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# **MCHIP Phase II Health Facilities Baseline Assessment Report**

**December 20-30, 2011**



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## ***I. BACKGROUND AND INTRODUCTION***

The MCHIP Ethiopia program will build upon current and previous USAID support of interventions addressing maternal and neonatal morbidity and mortality. MCHIP will work in four regions, namely Tigray, Amhara, Oromia and Southern Nations and Nationalities People, which have been identified by USAID as priority regions.

This is a narrative report on the assessment by MCHIP conducted in target sites in three regions, namely Amhara, Oromia and SNNPR for the period of December 20-30, 2011. A total of 44 health centers were assessed. The team that conducted the assessment comprised of MCHIP M&E team members, regional advisors, and MNCH team members.

The objective of this assessment was to identify challenges, opportunities, strengths and gaps in the target health centers with regard to effectively undertaking program activities. It also review the health personnel and the qualities of services provided in line with maternal and newborn care, so as to prioritize interventions and also to serve as a benchmark for the program monitoring and evaluation purposes.

## ***II. OBJECTIVES***

The main objective of the assessment was to identify:

- capability and main gaps of facilities to provide high-quality MNCH services;
- the nature and types of problems associated with accessibility, utilization and service delivery of maternal health care in the selected health facility; and
- the possibilities for the future interventions to improve MNCH at each level of service provision.
- feasibility of introducing PMTCT services in the target sites as part of the overall MCHIP program objectives

## ***III. METHODOLOGY***

Prior to the assessment, a half-day orientation on the assessment tools was conducted for the assessment team. The team designed and utilized various methods and approaches to achieve the objectives of the assessment, including in-depth interviews, observation, and review of registers and client records.

The rapid assessment focused on key areas of MNCH services such as general health facility information, tools and approaches for MNCH, PMTCT, infrastructure and equipment, MNCH service accessibility and availability, referral services, and PQI and KMC implementation.

#### ***IV. FINDINGS OF THE BASELINE ASSESSMENT***

The findings of the assessment are presented in a summarized form within the following major categories/services. These include:

##### ***a. Infrastructure***

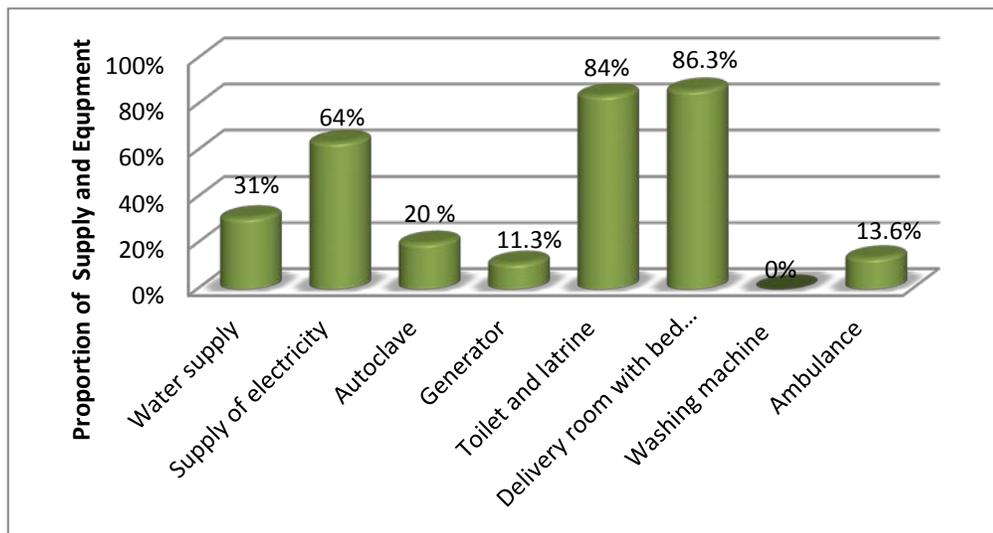
Having adequate infrastructure is essential to enhance MNCH service utilization. 40(90.9%) of the health facilities visited had examination rooms providing client privacy, out of these 5(11.3%) of health facilities do not have adequate examination room.

