Government of Malawi Ministry of Health and Population 2019

# Malawi

# Harmonised Health Facility Assessment (HHFA)

2018/2019 Report

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Malawi | HHFA 2018/2019 Short report









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The views expressed in this report are entirely those of the authors and contributors. The findings, interpretations and conclusions expressed herein do not necessarily reflect the views of the organizations involved or their Board of Directors.

# Introduction

The 2018/2019 Malawi Harmonized Health Facility Assessment (HHFA) was conducted to ascertain the availability, readiness, and quality of health service delivery at the facility level to better understand existing gaps and identify potential approaches for improving health care services in Malawi and as ultimately health outcomes. In particular, the survey focused on better understanding supply-side constraints on the provision of reproductive, maternal, newborn, and child health (RMNCH) and nutrition services given that despite steady programmatic gains, health outcomes remain relatively poor.

The Malawi HHFA survey instrument was comprised of the standard service availability and readiness assessment (SARA) and the service delivery indicators (SDI) surveys harmonized into a single tool with five modules: facility inventory, health worker roster, clinical vignettes, facility finances and governance, and client exit interviews.

The Malawi HHFA was conducted in a census of health facilities and included 1106 health facilities in Malawi between November 2018 and March 2019. Of the surveyed facilities, there were 101 hospitals, 492 health centres, and 513 dispensaries, clinics, and health posts. A total of 12 773 health care workers were observed for absenteeism, 1433 health workers were assessed with clinical vignettes, and 4118 clients were interviewed (2333 mothers regarding their children under the age of 5 and 1785 pregnant women receiving ANC).

The HHFA provides critical information on the performance of the health system in Malawi, including service readiness of the facilities (measured by availability of trained staff and guidelines, diagnostics, equipment and medicines), the quality of care delivered by health care workers both for general health services and for specific key health interventions (e.g. services for maternal health, neonatal health, child health, infectious diseases, and noncommunicable diseases), and client perceptions of service quality.

# **General service availability**

General service availability refers to the physical presence of the delivery of services and encompasses three domains of tracer indicators: health infrastructure, core health personnel, and service utilization. On average, Malawi is 52.8%, of the way towards achieving health infrastructure targets, 45.3% of the way toward achieving health workforce targets, 31.2% of the way toward achieving service utilization targets.

### Health infrastructure

### Health workforce

The health workforce domain is comprised of a single indicator: core health workforce density. Malawi has 10.42 core health workers per 10 000 population and is, on average, 45% towards achieving the health worker density target of 22 health workers per 10 000 population as recommended by the World Health Organization.

### Provider absenteeism

In addition to having the requisite number of staff trained in place, staff should be available at health facilities to provide services. The average absenteeism rate at a facility is measured by assessing the presence of at most 10 randomly selected clinical health staff at a facility during a second, unannounced visit based on the staff roster. Nationally, 18% of health workers were found to be absent. This is a relatively low level of absenteeism compared to other countries in the region including Kenya, Sierra Leone, and Tanzania where provider absenteeism was 39%, 27%, and 12% respectively. However, having almost 20% of the health workforce absent on any given day creates a significant challenge for providing timely, efficient, high-quality health services. Of the provider absences in Malawi, 95% were deemed to be sanctioned absences while only 5% of absences were not sanctioned.

### Service utilization

Service utilization examines how health facility services, both outpatient and inpatient, are utilized by the target population in a given year. There are two indicators that measure the service utilization of a country: outpatient service utilization and inpatient service utilization. Nationally, there are 0.8 outpatient visits per person per year. The country, on average, is 15% of the way towards achieving the outpatient service utilization target of five outpatient visits per person per year. Nationally, there are 4.72 hospital discharges per 100 population per year and the country, on average, is 47% of the way to achieving the target of 10 hospital discharges per 100 population per year.

