

HUMAN RESOURCES AND WORKFORCE

The ‘Gestalt’ effect: The added-value of integrating leadership, management, and governance training for postpartum family planning service providers

M. Baba-Djara¹, M. Conlin¹, R. Trasi²; ¹Management Sciences for Health, Arlington, VA, USA, ²Pathfinder International, Watertown, MA, USA

Background: In many developing countries, health practitioners are responsible for managing health facilities. While formally trained in clinical knowledge and skills, their leadership, management, and governance (L+M+G) skills are often learned on the job. While there is general agreement that L+M+G skills are important, there is little evidence of the value-added of L+M+G or its effect on clinical service delivery improvements. This abstract presents new evidence of the effects of strengthening L+M+G on an existing postpartum family planning (PPFP) intervention.

Methods: The USAID-funded Leadership, Management & Governance (LMG) Project implemented a quasi-experimental, three-armed study in six urban tertiary public hospitals in Yaoundé, Cameroon. The Leadership Development Program Plus (LDP+), an L+M+G program that imbues L+M+G practices for team-based problem solving- convened hospital teams to identify and address management issues affecting postpartum family planning (PPFP) service delivery. The three arms were as follows: Arm 1 (2 hospitals) received the LDP+, PPFP Clinical and Counseling Capacity Building, and Commodities, Arm 2 (2 hospitals) received PPFP Clinical Capacity Building and Commodities, and Arm 3 (2 hospitals) had access to commodities only. Pre-post FP service delivery outcomes were collected at all six hospitals. Focus group discussions (FGDs) and key informant interviews (KIIs) were conducted with hospital teams and other staff to explore the L+M+G barriers and facilitators to integrating PPFP in MNCH departments.

Findings: Preliminary results show that facilities with LDP+ intervention have larger increases in number of women adopting a FP method compared to control hospitals. Interviewees reported that the LDP+ increased PPFP service delivery by improving management of commodities and human resources, promoting transparent communication, and motivating staff to engage in the improvement process. Interviewees reported improvements in hospital leaders/managers’ attitudes and practices towards PPFP provision, while highlighting other barriers (norms around fertility, family size, birth spacing) to increasing uptake of PPFP.

Interpretation: Our findings suggest that integrating L+M+G into clinical service delivery interventions may improve service delivery results. Specifically, our results indicate that L+M+G can improve the uptake of PPFP in low-resource settings through effective management of commodities, human resource management, and transparent communication.

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Utilizing process map-driven protocols as educational tools: Developing hypertension protocols for management of preeclampsia in Botswana

O. Chang¹, K. Johnson¹, J. Jordan¹, N. Ramotshabi², T. Golen¹; ¹Beth Israel Deaconess Medical Center, Boston, USA, ²Scottish Livingstone Hospital, Molepolole, Botswana

Background: At Scottish Livingstone Hospital (SLH) in Botswana, medical providers are trained to recognize signs of hypertensive disorders in pregnancy (HDIP). However, management of HDIP is not standardized, leading to delays in diagnosis and treatment.

The objective of this study was to develop and introduce protocols to standardize the admission process and delivery indications for HDIP. The protocols were developed using a novel method of process map-driven protocols, and the second objective was to demonstrate proof of concept for this method.

Methods: 1. Protocol Development: Process maps of existing clinical practices related to HDIP at SLH were created with the medical officers. The protocols were then created by simplifying the process maps and then integrating up-to-date clinical guidelines. Two protocols, titled “Indications for Delivery” and “Indications for Admission,” (Figure 1.) were developed. 2. Educational Training: Two educational sessions consisting of didactics with case-based scenarios were held at SLH in May, 2015. All participants completed pre- and post-intervention knowledge application tests (maximum score of 8 points), with the protocols as reference. Satisfaction surveys also were administered.

Findings: A total of 24, including 4 midwives and 20 medical officers and interns, participated. The median score was 6.0 (5.0–7.0) for the pretest and 7.0 (6.0–7.0) for the posttest. The pre- and post-intervention scores were not significantly different ($p = 0.07$); however, participants with the lowest pretest scores showed the most improvement on their pre-eclampsia knowledge application tests. All participants reported that they wanted more process map-driven protocols.

Interpretation: Process map-driven protocols improved clinical decision-making for hypertensive disorders in pregnancy in Botswana; providers were highly satisfied with process map-driven protocols as a method to standardize and improve care. This proof-of-concept supports generalizability and is encouraging for the development of future educational and clinical protocols for obstetrical care in developing countries.

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The development of a difficult intravenous access algorithm in Guayaquil, Ecuador: Trials and triumphs

S.K. Hunsaker¹, S. Heaston²; ¹Brigham Young University College of Nursing, Provo, Utah, USA, ²Luis Vernaza Hospital, Guayaquil, Ecuador