Delays in getting to health centers are major causes of maternal deaths. The majority of health center clients had to travel on foot, to reach the health center. 6 (13.6%) of the health centers use ambulances for their referral cases either from the woreda office or from the hospital. Because of poor infrastructure, referred clients are forced to use local transportation systems. Some of the clients close to main road use public transport to reach the health facilities. 12 (27.2%) facility clients either walk or use local animals since health centers were located outside the main road.

##### ***b. Supply for MNCH services***

In order to implement MNCH programs effectively, adequate and reliable supply of equipment is necessary. Better availability of medicines and related supplies plays a great role in increasing MNCH service utilization. According to the assessment, out of the 44 facilities 14 (31%) health centers have enough supply of water, 28 (63.6 %) of them have adequate supply of electricity, 28 (63.6%) have autoclave, 5 (11.3%) have generator and 37 (84%) have toilet/ latrine facility. About 38 (86.3%) of health facilities have delivery / labor room with bed and light while 40.9% have post-natal room. There is no washing machine in any of the facilities.

**Fig 1: Availability of equipment and supply among health facilities (July-Sept, 2011)**



As shown in figure 1, the situation in the health facilities is critical with regards with basic infrastructure for power and water. The common equipment and supply available in majority of the health facilities are the, toilet / latrine and delivery room with bed. However, access to an ambulance was only present in 6 (13.6%) of health facilities.

**c. Human Resources and training**

A total 533 health workers are assigned to the 44 health facilities including Health Officers, Nurses, Midwives, Laboratory Technicians and Pharmacists. Out of the 180 (20.2%) health workers assigned for MNCH services, 96.6% are currently providing the services. According to the three tier health system structure of Ethiopia presented in Health Sector Development Plan (HSDP) IV, a health center is expected to be staffed with 20 technical staff to serve an average of 25,000 clients. In the health centers assessed, it was observed that there was an average 12 technical staff working in the respective health facilities, below the standard. For each facility an average 9 HEWs are attached to the nearby health center in order to create demand for MNCH service.

**Table 2: Total Number of Technical Staff in the Assessed Facilities assigned to MNCH Area**

S.No	Cadre	Total # of HWs assigned to All facilities	Total # of HWs assigned to provide MNCH services	Total # of currently providing MNCH service
1	Physician	-	-	
2	Health Officer	49	15	14
3	Nurse	336	119	117
4	Midwife	45	45	43
5	Laboratory personnel	51	0	0
6	Other(Pharmacist & Sanitarian)	52	1	0
7	Total	533	180	174

As shown in the table above, a total of 43 midwives are working in 44 health facilities, which is below the national standard of 2 midwives per health centre.

#### ***d. Training of MNCH staff***

To provide standard health care services and implement health programs effectively, the health work force is also one of the key aspects. Moreover, in order for the health system to function well, health workers should be adequate in number as well as properly trained.

As from the assessment results, out of total health workers assigned (533) to the facilities a total of 106 (19.8%) health workers trained had been trained on PMTCT. From 174 health workers assigned to MNCH service 16 (9%) had been trained on BEmONC and 34 (19.5%) had been trained on Postpartum family planning methods; none of the staff had been trained on KMC.

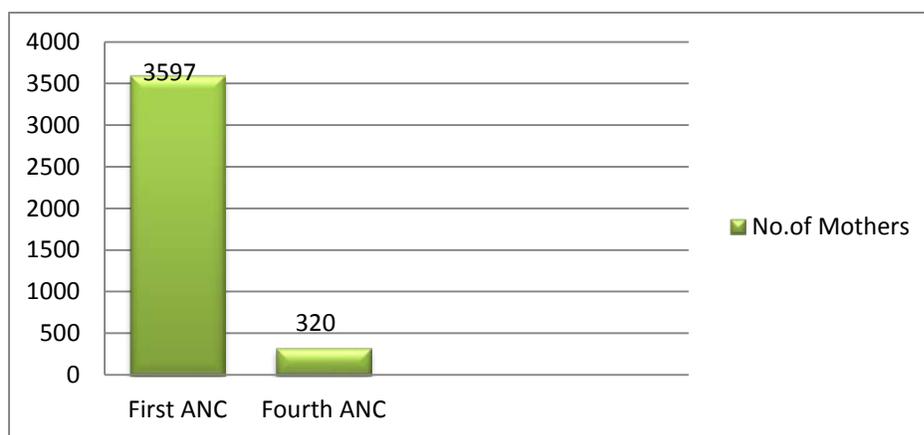
#### ***e. Service Provision***

On average one health center is providing services for a total of 26,330 catchment populations for three to eight kebeles. During the assessment, document review was conducted in all facilities covering the period from July to September 2011. The services are presented in the following sections:

### ANC services

The WHO has set a minimum standard of four ANC visits. Out of 9945 expected pregnancies during the quarter 3597 (38%) pregnant women attended one ANC visit, with 320 women receiving 4 ANC visits (the denominator is not available). ANC was provided during working hours of week days in all facilities. On average each health facility provided ANC services for 87 pregnant women in the quarter.

**Fig 2. Use of antenatal care services during pregnancy (July-Sept, 2011)**



### Safe Abortion services

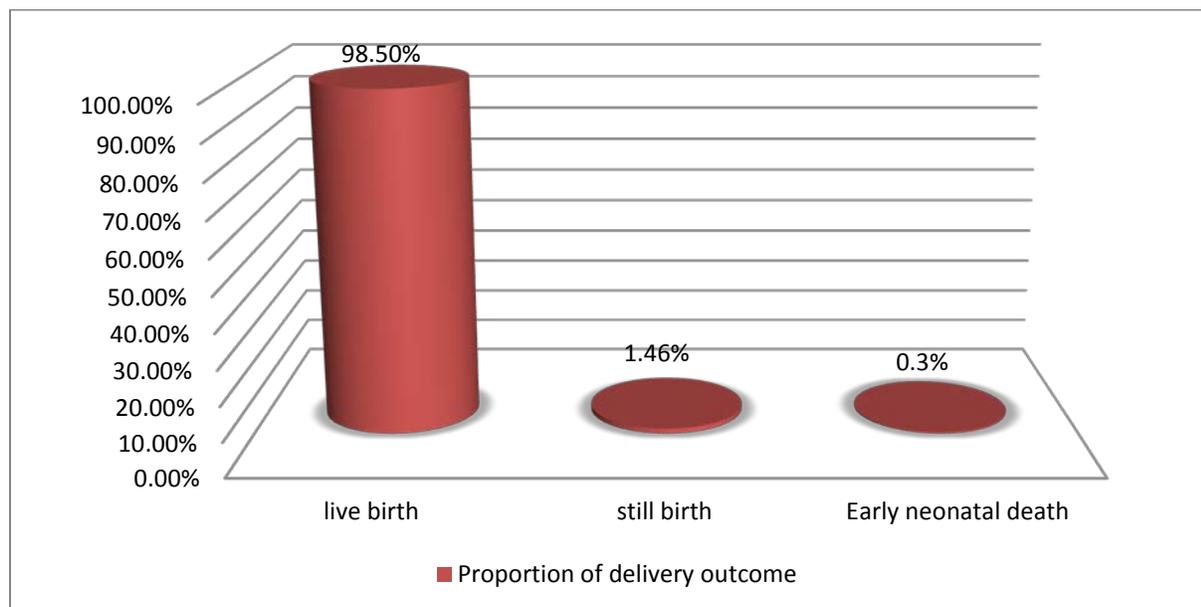
Out of the 44 facilities, only 6 (13.6%) health facilities were providing comprehensive safe abortion services.

### Labor and Delivery services

Out of the 9445 expected deliveries, 545 (6%) were delivered in health facilities. Out of these 537 (98.5%) were live births with 8 (1.46%) stillbirths. There were 2 (0.3%) early neonatal deaths; no institutional maternal death had occurred during the quarter. 77.6% of the newborns delivered in the facility had been weighed immediately after birth. Of these 21 had low birth weight (< 2.5kg). On average each facility provided delivery services for 13 mothers in the quarter.

In terms of service availability 43 (98%) of the health facilities were providing labor and delivery services 24 hours a day, 7 days a week. 15 (36.6%) provided immediate newborn care; the remaining 28 (61.1%) health facilities did not provide immediate newborn care. In order to improve demand for MNCH services, woreda offices were utilizing HEWs, Mother support groups and community volunteers.