### Caseload

The caseload indicator is defined as the number of outpatients seen by a health provider who conducted patient consultations (i.e. doctors, medical assistants, clinical officers, and nurses) per day. Caseload was calculated from the total number of outpatients (recorded in outpatient records) seen at the facility in the three months prior to the survey (August to October 2018), divided by the product of the total number of days the facility was open during the three-month period and the number of health workers who conduct patient consultations (i.e. doctors, medical assistants, clinical officers, and nurses). The average national caseload was 40.1 cases per health provider per day and highest in facilities which had 1–2 health workers per facility compared to those with more health workers. This caseload is substantially higher than the caseload seen in other countries in the region including Kenya, Tanzania, and Sierra Leone which were 13, 10 and 8 patients per day, respectively.

# **General service readiness**

General service readiness refers to the overall capacity of health facilities and health care workers to provide minimum quality health services. It measures the availability of items necessary to provide basic services at health facilities within the following five aspects: basic amenities, basic equipment, standard precautions for infection prevention, diagnostic capacity, and essential medicines. Across these domains, general service readiness was found to be 60%. In other words, of all the items that were considered particularly important for providing basic health services, facilities in Malawi had on average only 60% of them.

### **Basic amenities**

Basic amenities included power, improved water source, room with privacy, adequate sanitation facilities, communication equipment, access to computer with internet, and emergency transportation. On average, facilities had 64% of basic amenities items and 8% of facilities had all basic amenities items. Almost nine out of 10 facilities reported having improved water sources, consultation rooms, and sanitation facilities. Hospitals were found to be better equipped than other facility types. Basic amenities were generally more available in non-profit and NGO facilities than in government facilities. On average, 73% of the basic amenities' items were available among urban facilities, while 61% were available in rural facilities.

### **Basic equipment**

Assessment of the availability of basic equipment was based on the presence of the following items: adult weighing scale, child weighing scale, thermometer, stethoscope, blood pressure apparatus, and light source. On average, facilities had 75% of basic equipment items available and 31% of facilities had all basic equipment items. About 85% of facilities reported having an adult scale, thermometer, stethoscope, and blood pressure apparatus. Hospitals had the highest availability of basic equipment items of all facility types, while health posts had the lowest availability of basic equipment items. NGO and CHAM facilities had higher mean availability of basic equipment items than government facilities. Urban facilities had greater availability of basic equipment tracer items, on average, compared to rural facilities.

### Standard precautions for infection prevention

Assessment of the availability of standard precautions for infection prevention was based on the presence of the following items: safe disposal of sharps, safe disposal of infectious wastes, appropriate storage of sharps wastes, appropriate storage of infectious waste, disinfectant, disposable or auto-destruct syringes, soap and water or alcoholbased hand rub, latex gloves, and guidelines on standard precautions. On average, facilities had 76% of standard precautions items available and 22% of facilities had all standard precautions for infection prevention items. Hospitals had the highest availability of standard precautions items of all facility types, while health posts had the lowest availability of standard precautions items. Private non-profit and NGO facilities were found to have a higher mean availability of standard precautions items compared to government facilities. Urban facilities had greater availability of standard precautions tracer items compared to rural facilities.

### **Diagnostic** availability

Diagnostic capacity included the availability the following tests on site at the facility: haemoglobin, blood glucose, malaria diagnostic capacity, urine dipstick – protein, urine dipstick – glucose, HIV diagnostic capacity, syphilis rapid test, and urine test for pregnancy. On average, facilities were able to perform 47% of the basic diagnostic tests and 6% of facilities had the capacity to conduct all basic diagnostic tests. Most facilities were able to conduct malaria, HIV, and syphilis rapid diagnostic tests. As seen across other general service readiness domains, diagnostic capacity was highest among hospitals and lowest among health posts. The availability of diagnostic tests was greater in CHAM facilities compared to government facilities. Results also showed urban facilities had greater diagnostic capacity than rural facilities.

