



# **Basic Emergency Obstetric and Newborn Care Post- training Supportive Supervision Visit Report**

**MCHIP Ethiopia**

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## ***Contents***

I. Introduction .....	3
II. Objectives.....	3
III. Methodology .....	3
IV. The Supervision Tool.....	3
V. Major Findings .....	4
VI. Provider Skill Assessment.....	6
VII. Additional Findings of the Supportive Supervision Visit.....	7
VIII. Challenges for Providing MNCH Service in the Facilities .....	7
IX. Suggestion and Recommendation .....	7
X. Way Forward.....	8

## ***Tables***

Table 1: List of Health Facilities Visited per Region.....	3
Table 2: Facility Information and Service Delivery Assessment.....	4

## ***Figures***

Fig 1: Availability of Anticonvulsant and Antihypertensive Drug at five Hospitals.....	5
Fig 2: Availability of Drugs and Equipment at 11 Health Centers.....	5

## ***I. Introduction***

This is a summary report of supportive supervision visits conducted for MCHIP supported sites in three regions namely: Amhara (South Wollo and West Gojam zones), Oromia (West Arsi zone) and SNNPR region (Gamogofa and Hadya zones). The supportive supervision visits, conducted from December 20 – 31, 2011, covered a total of 16 public health facilities as outlined in Table 1 below:

**Table 1: List of Health Facilities Visited per Region**

S.no	Region	Zone	Hospital	Health Centers
1	Amhara	South Wollo West Gojam	Dessie Hospital Felege Hiwot Hospital	Kombolcha Health Center and Haik Health Center  Adet Health Center and Merawi Health Center
2	Oromia	West Arsi	Shashemene Referral Hospital	Kello Health Center and Kore Health Center
3	SNNP	Gomogofa and Hadya	Arbaminch and Hossana Hospital	Shelle Health Center and Birbir Health Centers  Morsito Health Centre and Homecho Health Centre

## ***II. Objectives***

The main objectives of the supportive supervision were:

- To identify key technical gaps and practices in BEmONC services performed by trained providers
- To provide clinical mentoring for trained providers as per the key gaps identified and
- To assist the skill birth attendants to develop an action plan to address gaps identified

## ***III. Methodology***

The first task was to introduce the goal of MCHIP and the purpose of the visit to the respective heads of the facilities. Woreda Health Office and the health facility staff were also orientated on MCHIP activities before starting the actual assessment and clinical mentoring. The competency and the performance of the BEmONC trained health workers was assessed using structured interviews, direct observation, case studies and document review. MCHIP staff provided individualized clinical mentoring to the providers on the key performance gaps identified. An action plan was developed after exploring existing opportunities and challenges.

## ***IV. The Supervision Tool***

The supervision tool consisted of closed-ended questions on facility information, assessment of service delivery, availability of supplies and equipment for Emergency Obstetric Care, and provider skill

assessment. The in-charge of the facility, or BEmONC staff trained who were present in the delivery room during the supervision visit, were informed about the objectives of the supportive supervision.

