



Nepal Safer Motherhood Project a part of HMGN Safe Motherhood Programme

Quality of Care Approach – Results and Lessons Learnt

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ABBREVIATIONS

CQI	Continuous Quality Improvement
DFID	Department for International Development
EOC	Essential Obstetric Care
HMGN	His Majesty's Government of Nepal
HRDO	Human Resource Development Officer
IEC	Information Education and Communication
NSMP	Nepal Safer Motherhood Project
QA	Quality Assurance
QoC	Quality of Care
WHO	World Health Organisation

1. INTRODUCTION

The Nepal Safer Motherhood Project (NSMP) envisaged that by the end of Phase One, the three project hospitals - Surkhet and Baglung District Hospitals and Seti Zonal Hospital in Kailali - would be able to offer 24-hour comprehensive Essential Obstetric Care (EOC) in an environment that was:

- Safe and clean;
- Adequately equipped;
- Woman and family-focused;
- Staffed by personnel committed to working as a team to improve maternal health;
- Managed by staff confident and competent to treat obstetric emergencies appropriately.

A hospital needs assessment was conducted in August 1997 to identify the quality of existing obstetric care.¹ The findings showed that obstetric care was significantly substandard - none of the hospitals were meeting the "elements of quality" identified by the World Health Organisation (WHO)². NSMP intervened: physical facilities were improved; hospital equipment and supplies were upgraded, and clinical and non-clinical training was provided to the entire hospital staff. At the same time, a Quality of Care (QoC) philosophy was introduced. Two years have passed and the timing is now opportune to reflect upon the impact of the QoC process.

This report aims to:

- Describe the QoC model employed;
- Record the changes realised between the 1997 needs assessment survey and the 1999 self-assessment exercise;
- Demonstrate that the QoC model does more than effectively monitor and document change. It actually stimulates change in the attitudes and behaviours of healthcare providers, which then improves the quality of care; and
- Identify the lessons learned.

¹ For an overview of the needs assessment, see "Challenges to Reducing Maternal Mortality: Experiences from the three districts in Nepal supported by the Nepal Safer Motherhood Project - Kailali, Surkhet and Baglung" by Joyce Abbatt, pp. 12-15, August 1999, 176/96/DFID. For details see the "Summary Report on Hospital Needs Assessment," November 1999.

² WHO, 1994, "Mother-Baby Package: Implementing Safe Motherhood," (WHO/FHE/MSM/94.11), Geneva: WHO (see Appendix 1).

2. THE QUALITY OF CARE APPROACH

2.1 Principles of the Quality of Care Improvement Models

Two approaches to improving the quality of healthcare are the Quality Assurance (QA) approach and the Continuous Quality Improvement (CQI) approach. There are significant differences between these two approaches. The QA approach relies on pre-set standards and measures "quality" against these standards. The approach presupposes that "quality" is achieved when these standards are met. The CQI approach assumes that standards are created through process; therefore, that quality can always be improved upon. The CQI model uses a step-by-step approach to assist staff to analyse, plan, improve and monitor their services and thereby make incremental changes. The focus is on improving service delivery rather than on individual staff performance. Quality is achieved when client needs are met.

2.2 NSMP Quality of Care Model

The NSMP QoC model falls within the CQI model in that it adheres to the CQI principle that improving quality is a continuous process therefore standards of quality evolve. NSMP believes that:

- People are capable of change, growth and adaptation;
- People want to learn;
- People want to work with change and contribute to the institution in which they work.

Hence, NSMP adopted a modified version of COPE - a CQI model developed by AVSC³. This process involves first satisfying the needs of the service providers, then assisting them in:

- Setting local maternal healthcare standards;
- Analysing problems and the causes which hinder quality;
- Developing action plans to improve healthcare services; and
- Monitoring progress towards their own standards.

2.3 NSMP Quality of Care Process

The Quality of Care Process is one of trial and error. As the objective is to satisfy client needs, service providers must be flexible in considering local standards and local solutions to barriers to improvements. Therefore, pre-set programmes must give way to creativity. To accomplish this, it is necessary to identify enthusiastic team players early in the process⁴. Team members need to be open to change as they are agents of change - bringing about changes in institutional attitudes, staff motivation, and ultimately, the quality of service to clients.

After all members of the teams have received technical training (midwifery and/or infection prevention), they are able to determine and set their own standards for maternal healthcare and infection prevention practices. Using previously developed checklists based on WHO guidelines, the teams conduct assessments monthly and semi-annually. Quality of care is assessed as it applies to both client and provider needs (see Appendix 2 for copies of checklists).

- The Monthly Assessment Process

³ COPE is made up of four tools, two of which - the use of self-assessment exercises and self-initiated actions - have been adopted by NSMP.

⁴ Two teams have been established: one to oversee the maternity unit, the other the infection prevention unit. The maternity team consists of the nursing staff, a medical doctor, peons and the Human Resources Development Officer (HRDO). The infection prevention committee consists of a medical superintendent, the sister-in-charge, a storekeeper, an administrator, peons, sweepers, a representative for each hospital unit and the HRDO.

Each team holds informal monthly meetings to assess the quality of care provided by its own unit. For example, members of a maternity unit assess their maternity unit; the infection prevention committee assesses units under its area of responsibility. Using checklists, teams identify barriers to quality healthcare, analyse the causes, develop local action plans, and implement changes in their own units. Enlarged copies of action plans are posted in the maternity unit to encourage all staff members to participate in the assessment process (see Appendix 3 for a copy of the monthly local action plan form).

- The Quarterly Review Process

Quarterly, the maternity and infection prevention teams reconvene to follow up on the previous three months' action plans. Areas of improvement are noted and, in cases where activities have stalled, follow-up actions are developed. Incomplete actions are carried over to the next month's report. Efforts are made to solve problems with local resources. Findings are recorded and a quarterly report is completed. The report is sent to the project office in Kathmandu and a copy retained at the site (see Appendix 4 for a copy of the quarterly review form).

- The Semi-Annual Assessment and Review Process

In September 1999 the first semi-annual assessment exercise was introduced. The entire hospital staff participated in a thorough review of the quality of care available to women and their families. The process was so rewarding that staff expressed an interest in repeating the exercise every six months (see Appendix 5 for a copy of the guidelines used in the Self-Assessment exercise).

The objective of this first internal evaluation was to provide opportunities for:

- The hospital staff to evaluate situations that require change, learn from each other and share assessment findings in a non-threatening environment;
- The maternity teams and infection prevention committees to share with other staff the progress made towards improving the quality of care in their units using the Quality of Care process;
- The entire hospital staff to evaluate the overall quality of maternal healthcare;
- The group to identify areas related to safe motherhood that require improvements, and to explore solutions including those that may require further assistance from NSMP; and
- The group to assess basic health services that affect the quality of maternal healthcare, such as laboratory services, drug management systems, and emergency services; and to take steps to overcome obstacles.

2.4 How the Semi-Annual Assessment Process Differs from the Monthly and Quarterly Processes

- The semi-annual assessment exercise is significantly more extensive than monthly and quarterly assessments. Every six months the entire hospital staff conducts a review of all functions related to maternal healthcare. It includes evaluation of auxiliary units such as the drug management system and the referral system. Based on assessment findings, action plans are developed in collaboration with stakeholders. This differs from the monthly and quarterly reviews at which only the maternity and infection prevention teams assess only their respective functions.
- The semi-annual assessment review is a formal process, scheduled in advance and lasting a full week; whereas, the monthly and quarterly sessions are informal and flexible.
- The semi-annual assessment process uses clinical checklists based on HMGN's National Reproductive Health protocols to evaluate the technical competence of service providers. Technical competence is not evaluated during the monthly and quarterly reviews.