### **Essential medicines**

Assessment of the availability of essential medicines was based on the presence of medicines that were considered to be particularly important. The essential medicines domain is comprised of 24 essential medicines including amitriptyline tablet, amlodipine tablet or alternative calcium channel blocker, amoxicillin syrup/amlodipine tablet or alternative calcium channel blocker, amoxicillin tablet, ampicillin injection, aspirin cap/tab, beclomethasone inhaler, beta blocker, carbamazepine tablet, ceftriaxone injection, enalapril tablet or alternative ace inhibitor, fluoxetine tablet, gentamicin injection, glibenclamide tablet, haloperidol tablet, insulin regular injection, magnesium sulphate injectable, metformin tablet, omeprazole tablet or alternative, oral rehydration solution, oxytocin injection, salbutamol inhaler, simvastatin tablet or other statin, thiazide, and zinc sulphate tablet or syrup. On average, facilities had 38% of the essential medicines and no facilities had all 24 essential medicines. Hospitals displayed the highest essential medicines availability compared to all other facility types. CHAM, private for-profit, and NGO facilities had greater availability of essential medicines than government facilities. As found with the other indicators of general service readiness, mean availability of essential medicines was higher among facilities located in urban areas compared to rural areas.

### **Referral systems**

An effective referral system is paramount to ensure that people receive the optimal care at the appropriate level of the health system and that facilities and human resources are used in the most cost-effective way, i.e. where their

contribution is most needed. In fact, clients bypassing lower level services to seek care at higher level facilities is a common problem in many countries, leading to overcrowding at higher-level facilities and misuse of specialized providers. Overall, 94% of all health facilities in Malawi have a system for referring patients to any other facility. About two-thirds of health facilities reported that they have a referral system from the community level and have HSAs/CHWs who refer client to the health facility.

# Maternal, neonatal, and child health services

For each service, the percentage of facilities offering the service was computed as a measure of the availability of the service. In addition, for facilities offering the service, readiness to provide the service was assessed based on the presence of a number of tracer items in the following domains:

- Guidelines and trained staff
- Equipment
- Diagnostic capacity
- Medicines and commodities

### Family planning/birth spacing

Countrywide, 81% of facilities reported that they offered modern family planning/birth spacing services of which about two third of facilities reported providing male condoms as well as combined oral contraceptives. Health centres were most likely to offer this service compared to other facility types. Government facilities, and those located in urban areas, have greater availability of family planning/birth spacing services compared to nongovernment facilities and facilities located in rural areas. Overall readiness to provide family planning/birth spacing services was calculated at 70%, indicating that on average, facilities had 4–5 of the 6 tracer items needed to deliver this service.

### Antenatal care

Nationally, 60% of all facilities reported offering antenatal care (ANC) services. ANC services were most available in hospitals and health centres compared to other facility types. CHAM and government facilities were more likely to offer ANC services compared to NGO and private for-profit facilities. ANC services were more available in rural areas than urban areas. On average, facilities in Malawi had 7–8 of the 11 items (69%) needed to deliver this service.

### Basic emergency obstetric and newborn care

Slightly more than half of facilities (51%) reported that they offered normal delivery services. Nearly all CHAM facilities offered delivery services (88%) as did the majority of government facilities (66%), while only 9% of NGO facilities offered delivery services. Facilities located in urban areas were more likely to offer delivery services as compared to facilities located in rural areas (64% vs. 25%). Among facilities offering delivery services, 45% met basic emergency obstetric and newborn care (BEmONC) criteria which was defined as availability of the seven signal functions. On average, facilities offered 84% of the BEmONC signal functions. Only 4% of facilities had all 21 tracer items for basic obstetric and newborn care. On average, facilities had approximately 15 of the 21 items, for an overall readiness score of 71 out of 100.

