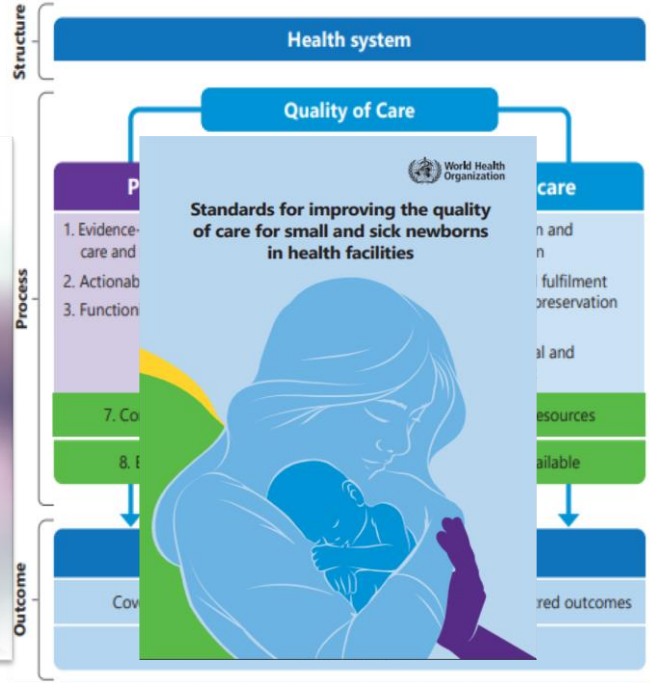
- Issues related to:
  1. Case management in maternal care
  2. Case management in neonatal care
  3. Hospital policies
  4. Hospital infrastructure
- Severity and frequency of quality gaps in relation to WHO standards
- A **gap** in a specific area of care was considered "**severe**" if, according to the tool scoring system, the assessment indicated "*inadequate care" or "very poor care",* and "**frequent**" when observed in at least 1/3 of all the assessed facilities, irrespective of the country
- Selection of quotations from women on effective communication, respect and dignity, emotional support and cost incurred

Results

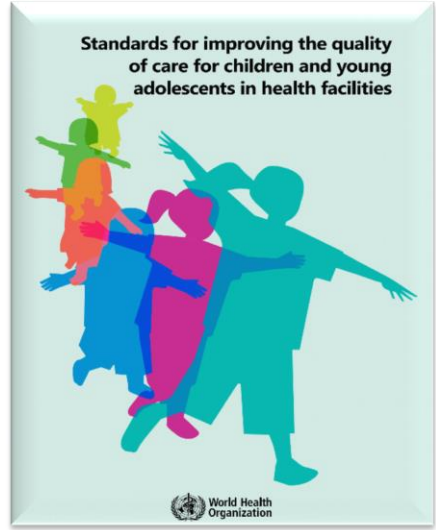
- Use of the tool documented in 25 countries: Central and Eastern Europe (8), Central Asia (4), Sub-Saharan Africa (11), Latin America (1) and Middle East (1)
- 133 hospitals (1-29 per country), in 22 countries it was a sample of hospitals
- Assessment led/supported by WHO in 18 countries (>1 hospital), led by NGO in Ethiopia, Uganda and Tanzania (only 1 hospital)
- Time required: 1-2 days for training of the national or local assessment team, and 2-3 days for the assessment, including feedback

Quality of Care Framework and Standards

Maternal and newborn health



Small and sick newborn health



Children and young adolescents

Main gaps from baseline assessments
Provision of effective, safe and respectful care to mothers (WHO standard of QoC 1)

WHO standards	Areas with serious gaps identified in at least 1/3 of facilities	Examples of gaps
Standard 1	Monitoring of maternal and foetal conditions during labour and birth	Partograph often filled a posteriori, monitoring of foetal heart rate rarely done more than 4 hourly, and maternal heart rate never recorded, fluids and medications rarely recorded.
	Excess and/or inappropriate interventions	Unnecessary / dangerous interventions and medications for healthy women (e.g. practice of episiotomy).
	Early identification and management of emergencies	Women not assessed for over 5h during labour, inappropriate management of 3rd stage of labour, use of IV oxytocin to augment labour not recorded/monitored, lack of basic emergency procedures.
	Management of complications	Inappropriate management of severe preeclampsia, women with complications discharged too early.
	Caesarean section indications & procedures	General anesthesia used for CS, indications for CS not reported, sometime questionable (e.g. foetal distress with FHR not measured)

Main gaps from baseline assessments
Provision of effective, safe and respectful care to mothers
(WHO standards of QoC 4, 5 &6)

WHO standards	Areas with serious gaps identified in at least 1/3 of facilities	Examples of gaps
Standard 4	Effective communication	Women not told about indications for CS, not given information about their baby's conditions, poorly informed about care after discharge and not involved in decision about care for themselves or their baby.
Standard 5	Respect and dignity	Freedom to move in labour not ensured, lack of privacy during birth, disrespectful attitude, inadequate consideration of feelings, users' needs neglected in ward layout.
Standard 6	Emotional support	Companion presence not allowed/encouraged during labour and childbirth, one-to-one care not ensured.

