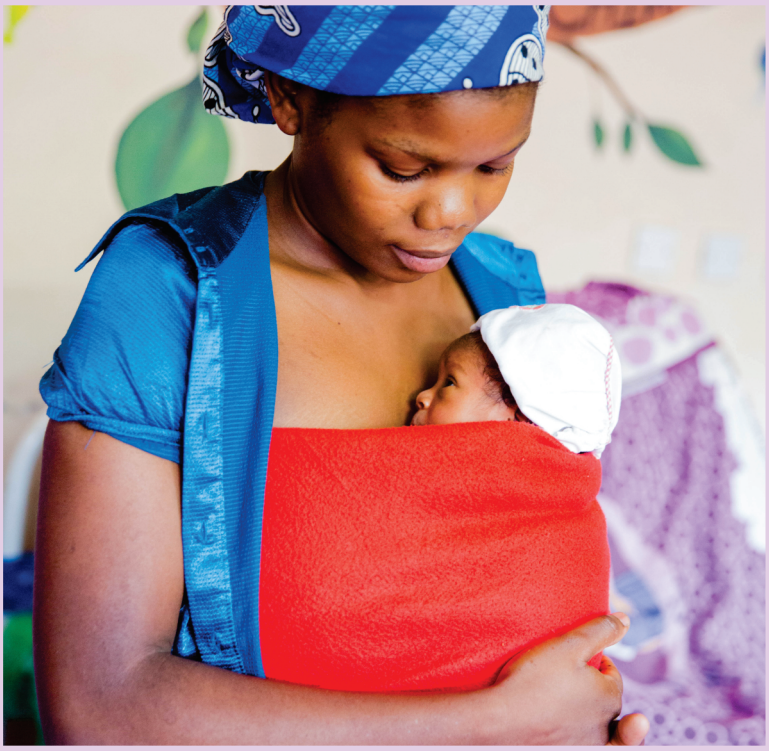
District-Led Quality Improvement and Mentorship for Newborn Care in Malawi: Model for Implementation

Background

Newborn health and survival is a major concern in Malawi with over 13,700 newborns deaths in 2015. Progress on newborn health has been slower than progress on health for children under the age of 5 years. Malawi also has the highest rate of preterm birth worldwide, with 18% of live births occurring before 37 completed weeks of pregnancy. The country introduced Kangaroo Mother Care (KMC) into facilities nationwide in 1999, but an evaluation in 2012 found that only 36% of facilities were making significant progress in institutionalizing the practice. Improving quality of and access to newborn services will be fundamental in order for Malawi to achieve the new Sustainable Development Goal target of ending preventable newborn deaths by 2030.

In order to promote institutionalization of quality newborn services throughout Malawi, including KMC services, Save the Children's Saving Newborn Lives (SNL) program has piloted a locally-driven quality improvement (QI) and mentorship model in two district hospitals in Malawi's Southern Region: Thyolo and Machinga. This brief describes implementation of that process, summarizes lessons learned, and provides a model that could be used for implementation expansion in Malawi and in other contexts and countries.



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DETAILS FOR EACH STEP IN THE MODEL FOR IMPLEMENTATION

Planning and Stakeholder Buy-In

Lead Mentor Identification: The lead mentor leads the process, serves as a mentor to district staff, and advocates for necessary changes to be made at all levels. An ideallead mentor is a newborn heath specialist and leader (perhaps a pediatrician working in a hospital) who is well-respected by staff and MOH officials alike.

National-Level Meetings: Meetings held with national-level MOH officials are crucial to ensure buy-in and to gather essential input on QI plans.

Zonal-Level Meetings: These meetings include key zonal and national officials. Participants discuss quality of current services, agree on the QI and mentorship process, identify focus districts, and ensure zonal-level ownership.

District-Level Meetings: These meetings ensure that district leaders drive the QI and mentorship process based on their self-identified needs. They include all staff that work on maternal and newborn health. Participants agree on the importance of quality care for newborns, discuss issues for improvement, and agree on the proposed process.

Start-UpActivities

Designation of Dedicated Staff and Space for Newborn Care: QI requires non-rotating staff that are dedicated to care of newborns, so they can learn about issues specific to newborns and continuously improve quality of care. Creation of a neonatal ward (even through partitioning) is a key intervention that should be strongly considered.

Focal Person Identification: Focal persons are usually clinical and nursing leads for newborns in the hospital and are chosen by hospital management to serve as the primary contact and on-site coordinator for the lead mentor, bring QI issues to management when needed, and train to serve as on-site mentors to other staff.