- The semi-annual assessment incorporates the means to obtain client feedback about the quality of care received. It includes exit interviews with clients who had received antenatal care and/or attended health education sessions to get their opinions of the quality of services and information received.

2.5 Managing NSMP's Quality of Care Process: The Role of the Human Resources Development Officers

Human Resources Development Officers (HRDOs) are located in each district. Their role is to facilitate and supervise the QoC process, to provide on-site coaching for hospital staff and to create a supportive environment conducive to bringing about change.

3. 1999 SELF-ASSESSMENT WORKSHOP FINDINGS

Self-assessment workshops were held in all three districts in the autumn of 1999 to evaluate the quality of maternal healthcare against previously identified standards. The findings were compared with the initial 1997 needs assessment findings and show that in combination with other interventions - clinical and non-clinical training for the entire hospital staff, improved physical facilities, and upgraded equipment and supplies - the QoC process is effective in bringing about changes in the quality of care. The following is a summary of the findings (see Appendix 6 for details).

- **Technical Competence:** The most significant improvement is in the area of technical competence;
 - Staff are now able to provide essential obstetric care according to HMGN's National Reproductive Health protocols.
 - Post-abortion care is available in two hospitals. The staff of the third hospital expressed their commitment to providing post-abortion care after they receive training.
 - The majority of nursing staff are now competent in antenatal care and normal midwifery care. However, some nursing skills need to be upgraded.
- **Availability of Services:** Another dramatic improvement is in the availability of services; all three project-supported hospitals are now able to provide basic and comprehensive EOC 24 hours a day, seven days a week.
- **Blood Transfusion Services:** Improvement is noted in the quality of blood transfusion services. All three blood transfusion centres are now providing safe and adequate blood transfusions to women during pregnancy, labour, and/or during the postpartum period. In addition, free blood transfusions are now available for women unable to pay. This is a significant break with the past when women without money were denied care.
- **Physical Facilities and Essential Equipment:** Improvements in physical facilities and in the availability of essential equipment have significantly contributed to the ability to provide quality basic and comprehensive EOC services. All three hospitals now have good operating theatres, labour rooms, and wards. Rooms are well screened and provide privacy for women and their families. Neonatal equipment is available at all three hospitals allowing for normal care and for neonatal resuscitation.⁵
- **Client-Provider Interaction:** There has been some improvement in client-provider interactions but continuous monitoring and support is required.
- **Promotion of Essential Obstetric Services to the Local Community:** Little progress was seen in this area. This was a conscious decision as it was felt that it would be improper to promote the use of EOC services until such time that the quality of care reached acceptable levels. Information Education and Communication (IEC) activities and materials are required, and now that the level of quality has improved, NSMP teams (increasing access and capacity building) are working together towards promoting awareness.
- **Integration of Reproductive Health Services:** Another area still requiring attention is the integration of reproductive health services with maternal healthcare. The HRDOs are working with the hospitals to integrate into maternal healthcare programmes other related needs such as treatment for sexually

⁵ For information on facility improvements, see "Review of NSMP's Procurement, Facility Improvement, Maintenance and Stores Management Inputs" by Andy Barraclough, December 1999, report produced by Options on behalf of DFID

transmitted diseases, post-abortion follow up, antenatal care, and postpartum family planning services. In addition, they are exploring the integration of childcare services.

- **Referrals to Essential Obstetric Care:** Although little effort was directed toward improving internal hospital referrals because of the amount of coordination required, some progress was seen at the hospital level. However, referrals from the community need to increase. Both stakeholders and hospital staff have agreed to work with local reproductive health organisations (such as Red Cross and FPAN) to expand the referral network.
- **Basic Healthcare Services:** As they relate to maternal healthcare, infection prevention practices are good. Guidelines were produced that are appropriate for use in hospitals throughout Nepal.
- **Related Healthcare Functions:** Other hospital management systems need to be strengthened.

4. CHANGES STIMULATED BY THE QUALITY OF CARE PROCESS

There are many obstacles to providing high-quality maternal healthcare: inadequate training, lack of resources, etc. However, it appears that the QoC process implemented by NSMP has given providers the ability to overcome many obstacles. As a result of training and the emphasis on teamwork, attitudes are changing. Strong maternity units are developing and they are receiving support from hospital management.

- One of the most difficult situations has been the frequent transference of skilled service providers away from NSMP-supported hospitals. To overcome this problem NSMP has provided extensive training to entire teams. Now when trained staff are transferred by HMGH to another post, the remaining staff have the skills, knowledge, and motivation to train new arrivals. Thus, the lessons learned are sustained and the unit is able to continue providing quality care.
- Another obstacle related to training involves staff with only theoretical training. Where practical skills are lacking, the NSMP-trained maternity team has taken on the responsibility to convert theoretical knowledge into practical skills.
- A common practice has been inappropriate utilisation of service providers. For example, nursing staff trained in midwifery skills used to be assigned to work in general medical units. The NSMP-supported maternity team is now successfully advocating for appropriate posting.
- In the past, there was no coordination among various hospital departments. Time schedules for services were set without consideration for patient needs. A pregnant woman may have travelled four to six hours for antenatal care, seen a medical professional who advised laboratory tests, only to discover that the laboratory had closed at noon. She would need to return another day or forego the tests. The maternity unit recognised difficulties of this type and successfully eliminated them.

5. LESSONS EMERGING FOR NSMP

- **Sustainability:** The Quality of Care model adopted by NSMP accommodates local people working in their own environment, in their own way, to meet their own needs. Staff see the benefits of the process and have demonstrated a commitment to the improvement process. For example, hospital teams now conduct monthly assessment meetings without cost to NSMP, even in the absence of the HRDOs; and action plans are now implemented with local resources. However, even though the teams have assumed many of the responsibilities once performed by the HRDOs, NSMP acknowledges that continuous follow-up and support by HRDOs is a major factor in the project's success. The question then arises about who will take over this function after the project ends.
- **Teamwork:** Due to the hierarchical nature of Nepali culture, the concept of teamwork has been very difficult to practice. Traditionally staff are supposed to follow the instructions without question and abstain from expressing their concerns or opinions. The result of this type of institutional climate was apathy. However, things are changing as a result of the institutional development and technical training provided by NSMP. A team mentality is developing. Support staff and service providers have learned to work together. Management skills have improved, as has communication among colleagues. Staff now feel they are part of a team and can contribute to improving the quality of care. For example, a sweeper now attends the monthly infection prevention meeting alongside the hospital superintendent and feels comfortable enough to give his suggestions on 'infection prevention practices,' knowing that quality is everyone's responsibility.
- **The NSMP "Package of Inputs":** NSMP believes that its "package of inputs" - improved physical facilities, upgraded equipment and supplies, and extensive training - is essential in providing quality maternal healthcare. The Quality of Care process is one part of this package. It advocates involving service providers in all project activities to give them a clear vision of objectives, to ensure interest in the process, and to motivate them to improve outcomes. Through the QoC process, service providers are now able, incrementally, to improve the quality of service to women and their families.
- **Local Resources:** As a result of NSMP's "package of inputs," service providers have gained a degree of self-confidence that allows them to manage resources effectively and to resolve local problems without external interventions. As a result, hospital management committees are impressed with the improvements they see and are responding. They are allocating additional resources for essential drugs, for increased staffing, for replacement of infection prevention supplies (such as Virex, utility gloves, etc.) and blood for needy women.
- **Record Keeping:** The record-keeping component of this project needs to be overhauled. Aside from the fact that most Nepalis have an aversion to reading and writing, the staff are unable to complete reports because they do not understand the forms. The reporting forms are long, complex and heavy with terminology that is culturally meaningless. Furthermore, they are written in English. Forms should be in Nepali and include only essential information. The language should be simple and culturally appropriate.
- **Reliance on HRDOs:** Experience shows that with the "package of inputs" in place, the role of HRDOs is reduced to providing follow-up and on-site support. HRDOs, now feel confident with the QoC process and in facilitating it. NSMP feels that given experience, it may be possible, that in phase two HRDOs are not required to work full time in one district but could manage to support two or even three districts provided they are clustered around a phase one district.

