

Process Indicators Reveal Important Information About Programme Effectiveness

Measuring the impact of safe motherhood programmes can be challenging, and other ways of assessing maternal health and survival must often be used. One way to monitor progress is process evaluation—which assesses the performance of a programme rather than its impact on health or behaviour.

Impact, a global research initiative, has enhanced the methods and tools used to measure the effectiveness and cost-effectiveness of safe motherhood programmes using process indicators. Impact focused its research on measuring progress at the district or higher level of the health system, where data was easily collected by routine information systems.

Findings

In developing countries, the unmet need for lifesaving obstetric care among the poor is huge.

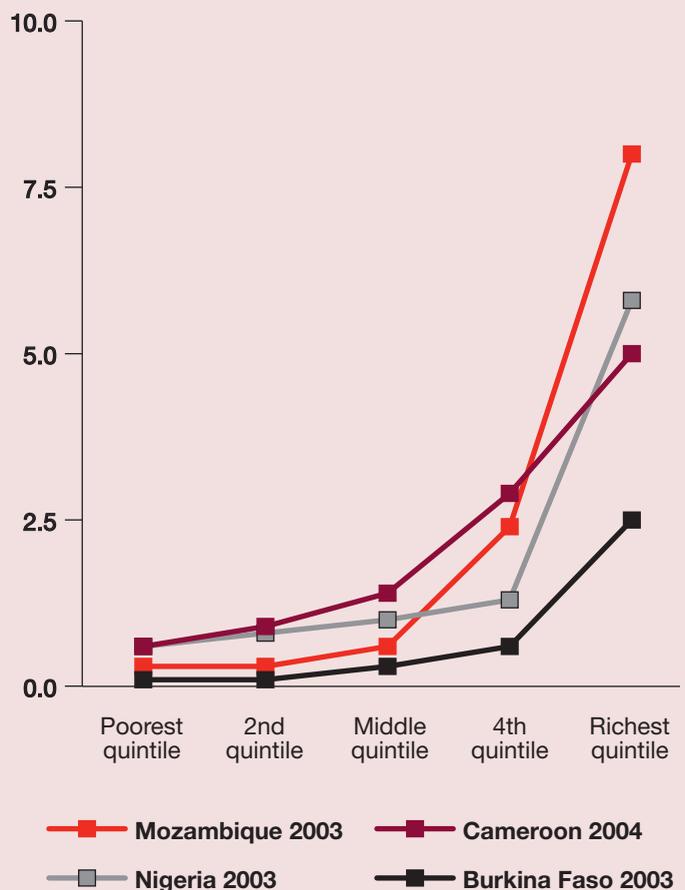
Caesarean rates are extremely useful indicators of access to lifesaving obstetric care, particularly when measured across poverty quintiles. A review of 42 Demographic and Health Surveys revealed that caesarean rates were below 1 percent for the poorest 20 percent of the population in 20 developing countries. This data suggest that the poorest have extremely limited access to lifesaving emergency obstetric care (see figure). Data from Indonesia also illustrate the importance of measuring population-based caesarean delivery rates alongside professional attendance at birth. While professional attendance rates rose dramatically over the last 15 years—particularly among the poor—the increase in caesarean rates occurred mainly among rich women. In other words, the Indonesian strategy of a midwife in every village successfully narrowed the rich-poor gap in rates of professional attendance at birth, but the gap in use of potentially lifesaving emergency obstetric care widened.

“Near miss” is a promising new indicator of access to emergency care and of quality of care.

Impact conducted research on near misses (cases of life-threatening obstetric complications during pregnancy, childbirth, or postpartum). Near miss cases were extremely common in Indonesia and Burkina Faso. In

Caesarean Rates by Wealth Quintile in Four Countries With Rates Below 2 Percent

Percent of births with caesarean delivery



Source: Impact.

Burkina Faso, for example, near misses represented one-third of all admissions in the teaching hospital. About one-third of near miss cases were due to malaria and severe anaemia. Private hospitals accounted for a much smaller number of near miss cases, suggesting that the private sector's contribution to addressing the unmet need for lifesaving emergency care is limited. Interestingly, the large majority of cases in both countries arrived in a critical state at the hospitals, suggesting that the cases

of near miss largely reflect issues of access rather than quality of care in hospitals.

Impact explored the use of near misses as an indicator of access to and quality of obstetric care at the population level. The incidence of near miss cases was between 1,000 and 2,000 near misses per 100,000 live births in Burkina Faso and Indonesia, and was much higher in urban than in rural areas. This finding confirms the role of proximity to hospital in facilitating earlier admission and better chances of survival.

The quality of obstetric care in hospitals and health centres is poor and difficult to measure.

Impact measured the quality of obstetric care in two ways: record review in Ghana and observation of deliveries in Cote d'Ivoire. Observation is the best way to ascertain the quality of basic obstetric care offered by midwives, particularly where the focus is on assessing clinical skills in managing labour and delivery. Record review appears to offer an easier alternative, but the quality of records is such that the distinction between completeness of records and actual performance is difficult to disentangle.

In Ghana, Impact assessed the clinical management of complications—haemorrhage, hypertensive diseases of pregnancy, and deliveries requiring caesarean surgeries—to determine the quality of care provided in hospitals. Overall the quality appeared to be poor. The partograph, a chart used to plot the progress of labour, was used for only one-third of women admitted in labour, and the foetal heart rate was not recorded in one-fifth of women. For caesareans, the time from recognition of complications at the hospital to arrival in the operating theatre was, on average, over two hours, far in excess of the 30 minutes recommended internationally. The findings from a study in four health centres in Cote d'Ivoire were similar: The partograph was seldom (5 percent) completed during labour, and foetal wellbeing was rarely monitored. Interestingly, the time that women spent in the delivery room was surprisingly short (less than two hours), suggesting that women generally arrive too late for the partograph to help manage labour.