



# Improving the Quality of Maternal and Newborn Health Care Oromia



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Maternal and Child Health  
Integrated Program

## Maps of Oromia Region

Ethiopia is divided into nine administrative regions and two cities. West Arsi Zone is located in the Oromia Region of Ethiopia.



In West Arsi Zone, MCHIP is present in two of six woredas (districts)—Arsi Negele and Kore—where six rural health centers serve a population of nearly 300,000 and one hospital serves a catchment area of more than 2.2 million people.

The Maternal and Child Health Integrated Program (MCHIP), which is present in 30 priority countries, is funded by the U.S. Agency for International Development and led by Jhpiego, which partners with Save the Children International in Ethiopia. MCHIP aims to accelerate the reduction of maternal, newborn, and child mortality by building on program experience and lessons learned from previous maternal and child health focused programs. MCHIP addresses major causes of mortality, including malnutrition, by scaling up evidence-based, high-impact maternal, newborn, and children health interventions. MCHIP's goal is to help reduce maternal and child mortality by 25 percent across the 30 priority countries through field-based implementation and global leadership. For more information, contact Hannah Gibson at [Hannah.Gibson@jhpigo.org](mailto:Hannah.Gibson@jhpigo.org) or visit [www.mchip.net/ethiopia](http://www.mchip.net/ethiopia).

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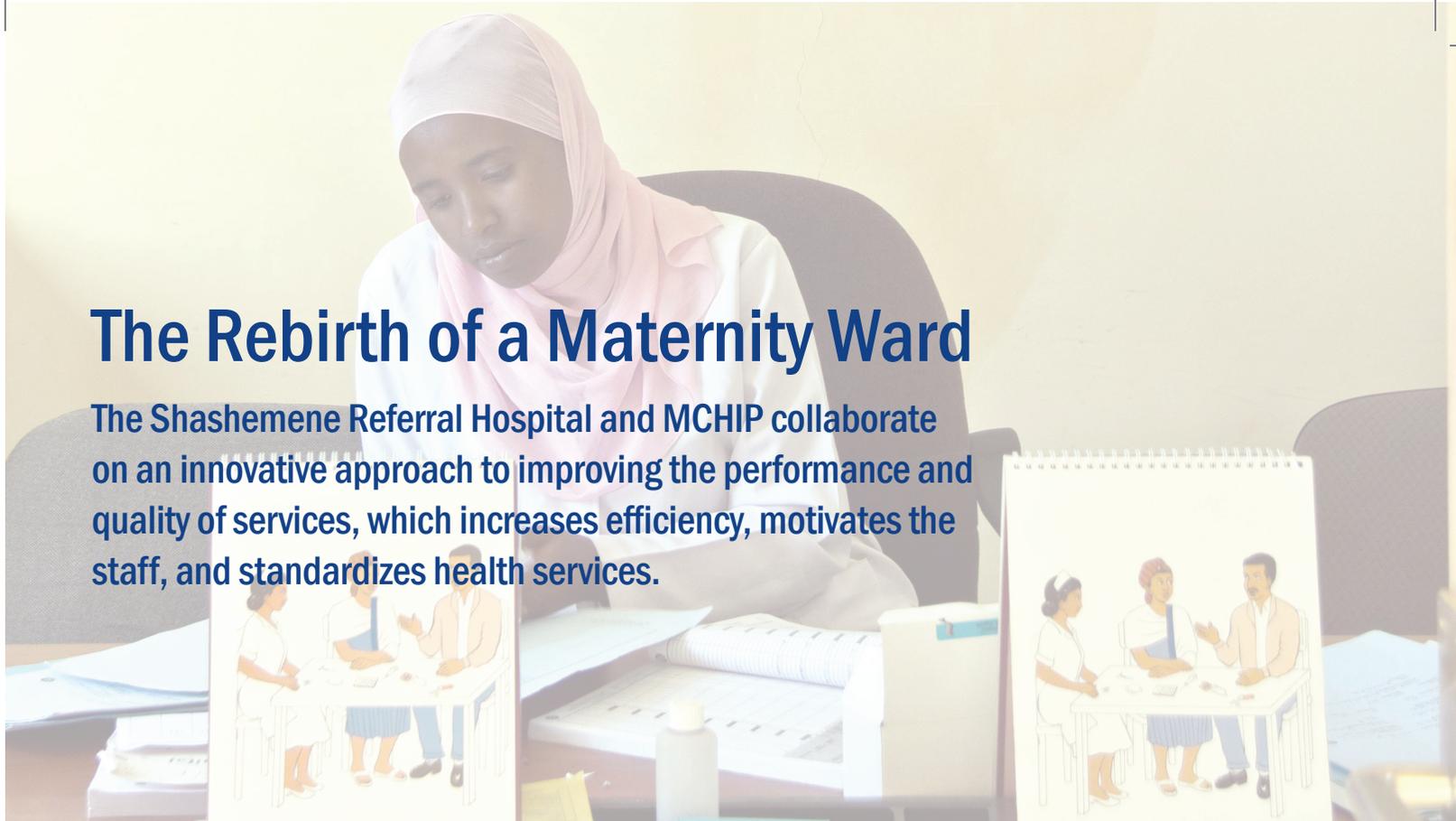
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Cover: A midwife reviews family planning methods with a client at the Arise Negele Health Center in the Oromia region of Ethiopia, where MCHIP has provided training to the staff in order to improve the quality of maternal, newborn, and child health.

