How to do (or not to do) . . .

Obstetric audit in resource-poor settings: lessons from a multi-country project auditing ‘near miss’ obstetrical emergencies

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This paper outlines the practical steps involved in setting up and running multi-professional, in-depth case reviews of ‘near miss’ obstetrical complications. It draws on lessons learned in 12 referral hospitals in Benin, Côte d’Ivoire, Ghana and Morocco. A range of feasibility indicators are presented which measured the implementation and frequency of audit activities, the quality of participation, adherence to the planned protocol for the near-miss audits, the quality of audit discussions and the sustainability of the project. Although the principles of the audit approach were well accepted and implemented everywhere, near-miss audits appeared most successful in first referral level hospitals. Contextual factors that determine the successful implementation of near-miss audit include staff finding adequate time for audit activities, financial incentives to groups rather than individuals, involvement of senior staff and hospital managers, the ease of communication in smaller units, the employment of social workers for the incorporation of women’s views at audits, and the strength of external support provided by the research team. The poor quality of information recorded in case notes was recognized everywhere as a deficiency, but did not present a major obstacle to effective case reviews. Ownership and leadership within the hospital, more easily achieved in the first-level referral hospitals, were probably the most important determinants of successful implementation. Sustainability requires a commitment to audit from policy makers and managers at higher levels of the health system and some devolution of resources for implementing recommendations.

Key words: audit, obstetrics, complications, near-miss, maternal health, methodology

Introduction

Effective clinical care provided by a responsive health system is the cornerstone for the reduction of maternal mortality in poor countries (Goodburn and Campbell 2001). Guidance on how to introduce and implement quality assurance systems in developing country hospitals has been limited. Audit is one such mechanism, defined as: ‘the systematic and critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient’ (Department of Health 1989; Crombie et al. 1997). Ensuring that care processes adhere to quality standards is one of the best approaches to improving the quality of health care in resource-poor settings (Reerink and Sauerborn 1996); and specifically for preventing maternal deaths (Graham et al. 2000). Audit aims to address and improve technical accuracy of diagnosis or treatment, but can also address timeliness of interventions, service organization, and staff roles and responsibilities (Ronsmans 2000).

Since the United Kingdom’s introduction of Confidential Enquiries into Maternal Deaths in 1952 (Department of Health and Social Security 1982), the use of audit as a tool to promote quality of care has evolved and been applied more widely (Lawrence and Schofield 1993; Crombie et al. 1997). Audits, which is typically represented as a cycle, starts with a review of current clinical practice, progresses to setting standards for care, monitoring practice against these standards, analysis of findings, assessment of options for change and implementation of new practices, finally returning to the starting point of reviewing the newly instituted practice (Crombie et al. 1997). Approaches on how to review clinical practice vary substantially, ranging from informal discussions of a selected number of cases among peers to structured reviews involving the statistical analysis of a large number of cases. An example of the latter is criterion-based clinical audit, where a set of explicit, measurable criteria for case management are agreed which can then be used to monitor practice and determine if standards of care have been met, through a review of patients’ case notes (Graham et al. 2000).

While in peer reviews of individual cases, a method widely used in the UK, implicit criteria which are based on clinical judgements are the norms (Robinson 1994).
Elements of the audit cycle have been instituted or piloted in low- and middle-income countries over the last decade, mainly restricted to approaches for ascertaining the causes of maternal deaths. These include confidential enquiries into maternal deaths in several middle-income countries (Walker et al. 1986; Ministry of Health 1994; Department of Health 1998; Suleiman et al. 1999); and the verbal autopsy method, where relatives of the dead woman are interviewed (Kwast et al. 1989; De Muylder 1990; Fawcus et al. 1996; Langer et al. 1999; Walraven et al. 2000; Supratikto et al. 2002; Ronsmans et al. in press). However, guidance on the use of audit in resource-poor settings, where health facility staff themselves identify and analyze deficiencies and apply the findings to improve their patient care practices, is limited.

