



USAID
FROM THE AMERICAN PEOPLE

HEALTH CARE
IMPROVEMENT
PROJECT

RESEARCH REPORT SUMMARY

Spread of EONC Best Practices from Niger to Mali

Introduction

The USAID Health Care Improvement Project (HCI) has shown that improvement collaboratives can have a significant impact on clinical indicators, staff and health facilities. In Niger, for example, an Essential Obstetric and Newborn Care (EONC) collaborative, which aimed to reduce maternal and neonatal mortality by improving care during the pre- and post-natal periods, achieved significant reductions in maternal and neonatal morbidity and mortality. Facilities that participated in the EONC collaborative reached a level of adherence to clinical norms of maternal and neonatal care of at least 80% over a period of eight to 18 months.

Based on the successful results in Niger and the similarities between the socio-economic and health situations in Niger and neighboring Mali, in late 2009, HCI was invited to undertake an EONC collaborative in the Kayes Region of Mali, applying approaches and best practices that had been developed in Niger. HCI's support in Mali was much less intensive than in the original EONC collaborative in Niger. While in Niger, full-time HCI staff members oversaw trainings and the implementation of the intervention, HCI's Niger staff led the work in Mali through a series of short-term visits. Medical doctors and midwives who were district supervisors, active management of third stage labor (AMTSL) trainers, or members of the Ministry of Health regional management teams were selected as coaches. All coaches received training on AMTSL and essential newborn care (ENC), and coaching techniques. They conducted quarterly supervisory visits to quality improvement teams and spent on average one day per site at the beginning of the intervention and half a day towards the end of the collaborative.

While HCI has demonstrated the efficient spread of improvement interventions within or across regions of a country, little research has focused on studying spread from one country to another. To address this gap, HCI initiated a study on the transfer of the EONC collaborative and best practices from the intervention from Niger to Mali. The objective of this study was to explore the nature, extent and effectiveness of the spread of the EONC collaborative and best practices derived from the collaborative from Niger to Mali. We sought to assess how clinical content and best practices implemented in one country can be transferred to another country in order to develop appropriate strategies to spread improvement interventions from a country to another. Specifically, we wanted to shed light on the experience of quality improvement teams and coaches during the transfer of the EONC collaborative and best practices from Niger to Mali.

Methodology

This cross-sectional study includes quantitative measures as well as a qualitative approach designed to better understand the context in which the improvement of clinical indicators occurred. Fifteen community health centers (CsCom) in two districts (Kayes and Diéma) in the Kayes Region were included in the study. At each site, three members of the quality improvement (QI) teams were interviewed. Information was collected from QI team members through in-depth interviews and from coaches during focus group discussions. Clinical data were collected from health facilities, but no direct contact with patients occurred. Respondents received explanations regarding the nature of the study and their consent was requested. To maintain the anonymity of the participants, neither the names of respondents nor the name of their facility were included in the findings. All interviews and focus groups