**Fig3. Delivery outcome at all facilities (July-Sept, 2011)**



**Postnatal care**

Postnatal care records were assessed to review how many women were receiving PNC at the health facility post delivery or if PNC care carried out by HEWs was being recorded in the health facility. In the facilities assessed 806 post-natal visits were recorded; however the timing of the PN visit and where it took place (i.e. health centre or health post) could not be disaggregated from the records. Staff are counting PN visits conducted by HEWs in their catchment area, again irrespective of whether it took place within 6 hours, 48 hours, 3-6 days or 6 weeks post-delivery. It was also unclear whether the PNC visit looked at both mother and baby. Out of 44 health facilities, 29 (66%) provided PNC service 24 hours a day and seven days per week.

**Prevention of Mother-to-Child Transmission**

The majority of health facilities assessed provided HIV counseling and Testing (HCT) services during the ANC appointment. Only 5 health centers (11.3%) are not currently providing an HCT service. 27 (61.3%) of the health centers said they provided PMTCT services; out of these 17 (38.6%) provide ART prophylaxis. The remaining facilities refer HIV positive mothers to the nearest health referral facility for ART prophylaxis.

A total 2091 pregnant women were tested for HIV at their first ANC visit at the health centre i.e. only 58% of women attending ANC were being counseled and tested for HIV. Out of this 41 pregnant women tested positive for HIV. Of these positive women,, 10 (24.3%) women went on to deliver in one of the health facilities assessed. Of the HIV positive women who did deliver in the facility, 9 (90%) mothers and 8 (80%) newborns received the full course of ART prophylaxis.

In discussions during the assessment the woreda officials outlined their plans to expand PMTCT services by enhancing partner testing through community mobilization, partner collaboration and coordination, training and capacity development of health workers on improving the quality of care and strengthening referral services. However, cultural and traditional beliefs and stigma about HIV, severe shortages of test kits and irregular supplies of ART drugs and drugs for opportunistic infections are considered by woreda health officials to contribute to the lack of comprehensive PMTCT services in the facilities assessed. .

### **Neonatal Resuscitation and Kangaroo Mother Care**

35 (79.5%) of the health facilities were able to provide resuscitation for asphyxiated newborn babies using manual suction and bag and mask resuscitators. Only 2 (4.5%) of the health facilities assessed were able to provide a KMC service using pediatric beds in the pediatric IPD section; however there are shortages of essential supplies to provide KMC in the facilities.

#### ***f. Performance Quality Improvement on MNCH***

With regards to quality improvement initiatives, it was observed that 8 (18%) of the health facilities assessed were implementing government initiatives in quality improvement for MNH services. The remaining health facilities were not implementing any quality improvement initiatives or programs.

#### ***g. Supervision***

All health facilities surveyed reported that they had received a regular supportive supervision from the woreda and/or zonal health office experts in the last three months. The supervision visits was held in an integrated manner with the supervision team comprising experts from different departments from

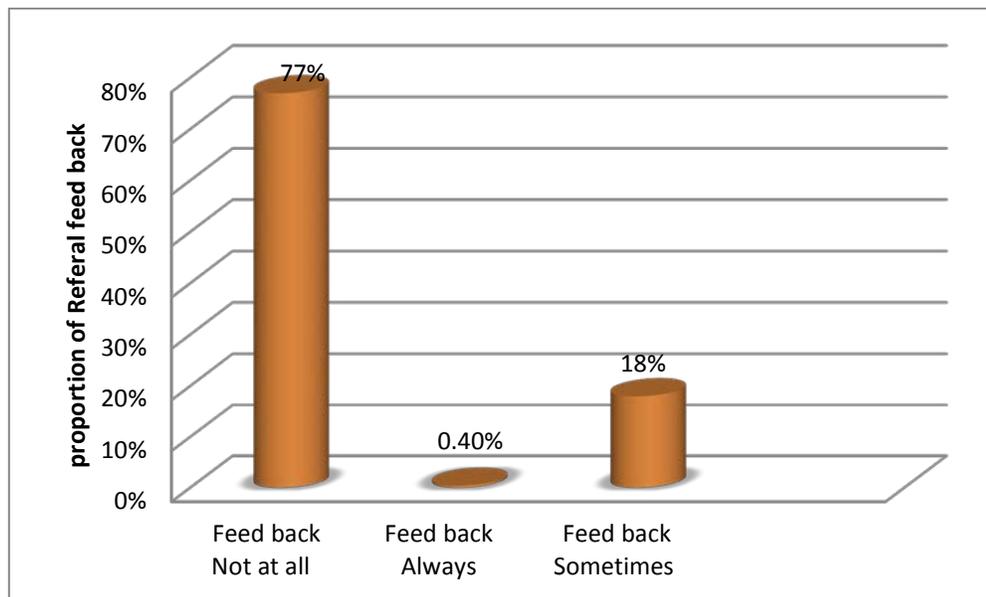
the respective woredas and zones. Supervision from different partner organizations to health facilities was also reported although was viewed as less regular.