Main gaps from baseline assessments
Provision of effective, safe and respectful care to newborn (WHO standard of QoC 1)

WHO standards	Areas with serious gaps identified in at least 1/3 of facilities	Examples of gaps
Standard 1	Early mother – baby contact and immediate initiation of breastfeeding	Early skin-to-skin not ensured, initiation of breastfeeding within the first hour after birth not ensured
	Resuscitation preparedness and procedures	Insufficient preparedness for newborn resuscitation (e.g. equipment), resuscitation not started according to recommended algorithm.
	Care for premature/LBW babies	KMC not implemented, inadequate nutrition of preterm and sick babies.
	Excess and/or inappropriate interventions	Unnecessary nasogastric aspiration, unjustified use of drugs based on inappropriate diagnosis of perinatal asphyxia.
	Early identification and monitoring of risk factors and complications	Poor recording of vital signs, poor recognition of signs of infection, monitoring in delivery room (first 2h) not ensured.
	Management of newborn complications	Delayed diagnosis of infection, overdiagnosis of infection.
	Mother-baby bonding	Unjustified separation at birth, babies kept separated with no reason.
	Pain prevention and relief	Excess of painful procedures, no attention paid to prevent pain and to

Main gaps from baseline assessments Human resources and infrastructure (WHO standards of QoC 7 and 8)

WHO standards	Areas with serious gaps identified in at least 1/3 of facilities	Examples of gaps
Standard 7	Human resources number and skill mix	Insufficient number of midwives and neonatal nurses, newly graduated staff utilized in NICU without supervision.
Standard 8	Hygienic facilities and waste management	Insufficient/inadequate toilets, lack of sufficient washing facilities for patients, unsafe disposal of waste.
	Water and energy	Frequent power breakdown, discontinuous availability of running water and warm water.
	Physical structure	Insufficient number of individual delivery rooms, delivery room layout not ensuring privacy, operating theatre far from maternity, no specific dedicated area for the care of sick or preterm newborns.
	Essential equipment and supplies	Poor maintenance of equipment, lack of basic equipment (e.g. wall clock, thermometers), underutilization of up-to-date equipment, substandard laboratory services, lack of bold bank even at tertiary level.
	Essential medicines	Irregular procurement and stock.

Main gaps from baseline assessments: policies (WHO standards of QoC 1,2,3,5 and 7)

WHO standards	Areas with serious gaps identified in at least 1/3 of facilities	Examples of gaps
Standard 1	National clinical guidelines and local protocols	Lack/poor access to clinical guidelines for case management, lack of local protocols, lack of essential drugs list.
	Infection prevention and control	Inappropriate hand washing by staff, sterile gloves used as a substitute of hand washing, mosquito nets available but patients non encouraged to use them, inadequate registration of nosocomial infections, lack of guidelines on appropriate use of antibiotics.
Standard 2	Data collection and use	Poor information system, poor local use of data for action, substandard or poorly filled medical records.
	Periodic perinatal audits	Lack of medical records for newborn babies, absence of maternal and perinatal reviews, insufficient capacity to use maternal and perinatal audits.
Standard 3	Referral system	No criteria-based functional referral system for mothers and newborns, insufficient communication among different levels of care.
Standard 5	Access to care	Official and unofficial fees, need to pay for drugs and consumables.

Examples of women's views among perceived quality gaps in their experience of care

Main area	Women's quote
Effective communication	"I wish I had not been only checked, but given information about breastfeeding, contraceptive methods after birth, how to take care of my child, and more…"
Respect and dignity	"Old windows cannot be closed, the wind howled through them, there is only one toilet and no way of closing the door." "No conditions to wash, to take a shower." "The doctor didn't ask me permission for vaginal examination." "I could eat only on the day after birth".
Emotional support	"They don't even come to ask me how the baby is doing, they didn't even weigh the baby." "Since I came I didn't receive any care for my baby or myself"(Mother who had preterm home birth, crying while waiting). "I wanted to have my partner with me, but it was not allowed".
Incurred cost	"For laboratory analysis payment is requested, but there is something you can get for free." " There are no syringes in the treatment rooms, and if you forgot you have to find and buy them." "Why are we paying for maternal care, while the government is emphasizing free care for mothers and babies?"

Conclusions

Quality of care is a global issue.

The review provides a comprehensive insight into existing quality gaps in a variety of different settings.

Common macrotrends, but also significant differences among facilities belonging to the same health system.

The tool performs well, with different features providing added value to the QA/QI process: inputs, case management, experience of care, capacity building, and moving from analysis to planning.

Value of QI cycles at facility level based on assessment made by multidisciplinary teams of professionals who look at health care pathways that require improvement and plans developed at local and national level.

World Health Organization

USE OF A PARTICIPATORY QA AND QI TOOL FOR MATERNAL AND NEONATAL HOSPITAL CARE

Dr Maurice Bucagu, MD. M. Med. Ob/Gyn, PhD.

WHO/ UHC-LC/MCA Department.