6. CONCLUSION

In summary, NSMP has piloted a flexible QoC model where the first needs addressed were those of the service providers who, by the time implementation activities started, were already motivated to meet the needs of their clients.

A “package of inputs” was supplied by NSMP; service providers, supported by NSMP’s HRDOs, were encouraged to employ the QoC model as they saw fit. Based on results, the QoC model appears to stimulate change in the attitudes and behaviours of healthcare providers, and effectively monitors and documents change. As seen in this report, the QoC model can act as a catalyst in bringing about change. When viewed alongside the 1997 survey, the findings of the 1999 Self-Assessment Workshop are impressive.

Valuable lessons have emerged. The QoC process is a sustainable process when the staff work as a team. Positive results (improved quality of care) can lead to additional positive results (increased local resources) that lead to further improvements in quality.

APPENDIX 1: ELEMENTS OF THE QUALITY OF MATERNAL HEALTHCARE (MOTHER-BABY PACKAGE, WHO, 1994)

1. Promotion and protection of health
People need to know about pregnancy and childbirth, and to understand the danger signs and symptoms.
2. Accessibility and availability of services
Women should be able to benefit from quality of care, understand the full range of services available to them, and receive care at the lowest appropriate level of the system close to where they live.
3. Acceptability of services:
Women need privacy; they may prefer to consult a female health worker; and they should be assured of confidentiality.
4. Technical competence of healthcare providers:
Technical competence depends on regular training and retraining and on clear guidelines for clinical treatment.
5. Essential supplies and equipment:
Norms and standards should be established for the necessary supplies and equipment at each level of care and their availability should be ensured.
6. Quality of client-provider interaction:
Providers must treat clients with respect, be responsive to their needs and avoid judgmental attitudes.
7. Information and counselling for the client:
Clients should have the opportunity to talk to healthcare providers, and should be offered guidance on any health problems identified.
8. Involvement of clients in decision-making:
Providers should see clients as partners in healthcare, and should involve them in decision-making as active participants in their own health care.
9. Comprehensiveness of care and linkages to other reproductive health services:
Maternal healthcare is a unique opportunity to provide women with comprehensive reproductive healthcare, and to address other issues, such as nutrition and sexually transmitted diseases.
10. Continuity of care and follow-up:
Maternal healthcare should be part of a continuum of care consisting of antenatal, delivery and postpartum care. Clients must, however, be seen as people with healthcare needs that continue throughout their lives.
11. Support to healthcare providers:
Healthcare providers at all levels need the backup, and economic and social support from the authorities and the communities where they work.

APPENDIX 2: MONTHLY CHECKLISTS

1. Accessibility and availability of basic and comprehensive essential obstetric services

Please check the following during monthly meetings. If any answer is other than 'always,' develop an action plan.

	The following obstetric services are available	Always	Sometimes	Rarely	Never
Q1.1	1. Basic Obstetric Services are available				
Q1.1.0	Injectable oxytocic				
Q1.1.1	Injectable antibiotics				
Q1.1.2	Injectable sedatives/anticonvulsant				
Q1.1.3	Injectable anti-hypertensives				
Q1.1.4	Plasma expanders				
Q1.1.5	Instrumental delivery (Forceps/Vacuum)				
Q1.1.6	Manual Removal of Placenta				
Q1.1.7	Destructive delivery				
Q1.1.8	D&C				
Q1.1.9	MVA/Post Abortion Care				
Q1.2	2. Comprehensive Obstetric Services are available				
Q1.2.1	All of the above				
Q1.2.2	Caesarean Section				
Q1.2.3	Laparotomy				
Q1.2.4	Blood Transfusion				

2. Blood transfusion services

Please complete the following table monthly:

Q2.1	Blood transfusion	Collection from donors	Requested		Given	
			Persons	Units	Persons	Units
Q2.1.1	Total this month (includes men, women, and children)					
Q2.1.2	Reproductive age women (-includes all women between the ages of 15 and 49 inclusive)					
Q2.1.3	For obstetric purposes (includes all pregnant women with an obstetric indication)					

If a request for a transfusion could not be met this month, please complete the following table. Tick all that apply:

Q2.2	Reason blood transfusion was not provided	Tick if applicable	Comments
Q2.2.1	Donor not available		
Q2.2.2	Technician not available		
Q2.2.3	Screening tests not available (specify which)		
Q2.2.4	Patient party not able to pay for units		
Q2.2.5	Others - Please specify		

2.3	This month -	Always	Sometimes	Rarely	Never	Comments
Q2.3.1	Was a trained technician available?					
Q2.3.2	Were quick tests (for HIV) available?					

3. Availability of essential supplies and equipment

Please check the following during the monthly meetings. If any question is other than 'always,' develop an action plan.

		ALWAYS	SOMETIMES	RARELY	NEVER	COMMENTS
Q3.1	1. FACILITIES AVAILABLE					
Q3.1.1	Running water in delivery room					
Q3.1.2	Running water in OT					
Q3.1.3	OT with clean and dirty layout					
Q3.1.4	Screens in delivery room					
Q3.1.5	Functioning light in OT					
Q3.1.6	Functioning light in delivery					
Q3.2	2. EQUIPMENT AVAILABLE					
Q3.2.1	Functioning steriliser for equipment & supplies					
Q3.2.2	Functioning vacuum extractor					
Q3.2.3	Functioning suction in OT					
Q3.2.4	Functioning suction in delivery					
Q3.2.5	Sterile Pack for normal delivery					
Q3.2.6	Sterile Pack for Caesarean Section					

OT= Operating Theatre

4. Promotion & Protection of Health

Please check the following during the monthly meetings. If any question is other than 'always,' develop an action plan.

Q4		ALWAYS	SOMETIMES	RARELY	NEVER

Q4.1	1. Women are alerted to the warning signs of Obstetric emergencies				
Q4.1.1	Verbally during antenatal care				
Q4.1.2	Verbally during the postnatal period before discharge.				
Q4.2	2. IEC materials on warning signs are				
Q4.2.1	Available				
Q4.2.2	Used				

5. Acceptability of Services

Please check the following during the monthly meetings. If any question is other than 'always,' develop an action plan.

Q5	The following provisions are made to improve the acceptability of services to women and their families	ALWAYS	SOMETIMES	RARELY	NEVER
Q5.1	Screens are used to ensure privacy during labour and physical examination.				
Q5.2	A companion was allowed with the client during 1 st stage of labour.				
Q5.3	A female companion was allowed with the client during 2 nd & 3 rd stages of labour.				
Q5.4	A female attendant tends to the woman during delivery.				

