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Research Article

ASSESSMENT OF QUALITY ASSURANCE PROGRAMME OF A DEPARTMENT OF HEALTH AND FAMILY WELFARE OF INDIA

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ABSTRACT

Background: Internationally there is growing recognition for increased focus on quality of care in population programs. Assessment was carried out with the overall aim of reviewing the whole process of Quality Assurance Programme (QAP), to identify gaps and to take corrective measures in accordance to the action plan that would originate from the assessment.

Methodology: A multi-stage sampling technique was used to select districts from the state being divided into 6 administrative regions. First, one district was selected randomly from each region. 4 PHCs and 2 CHCs were randomly selected from each of the selected districts based on the performance. Clients' perspective about the quality of services was obtained through exit interviews of the clients from the selected facilities. To include the perspectives of the stakeholders directly related to QAP at various levels, Focus Group Discussions and In-depth interviews with the providers and managers were utilized.

Results & Conclusions: The findings suggest that the major area of improvement or positive outcome were mainly those related to INPUT section viz; physical infrastructure, equipments and overall improvements in labor rooms. Improvement was also observed for maintenance of privacy at the facilities. The areas that needed further attention were; Maintenance of records specifically those related to continuity of care, availability of service protocols and guidelines, RTI/STI Lab Services, MTP Services, monitoring & review of QAP, client provider interaction and supportive communication between district and facility level.

Recommendations: Additional inputs required such as training of grass root level workers, recruiting staff, improving infrastructure facilities to upgrade CHCs and PHCs.

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INTRODUCTION

Background

Quality of Health Care has been the center-stage in the arena of Public Health System for quite some time now. Internationally there is growing recognition for increased focus on quality of care in population programs. (1) Different frameworks have been devised for Quality assessment and improvement for broader reproductive health (RH) services in different settings. (2,3) Apart from the techno-managerial aspects such frameworks have taken into consideration the perspectives of the clients as well. These frameworks also intend to bring an element of measurement in the quality of services. In India, much work is going on in this area for some time; lately the Reproductive and Child Health (RCH) programme as well as the National Rural Health Mission/ National Health Mission(NRHM/NHM) has also stressed the importance of providing quality reproductive health services.(4) Government of the state studied had recognized this as an important issue and had shown commitment for bringing improvement in the quality of reproductive health services provided through the public health system. In line with this the UNFPA and Population Council supported District Quality Assurance programme was started in two districts of the state on a pilot basis. It was later expanded to the entire state.(5) After two years of implementation of this programme an assessment was carried out with the overall aim of reviewing the whole process of Quality Assurance Programme, identify gaps and taking corrective measures in accordance to the action plan that would originate from the assessment.

METHODOLOGY

Objectives of the assessment; To assess health services provided by Primary Health Centers (PHC) and Community Health Centers (CHC) in terms of Input, Process & Output; to understand the facilitating factors, impeding factors and barriers to the implementation of the Quality Assurance

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Programme and; to suggest plausible ways of improving the Programme.

The first component of the assessment was to look at the status of the facility scores all over the state using Assessment Checklist. For this a multi-stage sampling technique was used to derive the sample. The state was divided into 6 regions. At first stage, one district was selected randomly from each of the region. Four PHCs and two CHCs were then randomly selected from each of the selected districts based on the performance. For CHCs, it was decided to select one good performing and one not so good performing CHC randomly from each district based on the data of Performance/Grading available for PHC's and CHC's that were visited by Quality assurance (QA) Officer. Likewise, for PHCs; two good performing and two not so good performing PHCs were selected from each district randomly. For districts where data was not available, CHC/PHC's were selected randomly to complete the sample size. To get the clients' perspective about the quality of services being provided, it was decided to conduct exit interviews of the clients availing services from the selected facilities. 50 clients were interviewed at each facility selected for the assessment. A semi-structured pre-tested instrument was used to get an idea about the client satisfaction regarding the services being provided by these facilities. In all 1800 clients were interviewed from all over the state. A thorough training of the supervisors and investigators for the entire process of data collection was conducted for one day before starting the exercise. The perspectives of the providers and stakeholders who were directly related to QAP, at various levels; the state, district, block and field officers in the hierarchy of public health system in the state were obtained by In-depth Interviews & Focus Group Discussions (FGDs).

