

Institutionalization of Quality Assurance within District Health Management: Experiences from Maharashtra and Karnataka

Population Council

M E Khan
Anurag Mishra
Vivek Sharma
Jaleel Ahmad
Jose Joseph

UNFPA

Venkatesh Srinivasan
K M Sathyanarayana
Viji Vargees

MOHFW, GOI

K D Maiti
Rashmi Sharma

State Health Departments

State QA Nodal Officers
DHO, Ahmadnagar
DHO, Tumkur
RCHO, Ahmadnagar
RCHO, Tumkur

May 2008

This intervention has been possible because of the financial support of the United Nations Population Fund (UNFPA) under the terms of Cooperative Agreement No. UNFPA/India Award IND/03/P21, and by the generous support of American people through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. HRN-A-00-98-00012-00 and In-House Project No. 5800.53116. The contents are the responsibility of the FRONTIERS Program and do not necessarily reflect the views of UNFPA and USAID or the United States Government.



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Suggested citation: Khan, M.E., Anurag Mishra, Vivek Sharma, Jaleel Ahmad, Jose Joseph, Venkatesh Srinivasan, K.M. Sathyanarayana, Viji Vargees, K.D. Maiti, and Rashmi Sharma. 2008. "Institutionalization of quality assurance within district health management: Experiences from Maharashtra and Karnataka," *FRONTIERS Final Report*. Washington, DC: Population Council.

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EXECUTIVE SUMMARY

The National Rural Health Mission (NRHM) of the Ministry of Health and Family Welfare (MOHFW) proposed introducing a Quality Assurance (QA) program for assessing and improving of the quality of services at public sector health facilities. The Population Council and UNFPA jointly developed and tested a QA manual in Gujarat and Maharashtra states to demonstrate that QA can be readily integrated within district level management structures and procedures; subsequently, the QA program has been scaled-up to all 25 districts in Gujarat. Appreciating the potential of this QA model for improving quality of care, the MOHFW decided to pilot test a slightly modified version of the QA tools and manual in six states, including Karnataka and Maharashtra. The revised QA manual also covers a wider service delivery network by including sub-centers and Reproductive and Child Health (RCH) camps. The Population Council, with financial support from UNFPA, provided technical assistance to the states of Maharashtra and Karnataka in implementing the QA program and helped its institutionalization in the district level management.

To build the capacity of district officials to undertake QA visits, the Population Council and state authorities organized a series of events to orient and train state and district officials, facility level workers and members of the District Quality Assurance Group (DQAG). QA visits started in May 2007 in Ahmadnagar, Maharashtra and in July 2007 in Tumkur, Karnataka.

In the first round, 89 facilities in Ahmadnagar and 100 facilities in Tumkur were selected for QA visits. As of December 2007, the DQAG had completed the QA assessment in 80 facilities of Ahmadnagar and 100 facilities of Tumkur. Observations by Council staff of the quality of visits indicate that 64 percent were of good quality, about one-third were average, while a small proportion (6 percent) were of poor quality.

An analysis of all the facilities covered until the end of December 2007 revealed substantial gaps in the infrastructure and human resources available to provide good quality services, as well as adherence to standards for providing the services. The analysis of CHC/PHC inputs shows that 75 percent of facilities in Ahmadnagar and 94 percent of facilities in Tumkur were in grade B or C. Regarding the process of service delivery, more than two-thirds of facilities in Ahmadnagar (67 percent) and about 45 percent of the facilities in Tumkur scored C or D grade. This clearly points to the existing poor quality services provided by these facilities and need for improvement. The key gaps identified at facilities in both the districts are similar, including training of different providers, shortage of essential equipment and supplies, general cleanliness, infection prevention practices, repair and maintenance of buildings, updating of records, poor waste management, availability of protocols and job aids, display of information at facilities, among others.

The DHOs of both districts have established a mechanism to monitor and assess the extent to which the facilities have taken initiatives to address the gaps identified during QA visits. A review of the 'actions taken' show that in both the districts' facilities are using findings of the QA visits for improving the functioning of their facilities. For example, 51 percent of the suggested actions at CHC/PHC in Ahmadnagar and 48 percent in Tumkur have already been taken. Similarly, in the case of Sub-centers, the process of filling service delivery gaps has started in both the districts. A review shows that 28 percent of the gaps identified in Ahmadnagar

sub-canters and 50 percent in Tumkur have already been addressed. Analysis of the activities executed to date indicates that no-cost actions, which are mostly taken at the facility level, can be quickly executed as compared to the more costly actions for which the district or state require more time for allocating resources or making an approval before executing them. It is encouraging to note that beside no-cost actions many cost actions are also being attended to. For example, in Ahmadnagar more than half (54 percent) of the cost actions for CHC/PHCs and in Tumkur more than one-third (37 percent) have been executed.

Until January 2008, QA teams had revisited 40 facilities in Ahmadnagar and 8 facilities in Tumkur. A majority of the facilities in both the districts scored higher grades during the second visit as compared to their corresponding grades obtained in the first visit. Average scores of the facilities visited increased by 13 percent points in Ahmadnagar (from 68 to 81 percent) and 26 percent points in Tumkur (from 53 to 79 percent). This indicates that QA is making difference in the quality of services.

There are indications that the QA process is being institutionalized in the overall NRHM/ RCH program. The DHO of both the districts have provided all the logistics support to conduct QA visits and the funds for carrying out these visits are allocated in the District Project Implementation Plan (DPIP). In both the districts, the outcomes of the QA visits are now routinely being discussed in the monthly meeting of MOs at the district headquarter. All QA activities and related correspondence are now being referred to as NRHM work. Unrestricted funds made available at the facility level are being utilized for addressing minor gaps identified by the QA visits. More importantly, districts have started using PIP mechanism to generate funds to address gaps in services.

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ABBREVIATIONS

ADHO	Additional District Health Officer
ANC	Antenatal Care
ANE OR/TA	Asia and Near East Operations Research and Technical Assistance
ANM	Auxiliary Nurse Midwife
BP	Blood Pressure
BPHC	Block Primary Health Center
CDHO	Chief District Health Officer
CHC	Community Health Center
CMO	Chief Medical Officer
COPE	Client-Oriented Provider-Efficient
DPHN	District Public Health Nurse
DPIP	District Project Implementation Plan
DQAG	District Quality Assurance Group
ECP	Emergency Contraceptive Pills
EmOC	Emergency Obstetric Care
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
FP	Family Planning
FHW	Female Health Worker
FRU	First Referral Unit
FW	Family Welfare
FWTC	Family Welfare Training Center
GOI	Government of India
HA	Health Assistant
HIV	Human Immuno-deficiency Virus
HLD	High Level Disinfection
ICPD	International Conference on Population and Development
IPC	Inter-Personal Communications
IPD	Integrated Population and Development
IPHS	Indian Public Health Standards
IUD	Intra-Uterine Device
JSY	Janani Suraksha Yojana
LAM	Lactational Amenorrhea Method
LHV	Lady Health Visitor
MH	Ministry of Health
MIS	Management and Information System
MO IC	Medical Officer In-Charge
MOHFW	Ministry of Health and Family Welfare
MS	Medical Superintendent
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organization
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
NSV	No scalpel Vasectomy
OCP	Oral Contraceptive Pills

OPD	Out-Patient Department
OR	Operations Research
OT	Operation Theatre
PHC	Primary Health Center
PNC	Post-Natal Care
POL	Petrol, Oil and Lubricants
QA	Quality Assurance
QAC	Quality Assurance Committee
QAG	Quality Assurance Group
QI	Quality Improvement
QoC	Quality of Care
RCH	Reproductive and Child Health
RCHO	Reproductive and Child Health Officer
RH	Reproductive Health
RKS	Rogi Kalyan Samiti
RTI	Reproductive Tract Infection
STI	Sexually Transmitted Infections
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

BACKGROUND

To give impetus to improving the quality of services, the Ministry of Health and Family Welfare (MOHFW), Government of India, recently decided to establish a District Quality Assurance Committee (QAC) headed by the Civil Surgeon of each district. Until now, however, the mandate of the QAC was only to ensure the quality of sterilization services, the key family planning method contributing 68 percent of the total contraceptive prevalence rate in India. The MOHFW has the intention to increase the role of this committee to cover the entire Reproductive and Child Health (RCH) program in the district. For this purpose, the Quality Assurance (QA) initiative has been extended on a pilot basis in six states in collaboration with three development partners (UNFPA, USAID and GTZ).

