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Assessing the Quality of Facility-Level Family Planning Services in Malawi





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About this series

The Case Study series presents real applications of Quality Assurance (QA) methodologies in developing countries at various health system levels, from national to community. The series focuses on QA applications in maternal and reproductive health, child survival, and infectious diseases. Each case study focuses on a major QA activity area, such as quality design, quality improvement, communication and development of standards, and quality assessment. In some cases, more than one QA activity is presented

Quality assessment is the measurement of the quality of healthcare services. A quality assessment measures the difference between expected and actual performance to identify opportunities for improvement. Performance standards can be established for most dimensions of quality, such as technical competence, effectiveness, efficiency, safety, and coverage. Where standards are established, a quality assessment measures the level of compliance with standards. For dimensions of quality where standards are more difficult to identify, such as continuity of care or accessibility, a quality assessment describes the current level of performance with the objective of improving it.

A quality assessment frequently combines various data collection methods to overcome the intrinsic biases of each method alone. These methods include direct observation of patient provider encounters, staff interview, patient focus group, record review, and facility inspection. The assessment is often the initial step in a larger process which may include providing feedback to health workers on performance, training and motivating staff to undertake quality improvements, and designing solutions to bridge the quality gap.

This case study describes how local staff in Malawi collected, analyzed and interpreted quality assessment data to identify opportunities to improve family planning services.

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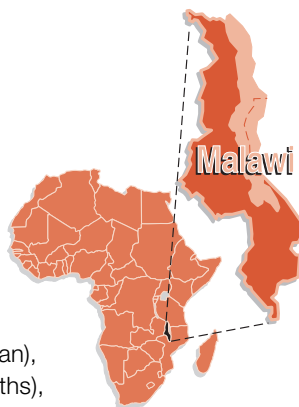




□ □ □ Assessing the Quality of Facility-Level Family Planning Services in Malawi

Background

Malawi has a predominantly rural population of 10 million people. The combination of the country's high birth rate (39.54 per 1,000) and short life expectancy at birth (36 years) are reflected in high rates of total fertility (5.5 children per woman), infant mortality (132 per 1000 live births), and maternal mortality (560 per 100,000 live births).¹ According to the 1992 Demographic and Health Survey, while knowledge of modern contraception among married women was high (92 percent), contraceptive prevalence is quite low. The survey found a contraceptive prevalence rate of 7.4 percent for modern contraceptive methods and 6 percent for traditional methods. At the same time, 61 percent of married women surveyed wanted to space or stop childbearing, a high potential demand for family planning services.



A national Family Planning Quality Improvement Steering Committee was established in late 1995 to guide efforts to improve the quality of family planning programs in Malawi. The committee included the Ministry of Health and Population's (MOHP) Family Health Coordinator and staff from the National Family Welfare Council, the Support to AIDS and Family Health (STAFH) Project,² Regional Health Offices, and a non-governmental family planning organization.

¹ Source: 1990-1999 data compiled by the Center for International Health Information, Country Health Statistics, Malawi (Published in 10/29/99).

² A project carried out from August 1994 to July 1998 and funded by the U.S. Agency for International Development under contract number 623-0238-C-00-4058 with John Snow International.

In 1996, the steering committee developed a two-stage plan to first identify opportunities for improving the quality of family planning services and then to apply a structured, team-based, problem-solving method to address them. The committee decided to pilot test this plan in six health facilities in two rural districts. One innovative aspect of this pilot test was the “self-assessment” approach to identifying quality problems, i.e., that the facilities themselves would, using structured data collection techniques, collect and examine data on their own performance. Staff of the Quality Assurance Project (QAP) provided technical assistance to support this effort in coordination with the STAFH Project.

Designing and Preparing for the Assessment

Selection of target districts. Based on equity considerations, the steering committee selected two districts that had not yet benefited from other intensive family planning projects, Mchinji District in the Central Region and Chiradzulu District in the Southern Region. The two District Health Management Teams (DHMTs), in consultation with their Regional Health Offices, chose one hospital and two health centers in each district. The choice was based on geographic accessibility and staff interest in self-assessment.

Development of data collection instruments. With technical support from the STAFH project, the steering committee designed the assessment based on the MOHP publications: *Family Planning Guidelines for Providers* and *Rights of Clients*. The assessment instruments were organized around the principles outlined in the Client-Oriented Provider-Efficient (COPE) methodology,³ already being used in other areas of Malawi. The COPE technique focuses on the delivery of care as it affects client rights to information, access, choice, safety, dignity, opinion, comfort, continuity, privacy, and confidentiality.