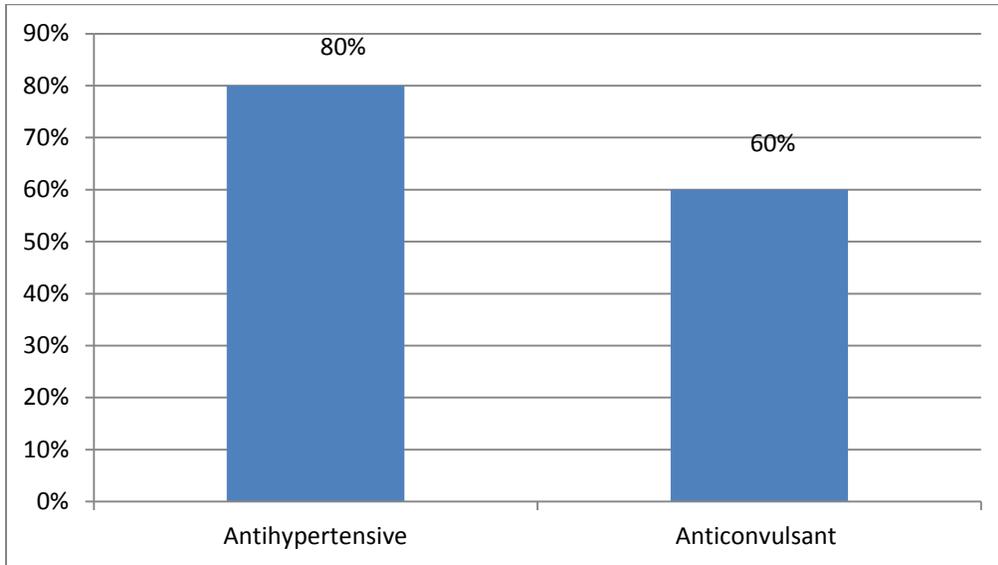
## V. Major Findings

**Table 2: Facility Information and Service Delivery Assessment**

No	Name of facility	Number of MNCH staff	Number of BEmONC trained staff (By MCHIP & other partners)	BEmONC functions provided in the facility	Gaps on BEMONC signal function
1	Dessie Hospital	14	8	7/7	None
2	Shashemene Referral Hospital	15	05	6/7	Assisted Vaginal Delivery (Forceps delivery) not performed.
3	Arbaminch Hospital	26	5	7/7	None
4	Hossana Hospital	9	2	7/7	None
5	Kombolcha Health Center	2	1	6/7	Absence of parenteral anticonvulsant
6	Haik Health Center	2	1	6/7	Absence of parenteral anticonvulsant
7	Kello Health Center	02	01	3/7	Parenteral antibiotic, anticonvulsant and lack of equipment to perform MVA
8	Kore Health Center	03	01	4/7	Absence of parenteral antibiotic and anticonvulsant, lack of performing assisted vagina delivery
9	Shelle Health Center	03	02	6/7	Absence of parenteral anticonvulsant
10	Birbir Health Center	03	01	4/7	Absence of anticonvulsant, MVA& newborn resuscitation
11	Morsito Health Centre	05	2	5/7	Absence of parental antibiotics and anticonvulsants.
12	Homecho Health Centre	8	2	5/7	Absence of parenteral antibiotics, diazepam, MgSo4.
13	Felegehiwot Hospital	15	11	7/7	None
14	Merawi Health Center	2	2	6/7	Absence of parenteral anticonvulsant
15	Adet Health Centers	4	2	6/7	Absence of parenteral anticonvulsant

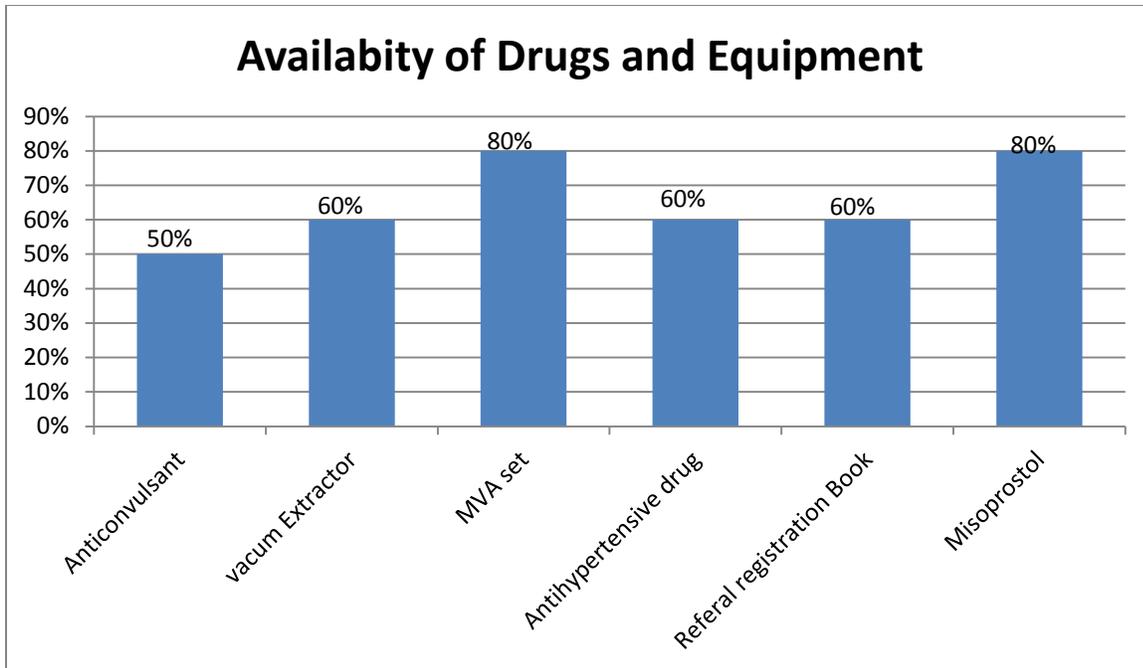
Though the health facilities were designated as BEmONC centres but they do not provide all signal functions. For e.g. Kello and Birbir Health centers which are BEmONC centers but during the supervision they were found to be absence of MVA services due of lack of instrument. Out of 5 hospitals only 1(80%) implemented all signal function except Forceps delivery. The most common gaps of health facility were absence of parental anticonvulsant.