To ensure implementation of the QA program, responsibility for providing technical assistance (TA) to the study states was entrusted to three agencies, including the Population Council. The objective of the TA was to train the district level officials to carry out quality assurance visits, identify the gaps and address them. TA was also extended to help district and state officials to institutionalize the QA process in the district management, integrate it in the National Rural Health Mission (NRHM), and make it a part of Program Implementation Plan (PIP) efforts both in districts and at the state level. Population Council, with support from UNFPA, is providing TA in the states of Maharashtra and Karnataka; other development partners are supporting this activity in the states of Uttar Pradesh, Uttaranchal, Assam and West Bengal.

TOOLS AND METHODOLOGY

The tools, checklists and manual for assessing quality assurance measures has been developed by the FRONTIERS Program of Population Council and was first tested in the states of Maharashtra and Gujarat (Varkey, Caleb, Khan, Agarwal and Sharma 2006). An evaluation of the program revealed that institutionalization of QA at the district level management is both feasible and useful for program development. It further showed that QA visits led to significant improvements in the readiness of the health facilities - PHC and CHC – and guidance for enhancing the process of service delivery. Encouraged by these results, the Government of Gujarat, with the technical assistance from the Council, expanded the QA program throughout the entire state in a phased manner (Khan, Mishra and Sharma 2007).

Appreciating the potential of QA checklists for improving the quality of care, the same tools and methods were used in the six states' pilot districts. However, before using the tool UNFPA and the MOHFW, in consultation with Population Council, EngenderHealth and PATH, expanded the scope of the manual by including checklists for Sub-center and RCH camps and coverage of immunization programs. The revised version of the manual has been used in this pilot study.

IMPLEMENTATION OF QA WITHIN DISTRICT HEALTH MANAGEMENT

Preparatory Work

Implementation of QA by the state governments is being carried out under a memorandum of understanding between MOHFW, Government of India and the Departments of Health and Family Welfare in the study states. Before initiation of QA program, the states and districts had to carry out certain preparatory work. This included: (a) allocation of adequate funds in the district plan for carrying out the QA activities, (b) identifying nodal officers- one each at state and district level to coordinate the QA program, and (c) constitution of District Quality Assurance Group (DQAG). It also included the provision of all logistic support for QA activities including transportation, Petrol, Oil and Lubricants (POL) for visits, printing of checklists, a dedicated computer for the QA program and office space for QA staff seconded by Population Council at the district health office to provide TA in the implementation of the QA activities. It was also suggested that the study district should be advised to use unrestricted funds available to the districts and health facilities under the RCH II program to address the gaps and problems identified in service delivery during quality assurance visits.

To build the capacity of district officials to undertake QA visits, a multi-layer training strategy was adopted to orient and train state and district officials, facility level workers and the members of DQAG. These workshops were organized back-to-back in both the states in April 2007 in Maharashtra and in May 2007 in Karnataka. A description of these meetings is given below.

Orientation

Orientation of State and District Nodal Officers: At the request of the MOHFW, each state nominated state and district level nodal officers to collaborate and manage QA activities. These state and district nodal officers were first oriented about the QA program before launching the program in the states. Accordingly, MOHFW requested these officials to attend the orientation meeting which Population Council organized on April 9-10, 2007 (DO No. Y 15011/2/2004-Stat, Dated March 05, 2007). The state and district nodal officers attended the meeting from the states of Maharashtra and Karnataka. Colleagues from UNFPA also attended the orientation meeting and provided valuable inputs in orienting the nodal persons.

Initially the officials were apprehensive about the time required to complete the QA visits since they were already overburdened with special health programs such as malaria eradication, Directly Observed Treatment Short-course (DOTS), Pulse Polio, Janani Suraksha Yojna (JSY), among others. However, the initial apprehension was short-lived. Once the officials went through the checklists, they found the tools useful in assessing and improving the quality of reproductive and child health services, and lent their full support to the QA program.

Orientation of State Officials: The QA program began with orientation of state level officials at the state headquarters of both the states. The purpose of the orientation was to make the state officials aware of the QA intervention, bring them on-board for future support,

institutionalization and its scaling-up. In Maharashtra, a half-day meeting with state officials was organized in Mumbai on April 16, 2007. Twenty-two senior level officials including the Secretary and Commissioner of Health and Family Welfare, Joint Secretary, Director Health Services, and Directors of other health programs participated in the meeting. Representatives of UNFPA and MOHFW, GOI, also participated in the meeting. Similarly, in Karnataka, a half-day meeting for the state officials was organized in Bangaluru on May 3, 2007. The Principal Secretary of Health and Family Welfare inaugurated the orientation and underlined the importance of the project. Other participants included the Director Health Services, Project Director RCH, and Directors of different health programs. Forty-one state level officials participated in the meeting. Representatives of MOHFW, GOI and UNFPA also attended the meeting.

Orientation of District Officials: Following the state level orientations, a half-day QA orientation meeting was organized in the project districts of Ahmadnagar, Maharashtra and Tumkur, Karnataka to orient the district level officials about the QA intervention. In both the districts, the Chief Executive Officer (CEO), District Health Officer (DHO), Civil Surgeon, Reproductive and Child Health Officer (RCHO), Additional District Health Officers (ADHOs) of different departments, District TB Officer, District Malaria Officer, among others, attended the meeting. The QA nodal officers of respective states and UNFPA and Ministry representatives also participated. In all, 28 and 38 district level officials attended the orientation meeting in Ahmadnagar and Tumkur, respectively. During these meetings, the DQAG consisting of 21 officials (15 male and 6 female members) was constituted in Ahmadnagar and the DQAG consisting of 20 officials (14 male and 6 female members) was constituted in Tumkur district.

Orientation of Rural Hospital/CHC/PHC MOs: All Facility In-charges of Rural Hospitals (RH)/CHCs and PHCs were oriented in QA to make the QA process more transparent and an effective tool for improving the quality of services rather than making it a policing and monitoring visit. Accordingly, in both the project districts, a full day QA orientation workshop was organized at the district headquarters to orient the Medical Officers In-charge (MOIC) of selected PHCs and Medical Superintendents of all CHCs/Rural Hospitals. These workshops were conducted immediately after the district level orientations. In Ahmadnagar, 46 Facility In-charges participated in the workshop. In Tumkur, the MOICs of all 89 CHC/PHCs attended the meeting. Beside presentations on tools and the manual, the MOICs were also given copies of checklists so that they could better understand the parameters of how their facility would be assessed and in turn, could assess the quality of RCH services at their facility, if they wished to.

Initially the MOICs felt that the QA visits were yet another kind of supervisory visit by district officials. However, when the de-briefing process and their involvement in decision-making to fill the gaps were explained, they became quite interested in the QA visits. Some of them also suggested that would conduct the assessment themselves every month. This was an ice-breaking exercise and turned out to be useful. The fact that the QA process provided an opportunity for introspection rather than policing was appreciated. Table 1 gives an overview of the training efforts to build QA capacity of officials at state and district levels.

Table 1: Orientation/Training Workshops in Maharashtra and Karnataka

Orientation/Training of	Location of Training	No. of Persons Participating
Nodal officers and UNFPA State Program Officer of Maharashtra	Population Council, New Delhi	5
State level officials	Mumbai and Bangaluru	22 41
District level officials	Ahmadnagar, Maharashtra Tumkur, Karnataka	28 38
MO I/Cs of RH/CHC/PHCs	Ahmadnagar, Maharashtra Tumkur, Karnataka	46 89
DQAG	Ahmadnagar, Maharashtra Tumkur, Karnataka	21 20

Training of DQAG

In Ahmadnagar, a four-day training of 21 DQAG members was conducted during April 19-23, 2007 at the district headquarters. Similarly, in Tumkur, 20 DQAG members were trained during May 7-10, 2007. At both the places, the first two-day classroom training covered the introduction of the QA program, institutional mechanism and formation of DQAG, roles and responsibilities of key players, detailed presentation of PHC/CHC, Sub-centre and RCH camp checklists, and how to analyze data and prepare summary reports. On the third day of training, the trainees were divided into 4-6 teams for field practice and they visited different CHC/PHCs/Sub-centers. The field practice was organized similar to how they would be conducting the QA visits. The trainers observed each of their activities during field practice. On the concluding day, the trainees first discussed their field experiences. This was followed by an observation of the trainers in terms of how the work was divided, how the questions were posed and recorded, and views on debriefing. Later, they were given training on how to analyze the data and prepare QA reports. The process of administering the checklist, its completeness and debriefing of facility staff during field practice suggested that trainees had good understanding of how to conduct QA visits. Following the training, a bi-annual QA itinerary was also finalized in consultation with the DQAG.