### **Comprehensive emergency obstetric care**

As expected, hospitals were more likely to offer comprehensive obstetric care services compared to all other health facilities combined. Among facilities offering delivery services, 66% of hospitals and 2% of all other facilities met comprehensive emergency obstetric and newborn care (CEmONC) criteria which was defined as availability of the seven BEmONC signal functions plus caesarean section and blood transfusion. Urban and rural disparities were evident, with facilities located in urban areas more likely to offer caesarean section, blood transfusion, and CEmONC services. CEmONC criteria was met for 51% of facilities offering delivery services in urban areas compared to 6% in

rural areas. Only 1% of facilities offering caesarean-section services had all tracer items needed to provide comprehensive obstetric care services. However, facilities had on average 72% of items needed to offer comprehensive obstetric care services.

### **Blood transfusion**

Only 8% of facilities offer blood transfusions services. Hospitals are much more likely to offer blood transfusions than clinics and health centres. CHAM facilities had a greater availability of blood transfusions services compared to government and NGO facilities. Urban and rural disparities were evident, with facilities located in urban areas being more likely to offer blood transfusion services. Overall readiness to provide blood transfusion services was 83%, indicating that on average, facilities had 5–6 of the 7 items needed to deliver this service.

### **Child immunization**

Most facilities in Malawi (73%) reported that they offered routine childhood immunization. The majority of hospitals, health centres, and health posts offered child immunization services. A greater percentage of CHAM and government facilities offered child immunization services compared to NGO and private for-profit facilities. Overall readiness to provide child immunization was 88%, indicating that on average, facilities had 11 of the 13 items needed to deliver this service.

### Child health preventive and curative care services

The majority of facilities (89%) reported that they offered preventive and curative child health care services. Almost all health centres (99%), hospitals (93%), and dispensaries (89%) in the country reported providing preventive and curative child health care services for children under five years of age. CHAM and urban facilities were more likely than NGO and rural facilities to offer preventive and curative child health care services for children under five. Overall readiness to provide preventive and curative child health care services was 57%, indicating that on average, facilities had 10 of the 18 items needed to deliver this service.

### Nutrition services for children

Growth monitoring and malnutrition diagnosis and treatment were the most commonly offered child nutrition services (78% and 76% respectively). Almost all health centres (99%) and the majority of health posts (94%), hospitals (93%), and dispensaries (85%) offered growth monitoring services. Similarly, almost all health centres (98%) and the majority of hospitals (94%), dispensaries (82%), and health posts (72%) offered malnutrition diagnosis and treatment services. Government and CHAM facilities were more likely than private for-profit, private non-profit facilities, and NGO facilities to offer child nutrition services for children under five. Overall readiness to provide child nutrition services was 60%, indicating that on average, facilities had five of the nine items needed to deliver this service.

### **Adolescent health**

The majority of facilities in Malawi offered adolescent health services, including HIV testing and counselling and family planning services. However, other adolescent health services were less available. Almost all hospitals (95%) and health centres (97%) offered HIV testing and counselling services for adolescents. The majority of government and NGO facilities offered combined oral contraceptive pills for adolescents. Rural facilities were more likely than urban facilities to offer HIV testing and counselling services for adolescents.

# **Infectious disease services**

For each service, the percentage of facilities offering the service was computed as a measure of the availability of the service. In addition, for facilities offering the service, readiness to provide the service was assessed based on the presence of a number of tracer items in the following domains:

- Guidelines and trained staff
- Equipment
- Diagnostic capacity
- Medicines and commodities

### **Malaria services**

Almost all facilities (96%) reported that they offered diagnosis or treatment of malaria. More hospitals provided malaria services (99%) than health posts (80%). Almost all government (96%), CHAM (98%), and private non-profit facilities (92%) offered malaria services. Facilities that reported offering malaria service had, on average, 68% of the items that are necessary for delivering malaria services.