A total of three separate focus group discussions (FGDs) were conducted, one each with the District Quality Assurance Medical Officers (DQAMO), Block Health Officers (BHO) and Medical Officers (MO) of PHCs & CHCs. All the three FGDs were conducted at a place decided as per convenience of the participants. The first FGD was conducted with the District Quality Assurance Medical Officers who are the district level officers primarily responsible to look after the Quality of health services issues in the district. A total of six DQAMOs from various districts participated in the FGD. Before the post of DQAMO was introduced, the Block Health Officers were actively involved in the QAP. So, it was necessary to include the perspectives of the Block Health Officers too. The second FGD was conducted with Block Health Officers. A total of eight BHOs from various districts participated in the FGD. Finally, to include the perspective of the facility level officials, one more FGD was conducted which was attended by seven PHC Medical Officers and two CHC Medical Officers from different districts.

To get an account of the views of State Level Authorities an In-depth Interview (IDI) was conducted with a State level officer. At the district level, the Chief District Health Officer (CDHO) is the nodal authority for implementation of QAP. CDHO is such a vital link in the overall functioning of the programme that it was imperative to include the views of this cadre in the assessment process. In all three IDIs were conducted with CDHOs. One more IDI was conducted with a District Quality Assurance Medical Officer. All In-depth Interviews were conducted at the offices of respective officers during the office hours.

RESULTS AND DISCUSSION

Facility assessment findings; The findings from facility assessment were divided into three parameters namely**;** Input, Process and Output. Inputs include all the material efforts that facilitate the readiness of the PHC/CHC to provide quality services, when a client visits the clinic. Inputs include physical infrastructure, staffing, supplies, equipment etcetera. The process section includes review of maintenance of records and some process observations. Process observations on the day of visit were to assess whether the providers were maintaining standards of care as specified in service guidelines. Output section includes usage change in different services over a period of time. The findings of the facility assessment show that major area of improvement was the Inputs section whereas the intended improvement was not observed in the Process and Output sections as shown in Fig.1. The scores were very poor in the process and output section. The scores were relatively higher for CHCs as compared to the PHCs in all three parameters. Inputs section had shown maximum improvement among all the three indicators of measurement of quality of services. The denominator score for PHCs was calculated to be 131 and the same for CHCs was 143. Grades according to Percent Scores were**; A** (76%+), B (51-75%), C (26-50%), D (0-25%). The assessment showed that the majority of the facilities had come up to B grade, with some in A and C grade. No facility was in D grade. The scores were better for CHCs where half of them were in A grade and half in B grade. For PHCs majority of the facilities were in B grade followed by C and A. Similar findings were observed by Misra S., Desai Niraj in their study in 2014(unpublished thesis).[6] It was found that infrastructure facilities were available in almost all the CHCs**,** findings similar to study by Sodani P R, Sharma K (as per IPHS 2010 guidelines for CHCs) in Bharatpur district. [7] It was observed that there was deficiency of specialists at CHCs; inadequate number of General surgeon, Anesthetist, Dentist, Pediatrician, Obstetrician/ Gynecologist, Nursing Staff and AYUSH. None of the CHCs had a Physician or Public health programme manager, Public Health Nurse these findings are also similar to study by Sodani P R, Sharma K.[7] Gaps were most striking in availability of skilled human resources and emergency obstetric services**;** was observed by Sharma J, et.al.[8] Similar result was seen for CHC by Nair A, *et al* in 2019, at the national-level WISN differences**;** they depicted workforce shortages for all considered HRH cadres.[9]

