MCHN ACTIVITY

QUALITY OF CARE SELF-ASSESSMENT LEARNING REPORT

Understanding Health Workers Experiences in Implementing the Maternal Newborn and Child Health Quality of Care Self-Assessment Tool in Kampala, Uganda

INTRODUCTION

The World Health Organization (WHO) developed the Maternal Newborn and Child Health (MNCH) Quality of Care (QoC) Self-Assessment Tool and the Ministry of Health in Uganda adapted the tool for its use in 2017. The tool provides healthcare facilities with a standardized method of continuously assessing and monitoring the implementation of MNCH QoC standards. Key inputs necessary to ensure quality services are grouped into seven standard domains (Table 1).

Table 1: Description of the seven MNCH QoC standard domains

Domain	Description
A	Infrastructure to cater for high- and non-high-risk patients, addressing part of the WHO Standard 8 on basic physical resources (physical space)
B	Management systems, addressing WHO Standard 2 on actionable information systems, WHO Standard 7 on competent and motivated human resources, and WHO Standard 8 on basic physical resources (equipment, medicines and supplies)
C	Infection prevention and patient safety, address WHO Standard 1 on evidence-based practices for routine care and management of complications and WHO Standard 8 on essential physical resources (water, energy, sanitation, hand hygiene. disinfection and reprocessing equipment)
D	Information, education, and communication, addressing WHO Standard 4 on effective communication
E	Clinical services, addressing WHO Standard 1 on provision of routine, evidence-based, maternal and newborn care according WHO guidelines.
F	Client centered care, addressing WHO Standard 3 on referral care, WHO Standard 5 on respectful and dignified care, and WHO Standard 6 on emotional support
G	Community services

In April 2021, USAID MCHN Activity trained 52 health workers (Enrolled Midwives-40%, Nursing Officers-29%, Clinical Officers-12%, Registered Midwives-7%, Medical Officers-7%, and Biostatisticians-5%) from 19 healthcare facilities in Kampala (7 public, 5 private not-for-profit, and 7 private-for-profit) on how to use the MOH's MNCH QoC Self-Assessment Tool. Makerere University School of Public Health, as part of the MCHN consortium, conducted a qualitative study to document the self-assessment process, identify areas of how the assessment tool or process could be improved, and inform the scale-up of future MNCH QoC self-assessments.

METHODS

The qualitative study involved a total of 36 health workers from a sample of 16 healthcare facilities (7 public, 3 private not-for-profit, and 6 private-for-profit). Health workers who were trained on the use of the MNCH QoC Self-Assessment tool and had taken part in the self-assessment exercise for their respective health facilities were purposefully sampled and invited to participate in an in-depth interview (IDI), or a group discussion. Three in-person group discussions comprising 6-8 members were held in April 2021. Telephone-based IDIs were conducted in July and August 2021 with 10 individual respondents to gain deeper insights. The study team conducted one health facility visit to two facilities, to verify the changes mentioned by the respondents. Some of the qualitative interviews were audio-recorded, while for others, notes were taken. In all cases, these were transcribed and analyzed using a thematic approach.

RESULTS

Salient results from the FGDs and IDIs are summarized under four broad themes: 1) a description of the QoC self-assessment process; 2) reported benefits and impact of using the assessment tool; 3) reported challenges of using the tool; and 4) recommendations from the respondents.

Theme ONE: QoC self-assessment process

Time period over which the assessment was conducted

Shortest 2-3 hours **Longest** 2 weeks **Average** 1-2 days

Influencing factors on time:

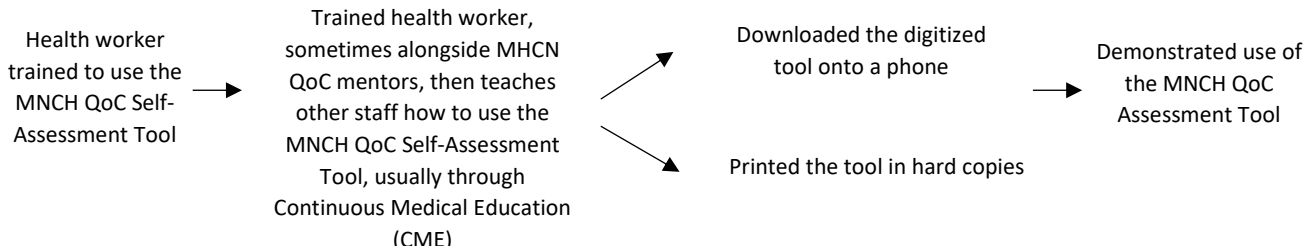
- ✓ availability of staff to participate in assessment
- ✓ busyness of staff
- ✓ size of the facility

Number and cadres of staff involved

Number: 2-6 staff per health facility (PFPs fewer staff, hospitals more staff)

Cadres: Midwifes, Nursing Officers, Clinical Officers, Medical Records Officer, Quality Improvement Officer, and Nurses from the outpatient department. Facilitators were the staff who had attended training

Preparation for the assessment



Conducting the assessment

- ✓ Some teams divided the sections and allocated different individuals to complete the different domains on their own.
- ✓ Some teams worked together to complete each section and allocated more than one person per section to ease the workload.
- ✓ All three FGD groups highlighted infrastructure and infection control as the easiest domains to complete, and only one group mentioned the community domain as easiest to complete.

