Quality Improvement of Maternal and Newborn Health Services: Introducing Standards and Recognizing Achievements

THE APPROACH
The ACCESS Program used a quality improvement approach in 11 countries (see Table 5) to improve maternal, newborn and reproductive health services. The process—Jhpiego’s Standards-Based Management and Recognition Approach (SBM-R)—was used in a fairly consistent manner across all countries. SBM-R, which focuses on standardization around clearly defined service delivery processes or a specific content area, is an internal quality improvement process that involves providers, health workers and managers, and emphasizes internal learning and continuous improvement.

Through recognition, improvements achieved are formally or informally recognized, providing motivation to maintain progress and institutionalizing a culture of quality at the facility. The approach is less focused on problem analysis and more aimed at generating solutions to close gaps between expected (standardized) and actual performance. The SBM-R process strengthens health systems by linking national clinical standards, preservice education, in-service training and supervision to the service delivery point. It puts standards into the hands of providers and facility-based quality improvement teams, providing a concrete set of expectations for performance.

The SBM-R process is based on the model presented below. In the first step, standards are set by a broad group of national-level stakeholders, drawing from national and international guidelines. Based on the level of facility targeted (hospital or health center) and the clinical areas covered, the standards vary in complexity and scope. In the second step, the standards are introduced to service delivery points by training facility-based quality improvement teams (QIT), which typically include service providers, administrators and support staff. At this stage, the QIT conducts a baseline assessment to determine how the facility measures against the standards and prepares an action plan to make improvements. In the third step, progress is periodically measured against the baseline, usually by the internal QIT. At this stage it is important to involve district-level stakeholders in the process as some gaps are beyond the control of the facility to address and external support may be needed (i.e., in resolving stockouts or human resource shortages). Finally, when a predetermined threshold is reached and verified by an external assessment team, achievements are rewarded or recognized. This recognition can range from informal mechanisms such as community celebrations to formal recognition involving certification through governmental or professional bodies.

ACHIEVEMENTS
The application of SBM-R varied in technical and geographic scope across the 11 ACCESS countries. (See Table 7 below.) While most standards covered a broad range of services, in some settings the quality improvement process was more focused. In Kenya, the SBM-R process was used to strengthen PMTCT, for instance, and in Tanzania the process focused on ANC and malaria in pregnancy. In all cases, standards were set through a collaborative process at the national level and were endorsed by ministries of health and/or professional associations.
Table 7. Where and How SBM-R was Applied by the ACCESS Program

<table>
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<th>Country</th>
<th>Technical Area</th>
<th>Purpose</th>
<th>Scope of Intervention</th>
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| Afghanistan| 1) Pre-service education  
2) Comprehensive maternal/newborn/ reproductive health services | 1) To strengthen community and hospital midwifery schools  
2) To strengthen service delivery | 1) All midwifery programs in the country use the SBM-R process as basis for accreditation\(^{37}\)  
2) 319 facilities – hospitals, basic and comprehensive health centers and health posts (expansion continues) |
| Ethiopia   | Comprehensive maternal/newborn/reproductive health services | To assess and strengthen clinical training sites for Health Officer Training Program | 4 hospitals                                                                                                                                          |
| Ghana      | Comprehensive maternal/newborn/reproductive health services | To strengthen service delivery                                          | 11 facilities in Birim North District including 2 district hospitals                                                                              |
| Haiti      | Postabortion care                                      | To strengthen service delivery                                          | 6 hospitals                                                                                                                                          |
| Kenya      | PMTCT                                                | To strengthen service delivery                                          | 8 provincial and general hospitals                                                                                                                |
| Madagascar | Malaria in pregnancy                                  | To strengthen service delivery                                          | 5 model facilities                                                                                                                                 |
| Malawi     | Comprehensive maternal/newborn/reproductive health services | To strengthen service delivery                                          | 16 district hospitals  
All 4 central hospitals  
12 health centers (expansion continues)                                                                                                           |
| Nepal      | Comprehensive maternal/newborn/reproductive health services and training standards | To assess and strengthen SBA clinical training sites                     | 10 hospitals/clinical training sites (expanded to 25 after ACCESS assistance ended)                                                            |
| Nigeria    | EmONC and FP                                          | To strengthen service delivery                                          | 15 hospitals  
15 primary health care centers (expansion continues)                                                                                             |
| Rwanda     | BEmONC                                               | To strengthen service delivery                                          | Six hospitals                                                                                                                                        |
| Tanzania   | 1) Pre-service education  
2) ANC                                                   | 1) To strengthen preservice education  
2) To strengthen service delivery | 1) 24 Nurse Midwifery schools  
2) 2,633\(^{38}\) facilities (55% of all facilities)                                                                                              |

\(^{37}\) At the time of writing there are 34 hospital and/or Community Midwifery education programs in Afghanistan; the number continues to grow.

\(^{38}\) Tanzania was able to reach so many facilities through a modified abbreviated SBM-R approach that provided an “orientation” to SBM-R combined with provider ANC raining.
In all cases, ACCESS saw increases in achievement of standards, regardless of the technical area or level of facility. In many cases, the baseline assessment provided facility-based staff with their first opportunity to actually see what they were supposed to be doing and how close or how far they were from performing to standard. In some cases, notably Northern Nigeria, the baseline performance was shockingly low with no facility achieving greater than 20% of EmONC standards. However, even in those cases, improvements were seen over time. (See Figures 12 and 13 below.)