# The Rebirth of a Maternity Ward

The Shashemene Referral Hospital and MCHIP collaborate on an innovative approach to improving the performance and quality of services, which increases efficiency, motivates the staff, and standardizes health services.



**Shashemene, Ethiopia**—In 2006, the Shashemene Referral Hospital was scheduled for closure due to a steady decline in patient flow. The community avoided the hospital as a result of deteriorating service and a lack of basic infrastructure. The hospital—founded in 1943 as a leprosy control center in the Oromia region of central Ethiopia—was still using the original building, which was constructed from mud and straw.

Pregnant women in the community usually preferred giving birth at home. For a routine visit, an expectant mother had to first wait in line to receive antenatal care, then wait in other lines to get laboratory results, medicine, and immunizations. If a mother did choose to deliver in the hospital, instead of a postnatal ward, she and her newborn were housed in the same room as post-surgery patients. Infections were routine.

The hospital's closure would have forced more than 2 million people living in Shashemene, Arsi Negele, and the surrounding area to travel to the overcrowded Hawassa Referral Hospital, two hours to the south. The community protested the government's plans and at the same time made a case for the government to invest money in the expansion of the hospital's services.

The government agreed to keep the hospital open and improve services. In 2007, Jhpiego, an affiliate of Johns Hopkins University, helped the hospital take the first step towards standardizing maternal and child health services by training one-third of the staff on the prevention of mother-to-child transmission (PMTCT) of HIV. In addition, Jhpiego provided the hospital with medical equipment to reduce infections and with delivery sets for the maternity ward.



Midwife Abdela Abdosh checks the blood pressure of a expectant woman in the antenatal unit of Shashemene Hospital. Abdela received training from MCHIP in basic emergency obstetric and newborn care as part of the hospital's efforts to improve and standardize care.



Shashemene Hospital medical director, Dr. Belayneh Leta Robi, led efforts to improve the hospital's maternal, newborn, and child health care services by implementing SBM-R.

In June 2011, the hospital board selected six focal participants from the hospital to collaborate with the Maternal and Child Health Integrated Program (MCHIP), which is led by Jhpiego with its partner Save the Children International. The hospital team and MCHIP staff used evidence-based clinical standards to assess the hospital's maternity ward and other departments. The baseline document identified and allowed staff to prioritize problematic areas and was the first phase of the Standards-Based Management and Recognition (SBM-R®) process—a practical management methodology to improve the performance and quality of health services by focusing on streamlining standardization and implementation of best practices (Figure 1).