Initial Bottlenecks

Although the MOHFW had asked the state and districts to identify nodal persons, ensure the necessary logistic arrangements and allocate resources to conduct QA activities, there were delays in initiating the activities. Some of the problems encountered were:

- **Delay in identifying and orientation of state and district nodal persons.** Several letters and telephonic calls were made to expedite the process. This delayed the initiation of work considerably.
- **Delay in approval of the budget by the state for QA activities.** While this did not affect the QA activities in Ahmadnagar district, it delayed the initiation of QA visits in Tumkur. In Ahmadnagar, the CEO and DHO along with his DQAG team decided to initiate QA visits immediately after the training and they allocated resources for vehicle and POL from the flexi-budget until the formal approval came from the state. In Tumkur, the DHO and District Program Manager (DPM) could not take a similar

decision but had to wait for formal approval of the State. Repeated letters to concerned state officers by Population Council staff and interventions from the MOHFW and UNFPA were made to initiate the process. Thus, visits in Tumkur started only after two months of training.

- **Delay in provision of logistic support to QA staff in both states.** Delayed provision of office space, a computer for data entry and analysis, and a printer to QA staff at the district level reduced their efficiency and effectiveness in functioning for few months.

Implementing QA Visits

In the first round, 89 facilities in Ahmadnagar consisting of 22 Rural Hospitals, 24 PHCs and 43 Sub-centers and 100 facilities in Tumkur consisting of four CHCs, 31 PHCs, 47 Sub-centers and 18 RCH camps, were selected for QA visits. As of December 2007, the DQAG had completed the QA assessment in 80 facilities of Ahmadnagar district of Maharashtra and 100 facilities of Tumkur district of Karnataka, respectively. Although the DQAG of both the districts had made a bi-annual visit plan and did their best to adhere to it, some of the visits could not be carried out as planned. As a result, 35 percent of visits in Ahmadnagar and 16 percent of visits in Tumkur were postponed and carried out on a rescheduled date. The key reason for rescheduling the visits was the non-availability of team members or the facility staff because of conflicting dates with other programs. The distribution of QA visits is presented in Table 2.

Table 2: Distribution of QA Visits Conducted until December 2007

Facility	Ahmadnagar, Maharashtra (May-December)	Tumkur, Karnataka (July- December)
CHC/RH	18	4
PHC	23	31
Sub-center	39	47
RCH Camps	0	18
Total	80	100

Under the project, a wider service delivery network was to be included with Sub-centers and RCH camps. However, until recently, in neither of the two states were QA visits to RCH camps made. An inquiry on the reasons for the non-compliance revealed that RCH camps as defined by Government of India should provide Antenatal Care (ANC), Postnatal Care (PNC), Immunization and Reproductive Tract Infections (RTI)/ (Sexually Transmitted Infections (STI) services apart from Family Planning Services. In Ahmadnagar, however the camps offer only sterilization services. In Tumkur district, the health machinery is in the process of transforming the sterilization camps into RCH camps by including ANC, PNC and Immunization services.

Council staff regularly accompanied the QA team, assisted them in collecting the data, and provided TA, if required. They were also provided with a checklist to complete for each of their QA visit, based on how the QA visit was organized and implemented. Based on the checklist and observations made they were asked to prepare a report on their QA visit and classify the quality of the visit under ‘good’, ‘average’ and ‘poor’ categories (See facility visit report in Appendix 2-b). The attributes for classifying ‘good’ quality visit are presented in Box 1. The absence of two or more of the quality attributes lead to a visit being classified as ‘average’ or ‘poor’. An analysis of the results showed that majority of the visits (64 percent) were of ‘good’ quality, about one-thirds (30 percent) were marked as ‘average’, while the rest (6 percent) were of ‘poor’ quality (Table 3). Observations on the debriefing sessions with Facility In-charge were generally precise, all gaps were pointed out and action points were listed and discussed. This points that at the initial stage of the implementation of the QA initiative TA is critical to ensure the institutionalization of the procedure for district level management.

Box 1: Attributes of Good Quality Visit

- Proper logistic arrangement
- Good coordination and communication among the team members and with the Facility In-charge
- Proper timing for QA visit
- Following manual instruction in filling out checklists
- All team members participating in assessment
- Conducting assessment in a cordial and supportive manner
- Precise and appropriate debriefing by the team leader

Table 3: Observation on QA visits

Observation Indicators	Ahmadnagar (n=26)	Tumkur (n=18)
Usual time when the QA team starts from District Headquarter	Between 8.00 to 10.00 a.m.	Between 9.00 to 10.00 a.m.
Average time spent by QA team in the facility <ul style="list-style-type: none"> • All facilities • At CHC/PHCs • At Sub-centers 	2.5 hours 3.0 hours 2.0 hours	3.0 hours 3.5 hours 2.5 hours
Pre-assessment briefing with facility staff conducted <ul style="list-style-type: none"> • Average number of providers present at CHC/PHC including MOIC 	26 (100 %) 3	18 (100 %) 3
QA team members divided up the assessment work	26 (100 %)	18 (100 %)
All members engaged in assessment work	26 (100 %)	18 (100 %)
Maternity/immunization clients present during visit and QA teams observed service delivery process	17 (75 %)	12 (67 %)
Debriefing with the Facility In-charge conducted <ul style="list-style-type: none"> • Average number of staff participated in debriefing at CHC/PHC 	26 (100 %) 3	18 (100 %) 4
Overall impression on quality of visit		
Good	16 (62 %)	12 (67 %)
Average	7 (19 %)	6 (33 %)
Poor	3 (19 %)	0

GAPS IDENTIFIED AND ACTIONS SUGGESTED BY QA TEAMS

Service Delivery Gaps Identified

The key gaps identified at CHC/PHCs in both the districts are similar and include: training of different providers; purchase of equipment and capital goods; general cleanliness; infection prevention practices; repair and maintenance of buildings; updating of records; waste management; and the availability of protocols and job aids, among others. At Sub-centers, the key gaps in RCH service delivery include: incomplete or no record keeping; poor waste management practices; non-display of citizens' charter and information about other government programs; lack of equipment and medicines; and poor maintenance of the buildings. Table 4 gives the district-wise distribution of gaps identified at the facilities.

Table 4: Key Service Delivery Gaps Identified during QA Visits

Type of facility	Ahmadnagar, Maharashtra	Tumkur, Karnataka
CHCs/ PHCs	<ul style="list-style-type: none"> • MOs training in BeMOC/ EmOC, RTI/STI, MTP • RTI/STI training for LHV/ANMs/Lab Technicians • Counseling skills of ANMs/LHV • Filling of vacant posts of lab technicians • Establishment of labs at PHCs • Building needs repair and maintenance • Equipments supply, such as autoclave, Ambu Bag, weighing machine • Supply of reagents such as gram staining, RPR kits, kits for ABO/Rh blood grouping • Supply of ECPs • Improvement of general cleanliness and infection prevention practices • Incorporation of proper waste management practices • Updating of records and its proper maintenance • Essential protocols and guidelines • Display of citizen's charter and information on government programs 	<ul style="list-style-type: none"> • MOs training in BeMOC/EmOC, MTP • Availability of anesthetists • Training of surgeons for sterilization • Counseling skills of ANMs/LHVs • Staff orientation in clinical practices such as giving Polio-0 dose and BCG at birth, use of needle cutter/puncture proof box • Building maintenance and cleanliness • Functional toilet for women • Equipments supply such as autoclave, Ambu bag, weighing machine • Supply of reagents such as gram staining, RPR kits, kits for ABO/Rh blood grouping • Functional OT at PHCs to provide Anesthesia and conduct a C-section • Supplies of drugs and consumables such as Injectable Magnesium Sulphate, Misoprostol, and glutaraldehyde concentrate, ECPs • Updating of records and its proper maintenance • Essential protocols and guidelines • Display of citizen's charter and signboards
Sub-centers	<ul style="list-style-type: none"> • Improvements in ANMs knowledge on ECPs, IUD • Repair/maintenance of building • Electrification of some Sub-centers • Equipments and supplies- Baby Ambu bag, Partograph, Labor table, step stool, mattress, Mackintosh and Kelly's pad • Updating various records. • Incorporation of proper waste management practices • Display of citizen's charter and information about available services and timing 	<ul style="list-style-type: none"> • Improvements in ANMs knowledge on ECP • Repair/maintenance of building • General cleanliness of sub-centers • Amenities for clients' comfort, such as drinking water, benches in shade, toilet • Equipments and supplies- Baby Ambu bag, Partograph, Labor table, step stool, mattress, Mackintosh and Kelly's pad • Updating of various records • Display of sign boards exhibiting available services, day and timing