Mentorship Start-Up: Initial mentorship visits involve the lead mentor walking through the wards with staff to discuss cases and teach on a case-by-case basis, identifying primary issues, and advocating to make necessary initial changes.

Introduction of Standardized Monitoring Forms: Initial mentorship visits also include teaching staff to use and maintain monitoring forms for newborns. The forms ensure standardized data on and monitoring of each newborn, enable staff to assess treatment needed for each case, and inform discussion of patients during mentorship visits.

Baseline Data Collection: Collection of baseline data is facilitatedby the lead mentor and enables cross-hospital learning, as select staff from each hospital are invited to participate in the assessments of other hospitals.

Ongoing Process

Capacity Building

On-Site Mentorship: The lead mentor conducts on-site mentorship visits at each hospital every 2 weeks. Visits start with ward rounds, during which the lead mentor reviews each patient chart with neonatal ward staff and continuously asks questions to facilitateon-the-job learning. Later, the lead mentor facilitates teaching sessions that cover essential knowledge and skills, using examples from cases seen on the ward. Mentorship and teaching sessions also include preparing high-performing staffto serve as on-site mentors for other staff.

Attachment Mentorship: Groups of 2-3 staff at all levels from district hospitals come to a central hospital for 2 weeks of intensive on-the-job training. Staff must be assigned to the neonatal ward upon their return. Staff fill out a form setting their expectations for learning, and they shadow central hospital staff for the first few days. During the rest of the first week, they work under close supervision, and for the second week they function as part of the staff. On the final day, theymeet with the lead mentor and write a report on their experience and plan for continuous improvement.

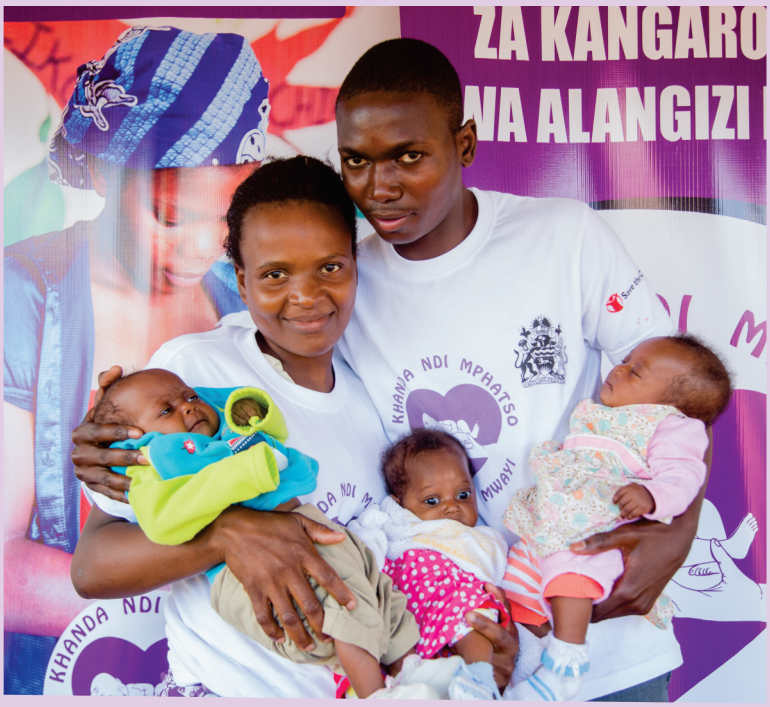
Neonatal Death (NND) Audits: All staff working on newborn and maternal health meet once a month for an audit, in which they discuss the case notes for all NNDs including Fresh Still Births (FSB) from which they generate data to determine areas of success and challenges. Staff prioritize the issues that they want to work on and identify 5 action items for the following month.

Feedback Loops with Hospital Management and Officials at All Levels: The lead mentor meets with district officials after each hospital visit to give a progress update discussareas that need attention. Audit results are also presented at zonal review meetings to discusschallenges and improvements and to maintain buy-in from zonal officials. The lead mentor addresses issues needing government attention directly with MOH officials to advocate for change.

Monitoring, Evaluation, and Scale-Up

Monitoring and Documentation: Regular monitoring visits and interviews with hospital providers allow for consistent documentation of lessons learned. Follow-up and endline assessments are also conducted using the same tools employed for the baseline assessment to evaluate progress.

Spread and Institutionalization: Working with partners, sharing results, and continuously identifying new mentors at all levels ensures spread of the QI process to other districts and increased buy-in from stakeholders nationwide.



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