We invite you to join our Care-Seeking & Referral CoP webinar:

Re-Visioning Emergency Obstetric & Newborn Care (EmONC)

July 2, 2020 at 9:00 a.m. EDT

Presenters:

Dr. Lynn Freedman, Columbia University Mailman School of Public Health

Dr. Mohammed Ali, ACERS Project

Dr. John Koku Awoonor-Williams, Ghana Health Services

Loveday Penn-Kekana, London School of Hygiene & Tropical Medicine

Theresa Shaver, Sr. Maternal Advisor, USAID

Join the webinar at the following link:
https://us02web.zoom.us/webinar/register/WN_mjpVSqzOTD6kQ9NjyKSuQ

www.harpnet.org

Hosted by USAID’s Coordinating Implementation Research to Communicate Learning and Evidence Project (CIRCLE)
Re-visioning EmONC:
A project to review, rethink and revise the EmONC framework and indicators

Lynn Freedman
2 July 2020
Care-seeking and Referral CoP webinar
Monitoring emergency obstetric care

A handbook
Objectives

• Review and potentially revise the EmONC framework,

• Add newborn and possibly routine delivery care (SFs)

• Harmonize with other measurement, MNH and health systems strengthening initiatives

• Revise 2009 UN Handbook for Monitoring EmONC and

• Provide a roadmap for use of the indicators, including analytic strategies
Re-visioning EmONC project

• Steering committee: AMDD/Columbia, WHO, UNFPA, UNICEF, LSHTM

• Global engagement through:
  – Workstreams with diverse members & country studies
  – human-centered design and human-centered dissemination

• Key to success will be a process for genuine country-level input and direction

• Funding from Gates Foundation & UNFPA
EmOC Signal Functions

1. Parenteral oxytocics
2. Parenteral anticonvulsants
3. Parenteral antibiotics
4. Manual removal of the placenta
5. Removal of retained products
6. Assisted or instrumental vaginal delivery
7. Neonatal resuscitation
8. Blood transfusion
9. Cesarean delivery
EmOC Indicators: Logical Flow of Questions

Availability
- Are there enough facilities providing EmONC?
- Are they well distributed?

Utilization
- Are enough women using these facilities?
- Are women with obstetric complications using these facilities?
- Are sufficient critical services being provided?

Quality of Care
- Is the quality of the services adequate?

What services are needed in addition to EmONC?
### EmOC Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Acceptable level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Availability of EmOC: Basic EmOC &amp; Comprehensive EmOC facilities</td>
<td>For every 500,000 pop., there should be <em>at least</em> 5 EmOC facilities (including at least 1 offering Comprehensive EmOC)</td>
</tr>
<tr>
<td>2) Geographic distribution of EmOC facilities</td>
<td>All sub-national areas have <em>at least</em> 5 EmOC facilities per 500,000 pop. (including at least 1 offering Comprehensive EmOC)</td>
</tr>
<tr>
<td>3) Proportion of all births in EmOC facilities</td>
<td>Minimum acceptable level to be set locally</td>
</tr>
<tr>
<td>4) Met need for EmOC</td>
<td>100%</td>
</tr>
</tbody>
</table>
EmOC Indicators *(continued)*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Acceptable level</th>
</tr>
</thead>
<tbody>
<tr>
<td>5) Cesarean sections as a proportion of all births</td>
<td>5-15%</td>
</tr>
<tr>
<td>6) Direct obstetric case fatality rate</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td>7) Intrapartum and very early neonatal death rate</td>
<td>Standard to be determined</td>
</tr>
<tr>
<td>8) Proportion of maternal deaths due to indirect causes in EmOC facilities</td>
<td>No standard can be set.</td>
</tr>
</tbody>
</table>
Global Guidance on EmOC Indicators

- 5 EmONC facilities per 500,000 population (minimum recommendation)

- At least one of these provides C-EmONC level care; others might be B-EmONCs or additional C-EmONCs

- Defined by the number of signal functions performed in the last 3 months

- “Fully functioning” means all signal functions are performed vs. partial functioning where fewer are performed
Data Collection Modules
(adapted by each country)