Type of facility	Ahmadnagar, Maharashtra	Tumkur, Karnataka
RCH Camps	No RCH camp conducted as per GOI guidelines. No QA visits made.	<ul style="list-style-type: none"> Poor surgical practices Non-availability of Anesthetist, who needs to be available in RCH camps Non-adherence of camp timings Non-availability of ANC services Non-availability of IUD cards, IEC material, electricity generator, functional vehicle Lack of NSV sets, RTI/STI medicines, Gram staining, Centchroman and ECPs

Number of Actions Identified and Responsibility Assigned for Actions

The gaps identified during QA visits were classified into three categories by the level where the specific action should be taken to address the gaps identified, i.e., facility level, district level and state level. Accordingly, problems such as cleanliness, minor repairs and maintenance of buildings, proper maintenance of records, and observing standard infection prevention practices and proper clinical procedures were classified as actions that should be taken by the concerned facility. The actions related to supply of equipment, medicines and consumables, supply of protocols and guidelines, arranging training of different providers and requesting state for the purchase of capital goods were classified as district level activities, and the action related to actual organizing the training of providers and purchase of capital goods were classified as state level activities. However, in this analysis all state level actions have also been combined with district level actions (See Table 5) because it is assumed that districts are primarily responsible for requesting the states to initiate state level actions. The analysis of gaps identified and actions suggested by QA teams during the visits made until December 2007 indicates that in Ahmadnagar, on average 28 action points for CHC/PHCs and 16 action points for Sub-centers were identified to improve the quality of service delivery. The corresponding figures for Tumkur were 43 and 27 respectively (Table 5).

Table 5: Number of Actions Suggested by QA Teams by Facility and Level of Actions

Facility	Ahmadnagar (n=80)			Tumkur (n=100)		
	Facility level	District/ State level	Total	Facility level	District/ State level	Total
CHC/RH	135	267	402	56	91	147
PHC	257	481	738	536	820	1356
Sub-center	282	345	627	581	722	1303
RCH Camps	-	-	-	101	157	258
Total cumulated actions	674	1093	1767	1274	1790	3064
Avg. no. of actions at CHC/PHC	10	18	28	17	26	43
Avg. no. of actions at sub-centers	7	9	16	12	15	27
Avg. no. of actions at RCH Camps	No visit to RCH Camp		-	6	9	15

The gaps that have been identified and follow-up actions suggested to be taken at the facility level are mostly no-cost actions such as efforts to improve cleanliness, record keeping, and infection prevention. However, the facility level actions also include maintenance of building and equipment and the purchase of supplies by using unrestricted funds. Due to limited resources, not all gaps can be fully addressed but many improvements can be initiated. The actions that have been suggested at the district level require approval or procurement at the district or state level. These include the training of providers, availability of protocols and job aids, and the supply of equipment, medicines and other consumables.

ACTIONS TAKEN: PROCESS AND PERFORMANCE

Process

DHOs in both the districts have established mechanism to monitor and assess the extent to which facilities have taken the initiative to address the gaps identified by QA visits. For this purpose, the MOICs of each CHC/PHC have been asked to provide information on the Action Taken Reporting Form about the initiatives they have taken to address the gaps and provide reasons in case of failure to take action. They have been instructed to return the filled out form to the Taluka Health Officer (THO) in Ahmadnagar and to the Actions Review Committee in Tumkur. Experience from the field shows that this mechanism has been largely institutionalized in the system and the district authorities are getting regular feedback on 'actions taken' (See Actions Review Form in Appendix 3).

Performance

The review of the 'actions taken' form shows that in both the districts, facilities are using findings from the QA visits for improving functioning of their facilities. For example, 51 percent and 48 percent of the gaps identified in the CHC/PHCs have already been addressed in Ahmadnagar and Tumkur, respectively. Similarly, in case of Sub-centers the process of addressing service delivery gaps has started in both the districts. A larger proportion of gaps identified at sub-centers have been addressed in Tumkur (50 percent). However, Ahmadnagar needs to accelerate the execution of 'actions taken' at the Sub-center level, where only 28 percent of identified actions have been addressed so far (Table 6). The possible reasons for fewer Sub-centers level actions in Ahmadnagar as compared to Tumkur could be the DHO's decision to move stepwise and address the gaps at CHC/PHCs first followed by Sub-centers. A majority of Sub-centers in Ahmadnagar are in Grade A or B (84 percent) and they require fewer but major actions such as training of providers, construction of building, electrification, water supply, training of ANMs on RTI/STI screening, which demand more time and resources for execution.

Table 6: Number of Facility and District Level Actions Executed in Both the Districts

Type of Facility		Ahmadnagar (n= 23 CHC/PHCs, 21 SCs)			Tumkur (n= 29 CHC/PHCs, 38 SCs)		
		No. of Actions Executed	No of Actions Identified	Average Actions Taken	No. of Actions Executed	No of Actions Identified*	Average Actions Taken
CHC/ PHC	Facility level	119	248	48%	370	548	68%
	District level	224	421	53%	185	616	31%
	Total	343	669	51%	555	1164	48%
Sub-center	Facility level	77	137	56%	402	636	63%
	District level	21	210	10%	143	454	31%
	Total	98	347	28%	545	1090	50%

The identified service delivery gaps not requiring resources for corrective actions were grouped together as ‘no-cost actions’. Similarly, the gaps requiring resources to address them were grouped and identified as ‘cost actions’. Analysis of the activities executed indicates that no-cost actions, which are mostly to be taken at the facility level, can be quickly executed as compared to the cost actions for which the district or state require more time for allocating resources or obtaining approval before executing them.

The analysis of the ‘actions taken’ reports submitted by 44 facilities of Ahmadnagar and 67 facilities of Tumkur shows that in Ahmadnagar around half of all no-cost actions, and in Tumkur around two-thirds of no-cost actions have been executed. The no-cost actions are mostly related to the process of service delivery, and are largely meant to be taken at the facility level. These include cleanliness, infection prevention, and record maintenance, among others. Alternatively, most of the cost actions are expected to be taken at the district or state level, which include: supply of equipment, medicines, contraceptives, protocols and job-aids, repair or construction of building, training of providers and purchase of capital goods such as a generator or a vehicle. The analysis shows that in Ahmadnagar more than half (54 percent) of the cost actions for CHC/PHCs and in Tumkur more than one-third (37 percent) have been executed. Some cost actions have also been reported at the Sub-center level (18 percent in Ahmadnagar and 40 percent in Tumkur (Table 7).

Table 7: Cost and No-cost Actions Identified and Executed at Facility and District Level

Type of Facility		Percent of No-cost Actions Taken		Percent of Cost Actions Taken	
		Ahmadnagar % (N*)	Tumkur % (N)	Ahmadnagar % (N)	Tumkur % (N)
CHC/ PHC	Facility level	48 (211)	67 (412)	46 (37)	68 (136)
	District level	0 (10)	--	55 (411)	31 (616)
	Total	46 (221)	67 (412)	54 (448)	37 (752)
Sub-center	Facility level	55 (99)	62 (499)	60 (38)	66 (137)
	District level	0 (8)	--	10 (202)	31 (454)
	Total	51 (107)	62 (499)	18 (240)	40 (591)

* N = Number of actions identified are given in brackets

These results are encouraging as they indicate that QA findings are being used for improving the quality of services and actions are being taken to fill the gaps in services even if it costs resources. However, the process of these addressing and completing the ‘actions taken’ needs to be accelerated. The required resources for filling the gaps could be easily addressed by including the suggested actions in the DPIP and allocating required resources in the budget.

Some district level actions, which have been initiated, are presented in Table 8.

Table 8: District Level Actions Initiated in Ahmadnagar and Tumkur

Ahmadnagar	Tumkur
<ul style="list-style-type: none"> • Sub-center strengthening fund of Rs.10,000/- has been released • A letter to Principal, Health and Family Welfare Training Centre, Nasik division has been approached to organize RTI/STI training for MOs, Lab technicians and ANMs • Purchase order for essential medicines as per QA checklist placed • Action initiated to procure Baby Warming Equipment. 	<ul style="list-style-type: none"> • Sub-center strengthening fund of Rs.10000/- has been released • ANMs training on partograph use has been done • Order placed to procure baby ambu bag and supply to Sub-centers • Order has been placed to purchase Injectable Atropin • Order placed to procure baby scale for Sub-centers • NRHM Director approached for MOs training on a range of maternal health services and Lab technicians and ANMs training on RTI/STI.