I. Supplies and Equipment for Emergency Obstetric Care:



**Fig 1: Availability of Anticonvulsant and Antihypertensive Drug at five Hospitals**

Based on the assessment checklist 60% of hospitals had anticonvulsant and 80% had antihypertensive. Generally the availability of equipment and supplies as some simple but very important items like anticonvulsant and anti-hypertensive drugs are missing at few of facilities.



**Fig 2: Availability of Drugs and Equipment at 11 Health Centers**

All the necessary BeMONC equipment and supplies were available in the hospitals visited. However, at the health center level, critical shortages were noted at many sites, including a lack of anticonvulsant (50% of health centers visited), lack of antihypertensive drugs, vacuum extractors, referral books and registration forms (40% of health centers visited), and lack of MVA equipment and misoprostol (20% of health centers visited).

## **VI. Provider Skill Assessment**

MCHIP provided appropriate guidance and mentoring on the spot for the following areas in which gaps were identified.

### **1. ANC**

- Performing a quick check for ANC clients.
- Counseling services were not as holistic as expected
- Birth preparedness and complication readiness was not in place.

### **2. Assisting Normal Delivery**

- Incorrect plotting and inconsistent use of parthograph
- Absence of woman friendly care (such as support person, fundal pressure, stretching the perineum, performing premature episiotomy)

### **3. Poor newborn hypothermia prevention techniques during post natal care (PNC)**

- Incomplete assessment of the mother and her newborn (Poor clinical decision making)
- Lack of counseling on complication readiness planning and postponing baby bath.

### **4. Manual removal of placenta**

- Prophylactic antibiotic was not administered. (antibiotic was given at the end of the procedure)

- Skills gaps in the manual removal of placenta.

## ***VII. Additional Findings of the Supportive Supervision Visit***

The following important observations were also made in the facilities visited:

### **Strengths**

- Provision of integrated services (ANC, HCT/PMTCT)
- Motivation and cooperation of facility staff
- Strong communication between health centers and the respective woreda offices
- ANC and delivery areas were well organized with the necessary equipment and supplies
- In some facilities, pharmacies were open 24 hours for all the days during week.

### **Limitations**

- Difficulty to access some of the health facilities due to lack of infrastructure.
- Facility staff were overburdened with additional work during the supportive supervision.
- Information on no of cases, no of partograph uses are not well documented in the health facilities therefore it was difficult to collect complete information.
- Some indicators in the supervision tools were difficult to collect in practice. For instance, in some sites actual cases could not be found due to very low client load.
- Lack of fee exemption for baseline investigation of ANC clients particularly in Shashemene hospital
- Supervision visits were conducted in 1 day or less per site; however, ideally, a minimum of at two days is required so as to allow for observation of cases to assess provider skills, and allow for adequate time to practice skills on Manikins.

## ***VIII. Challenges in Providing MNCH Service in the Facilities***

The most commonly reported challenges encountered by health providers working in the health facilities are:

- Lack of equipment such as vacuum Extractor, MVA set and bag and mask resuscitator, and a shortage of essential drugs namely FeSo4, vitamin K, Lidocane, anticonvulsants, anti-hypertension.
- Lack of material and supplies such as baby towels, drapes, personal protective equipment and delivery couches
- Poor data recording and report keeping system and the late initiation of HMIS implementation in some facilities
- High turnover of trained health workers
- Replacement staffare not trained on BEmONC which creates inconsistency in the service provided.

## ***IX. Recommendations***

During the discussions with health facility staff the following suggestions and recommendations were made to improve standard MNCH services:

- Making equipment, supplies, drugs and laboratory reagents available by purchase or donation
- Encourage partners and the WHO to implement BEmONC at health center level.
- Improve the skills of health care providers in delivering effective and quality services by providing training on BEmONC, Kangaroo Mother Care (KMC) and PMTCT, focusing on counseling about birth preparedness and developing complication readiness plans during ANC visit to prepare potential blood donors from the family in case of need.

## ***X. Way Forward***

In conclusion:

- Future supervision visits should involve the regional and woreda MNCH focal people
- Supportive supervision checklists need to be shortened and revised to be in line with the standard emergency obstetric monitoring indicators after field test. The objective and methods of the supportive supervision should be clearly devised and shared to all. Allocating adequate time for the visit is critical and will ensure the quality of the supervision
- The presence of Frequent and close follow up after training will be essential. of the health facilities is ideal
- Providing need- based supportive supervision guided by the health providers individual action plan developed during the training will help give a more focused and specific support.
- Ensuring the availability of necessary emergency equipment and supplies immediately after the training
- Additional BEmONC training should be provided for the health facility staff working on MNCH and have not yet been trained.