

Participatory Community Quality Improvement Approach (PCQI) in Ethiopia

The Last Ten Kilometers (L10K) Project

supports Ethiopia's Health Extension Program (HEP) by strengthening linkages between households, communities and the HEP and ultimately improves household and community health practices and outcomes. The HEP—the Government of Ethiopia's flagship program in the health sector—supports the goal of universal primary health care coverage, giving priority to the prevention and control of communicable diseases through active community participation. The main strategy of the HEP is to expand physical health infrastructure, training, and the deployment of a cadre of female Health Extension Workers (HEWs) who will provide basic curative and preventive health services throughout the country.

The L10K Project works in 115 woredas (i.e., districts) covering 13.8 million people in Amhara, Oromia, Tigray and the Southern Nations, Nationalities and Peoples Region. The project examines community solutions that help mobilize families and communities in these woredas to improve household and community reproductive, maternal, neonatal, and child health practices. Much of this work is done by supporting the HEWs extend their reach through mobilizing communities and utilizing a geographically spread network of volunteer community health promoters (CHPs) to promote health messages and practices to families residing in every part of the kebele (i.e., smallest administrative unit).

The PCQI Approach

Participatory community quality improvement (PCQI) is an approach implemented by the Last Ten Kilometers (L10K) Project in Ethiopia to improve quality and accessibility of health care through greater involvement of the community and Health Extension Workers (HEWs).

PCQI's Primary Objective

To improve the quality of community maternal and neonatal health care services by:

- Creating a shared sense of responsibility among the community members and health providers for better health services;
- Stimulating demand for and utilization of quality services; and
- Empowering communities to take initiative and responsibility to improve the quality of maternal and neonatal health services through a continuous quality improvement process.

Using this approach, community members and HEWs are involved in defining, implementing and monitoring the quality improvement process.

PCQI's primary objective is to increase access to and quality of maternal and neonatal health care services in order to improve maternal and newborn health outcomes.

This approach encourages a sense of shared responsibility among community members and health providers for better health services, the stimulation of the demand for and utilization of quality services, and the empowerment of communities to take initiative, responsibility, and ownership of the quality of maternal and neonatal health services through a continuous quality improvement process.

PCQI is being piloted in 90 kebeles (sub-districts) in 14 L10K-supported woredas (districts). Within each of these woredas PCQI is being implemented in one or two health centers, each with five to ten health posts. Each health post serves a population of approximately 5,000 people.



Similar to other community-based quality improvement approaches, PCQI relies on the involvement of community members. First, the community members are critical to identifying the main bottlenecks and barriers to the access and quality of services. Second, community members have the responsibility of monitoring and targeting improvements of access to services and quality of service provision, as well as suggest possible adjustments and advances in these problem areas. Similarly, HEWs meet quarterly to discuss these issues. Then, representatives from each of the above mentioned meetings share their findings through a “Bridging the Gap” workshop, and then establish a Quality Improvement team and a clear plan of action to improve access to and quality of services provided.

Findings

Even though it is too early for quantitative changes in outcomes to be measured, as it is less than a year into the implementation of PCQI, a number of positive changes have been observed using the ‘Most Significant Change’ technique. Some of the barriers to better access to and quality of care identified through the PCQI process include: harmful traditional beliefs, lack of access to services by pregnant and laboring women, lack of services available at night, and HEWs’ insufficient practical experience in assisting with deliveries.

While each community has developed its own strategies to mitigate these challenges, some common themes have emerged. The PCQI process has been instrumental in increasing the involvement of, and sense of responsibility for, the health services provided for the community. This has resulted in a number of community-driven initiatives. Examples include: a firm commitment to the maintenance and improvement of roads leading to clinics, building stretchers to carry laboring or sick women to health facilities, building HEW lodgings near health facilities to enable them to provide emergency services during the night, and a pooling of funds to buy supplies such as a bed and linens for the health posts. In at least one woreda, youth associations have been recruited to assist in transporting laboring women to the clinic.



“Lodging for both HEWs is under construction within the Health Post compound. This is done in response to one of the identified barriers, which was: the inability for HEWs to provide [maternal and neonatal health] MNH services during the night, due to their unavailability after dark.”

Guto Gida Woreda, Oromia Region

To address the lack of understanding in regards to the services provided by the clinic, orientation sessions were conducted at clinics to provide community leaders and members of the general public with a better understanding of the services offered at the clinics, as well as the standards of care that these individuals can expect to receive. In addition, religious leaders and teachers were trained to provide messages condoning harmful practices and to promote the use of health clinics.

“Members of the community have contributed 295 people to maintain 5 km of road ... to help the pregnant mothers get transported easily.”

Adimenaber kebele in Tahatay Koraro Woreda, Tigray Region



Finally, in order to address issues related to gaps in the abilities of HEWs to perform safe deliveries, Quality Improvement teams organized learning exchange visits for HEWs. Visits were conducted to larger health centers that specialize in maternal care so as to provide practical experience for the HEWs in delivery and immediate newborn care. Mentoring is also encouraged and provided on-the-job.



“HEWs were also sent to the Shire MCH specialized clinic to receive ... training on safe and clean delivery – the training included theoretical and practical mentoring on attending deliveries.”

Kola Tembien Woreda, Tigray Region

Recommendations and Next Steps

Less than a year into its implementation, the PCQI approach has noticeably increased community involvement in and responsibility for health service delivery. This involvement has resulted in tangible improvements such as the commitment of community resources for the procurement of beds and stretchers for transporting laboring women, as well as noticeable bettering of infrastructure at the community level (including roads to health facilities). It is anticipated that the PCQI approach could yield similar results in other resource poor settings. Further, this process has helped ensure that HEWs improve their skills in safe delivery through practical experience working with experienced staff at specialized maternal health centers.

In the coming months, JSI will continue to implement the PCQI approach, and will focus on evaluating and documenting the process to further identify and apply lessons learned. Baseline data on service utilization, quality of services, and health outcomes have been collected, and these measurements will be repeated to assess for changes in these outcomes.



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