### HIV/AIDS

Over half of facilities reported providing HIV/AIDS care and support services (58%), ARV services (65%), and PMTCT services (60%). Hospitals and health centres were more likely to provide HIV/AIDS care and support services, ARV services, and PMTCT facilities than other facility types. CHAM facilities were more likely to provide HIV care and support services and ARV prescriptions than government or private for-profit facilities. Urban facilities were more likely to offer HIV care and support services and ARV prescriptions than government or private for-profit facilities. Overall readiness to provide HIV/AIDS care and support services was 69%, indicating that on average, facilities had 6–7 out of 10 tracer items needed to deliver this service. Overall readiness to provide ARV services was 46%, indicating on average, facilities had 3–4 of the 7 tracer items needed to deliver this service. Readiness to provide PMTCT was found to be 65%, indicating that on average, facilities had 6–7 of 10 items needed to deliver this service.

### **Tuberculosis**

About half of the facilities in Malawi reported offering tuberculosis (TB) services (49%). Almost all hospitals offered TB services (91%), however only 13% of clinics offered these services. CHAM facilities were more likely to offer TB services than government and private for-profit facilities. Rural facilities were more likely to offer TB services compared to urban facilities. On average, facilities offering TB services had 8–9 of the 12 items (73%) needed to deliver this service.

### Sexually transmitted infections

The majority of health facilities in Malawi (87%) reported offering treatment services for sexually transmitted infections (STI). These services were available at almost all hospitals (97%) and health centres (99%). CHAM facilities and facilities in urban areas were more likely to provide STI services than government facilities and facilities in rural areas. Readiness to provide STI services was 74%, indicating that on average, facilities had 5–6 of the 7 items needed to deliver this service.

# Noncommunicable disease services

For each service, the percentage of hospitals offering the service was computed as a measure of the availability of the service. In addition, for hospitals offering the service, readiness to provide the service was assessed based on the presence of a number of tracer items in the following domains:

- Guidelines and trained staff
- Equipment
- Diagnostic capacity
- Medicines and commodities

### **Cardiovascular disease**

Eighty–two per cent of hospitals in Malawi offered cardiovascular disease (CVD) diagnosis and/or management services. Government and CHAM hospitals were more likely to provide CVD services than private for-profit hospitals. Hospitals in rural areas were slightly more likely to provide CVD services than those in urban areas. Readiness to provide CVD services was 82%, indicating that on average, hospitals had 9–10 of the 12 items needed to deliver this service.

### **Chronic respiratory disease**

Eighty–four per cent (84%) of hospitals in Malawi offered chronic respiratory disease (CRD) diagnosis and/or management services. Almost all CHAM (93%) and government (90%) hospitals offered CRD services compared to private for-profit hospitals (22%). Hospitals in rural areas were more likely to offer CRD services than hospitals in urban areas. Readiness to provide CRD services was 69%, indicating that on average, hospitals had 7–8 of the 11 items needed to deliver this service.

### **Cervical cancer**

Sixty–nine per cent (69%) of hospitals offered cervical cancer services. Government hospitals had greater availability of cervical cancer services compared to CHAM and private for-profit hospitals. Rural hospitals were more likely to offer cervical cancer services than hospitals in rural areas. Readiness to provide cervical cancer services was 89%.

# **Clinical quality of care**

Measuring the availability and readiness of facilities to provide health services by observing availability and functionality of supplies and personnel is critical but insufficient to ensure that patients receive quality care. The health providers must have the clinical knowledge to correctly handle health conditions. The ability to provide the appropriate services was measured by assessing provider knowledge for specific health conditions using clinical vignettes. Providers' clinical knowledge was assessed for eight conditions common in children (pneumonia, malaria with anaemia, and diarrhoea with dehydration), adults (pulmonary tuberculosis and type 2 diabetes), and pregnancy-related conditions (anaemia in pregnancy, postpartum haemorrhage and neonatal asphyxia) in Malawi and other low-income settings. For each condition, the health providers were assessed for correct diagnosis, correct treatment and adherence to clinical guidelines.