Geneva, 22 June 2021

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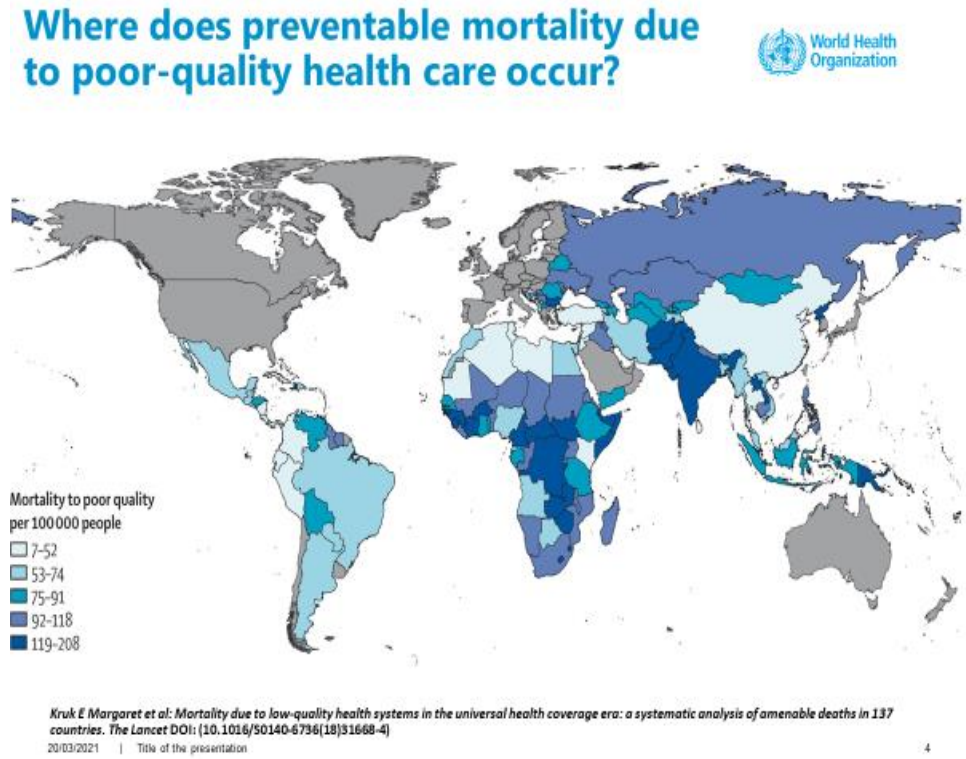
PAPERS

PART 1: OBSERVED QUALITY IMPROVEMENT (A)

PART 1: QUALITY CYCLES AND FACTORS INFLUENCING CHANGE

Reassessment done and documented in:

- 27 facilities;
- 9 countries;
- 4 regions:
  - Central & Eastern Europe (3 countries);
  - Central Asia (3 countries);
  - Sub-Saharan Africa(2 countries);
  - Latin America (1 country).



PROVISION OF EFFECTIVE, SAFE AND RESPECTFUL CARE TO MOTHERS (WHO STANDARDS OF QOC 1, 4, 5 &6)

WHO standards	Key related practices	Observed improvements (examples)
Standard 1	Monitoring of maternal and foetal conditions during labour and birth	Improved (more frequent, regular & recorded) monitoring of foetal heart rate and maternal parameters.
	Excess and/or inappropriate interventions	Reduction of many unnecessary / dangerous medications and interventions for healthy mothers and newborn (e.g. practice of episiotomy decreased substantially).
	Early identification and management of emergencies	Improved active management of 3rd stage of labour to prevent PPH.
	Management of clinical complications	Improved management of preterm labour (e.g. use of corticosteroids and appropriate tocolytics when required).
	Caesarean section indications & procedures	Reduction of inappropriate indications for CS; Adoption of Robson classification; Increased use of regional analgesia.

PROVISION OF EFFECTIVE, SAFE AND RESPECTFUL CARE TO MOTHERS (WHO STANDARDS OF QOC 1,4,5 &6)

WHO standards	Key related practices	Observed improvements (examples)
Standard 4	Effective communication	Improved written and oral information to pregnant women and mothers (e.g. a discharge note for mothers developed, with information on postnatal issues).
Standard 5	Respect and dignity	Improved privacy for labour and childbirth.
Standard 6	Emotional support	A more friendly attitude towards women and their families observed (e.g. acceptance of companionship during labour and childbirth).

PROVISION OF EFFECTIVE, SAFE AND RESPECTFUL CARE TO NEWBORN (WHO STANDARDS OF QOC 1)

WHO standards	Key related practices	Observed improvements (examples)
Standard 1	Early mother – baby contact and immediate initiation of breastfeeding.	Skin-to-skin after birth introduced as standard practice; Increased practice of initiation of breastfeeding within the first hour after birth.
	Resuscitation preparedness and procedures.	Improved readiness for newborn resuscitation (e.g. equipment, supplies, training, SOPs).
	Care for premature/LBW babies	Introduction of Kangaroo mother car (e.g. training, guidelines, specific room).
	Excess and/or inappropriate interventions	Reduced use of unnecessary drugs, diagnostics and hospital stay.
	Early identification and monitoring of risk factors and complications	Advice given to mothers on babies' danger signs.
	Management of newborn complications	Improved indication and choice of antibiotics.
	Mother-baby bonding	Involvement of mothers in care of sick newborn, including in NICU.