**Figure 1: Standards-Based Management and Recognition**

<p><b>Standards-Based Management and Recognition (SBM-R®) is a practical management approach for improving performance and quality of health services that uses detailed, operational, observable performance standards for site assessments and problem-solving. The process has four steps:</b></p>	<p><b>Step 1: Set standards of performance</b></p> <ul style="list-style-type: none"> <li>• Define the desired level of performance for each health service delivery area to be addressed</li> </ul>	<p><b>Step 3: Measure progress</b></p> <ul style="list-style-type: none"> <li>• Monitor process</li> <li>• Assess success of interventions</li> <li>• Identify resistant gaps</li> <li>• Make necessary adjustments</li> </ul>
	<p><b>Step 2: Implement the standards</b></p> <ul style="list-style-type: none"> <li>• Identify gaps through baseline analysis</li> <li>• Identify causes of the gaps</li> <li>• Decide on appropriate interventions</li> <li>• Implement interventions</li> </ul>	<p><b>Step 4: Recognize achievement</b></p> <ul style="list-style-type: none"> <li>• Provide public acknowledgment of achievement</li> <li>• Give timely and specific feedback</li> <li>• Offer social and/or material recognition</li> </ul>
	<p><b>Increasing compliance with these operational standards is tied to recognition of achievement. The correlation between SMB-R standards achieved and higher coverage in antenatal, birth, and postnatal care suggests that by achieving 100 percent of the standards presented in the SBM-R methodology, hospitals and health centers can make significant changes in maternal and child health.</b></p>	

“The SBM-R methodology creates a sense of agenda among the hospital management and board. You have to be creative. This aspect of MCHIP is not an isolated program. Rather, it’s a way to improve the quality of the overall service offered in our hospital,” says Dr. Belayneh Leta, Shashemene Referral Hospital medical director.

In March 2012, Shashemene Hospital entered the second phase of SBM-R, in which the hospital staff focused on mobilizing resources to close the gaps they had identified in the baseline assessment. The second phase of SBM-R also stresses recognition by motivating hospital leaders—administrators, doctors, nurses, and midwives—to take ownership of the changes and continue improving key areas. The hospital’s former antenatal unit consisted of two rooms with no

running water. In 2011, an international donor awarded the hospital a new building for antenatal care, tripling in size the earlier unit. Using the SBM-R process, Dr. Belayneh and the team integrated antenatal care with HIV mother support groups and family planning counseling services.

One of the first assignments was to create a storeroom for all resources related to these services. “We reorganized everything to provide all mother-related services in the same department,” Dr. Belayneh explains. “We bring the antiretroviral drugs into the storeroom and provide the medicine in confidentiality. No longer do mothers wait in line at the pharmacy and whisper their orders to protect their HIV status.” The head of the antenatal care unit is tasked with restocking the storage room every two weeks and tracking the unit’s consumption rate.

Next, the hospital evaluated the skills and knowledge of the staff in the maternity ward. Since June 2011, MCHIP has trained six midwives and nurses in basic emergency obstetric and newborn care (BEmONC), two midwives in immediate postpartum insertion of an intrauterine contraceptive device (IUCD), and two midwives in counseling mothers of low birth weight and pre-term babies on kangaroo mother care (KMC)—the practice of skin-to-skin contact in which a mother swaddles her baby to her chest to keep the baby warm and to facilitate breastfeeding. The unit then held internal facility orientation training to share the knowledge and skills acquired. In addition to the MCHIP-sponsored trainings, all the midwives and nurses working in the antenatal care unit were trained in PMTCT (Figure 2).

“Previously, the hospital assigned staff according to patient flow, not staff expertise. Today, we utilize the staff member in the area for which they have been prepared and trained,” says Dr. Belayneh. “We used to have all our nurses in the OR and out-patient because the mentality was that the antenatal unit was nothing more than a few injections and some pills. We’re changing that mentality.”

Dr. Belayneh says that overall, services in the maternity unit improved during the past year. Proof of the improvements is found in the instructional job aids hanging on the walls of the antenatal care and labor units: management of eclampsia with magnesium sulfate, malnutrition, resuscitation of newborns, application of a vacuum for delivery, and management of the third stage of labor. These tools once collected dust in the hospital’s storeroom but now remind midwives and nurses of protocols for evidence-based care and techniques that were rarely performed by staff.

“Donors brought us these posters, but nobody really knew what to do with them. Now we’re reminded that we can treat malnutrition in the antenatal unit,” he says. “We keep the SBM-R performance quality checklists in all the offices because we want staff to use them until these services and methodologies are internalized.”

## Antenatal Care Unit

*“The SBM-R methodology creates a sense of agenda among the hospital management and board. You have to be creative. This aspect of MCHIP is not an isolated program. Rather, it’s a way to improve the quality of the overall service offered in our hospital.”*

*- Dr. Belayneh Leta, Shashemene Hospital medical director*



A health worker at Shashemene Hospital participates in the basic emergency obstetric and newborn care training provided by MCHIP.