6. Technical Competence of HealthCare Providers

Please check the following during the monthly meetings. If any question is other than 'always,' develop an action plan.

Q6.1	Protocols/Guidelines are available	Always	Sometimes	Rarely	Never	Comments
Q6.1.1	Normal care during labour					
Q6.1.2	Care of normal neonate (immediately following delivery)					
Q6.1.3	Care of a woman with pre-eclampsia					
Q6.1.4	Care of a woman with obstructed labour					
Q6.1.5	Care of a woman with an incomplete abortion					
Q6.1.6	Care of a woman with puerperal sepsis					
Q6.1.7	Care of a woman with a PPH					
Q6.1.8	Infection control procedure					
Q6.1.9	Waste disposal					
Q6.1.10	Referral to another centre					
Q6.1.11	Postnatal care of mother and baby					

6. Technical Competence of HealthCare Providers (continued)

Please check the followings during monthly meeting. If any question is other than 'always,' develop an action plan.

Q6.2	Protocol/Guidelines are used for	Always	Sometimes	Rarely	Never	Comments
Q6.2.1	Normal care during labour					
Q6.2.2	Care of a woman with pre-eclampsia					
Q6.2.3	Care of a woman with obstructed labour					
Q6.2.4	Care of a woman with an incomplete abortion					
Q6.2.5	Care of a woman with puerperal sepsis					
Q6.2.6	Care of a woman with a PPH					
Q6.2.7	Infection control procedures					
Q6.2.8	Waste disposal					
Q6.2.9	Referral to another centre					
Q6.2.10	Postnatal care of mother and baby					
Q6.3	There is evidence of:					
Q6.3.1	Use of the partograph					
Q6.3.2	Monitoring progress during the first stage of labour					
Q6.3.3	Acting on deviations from normal which are detected					
Q6.3.4	Registers are completed correctly and information is complete					

7. Client-Provider Interaction

Please check the following during the monthly meetings. If any question is other than 'always,' develop an action plan.

Q7	There is evidence that:	Always	Sometimes	Rarely	Never	Comments
Q7.1	Procedures are explained to woman and their families					
Q7.2	Verbal consent for procedures is obtained					
Q7.3	Clients are actively involved in conversations about care (e.g. they ask questions, give opinions, staff checks for understanding)					

8. Comprehensiveness of Care and Linkages to other Reproductive Health Services

Please check the followings during monthly meeting and ensure that specific services are available on certain days of the week

Q8	The Maternal and Child Health clinic offers comprehensive reproductive health services 6 days a week. This should include:	SUN.	MON.	TUES.	WED.	THUR.	FRI.	Comments
Q8.1	Antenatal care							
Q8.2	Tetanus toxoid immunisation							

Q8.3	STD diagnosis and treatment							
Q8.4	Postnatal care							
	Family planning advice & services							
Q8.4	Depo Provera							
Q8.5	Contraceptive Pills							
Q8.6	Norplant							
Q8.7	Intra Uterine Device							
Q8.8	Condoms							
Q8.9	Female sterilisation							
Q8.10	Male sterilisation							

STDs = Sexually transmitted diseases

9. Continuity of Care and Follow Up

Please check the following during the monthly meetings. If any question is other than 'always,' develop an action plan.

Q9.1	Protocols/guidelines for referral to follow-up services are available for:	Always	Sometimes	Rarely	Never	Comments
Q9.1.1	Referring postnatal women for family planning					
Q9.1.2	Referring postnatal women for childhood immunisation					
Q9.1.3	Referring emergency obstetric cases that cannot be handled at the hospital to the next referral centre					
Q9.1.4	Feedback to peripheral staff who referred a woman to the hospital for essential obstetric care (EOC)					

Please check the followings during monthly meetings. If any question is other than 'always', develop an action plan.

Q9.2.0	Protocols/guidelines for referral to follow-up services are used for:	Always	Sometimes	Rarely	Never	Comments
Q9.2.1	Referring postnatal women for family planning					
Q9.2.2	Referring postnatal women for childhood immunisation					
Q9.2.3	Referring emergency obstetric complicated cases which cannot be handled at the hospital to the next level referral centre					
Q9.2.4	Feedback to peripheral staff who referred a woman to the hospital for essential obstetric care (EOC)					

APPENDIX 3: MONTHLY LOCAL ACTION PLAN FORM

No.	Problems/Needs	Factors/Issues	Action to be taken	Action by whom	Review date

Persons involved in problem identification and monitoring process:

APPENDIX 4: QUARTERLY REVIEW FORM

Problem No.	Outcome/Achievements	Constraints to achieving target	Implemented by	Date

Persons involved in achievement identification and monitoring process:

APPENDIX 5: GUIDELINES USED IN THE SELF-ASSESSMENT EXERCISE

Method of data collection	Purpose	Tools used
1. Accessibility and availability of EOC <ul style="list-style-type: none"> ● Observation of Registers (delivery, OT, and post abortion care) ● Interview with nursing staff and medical doctors 	<ul style="list-style-type: none"> ● To assess the accessibility and availability of Basic and Comprehensive Essential Obstetric Care 	Monthly checklists
2. Blood transfusion services <ul style="list-style-type: none"> ● Observation of blood transfusion register ● Interview with blood transfusion technician 	<ul style="list-style-type: none"> ● To assess the standards of blood transfusion services 	Monthly checklists
3. Equipment and supplies <ul style="list-style-type: none"> ● Observation of labour room, operating theatre and maternity ward ● Focus group discussion with nursing staff, medical officer, store & trained peon in maintenance 	<ul style="list-style-type: none"> ● To assess the availability of essential supplies and equipment 	Monthly checklists
4. Promotion and protection of health <ul style="list-style-type: none"> ● Observation of health education session ● Exit interview with antenatal clients 	<ul style="list-style-type: none"> ● To assess the standards used in promoting and protecting health 	Monthly checklists & Pre-set questionnaire
5. Acceptability of services <ul style="list-style-type: none"> ● Observation of the antenatal clinics, labour room and maternity ward 	<ul style="list-style-type: none"> ● To assess the acceptability of services for women using the hospital 	Monthly Checklists
6. Technical competence <ul style="list-style-type: none"> ● Observation of skills while providing normal antenatal care, delivery care, neonatal care and postpartum care. Use of Partograph ● Observation of the skills in managing complicated obstetric cases through clinical drills 	<ul style="list-style-type: none"> ● To assess the technical competence of healthcare providers ● Normal midwifery care ● Normal neonatal care ● Emergency obstetric complications care 	Four case studies on partograph; four on APH, PPH, pre-clampsia & eclamptic fit; RH protocol checklists on normal & neonatal care, APH, PPH, pre-eclampsia, & eclamptic fit mgmt.
7. Client-provider interaction <ul style="list-style-type: none"> ● Observation in labour room, antenatal clinic, and in health education session 	<ul style="list-style-type: none"> ● To assess the standards of client-provider interaction 	Communication checklists
8. Comprehensiveness of care <ul style="list-style-type: none"> ● Observation in the antenatal, immunisation & family planning clinics, and STD management 	<ul style="list-style-type: none"> ● To assess the comprehensiveness of care and linkages to other reproductive health services 	Monthly checklists
9. Continuity of care and follow up <ul style="list-style-type: none"> ● Review of different registers and focus group discussions with nursing staff 	<ul style="list-style-type: none"> ● To assess the continuity of care and follow-up 	Monthly checklists