HUMAN RESOURCES & INFRASTRUCTURE (WHO STANDARDS OF QOC 7&8)

WHO standards	Key related practices	Observed improvements (examples)
Standard 7	Human resources number and skill mix	Extension of clinical tasks for midwives & nurses. Role of nurses in the care of sick and premature babies enhanced and skills improved (e.g. communication skills). Increased training opportunities.
Standard 8	Sanitation & waste management	Availability of cold and warm water, toilets and basic supplies such soap and antiseptics for pregnant women, mothers & their babies.
	Water & energy	Greatest improvement for continuous availability and energy.
	Physical structure	Improved privacy (e.g. individual rooms with curtains for labour and childbirth). A dedicated area for the care of sick newborn.
	Essential equipment & supplies	Emergency kits available in every delivery room. Improved basic supplies for laboratory services.
	Essential medicines	Improved availability of essential drugs at different points of care (emergency, wards, delivery room & operating theatre).

IMPROVEMENTS RELATED TO MNH POLICIES (WHO STANDARDS OF QOC 1,2,3&5)

WHO standards	Key related practices	Observed improvements (examples)
Standard 1	Infection prevention & control	Water tank installed; hand sanitizer gel available in every ward. Staff wash their hands and use disposable gloves for handling each patient. In every ward, protocol for standard hand washing displayed.
	National clinical guidelines & local protocols	Local neonatal protocols developed based on international / WHO guidelines.
Standard 2	Data collection & use	Improved data collection & reporting: e.g. A neonatal nursing record developed.
	Maternal & perinatal audits	MPDSR system institutionalized; blood bank established as recommendation from national MDSR report.
Standard 3	Referral system	Improved referral system for pregnant women in case of complications & emergencies.
Standard 5	Mistreatment, detainment, extortion or denial of services	Reduced or cancelled fees for hospital care provision, emergency services & medicines (for specific vulnerable sections of the population).

PART 2: FACTORS INFLUENCING CHANGE, BARRIERS & FACILITATORS (B)

MAJOR INTERNAL FACTORS AFFECTING QUALITY IMPROVEMENT

Factors facilitating QI process:

Capacity of managers to involve & motivate staff members;

Professional recognition;

Availability of career opportunities;

Adequate professional qualification of involved staff;

Quality of care assessment process in place.

Barriers:

High turn-over leading to lack of continuity;

Poor motivation due to lack of professional and monetary incentives.

High workload with respect to available human resources.

Changes in management leading to poor follow-up of baseline recommendations.

EXTERNAL FACTORS AFFECTING QUALITY IMPROVEMENT

Factors facilitating QI process:

Financial & professional incentives provided by partners & government.

Reasonable autonomy at facility level for budget use.

Effective communication with health centres.

Barriers:

Financial constraints with impact on staff salaries & equipment.

Frequent changes in MoH regulations about human resources and organizational procedures.

Absence of result-based professional recognition for staff members involved in QI processes.

CONCLUSIONS PAPER 2

The use of the tool promoted significant changes in quality of care.

Improvements were observed in all areas of care and were particularly important and more frequently observed in the areas corresponding to appropriate case management and respectful care for both mothers and newborns (WHO standards 1 to 6) than in those related to staffing and infrastructure (WHO standards 7 and 8).

There is critical need to develop an action plan with timelines & responsibilities to help address priority gaps.

Value of participatory approach involving managers, staff and users.

ACKNOWLEDGEMENTS

Centro per la Salute del Bambino and Teams

Country teams

EURO; AFRO; SEARO; PAHO; EMRO.


World Health Organization
THANK YOU and let's continue
to stand for mothers and their newborn

MNH Quality of Care Assessment in Pakistan 2020

Dr Qudsia Uzma
National Professional Officer MNCAH
WHO Pakistan

World Health Organization

Presentation Outline

- Key MNH Statistics in Pakistan
- Background and Methodology
- Selected Facilities
- Assessment Objectives
- Summary of hospital scores
- Standards assessing hospital resources
- Hospital policies and organization of services
- Case management of maternal conditions
- Case management of common newborn conditions
- Key recommendations
- Next steps and Conclusion

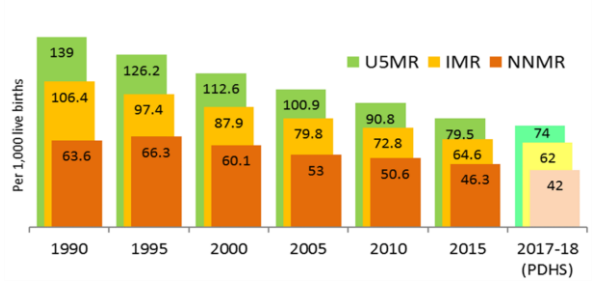
Key MNH Statistics in Pakistan

High maternal mortality ratio
178
/100,000 LB

29 **Abortions** per 1000 WRA

46 **Adolescent birth rate** per 1000 population

25 **Modern contraceptive prevalence rate** percent of married women

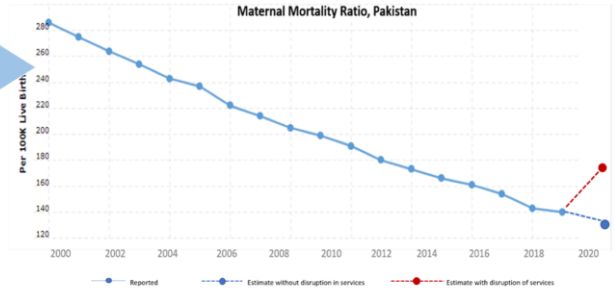


34% births occur at home

31% NOT assisted by skilled provider

For every **1000** babies born..... → **42** die as **NEWBORNS** → **62** die as **INFANTS**