# Correct diagnosis, treatment, and adherence to clinical guidelines for childhood, adult, and pregnancy-related conditions

Based on the clinical vignettes, the majority of providers demonstrated an ability to both diagnose and treat pneumonia (75%), tuberculosis (88%) and diabetes (78%); however, less than a quarter of the providers demonstrated an ability to both diagnose and treat malaria with anaemia (25%) and diarrhoea with severe dehydration (23%). For anaemia in pregnancy, 59% of providers mentioned the correct diagnosis and treatment.

Correct diagnosis and treatment varied by health provider, managing authority and level of facility. Overall adherence to guidelines, i.e. the average proportion of relevant clinical assessment components mentioned by the providers, for the six conditions was 53%. Adherence was highest for malaria with anaemia and lowest for diarrhoea with dehydration. Adherence to clinical guidelines was generally higher among doctors as compared to other provider cadres.

# Correct diagnosis, management, and adherence to clinical guidelines of maternal and neonatal complications

Although most providers were able to diagnose post-partum haemorrhage (91%) and neonatal asphyxia (81%), on average, providers mentioned only half of the treatment actions required for the appropriate management of the conditions (52% and 53%, respectively). Adherence to clinical guidelines for assessing the conditions was higher for neonatal asphyxia (56%) than for post-partum haemorrhage (47%).

### Appropriate assessment and counselling on nutrition for sick children

Nutrition screening and counselling during the delivery of health services are critical to address the challenges related to malnutrition in Malawi. In this survey we investigated the nutrition relevant actions taken by providers when visiting a sick child. The average proportion of items providers mentioned in their assessment on nutrition for a sick child ranged from 27% for pneumonia to 33% for diarrhoea while the average proportion of items providers mentioned related to counselling on nutrition for a sick child ranged from 31% for pneumonia to 58% for diarrhoea. There was little variation in the assessment and counselling scores based on provider cadre, managing authority, and urban/rural location.

# **Client experience**

User perspective provides critical information to better understand the drivers of service utilization and the responsiveness of the health care system to clients' needs. A total of 1785 ANC client exit interviews and 2333 exit interviews with caregivers of under-five children were conducted in order to assess the client experience after visiting a health facility.

### **Reasons for choice of facility**

The majority of pregnant women attending ANC (78%) and caregivers of under-five children (73%) chose a health facility because it was close to home. The second common reason for health facility choice was that it offered quality service (10% among women attending ANC and 9% among caregivers of under five years old children).

### Distance travelled, transport costs, and waiting times

The majority of ANC clients (61%) reported walking to the health facility and 21% reported using bicycle as a mode of transport to the health facilities. The average distance antenatal clients travelled to access a health facility for ANC services in Malawi was 6.2 km. Only 20% of ANC clients reported having to pay for transportation to the health facility. On average, the transportation cost for ANC clients who paid for transportation to the health facility was MK 753.1. antenatal clients in rural areas spent more on transportation cost than those in urban areas, which was estimated at MK 825.40 and MK 545.10, respectively. The average waiting time for an ANC client to be seen by a provider was 41.3 minutes.

The majority of caregivers of under-five sick children (75%) reported walking to the health facility, while 13% used bicycles. The average distance that caregivers travelled to access under-five health services in Malawi was 5.4 km. Only 20% of caregivers of under-five children reported having to pay for transportation to the health facility. On average, the transportation cost for caregivers of under-five children who paid for transportation to the health facility was MK 383.7. Caregivers accessing under-five care from hospitals and clinics were more likely to pay for services (30% and 34% respectively) compared to those accessing health centres, dispensaries, and health

posts (13%, 4%, and 1%, respectively). In addition, the cost of care was higher at clinics (MK 539.60) and hospitals (427.90) as compared to other facility types. The average waiting time for an under-five client to be seen by a provider was 38 minutes.

