Quality, Equity, Dignity
A Network for Improving Quality of Care for Maternal, Newborn and Child Health

Malawi

A. Background[1–6]

Core demographic data

Population size (thousands)	17,564
Total fertility rate (children per woman)	4.4
Maternal mortality ratio (MMR) (per 100,000 live births)	439
Neonatal mortality rate (NMR) (per 1,000 live births)	27
Child mortality rate (per 1,000 live births)	23
Stillbirth rate (per 1,000 live births)	13
Domestic general government health expenditure as percentage of gross domestic product (GDP) (%)	2.7
Domestic general government health expenditure per capita (in US$)	9.8

National coverage of key interventions

	%
Antenatal care (4 or more visits)	51
Skilled attendance during delivery (%)	90
Institutional deliveries	91
Cesarean section rate	6
Initial breastfeeding (1 hour of birth)	76.3
Exclusive breastfeeding rate (of infants under age 6 months)	61
Postnatal visit for baby (within 2 days of birth, medically trained provider)	60
Postnatal care for mother (within 2 days of birth, medically trained provider)	42

B. Implementation milestones

completed · in progress · not started or incomplete · no data

National leadership for quality of care (QoC)	
Supportive governance policy and structures developed or established	in progress
QoC for maternal and newborn health (MNH) roadmap developed and being implemented	completed
Learning districts and facilities selected and agreed upon	completed
QoC implementation package developed	not started or incomplete
Adaptation of MNH QoC standards	completed
Action: Learning sites identified and prepared	
Orientation of learning districts and facilities	completed
District learning network established and functional (reports of visits)	in progress
QoC coaching manuals developed	in progress
Quality improvement (QI) coaches trained	completed
On-site coaching visits occurring in learning districts	in progress
Learning and accountability: QoC MNH measurement	
QoC for MNH baseline assessment completed	completed
Common set of MNH QoC indicators agreed upon for reporting from the learning districts	in progress
Baseline data for MNH QoC common indicators collected	in progress
Common indicator data collected, used in district learning meetings, and reported upwards	not started or incomplete
Identification and agreement with an academic or research Institution to facilitate documentation of lessons learned in the implementation of QoC activities	completed
Accountability and community engagement	
Mechanism for community participation integrated into QoC planning in learning districts	no data

C. Progress at the national level (2017–2018)

National overview of QoC for MNH

National quality policy or strategy

- National Quality Management Policy (NQMP) (2017–2022)
- National Sexual and Reproductive Health and Rights (SRHR) Policy (2017–2022)
- National Quality Management Strategy and SRHR Strategy are under development

National aims

- "to improve quality of health services across the health system of Malawi. Improved service quality will lead to improved health status, increased client satisfaction, and financial risk protection, thereby contributing to the achievement of Malawi's national development goals." (NQMP)

National targets

- Reduce MMR to 269/100,000 live births by 2022 and 140/100,000 live births by 2030
- Reduce NMR to 22/1,000 live births by 2022 and 12/1,000 live births by 2030
- Reduce child deaths to 48/1,000 live births by 2022 and 25/1,000 live births by 2030

QoC technical working group (TWG)

- Members of the quality management TWG include Ministry of Health (MoH) departments and programs, partner organizations, separate regulatory bodies, academic institutions and civil society organizations
- Formed in 2017
- Met 3 times in 2018 and once so far in 2019

Joint products and activities by the QoC TWG

- Finalized:
  - Maternal, newborn, and child health (MNCH) QoC assessment tools
  - MNCH QoC baseline assessment reports
  - Hospital ombudsman training manual
  - Quality improvement (QI) training manual
  - Action plans by learning districts
  - Mentorship guidelines and training manual
  - M&E framework and indicators for QoC
  - National Quality Management (QM) Conference
  - National launch of QM Policy
  - Adaptation of QoC standards for MNH and pediatrics
- Under development:
  - Perinatal death surveillance review (PDSR) guidelines
  - Maternal death review analytical report

Learning districts and facilities

- 6 learning districts (Mzimba South, Kasungu, Lilongwe, Thyolo, Zomba, Mangochi)
- 4 learning facilities per distric

District aims towards national strategy

- Each district has developed an action plan with activities for improving the QoC in MNCH at the facilities.
- Overall, the districts will contribute to the national target of reducing the MMR, NMR, and the child mortality rate by improving the quality of services

Clinical improvement aims

- No current facility-specific aims
- However, each district has come up with action plans for improving QoC in MNCH at the facilities. These actions plans include action needed, priority level, timeframe, and the responsible person for each action.

