Measuring quality in Malawi's community health system: Barriers and challenges

> "There is significant data collection through various methods and implementers of community health. HSA's are technically assigned to complete over 40 M&E forms and processes while there are currently 15 different types of data used in community health. The amount of data collection creates a burden for implementers around consistency and quality of data that is weakened by insufficient quality assessments and training for data collection... Multiple processes for data collection also raises questions around data quality given the amount of time needed to devote to multiple M&E processes as well as limited trainings and supervision."
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> Malawi National Community Health Strategy
> 2017 - 2022

As the drive for Universal Health Coverage and the Sustainable Development Goals (SDGs) has led to a push for greater health service access, the issue of sustaining and embedding quality in the ways in which these services are delivered has gained prominence.

Measurement of quality and attribution of its effects in health is challenging at any level. But little is known about how quality is assessed within community health programmes, who are on the frontline of health service delivery in many low- and middle-income settings. The degree to which new initiatives like the Lancet Commission on Quality in Health Systems will include community health programming and the role of close-to-community health providers is currently unclear.

Health systems are shaped around well analysed power asymmetries. Relatively less powerful staff who labour at the interface of the community and health sector are rarely canvassed on their opinions of quality nor are their voices prominent in the decision-making processes that effect their daily labour. At the more local level differences in the personal characteristics of community health workers and their supervisors (such as sex, educational level, class, experience of poverty etc.) also act to reinforce power asymmetries.

This brief explores how close-to-community health providers in Malawi perceive quality as an aspect of their work and highlights some key challenges which may hinder the definition, measurement, and achievement of quality at the community level. It is based on research conducted by REACH Trust.
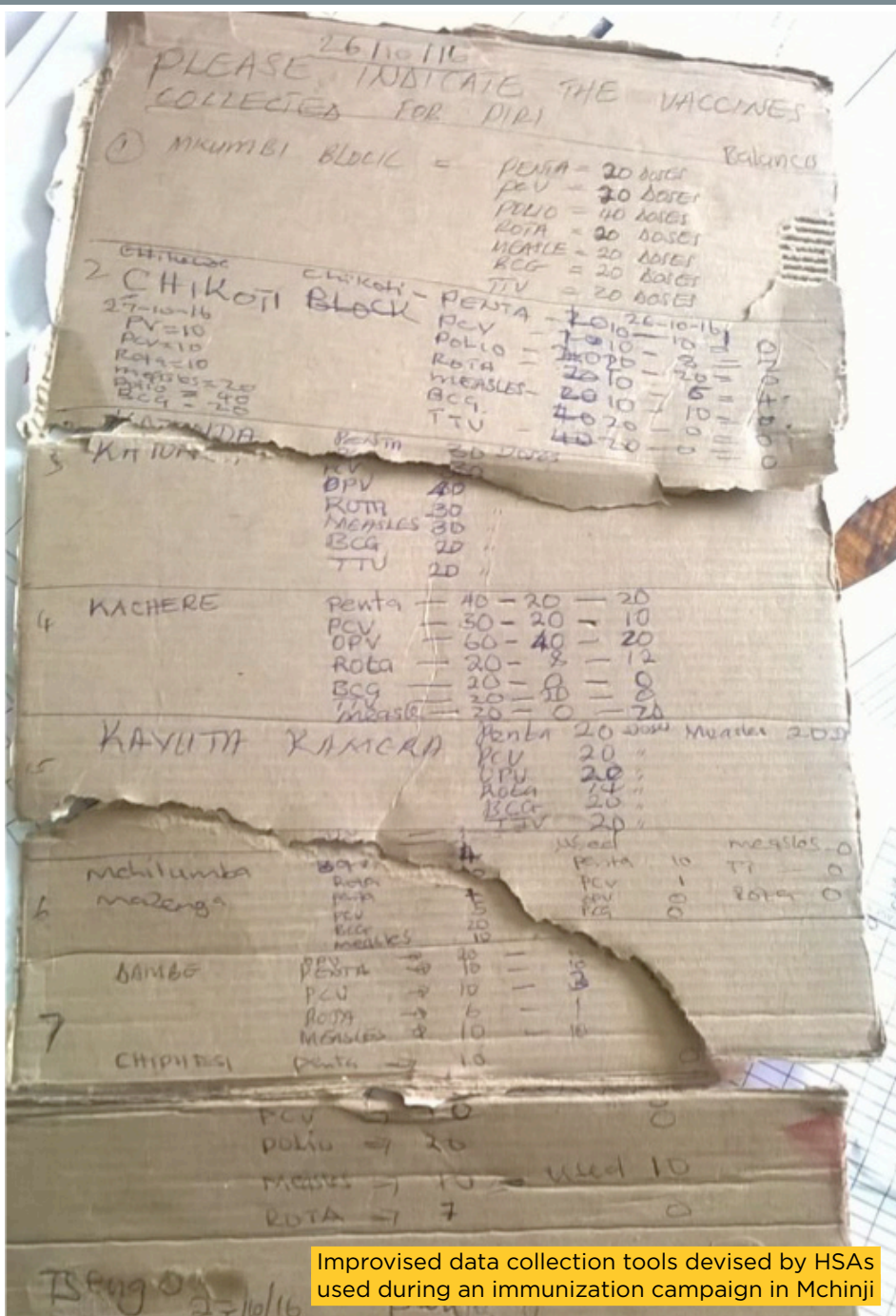
Improvised data collection tools devised by HSAs used during an immunization campaign in Mchinji