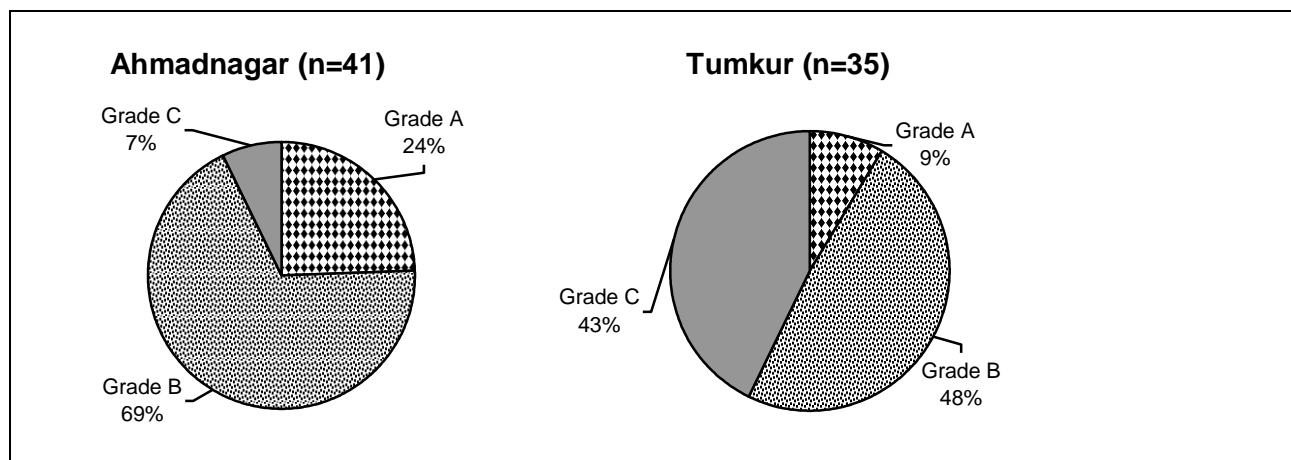
ANALYSIS OF QA DATA

The data collected during QA visits were scored and analyzed every month for each facility. The aggregate analysis of all the facilities covered through December 2007 revealed substantial gaps in the infrastructure and human resources to provide good quality services, as well as in adherence to standards set out for providing these services.

Overall Facility Grades

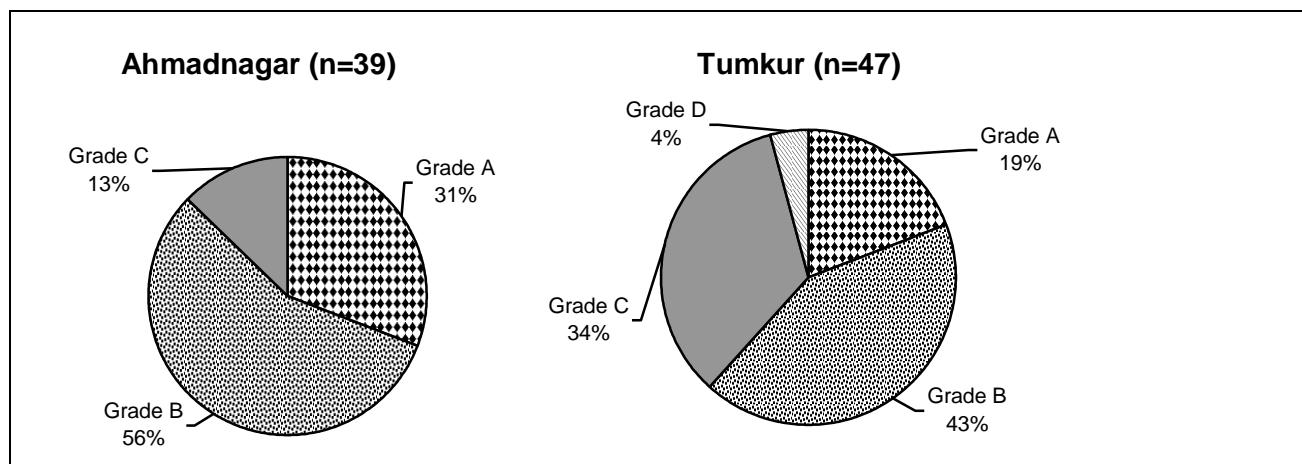
The analysis of overall facility scores shows that nearly about 24 percent of CHC/PHCs in Ahmadnagar were in Grade A (scored more than 75 percent of the total score), 69 percent in Grade B (scored 51-75 percent of the total score), and remaining 7 percent were in Grade C (26-50 percent of the total score). The corresponding figures for Tumkur were 9, 48 and 43 percent respectively (Figure 1).

Figure 1: Overall Grades of CHC/PHCs in Ahmadnagar and Tumkur



The overall scores for Sub-centers revealed that about 31 percent of Sub-centers in Ahmadnagar and 19 percent of Sub-centers in Tumkur scored Grade A. The percentages for Sub-centers scoring grade B were 56 and 43 percent respectively in Ahmadnagar and Tumkur districts. Of greater concern, 19 percent of sub-centers in Ahmadnagar and more than 38 percent of Tumkur scored C or D (less than 25 percent score) grade (Figure 2). The analysis thus shows that CHC/PHCs and Sub-centers in Ahmadnagar are relatively better equipped than Tumkur to provide quality RCH services. However, a large number of facilities in both the districts require significant amount of improvements to qualify for Grade A and provide quality services.

Figure 2: Overall Grades of Sub-centers in Ahmadnagar and Tumkur

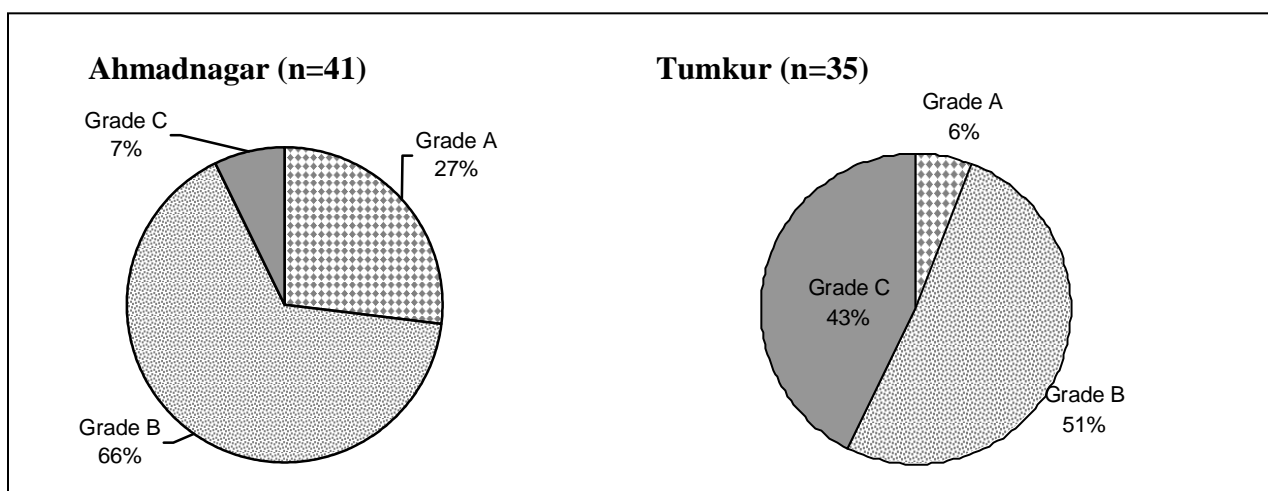


To gain greater insight into the causes of lower facility grades, the ‘input’ and ‘process’ scores have been separately analyzed and presented below. The elements relating to facility readiness such as, human resources, infrastructure, equipments and supplies and availability of service delivery protocols have been grouped together as ‘inputs’. Similarly, the elements relating to the service delivery environment and procedures are have been grouped together as ‘processes’. These include cleanliness, infection prevention practices, maintenance of records and maintaining the hygiene and asepsis among others.