**Figure 12. Baseline and Follow-up Scores for EmONC Performance Standards at 13 ACCESS-supported Hospitals in Kano and Zamfara States**

In most countries, SBM-R standards were adopted by the central ministries of health (or other central bodies) for application beyond the ACCESS intervention areas. In Nigeria, although ACCESS worked in a limited number of Local Government Authorities (LGAs) in three states, the first stage of setting the standards resulted in the Federal Ministry of Health directing that the performance standards be institutionalized in all tertiary health facilities in the country.
In Nepal, ACCESS supported the National Health Training Center (NHTC) to develop training site quality improvement tools for the training of skilled birth attendants. ACCESS introduced the process to 10 sites; however, it continued beyond the project period and was institutionalized within the NHTC, which continued to expand the process to a total of 25 sites without ACCESS assistance.

Similarly, in Malawi, the SBM-R process had a national scope. Prior to ACCESS, Jhpiego had worked with the Reproductive Health Unit (RHU) in Malawi’s Ministry of Health to introduce performance standards for infection prevention in all hospitals in the country. Based on a positive experience, the RHU requested that PQI (as SBM-R is called in Malawi) for a broad range of maternal, newborn and reproductive health services (PQI-RH) be part of the ACCESS program design. Figure 14 below shows the broad range of services covered by this national quality improvement program and the steady improvements made over time in one of the district hospitals.

**Figure 14. Percentage of selected RH areas achieved by Mchinji District Hospital Pre- and Post-PQI**

![Graph showing percentage of selected RH areas achieved by Mchinji District Hospital Pre- and Post-PQI](image)

Malawi is also looking to document how achievement of standards affects health outcomes. The effect of SBM-R on improved maternal and newborn health outcomes is beginning to emerge based on routine service statistics gathered at the facility level. Preliminary analysis from a 2009 evaluation of PQI showed a dramatic difference in the rate of cesarean sections at RH sites compared to the control, with cesarean sections increasing rapidly after the introduction of PQI RH across all intervention facilities. (See Figure 15). The increasing trend indicates that providers are able to readily identify emergency obstetric complications, refer, and conduct timely cesarean sections to avoid obstetric complications.

**Figure 15. Service Statistics from Malawi SBM-R Evaluation: Cesarean Sections Increased More in Intervention Group**

![Graph showing service statistics from Malawi SBM-R Evaluation: Cesarean Sections Increased More in Intervention Group](image)
Lessons Learned

- **SBM-R strengthens the health system by serving as a bridge from pre-service education and in-service training to the service delivery point.** Putting performance standards into the hands of service providers allows for continuous learning at the service delivery point. One aspect that service providers like most about SBM-R is that the standards can be used as “job aids” to help remind them of how to do their job correctly. In Nepal, the MNH standards were actually made into a “pocket guide” so that providers could keep them with them for easy reference.

- **SBM-R strengthens the health system by making supervision more relevant and focused.** In many countries, supervision is cursory, unfocused and ad hoc. In countries where SBM-R has been linked to the supervision system (Kenya and Malawi) it has provided supervisors with a meaningful tool to assess performance.

- **SBM-R can successfully be applied in the pre-service setting.** Pre-service education lends itself to standardization. ACCESS supported the application of SBM-R to the pre-service system in Afghanistan and Tanzania. The process now forms the foundation for Afghanistan’s National Midwifery Education Accreditation Board and is used to accredit all midwifery schools across the country.

- **By starting at the national level, SBM-R can be sustained over time.** Setting standards with national-level stakeholders allows quality improvements to be expanded beyond a project intervention area because there is ownership at the country level. In Afghanistan, for example, all donors working in midwifery education use the same educational standards because they are now institutionalized in the National Midwifery Education Accreditation Board.

Recommendations for Future Programming

- **Linking facility improvements to community mobilization will likely increase the impact.** In some ACCESS countries—such as Nigeria, Malawi and Rwanda—the quality improvement process was loosely linked to community mobilization work. Given that communities have a stake in facility performance and have the power to mobilize resources, closer ties between these approaches should be promoted as they are expanded within MCHIP and elsewhere.

- **Selected outcome indicators should be tracked alongside of improvement in standards.** Although most standards promoted through SBM-R are evidence based, it is important to demonstrate that achievement of standards is directly linked to improved practices and health outcomes. The work started by Malawi to track health outcomes should be expanded and replicated in other countries.

- **Build on what is in place: promote quality improvement principles, not a branded approach.** ACCESS did not insist on calling the quality improvement process “SBM-R” if a country already had a quality strategy in place. The term “SBM-R” is not used at all in Tanzania or Malawi, for instance. And, in Afghanistan, the ACCESS Associate Award and the HCI project are collaborating on improving quality of health services with the MoPH, and the term used for the process is “quality assurance.”

- **Ensure involvement of district level stakeholders to avoid “plateau-ing”.** A typical pattern for achieving standards is quick initial gains followed by a slowing down and possible stalling when some of the barriers are out of the control of hospital management (e.g., supply chain issues). The SBM-R process is designed to tackle the “quick wins” first and then engage a broader group of stakeholders to tackle the more systemic problems. Broad and representative stakeholder involvement from the beginning can help facilities resolve the more difficult problems.
• **Recognition is a critical component of the process, and linking incentives with quality improvements should be vigorously pursued.** Recognition increases motivation; it can promote healthy competition and help increase utilization of services. While formal accreditation based on provision of quality services is the ultimate goal of this process, incremental and informal recognition can motivate providers and “advertise” high-quality services to surrounding communities. Linking quality improvements to tangible incentives should be expanded where governments are seeking to base financing on performance.