Examining Malaria Service Delivery

Democratic Republic of Congo Pilot Summary

PMI | U.S. PRESIDENT'S MALARIA INITIATIVE

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Breakthrough ACTION FOR SOCIAL & BEHAVIOR CHANGE

Pilot objectives

- Designed light-touch tool for rapid deployment to target facilities
- Tool has two functions: identify challenges and identify programmatic recommendations
- Tool includes templates and instructions for identifying facilities, conducting data collection, rapidly synthesizing data, and developing recommendations/action plan

Pilot Summary

- Findings from 6 site visits in two provinces
- Added value

Site 1

Private integrated hospital

Private facility owned by husband-wife team who established and expanded it. While the lab has cutting-edge diagnostic tools, patients intake forms are electronic, and HMIS data indicates it is a high-performing facility, a closer look reveals:

1. Staff at all levels lack any malaria, malaria case management, or laboratory training
2. Regular inventory of stock is not taken and malaria commodities stock-outs are common
3. Record-keeping and data collection tools are misused resulting in inaccurate data submission (severe underestimates of malaria deaths)

Site 1

Private integrated hospital

4. Several providers appeared nervous, particularly those with data recording responsibilities
5. Providers asked about specific case management and malaria in pregnancy guidelines
6. Non-adherence to diagnosis and treatment guidelines is common: providers openly discussed taking client socioeconomic status into account when deciding what tests and kinds of drugs to prescribe
7. Free malaria medicine is co-mingled with privately purchased medicine in the pharmacy
8. Reception, pharmacy, and records rooms are shared, making sale or misuse of government provided malaria commodities untrackable

Site 1

Private integrated hospital

A soft-spoken laboratory technician named Annabel has been working at this facility for four years. She has no formal laboratory training and has been instructed to always conduct a rapid diagnostic test and microscopy (both) for all cases of fever.* When asked about an incorrectly used diagnosis register she was flustered and did not make eye contact during the interview. Providers interviewed in this facility did not feel as though monthly facility meetings are a safe space to voice personal concerns.

Site 2

Public integrated health center

It was ANC day and it was busy on the day of the site visit. Space is limited and the design of the physical structure impedes standard operations in several ways.*

Examination of facility records and provider interviews reveal:

1. Issues of allocation of responsibilities among staff (all levels)
2. Non-adherence to stock management procedures
3. Non-adherence to standard data recording procedures

- Submission of HMIS records do not reflect actual service provided or commodities consumed.
- Inventory of malaria commodities is not taken so orders do not reflect needs (leading to stock-outs and failure to provide peripheral facilities with stock).
- Staff work in relative isolation and a result links between data capture and use missing.

Site 2

Public integrated hospital

Arielle is an elderly midwife with a lifetime of experience assisting childbirth. She began providing ANC services at this health center in 2005. She has no formal malaria training but correctly describes every standard ANC protocol. While there isn't much overlap in services, she feels providers work well as a team. Arielle dislikes having to send women away with prescriptions for malaria commodities when the center is stocked out. She enjoys helping pregnant women and giving them advice that will keep their children healthy.

Site 3

Public integrated health center (class 2)

In an uncommon scenario, the in-charge is a nurse who oversees two doctors and who has been working in facility since its inception. While not designated to treat severe malaria, doctors do. A number of irregularities were observed:

1. Provision of services that both exceed and fall short of the center's official designation
2. Non-adherence to malaria case management and malaria in pregnancy guidelines
3. Inventory of stock is not taken and malaria commodities are often misused (adult doses of ACTs split for children during stock-outs)

Site 3

Public integrated health center (class 2)

4. Two doctors placed in facility by head of health zone who is aware they are performing unauthorized services
5. The In-charge silos roles and responsibilities such that he controls every aspect of facility
6. Team morale is mixed. Some providers appeared to have been coached while others candidly spoke about a lack of meaningful avenues for feedback or suggestions in how the facility is run

Site 3

Public integrated hospital

Gilbert is a nurse with 18 years of experience in his third year at the center. He has limited access to data collected at the center but uses what he has: he gives an example of examining ANC attendance data to understand why ANC services seem popular but women don't tend to deliver at the facility. He admits he has too many responsibilities and isn't formally trained to perform his duties. He thinks working more closely with community health volunteers could improve basic care and reduce the workload at the facility.

Summary In Short

Combination of central, provincial, health zone, facility in-charge, and provider factors influencing adherence to diagnosis and treatment guidelines, inaccurate data collection and reporting, and mismanagement of stock.

In all facilities visited, these factors result in:

- Mismanagement of uncomplicated and severe cases of malaria
- Severe under-reporting of malaria morbidity and mortality
- Chronic stock-outs of RDTs, ITNs, and ACTs (and subsequent inability to provide satellite facilities with adequate stock)

Highlighted Learning (1 of 4)

- Tool achieved original vision
- Talking to multiple people, triangulating data, and providing all interviewed with feedback makes tool unique and effective
  - Not enough to speak only to in-charge/manager
- Easily deployed by NMP staff with minimal orientation
  - Following a brief orientation, learning by doing approach worked
- Major discrepancies between HMIS and actual data in all 6 facilities
- Proved essential to examine both clinical practice and workplace environment; including quality of teamwork
- Unique in asking all interviewed providers whether findings reflect their reality; opened up real dialogue
- Tool uncovers the "why" underpinning service delivery challenges

Learning (2 of 4)

- Tool deployed within same amount of time as other supportive supervision tools; allowed for deep exploration with speed
- Process creates safe space and draws out important qualitative data
- Combination of quantitative data review and qualitative reflection to explain the why helps uncover full story
- Each visit uncovered recommendations for quick wins and easy changes as well as other systemic issues requiring greater intervention
- Challenges and root causes vary and exist at different levels of health system; observed some common trends
- Worked equally well in PMI- and Global- Fund supported facilities given government structure for oversight

Learning (3 of 4)

- Process identifies challenges as well as best practices for replication elsewhere
- Extraordinary wealth of knowledge among providers related to their challenges and how to address them; they just need to be asked
- Uncovered health zone/district weaknesses beyond any given facility
- Several low hanging fruit and opportunities for task sharing and greater efficiencies, which in turn would help with staff workload
- Combination of team members with clinical expertise and a behavioral lens made for a strong team
  - NMCP immediately understood importance of behavioral lens; intuitive and easy to grasp and provided added value
- Flexible use:
  - Sentinel sites
  - Quarterly
  - Entirely up to each country to decide what works best

Learning (4 of 4)

- Emotional component impactful
  - Process not framed as supervision visit per se and instead more as an exploration with facility staff without expecting a certain answer or response
  - Builds empathy which breeds open reflection and discussion; doesn't feel like typical supervision visit
  - Process allowed for frank feedback session and dialogue; didn't sugarcoat findings
  - Staff opened up and engaged during validation of findings; hungry for feedback
- May need to consider adding community dimension
- Complements other supervision/QI tools
  - Allows for f/u in next supervisory visit (tool could be a one-off exercise)
  - e.g. OTSS could signal deeper exploration and use of this tool

"This is human work we are doing"