*“Previously, the hospital assigned staff according to patient flow, not staff expertise. Today, we utilize the staff member in the area for which they have been prepared and trained.”*

*- Dr. Belayneh Leta*

## Improving Delivery and Postnatal Wards

Dr. Belayneh believes that creating an efficient and friendly antenatal care unit is the first step to increasing institutional births. Since unveiling the new unit, hospital deliveries have increased nearly 40 percent, from 337 in July-September 2011 to 550 during the same period in 2012. The increase is due to the implementation of the SBM-R approach to performance quality improvement, as well as the Government of Ethiopia’s community outreach program and waived of fees for maternal and child health services. With the increasing number of institutional births and increasing mother satisfaction, will be more likely to return for postnatal care and family planning counseling.

MCHIP trained government officials from the area health bureau alongside the providers and health administrators to improve communications related to quality improvements. By strengthening its link to the government, the hospital was able to access materials and additional funds to fill gaps discovered in the baseline assessment.

Feyessa Gose, the Family Health and Extension Coordinator for the Arsi Negele Woreda Health Bureau, helped the hospital and health centers create a central SBM-R committee. He also audits SBM-R assessments and helps train the rest of the staff in standards-based quality care. And, every three months Feyessa joins the committee for a standards checklist evaluation.

“Before standards assessment, we used traditional ways of administering health care. We had many gaps in our knowledge and skill sets. Perhaps most importantly, we have now built client-friendly service into health care. That has made a big difference to clients,” explains Feyessa.

In the building next to the antenatal unit are the hospital’s delivery ward, pediatrics unit, and postnatal care ward, which the hospital created after seeing the results of the initial SBM-R assessment. Instead of being placed in the post-operative ward or pediatrics unit after delivery, mothers can now rest and recover in the dedicated postnatal ward on beds donated by MCHIP.

Until a year ago, the current postnatal unit was underutilized as a default store room for material that was broken or that staff did not have the confidence to use. In addition, other rooms in the ward have been turned into convenient storage rooms for essential medicines and equipment for mothers and newborns, saving midwives and nurses precious time.

The newly renovated room provides ample space for postpartum mothers to rest. Beds are spaced so that midwives can better monitor mothers and newborns in the hours following birth. In the postpartum stage, attendants provide comprehensive family planning counseling and offer interested mothers postpartum IUCD insertion, among other contraception choices.

“In the past, we missed the opportunity to provide family planning services because mothers were not returning to hospital. Now in the postpartum stage, we offer family planning counseling while we have their attention,” says midwife Abdela Abdosh, who was trained by MCHIP in IUCD insertion and family planning.

Many of the changes made as a result of the SBM-R assessment are vital to the entire hospital and not just the maternity ward. A year ago, doctors and nurses struggled to produce and find patient records. After receiving an orientation on monitoring and evaluation, they started archiving Shashemene Referral Hospital’s records in departmental filing cabinets, providing easy access to patient medical history.

In addition, using SMB-R to improve record management, the hospital team has used the SBM-R process for the hospital’s laboratory, pharmacy, and other departments. The hospital staff continues to reorganize the delivery ward as well as the pediatric department to provide comfort to mothers and their babies. And, recently, the maternity ward unveiled the neonatal care unit for babies in need of special care after delivery.

In March 2013, Dr. Belayneh and his team attended the third module of the SBM-R methodology and conducted an internal assessment to verify that previous gaps were filled. The training also pushed the team as well as government officials to embrace the methodology and duplicate it on other levels, such as at health centers not currently participating in the MCHIP program. In addition, the hospital’s central committee created standards for three new areas not included in the original SBM-R checklist: ophthalmology, the operating room, and the dental clinic.

“SBM-R is better than other approaches because it doesn’t necessarily ask for money from donors. The standards put us in the right direction. It’s not a new science, but it puts us on the path in the right direction towards quality care, and as a result more patients arrive,” says Dr. Belayneh.



Shashemene Hospital medical director, Dr. Belayneh Leta Robi, stands in the postnatal ward that was renovated as part of the SBM-R process. Since its implementations, the numbers of births at the hospital have increased—skilled care at birth reduces maternal and newborn mortality.