The aim of this paper is to outline the practical steps involved in setting up and running multi-professional, in-depth case reviews of what are termed ‘near miss’ obstetrical complications. These refer to women ‘in whom immediate survival is threatened and who survive by chance or because of the hospital care they receive’ (Ronsmans and Filippi, in press). The rationales for auditing these events are that they are more common than maternal deaths; because the woman has survived and her views and experiences of care can inform the audit; and because they allow staff to consider the positive aspects of care that contributed to the woman’s survival, as well as identifying and analyzing elements of poor care. The paper draws on lessons learned through conducting near-miss audits in referral hospitals in Benin, Côte d’Ivoire, Ghana and Morocco. Achievements and problems encountered are presented, followed by an analysis of contextual factors likely to determine success or failure, concluding with a summary of lessons for implementing audit in resource-poor settings.

**Near-miss audit project**

**Settings**

The study took place in 12 hospitals in Benin, Côte d’Ivoire, Ghana and Morocco, during 1998–2001, and was conducted by local research institutions, supported by researchers from the United Kingdom, Belgium and Italy. Hospitals (identified in this paper by letters rather than their actual names) were purposely selected to include first-level referral hospitals in all countries, and more specialized – regional (identified in this paper by letters rather than their actual names) were purposely selected to include first-level referral hospitals in all countries, and more specialized – regional and/or teaching – hospitals in Benin, Côte d’Ivoire and Ghana (see Table 1). The near-miss incidence in these hospitals varied from 1.2 to 22.9 cases per 100 deliveries, while the maternal mortality ratio ranged from below 100 to above 3000 maternal deaths per 100 000 live births (Sahel et al. 2002; Filippi et al. forthcoming). Maternity units differ considerably in size, as expressed by the number of maternity beds (from 5 to 200) and midwives (4 to 185).

**Introducing and piloting the audit approach**

The audit approach was introduced in stages. First a near-miss audit enquiry committee was established in each country, comprising relevant policy makers and obstetric specialists. Then an international workshop followed by national workshops were held to agree the types of ‘near-miss’ complications to be audited: hypertensive disorders of pregnancy, haemorrhage, infections, obstructed labour and anaemia. Case definitions were agreed, national and international protocols for managing these complications were reviewed, and a framework for analyzing case management was developed. Audit meeting guidelines and data collection tools were prepared and audit moderators (usually senior doctors or midwives) and core audit teams from each hospital were trained in how to conduct audit meetings. This preparatory phase was followed by a 6-month piloting of the audit approach in each hospital. Findings, audit methods and objectives were reviewed at interim country workshops; and a second phase of audits was then conducted, with sometimes adjustments in methods, followed by a final assessment of lessons learned.

**Near-miss case review methods**

We chose to conduct multi-professional case reviews because many types of staff and different types of services contribute to the care of women with obstetric emergencies (Maresh 1994). They also encourage local ownership, problem-solving approaches to sub-optimal care and could be done with modest extra resources (Crombie et al. 1997; El-Amin et al. 2002). Practical steps of the audit process are presented in Box 1. Audit guidelines recommended that all those involved in the care of the women whose cases were being audited should attend the audit meetings, including doctors, midwives, laboratory staff and administrators. As an introduction to auditing each case, a designated staff member presented a case summary, based on a review of the woman’s case notes. The meeting participants then used the ‘gate-to-gate approach’ to review the appropriateness and timeliness of care activities, from the time the woman arrived in the hospital to the time she was discharged (Box 2). Where they judged that elements of care were below standard, the reasons were explored and recommendations made to ensure sub-standard care did not recur. In Benin, Côte d’Ivoire and Ghana, a social scientist or a social worker interviewed the women whose cases had been selected for audit and reported the women’s experiences of quality of care to the audit meetings. Audit guidelines advised that recommendations should focus on measures that were within the resources and capacity of the hospital to implement. An important ground rule had been established – that audit meeting discussions were to be kept confidential and blame was not to be attributed to individual staff who had cared for the women.