Inputs

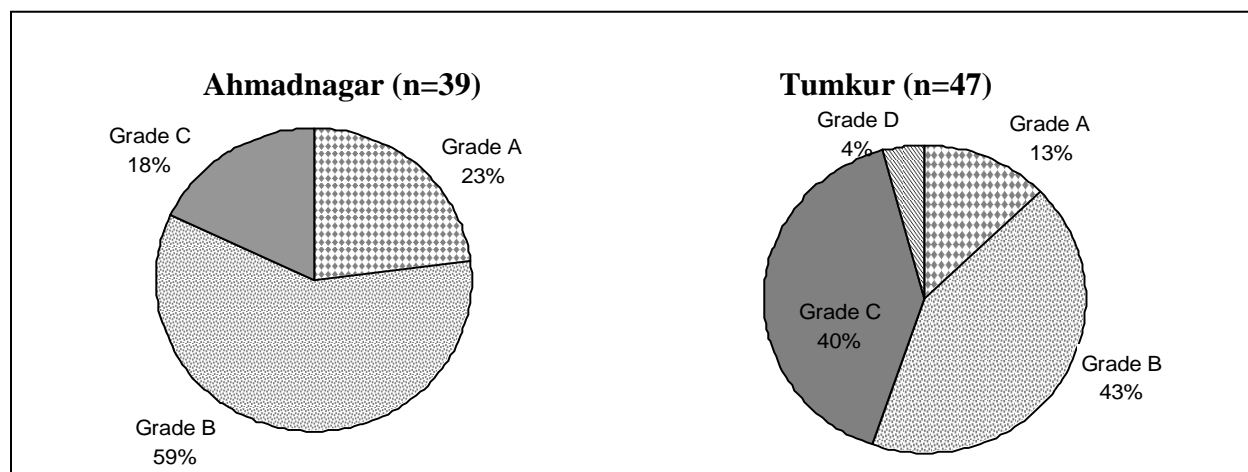
The analysis of CHC/PHC inputs shows that Ahmadnagar CHC/PHCs have relatively better infrastructure to provide quality RCH services as compared to the CHC/PHCs in Tumkur. While in Ahmadnagar, 27 percent of CHC/PHCs scored grade A, 66 percent scored grade B, seven percent scored grade C in inputs, no facility were in grade D. In Tumkur, only six percent of facilities could score grade A with respect to their inputs, about 50 percent scored grade B while remaining 43 percent were in grade C (Figure 3).

Figure 3: Input Grades of CHC/PHCs in Ahmadnagar and Tumkur



The input score of Sub-centers in Ahmadnagar was relatively better than the score of Sub-centers in Tumkur. In Ahmadnagar, 23 percent of Sub-centers scored grade A, 59 percent scored grade B and only 18 percent scored C. The corresponding percentage of Sub-centers in Tumkur was 13, 43 and 40 percent, respectively. Besides this, four percent of Sub-centers fell in the grade D. Refer to Figure 4. The analysis thus revealed substantial gaps in infrastructure and human resources that are essential elements to provide good quality services. The challenge therefore is just not identifying gaps but to address them in a systematic manner and reduce them so that QA does not appear to be a statistical exercise.

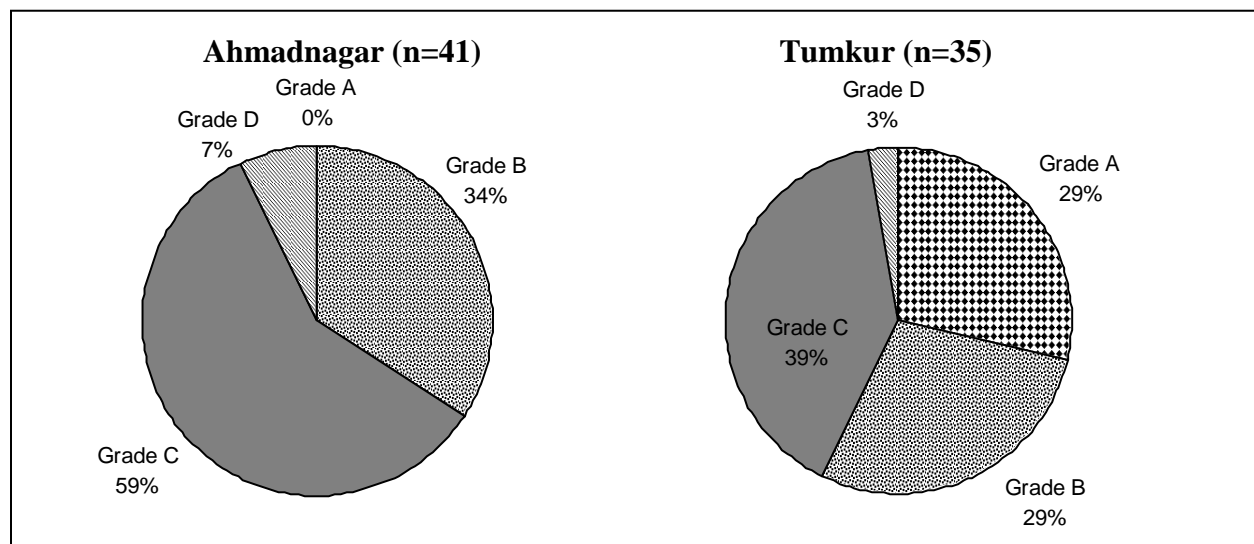
Figure 4: Input Grades of Sub-centers in Ahmadnagar and Tumkur



Process

The data on the process of service delivery provide information on “how” the services are delivered and thus it is a critical part of the quality of services. The analysis of process data revealed that the quality, in general, was poor in both the study districts. The aggregate analysis revealed that more than two-thirds of the facilities in Ahmadnagar (66 percent) and about 42 percent of the facilities in Tumkur had scored C or D grade. This clearly reflects the existing poor quality of services provided by these facilities and the need for improvement (Figure 5).

Figure 5: Grades of CHC/PHCs with Respect to Processes of Services



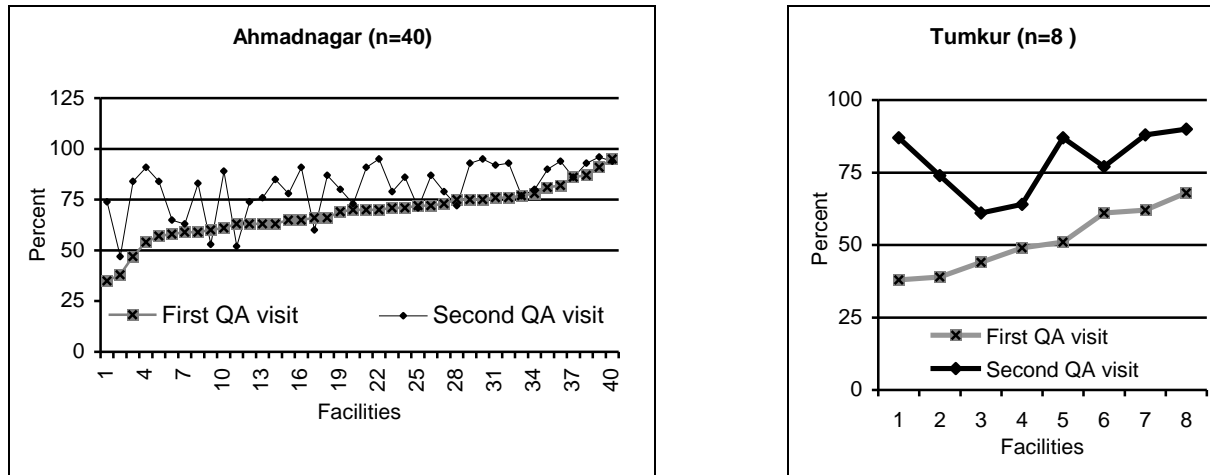
It is important to point out that while the CHC/PHCs of Ahmadnagar had better input scores than the CHC/PHCs in Tumkur, the aggregated score for the process indicators was relatively better in Tumkur than Ahmadnagar. This shows that while infrastructure and human resources (inputs) are necessary, they are not sufficient conditions for good quality services. The quality of service could be improved by focusing more on the processes of service delivery, which often demand more of behavioral change among providers and observing standard clinical practices, e.g. washing hands for infection prevention, than of expensive inputs.

Repeat Visits to Assess Impact

The first round of visits in Ahmadnagar and Tumkur was completed by December 2007. Since then DQAGs have started revisiting the facilities after an interval of six months. The purpose is to assess the improvement in the quality of services as an outcome of QA visit and follow-up on ‘action taken’. The information collected during the first visit is used as the baseline to be able to measure changes. The revisiting QA teams carried the checklists completed during the first visit for comparison purposes and for a quick assessment of the improvements made in quality of services. Until January 31, 2008, QA teams revisited 40 facilities in Ahmadnagar and 8 facilities in Tumkur. Majority of the facilities in both the districts scored higher grades during second visit as compared to their corresponding grades obtained in the first visit. For instance, in Ahmadnagar out of 28 facilities which had scored grade B during first visit, 19 moved to grade A. Similarly, in Tumkur, all the eight facilities revisited in the second round moved to the next

higher grade. The average score of the facilities visited increased by 13 percent points in Ahmadnagar (from 68 to 81 percent) and 26 percent points in Tumkur (from 53 to 79 percent) (See Figure 6).

Figure 6: Overall Facility Scores from First and Second Round of QA visits



The results demonstrate a good beginning for the QA project and the pace of change is expected to accelerate during the second year when QA visits will be fully integrated into the National Rural Health Mission (NRHM)/RCH program.