*“In the past, we missed the opportunity to provide family planning services because mothers were not returning to hospital. Now in the postpartum stage, we offer family planning counseling while we have their attention.”*

*- Abdela Abdosh, midwife*

## Figure 2: MCHIP Contributions in West Arsi Zone

BEmONC trainings	16 health professionals (midwives and clinical nurses)
KMC training	59 health extension workers and health center providers
Essential newborn care training	15 midwives and nurses
PMTCT training	12 health professionals
PPFP counseling/IUCD insertion training	8 providers
SBM-R methodology training	11 health centers; 1 hospital

*“Labor can be very painful but the staff has provided me with great support today. Following the delivery, they gave me iron supplements, porridge, and coffee.”*

*- Haweni Goye, mother*

In February 2012, MCHIP began focusing on postpartum family planning (PPFP) and promoting the use of IUCDs among pregnant and postpartum women (Figure 3). The program provides training as well as insertion supplies to 18 health facilities in the Addis Ababa, Amhara, Tigray, and Oromia regions of Ethiopia. The initiative has trained more than 64 health professionals in postpartum family planning and IUCD insertion; half of them work in labor and delivery wards.

**Figure 3: Postpartum Family Planning at Shashemene Hospital, February 2012 and March 2013**

Total number of women counseled for PPFP at labor and delivery	1,078
Total number of postpartum IUCD insertions	136
Total number of deliveries attended in the hospital during the same period	1,540

## New Mother Appreciates Care at the Arsi Negele Health Center

**Arsi Negele, Ethiopia**—Inside the Arsi Negele Health Center, Haweni Goye is resting on a bed in the postnatal care ward several hours after giving birth. Her baby lies quietly sleeping in her lap, bundled in a blanket. “Labor can be very painful but the staff has provided me with great support today,” she says. “Following the delivery, they gave me iron supplements, porridge, and coffee.” Haweni plans to return to the health center for the six-week postnatal checkup. Thanks to the positive experience in the health center, she now trusts the midwives on duty. “And I know that if my baby or I have any problems or sickness, I can come back,” she says.

The Arsi Negele Health Center was founded in 1999 and serves a population of more than 76,000 people. Just two years ago, the two midwives on duty didn’t speak the local Oromifa language; nor did they live in Arsi Negele.

“The midwives weren’t devoted to the mothers and just referred them to the Shashemene Referral Hospital for simple complications,” says Xahaa Dhaabii, a midwife who works at the center.

In June 2011, MCHIP started working with the health center to assess major gaps in the center’s ability to provide quality maternal, newborn, and child health services and trained the staff on the use of SBM-R (Figure 1), BEmONC (Figure 4) and KMC—the practice of skin-to-skin contact in which a mother swaddles her baby to her chest to keep the baby warm and to facilitate breastfeeding.

“The midwives here used to refer women with a retained placenta to the Shashemene Referral Hospital, but now we can handle that and other types of complications and emergencies,” says Xahaa. “I have also learned how to use a partograph to manage labor and I have given orientation to my colleagues on how to use partographs.”



Midwife Xahaa Dhaabii attends to Haweni Goye and her new baby in the Arsi Negele Health Center.



# Long-Term Family Planning Solution Appeals to Ethiopian Mother

Midwife Abdela Abdosh discusses postpartum family planning options at the Shashemene Referral Hospital. He uses a flip-book as a job aid to reinforce his messages.

**Shashemene, Ethiopia**—In the tradition of arranged marriages, which is common in the Oromia region, Etenish Tadesse was a 14-year-old bride. Before she turned 24, she already had four children and she began to wonder how she would send all her children to school.

“I’m responsible for my children getting an education, which is something that I couldn’t finish. I saw the problems that arise due to having too many children, so when I was pregnant with my fourth, I decided I would use family planning,” she explains.

During her fourth pregnancy, Etenish traveled 20 kilometers south to the Shashemene Referral Hospital for antenatal care, where the midwife told her about family planning options, including the IUCD.

Midwife Abdela Abdosh is one of two health care professionals trained by the MCHIP on immediate postpartum IUCD insertion techniques at the Shashemene Referral Hospital. The training is part of an MCHIP initiative to introduce the method while mothers are still in the hospital.

“I counseled her and her husband on family planning. She was considering the hormonal injection, but when I told her about the IUCD, she was convinced,” explains Abdela.