Methods

This brief draws on research conducted during the five-year REACHOUT consortium project in Salima and Mchinji districts of Malawi by REACH Trust using the following methods:

1. Qualitative interviews with key cadres including Facility-in-Charges, Assistant Environmental Health officers (AEHOs), Senior Health Surveillance Assistants (SHSAs), programme coordinators, and Health Surveillance Assistants (HSAs) covering:
   • (Qualitative interviews with key cadres including Facility-in-Charges, Assistant Environmental Health officers (AEHOs), Senior Health Surveillance Assistants (SHSAs), programme coordinators, and Health Surveillance Assistants (HSAs) covering data collection, management, and quality, expanding the sample to include focus groups with community health volunteers
2. A participatory tool examining indicators of an enabling environment for quality improvement completed through a workshop and interviews at district and national levels.

Policy and programmatic approaches to quality

Quality and quality assurance are central to the Government of Malawi's policy and programmatic guidance in the health sector. The overarching guideline is the National Quality Assurance Policy which stipulates the importance of monitoring quality of care and management across hospitals (who are also responsible for community health services) using indicators that are locally developed with central hospital management and nationally selected indicators. Simultaneously measures of quality are captured in the different national standards for Community Health Services (CHS). Other programme-specific guidelines and standards are also used to monitor and measure quality such as integrated community case management (iCCM) guidelines, maternal, neonatal and child health (MNCH) guidelines and others.

In 2016 the Ministry of Health established a national Quality Management Unit which is responsible for standards in the health sector. According to government policy assessments of quality indicators are made monthly at the district level. Ministry of Health officials and key stakeholders visit health facilities, capturing areas of strength and weakness. These observations are shared with facility-level health care teams and an action plan is developed to address challenges. Quarterly follow-up visits and reviews have the action plan as their entry point showing leadership symbolising momentum from the top on improving quality.

There are District Quality Improvement Teams who have a focus on curative services, infection prevention, and maternal health (including maternal deaths audits). Quality management is included in budget lines at the national level. 50 curative staff at national and district levels have received training on Quality Improvement/Quality Assurance for infection prevention between 2007 and 2012. The majority of HSAs got some form of training in Quality Improvement/Quality Assurance for infection prevention in 15 districts by Support for Service Delivery Integration (SSDI) initiative. The community volunteers who assist HSAs have not been included in this training.

Definitions of quality

A 2016 revised draft of national quality assurance policy defines "total quality management" as:

"A process and philosophy of achieving the best possible outcomes from the inputs, by using them effectively in order to deliver best value for the client, while achieving long term objectives of the organizations."