### Components of antenatal and under five care provided by health workers

The survey assessed the different components of antenatal and under-five care that were provided in health facilities across the country. Only 17% of ANC clients reported receiving all eight ANC components. However, on average, ANC clients received 75% of the components. In terms of physical examinations and assessments, most antenatal clients had their weight measured (91%) and uterine height measured (79%). However, fewer ANC clients had their blood pressure checked (69%). In terms of drug administration and immunization, there was a reasonably high proportion of women receiving iron/folic acid supplementation (89%) and asked if they have ever received a TT injection (71%). The most common counselling provided at ANC was on HIV (93%), followed by exclusive breastfeeding (54%), and lastly on diet (52%).

Only 4% of under-five child visits reported receiving all seven service components. However, on average, under-five child visits received 40% of the components. Most of the children had their age assessed (88%), while only 58% of the children were weighed, 14% had their height measured, 27% had their weight or height plotted, and 21% were told if the child's weight and height were adequate. Fifty per cent (50%) of under-five visits reported having a physical exam and 22% of under-five visits reported receiving counselling on continuous feeding of a sick child.

### Client feedback regarding facility, provider, and quality of care provided

In general, there was very good client feedback on antenatal care services. Most antenatal clients were satisfied with the operating hours (88%), number of days the facility is open (91%), time spent with health provider (92%), and the cleanliness of the facility. A few clients thought the facility was not clean (9%) and operating hours were inadequate (8%). On average, ANC clients were satisfied with 90% of the feedback items while only 62% of ANC clients were satisfied with all the feedback items.

In general, there was good client feedback on the quality of under-five care provided. 94% of under-five child visits reported that they had trust in the skill and abilities of the health worker, 89% reported the facility was open for an adequate number of days in a week, 88% reported it was easy to discuss health problems, 88% reported that the health worker spent sufficient time, 85% reported that the facility had adequate opening hours, and 84% reported that the facility was clean. There were a few under-five child visits that reported dissatisfaction with the facility opening hours (11%) and with the cleanliness of the facility (11%). In addition, 17% of under-five child visits did not think the health worker spent sufficient time with them.

# **Facility management and finance**

Facility management is an important contributor to health facility performance. The quality of health care delivered at hospitals and patient health outcomes are dependent not only on the availability of physical inputs and competent providers, but also on the health care system including management, leadership, and financing. Health authorities in Malawi responsible for managing hospitals in the country were interviewed on governance and accountability, patient feedback processes, management and leadership, health information systems and health financing.

### **Governance and accountability**

Most government (70%) and CHAM (76%) hospitals had a Hospital Advisory Committee (HAC). On average, government hospital HACs met five times in 2017 while CHAM hospital HACs met less often (three times in the same period).

### Patient feedback on health delivery

The majority of government (96%), CHAM (95%) and private for-profit (100%) hospitals had mechanisms of obtaining patients opinions on health services delivered and informing the hospital staff of patients' opinions. The most common complaints by patients overall were inconvenient opening hours (72%) followed by unavailability of doctors (39%). High consultation cost (46%) was mentioned for as a common patient complaint at CHAM hospitals while disrespectful support staff was additionally mentioned as a common patient complaint at private for-profit hospitals.

### **Management and leadership**

Supervision of facilities ensures that required standards are maintained and challenges in the provision of services are identified. Government hospitals received on average 5.3 supervision visits (approximately once every two months) and CHAM hospitals received on average 3.5 visits (approximately once every three months) in 2017. The quality of supervision varied according to managing authority with hospitals reporting that a supervisor used a checklist in 87% of government hospitals, 97% in CHAM hospitals and 50% in private for-profit hospitals. The most common constraints affecting the functioning of the hospital were unavailability of doctors in government (75%) and CHAM hospitals (51%) and unavailability of medicines in government (62%) and CHAM (35%) hospitals.

# **Review of routine health information**

Routine health information is used to monitor the trends in the burden and distribution of diseases, evaluate the impact of a health intervention, and inform health decisions or interventions. Regular quality review of health information is important to ensure sustained quality of the information. Less than half of the government and CHAM hospitals had monthly data review meetings (38% and 38%, respectively) and 11% of government hospitals and 8% CHAM hospitals did not conduct any such meeting.



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