Before starting the audit process, audit teams were advised to develop explicit criteria of care for each type of near-miss for assessing the clinical management of specific complications. External support was provided during the inter-country meetings and some national meetings, promoting the principles of evidence-based medicine and encouraging the use of international case management guidelines. The aim was to introduce an alternative to sometimes outdated textbooks, consensus of opinions or personal experience to guide clinical discussions. Unlike the criterion-based audit, where data on criteria are extracted from a large number of cases and achievements towards targets are measured...
Table 1. Characteristics of participating hospitals

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Benin</th>
<th>Côte D'Ivoire</th>
<th>Ghana</th>
<th>Morocco</th>
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<tbody>
<tr>
<td>Hospital A (Teaching/tertiary level)</td>
<td></td>
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<tr>
<td>No. of maternity beds</td>
<td>78</td>
<td>138</td>
<td>138</td>
<td>16</td>
</tr>
<tr>
<td>No. of doctors covering maternity*</td>
<td>19</td>
<td>185</td>
<td>185</td>
<td>16</td>
</tr>
<tr>
<td>No. of midwives</td>
<td>42</td>
<td>42</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>1 to 1 monitoring*</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Availability of O negative blood*b</td>
<td>Sometimes</td>
<td>Sometimes</td>
<td>Sometimes</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Availability of caesarean sections*c</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
</tr>
<tr>
<td>Maternal mortality ratio*e</td>
<td>1200</td>
<td>138</td>
<td>138</td>
<td>138</td>
</tr>
<tr>
<td>Maternal near-miss incidence*f</td>
<td>10.4</td>
<td>10.4</td>
<td>10.4</td>
<td>10.4</td>
</tr>
</tbody>
</table>

Notes: a Maternity has an area specifically assigned for very ill patients where 1 to 1 monitoring can take place; b O negative blood is available in blood bank 365 days/365 days, 24h/24h; c caesarean sections can be done in the service 365 days/365 days, 24h/24h; d emergency drugs are immediately available in the service; e per 100 000 live births (rounded figure) – (in Benin and Ghana, data are for 1999; in Côte d'Ivoire for 2001; in Morocco for 2000); f per 100 deliveries.
Box 2. Case review framework

Identification of deficiencies (gate-to-gate approach)
- Referral
- Admission
- Diagnosis
- Treatment
- Monitoring and further treatment
- Discharge

Identification of reasons for deficiencies
- Personnel
- Drugs
- Equipment and supplies
- Protocols
- Organization and administration
- Patient and family
- Infrastructure

Evaluation of feasibility

The feasibility, enabling factors and obstacles to implementing clinical audit were evaluated, mainly qualitatively, using: the observational notes of audit implementation and 223 audit meetings that had been prepared by local and international researchers (several of whom became the authors of this paper); analysis of audit documents including minutes and lists of attendance for 228 meetings; and 162 individual interviews with audit team members and other hospital staff conducted by the local and international researchers. The results of four group evaluations were also used. On this basis, a range of feasibility indicators were prepared, which measured the implementation and frequency of audit activities, the quality of participation, adherence to the planned protocol for the near-miss audits, quality of audit discussions and the likely sustainability of the project (Table 2).

Achievements

Hospital audit teams were successfully established in all hospitals and a range of categories of staff involved directly in the care of the cases attended audit meetings, including administrators, midwives and obstetricians (Table 2). Ten out of 12 teams met regularly until the end of the project. The two exceptions were Hospital D in Benin, where two lead moderators left in succession, and Hospital H in Ghana, where audit team meetings were infrequent because the project failed to engage sufficient commitment from senior staff, notably the Head of the Obstetrics Department (Brugha et al. forthcoming). Midwives were actively involved almost everywhere and often moderated meetings in eight, mainly first-level referral hospitals. The ground rule of avoiding blame was well accepted, if not always adhered to in two hospitals, where the care provided by a named staff member was frequently debated.

The poor quality of information recorded in women’s case notes was often recognized as a deficiency, but did not present a major obstacle to effective audit when staff who had cared for the woman were present and could contribute missing information. The improvement of recording practices by doctors and nurses was a recommendation of audit meetings in all hospitals, and the quality of patient records improved during the course of the project in some. Hospital audit teams expressed appreciation of the audit meeting process, notably that it promoted discussion and reflection on their own quality of care practices in a non-hierarchical environment, involving different categories of hospital staff. They expressed interest and sometimes surprise during audit meetings on hearing the views of the women, as they generally had not been aware of their expressing negative attitudes to the women or their failure to explain to the women what care they had received. The women’s views were presented at the audit meetings in three of the countries; and separately at the end of each audit cycle in Morocco.