Theme TWO: Reported benefits and impact

Reported benefits

All respondents reported the tool and process of self-assessment to be beneficial to the individual health worker and the health facility. All the health workers appreciated the tool once they had been oriented to it; they felt it was easy to understand and to use.

"It assesses you as the individual and assesses the facility in terms of quality of care we give to our clients" (Respondent, government hospital)

All the respondents agreed that the self-assessments helped them in identifying the health facility's gaps in equipment, supplies, infrastructure, and service delivery. For example, some respondents explained that

they realized their facilities were lacking in equipment for infection prevention when they went through the tool's questions on infection control.

Impact of MNCH QoC self-assessment on provision of services

Interviewees reported that the assessment exercise triggered them to quickly make corrective changes within their facilities, across all domains except Domain A (infrastructure).

Table 2: Changes in health facilities after the self-assessment, by domain

Domain	Label	Corrective changes made
A	Infrastructure	• None reported
B	Management systems	• Procured more delivery sets, nutrition assessment tools (tapes, stadiometers, and weighing scale), NICU equipment (phototherapy, warmers, and vacuum sets, headlamps) • Acquired new HMIS tools • Set up emergency trays • Put up a duty roster with staff contacts • Improved death reviews, for example through notifications and review meetings every Monday • Set up appointment and defaulter registers in the MCH clinic
C	Infection prevention and patient safety	• Instituted hand washing before touching any patient, sanitizing, and cleaning of nasal prongs • Improved sterilization, waste segregation • Emptied bins when at ¾ full • Put in place hand washing guidelines • Oriented caregivers in handwashing • Cleared resuscitation areas
D	Information, education, and communication	• Established health education schedule
E	Clinical services	• Strengthened partograph use following a continuous medical education • Nutrition assessments provided children and pregnant women • Triage done where it was not before • Improved stock management that helps pharmacists easily tell they are running out of stock • Ordered emergency drugs • Decrease in turnaround time in service delivery
F	Client centered care	• None reported
G	Community services	• Selected VHTs to work with and established community linkages

"Some changes we made because at first there are some things we never used to do like nutritional assessment, yet it was in that tool. We didn't have tools to use but now they supplied. Uganda Health Federation (UHF) supplied tools they are doing it now. The registers were not being filled well but now they are being filled well. Those are some of the improvements." (Respondent, PFP health center II)

Theme THREE: Reported challenges

Health workers reported three main types of challenges encountered during the self-assessment exercise.

Tool-related

- The tool is too long and time consuming
- Questions are not contextualized to the health facility level, thus lower-level health facilities had to answer questions about services they were not expected to have/provide
- Unfair scoring system: even if the facility had some items that the question asked about but not have others, it scored a zero on that question (no partial scoring, it is all or nothing)
- Challenging domains, particularly the community aspect that required facilities to have VHTs, or those that required input from in-charges
- Lack of standard checklists- health workers pointed out that they often did not have the checklists the tool asked for; instead, they had expected to find a standard checklist within the tool against which to assess themselves

- One PNFP facility did not use the tool because they were already engaged in the use of a similar, internationally accredited tool

Process-related

- Technology barriers (ODK tool requires smartphones; skills in internet use; it is large; takes a lot of data to download and was hard for groups to view on the phone together)
- Tool is more cumbersome to use in the larger facilities (due to the bigger size, there are many areas to assess)

Human resource

- Negative attitude among health workers who had not been trained; they were uncooperative, did not want to be involved and expected those who had been trained to do the assessment themselves
- Some managers were unwilling to share information required for the assessment
- Some health workers asked for a financial incentive before participation
- Some health workers were too busy to participate in assessment

Theme FOUR: Recommendations from the health workers

In response to the challenges experienced, the health workers recommended the following:

1) Shortening the tool
2) Contextualizing the questions so they are relevant as per health facility level
3) Developing a fairer scoring method
4) Orienting additional health workers so they can appreciate the QoC self-assessments
5) Providing external supervision during the QoC self-assessment to avoid dishonesty
6) Providing motivation to the trainers of the trainees in the facilities (the health workers who were trained and are training others)
7) Conducting quarterly QoC self-assessments

"…I think if you have time, you can modify the tool and make it shorter because as you know health workers we don't have time, the little time we have we need to give it to our patients" (Respondent, PNFP hospital)

"Change the scoring style. Some questions have a, b, c, d and if a facility passes "a" or 3 out of the 5 parameters and fails 2, it should not be scored "0". There should be another way of scoring" (Respondent, government health center III)

Conclusion: Implications for practice / programs

The MNCH QoC Self-Assessment Tool was useful to both public and private healthcare facilities and resulted in staff and management making positive changes to improve service delivery and quality of care. We observed high acceptability once the self-assessment was completed, and the staff came to understand its benefits. When the facility in-charge or management was actively involved, or commanded staff to join the activity, it made implementation easier. Similarly, it was easier to make service delivery systems and processes changes following the self-assessment if the facility management were on-board, as they were the final decision-makers. This review was conducted in Kampala, an urban setting with relative ease of access to electricity, internet, and staff who are familiar with using smart IT devices, but even then, they faced challenges. However, these amenities and technology capacity should not be assumed to be readily available at facilities located in rural parts of Uganda.