SUPPORTIVE SUPERVISION VISITS BY COUNCIL AND UNFPA STAFF

Close monitoring of a public health program is critical for its proper implementation and its institutionalization in the system. Population Council and UNFPA staff as well as national and state level officials have taken this role seriously and made several visits to the states and districts to provide TA in the implementation of QA activities and its institutionalization in the NRHM/RCH program. After the start of QA visits, during the last 9 months, national level staff have visited each district three times, with the support of Council and UNFPA colleagues. Besides these visits in each district, the Council has seconded a person to each district health office and plays a key role in building the capacity of the district authorities by making joint visits in the field, helping in data analysis and in preparing monthly reports. Council staff regularly discuss the implementation barriers that need to be resolved with DHO and the district nodal person, particularly, expediting process of 'actions taken' at all levels and institutionalization of QA in the NRHM/RCH program.

The visits of Council, UNFPA and national and state level officials have helped to strengthen the implementation process and its utilization by the system. The key activities performed during the visits include: working as resource persons in trainings, reviewing the work done, and offering suggestions on how the gaps identified could be addressed using the PIP mechanism. They also visited the field with the teams and provided hands-on technical assistance. The achievements made during their visits are summarized in Appendix 1.

INSTITUTIONALIZATION OF QA WITHIN DISTRICT HEALTH MANAGEMENT

Strengths

In both the districts regular QA visits are now being made. There are indications that the QA process is getting institutionalized in the overall NRHM/ RCH program. The following observations point to the initiatives taken by the district authorities for institutionalizing the QA measures within the district health management:

- In both the districts' all required logistic support to conduct QA visits are available and the funds for carrying out these visits have been allocated in the DPIP.
- The outcomes of the QA visits are now routinely discussed in the monthly meetings of MOICs at the district headquarters. The results of QA visits and actions to be taken are discussed in monthly DQAG meetings. However, there is a need to integrate these two meetings or the DQAG meeting should be held just a day before the MOIC meeting.
- For institutionalizing QA activities, a regular mechanism has been established to review the 'actions taken' on the gaps identified at the facility level and it is functioning well.
- Data provided by the facilities on 'actions taken' is encouraging, as almost half of the gaps identified at the facility level have been addressed.
- All QA activities and related correspondence are now being referred as the work of the NRHM. In Tumkur, a QA cell has been constituted under the NRHM and their staff is being involved in QA activity. Some of the DQAG members are now merging their prime monitoring work along with the QA visits.
- In November 2007, in a major step forward, the District Magistrate (DM) in Ahmadnagar and Chief Executive Officer (CEO) in Tumkur advised that reports on QA activities would be on the agenda of the NRHM in their monthly review. The DM, by virtue of his position, is the supervisor of all development programs in the district. A review of the QA activities and of 'actions taken' by the DM in the monthly NHRM meeting will give a clear signal of the commitment of system to QA and ensure its institutionalization in the district level management.
- The resources required for addressing the gaps identified by QA visits have now been incorporated in the revised DPIP. However, in Tumkur, it is primarily for expensive capital items (e.g. vehicles and instruments) while in Ahmadnagar one line item has been included as resources required for QA activities without giving any further definition. These initiatives need to be further refined so that the DPIP could precisely reflect the purposes of the resources required, the estimated cost, and facilitates the control of expenditures.
- Unrestricted funds made available at the facility level are now being utilized for addressing minor gaps identified by the QA visits.
- Appreciating the usefulness of the checklists in identifying the gaps in services, the DHOs of both Ahmadnagar and Tumkur districts have now provided copies to even those CHCs and PHCs that are not covered in the first phase of QA implementation. MOICs of

those facilities are using the checklists as a self-evaluation form to identify the gaps and make improvements. MOICs of those facilities are using it as a self-evaluation form to identify the gaps and make improvements. This is well reflected in the statement of one of the MOIC:

“The benefit that now we have is that we have found a readymade checklist which quickly lets us know what we have and what we have to do.”

- In Karnataka, the State NRHM Director who was fully aware of the QA activities has been made the Principal Secretary of Health and Family Welfare, Government of Karnataka. Recently, he has called a meeting of DHOs of all the districts and asked the DHO of Tumkur to make a presentation on the QA effort. At the end of the meeting, he suggested to all DHOs to adopt the QA procedures and ensured the support required for scaling up of the QA activity.

Weaknesses

While the QA program is certainly being institutionalized, a number of weaknesses have also been observed that highlight the need for continued technical assistance and greater involvement of state officials. Some of the key weaknesses that need to be addressed in the second year of implementation include:

- At the time of planning QA visits, other engagements of officials or dates of other meetings are not considered. As a result, in case of conflicts in the dates of events, the QA visit is rescheduled.
- The gaps identified with the facility are often not addressed, if the responsibility for actions to be taken falls on the district authorities. There is a general tendency to postpone decisions, particularly for actions where state involvement is required.
- The link between district and state on the outcome of the QA visits is often limited. In case of one district experimentation, the consequences for the state are minor and hence the QA work is left to district authorities without any guidance, monitoring or expression of interest. At the district level, more attention is given to those activities for which they have to report to the state and district performance is monitored at the state level.

LESSONS LEARNED AND NEXT STEPS

- *Quality assurance checklists are useful and could be institutionalized by district level management.* The pilot study in the districts of Ahmadnagar and Tumkur reconfirmed that the QA procedure has the potentiality to monitor and improve the quality of the services. It also shows that the revision of the manual and inclusion of other facilities has made it more useful.
- *Difficulties faced in the analysis of the collected data indicate that the manual should provide more precise guidance on classification of actions and the level at which they should be taken.* It was observed that many actions, which cannot be taken without district's involvement, were marked as the responsibility of the facility. Similarly, checklist of Sub-center needs to be revised in the light of the experience in the classification of list of 'actions to be taken'.
- *Building the capacity of the district officials who constitute the DQAG is critical and requires substantial technical assistance.* The key areas where TA is required include: conducting the QA visit and classification of actions to be taken at proper level (e.g., facility, district and state), analysis of the completed checklist, development of the review system to ensure that the gaps identified are properly understood, remedial measures are discussed and follow-up of 'actions taken' is undertaken at all levels, i.e., facility, district and state.
- *Right from the beginning, the focus should be on the institutionalization of the QA.* The key district officials must be involved and they must appreciate the value of the intervention (QA) in making NRHM/RCH programs successful. This includes the DM, CEO, DHO, RCHO, and other key persons involved in the decision-making
- *Unless state level officials are fully involved in such experimentation, complete institutionalization of the activities and sustainability will be difficult.* In the absence of state level involvement, interventions are often considered a pilot study and thus receive low priority by the senior district officials and receive only marginal attention by the state.
- *To create the conditions for scaling up, the intervention should be experimented at a scale, which makes it necessary to involve all levels of the system—state, district, facility.* Experimentation in one district or smaller area is often left unnoticed and un-replicated.
- *The QA should be included in DPIP/State PIP with an earmarked budget for assessment and improvement.* Although, the DPIP has included the resources required for QA activities, it does not clearly indicate how the funds will be used. Both DPIP and state PIP should provide the detailed specification of the QA activities and the corresponding estimated cost for undertaking them.

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Appendix 1: Field Visits by Population Council and UNFPA Staff

Date	Purpose	Person Visited	Activities performed
Initiation of QA Activities			
Mumbai and Ahmadnagar (April 16-23, 2007)	Orientation of state officials and training of district/RH/PHC doctors, and DQAG	GOI: Rashmi Sharma PC: M E Khan, Anurag Mishra, Vivek Sharma, Jaleel Ahmad UNFPA: KM Sathyanarayana,	Worked as resource person in state and district level trainings
Bangaluru and Tumkur (May 3-10, 2007)	Orientation of state officials and training of district/CHC/PHC doctors, and DQAG	GOI: K D Maiti PC: M E Khan, Anurag Mishra, Vivek Sharma, Jose Joseph UNFPA: K M Sathyanarayana,	Worked as resource person in state and district level trainings
Monitoring Visits			
Ahmadnagar, June 22, 2007 – Two months after initiation of QA visits	TA to district authorities and review of QA activities	UNFPA: Venkatesh Srinivasan, Viji Vargees	<ul style="list-style-type: none"> • Review of QA activities and support provided by PC staff seconded to district health office (observations were very positive and Jaleel Ahmad's, PC staff in Ahmadnagar, work was appreciated) • Concerns expressed on lack of actions taken and procedure to monitor the program • Emphasized the institutionalization of QA process, disbursement of unrestricted funds and use for filling gaps and using DPIP mechanism to generate funds needed for addressing problems identified through QA visits
Ahmadnagar (Aug 8-10, 2007) – Four months after initiation of QA visits	TA to district authorities and PC staff	PC: Vivek Sharma	<ul style="list-style-type: none"> • Reviewed operational difficulties and suggested possible solutions • Accompanied two QA visits, observed process and hands-on training on data collection for further improving the QA visit • Worked with RCHO and PC staff at the district to analyze collected data • Made power-point presentation to DHO and DQAG on how QA data could benefit NRHM/RCH program implementation
Ahmadnagar (Nov. 22-26, 2007) - Six months after initiation of QA visits	TA to district authorities and institutionalization of QA measures in NRHM	PC: Vivek Sharma	<ul style="list-style-type: none"> • Reviewed how QA findings are used and process established to monitor "actions taken" on QA reports • Discussed with DHO/nodal officer (RCHO) operational issues, reviewed QA visits, discussed problems of rescheduling of visits and received assurance for future care in this regard • Met with DM and CEO, briefed about QA and need of its institutionalization in the district program. DM agreed to keep QA on the monthly agenda for reviewing NRHM/RCH and instructions were issued during the meeting • Made two field visits to observe the process and provide TA, if required