APPENDIX 6: COMPARISON OF FINDINGS 1997 WITH 1999

Baglung Hospital

SN	Elements of Care	Needs Assessment Findings (1997)	Self Assessment Findings (1999)	Areas of Improvement
1.	Accessibility and Availability of Emergency Obstetric Services and Continuity of Care	<ul style="list-style-type: none"> • Only basic emergency obstetric care was available. • All essential drugs were not available in labour room. • Only one nurse was able to perform procedures such as breech delivery, vacuum delivery, and manual removal of placenta. • Post abortion care was not available. • Nursing staff were not trained or legally entitled to carry out 'essential life saving skills'. • Ambulance service was not available. 	<ul style="list-style-type: none"> • Only basic emergency obstetric care is available. • All essential drugs except magnesium sulphate are available in labour room. • Four nurses are performing procedures such as breech delivery, vacuum delivery, and manual removal of placenta. • Post abortion care is available. • Nursing staff are trained and legally entitled to carry out 'essential life saving skills'. • Ambulance service is available. 	<ul style="list-style-type: none"> • By the end of the self-assessment workshop a MDGP doctor skilled in caesarean section was transferred, therefore by the time of this report writing comprehensive essential obstetric care was available 24 hours a day in Baglung hospital
2.	Blood Transfusion Service	<ul style="list-style-type: none"> • Adequate and safe blood was not available 24 hours a day. • Blood transfusion centre suffered from lack of equipment, staff and donors. • Poor women did not have access to blood transfusions. 	<ul style="list-style-type: none"> • Adequate and safe blood is available 24 hours a day. • Blood transfusion centre has appropriate equipment, and three trained blood transfusion technicians are available. • Poor women also have access to blood transfusion services. 	<ul style="list-style-type: none"> • Blood transfusion centre wants management training
3.	Availability of essential supplies and equipment	<ul style="list-style-type: none"> • The supply of drugs for the hospital was not always sufficient; clients were asked to buy certain drugs. • There were inadequate facilities for basic and comprehensive essential obstetric care (operating theatre, 	<ul style="list-style-type: none"> • Essential drugs and supplies are always available in labour room. Needy women now have an access to essential drugs. • A drug replacement mechanism is available in labour room. 	<ul style="list-style-type: none"> • Vacuum extractor needs to be changed • An anaesthetic machine (EMO) needs to be changed • Operating table needs to be changed

		<p>labour room, autoclave room and anaesthesia).</p> <ul style="list-style-type: none"> Essential surgical equipment was either broken or not functioning. Protective clothing for staff was needed. 	<ul style="list-style-type: none"> Adequate facilities are available to provide B/CEOC services. Appropriate equipment is available to provide B/CEOC services Functioning suction in OT Functioning steriliser for equipment and supplies Functioning suction in delivery Sterile pack for normal delivery Sterile pack for caesarean section Functioning equipment for normal neonatal care and for resuscitation Protective clothing for staff is available 	<ul style="list-style-type: none"> A chimney hood needs to be put in autoclave room Supply of magnesium sulphate is needed A supply of protective eye wear is needed Additional oxygen cylinder are needed.
4.	<p>4.1 Promotion and protection of health 4.2 Information and counselling</p>	<ul style="list-style-type: none"> Women and their families were not told information about the warning signs during pregnancy, labour and the postpartum period One- to- one counselling was not in practice IEC activities and materials were not available regarding obstetric emergencies in pregnancy, labour, or the postpartum period 	<ul style="list-style-type: none"> Women and their families are given information about the warning signs during pregnancy, labour and the postpartum period. During exit interviews, pregnant women confirmed that they were given information about the importance of antenatal care, and also about where to seek help during obstetric complications One-to-one counselling is in practice IEC materials are not available regarding obstetric complications in pregnancy, labour, and the postpartum period 	<ul style="list-style-type: none"> Specific materials on emergency obstetric care need to be developed Service providers need to gain skill in facilitating discussions
5.	<p>Acceptability of services in Ante-Natal Clinic and In Labour and in Maternity ward</p>	<ul style="list-style-type: none"> There were no screens in the post natal ward The majority of health workers providing care in the labour ward were female The antenatal clinic did not open on time and seating was inadequate for the number of women waiting 	<ul style="list-style-type: none"> Screens are always used to ensure privacy during labour and physical examinations A companion is always allowed during the first stage of labour A female companion is always allowed with the client during 2nd & 3rd stages of labour A female attendant opens on time The antenatal clinic opens on time, however sometimes due to shortage of staff, it is not well managed 	<ul style="list-style-type: none"> Cultural and social needs should be explored and consider during health education sessions Antenatal clinic needs to plan staff schedule in advanced to ensure the availability of service providers
6.	<p>Technical Competence of Health Care Providers</p>	<ul style="list-style-type: none"> Urinalysis for protein was not undertaken in the antenatal period 	<ul style="list-style-type: none"> Urinalysis for protein and blood tests for haemoglobin are routinely carried 	<ul style="list-style-type: none"> Nursing staff require orientation on the use of magnesium sulphate to treat

		<ul style="list-style-type: none"> No blood tests or clinical examination were carried out to assess the haemoglobin levels 3rd stage of labour was not managed properly Basic neonatal care was not appropriate Postnatal care was not appropriate Protocols for care were not available No evidence of use of Partograph Nursing staff were not allowed legally to carry out lifesaving skills for emergency obstetric care Infection prevention practices were below standard 	<p>out for each pregnant woman in the antenatal period</p> <ul style="list-style-type: none"> 3rd stage is managed actively Basic and essential neonatal care has improved Postnatal care of mother and baby is routinely carried out and referrals on postnatal care from maternity unit to family planning has much improved Protocols and guidelines are available to provide care There is evidence of use of Partograph and of prompt action if any deviations are found in Partograph Staff are providing care according to the protocols Nursing staff are legally allowed to carry out lifesaving skills to manage emergency obstetric complications Registers are completed correctly and information is complete There are good infection prevention practices 	<p>pre-eclampsia and eclamptic fit</p> <ul style="list-style-type: none"> Essential drugs and equipment need to be made available in labour room Required post abortion training to additional staff Midwifery refresher training to additional nursing staff
7.	Client provider interaction	<ul style="list-style-type: none"> Clients were not involved in making decisions Verbal consent for procedures was not obtained Clients were passive during the consultation 	<ul style="list-style-type: none"> Involving clients in decision making process requires improvement Verbal consent for procedures is obtained Clients are taking part in conversations to some extent, but largely passive The clients in labour room are more actively involved in conversation and in decision making. Service providers more often seek verbal consent in labour room than in antenatal clinic 	<ul style="list-style-type: none"> This area requires continuous monitoring and regular feedback to service providers as several issues need to be managed such: antenatal clinic opening time, and availability of service providers
8.	Comprehensiveness of care and linkages to other reproductive health services	<ul style="list-style-type: none"> Antenatal and tetanus toxoid services were only provided two days a week Clinic opening times were restricted to between 10-2 pm Reproductive health services were 	<ul style="list-style-type: none"> Antenatal and tetanus toxoid services are provided three days a week Clinic opening times are restricted to between 10-2 pm, however, maternity unit provides maternal 	<ul style="list-style-type: none"> Nursing staff need a refresher training on the management of STDs during pregnancy Postpartum family planning service needs to be strengthened Postnatal care for mothers should be