0. National Level Information
1. Identification of Facility & Infrastructure
2. Human Resources
3. Essential Drugs, Equipment and Supplies
4. Facility Case Summary / Service statistics
5. EmONC Signal Functions & Other Important Services
6. Partograph Chart Review
7. Provider Knowledge & Competency Interview
8. Cesarean Delivery Chart Review
9. Maternal Death Chart Review
10. Neonatal Death Chart Review
11. Referral
Added to assessments in 2015

• Routine delivery (proposed) signal functions

• Newborn (proposed) signal functions
Examples of some issues raised over the years

- Are they the right Signal Functions?
- Does the two-level categorization – basic & comprehensive -- make sense as a framework?
- Should all SFs actually have to be PERFORMED in a time period in order to be considered “functioning” (so dependent on case load)?
- Should availability be calculated based on population (per 500,000) or births (e.g. per 20,000)?
- Are these the right indicators and the right recommended levels?
- Is this sequence – availability, accessibility, utilization, quality (Tanahashi style) -- the right way to think about indicators or should it be: inputs, process, output, outcomes, impact?
Potential new areas for future EmONC indicators?

• Experience of care measures

• Patient-reported outcome and experience measures

• Equity – which dimensions?

• Referral systems
Country and local level realities

- How to develop indicators and analysis strategies that can raise and overcome the serious implementation challenges in health systems in high-mortality countries?
Coverage of EmONC by Problem Type

- **Planning Problem**: Designated
- **Technical Problem**: Available, Accessible, Acceptable, Ready
- **Adaptive Problem**: Functioning, Functioning equitably, Functioning effectively with quality

Target Population

- **Planning Problem**: 100%
- **Technical Problem**: 100%
- **Adaptive Problem**: 100%
Coverage of EmONC by Problem Type

Target Population

Planning Problem

Technical Problem

Adaptive Problem

Designated

Recommended

Available

Accessible

Acceptable

Ready

Functioning

Functioning equitably

Functioning effectively with quality
Health Facilities designated as EmONC versus Global Recommendations for Minimum Coverage

- Burkina Faso
- Cameroon
- Liberia
- Madagascar
- Sierra Leone
- Somalia

Designated EmONC
Minimum EmONC recommended
Coverage of Recommended EmONC

Source: Cameroon Needs Assessment report and SOWMy data
EmONC availability in high burden countries – analysis of 2016 data from 39 countries supported by UNFPA MHTF

EmONC availability compared to international standard (5 EmONC per 500,000 population)

Country-level engagement and guidance

• What principles, practices and investments do we need to make sure the EmONC indicator review and revision process is truly based on and guided by the realities of implementation of EmONC on the ground?
Thank you!
How does this relate to the lived experiences of women & newborns trying to access care

Loveday Penn-Kekana
London School of Hygiene and Tropical Medicine
Technical Advisor: Care-Seeking & Referral Community of Practice
Easy Journeys

- Attending routine ANC (can be from multiple providers)
- Attending postnatal care
- Babies to well baby clinic

- During the day
- Can be planned for
- Not too far
- Free or low cost
- Public transport might be available
- Woman and baby well
- Doesn’t need accompanying
Not So Easy Journeys

- Woman referred in ANC (but generally well)
- Baby referred (but generally well)
- Baby referred to other services (but generally well)

- During the day
- Can be planned for
- Likely to be further away and cost more
- Public transport might be available
- Other costs incurred
- Woman and baby generally well
- Doesn’t necessarily need accompanying
Uncomfortable Journeys

- Woman in normal labour to a facility to deliver
- Woman home from the hospital after delivering
- Unwell baby to facility
- Can be any time of the day or night
- If at night – maybe security issues
- Might need to arrange or hire private transport – so more expensive
- Body fluids
- Urgency
- Companion needed
- Ergonomics
- Women / Baby in pain
Emergency Journeys

- Pregnant woman seriously ill
- Woman in labour with complications home to facility
- Woman in labour with complications facility to facility
- Sick & small newborn facility to facility

- Can be any time of the day or night
- If at night – maybe security issues
- Might need to arrange or hire private transport – so more expensive
- Body fluids
- Urgency
- Companion needed
- Ergonomics
- Woman/ Baby In Pain
- Everyone extremely stressed
Skilled birth attendant strategies

Go to maternity waiting home ahead of labour

Routine transport pathways

Facility with routine care only

Facility with routine care & BEmOC

Facility with routine care & (or alongside midwife unit) & CEmOC

Emergency transport pathways

Maternity Waiting Home

0

1

2

3

4

Home

Facility with routine care only

Facility with routine care & BEmOC

Facility with routine care & (or alongside midwife unit) & CEmOC

Conclusions

- In the discussions at a national and international level about what levels of care, staffing and equipment should be/ can be provided and where ....