Each year children under 5..... → **91,000** die from **PNEUMONIA** → **53,300** die from **DIARRHOEA**



Background and Methodology

- QoC assessment planned and implemented during COVID-19 situation;
- A team of consultants including Obstetrician and Pediatrician was involved;
- National Technical Working Group on RMNCAH and Professional Associations (Society of Obstetricians and Gynecologists of Pakistan and Pakistan Pediatrics Association) supported contextualization of the tool;
- Pilot completed in two facilities in July 2020;
- Assessment in 6 facilities conducted over 3 months – Jul to Sep 2020;
- Data was compiled using excel- a database was prepared and all hard forms were converted into soft excel database by an experienced Statistician;
- An international consultant was engaged for report writing;

Selected Facilities

S. No.	Selected healthcare facility	Abbreviations
Islamabad Capital Territory		
1	Pakistan Institute of Medical Sciences, Islamabad	**PIMS – Facility 1**
2	Federal Government hospital, Islamabad	**FGH – Facility 2**
Punjab – PILOT TESTING IN 2 FACILITIES		
3	Sir Ganga Ram Hospital Lahore	**SGRH- Facility 3**
4	Services Hospital Lahore	**SHL – Facility 4**
Sindh		
5	Shaikh Zaid Women Hospital, Larkana	**SZWH–Facility 5**
6	Peoples University of Medical & Health Sciences, Shaheed Benazir Abad	**PUMHS- Facility 6**
Khyber Pakhtunkhwa		
7	Lady Reading hospital, Peshawar	**LRH – Facility 7**
Balochistan		
8	Bolan Medical Complex, Quetta	**BMC – Facility 8**

Assessment Objectives

General Objective

– To assess the overall quality of hospital care given to mothers and newborns in Pakistan.

Specific Objectives

– To assess infrastructure, basic amenities and staffing for maternal and neonatal health care in Pakistan.

– To assess the status of health systems support and organization of hospital services.

– To evaluate the management of common maternal and neonatal conditions against standard recommendations.

– To assess hospitals' preparedness in managing COVID 19 cases.

– To assist the facilities' management, develop action plans to cascade implementation of quality improvement processes.

Summary of hospital scores

- Summary of the hospital score was done by calculating the percentage of assessment questions scored “yes” for the particular subsection of the assessment tool.
- Following is the template used to summarize scores for each sections based on the proportion of standards scored "Yes".

Very Poor	Poor	Fair	Good	Very Good
If no standard scored yes	If < 50% of all standards scored yes	If 50% of standards scored yes	If 80% of standards scored yes	If all standards scored yes

Standards assessing hospital resources

Standards	Participating Hospitals							
	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7	Facility 8
Physical facilities	100%	66.4%	96.5%	100%	82.85%	72.85%	90%	90%
Basic amenities	50 %	93.75%	93.75%	100%	87.5%	50 %	93.75%	68.75%
Policies on HR management	71.95%	65.6%	81%	68.7%	62.5%	56.25%	68.75%	62.5%
Staffing	79.15%	36%	77.2%	60%	53.3%	75%	73.35%	70.85%
Statistics, HMIS & Medical records	26.7%	43.35%	56.5%	46.7%	50%	30%	33.3%	50%
MDSR services	57.10%	43 %	71 %	57 %	57.1%	0 %	57.10%	85.7%
Pharmacy management	87.1%	80.6%	90%	90.3%	84%	67.7%	96.8%	64.5%
Medicine availability	61.5%	56.7%	68%	57%	71.6%	43%	52.7%	19.25%
Equipment	86%	74.95%	88.5%	87.1%	76.5%	71.7%	76.2%	70.5%
Supplies	90.5%	80.9%	90.3%	87.1%	72%	71.4%	73%	55.3%
Laboratory support	82.9%	46.3%	85.4%	85.4%	73.2%	85.4%	82.9%	61%
Ward infrastructures	72.6%	68.55%	79.65%	77%	72.8%	56.75%	73%	67.6%

Hospital Policies and Organization of Services

Standards	Participating Hospitals							
	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7	Facility 8
Infection prevention	72.65 %	72.5%	72.25%	77.8%	62.5%	42.55%	70.5%	50%
Organization of services for quality improvement	75%	37.45%	68.8%	65.6%	59.35%	31.2%	50%	31.2%
Access to hospital care and continuity of care	58.8%	47.1%	58.8%	64.7%	41.2%	14.7%	38%	35.3%
Mother and new-born rights	73%	60.85%	73%	71.65%	75.5%	59.5%	68.75%	58.15%