Date	Purpose	Person Visited	Activities performed
Tumkur (Aug 1-3, 2007) - One month after initiation of visits	TA to district authorities and PC staff	PC: Anurag Mishra	<ul style="list-style-type: none"> • Reviewed operational difficulties, suggested possible solutions • Reviewed data collected and explained gaps/mistakes in data collection • Trained PC staff at district (Jose Joseph) and data entry person on data entry using Excel sheets • Discussed with DHO on use of data collected and QA visits • Debriefed Director RCH and state nodal officer about observations made on QA activities in district
Tumkur (Sept 24-25, 2007) – Three months after initiation	TA to district authorities and review of QA activities	UNFPA: Venkatesh Srinivasan	<ul style="list-style-type: none"> • Reviewed QA activities and gaps identified, held discussions with DHO, RCHO and DQAG • Expressed concerns ex on lack of “actions taken” and procedure to monitor improvement in quality of services • Emphasized on institutionalization of process, disbursement of unrestricted funds and its use for filling gaps and using DPIP mechanism to generate funds needed for addressing problems identified through QA visits
Tumkur (Dec. 5-7, 2007) - Five months after initiation	TA to district authorities and institutionalization of QA measures in NRHM	PC: Anurag Mishra	<ul style="list-style-type: none"> • Reviewed QA visits findings and the mechanism established by DHO to review actions taken at facility and district level • Discussed with DHO/RCHO and DQAG the lack of initiation of actions at district/state level • Reviewed DPIP and suggested budget allocation for actions identified through QA visits such as training of providers, process improvement • Reviewed with DHO and RCHO the action taken reports submitted by MOICs. Suggested early initiation of district level actions and received assurance from DHO for prompt action. • Met with CEO and briefed him about QA and its institutionalization. CEO agreed to keep QA on the monthly agenda of reviewing NRHM/RCH • Debriefed Director RCH and state nodal officer about observations made on QA activities in district, requested state support for quick initiation of district/state level actions • Visited a PHC to observe QA visit

Appendix 2 (a): Monthly Reporting Format
Monthly Report
Quality Assurance Program
(Contract no. - UNFPA/India Award IND/03/P21)

District and State _____
Month and Year: _____

Executive Summary

Project Background

The Ministry of Health and Family Welfare (MOHFW), Government of India is actively pursuing improvements in the quality of reproductive and child health care provided through the network of public health institutions, RCH camps and outreach services. Presently the MOHFW is pilot testing the QA tools and manual in one district each in six states including Karnataka and Maharashtra. The Population Council, with financial and technical support from UNFPA, is providing TA to the Ministry in Maharashtra and Karnataka. The activities planned and carried under this project during the month are listed below.

Table 1. Number of QA Visits Proposed and Carried Out.

Type of Facility	Proposed for the month	Visited as per plan	Not visited at all	Reasons why visits not made
CHC				
PHC				
Sub-centre				
RCH Camps				

Table 2. Review Meetings

Activities	Result	
Did the DQAG team members meet and discuss the summary recommendations before the monthly QA meeting?	YES	NO
Was data from all visits made in the month available at the time of discussion?	YES	NO
Was the QA meeting held as planned in the month?	YES	NO
Number of officials who participated in the meeting	_____	
Designation of the person who chaired the monthly QA meeting	_____	

Table 3. Actionable Points Identified

Type of facility	Total Actionable Points	Number of actionable points with responsibility assigned		
		CHC/PHC/SC	District	State
CHC				
PHC				
Sub-centre				
RCH Camps				
All actionable points				

Key Actionable Points at:

(a) CHC/PHC

(b) Sub-centre

(c) RCH Camps

General Comments

(a) Observations on Team Work

(b) Observations on strengths/proper implementation

(c) Observations on limitations in planning/implementing the QA visits which need correction (both personnel and logistics problems)

Table 4. Number of actionable points suggested in the previous month and executed

Type of Facility	Suggested in the previous month	Number of actions executed
CHC		
PHC		
Sub-center		
RCH Camps		

Appendix 2 (b): Facility Visit Reporting Format
FACILITY VISIT REPORT- QA PROGRAM

District: 1 Ahmadnagar 2 Tumkur

Type of facility: 1 CHC 2 PHC 3 Sub-center 4 RCH Camp

Date visited: _____

I. Observation on Team Visit

1. Time of start from District HQ, _____ Arrival at facility _____ Departure from facility _____
2. Total time spent at the facility _____
3. Was the pre-assessment briefing (purpose of assessment) done with key facility staff present?
1. MO 2. LHV 3. ANM 4. PHN 5. Pharmacist 6. Lab. Tech. 7. Other _____
- 4(a) Did the QA team members divide-up the assessment work? 1. Yes 2. No
- 4(b) Were all the team members engaged in QA assessment work? 1. Yes 2. No
- 4(c) If No, who did not participate? (Specify) _____
- 5(a) Were maternity/immunization clients observed during the visit? 1. Yes 2. No
- 5(b) Did team members actually observe the delivery of services? 1. Yes 2. No
6. Was the completed checklist reviewed before departure? 1. Yes 2. No
- 7(a) Did the team leader debrief the MOIC and discuss the plan of action before leaving the facility? 1. Yes 2. No
- 7(b) Who else from the facility was present during this debriefing?
1. MO 2. LHV 3. ANM 4. PHN 5. Pharmacist 6. Lab. Tech. 7. Other _____
- 8(a) What was your overall impression about the quality of this visit?
1. Excellent 2. Good 3. Fair 4. Poor 5. Very poor
- 8(b) Please elaborate what were your considerations in ranking as above?

II. General Observation on the functioning of the facility (Not more than six lines)

III. What was your role in the team: what all did you do during the visit? (Specify in bullets)

Appendix 3: QA Actions Review Forms

QA Progress Report for PHC/CHC Prepared By MOIC						
	Name and Address of the PHC/CHC:					
	Taluk:		Block:			
	QA Progress Report for the Month of:					
No. of Actions Taken in the Previous Month:						
Section:	Problems Identified to be Solved by the Facility	What Actions Taken by the Facility	Due date given by MOIC	Date of action taken	Action taken (Yes/No)	If No Actions taken, why? (Need reason)
A: Providers' Availability						
B. Infrastructure						
C. Essential Protocols and Guidelines						
D. Infection Prevention Practices						

Section:	Problems Identified to be Solved by the Facility	What Action Taken by the Facility	Due date given by MOIC	Date of action taken	Action taken (Yes/No)	If No Actions taken, why? (Need reason)
E. Availability Of Equipment and Supplies						
F. Family Planning Quality Assessment						
G. Maternal Health Quality Assessment						
H. Child Health/Immunization Quality Assessment						

Signature of MO/IC

QA Progress Report for Sub-center Prepared By LHV/MOIC						
Name and Address of the Sub-Center :						
Taluk:		Block:				
QA Progress Report for the Month of :						
No. of Actions Taken in the Previous Month:						
Section:	Problems Identified to be Solved by the Facility	What Action Taken by the Facility	Due date given by MOIC	Date of action taken	Action taken (Yes/No)	If No Actions taken, why? (Need reason)
A: General Facility Readiness						
B. Essential Protocols and Job Aids						
C. Infection Prevention Practices						
D. Availability of Equipment and Supplies						

E. Family Planning Quality Assessment						
F. Maternal Health Quality Assessment						
G. Child Health/Immunization Quality Assessment						

Signature Of LHV/ MOIC