In process section, majority of the facilities were shown to be in D grade. None of the facility was in A grade. For CHCs half were in C grade followed by D and B. For PHCs majority of the facilities were in D grade. The denominator score for PHCs & CHC both were calculated to be 39. The process observations for this assessment did not include; Review of RTI/STI Records and Observation of Family Planning Services on Camp Day. Diarrheal disease care: History taking was excellent, but; examination, classification, treatment, ORT education were poor in a study by Rashmi *et al*. [10] While in the output section majority of the facilities were in D grade. None of the facility was in A grade. For both CHCs and PHCs, majority were in D grade. This was one more area with poor scores. The denominator score for PHCs was calculated to be 44 and the same for CHCs was 48. The mean obtained score for facilities in Input section was 65% (highest) and for process section it was 55%. Chavda Parag and Misra, [11] Malhotra S, *et al*[12] similarly found that no inpatient care was being rendered at the CHCs. Newborn care corners existed

within or adjacent to the labour room in all the facilities and were largely unutilized spaces in most of the facilities. Resuscitation bags and masks were available in four out of six facilities, with a predominant lack of masks of both sizes. Two CHCs in Chhatarpur did not have suction device. [12]

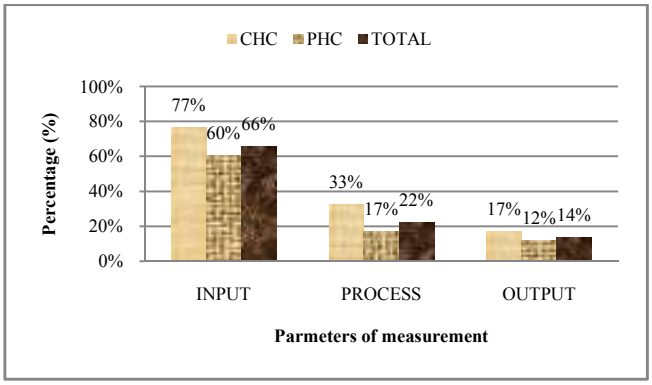

Figure 1 Comparison of the scores in three parameters of measurement

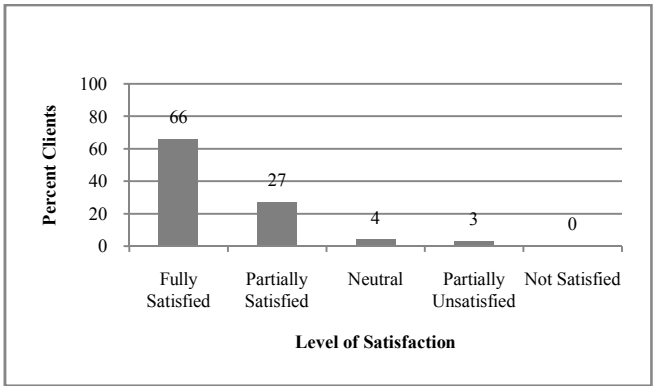

Figure 2 Client Satisfaction Level

Figure 2 shows that the majority of the clients were satisfied with the services. Client satisfaction was good in a study by Rashmi *et al*. [10] Overall the clients were satisfied with the obstetric care received at 24X7 PHCs, however post-natal stay needs to be extended to at least 48 hrs is quoted in a study by Macwana Jayaprakshkumar, Misra Shobha.[13]

Quality Assurance Programme (QAG) Visits: Findings from IDI & FGDs; As quoted by a participant "The QAP visits were regular earlier at the time of starting the programme. Gradually irregularities crept in and the frequency of visits started declining. Now the situation is that the visits are no more conducted except in few districts". Two prominent reasons for this were; District Quality Assurance Officer – the nodal person for QAP at the district level was being overburdened with assignments other than QAP and the second reason was a major policy change by the Health Dept of Government where they decided to go for Accreditation of the facilities. During the discussions; the officials of various cadres appreciated the checklist and the mandatory norm of observing each item as per checklist. The reason for deterioration in the visits was not the attitude of the District Quality Assurance Medical Officer (DQAMOs). In fact it appeared that the DQAMOs were quite involved in their work which was evident from their responses. But the same was not so for the cadre of Block Health Officer (BHOs). They were seen taking less interest in the QAP, some of whom (albeit minority) had negative opinion about QAP. Another reason for less involvement of BHOs was their busy schedule with their own routine work. About the formation of group for the visit the observation was that, it was difficult to gather 2 or 3 members at a place at a time to go for the visit, so they took the convenient path and only QAMO used to go for the visit.