Audit teams identified areas for quality of care improvement...
### Table 2. Feasibility evaluation of near-miss audit project in Benin, Côte d’Ivoire, Ghana and Morocco

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<tbody>
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<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>Y</td>
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<td>12</td>
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<tr>
<td>NMEC meets regularly</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<td>Hospital teams set up</td>
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<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Regular meetings till the end</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>NMEC meets regularly</td>
<td>N</td>
<td>N</td>
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<tr>
<td>Regular participation of Ob/Gyn Heada</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Active participation of midwives</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>Y</td>
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<td></td>
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<td>11</td>
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<tr>
<td>Midwives leadership in meetingb</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
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<td>N</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Views of women presented at meeting</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y/N</td>
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<td>N</td>
<td>N</td>
<td>8.5</td>
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<td>Hospital teams produced detailed audit documentation</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td>Implemented solutions go beyond feedback</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>12</td>
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<td>Objective standards used during audit</td>
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<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
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<td>Y</td>
<td></td>
<td>4.5</td>
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<tr>
<td>Audits continue after project end</td>
<td>N</td>
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<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
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<td>5</td>
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<tr>
<td>Preparations made for scaling up</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>Scaling up achievedd</td>
<td>N</td>
<td>N</td>
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<td>N</td>
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<tr>
<td>Total yes</td>
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</table>

*Notes:* Y: yes; N: No; Y/N: sometimes.

a attend > 75% of meetings; b midwives moderated meetings on occasion (at least once in each cycle); c one meeting only; d at the time of writing this paper.
Factors that determine successful implementation of audit

Competing for staff time

Finding adequate time for staff to carry out audit activities is one of the principal barriers to institutionalizing audits (NICE 2002). The average duration of audit meetings was between 1.5 and 2 hours, within which one or two cases were reviewed in-depth. Meetings were scheduled to take place monthly in each hospital, at a fixed time and place, usually towards the end of the morning or the beginning of the afternoon when there were reduced clinical activities.

These were busy referral hospitals, with a high patient load, including emergencies to which staff had to respond promptly. This was a major obstacle if staff who had cared for the case being audited were absent from the meeting, especially when case-notes were of poor quality. Staff involvement in activities outside of their hospitals also interfered. Staff in some hospitals supplemented their income by working outside routine working hours. Several obstetricians in urban specialist hospitals had off-site private practices; not infrequently they were interrupted by their mobile phones during meetings or were called away. In district and rural hospitals, it was not uncommon for senior doctors, especially those with management responsibilities, to be called at short notice to meetings and workshops, which necessitated rescheduling audit meetings.

The time commitment and effort to prepare for and conduct audit meetings is considerable, especially for staff who are responsible for preparing case summaries and recording audit meeting processes. It is only feasible if it is given a high priority by senior staff and those higher in the health system (see below); and also requires that staff are motivated and remunerated adequately so that their primary commitment is to on-site clinical care.

Incentives

The near-miss audit project entailed hospital staff taking on additional duties, on top of routine commitments. Staff were also aware that this was, relative to their salaries, a well-resourced research project, employing some full-time researchers. The decision to provide incentives to encourage staff to take on additional duties was hotly debated among researchers. In Ghana, Benin and Côte d’Ivoire, the project awarded a relatively generous stipend to core members of hospital audit teams for audit meeting preparatory activities and completion of research data collection forms; and in Ghana a small allowance as well as refreshments to all audit meeting participants. In Morocco, audit teams were given a computer; while in Benin, they were given a sum of money to administer themselves over the full length of the project which, among other uses, reimbursed them for transport. In Benin and Morocco, awarding incentives to audit teams was believed to have promoted team spirit, whereas the absence of this practice was reported to have undermined wider involvement of maternity staff in the tertiary hospital in Ghana.

