THE CHALLENGE:
Quality assurance is particularly important for obstetric care in low-resource settings

Maternal and newborn mortality are high in Khyber Pakhtunkhwa province. In 2014 Population Council reported that 1700 women were dying every year due to pregnancy-related complications and the 2012-13 Demographic and Health Survey found that 41 out of every 1000 babies died during their first 28 days of life.

The real tragedy here lies in the fact that these deaths are often avoidable. Most postnatal maternal deaths occur between 24 and 48 hours after birth; and the main causes of maternal and newborn mortality are well-known and can be prevented by relatively simple interventions.

However, conditions in local health care facilities are often challenging and there is a lack of quality assurance in obstetric care. As a consequence, health staff often have trouble remembering the correct procedures and can find it difficult to carry out the right steps in the right order.

THE OBJECTIVE:
Improved care quality and patient safety in two districts of Khyber Pakhtunkhwa

To respond to the weaknesses in the health system, the Reproductive, Maternal and Newborn Health Project (RMNHP) aimed to improve the delivery of essential maternal and newborn care by introducing the WHO Safe Childbirth Checklist to community midwives and public health care facilities in the Nowshera and Haripur districts of Khyber Pakhtunkhwa.

APPRAOCH:
A simple tool to improve the quality of maternal and newborn health care

The Safe Childbirth Checklist translates a wide range of best practices into a simple format that health workers can use in their daily work. Although the Checklist is still under development, the pilot edition contains 29-items that address the main causes of morbidity and mortality around the time of childbirth.

The list is designed to be used in institutional health care settings at four key pause points: i) admission, ii) before pushing or caesarean section, iii) within an hour of birth and iv) before discharge. Each item prompts the health worker to consider a critical action that, if missed, could lead to complications or death.

The RMNHP partnered with Jhpiego and the University of Göttingen to adapt and introduce the Safe Childbirth Checklist as part of a collaborative project to improve QUAlity and PATient Safety in Obstetric care (QUAPASO).
By adopting a phase-in randomized controlled design, the QUAPASO project planned not only to implement the Safe Childbirth Checklist but also to evaluate whether it was able to improve long-term training gains.

To begin with, it was planned that all health facility staff and community midwives in Nowshera and Haripur would be randomly assigned to two groups. Participants would then receive preparatory training from Jhpiego on issues included in the Safe Childbirth Checklist, as well as other standard skills related to delivery and Basic Emergency Obstetric and Neonatal Care.

This integrated training package would serve to standardize the clinical skills of the local health workers within the project areas. However to facilitate the evaluation component, the first “treatment” group of participants would receive training on the Safe Childbirth Checklist and also support using it following the roll-out, whereas the second “control” group would initially only receive the integrated training package and the Checklist would not be rolled out until shortly after the end of the study period.

OUTLOOK:
Some important first steps towards better quality standards in obstetric care
The first technical working group meeting to adapt the Safe Childbirth Checklist was held in September 2015. Baseline data collection was carried out in January-February 2016 and, in March 2016, Jhpiego started the initial Basic Emergency Obstetric and Neonatal Care training sessions and held the first workshop on the adapted Safe Childbirth Checklist. By November 2016, all health care staff has received the 4-day Basic Emergency Obstetric and Neonatal Care training session. After the training sessions, 126 of 141 birth attendants were able to demonstrate minimum delivery skills when assessed using the Objective Structured Clinical Examination scoring framework. Feedback from all health providers about the trainings was very positive.

Half of the targeted health providers in both districts have additionally received the one-day orientation on the Safe Childbirth Checklist. Hence, a total of nine public health facilities, twenty-five Lady Heath Visitors, and forty-seven community midwives are using the adapted Safe Childbirth Checklist. Initial reports from community midwives suggested that the roll-out monitoring had boosted confidence and was encouraging better standards of care and adherence to the Checklist. First data analysis showed that the regular use of the partograph increased from less than 30% among the majority of health providers to 100%.

Following the end of the RMNHP in March 2017, the University of Göttingen will continue with the monitoring and data collection activities until the endline assessment. This will take place in April/May 2017. The financing of the final phase of the Checklist evaluation will be covered by the Universities own funds. The final roll-out of the Safe Childbirth Checklist to all remaining providers is planned for July 2017. A coordination group meeting involving all stakeholders will be held in Pakistan at the end of the study to disseminate the final results.