		<ul style="list-style-type: none"> not integrated All family planning services are not provided on the same days 	<ul style="list-style-type: none"> health care services even after out patient unit is closed Other reproductive health services are integrated with the maternity unit such as post abortion care, postpartum family planning and post abortion family planning services Temporary family planning methods are available everyday and permanent methods are available only one day a week 	<ul style="list-style-type: none"> considered as one of the essential care
9.	Continuity of Care and follow up	<ul style="list-style-type: none"> Women were discharged as little as 6 hours after delivery Women were not given information about warning signs occurring in post partum period 	<ul style="list-style-type: none"> Women who have normal delivery and are living close by to the hospital, are discharged after six hours. Women who have complicated deliveries and living far from the hospital are discharged at least after 12 hours depending on the general condition During exit interviews, women confirmed that they were given information about the importance of post natal care and also where to seek care if any complications are seen in postpartum period 	<ul style="list-style-type: none"> Postpartum care needs to be improved
10.	Other general issues	NA	<ul style="list-style-type: none"> Lab services: The Lab is functioning well and providing services to all pregnant women Medical records: The delivery registers are updated by the nursing staff to match with the monthly Tally sheet Maternal death audit is difficult to fill out following the maternal death X-ray and ultra sonogram (USG) <ul style="list-style-type: none"> -Service providers do not use protective clothing -Staff does not have training in the use of ultrasonogram Referral system is functioning poorly 	<ul style="list-style-type: none"> Hospital admission form need to be standardised in order to match with maternal death audit form One medical doctor needs training in the use of ultrasonogram The following areas will improve the community referral system <ul style="list-style-type: none"> - Feed back mechanism using referral slip - Refresher training for maternal and child health workers(MCHWs) - Orientation for TBAs and FCHVs about the danger signs and symptoms of obstetric complications Community drug scheme programme needs to be introduced in Baglung

			<ul style="list-style-type: none"> Emergency drug management system: Hospital staff do not have much knowledge about how to improve the emergency drug system. 	district
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Surkhet Hospital

SN	Elements of Care	Needs Assessment Findings (1997)	Self Assessment Findings (1999)	Areas of Improvement
1.	Accessibility and availability of Emergency Obstetric Services & and continuity of care	<ul style="list-style-type: none"> Comprehensive emergency obstetric care was available only when skilled medical was in post Nursing staff were not trained or legally entitled to carry out 'essential life saving skills' Ambulance service was not available 	<ul style="list-style-type: none"> Comprehensive emergency obstetric care is available 24 hours a day Basic emergency obstetric care is available 24 hours a day Essential drugs except magnesium sulphate are available in labour room Procedures such as vacuum delivery, manual vacuum aspiration and manual removal of placenta are available Post abortion care is available Nursing staff are trained and legally entitled to carry out 'essential life saving skills' Ambulance service is available 	
2.	Blood Transfusion Services	<ul style="list-style-type: none"> Adequate and safe blood was not available 24 hours a day Blood transfusion centre suffered from lack of equipment, staff and donors Poor women did not have access to blood transfusion 	<ul style="list-style-type: none"> Adequate and safe blood is available 24 hours a day Blood transfusion centre has appropriate equipment and two trained technicians are available Poor women also have access to blood transfusions 	<ul style="list-style-type: none"> Blood transfusion centre wants management training
3.	Availability of essential supplies and equipment	<ul style="list-style-type: none"> The supply of essential drugs was not always sufficient, and clients were 	<ul style="list-style-type: none"> Essential drugs and supplies are available in labour room. Needy 	<ul style="list-style-type: none"> Vacuum extractor needs to be changed

		<p>asked to buy certain drugs</p> <ul style="list-style-type: none"> • Inadequate facilities to provide B/CEOC services • Surgical instruments were either not functioning or broken. Essential equipment needed to be supplemented. • Protective clothing for staff was needed 	<p>women also have access to essential drugs</p> <ul style="list-style-type: none"> • Adequate means is available to provide basic and comprehensive essential obstetric services • Appropriate equipment is available to provide essential obstetric services except some shortfalls • Functioning suction in operating theatre • Functioning steriliser for equipment and supplies • Functioning suction in delivery • Sterile pack for normal delivery • Sterile pack for caesarean section • Functioning equipment for normal Neonatal care and for resuscitation • Protective clothing for staff is available 	<ul style="list-style-type: none"> • Anaesthetic machine (EMO) needs to be changed • Operating table needs to be changed • Five additional oxygen cylinders are required • A supply of magnesium sulphate is needed • A supply of protective eye wear is needed
4.	<p>4.1 Promotion and protection of health 4.2 Information and counselling</p>	<ul style="list-style-type: none"> • Advice relating to warning signs in pregnancy, labour and the postpartum period was not given to women or their families • One-to-one counselling was not in practice • IEC activities & materials for women, their families and for the community members about warning signs during pregnancy, labour, and the postpartum period were needed 	<ul style="list-style-type: none"> • Women and their families are given information about the warning signs in pregnancy, labour and the postpartum period • One-to-one counselling is in practice • During exit interviews, pregnant women confirmed that they were given information about the importance of antenatal care, and they were also told where to seek help if any obstetric complications are seen during pregnancy, labour and postpartum period • IEC materials are not available regarding obstetric emergencies during pregnancy, labour and postpartum period 	<ul style="list-style-type: none"> • Specific IEC materials on emergency obstetric complications need to be developed • Service providers need skill in facilitating group discussions
5.	<p>Acceptability of services in Ante-Natal Clinic and In Labour and in Maternity ward</p>	<ul style="list-style-type: none"> • Privacy and confidentiality were not possible in labour room due to lack of screens and cramped conditions • All women were attended by a female health worker 	<ul style="list-style-type: none"> • Screens are always used to ensure privacy during labour and physical examinations • A companion is always allowed during first stage of labour 	<ul style="list-style-type: none"> • Cultural and social needs should be explored and considered

		<ul style="list-style-type: none"> • There were no separate postnatal beds, and no screens to ensure privacy 	<ul style="list-style-type: none"> • A female companion is always allowed with the client during 2nd & 3rd stages of labour • A female attendant conducts the delivery • A separate post natal ward is available for post natal mothers 	
6.	Technical Competence of Health Care Providers	<ul style="list-style-type: none"> • Urinalysis for protein was not undertaken in the antenatal period • No blood tests or clinical examination were carried out to assess the haemoglobin levels • 3rd stage of labour was not managed properly • Basic neonatal care was not appropriate • Postnatal care was not appropriate • Protocols for care were not available • No evidence of use of Partograph • Nursing staff were not allowed legally to carry out lifesaving skills for EOC 	<ul style="list-style-type: none"> • Urinalysis for protein and blood tests for haemoglobin are routinely carried out for each pregnant woman in the antenatal period • 3rd stage is managed actively • Basic and essential neonatal care has improved • Postnatal care of mother and baby is routinely carried out and improved referrals on postnatal from maternity unit to family planning • Protocols and guidelines are available to provide care • There is evidence of use of Partograph and of prompt action if any deviations are found in Partograph • Staff are providing care according to the protocols • Nursing staff are legally allowed to carry out life saving skills to manage emergency obstetric complications • Registers are completed correctly and information is complete • There are good infection prevention practices 	<ul style="list-style-type: none"> • Nursing staff required orientation on the use of magnesium sulphate to treat pre-eclampsia and eclampsia • Required post abortion training to additional staff • Nursing staff need coaching on vacuum delivery • Midwifery refresher training to additional nursing staff
7.	Client provider interaction	<ul style="list-style-type: none"> • Clients were not involved in making decisions • Verbal consent for procedures was not obtained • Clients were passive during the consultation 	<ul style="list-style-type: none"> • Involving clients in decision making process requires improvement • Verbal consent for procedures are obtained • Clients are taking part in conversation to some extent but at largely they are passive 	<ul style="list-style-type: none"> • This area requires continuous monitoring and regular feedback