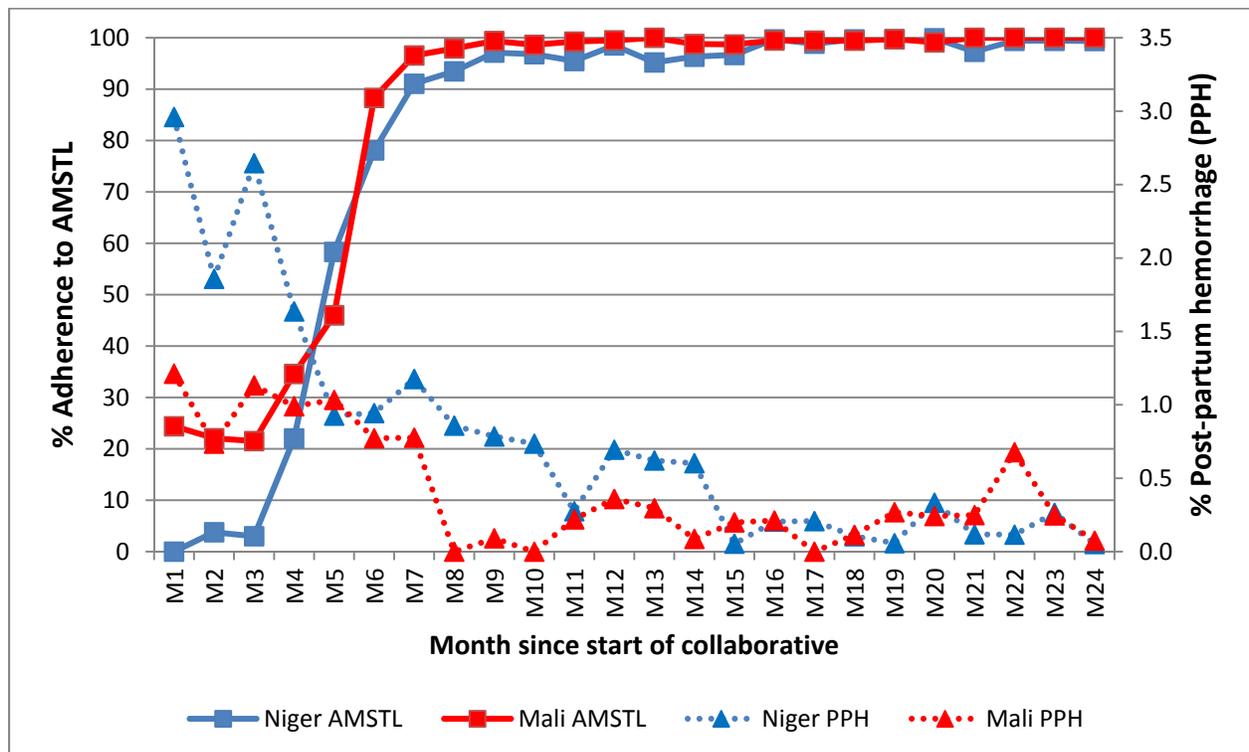
were audio-recorded and transcribed. Thematic analysis was used to analyze transcripts. Transcripts were read by two members of the research team. A coding scheme was developed based on a priori themes guided by the research questions and themes that emerged from a subset of the transcripts. All transcripts were then coded using the coding scheme with additional codes added as they emerged and were deemed important to addressing the broader study aim. All coding was conducted using QSR NVivo version 9.1. Changes in clinical indicators were analyzed as time series charts.

Results

Clinical indicators: Baseline indicators performance levels were higher in Mali than in Niger. As in Niger, the implementation of the EONC collaborative and best practices led to significant improvements in clinical indicators in Mali. Adherence to AMSTL increased from 24% to 100% in eight months. Postpartum hemorrhage and adherence to ENC also decreased significantly (Figure 1).

QI team members' experience: In-depth interviews revealed that the clinical content of the EONC intervention and some best practices from the collaborative were successfully spread from Niger in Mali. In addition to practices related to quality improvement such as data monitoring and regular meetings, respondents implemented best practices derived from Niger such as building the capacity of providers and addressing medicines, equipment, materials and support needs in facilities. Respondents also reported having implemented practices to improve adherence to norms of care and to strengthen the organization of services. They found AMSTL effective in reducing postpartum hemorrhage, which had previously been an important challenge. QI team members were also able to identify problems and take the necessary measures to reduce postpartum hemorrhage and mortality. Some respondents perceived the intervention as being difficult to implement initially, especially the monitoring period of six hours. However, the implementation became easier with time.

Figure 1. Adherence to AMSTL and percentage PPH in health facilities participating in the EONC collaborative in Niger and Mali



Changes to intervention: Most respondents reported that they had not made any changes to the best practices originating from Niger. However, two facilities reported having added a community awareness component to the intervention to address the high proportion of births that occur in homes and encourage pregnant women to deliver in health centers.

Hindering and facilitating factors: QI teams reported facing numerous obstacles during the implementation of the intervention, including staff shortage, lack of equipment and materials, poor state of health facilities, preferences for home births, non-functional QI teams, and issues related to numerous data collection activities. Specifically, some respondents mentioned the burden of spending too much time collecting and reporting data for various purposes. On the other hand, support from the community including the financial support from community health associations (ASACO) through the purchase of refrigerators and oxytocin, teamwork and the commitment of providers were perceived by respondents as enabling the successful implementation of the intervention.

QI team members' communication: Providers reported that communication was essential to the successful implementation of the intervention. In addition to learning sessions and staff meetings, other methods of communication, such as telephone calls to QI teams from other sites, were used to share experiences and lessons learned with colleagues in the district. Some respondents also reported that they had visited other health facilities in the district to share ideas on quality improvement. These visits helped facilitate the spread of change ideas within the district. Others reported making phone calls to coaches between coaching visits for additional support.