However, in our interviews, stakeholders defined quality in different ways. Some focused on adequately functioning systems. Others were more focused on patient outcomes and experiences of care and therefore defined quality as, "A better and outstanding way of delivering services to the satisfaction of clients e.g.

greeting, explaining and giving feedback". Facility-in-charges and district managers had a bias towards the clinical and medical perspectives of quality in their definitions.

Quality assurance was considered very important by most stakeholders. Both district and facility respondents indicated that practicing according to set standards results in building of trust between clients and service providers, community and health worker satisfaction, saves lives, and reduces the duration of suffering of clients. They also indicated that it encourages health care workers to become more focused and to produce admirable work, creates innovation, and builds confidence in service providers.

National-level interviews showed that quality performance mattered for HSAs because they were recognised by the communities in which they work if they did well. However, it was also noted that as communities gained a better understanding of their rights they began to demand better services and the providers "just needed to be careful". It was therefore acknowledged that a focus on quality could be a double-edged sword for frontline health service providers who are struggling to meet communities' needs.

Despite commitments to quality at the policy, programmatic, and personal levels in practice there were a variety of barriers that hindered its achievement.

Reachout Linking Communities & Health Systems

What hinders a quality approach?

Inadequate training: Despite having been trained in Quality improvement/Quality Assurance some HSAs were reluctant to share their new-found skills with others at community level. In many cases those that did not attend the training refused to be oriented by their colleagues – citing lack of (financial and other) incentives for the in-training as reason.

Non-supportive supervisory approaches:
Some HSAs mentioned that their supervisors do sometimes discuss performance against quality indicators during routine supervisions following some specific indicators such as those of iCCM, family planning, Sexually Transmitted Infection (STI) and safe motherhood programmes. However, a majority reported that infection prevention dominated these discussions. Our analysis showed that data on service activities and quality of care are rarely used in supervision meetings or feedback on performance. It was also noted that supervisors may hinder a quality culture if the supervisions were not as frequent as they should be. The supervisor may also obstruct a quality culture if he/she was not an effective communicator.

Guidelines are not received or used at the District and sub-District levels:
Interviews with district-level stakeholders suggested that few conversations about quality in community health services have occurred and some necessary guidelines (for example on task shifting) have yet to be disseminated at this level. Others reported that when guidelines are distributed to the district health offices, they were just "gathering dust in stores for years" without being used.

Monitoring visits are erratic and not properly documented:
Monitoring visits were supposed to occur on a monthly basis and it was reported that their frequency increased when preparing for external assessment. However, researcher observations during the period of study showed that such visits were either erratic or did not take place and documentation of these visits was not always available.

Multiple and inadequate quality measures:
Community health programming in Malawi is characterised by a plethora of vertical interventions which are managed by NGOs. This means that in addition to the formal Ministry of Health guidelines there are a multitude of vertical reporting forms for particular programmes, implemented piecemeal in certain areas. This stems from a lack of coordination around projects and implementation from those responsible for the HSA programme.

Reviewing community health registers

A lack of tools to enable HSAs to measure progress: Although NGO programmes collect data there are no standard Ministry of Health tools for collecting basic activity and incidence data below the facility-level, especially from HSAs.

"We talked of hard covers, at one time when the village health register came here, I told them the same thing that the village health register is a storehouse for all the data that anyone can need; sanitation data, population data, data for pregnant women, all is found in there. But at the moment there are no tools like that, and we then resort to using the hardcovers; so you know what it means when you are making your own plans and not using the designed paperwork".

(Senior Health Surveillance Assistant, Salima)

This leads HSAs to create their own informal summary activity reports which are often supplemented by a multitude of programme-specific reporting forms (e.g. for nutrition, iCCM, family planning). The tools used include registers, reporting forms, manuals, and supervision checklists. This creates a high burden of reporting despite a lack of standard tools. Furthermore, some HSAs felt that available data collection tools were being developed without input from those using them. The lack of input to and pre-testing of new tools was also seen as a barrier to data quality.

"We usually just receive forms and use them. There are times when we are just called to be trained on the use of the forms but not to help in designing the forms. We have never had that chance as SHSAs and I believe the volunteers too".