Case Management of Maternal Conditions

Standards	Participating Hospitals							
	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7	Facility 8
Antenatal care	92.30%	76.90%	92.30%	96.20%	80.70%	88.50%	92.30%	76.90%
Infections	97.10%	67.60%	94.30%	94.30%	88.20%	67.60%	86%	74.30%
Pre-eclampsia and eclampsia	96.00%	92.00%	96.00%	100%	92%	80.00%	100%	96.00%
Preterm labour	89.50%	42.10%	73.70%	78.90%	57.90%	57.90%	63.20%	68.40%
Normal labour and vaginal birth	82.40%	70.60%	82.30%	86.80%	78.80%	73.50%	70%	67.60%
Unsatisfactory progress of labour	84.60%	88.50%	92.30%	88.50%	96.20%	80.80%	84.60%	84.60%
Caesarean section	89.30%	84.00%	90.70%	89.30%	89.30%	80.00%	92.00%	85.30%
*PPH	89.90%	74.10%	96.30%	96.30%	92.60%	77.80%	92.60%	81.50%
Abortion	100%	68.70%	87.50%	100%	88.60%	52.80%	93.70%	93.70%
Family planning and contraception	73.30%	44.40%	95.70%	88.20%	76.50%	82.30%	68.40%	66.70%
Postnatal care	88.90%	61.10%	80.60%	83.30%	93.70%	75.00%	63.90%	66.70%
Monitoring and follow-up	92.30%	84.60%	92.30%	92.30%	92.30%	84.60%	84.60%	92.30%

Case Management of Common Newborn Conditions

Standards	Participating Hospitals							
	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7	Facility 8
New-born care soon after birth	87.7%	61.4%	82.5%	89.5%	87.7%	49.1%	57.9%	59.6%
Care of a healthy newborn	88.6%	79.5%	90.9%	93.2%	77.3%	56.8%	72.7%	72.7%
Care of premature and *LBWT new-borns	88.9.%	0.0%	88.9%	93.3%	86.7%	57.8%	60 %	68.9%
Care of the sick newborn	89 %	0.0%	90.4%	91.7%	87.7%	67.8%	75.3%	75.3%
Advanced new-born care	72.8 %	0.0%	80 %	76.5%	60.5%	38.3%	47%	42 %
Monitoring and follow up	91.7 %	0.0%	91.7%	91.7%	91.7%	75 %	91.7%	75 %

Key Recommendations

- All hospitals need **Intensive Care Units** (ICU) and **Kangaroo Mother Care** (KMC) to improve survival of sick, preterm and LBW babies.
- Regular training programmes for **continuing professional and skills development**
- Monitor regular recording and **completeness of registers** and forms.
- Strengthen **birth and death registration system** and link to the national vital registration system as well as to the MPDSR system,
- Updated plan for improving **quality of care & patient safety** and to establish quality improvement team.
- Up-to-date **clinical protocols and guidelines** for identification, management and referral of newborns and mothers with complications.

Next Steps & Conclusion

- Dissemination and discussion on the assessment report;
  - ✓Facility level
  - ✓Provincial level
  - ✓National level – RMNCAH&N Technical Working Group

- Identification of immediate actions for strengthening MNH quality of care and mobilizing resources for addressing needs e.g. introducing and implementing the QoC standards for improving the quality of care for mothers and newborns in health facilities;

- Linking the medium and longer-term needs to the Government's agenda on Universal Health Coverage using the defined benefit package with integrated key MNH interventions and highlighting the quality of care aspects;

- Joining the Quality, Equity, Dignity (QED) network of countries for cross-learning;

World Health Organization

REGIONAL OFFICE FOR Africa

Use of WHO QOC Assessment tool: AFRO Experience

Dr. Nancy Kidula

WHO AFRO IST ESA

Rationale

- High maternal and infant mortality despite increased coverage of key interventions: (facility delivery, skilled birth attendance, ANC 1, PMTCT, IMCI AND VACCINATION)
- MPDSR Reports consistently revealed poor QOC as main cause of Maternal and perinatal mortality
- If Region continues BAU, unlikely to meet the SDG 2030 targets 3.1 and 3.2
- Need for objective information to formulate tailored high impact actions to improve quality of MNCH services in line with the WHO MNCH Standards

Methodology

- **Preparatory:** Consensus between MOH, WHO and partners on need for QI in MNCH. Countries then requested TA to conduct baseline QOC assessment to inform the process. High level approvals from Health Directors in the MoH was sought considering the sensitivity of the exercise.
- WHO worked with country team on concept note , work plan, resource mobilization, Scope of assessment, sampling of health facilities, identification of assessors, etc;
- WHO provided the generic QOC assessment tool and technical support to the process

- ***Adaptation of the QOC assessment tool***
  - *Orientation on QOC assessment tool- sections, scoring, etc.*
  - *Adaptation for different levels of care (hospitals, health centres/ clinics)*
  - *Customization based on local terms, cadres, levels, procedures, national standards for hospital care, etc*
  - *Dividing into modules for ease of deployment; extra modules added as need arose*
  - *Removal of sections not applicable for the country e.g. drugs not on EML, dxx not in local epidemiology*

- Training of data collectors, standardisation of methods, printing of tools, formulation and deployment of field teams
- Data collection; cleaning; analysis and report writing
- Debriefing of managers at all levels and dissemination of assessment report
- Use of data for decision making

Where has the tool been used in AFRO?

22 countries have used the MNH QOC Assessment tool (1 has used other tools/ methodologies for QOC assessment.