- We need to not forget the journeys that women and newborns have to make to get to, between and home from these levels of care

- Not all of these journeys need to be or should are or need to be in emergency transport – but we need to think more about them in our planning and documenting of services
Re-Visioning Emergency Obstetric & Newborn Care (EmONC)

Reflections from the ACERS Project

Mohammed Ali, John Koku Awoonor-Williams, Rachel T. Moresky and Bawah Ayaga

July 2, 2020
ACERS delivers innovative interventions, leverage community support systems and structures in existing healthcare system to improve care-seeking and strengthening of referrals for EmONC while learning and documenting to inform related policies and guidelines.

- **Duration:** 3 years (Sept. 2018 – Sept. 2021)
- **Location:** Oti and Northern Regions

- **Consortium members:**
  - Catholic Relief Services (CRS),
  - Ghana Health Services (GHS),
  - Columbia University (CU) &
  - Regional Institute for Population Studies (RIPS) - Ghana

Focus: Emergency Referral Systems & Acute Care
Organization Structure of Ghana’s Healthcare System

Key: → Supervision  ————> Patient referral
Journeys in Search of EmONC Services, Our Story Map
Journey for EmONC Service in ACERS Settings: What are Systems and Structures?

D1. Community Demand Generation: Identification of complications/Care seeking

D2. Timely Referrals: Reaching Care Stabilization: from the onset of emergency until definitive care

D3. Receiving Quality & definitive care Care

First Level: CHPS/HC (B-EmONC)

2nd/3rd level: District Hospital/Teaching Hospital (C-EmONC)

Community
First responders
MMT drivers

Midwives
Community health officers

Ambulance systems: NAS/MMAs

IMMTs

Catholic Relief Services
Columbia
Univ of Ghana
MS School Pub Health

Hyperlinks:
[ACERS] [EmONC] [Catholic Relief Services] [Columbia] [Univ of Ghana] [MS School Pub Health]
ACERS Design and EmONC Services: the Theory of Change

INPUTS

- Human Resources - community and Health System
- Equipment & Supplies
- Infrastructure (MMAs, EDCs, etc.)
- Technical Expertise & Relevant work

INTERVENTIONS/ACTIVITIES

- Implementation Research (Baseline, Ongoing & Endline)
- Community Demand Generation
- Timely Referral

OUTPUTS

- Evidence of ACERS IR work shared and advocated for integration into GHS EmNOC policies and strategies
- Communities and target clients sensitized on ACERS Demand Generation Package
- Community Emergency Transport System & Emergency Dispatch Center are established and in use
- Quality Improvement strengthened and implemented across levels

OUTCOMES

- 1. GHS EmONC programming is informed by the evidence generated from ACERS IR
- Pregnant women/neonates:
  - 2. Seek timely, affordable, high quality EmONC services
  - 3. Receive, and caregivers provide, high quality, accessible emergency referral services informed by clinical and operational data
  - 4. Receive, and caregivers provide, a positive user experience and high quality, timely, definitive EmONC services

ASSUMPTIONS:

I = Exchange knowledge & ideas among stakeholders will be effective
II = Stakeholders will view ACERS package as acceptable, appropriate and feasible
III = Social & financial services is reduced; Knowledge and empowerment approaches are appropriate
IV = ACERS community package of services is appropriate & acceptable to communities
V = ACERS referral package is acceptable & feasible to HCPs and implemented with fidelity
VI = Referrals services are acceptable and affordable and accessible to women & neonates; EDC activates timely referral pathway
VII = ACERS Clinical package is feasible and acceptable to HCPs and implemented with fidelity
VIII = Quality of care interventions are effectively used; Competent HCPs are motivated to provide timely EmNOC; Receiving facilities are equipped to manage EmNOC cases in a timely manner using correct pathways

Advancing IR Approach in GHS

Patient Pathway to Care