(SHSA, Salima)

Poor data quality at community level:
Previously, volunteers and HSAs used to collect data on demographics, sanitation, pregnancies, births, and deaths using what was known as village health registers which are now defunct. In practice, data from volunteers are reported on an ad hoc basis if/when requested by NGOs or HSAs. Volunteers, and in some instances even HSAs, use plain paper, or anything else available to document their work.

When data are collected and collated, they are not always analysed and are provided to the next level as a 'tick-box exercise' without interpretation. At the level of the health centre, the Facility-in-Charge is responsible for checking the monthly HMIS report, and at district level the HMIS officer is responsible. Only in case of significant missing data will these officers follow up with the people who are responsible for inputting and reporting these data and there is no tool for assessing data quality.

Inadequate data feedback: Interviews at national-level revealed that with the introduction of the HMIS in 2003, community health data were now being used for planning and improving the provision of community health services and played an integral part in policy formulation and implementation. Feedback was reported to be provided through reports and meetings. This was reported to have ensured that a culture of analysing data and provision

of feedback were embraced. Feedback, however, did not extend to the communities where data were collected and community members and volunteers felt this was an extractive process. Volunteers suggested that once they had given the data they collected for Non-Governmental Organisations to HSAs the information was "gone" (not in the village anymore) unless the volunteers made a copy for him or herself.

"Feedback is there only when they have seen a discrepancy in the data that you have sent to the district. Even in our case I would honestly say that we never give feedback to the volunteers who help us with the collection of the data. We would go back to them only when something is not clear and we want to understand things. Generally, I think we have not internalized the culture of giving feedback."

Facility-in-Charge, Mchinji

A lack of feedback leads to a devaluation of the data and disinterest in generating quality data. It also led some HSAs to test what they considered a failing system,

"Because the supervisors do not come from the district, sometimes we deliberately send wrong data just to see if the supervisors will have time to check our work...and then it can force them to come and verify with us...they don't even check our work it is sent like that and we never see them coming either."

Male HSA, Mchinji

However, a few examples of data use for action or decision making were provided by Facility-in-Charges and SHSAs. For example, data on pregnant women were used to follow up on them, even after child birth, and data on hygiene and sanitation informed health centres on which supplies to request (e.g. chlorine).

Generally, respondents reported that data systems were better explained and understood in the case of vertical programmes run by NGOs, and thus data use was also better within those programmes (but primarily above village level and community health volunteers still felt distanced from this).

Way forward
In both Salima and Mchinji, Quality Improvement teams have been formed at the district level and in three health centres. The teams received a training in quality improvement approaches; identified quality problems and made action plans. In both districts, priority was given to achieving better quality of data from community to district level. Over the

course of 2017, this intervention is being followed by the Reach Trust, to assess to what extent the quality improvement approach for community health could be embedded in the health system over the period of one year.

Resources
Introducing The Lancet Global Health Commission on High-Quality Health Systems in the SDG Era http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30101-8/fulltext

USAID: The Improvement Collaborative: An Approach to Rapidly Improve Health Care and Scale Up Quality Services. USAID Health Care Improvement Project 2008

Ministry of Health, 2005. National Quality Assurance Policy.

Ministry of Health, April 2016. National Quality Management policy for the health sector in Malawi. April, 2016 first draft

Ministry of Health, July 2017, National Community Health Strategy 2017 - 2022

About
REACHOUT is a five-year project funded by the European Commission led by the Liverpool School of Tropical Medicine and with partners in the Netherlands, Bangladesh, Kenya, Mozambique, Malawi, Ethiopia, and Indonesia. Its goal is to improve the equity, efficiency, and effectiveness of close-to-community health services. In Malawi, the REACHOUT project works in two districts of the central region - Mchinji and Salima - to promote the work of Health Surveillance Assistants (HSAs), a close-to-community cadre employed by the Ministry of Health. This brief was written by Kate Hawkins, Maryse Kok, Kingsley Chikaphupha and Meghan Bruce Kumar based on a longer report by REACH Trust.