Implementing Innovative Solutions for Effective Referral for Critical Maternal and Newborn Health Conditions in Ethiopia

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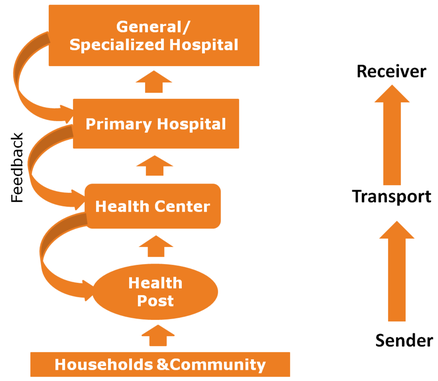
Country Background

- Ethiopia is a highly populated country with 83% rural population. MDG4, reducing under five mortality by 2/3rds has been met (45 67/1000 live births. Reducing maternal mortality remains a challenge (MMR 676/100,000 live births)
- Access to service increased through the government Health Extension Flagship Program, supported through the Health Development Army for Community mobilization and skilled care
- Major national efforts to improve maternal mortality currently include mobilizing communities to encourage pregnant mothers to give birth in health facilities; creating effective supportive and referral linkages within the primary health care units; staffing health centers with midwives to ensure continuous availability of basic emergency obstetric care services, and the provision of ambulances to *woredas* to mitigate transportation barriers

Ethiopia's Health Structure and Referral Network



L10K Project Overview

- The Last Ten Kilometers (L10K) Project, funded by the Bill and Melinda Gates Foundation and implemented by JSI Research and Training Institute, Inc. (JSI) aims to strengthen the bridge between Ethiopian families, communities, and the Health Extension Program and contribute to the achievement of sustainable maternal, neonatal and child health (MNCH) improvements at scale (in 115 districts).
- Through Community Based Data for Decision Making (CBDDM) which is simple map used by HDAs for surveillance to identify priority RMNCH service needs of individual households for targeted intervention. In the eight Primary health care units (PHCUs), care-seeking and referral builds on the platform activity and the platform activities increase contact with women during pregnancy, delivery and postnatal period

Why Referral?

- There is widespread acceptance of the importance of referral in the field of MNCH, as they increase both the number of women who deliver with a skilled birth attendant, and the number of women who receive necessary emergency obstetric care (EmOC). However, referral remains "under-documented, under-researched and under-theorized."
- With increased emphasis on health care systems and systems thinking, referral is being prioritized more frequently internationally, and by the Ethiopian Ministry of Health

Change Idea

- To bring about an increase in care-seeking and referral uptake through innovative ideas emerging from community engagement.
- Through the process, ensure appropriate management of complications at community, health post and health center levels, and appropriate handoff at referral hospitals. This approach is thought to increase local ownership of the referral process.

Testing a 3-step model for improving referral

1. Mapping / needs assessment to look at local resources in the community and across the system (such as resources, policies, and attitudes)
2. Information from the mapping / needs assessment are then used in the participatory design of innovative solutions to strengthen the referral system
3. Implementation and active management of the referral system

Step 1

Primary and secondary data used for needs assessment:

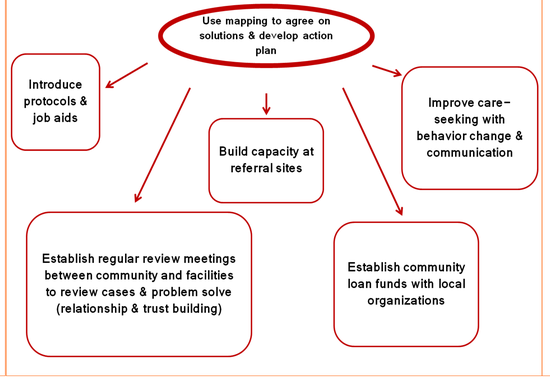
- Desk review
- In-depth interviews
- Key informant interviews
- Focus group discussions with pregnant women and those who gave birth in the last 12 months

Main findings

- Birth is considered normal and happens naturally, hence no need for facility birth
- Minimal decision-making power among women
- Culturally embedded norms
- Unfriendly care at health facilities
- Perceived cost for treatment
- Health care providers do adhere to protocols (information to clients, use of referral slip, alert call, escorting and feedback)
- Most health centers do not do full basic emergency obstetric care (BEMONC) signal function
- Electric and water system maintenance problems negatively affects quality of services.

Step 2

- Each PHCU conducted a day and half consultative work-shop to design innovations to be tested. Attendants were drawn from district health offices, referral hospitals, referral liaison officers, maternity staff, PHCU directors and MNH staff, and community representatives
- The outcome of the consultative process was designing solutions for improving care seeking and referral



Step 3:

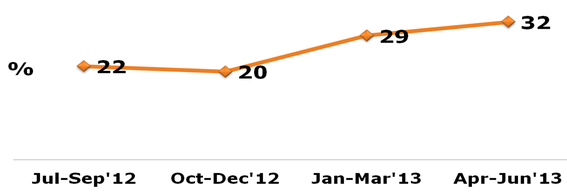
At Health Centers and Hospitals, a focal person for referral was assigned. Among his/her tasks are to:

- serve as a liaison between levels
- act as a contact/focal person
- ensure that the next level is alerted
- track referrals in and out,
- monitor adherence to set protocols and other 'good' referral practices,
- assist with transport,
- follow up with feedback and inform about system enhancements or breakdowns (e.g., ambulance not in service, surgeon on vacation)

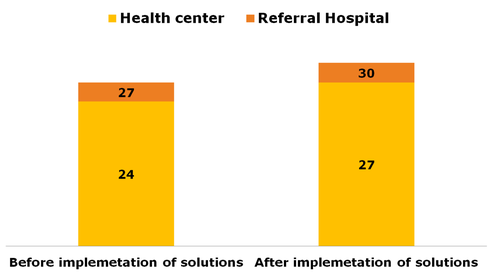
Progress to Date

- Improved team cohesion and personal relationship
- Cross-breeding of experiences from the different PHCUs
- Leadership and support from the referral hospital
- Increased cross-level providers accountability to community

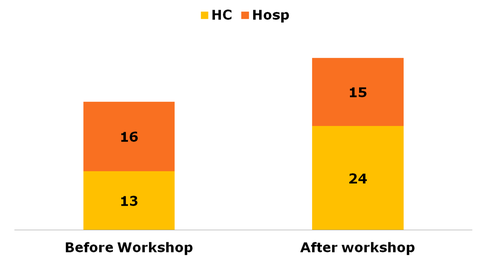
Proportion of Urgent Maternal Referrals that the Community Actively Facilitated



Delivery with a Skilled Birth Attendant



Met Need for Emergency Obstetric Care



Lessons Learned

- The process has helped communities to systematically see specific PHCU resources they could tap and gaps that need to be addressed to improve care seeking and referral in their specific context
- The "Across-level meetings" were an opportunity to look at successes and challenge to improve on performance
- The process has helped communities and providers across levels to own the responsibility for improving referral systems
- The process has shaped the implementation research for prototyping of the process for scale up

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