Quality interventions included in the national MNH QoC package*

Interventions to build a supportive environment

- **Service charters**
  The service charters are a mechanism to helps clients understand what packages of health service interventions they can expect to receive at health facilities. The charters serve as a standing consultation between communities and healthcare providers, and they communicate things such as opening times, services provided, cost of service, etc. The overall aim of the service charters is for communities to understand what care they can expect, what they are entitled to, and for the service providers to be accountable for it. It has been developed in alignment with the standards of care and aims to improve the accountability of the health services provided. The service charters were rolled out in some of the learning districts, but no evaluation of it has been done yet.
- **Hospital ombudsman**
  The hospital ombudsman was launched on 30 June 2018. The main function is to be a receiving platform for complaints from patients who have experienced poor quality care or have been treated inappropriately by the health provider. It also serves as a general feedback mechanism from clients/patients through exit interviews and community sensitization. It has been rolled out in some of the learning districts/facilities. No evaluation has been done yet since it is a relatively new intervention.

Interventions to support change at facilities

- Quality Improvement Support Teams (QISTs) have been set up in the learning facilities and Work Improvement Teams (WITs) in the individual departments. These teams function as specific working teams to improve the quality of care at the facilities through assessments, trainings etc. The QI teams consist of health managers, in-charges, coordinators, clinical officer, midwives, nurses, pharmacists, administrators etc.
- Ombudsman (see above)

Interventions involving people, families and communities

- Service charters (see above)
- Hospital ombudsman (see above)

*Interventions have started since the last update.

D. MNH QoC baseline data for learning facilities

Baseline common indicators

Challenges

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Opportunities and progress made

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Planned activities

- We are currently collecting baseline data for the common indicators from the last 6 months from learning districts.

E. Implementation progress in learning districts

On-site support for clinical skills and QI

Support for clinical skills

Who provides on-site support for clinical skills	• WITs consist of frontline health workers, other staff members, and community representatives who are coopted, depending on the improvement area they are working on. The teams are supposed to meet at least every fortnight and improve the QoC in their department. • QISTs consist of clinicians, pharmacists, midwives, nurses, administrators, etc. QISTs are multi-disciplinary teams and have one community representative. The teams are supposed to meet once a month at the facility to oversee and coordinate the QI interventions at the facilities. • District/facility QM focal persons (e.g. nurses, doctors, clinical officers) supervise and coordinate the QI initiatives in the facilities. • District Health Management Teams (DHMT) provide overall support on QI issues in the districts, such as resource mobilization, human resources, etc. They are reinforcing the QoC policies. • National-level officers supervise the functionality of the QISTs. They oversee the need for capacity building, provision of on-site support, and need for additional resources to improve QoC. This supervision occurs quarterly.
Challenges solved implementing on-site support for clinical skills	• Some staff members lacked skills and knowledge-mentorship. To solve this problem, they received coaching and training.
Unresolved challenges implementing on-site support for clinical skills	• Shortage of staff • Reallocation of staff means a loss of skills. New staff members that come in might need to be retrained in QI. • Some facilities lack electricity, running water and functioning waste disposal.