Coaches' experience: Coaches supporting QI teams reported that they acquired important skills during their training and during learning sessions in the areas of quality improvement, clinical care, and use of data to identify problems and make decisions but also in the areas of human resource management and coaching techniques. QI empowered them to make improvements in spite of limited financial means. Coaches stressed the importance of competition between QI teams and their relationship with QI teams as factors that strengthened their support to teams. For instance, they reported receiving regular phone calls from sites for additional support. One coach, however, reported not answering calls from QI teams. Coaches placed a lot of emphasis on the role data use plays in their support to QI teams; as one coach indicated "indicators speak." On the other hand, factors that limited their support to QI teams included time constraints, lack of transportation, lack of availability of QI teams at times, staff turnover, lack of financial incentives, gaps in knowledge and skills in clinical areas, insufficient documentation and data collection tools (specifically, QI team journals), and lack of computer equipment. To improve their efficiency, coaches called for more time and freedom in terms of how and when they conduct coaching visits. Some coaches advocated for attending QI team meetings, for example.

Conclusions and Recommendations

Findings from this study shed light on the experience of QI teams and coaches during the implementation of an EONC collaborative and best practices in Mali. These findings also provide an understanding of the factors that contributed to the successful transfer of the Niger EONC intervention to Mali.

The perceived value of the intervention was unanimous among QI teams and coaches and was confirmed by the improvement in clinical indicators. Improvements were achieved in a short period of time and with much less intensive support from HCI than had been provided of the original EONC collaborative in Niger.

This study shows that that a quality improvement intervention and best practices resulting from the intervention can be successfully transferred to another country with moderate external support when the new country is similar to the original country in terms of their socio-economic and health situations and when the intervention addresses a clinical area deemed a priority by the local health system and stakeholders. Key spillover effects seen in the Mali teams during the implementation of the intervention,

including taking initiative, recognition of the importance of data, teamwork, and commitment of providers, are particularly encouraging as they contribute to the overall performance of health centers beyond the improvement areas targeted by the EONC collaborative.

Based on the findings, the following recommendations are drawn:

- Increase time for coaching visits: Coaches and QI teams noted that the time allocated for coaching visits did not allow adequate support.
- Address time constraints of coaches: Coaches reported juggling multiple responsibilities given the time required to perform their coaching tasks in addition to their regular clinical duties. The fact that a coach reported not answering the phone when called by QI teams highlights this challenge.
- Strengthen the competence of coaches and QI teams: Coaches reported that their ability to fill in documentation and data collection tools, such as QI team journals, needs to be strengthened. For QI Teams, in addition to filling QI journals, gaps were reported in areas such as data collection and clinical competence. Respondents requested additional training in these areas.
- Continue to emphasize the importance of data: coaches as well as QI team members highlighted the importance of data. The statement, "indicators speak," made by one coach speaks volumes about the impact of data collection activities.
- Streamline data collection tools and reporting: QI teams reported that filling data collection tools is time-consuming and has an impact on their clinical duties. It is important to look into how to streamline data collection and reporting processes.

Recommended Citation and Further Information

This summary report may be cited as:

Coly A, Saley Z, Saleem H, Djibrina S, Boucar M, Sangare K. 2013. Spread of EONC Best Practices from Niger to Mali. *Research Report Summary*. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

It summarizes the full study report in French, which is available at:
<http://www.hciproject.org/publications/spread-eonc-best-practices-niger-mali>.

Coly A, Saley Z, Saleem H, Djibrina S, Boucar M, Sangare K. 2013. Dissémination du Niger au Mali du collaborative d'amélioration des soins obstétricaux et néonataux essentiels et des meilleures pratiques du collaboratifs : expériences, perception et efficacité. *Rapport de la Recherche et Evaluation*. Publié par le Project d'amélioration des Soins de Santé, Bethesda, MD : University Research Co, LLC (URC).

USAID HEALTH CARE IMPROVEMENT PROJECT

University Research Co., LLC • 7200 Wisconsin Avenue, Suite 600 • Bethesda, MD 20814

Tel: (301) 654-8338 • Fax: (301) 941-8427 • www.hciproject.org