4: Implementation of the EQUIP Continuous Survey

Background: Why do continuous surveys?

The lack of high quality, timely data for evidence-informed decision making at the district level presents a challenge to knowing what works to improve maternal and newborn survival in low-income settings. To address this problem, EQUIP implemented district-level continuous household and health facility surveys in Uganda (Mayuge and Namayingo districts) and Tanzania (Tandahimba and Newala districts) for the continuous feedback of data to the districts, both to support quality improvement teams and to evaluate the quality improvement intervention.

Method: What did EQUIP plan to do?

Continuous survey data were used for quality improvement in the intervention districts and for effect evaluation of the intervention. Over the 30 months of intervention (November 2011 to April 2014), EQUIP conducted continuous cross-sectional household and health facility surveys using independent probability samples of household clusters to represent each district each month, and repeat censuses of all government health facilities. All resident women aged 13–49 years (15–49 in Uganda) in selected households were interviewed about recent live births and use of health services (Photo 1). Geographical positioning was collected for all respondents for subsequent spatial analysis. Using repeat samples in this way allowed data to be aggregated at six four-monthly intervals to track progress over time for evaluation, and for continuous feedback to quality improvement teams in intervention districts.

Photo 1. Performing a survey

In both countries, one continuous survey team of eight people was employed to interview approximately 300 households, 10 health facilities, and complete 10 health worker interviews per district, per month. Data were collected using personal digital assistants. After every four months of data collection, routine tabulations of all indicators were produced and synthesized into **report cards** (*see overleaf*) for use to support decision making by the EQUIP quality improvement teams.

Results: What did EQUIP achieve?

The continuous surveys were implemented as planned. Completion of household interviews was consistently over 90% in both countries. Indicators across the continuum of care for mothers and newborns were tabulated every four months, the results were summarized and were discussed by the quality improvement teams. However, due to the limited sample size (to limit costs) report cards could only show district estimates but not estimates for the respective target populations of each health facility. At the end of the intervention period, the same data were used for the impact evaluation.

Conclusion

The continious surveys were feasible and provided high quality data throughout the EQUIP implementation period which were use for regular feed-back to the teams.

For further information contact: Tanya Marchant (tanya.marchant@lshtm.ac.uk) and Joseph Akuze (Joseph2.Akuzewaiswa@live.uwe.ac.uk) ; Peter Waiswa (pwaiswa@musph.ac.ug) in Uganda; and Yovitha Sedekia (ysedekia@ihi.or.tz) or Fatuma Manzi (fmanzi@ihi.or.tz) in Tanzania

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Using Report Cards for Feedback and Action

Background: The use of report cards to stimulate action

Both quality improvement and health system strengthening programs need health data as the basis for decision-making, planning, and monitoring. High quality population data on health outcomes are rarely available at the local level. The continuous household and health facility surveys implemented by EQUIP produced high quality real-time, district-specific data, which we summarised every three-to-four months for district, health facility, and community quality improvement teams using "report cards". We used reports card to introduce new topics for quality improvement during the learning sessions and, at the district level, to discuss progress.

"Community teams felt highly motivated by seeing data from their own areas."

Methods: What did the report cards look like?

Report cards were specifically adapted for three different levels of care. The community report cards included very few indicators and used a simple graphical display for ease of being understood by community quality improvement teams (Figure 1). Content of report cards was tailored to the interests of quality improvement teams and designed to trigger action.

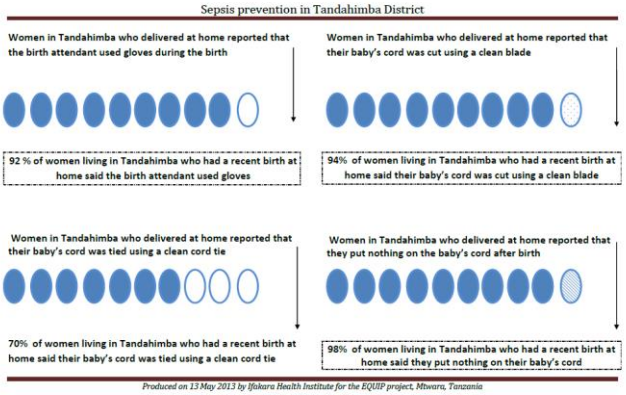

Figure 1: Community report cards used during a learning session to introduce infection prevention

The health facility and district report cards used bar charts and run-charts, which also allowed the indication of trends over time or levels in different parts of the district (Figure 2).

The use of the report cards was supported by the EQUIP team. The report cards were introduced during learning sessions and indicators were explained: how they were constructed; which questions were asked of respondents; and which limitations the indicators had.

This explanation led to discussions on the reliability of many common indicators. This process also built capacity to interpret indicators for monitoring of maternal and newborn health at the district level.

Conclusion: What did we learn?

The report cards were met with high interest at the community, health facility, and district levels and were able to trigger attention for neglected areas of health care. Help with interpretation of indicators was important so that improvement teams understood what the data could tell them. The capacity to interpret population- and facility-based data improved over time but required considerable facilitation by project staff.

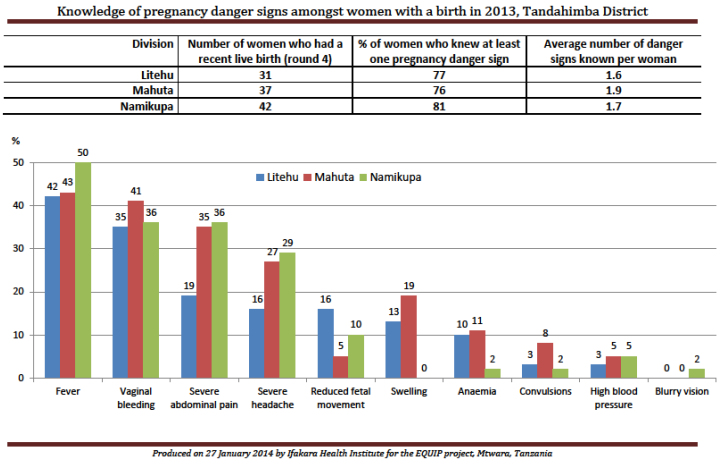

Figure 2: District and health facility report cards on knowledge of danger signs

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