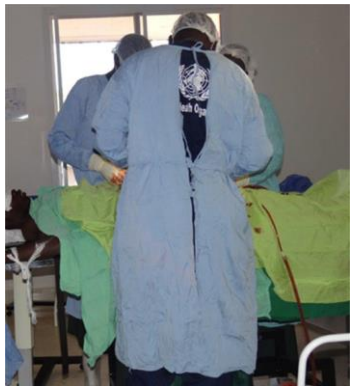
- **ESA:** Eswatini, Lesotho, Namibia, Malawi; Kenya; Uganda, (Tanzania)
- **CA:** Burundi, Cameroon, Congo, Gabon, Tchad,
- **WA:** Benin, Burkina Faso, Carbo Verde; Cote D'Ivoire, Ghana, Guinea Bissau, Mauritania, Mali, Niger, Togo, and Senegal

Experience in using tool: Pros

- Provided an objective way of establishing the state of MNCH Quality of care in selected facilities which could be applied to the rest of the country
- Assessors were from the country and from the MoH, This promoted ownership of the results and they were able to see for themselves the realities on ground
- Provided opportunity to reinforce the standards; identify available resources that were unused (e.g. resuscitation kits that were new but locked up and none on the floor
- Detailed structure facilitated specificity of tailored interventions
- Some countries were able to add modules (FP, GBV, Community, anaesthetic etc) based on prevailing standards
- Presentation in score card mode aided in easy identification of weak areas or facilities for immediate intervention
- Results are still being used to inform planning, training, and QI approaches

Experience in using tool: Challenges

- The tool is very voluminous leading to assessor fatigue
- Exercise was very resource intensive (financial, human, logistics, etc.)
- Tool is very intensive and the time to complete it well was inadequate for all sites in all countries; some modules not observed or incomplete; facility action plans not always completed
- Although evaluators were trained, not all had perfect command of the tool when tested in the field
- Some sections of the tool needed improvement, clarity, etc; new version doesn't have child module
- Scoring system may be subjective and subject to misinterpretation. The criteria for assigning scores are not understood in the same way, hence the large discrepancies between the scores assigned by the different members of the group
- Assessment of case management is not always possible in the absence of observed practical cases, despite the presence of procedures (assessing more the knowledge of staff than their practice)
- Some key elements are missing e.g., Sterilization equipment and procedures are not evaluated
- Some countries were reluctant to accept results especially if it revealed major weaknesses in the system



Comparing Hospital performance of different standards - example

Hôpitaux	L'offre de soins maternels				L'offre de soins néonatals					L'offre de soins pédiatriques			
	Prise en charge de la Pré-éclampsie et de l'éclampsie	Dépistage et prise en charge des femmes enceintes séropositives	Conditions d'accouchement	Hémorragie du post-partum	Lutte contre l'infection	Médicaments, matériels et produits	Soins néonatals courants	Prise en charge des nouveau-nés	Surveillance et suivi	Soins pédiatriques d'urgence	Lutte contre l'infection dans les hôpitaux	L'hygiène des mains dans les hôpitaux	Besoins nutritionn des malac hospitalis
CHU													
HCA de Brazzaville													
HR de Talangaï													
HR de Makélékélé													
HR de Mfilou													
HR de Bacongo					Pas de service								
HR de Loandjili													
HR de TIÉ-TIÉ					Pas de service								
HGA. SICE													

Récapitulatif des notes	Bien	A améliorer			
	5	4	3	2	1
Score = 5	Score =4	Score=3	Score=2	Score=1	
Bonne qualité des soins	Besoin d'amélioration mineur	Niveau d'amélioration nécessaire degré 2	Niveau d'amélioration nécessaire degré 1	Besoin urgent d'amélioration	

Comparison of Districts for selected parameters: example

Standards (%) May 2019

Facility/District	1:Evidence-based practices for routine care and management of complications	2: Actionable information systems	3: Functional referral systems	4: Effective communication	5: Respect and preservation of dignity	6: Emotional support	7: Competent, motivated human resources	8: Essential physical resources available
Hoima	45	87.5	55.6	25	20	12.5	52.4	56.7
Kamuli	69.8	100	44.4	26.7	20	12.5	61.9	50
Kasese	55	87.5	44.4	37.5	26.7	0	61.9	76.7
Kiryandongo	73	87.5	33.3	25	20	12.5	57.1	83.3
Nwoya	80	88	67	75	80	63	86	100
Sheema	70	75	66.7	50	20	25	57.1	93.3
	Cut offs: Dark Green ≥ 80	Light Green 70-<80	Yellow 50-<70	Red < 50				

Variation in young mothers' ratings of the quality of care provided: example

NORMES ET CRITERES	JM1	JM2	JM3	JM4	MOY JEUNES MAMANS	OBSERVATIONS
Soins prénatals	3	1	3	4	3	Signifiant un certain besoin d'amélioration pour atteindre les standards de soins
Admission	5	5	3	4	4	Montrant peu de besoin d'amélioration pour être conforme aux standards de soins
Travail et Accouchement	3	1	3	3	3	Signifiant un certain besoin d'amélioration pour atteindre les standards de soins
Soins du Nouveau-né	1	1	3	3	2	Indiquant un besoin considérable d'amélioration pour atteindre les standards
Attitude du personnel	4	4	3	4	4	Montrant peu de besoin d'amélioration pour être conforme aux standards de soins
Sortie de l'hôpital et Suivi	1	1	3	2	2	Indiquant un besoin considérable d'amélioration pour atteindre les standards
Acès aux soins hospitaliers	5	1	3	5	4	Montrant peu de besoin d'amélioration pour être conforme aux standards de soins
NOTE TOTALE	3	2	3	4	3	Signifiant un certain besoin d'amélioration pour atteindre les standards de soins