***h. Referral linkages***

In all of the health centers assessed clients were referred to higher level facilities but feedback was rarely provided to the facility initiating the referral. Lack of standardized referral tools as well as the absence of a well-established feedback system were cited by health facility staff as reasons for not closing the loop in the referral system. The health centers also served as a referral for their surrounding five to twelve health posts staffed by HEWs.

The assessment found that in the last quarter, 0.4% of the health facilities had received a complete referral (referral with feedback); 18% of the health facilities had received a complete referral on some occasions; 77% had never received any referral feedback on any of the referrals they had made in the last quarter. Most of the health care workers use a locally developed referral slip to communicate to the referral facilities (See Annex 1 for list of health centers and their corresponding referral hospitals).

***Fig 5. Status of Referral linkage and Feedback (July-Sept, 2011)***



***i. Health Management Information System***

The new HMIS system was rolled out throughout the country starting May 2010. The system has 107 reportable indicators to the higher level. Additional indicators that could be used for program management can be collected from the HMIS registration books. In the health centers assessed, 13 (29.5%) are not using the HMIS and of those facilities that were using the HMIS it was observed that registers lacked completeness and consistency. Although some of the health care providers had been trained on HMIS, some of the health facilities were not recording or reporting using the standardized format due to absence of HMIS registers at the facility level. The table in the annex summarizes service delivery data from available health facility data.

**V. KEY FINDINGS**

1. Recent staff training (or technical updates) in the areas of BEmONC, PMTCT or KMC are patchy. Some staff have received training on PMTCT but not BEmONC and vice versa. Given that KMC is a new initiative at the health centre level it is not surprising that training in this area is a need.
2. The lack of HCT services and couples counseling is impacting the provision of comprehensive PMTCT services. While lack of essential supplies (test kits) is hindering the service, establishment of an HCT service in some health facilities has never been initiated.
3. The absence of ART prophylaxis means that patients are referred to other facilities with the potential that they are then lost to follow-up.
4. Generally the referral system is incomplete with no effective means of communication (feedback) between facilities being provided.
5. Basic office furnishings such as tables and chairs, and clinical equipment such examination beds, mattresses and autoclaves was lacking in most of the health facilities. In some HFs the room or space dedicated for ANC and delivery service provision is considered inadequate. .
6. Poor quality record keeping and reporting mechanisms use of data for decision making was a finding in a number of health facilities.

## ***VI. RECOMMENDATIONS for MCHIP Programming***

1. Identify the providers that need clinical knowledge and skills training in targeted areas and seek ways to integrate training opportunities where possible (e.g. KMC with BEmONC).
2. In discussions with woreda officials and within the framework of the national PMTCT Accelerated Plan initiate HCT services (at least for pregnant women) in health facilities that do not currently provide this service. For all health facilities explore initiating couples counseling and testing for HIV. Identify strengthening linkages with health facilities that do not provided ARV prophylaxis with referral facilities that do, to prevent patients lost to follow up.
3. Interventions for referral should focus on identifying how health facility staff can use existing resources to improve transport and communication, particularly for the referral of emergency obstetric cases from health center to hospitals.
4. Strengthen resource mobilization at all levels for infrastructure, supplies, training, review meetings and supportive supervision, and hold regular discussions with relevant stakeholders on the establishment of ART prophylaxis is necessary e.g. with RHB, PFSA.

