IMPROVING MATERNAL AND NEWBORN HEALTH:

Measuring quality data at primary facilities and communities in developing countries

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SickKids Together We Will.

Context: Tanzania - Mtwara Regions

- 26 Regions
- 50 million people
- MMR 556 (2015-16)
- UMR 22 per 1000 (2015)
- NMR 59 (2015)
- ANC >98% (2015/16)
- Life expectancy birth 60/64

2016

- GDP $1000
- Health $5.6

Target

High quality health services should be provided for maternal and newborn health care

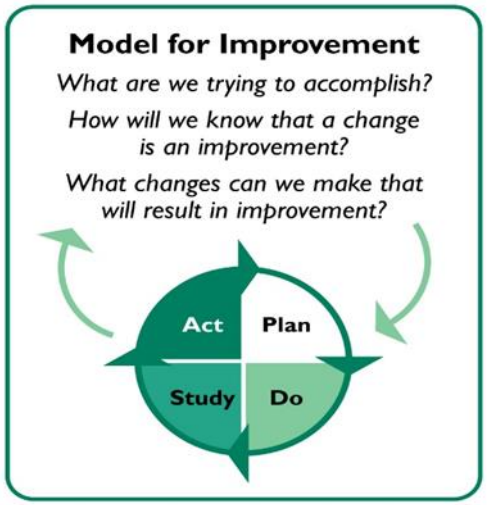
- Maternal & newborn mortality remain unacceptably high in sub-Saharan Africa
  - Affordable cost-effective evidence interventions are still not implemented at scale
  - Leading to poor quality maternal & newborn health services
- In Tanzania, 98% of women attend ANC BUT, a few receive the basic services for maternal care – Hb test, BP checks, Syphilis tests (coverage data has limitations)
- Management processes to delivering quality care are limited and not optimal – delayed action and due to low motivation
- Newborn life saving kits – less available in primary facilities, few in district hospitals
- Community effective demand for quality care is limited
  - Adherence to referral, emergency transport, importance of early booking

PROJECT INNOVATION 2015-2019

- Enhanced use of data and applying Quality Improvement approach
  - To get local stakeholders engage with information about quality of care such that the knowledge is turned into action
  - ***"Addressing gaps that ensure mothers get the care that they need"***
- Quality improvement (QI) - A structured bottom-up approach to close the "know-do-gap"
  - Starting with a clear aim, perform root cause analysis, indicators to follow up & use of collective power of many teams working on similar problems-collaboratives
  - It enlists/ counts on use of data by local stakeholders
  - Defining context-specific problems and
  - Creating strategies to address these problems
- The data is useful to to inform what works to improve maternal and newborn survival in low-income settings
- Encouraging action at 3 levels a)district managerial level, b)service delivery c)clients
- In general it aims to **institutionalize QI**
  - to get it implemented within the government health system - eliminating the need for full-time external facilitation

Measuring & use of quality data at primary health facilities and communities

QUADS



- Quality Improvement at district scale through
  - Strategic leadership in problem identification
- Quarterly meetings
- Mentorship and coaching
- Run-charts
- Community charts balls

National policy and guideline for MNH

Local level priority setting - regional and district

Bottom-up problem identification

Specific emphasis on measuring quality indicators

- Audience specific data presentation – liaison with producers and users of data
- To deeply reflect on the problem
- To motivate action
- To positively affect the outcome

MNH Indicators

- Pre-pregnancy
- Antenatal care
- Intra-partum care
- Post natal care-newborn
- Post partum care - mother

- Birth preparedness
- Newborn care seeking in the first week of life
- User perceived quality
- Facility readiness for MNC
  - Oxytocin
- Health worker practices
- Partograph use
- Resuscitation
- Infection prevention

Component 1:Policy makers engaged in routine use of data to improve MNH quality of care

- We aim to improve the measurement of the quality of MNH care, and to increase decision-makers' understanding and engagement in routine use of data to improve maternal and newborn quality of care
  - Decision-makers need to lead the investigation of quality of care and any quality improvement efforts directed at MNH
  - Increase the general capacity among decision-makers and health facility staff to engage with information about quality of care such that they can turn this knowledge into action

How is it achieved:

- To develop and validate a user-friendly electronic and paper-based quality of maternal and newborn care assessment tool
- To document the experiences of decision-makers and health facility staff in integrating a gender and equity perspective in the assessment and routine use of MNH quality of care data
- To generate evidence on the barriers and facilitators to the scale-up of the electronic tool, and its integration into routine use

Vital registration link to Policy makers engaged in routine use of data

- In Mainland Tanzania, the vital registration system is governed and mandated by the Registration Insolvency and Trusteeship Agency.
  - Launched in 2006 and replaces the Administrator General's Department in the Attorney General's Chambers, Ministry of Justice and Constitutional Affairs.
- For vital registration of births, the Agency collaborates with the President's Office Public Service Management
  - At present, the Agency has no offices at district level and collaborates with district and regional authorities in order
  - Vital registration is kept in the decentralized system -local government structure – harmlet, village, ward, district
- Main challenge
  - Village registers are not well updated
  - District birth registration system is continuously updated and has secure database that is subject to security and data integrity requirements being met, to other government organizations
  - UNICEF also support the processes
- The electronic tool might contribute to vital registration

Component 2: QUADS district level

District level staff

- Data summaries
- Supports health facility staffs
- Take action to improve quality care delivery in health facilities - Drug stock-outs, lack of human support or supportive supervision

- Engage in district level quality cycles
- Facilitating learning sessions to define problem with health facilities
- Mentorship and coaching
- Data collection and reflection
- Support the community program
- Liaise with regional systems for high level support