Additional module (example: Availability of FP policies, guidelines, job aids, models and tools)

	H1	H2	H3	H4	H5	Comments
Up to date FP guidelines available in the H Facility						Guidleines updated in 2017
FP counselling models' tools available e.g. penile model, samples of methods				But kept in drawer		Most health facilities b have penile modele and uterine model but kept in the drawers far fro counselling area
Fp counselling tools e.g. flip charts, tiart charts, available	DMT 2005		DMT 2005		DMT 2005	Decision making tool 2005 version, outdated PPFP charts
FP IEC Materials Available preferebly in local language						No take home materials available
Summary score	**0%**	**50%**	**25%**	**25%**	**50%**	**Summary Score: 30% - Poor**

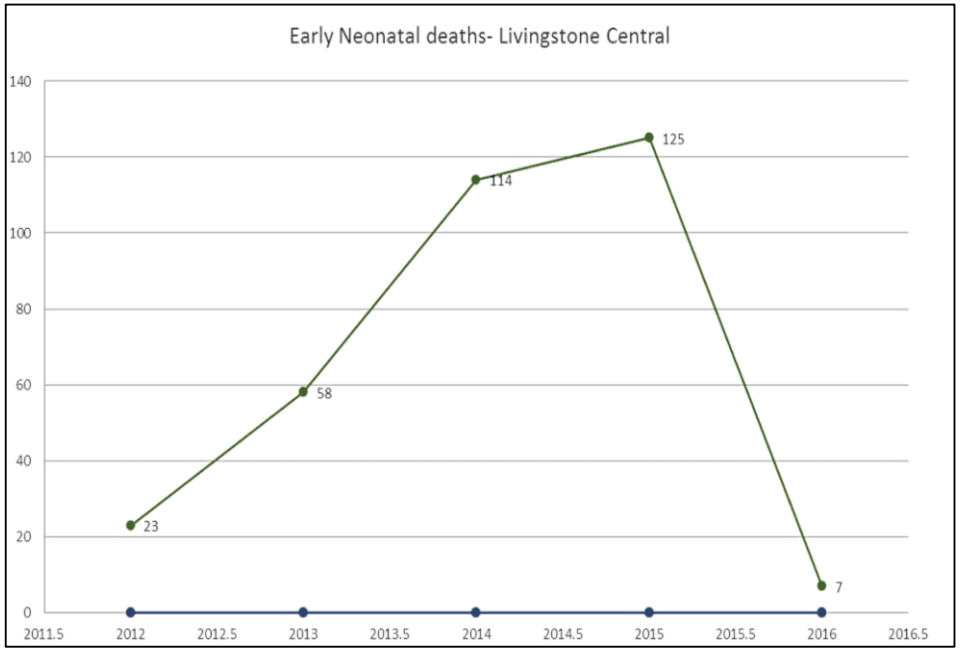
Utilization of QOC assessment results

- Health facilities were able to make action plans to address the gaps noted from the QOC assessment including organisation of services, triaging, IPC, staff duty rosters, judicious use of available space, availability of emergency drugs at point of care; etc.
- Used extensively in strategic planning process and guideline development by countries
- Informed capacity building activities around areas with most need
- Some countries have identified areas for POCQI activities in targeted facilities
- QOC now recognised as a priority area to mitigate preventable morbidity and mortality In mothers and children

Implementation of basic high impact interventions-

The case of Livingstone Central Hospital

- Noted that 15 – 20% of admissions to the neonatal unit die
- Implemented a set of basic interventions to reduce NM (*handwashing before & in between babies, KMC, early feeding of preterm babies, Breast feedings all babies, use of standardises clinical protocol)*
- Result: Reduction of INMR from 137 / 1000 to 90/ 1000



Recommendations

- Work on a shorter tool
- Divide maternity questionnaire by department (ANC, labour and delivery room, theatre, postnatal ward and hospitalization)
- Harmonize the numbering of the sections and subsections of the assessment tool
- Integrate the governance indicators of the quality tool
- Re-specify the method for calculating summary scores
- Establish a check list that summarizes the tool in line with RMNCAH standards
- Reformulate nutritional needs section
- Propose a shorter list of marker drugs for each area rather than have all drugs and commodities
- Develop a web application that health facilities can access on Smartphone (in French and English)
- Support the establishment of quality care networks in countries

Conclusions

- Implementation of quality of care is a continuous process
- Tool is very useful in detailing status of QOC and in monitoring improvements in care and adaptable to local context.
- Some refinement may be required to address the observations by the users

Questions and Answers

MODERATOR: DR. WILSON WERE, WHO HQ

PLEASE PLACE YOUR QUESTIONS IN THE CHATBOX

STAY ENGAGED

- Upcoming webinars

1. Private Sector Engagement for Quality MNCH – the experience of Ghana
   Monday June 28 2021- **Register: bit.ly/PrivateSectorGhana**
2. Expanding health workforce for small and sick newborn care & the experience of Kenya
   Wednesday June 30 2021- **Register: bit.ly/SSNB-2**

- Join the conversation: #qualitycare
- Visit our website: http://www.qualityofcarenetwork.org/about

Quality, Equity, Dignity
A Network for Improving Quality of Care
for Maternal, Newborn and Child Health