Financial incentives can be unavoidable (and understandable), where a new activity is being piloted under research conditions in resource-poor settings (El-Amin et al. 2003). However, quality assurance systems are unlikely to become embedded and sustainable in such settings if reliant on them. In Morocco and a handful of Beninese hospitals, alone, audit meetings continued after the project ended. Interviews with participants in other countries reported that staff wished to see the audit meetings continue, underpinned by policy directives from higher levels of the health system.
Local leadership

Involvement and regular attendance at audit meetings by senior staff, particularly department heads, was critical; where provided, leadership encouraged high attendance by more junior staff. An example of lack of leadership was at Hospital H, the Regional Hospital in Ghana, where the head of the Obstetrics Department retired soon after the project started. Despite efforts to involve him, his successor showed little interest and, instead, prioritized staff attendance at morning department meetings and monthly mortality meetings, which were well attended. The multi-disciplinary review and scrutinizing of case management, often of cases that had been managed by senior medical staff, helped to deconstruct hierarchical and professional boundaries, especially in the smaller hospitals in all four countries. This can be a powerful, ‘soft’ effect of the audit approach, especially in settings where open critical comment on the practices of senior staff is usually avoided. By auditing near-miss events, where the woman had survived the complication, criticism of substandard care could be balanced by acknowledgement of the ultimately positive outcome.

Involvement of hospital managers

The involvement of hospital managers was seen as central to the project, in that many recommendations required action by management. In Morocco, district managers and hospital directors actively participated in the selection of cases for discussion, and attended all the audit meetings. Elsewhere, attendance by managers was sporadic or rare. Various factors may have accounted for this, for example low levels of importance attached to the initiative and perceptions that this was an activity for clinical staff. A plausible reason was a reluctance by managers to attend meetings where requests would be made of them which they could not fulfil. An example of this in Ghana was the plea to an audit meeting by one hospital manager to stop making recommendations that required money (Brugha et al. forthcoming).

A project hypothesis was that quality improvements could more easily be achieved in resource-poor settings if recommendations were restricted to those that could be implemented within available resource limitations (Reerink and Sauerborn 1996). While this was useful and acceptable guidance in the first cycle of the project in Côte d’Ivoire, frustrations crept in at a later stage when audit teams felt that they had addressed all the locally soluble problems, and recommendations to address remaining problems would require additional resources. In Côte d’Ivoire and elsewhere, state hospitals are increasingly being transformed from institutions directly managed by the Ministry of Health to autonomous institutions, and many hospitals still lack the resources, skills, systems and mechanisms of accountability that are critical to the effective implementation of a user fee system (Gohou et al. forthcoming). The potential of locally driven, quality assurance systems in resource-poor settings is dependent on the degree of decentralization of resources, as well as decision making, to enable implementation of local recommendations.

Size of maternity units

Routine audit meetings were implemented and the effects on staff practice were rolled out more easily in smaller hospitals, where a high proportion of maternity and support staff participated. Midwives in these hospitals were also more likely to moderate meetings and take an active role in discussions, which probably reflected a closer working relationship between different categories of staff in these smaller units and more transparency in the rules of accountability. In the teaching hospitals, only a small proportion of staff who had been directly involved in managing the case attended audit meetings. Dissemination of recommendations to other staff proved difficult. In Benin, involvement of the head of the obstetrics department, who was the lead local collaborator on the project, facilitated this process. Whereas in the teaching hospital in Ghana, the project was described as belonging to a few, middle level consultants, and wider ownership and implementation of recommendations were not achieved (Brugha et al. forthcoming).

Patients’ (women’s) views

The perspectives and views of the women themselves were genuinely appreciated by hospital staff in all countries. Previously they had had little opportunity to evaluate patient satisfaction and were unaware of their failure to respond to women’s need for information on the care they had received. In Morocco, there was initial reluctance to having women’s views collected for presentation at audit meetings. The reason given was that this would require setting up a new system of data collection, hiring someone to conduct interviews in advance of audit meetings, which would be unsustainable once the research had ended. In Ghana, a researcher with social science training conducted the interviews with women. Potentially the most sustainable system was that in Benin and Côte d’Ivoire, where social workers employed as hospital staff interviewed the women and presented their experiences at audit meetings. Social workers could play a useful role in informing quality assurance strategies in the area of responsiveness to patients’ needs, providing, for example, information on the extent and the reasons for delays in receiving emergency care (Gohou et al. forthcoming), or on the financial burden of hospital care (Borghì et al. 2003). By focusing on patients who have experienced near-miss events, audit has the potential to improve quality of care in all of its main dimensions (Ronsmans and Filippi, in press).