Support for QI

Who provides on-site QI coaching	• District supervisors provide on-site support (DHMT members, district coordinators) and each district has a QM focal person, coordinators in SRH and child health that also provides on-sites support. • Other relevant staff members with skills and competency in QI may provide on-site support.
Challenges solved implementing QI coaching	--
Unresolved challenges implementing QI coaching	• Investments needed

Learning for QI

Tools for capturing learning from facilities	• At this moment, it is only done through reports.
Tools for sharing learning between facilities	• Review meetings and collaborative sessions have not yet started but are planned to take place. • Benchmarking: For example, if a facility or district has achieved some good results, it can promote what it did. Other facilities or districts can visit to learn how the facility/district approached the problem and how the success was reached. This has not yet started, but it is planned to take place. • Social media, such as WhatsApp, can be used between facilities to share learning between one another.
Challenges solved implementing a learning system	--
Unresolved challenges implementing a learning system	--

Measurement system for QI

Patient-level common indicator data	• Institutional maternal deaths • Institutional neonatal deaths (disaggregated by cause) • Perinatal deaths • Maternal death surveillance review audits • Perinatal death surveillance review audits • Experience of care • Women administered immediate postpartum uterotonic (%) • Facilities with birth and death registration linked to vital national registration system • Maternal deaths audited/reviewed with standard audit tools • Health facilities with functional client feedback mechanisms • Facilities with an Ombudsman • Facilities with functional QM structures
Programme-functioning data	• Facility-level: – Documented evidence of a QI project – Minutes of QI meetings – Reports • District-level: – Mentorship/supervision minutes – Evidence of health facility visits from visitors' books – Interviews with health facility staff on district support – Mentorship log books – Agreement check lists
Availability of data system for measuring QoC	• The system is not fully developed, but plans for 2019 to customize the reporting tool in the District Health Information System (DHIS) II (which is the main national health information system). • Some of the data needed are already available in DHIS II.
Challenges solved implementing a measurement system	--
Unresolved challenges implementing a measurement system	--

Community and stakeholder engagement

Approaches for community/ stakeholder engagement	• Each health facility has an advisory committee that includes community members. It meets periodically with facility teams. Facility QISTs have one community representative. Some health facilities and communities have community score cards. Civil society organizations are represented in the TWG. • Citizen hearings: Mothers and health care providers are bought together in the communities for a meeting to discuss the mothers' experiences of care, to initiate dialogue among the community members and health workers, and to build accountability.
Roles of community stakeholders or patient representatives	• Community stakeholders act as a link between the facility and community on issues that affect the facility/community. • Civil society organizations are represented in the TWG. • Community score cards exist to capture and identify gaps and to make recommendations on how things can improve
Challenges solved engaging communities and stakeholders	--
Unresolved challenges engaging communities and stakeholders	--

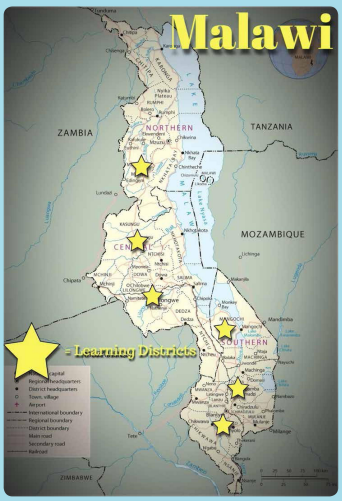
Programme management

Programmatic responsibility	• Facility-level: QI focal person • District-level: District QM focal person • National-level: Thematic directors (e.g. for MNH), Director for Quality Management
Challenges solved implementing program management	--
Unresolved challenges implementing program management	• Unavailability of representation from relevant implementing departments

Lessons learned implementing a QoC program

- It is important to have strong and knowledgeable leadership to provide guidance when setting up and implementing the QoC program
- For planning purposes, it is important to conduct a stakeholder mapping to understand who is doing what and where. Stakeholder mapping helps mobilize resources for the program, thereby maximizing use of resources

F. Example from implementation



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3. Malawi Demographic and Health Survey: 2015-2016 (February 2017)
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5. United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, DVD Edition.
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All other data received from the relevant Ministry of Health and WHO Country Offices.

Acronyms

DHIS	District Health Information System
DHMT	District Health Management Teams
GDP	gross domestic product
MoH	Ministry of Health
MMR	maternal mortality ratio
MNCH	maternal, newborn, and child health
MNH	maternal and newborn health
NMR	neonatal mortality rate
NQMP	National Quality Management Policy
QI	quality improvement
QISTs	Quality Improvement Support Teams
QM	quality management
QoC	quality of care
SRHR	sexual and reproductive health and rights
TWG	technical working group
WITs	Work Improvement Teams

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