During counseling, Abdela also dispelled common misconceptions among Ethiopia women, including that contraceptives such as the IUCD can cause infertility, perforate the uterus, or lead to death.

“I chose the IUCD because the choice was up to me and I wanted a long-term solution with few side effects,” says Etenish. Midwife Abdela inserted the IUCD after Etenish gave birth to her fourth child, while Etenish was still in the postnatal care unit.

“Not many people are using the IUCD in Ethiopia. Since then, I have been telling my neighbors about my choice,” explains Etenish.

## Family Planning

*“I saw the problems that arise due to having too many children, so when I was pregnant with my fourth, I decided I would use family planning.”*

*- Etenish Tadesse, mother of four*

# Wider Range of Maternal Health Services Builds Trust among Mothers

The Kore Health Center, which serves a population of 30,000 in the Oromia region of Ethiopia, has become an integral part of the community and now attracts more mothers from around the area due to the increase in quality of services at the center.



Makia Tukey, with two of her three children, has increased her use of the Kore Health Center as both the facilities and services have improved.

**Kore, Ethiopia**—Makia Tukey, 27, was born to a family of 12 children, and although her father was a farmer, he managed to put all his children through high school. When she was 21 years old Makia married, and the following year she was expecting her first child.

In 2005, the village of Kore—located in West Arsi Zone—opened its first health center and provided locals with limited antenatal services, such as immunizations. Makia went to the small health center for a checkup but never considered having her baby at the center.

“The service was basic and I was scared of what might happen if I put my baby in the hands of an inexperienced midwife,” she explains. As a result, her baby was born in her home less than a kilometer from the health center in the hands of a neighbor whose only experience was having several babies of her own.

“The women ululated and my husband waited outside of the house in the yard,” she remembers. Her son Ribera was born healthy and there were no complications.

In 2009, Makia was pregnant again and returned to the health center for antenatal services. This time, the center offered more than just immunizations, including free iron supplements, nutrition services, HIV testing, and family planning options.

Makia decided to have her baby at the center because she felt the nursing staff knew more about delivery and child health. Her second son, Duresa, was born without complications, and after her son was born, she went directly home.

Makia later opted for a hormonal injection to better space the birth of her next child.

In June 2011, the Kore Health Center, which today serves a population of 30,000, participated in MCHIP’s SBM-R training. Ato Boresa Mulisa, the health center’s head, used the SBM-R process to identify gaps in the center’s maternity ward services and the staff’s skills.

Until then, the center had one outdated delivery couch and no postnatal room for mothers and newborns. Instead, mothers were allowed to remain on the delivery couch as long as they wanted to rest and recover from labor. Each month in 2010, only five mothers came to the health center to give birth, while 60 showed up for the center’s antenatal services.

After conducting the baseline assessment and the introduction to the service standardization process, Boresa and his team conducted the second phase of SBM-R in March 2012. The second module teaches leaders to think critically about resource mobilization and action plans to fill gaps, and prods them to take ownership of the improvements taking place.

“After using the SBM-R methodology, we began to think more strategically about our delivery ward and how we could attract more mothers. We rearranged the rooms and assessed our equipment,” explains Boresa, who is also a nurse. Acting on the SBM-R assessment, the health center turned to the Shashemene Referral Hospital to request two delivery couches.

As a result of the findings of the SBM-R assessment, MCHIP trained two nurses in BEmONC (Figure 4) and three nurses in counseling and applying KMC for premature babies. After the training, the staff was tasked with orienting colleagues and health extension workers in the center’s catchment area.



Nurses and midwives use a model to practice applying drops to a newborn’s eyes as part of a BEmONC skills training session that was part of an SBM-R program to update and standardize skills at Shashemene Hospital in Oromia Region.