Regarding debriefing the Medical Officer and his team, DQAMOs said that after finishing the checklist, they discussed the problem areas with Medical Officers and improvements were observed in facility score over time. In majority of the districts they had the practice to bring the filled up forms at the district office where the operator entered the data in the software which compileed the data and gave grading. They got to know about the grading only at the district office and not at the facility. The observation regarding the post assessment follow up action was that the actions at the Medical Officer level were implemented easily. QAP was being discussed during the meetings at district level but all such discussions were general and no specific action points were decided upon. District level QA officers said that they were given some 15 minutes time for presenting their findings during such meetings. But they were also unhappy with the fact that the involvement of other higher officials likes CDHO, Additional district health Officer (ADHO), Reproductive and Child Health Officer (RCHO) etc., at the district level was not much. It appeared that the involvement of and action at the district level was largely dependent on the attitude of the chief of the health department at the district level. While the communication between the state level officials and the District QA officers was good and the same with the chief of the district health team- CDHO- needs to be strengthened.

Perspectives of Stakeholders; During the interactions, officials from all cadres acknowledged the importance of quality of health services. Their perception of quality of care included client satisfaction, adherence to professional standards, client provider interaction or behavior of the providers among others. Another essential element for which almost all agreed to; was the triad of infrastructure, manpower and materials. Opinion about the QAP; Almost all cadres agreed to and appreciated the concept and the programme. Many of them suggested that such a component should be included in every health programme and not only RCH. Largely the CDHOs appreciated the programme. They were of the opinion that this should have been an inbuilt component and that it should run as a parallel programme. DQAMOs were having opinion in favor of QAP. While the same for the BHOs was mixed, some of whom termed QAP a failure. The district level officers also raised concerns over the least intervention by the state level authorities. A handy example for them was; neglect of the Reproductive Tract Infection/ Sexually Transmitted Infection (RTI/STI) component by the state level authorities. Similar was the response of the facility level officers for district level authorities. It was also largely felt by the facility Medical Officers that the district level office failed to solve the action points which could have been solved at the district level. This was also corroborated by the notion of the higher officials about the programme that it was meant to bring improvement using the resources available at the facility and the block office itself.

Opinion about overall effectiveness of the programme

The major areas that they perceived where improvement was seen were; infrastructure, equipments, cleanliness, privacy and Labor rooms among others. Their perception was that the programme could bring about improvement mainly in the inputs section as is also shown by our assessment. The consensus was that the desired improvement was not possible

for the process and output section. All were also of the opinion that there wass almost no change in the element of behavior of provider or client provider interaction after introduction of the programme. Overall the DQAMO cadre opined that the programme could bring 50% improvement. Whereas the BHO cadre had a mixed response and amongst them also majority agreed that inputs section witnessed substantial improvement. The opinion of the state level authorities as obtained from the state level official suggests that in infrastructure, there was marked improvement. Improvement was also observed in record keeping. About the trainings it was said that, the efforts were put in for trainings in Comprehensive Emergency Obstetric Care (EmOC), RTI/STI and Medical Termination of Pregnancy (MTP) and also for sending in-service candidates for diploma in Obstetrics & Gynecology (OG) and Anesthesia. Regarding the overall effectiveness it was opined that the programme helped in a great way in sensitizing the system from top to bottom for quality issues and also mentioned that the facilities that had poor score in pilot studies were improved and were scoring better.

CONCLUSIONS

The findings of the assessment suggest that the major area of improvement or positive outcome were mainly those related to INPUT section viz physical infrastructure, equipments and overall improvements in labor rooms. Improvement was also observed for maintenance of privacy at the facilities. The areas that need further attention were; maintenance of records specifically those related to continuity of care, availability of service protocols and guidelines, RTI/STI Lab Services, MTP Services, monitoring & review of QA programme, client provider interaction and supportive communication between district and facility level.

Recommendations

- Adequate emphasis should be given to process and output as well apart from Inputs.
- There is need for training on quality issues to grass root level workers too.
- Some specific problems of District QA officers needs to be addressed like acceptance of this post as a part of district level team and these officials not being overburdened with other assignments. More sensitization of the district level health officials like CDHO so that enough importance could be ensured at district level
- The inclusion of RTI/STI component needs further evaluation specifically for laboratory services. With inclusion of other components of RCH services particularly child health.
- Monitoring and review of Quality Assurance Programme on a regular basis.

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