

Strengthening Accountability within Malawi's Health System with QuIC, a Low-Resource Data Collection Tool

Evidence for Action-MamaYe was established in 2011 with UK aid from the UK government and continues with funding from the Bill & Melinda Gates Foundation. Our goal is to save maternal and newborn lives in Africa through better resource allocation and improved quality of care.

This case is an excerpt from a collection of 22 case studies based on the experiences of the E4A-MamaYe programme, which brings to light new learning about the specific ways in which evidence, advocacy and accountability reinforce each other to bring about change.

District health management teams (DHMTs) in Malawi know that their facilities face many quality of care challenges, but lack access to regular, systematic evidence about what these are specifically. This makes it difficult for them to allocate resources to meet the most pressing needs. Health facility managers also struggle to advocate for additional investment from their DHMT without proof of where the gaps lie.

The last emergency obstetric and newborn care (EmONC) assessment for Malawi was conducted back in 2010 and the health management information system focuses more on the number of services delivered than on their quality. Neither of these information sources is packaged to facilitate decision-making. Furthermore, many facilities are extremely remote and regular transport from the district health office to each facility for monitoring and supervision visits is not practical given limited resources.

Description of the case

The Quality of Institutional Care (QuIC) approach is a rapid, low-cost assessment of EmONC readiness at a given point in time, developed by our international team in response to these challenges. A questionnaire is conducted over the telephone, which covers areas such as current performance of signal functions, referral systems, staffing, electricity, water and sanitation, equipment and drugs. Results are expressed in a simple scorecard format, which clearly outlines the areas where additional resources are needed for quality

improvement. In this way, QuIC overcomes the transport and resource challenges involved in face-to-face monitoring visits to generate more frequent information on quality of care, packaged in a way that facilitates evidence-based resource allocation, advocacy, and accountability for results.

QuIC was initially launched in four districts in Malawi, including Mangochi, the focus of this case study. After orientating the health workers in these facilities to the QuIC process, the first round of data was collected in December 2014 by members of the district health team, supported closely by our Malawi country team. Spot checks in each facility, conducted immediately after the first round of data collection, confirmed the accuracy of the telephone assessments. A second round was completed in July 2015, with the same facilities. Scorecards were sent to each facility within a day of each assessment, and the collated scorecards were presented to the DHMT at the end of each round.

Results

The QuIC data highlighted immediate gaps in quality of care, in an easily understandable format. Facility managers and DHMT officials now had the evidence they needed to prioritise resources and keep each other accountable for delivering results. For example, QuIC data highlighted the lack of manual vacuum aspiration kits, drugs and soap in specific facilities. There were not

enough staff trained to carry out procedures such as manual removal of the placenta and manual vacuum aspiration, and of the two facilities that have a lab, neither had a lab technician. These factors resulted in an inability to perform some life-saving signal functions. Transport for referrals was a further challenge. Some facilities did not have a functional autoclave, and either boiled their equipment or sent it over 20km away for sterilisation, which resulted in an insufficient number of complete, sterile delivery kits.

As soon as the issues were raised through each round of the QuIC process, the district health officer and district commissioner provided the missing autoclaves, kits and soap, and replenished drug supplies. Human resource gaps could not be addressed as lab technicians in particular are in short supply in Malawi, but QuIC evidence can contribute to national level advocacy to address these gaps. While acknowledging that funding from government to buy fuel for ambulances has been a significant challenge, the timing of the second assessment around the parliamentary review of the national budget meant that the DHMT was able to prioritise funds for fuel. The DHMT has committed to addressing the outstanding issues as soon as possible, and discussions continue with health workers in the facilities.

DHMTs have reported that they find the QuIC scorecards extremely effective in informing their decision making, and are taking over the implementation of the assessment. In Mangochi, for example, the second round was conducted without our support. An additional district, Mchinji, is using QuIC as an interim assessment in between more in-depth surveys conducted for a results-based financing programme. A further three districts in the north have undergone training and the first round of data collection thanks to additional funding, meaning there are now eight districts with QuIC experience.

Our country team has also presented the QuIC approach at the national technical working group on safe motherhood in May 2015. Feedback was very

encouraging and the QuIC data collection tool has subsequently been used to inform the process of adapting the World Health Organisation quality of care assessment tool for Malawi.

Challenges and lessons learned

We found it is important to emphasise very clearly to health workers and to the DHMT that QuIC is not conducted in order to attribute blame, but to identify gaps and enable prioritisation of resources. This is crucial to encourage honesty during assessments and focus energies on resolving the gaps identified. New gaps were identified in subsequent rounds of collection: for instance, Chilipa and Nankumba had functional autoclaves in round one, but not in round two, demonstrating the importance of conducting regular quality of care assessments in order to capture new gaps as equipment fails, stocks run out or staff leave facilities.

QuIC functions as an accountability mechanism targeting the DHMT, but the DHMT does not always have the power or resources to make all of the necessary improvements. The fact that the second round of results coincided with the parliamentary review of the national budget meant that QuIC's accountability function was more effective at that time. The QuIC approach informs facility managers and DHMT officials about key quality of care gaps in a timely, regular, and low-resource way. The presentation of these data in a simple to understand scorecard format is a powerful tool that enables facilities to keep the DHMT accountable for providing health system inputs, and enables the DHMT to prioritise resource allocation for improved quality.

This case study was informed by interviews with health workers at Nankhwali and Chilipa health facilities, representatives from the Mangochi district health management team, including the district nursing officer, as well as the district HMIS Officer who conducted the telephone assessments.

To read the collection of E4A-MamaYe case studies visit: www.mamaye.org/evidence/case-studies/evidence-action-mamaye-stories-change-selected-case-studies