			<ul style="list-style-type: none"> The clients in labour room are more actively involved in conversation and in decision making. Service providers are more tend to take verbal consent in labour room than in antenatal clinic 	
8.	Comprehensiveness of care and linkages to other reproductive health services	<ul style="list-style-type: none"> Antenatal and tetanus toxoid services were only provided two days a week Clinic opening times were restricted to between 10-2 pm Reproductive health services were not integrated All family planning services were not provided on the same days 	<ul style="list-style-type: none"> Antenatal care is provided daily Tetanus toxoid services are provided two days a week Clinic opening times are restricted to between 10-2 pm Other reproductive health services are integrated with the maternity unit, such as post abortion care, postpartum family planning, and post abortion family planning services Temporary family planning methods are available everyday and permanent family planning methods are available only one day a week 	<ul style="list-style-type: none"> Syndromic approach to manage STDs needs to be improved Postpartum family planning services need to be strengthened Postnatal care for mothers needs to be strengthened Out-patient unit needs to provide reproductive health care every day
9	Continuity of care & follow up	<ul style="list-style-type: none"> Women were discharged as little as 6 hours after delivery Women were not given information about the warning signs occurring in post partum period Antenatal and Family planning clinics were not linked to the hospital 	<ul style="list-style-type: none"> Women who had normal deliveries and are living close to the hospital are discharged after six hours Women who had complicated deliveries and living far from the hospital are discharged at least after 12 hours depending on the general condition During exit interviews, women confirmed that they were given information about the importance of postnatal care and also where to seek care if any complications are seen in postpartum period Antenatal and family planning services are being provided at the hospital so there is good referral system within the hospital 	
10.	Other general issues	NA	<ul style="list-style-type: none"> Lab services: The Lab is functioning 	<ul style="list-style-type: none"> Hospital admission form needs to be

			<p>well and providing services to all pregnant women.</p> <ul style="list-style-type: none"> • Medical records: The delivery registers are updated by the nursing staff to match with the monthly Tally sheet • Maternal death audit form is difficult to fill out following a maternal death as information required in audit form is not available on the patient admission form • Referral system is functioning poorly • Hospital emergency drug management system is not functioning well • Emergency block needs to be repaired • A small area in front of the maternity block is muddy and it needs to be cemented 	<p>standardised so that maternal death audit will match with this form</p> <ul style="list-style-type: none"> • The referral system needs strengthening • Maternal and child health workers (MCHWs) need refresher training according to RH clinical protocol • A feed back mechanism needs to be improved through a referral slip • TBAs and FCHVs require orientation on danger signs and symptoms of obstetric complications and the importance of timely referral • Hospital emergency drug system needs to be strengthened
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Seti Zonal Hospital

SN	Elements of Care	Needs Assessment Findings (1997)	Self Assessment Findings (1999)	Areas of Improvement
1.	Accessibility and availability of Emergency Obstetric Services and continuity of care	<ul style="list-style-type: none"> • Comprehensive emergency obstetric care was available only when skilled doctors were at the post • Post abortion service was not available • Nursing staff were not trained or legally entitled to carry out 'essential life saving skills' • Ambulance service was not available 	<ul style="list-style-type: none"> • Comprehensive emergency obstetric care is available 24 hours a day • Basic emergency obstetric care is available 24 hours a day • Essential drugs except magnesium sulphate are available in labour room • Procedures (except manual vacuum aspiration) such as vacuum delivery and manual removal of placenta are available • Post abortion service is not available • Nursing staff are trained and legally entitled to carry out 'essential life saving skills' • Ambulance service is available 	<ul style="list-style-type: none"> • Nursing staff need orientation on the use of magnesium sulphate
2.	Blood Transfusion Services	<ul style="list-style-type: none"> • Adequate and safe blood was not guaranteed • Communications between the blood transfusion service and hospital needs to be formalised • Blood transfusion centre suffered from lack of equipment, staff and donors 	<ul style="list-style-type: none"> • Adequate and safe blood is available 24 hours a day • Poor women also have access to blood transfusions • Nursing staff are responsible to manage blood transfusion without delay • Good working relationship between the hospital and the blood transfusion centre • Blood transfusion centre has appropriate equipment and two trained technicians 	<ul style="list-style-type: none"> • Blood transfusion centre needs management training
3.	Availability of essential supplies and equipment	<ul style="list-style-type: none"> • The supply of essential drugs was not always sufficient, and clients were asked to buy certain drugs • Poor women did not have an access to essential drugs • Facilities were inadequate to provide basic and comprehensive essential obstetric services • Surgical instruments either broken or not functioning. Required supplementing essential equipment • Protective clothing for staff is needed 	<ul style="list-style-type: none"> • Essential drugs and supplies are available in labour room. • Poor women also have access to essential drugs in labour room • Adequate means available to provide essential obstetric services • Appropriate equipment is available to provide essential obstetric services except some shortfalls • Functioning suction in operating theatre • Functioning steriliser for equipment and supplies • Functioning suction in delivery 	<ul style="list-style-type: none"> • Vacuum extractor needs to be changed • An anaesthetic machine (EMO) needs to be changed • Operating table needs to be changed • Three additional oxygen cylinders are required • A supply of magnesium sulphate is needed • A supply of protective eye wear is needed

			<ul style="list-style-type: none"> • Sterile pack for normal delivery • Sterile pack for C/S • Functioning equipment for normal neonatal care and for resuscitation is available • Protective clothing for staff is available 	
4.	4.1 Promotion and protection of health 4.2 Information and counselling	<ul style="list-style-type: none"> • Women and their families were not given information about warning signs in pregnancy, labour and the postnatal period • One-to-one counselling was not in practice • IEC activities & materials about obstetric emergencies in pregnancy, labour, or the postnatal period, were not available 	<ul style="list-style-type: none"> • Women and their families are given information about the warning signs in pregnancy, labour and the postpartum period • During exit interviews, pregnant women confirmed that they were given information about the importance of antenatal care, and also where to seek help if any obstetric complications are seen • One-to-one counselling is in practice • IEC activities & materials about obstetric emergencies in pregnancy, labour, or the postpartum period are not available 	<ul style="list-style-type: none"> • Specific IEC activities & materials on EOC need to be developed • Service providers need to gain skill in facilitating group discussions
5.	Acceptability of services in Ante-Natal Clinic and In Labour and in Maternity ward	<ul style="list-style-type: none"> • Privacy and confidentiality were not possible in labour room due to the lack of screens and cramped conditions • All women were attended by a female health worker • There were no separate postnatal beds, and no screens to ensure privacy • Pregnant women were satisfied with the quality of care they received, however, complained about the length of time they waited to be seen • Antenatal clinic was not attached to hospital 	<ul style="list-style-type: none"> • Screens are always used to ensure privacy during labour and physical examinations • A companion is always allowed in first stage of labour • A female companion is always allowed with the client during 2nd & 3rd stages of labour • A female attendant conducts the delivery • Postnatal ward is available and privacy is ensured • Antenatal clinic is attached to hospital but it is overcrowded, because clinic provides antenatal service only one day a week 	<ul style="list-style-type: none"> • Cultural and social needs should be explored and considered • Antenatal care is not sufficient only one day in a week; it should be available at least three days a week
6.	Technical Competence of Health Care Providers	<ul style="list-style-type: none"> • Urinalysis for protein was not undertaken in the antenatal period • No blood tests or clinical examinations were carried out to assess the haemoglobin levels • 3rd stage of labour was not managed properly 	<ul style="list-style-type: none"> • Urinalysis for protein and blood tests for haemoglobin are routinely carried out for each pregnant women in the antenatal period • 3rd stage is managed actively but not 	<ul style="list-style-type: none"> • Postnatal care for mothers needs more attention in terms of information about the advantages of the postnatal care