#### Figure 4: Basic Emergency Obstetric and Newborn Care

BEmONC, which can be provided in health centers of all sizes, includes:

- Administration (usually by injection) of:
  - Antibiotics for infection
  - Anticonvulsants for pre-eclampsia/eclampsia
  - Uterotonics to induce contractions for postpartum hemorrhage
- Manual vacuum aspiration of retained products of conception
- Vacuum-assisted delivery
- Manual removal of the placenta
- Newborn resuscitation

Essential newborn care consists of basic preventive measures that include:

- Clean childbirth and cord care to prevent infection
- Thermal protection to prevent and manage hypo/hyperthermia
- Early and exclusive breastfeeding, started within one hour after childbirth
- Initiation of breathing and resuscitation
- Eye care
- Immunization
- Identification and management of sick newborn
- Care of preterm and/or low birth weight newborn

The SBM-R team also examined how services were presented to expecting mothers. To make mothers feel more comfortable, the facility now allows husbands into the delivery room, and MCHIP

donated beds and chairs to the health center’s postnatal ward. In addition, today, the Kore Health Center now provides families waiting for the delivery of a baby in the maternity ward with the traditional coffee ceremony—an essential part of every occasion in Ethiopia.

*“After using the SBM-R methodology, we began to think more strategically about our delivery ward and how we could attract more mothers. We rearranged the rooms and assessed our equipment.”*

*- Ato Boresa Mulisa,  
head of the Kore Health Center*

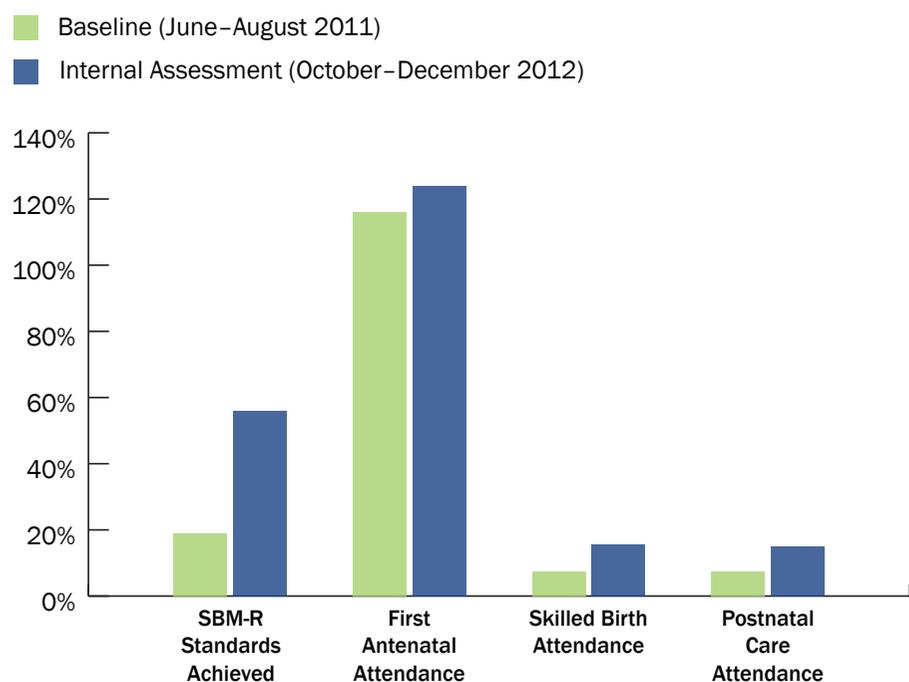
In conjunction with the SBM-R assessment, MCHIP provided delivery kits as well as other essentials, such as bed sheets and materials for infection prevention and workplace safety, including masks and aprons—materials that the facility had run out of years ago. Thanks to the improvements, the number of deliveries at the center doubled to 10, while some 140 mothers seek antenatal services every month (Figure 5).

In September 2012, Makia returned to the health center to deliver her third child. This time, after delivery, she spent the better part of the day in the center’s recently created postnatal ward.

“They were friendlier this time and treated me like a sister. I waited in a room with comfortable beds, and after the delivery I went back to the room to rest,” she explains. “The delivery bed is not comfortable to sleep on, but in the next room, they have beds.”

Makia intends to use contraceptive methods to plan her next pregnancy. As the health center improves, more and more mothers from Kore are using the health center for maternal and child health care.

**Figure 5: Improvements in Achievement of SBM-R Standards in Arsi Negele and Kore Health Centers, Before and After Implementation of SRM-R**



Following implementation of SBM-R at Arsi Negele and Kore Health Centers, surveys showed that overall achievement of SBM-R standards rose from 19% of the targeted standards to 56%; attendance at first antenatal care visit rose from 116% of the target to 124%; skilled birth attendance rose from 7% of the target to 16%, and postnatal care attendance rose from 7% to 15%.