Component 3: QUADS Health facilities level

Health facility staff

- Data capture
- Frontline service delivery
- Communicate systemic challenges - Drug stock-outs
- Engage in facility level quality cycles – learn and share best practices

- Health facility staff - Attend review meetings to define problem
- Provides continuum of care
- Delivering services
- Data collection and reflection
- Support the community program
- Liaise with district for systems improvement for quality care delivery

Component 4: QUADS Community – MNH messages

- The client
- Community leaders and
- Volunteers
- Sustainable & scaleable implementation

- Behaviour change at community for MNH

- Delivering health messages in households, women groups and village meetings
- Supported by village executive officers and ward executive officers
- Message target to improve MNH indicators
  - Preparations to deliver in health facilities
  - Timely utilization of health facilities

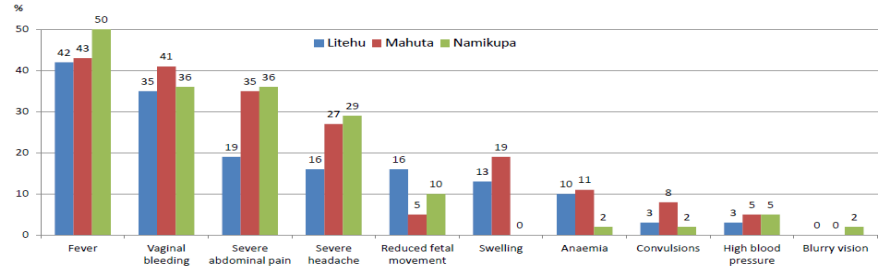
Data presentation – audience specific

Health facilities and district levels

- Use of report card - graphs

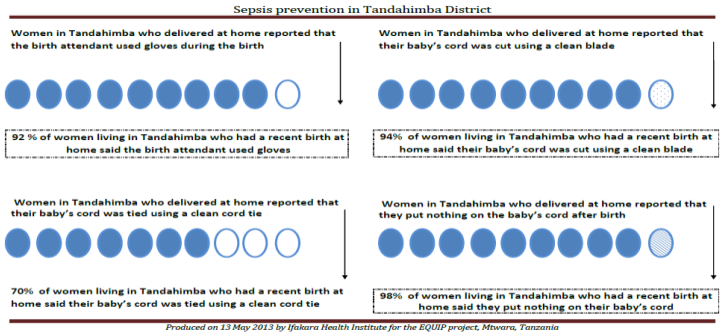
Knowledge of pregnancy danger signs amongst women with a birth in 2013, Tandahimba District

Division	Number of women who had a recent live birth (round 4)	% of women who knew at least one pregnancy danger sign	Average number of danger signs known per woman
Litehu	31	77	1.6
Mahuta	37	76	1.9
Namikupa	42	81	1.7



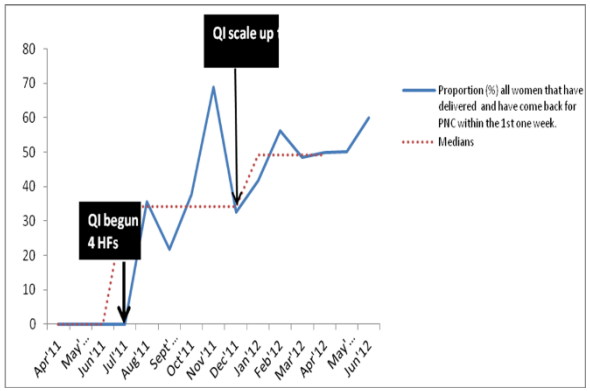
Community

- Use of report cards - balls



- Use of real life examples n

Annotated run-chart



Note: examples of the graphs are plot program – however the same will be deployed during scale-up program-the current work

Merits

- Data utilization at the point of collection to inform improvements and fine-tuning
  - Reflection on quality of care, understanding implementation barrier like key supplies
- Gender sub-analysis incorporated and immediate action taken
  - Eg specific needs of adolescent mothers, role of male partner, hard to reach areas
- Enhance accountability - behavior changes – taking pro-active approaches in delivering and managing services
  - It improves health worker ownership of processes and performance
  - Impact on strengthening health management at district level & increased accountability
  - System wide uptake, harmonization and institutionalization
- Actively engaging the community systems
  - volunteers, village leaders and ward
  - It stimulates demand for quality care
- Training, training, training not always enough - but **mentoring and coaching** is powerful
  - Data management and use and in delivering quality care
- Careful documentation of contextual factors to enhance our understanding of how health improvements were achieved
- Policymakers being involved throughout the processes

Implementation milestones

Repeated cycles have led to

1. Building the proper attitudes towards Quality Improvement to teams – Behaviour change
   - Through training, coaching and mentorship
   - Activation of QI Teams at the CHMT levels and health facilities
   - Involving all the staff not some selected members – district and facilities
   - Whatsapp group for health workers
2. Integrated supportive supervision & mentorship to the lower facilities
   - Change in timing of supervision - to conduct anytime of the day
3. Strengthening use of data at the point of collection to inform improvements
   - Created linkages of MNH interventions at District (CHMT) level with the facilities
   - Districts have real time information about their facilities - timely support
4. Sharing initial experiences with stakeholders – districts, regional & national
5. Policy makers engaged in routine use of data to improve MNH quality of care

- The processes of developing the user-friendly electronic and paper-based quality of maternal and newborn care assessment tool are ongoing

Lesson Learned

- Data used to recognize problems and inform appropriate timely reaction
- Overall health system strengthening
  - Starting with the software (interactions, norms, networking) and leads to development of strategies for hardware improvements (human resources, finance,…)
- Leaving no one out – supply and demand side
  - Data inform analysis and action for equity
- Going forward - we need to analyse how data informed quality improvement contributes to resilient health systems

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