		<ul style="list-style-type: none"> • Basic neonatal care was not appropriate • Postnatal care was not appropriate • Protocols for care were not available • No evidence of use of Partograph • Nursing staff were not allowed legally to carry out life saving skills for EOC • Infection prevention practices were poor 	<p>with oxytocin, because methergine is preferred by the doctors</p> <ul style="list-style-type: none"> • Basic and essential neonatal care is improved • Postnatal care of mother and baby is routinely carried out and referrals from the maternity unit to family planning have improved • Protocols and guidelines are available to provide care • There is evidence of use of Partograph and taking prompt action if any deviations are found in Partograph • Staff are providing care according to the protocols except the use of oxytocin • Nursing staff are legally allowed to carry out life saving skills to manage emergency obstetric complications • Registers are completed correctly and information is complete • Malaria counselling to pregnant women is not done • The standard of infection prevention practices is much below the standard. Staff agreed that this is due to encephalitis break down 	<ul style="list-style-type: none"> • Nursing staff requires orientation on the use of magnesium sulphate
7.	Client provider interaction	<ul style="list-style-type: none"> • Clients were not involved in making decisions • Verbal consent for procedures was not obtained • Clients were passive during the consultation 	<ul style="list-style-type: none"> • Involving clients in decision making process requires improvement • Verbal consent for procedures are obtained • Clients are taking part in conversation to some extent but they largely passive 	<ul style="list-style-type: none"> • This area requires continuous monitoring and regular feed back
8.	Comprehensiveness of care and linkages to other reproductive health services	<ul style="list-style-type: none"> • Antenatal and tetanus toxoid services were only provided one per week • Clinic opening times were restricted to between 10-2 pm • Reproductive health services were not integrated • All family planning services were not provided on the same days 	<ul style="list-style-type: none"> • Antenatal care and Tetanus toxoid one day per week • Clinic opening times are restricted to between 10-2 pm • Reproductive health services are not integrated either to maternity unit or to family planning • Complicated cases are referred to doctors from antenatal clinic 	<ul style="list-style-type: none"> • Service providers need improved diagnosis and treatment skills for STDs • Postpartum family planning services need to be strengthened • Postnatal care for mothers needs to be strengthened • Antenatal clinic needs to be

			<ul style="list-style-type: none"> Temporary family planning methods are available everyday but permanent family planning methods are not. 	made available everyday a week
9	Continuity of care & follow up	<ul style="list-style-type: none"> Women were discharged as little as 6 hours after delivery Women were not given information about warning signs occurring in postpartum period ANC & family planning was not linked with hospital, it is under DPHO's umbrella 	<ul style="list-style-type: none"> Women who had normal deliveries and are living close by to the hospital, are discharged after 6 hours. Women who had complicated deliveries and living far from the hospital they are discharged at least after 12 hours depending on the general condition During exit interviews, women confirmed that they were given information about the importance of post natal care and also where to seek care if any complications are seen Antenatal and family planning services are provided at hospital so there is good referral system within the hospital 	
10.	Other general issues	NA	<ul style="list-style-type: none"> Lab services: Lab services needs to be strengthened and there is no link between antenatal clinic and lab Medical records: The delivery registers are updated by the nursing staff to match with the monthly Tally sheet Maternal death audit form is difficult to fill following any maternal death Referral system is not functioning well Hospital emergency drug system is not functioning well 	<ul style="list-style-type: none"> The hospital admission form needs to be standardised to match with the maternal death audit form The referral system needs to be strengthened The MCHWs need refresher training The TBAs and FCHVs need an orientation The quality of the record system needs to be monitored daily by one responsible staff The maternal death audit form is too complex to fill in following the maternal death; it needs to be simplified

APPENDIX 7: SEMI- ANNUAL ACTION PLAN (DECEMBER-MAY 2000)

Activities	Timeframe	Responsible person	Expected Outcome	Review in March 2000
Trainings/Orientations				
Provide orientation to nursing staff on the use of magnesium sulphate.	Second week of December 1999	NSMP	Improved skills to manage pre/eclampsia, prolonged labour, and retained placenta	Completed for nursing Staff of all three hospital
Develop nursing skills on the procedures such as vacuum delivery and manual removal of placenta.	Jan 2000	NSMP/JHPIEGO FHD/NHTC		
Organise clinical teaching skills (CTS) course to implement MCHWs training.	Dec-1999	Nursing team and NHTC/FHD/JHPIEGO HRDO/Nursing staff	Improve clinical coaching & facilitation skills	CTS course was organised for all three hospital staff
Provide post abortion care training (PAC) for doctors and nurses.	Ongoing		Increase the availability of post abortion care services	PAC training is on going
Continue "on the job coaching" for new nursing staff and OJT students	Ongoing		Updated skills	Ongoing
Facility/equipment/ drugs/supplies				
Install permanent incinerator in Seti zonal hospital	Jan-Feb 2000	DHONSL	Improve the quality of infection prevention practices	A permanent incinerator Was installed at Seti Zonal Hospital. A local NGO provided the support.
Replace anaesthetic machine (EMO), and vacuum extraction	Dec 1999	NSMP	Improve infection prevention practices	Under process
Supply magnesium sulphate	Dec 1999	DHO	Improve the quality of drug management system	Completed
Supply three oxygen cylinders with new flow meters	Oct -Nov 2000	NSMP		Under process
Supply gown for women in labour	ASAP	NSMP		Completed
Supply protective eye glass for labour room and OT team	Dec 1999	NSMP		In process
Supply gown for supporting staff working in labour room	Dec 1999	NSMP		Completed

Supply hand towels	Jan-Feb 1999	NSMP		Completed
Supply plastic container to store virex	Jan-Feb 2000	NSMP		Completed
Locally made wrack to keep clean bed pens	Jan-Feb-2000	NSMP		Completed
Improve hospital emergency drug system	March 2000	DHO/DPHO		In Process
Referrals				
Refresher training to MCHWs	Jan-June 2000	NSMP/JHPIEGO/FHD/DHO	Improve the quality of referral system	Ongoing
Strengthen Management Systems				
Blood transfusion centre	March 2000	NSMP/DHO	Improved management capacity and to support hospital	Ongoing
Hospital management committee				
Developing IEC materials on emergency obstetric complications	Jan-June 2000	NSMP/NHEICC	Developed increasing awareness materials	Ongoing