External support

Local research teams varied in their approach to implementing the project, some taking a more active role in shaping the audit process while others strictly adhered to their observer roles. This ranged from Morocco, where audit meetings in the first phase were moderated by the researchers, to Ghana, where some meetings in the teaching hospital were not attended by researchers. Hospital audit teams generally welcomed the external view provided by the researchers. The Moroccan teams compensated for the withdrawal of the researchers at the end of the project by inviting a university
Sustainability: getting audit into policy and practice

Early involvement of decision-makers, notably Ministry of Health policy makers and programme managers, was considered important for getting project lessons subsequently into policy and practice. This was facilitated by inviting them to participate on near-miss enquiry advisory committees. In practice, involvement of senior policy makers and programme managers proved difficult in all countries. At the systems or policy level, there had been little experience in developing quality assurance systems within hospitals, apart from Morocco where the district medical officers showed sustained interest in the project. Lessons learned from a project to reduce patient waiting times and excessive prescribing at hospitals in Ghana, conducted several years earlier, were beginning to be rolled out in different regions during the course of the near-miss project. This illustrated the lengthiness and inherent delays in the process whereby project lessons inform policy and practice more widely.

A recommendation from an audit moderator in one hospital, at the final audit meeting, was that the audit process should be simplified when it shifted from project to routine service mode (Brugha et al. forthcoming). This reflected the tension between collecting sufficient data for research and the feasibility of incorporating the approach into routine service work. Another inherent limitation to sustainability, in a project focused on a small number of hospitals, was staff turnover. Several key hospital staff transferred away from the participating hospitals during or shortly after the project had finished.

Conclusions

Our near-miss case reviews resulted in a large range of positive, well-customized changes in the procedures and resources available for the management of obstetric complications. Lessons learned from first-level referral and specialist or teaching hospitals in the four countries point to recommendations for how to introduce and conduct obstetric audit in resource-poor settings. Ensuring that the principles of the audit approach are well understood and accepted is essential, notably that audit is a lesson learning exercise to enable local staff to improve their practices. The multi-disciplinary approach, bringing doctors, nurse midwives, social workers and other support staff together in a common forum, is a novel approach to quality assurance, which is also well accepted, especially in the smaller hospitals. Incorporating the views of patients into their quality of care assessments offers staff a new perspective on the care they provided, also providing insights into patients’ behaviour. The gate-to-gate approach gives audit-meeting participants a framework for reviewing how the different activities of staff contributed to (or detracted from) the quality of care the woman had received from the time of her arrival at the hospital.

Critical to the introduction of audit, as with other new initiatives that require fundamental changes in staff attitudes and practices, is a cluster of factors around leadership, systems’ support and an understanding of incentive systems. Ownership and leadership within the hospital, more easily achieved in the first-level referral hospitals, is the most important determinant of successful implementation. Where it exists, staff are more likely to allocate time to preparing for and conducting audits. The engagement of district and hospital managers, achieved in Morocco but much less so in the three poorer countries, may depend partly on the availability of resources to implement quality improvement recommendations. Guidance to hospital audit teams to work as far as possible within local resource constraints is appropriate. However, if it is to become successfully embedded, audit for quality assurance requires some modicum of support in the form of devolution of resources from higher levels for implementing recommendations. Incentives to implement the audit approach are shaped by the context; constrained in resource-poor settings where salaries are relatively low and staff may engage in other activities to make ends meet. Realistic mechanisms must also be found for dealing with the constraints of staff time, including fuller integration into existing hospital activities such as other staff meetings in the maternity unit. However, if prioritized by policy makers and managers at higher levels of the system, audit is feasible, acceptable to staff and less reliant on external inputs than other quality assurance approaches.

References


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