### ***Strengths of the rapid assessment include:***

- For the assessments in some health facilities the Woreda Health Office head was involved in the assessment;
- Assessment tools were user- friendly and easy to collect the required information;
- Facility health staff were very committed and cooperative in providing the information;
- The time allocated to the entire rapid assessment process was reasonably adequate.

### ***Limitations of the rapid assessment include:***

- For some health facilities advance notice about the assessment had not yet the reached health facility staff and woreda health office officials (MCHIP Officially contacted the RHB and asked them to inform the woredas ahead of time); .
- In 2 health centers the health center head was not available;
- Difficult access to a few health facilities due to poor road infrastructure;

- Improper data recording, reporting and record keeping in some health facilities;
- In some health centers other partners were holding meetings with staff which tied up health facility staff and took them away from service delivery as they attended the meeting and also responded to questions from the MCHIP assessment team.
- HCT questions in assessment checklist did not look at data for partner counseling.

## ***VII. Summary***

The findings of this assessment will be used to inform MCHIP programming to provide baseline service delivery data and determine our length of project targets. It will also be used to guide program design and implementation interventions for MCHIP in these sites. The findings and this assessment report will be shared with the facilities concerned (details as they pertain to each facility) and Woreda Health office.

## Annexes

*List of Health Centers with Corresponding Referral Hospitals*

#	HF Name	Woreda	Region	Referral Facility
1	Kebele 02 HC	Kombolcha	Amhara	Dessie Referral hospital
2	Kebele 05 HC			
3	Kebele 07 HC			
4	Sulula HC	Tehuledere		
5	Hara HC			
6	Saglen HC			
7	Agita HC	Yilmanadensa		Felege Hiwot Referral Hospital
8	Goshiye HC			
9	Densa Bata HC			
10	DebreMawi HC			
11	Enegade HC			
12	WetetAbay HC	Mecha		
13	Amarit HC			
14	Birakat HC			
15	Rim HC			
16	LehulumSelam HC			
17	Degi HC			
18	Ambo Mesk HC			
19	TagelWedefit HC			
20	Shire	Goba	Oromia	Shashemene Hospital
21	Goba			
22	Goljohta HC	ArsiNegele		
23	Meti HC			
24	Kelo HC			
25	GorbiArbo			
26	Chitu HC	Wenchi		Woliso Hospital
27	Dulele HC			

28	Dariyan HC			
29	Lemen HC			
30	Wajifo HC	<b>Mirab Abaya</b>	<b>SNNP</b>	<b>Arbaminch hospital</b>
31	DegaBarana HC			
32	Secha HC	<b>Arba Minch Zuria</b>		
33	Lante HC			
34	Arbaminch HC			
35	Zigiti Bakole HC			
36	Geja HC	<b>Misha</b>		
37	Was Gebeta HC			
38	Gemedo HC			
39	Siko HC			
40	Fugaja HC			
41	Anjama HC			
42	Megacho HC	<b>Gibe</b>		
43	Ambro HC			
44	Omochura HC			

**Baseline data on service delivery statistics**

S.No	Indicators	Total #
1	<b>Antenatal Care</b>	
	First antenatal attendance	3597
	4th antenatal attendance	340
2	<b>Abortion Care</b>	
	Abortion care	27
3	<b>Deliveries and Outcome</b>	
	Attended by skilled birth attendant	545
	Live birth	537
	Still birth	8
4	<b>Early Neonatal Care</b>	
	Early neonatal death	2
5	<b>Post Natal Care</b>	
	First post natal visit	806
	Second post natal attendance	24
	Third post natal attendance	0
6	<b>Child Health Weight monitoring</b>	
	Number of newborn weighed	423
	Low birth weight (<2500 gm)	21
7	<b>PMTCT</b>	
	ANC clients with at least 1 visit at PMTCT site	2091
	ANC clients with at least 4 visit at PMTCT site	51
8	<b>ANC Clients receiving</b>	
	ANC clients testing positive for HIV	41
	HIV positive women delivered in the facility	10
	HIV positive women delivered in the facility and received full course of HIV prophylaxis	9
	HIV positive Newborns delivered in the facility and received full course of HIV prophylaxis	8