Background

The Rebuilding Basic Health Services (RBHS) project has been committed to promoting quality of care through a process of continuous quality assurance (QA). Examples include supporting the Ministry of Health and Social Welfare (MOHSW) to develop both the Basic and Essential Packages of Health Services (BPHS and EPHS, respectively), and conducting a baseline study to measure compliance with the BPHS standards at RBHS-supported facilities. In addition, RBHS succeeded in building MOHSW capacity in the development of inpatient clinical standards and rolling them out through the introduction of an improvement collaborative (IC) in four RBHS-supported hospitals in August 2013.

The Liberian Health Context

Liberia is a small country with a population of approximately four million people. The country has faced many challenges over the last 20 years that have affected its health system and national health indicators. These indicators include a very high maternal mortality ratio (MMR) of 770 deaths per 100,000 live births (in 2011),\(^1\) an infant mortality rate (IMR) of 71 deaths per 1,000 live births, and a mortality rate of 110 deaths per 1,000 live births for children under age 5 (U5MR).\(^2\)

Based on these indicators, the MOHSW, supported by a group of health experts with knowledge of the main health issues in Liberia, prioritized a number of inpatient standards to be rolled out in the first phase of secondary EPHS implementation. High priority was given to clusters of standards for obstetrics/neonatal, pediatrics, and infection prevention, based on their proven effect on reducing maternal, neonatal, and child mortality. RBHS introduced a demonstration IC in four MOHSW hospitals that aimed to roll out those standards and contribute to the reduction of maternal, neonatal, and child mortality in Liberia.

What is an Improvement Collaborative?

An IC is a quality improvement approach that organizes teams or health facilities to work together to rapidly achieve significant improvements in processes, quality, and efficiency of a specific area of care, with the intention of spreading these methods to other sites.\(^3\) The intention is to accelerate both the pace and geographic spread of the technical package, even

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“THE [IMPROVEMENT COLLABORATIVE] APPROACH IS VERY GOOD, IT’S EYE OPENING.”

— MARIE PADMORE, SERVICES DIRECTOR, CB DUNBAR MATERNITY HOSPITAL IN BONG COUNTY

In the context of weak health systems facing severe material and human resource constraints. The IC methodology focuses on the efforts of health facility teams that learn together, rather than individual sites working on their own. The approach relies on training, job aids, coaching, and encouraging shared learning through regular sessions and the diffusion of innovations. The IC method was selected for implementation in Liberia for three reasons: 1) its proven effect on improved quality and building of local capacity and country ownership, which also supports institutionalization of the selected best practices; 2) the fact that the selected best practices were facility-based, which was beneficial for the creation and capacity building of QA teams who already worked together on a daily basis and thus had no recurrent cost for daily team interactions; and 3) the MOHSW’s commitment, stewardship, and support to rolling out the standards and improved quality of care.

Introducing the Improvement Collaborative to RBHS-Supported Hospitals

Phase 1: Preparation and Planning

In July 2013, RBHS mobilized a team to introduce the IC. The team met very early in the process with key MOHSW stakeholders (i.e., project leadership and ministry officials) to get Ministry buy-in and expertise for the IC design. Stakeholders recommended an organizational structure to manage the process and agreed upon the facilities to be part of the demonstration: one hospital from each of the three counties supported by the RBHS project (Bong, Lofa, and Nimba) and one additional hospital from Grand Bassa. In the introduction workshop held with the quality improvement teams from these four facilities, an agreement was reached on the implementation package, which included: three priority clusters (obstetrics/neonatal, pediatrics, and infection prevention; 14 indicators to monitor the implementation of these standards; checklists to help quality improvement teams comply with the standards; and tools for coaching, supervision, and data collection.

Infection prevention and obstetrics/neonatal practices at RBHS-supported hospitals improved as a result of participation in the IC workshop.

**Phase 2: Implementation**

Implementation focused on capacity building in three major quality improvement (QI) areas: 1) coaching of facility QI teams to strengthen their expertise which includes data analysis; 2) building capacity of the QI teams in the clinical aspects of the implementation package such as compliance with the standards; and 3) learning sessions for exchange of knowledge.

During the learning sessions:

- Teams shared effective changes tested during the past action period, which encouraged other teams to test the same changes in their facilities (for examples of positive changes, see box on the next page).

- Teams developed workplans for the next action period, which included effective changes and solutions to challenges that the teams discussed during the learning session.

- Quality improvements were accelerated primarily as a result of shared learning, but also due to the positive competition during the learning sessions as champion facilities acted as role models for other QI teams.

**Results**

The result of this IC approach in the three hospitals (one hospital dropped out due to reasons not related to the IC) was that the teams were successful in rolling out 31% of the currently developed clusters of inpatient clinical standards (122 out of 391 standards from three clusters) and in achieving high compliance with them over a period of nine months. This is considered a huge achievement given the short time of implementation. Gains were also found in management of labor and delivery and family planning (FP).

There was a gradual improvement in partograph use between the baseline period (May–July 2013) and the seven-month period after the IC introduction (August 2013–February 2014). The three teams worked hard to comply with the standard for partograph use that requires a correct partograph to be filled for every woman in labor. Partograph use allows easy detection and action on danger signs for mother and newborn.

Improvements in FP were also sustained as a result of the IC approach in the three hospitals. FP counseling improved from less than 16% during the baseline period to more than 90% after seven months of IC introduction. Women were counseled...
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on the importance of birth spacing for two years after a live birth and the range of contraceptives that can be used for breastfeeding and non-breastfeeding mothers. Informed choice was the focus of FP counseling and, when requested, contraceptives were offered to postpartum women before leaving the hospital. Thirty-one percent of women across the three facilities, after seven months of the IC, selected a contraceptive method such as lactational amenorrhea method, pills, and injectables.

Way Forward

Following the third learning session, a strategy for scale-up was developed by the QI teams and then further refined by stakeholders. To develop this strategy, the group determined the goals of the strategy, the clinical package of standards recommended for scale-up, the reasons why this package should be scaled up, and the location and time to do it. Additionally, stakeholders discussed who would be responsible for scaling up. Following this meeting, it was agreed that the MOHSW will take the lead in organizing a national-level meeting to refine the strategy and prepare for implementation.

Correct Partograph Use in 3 Hospitals: G.W. Harley, C.B. Dunbar, and Liberia Government Hospital

PPFP Counseling and Services in 3 Hospitals: G.W. Harley, C.B. Dunbar, and Liberia Government Hospital

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