The steering committee expanded and modified the COPE assessment method by adding tools for direct observation of

³ COPE: client-oriented, provider efficient services: a process and tools for quality improvement in family planning and reproductive health services, AVSC International: NY (1995).

care and exit interviews. By March 1996, the steering committee had prepared and tested five main data collection instruments, described in Figure 1.

Selection of personnel to carry out the quality assessment. The DHMTs selected three staff from each of the six facilities to participate in quality assessment training.

Figure 1. Malawi Family Planning Quality Assessment Data Collection Instruments

- **Group self-assessment** — A questionnaire designed to be completed collectively by facility staff. It covered organization of services, availability of supplies and equipment, application of infection control procedures, and management support for family planning.
- **Provider self-assessment** — A questionnaire to be filled out by each person currently providing family planning services at the facility. The instrument assessed a respondent's family planning knowledge and practices as well as those of the clinic staff in general.
- **Exit interview** — A questionnaire to be completed during interviews with clients at the conclusion of a visit. It covered client knowledge about service availability, satisfaction with the visit, and a range of key provider tasks. Different exit interview forms were developed for new acceptors of family planning, non-acceptors, and returning family planning clients.
- **Client-provider observation** — A form to document the tasks actively performed by a provider during a family planning encounter, including the communication of specific family planning information to the client. It was completed during observations of both new and returning family planning clients. Another version of the form was used for the group health talks that preceded client clinical visits.
- **Client-flow analysis** — A flow form filled out by each provider but carried by the client, starting at the time of arrival and proceeding through the client's series of encounters during a visit. Each provider recorded the beginning and ending time of the encounter with the patient. The data gathered on this form are used to calculate client waiting time and total contact time with providers.

Each facility team was composed of two family planning providers (medical assistants, state nurses, or enrolled nurses) and the facility in-charge. None of the 18 facility staff selected for data collection had experience collecting or analyzing data. The steering committee also chose six staff members from the regional and central levels, including some with previous data collection experience, to participate in the training and supervise the data collection.

Training of data collection teams. In April 1996, the 24 chosen health personnel attended a 4-day training workshop on techniques for assessing quality of health services and conducting team-based problem solving. The workshop served a dual purpose, for it also provided the participants with a comprehensive introduction to quality assurance. Participants reviewed and practiced using each of the five assessment instruments, first by conducting interviews with each other, followed by interviews with two to three clients at the nearby Central Hospital. Participants were also introduced to the compilation forms that would facilitate tabulation and presentation of the information collected through each data collection instrument. The teams also made plans for collecting the quality data for their facilities.

Developing data collection strategies. The workshop participants decided that health workers should not observe client-provider encounters or conduct client exit interviews at their own facilities; rather, peers from a neighboring facility who had participated in the training should fill out the client-provider observation and exit interview forms. They believed this arrangement would be more objective and, in addition, that clients would feel freer to speak their minds if exit interviews were handled by health providers from another facility. To keep the spirit of facility-based assessment, the group recommended that the data from client-provider observations and exit interviews be compiled and analyzed by the facility staff themselves rather than by those who performed the observations or interviews. Facilitators from the central and regional levels were assigned to visit each facility and help facility personnel compile the client flow analysis.

Collecting Quality Data

Data collection. Data were collected and compiled over a 1-month period, but the actual time spent collecting client flow, observation, and exit interview data amounted to only one or two days per facility. Except for noting a patient's time on the client-flow form, facility staff being observed proceeded

normally with their work. The STAFH Project provided transport for other facilities to travel to data collectors to conduct observations and interview clients. Facility staff conducting the assessment spent an average of one day as peer observers collecting data at a facility other than their own. Filling in the individual and group self-assessment forms consumed an additional few hours. By the end of the data-gathering period, quality assessment data obtained for each facility consisted of three to six observations of client-provider interactions, client flow data for all family

CLIENT-FLOW CHART* Page 1

OFF: MAINTANHO DATE: 4/5/96

Client number	In	Time	Out	Total minutes	Concns minutes	Waiting (minutes)	Visit code	Method code	Comments
1	7:45	8:25		394	25	369	Y	ANC	
2	7:4	8:50		324	19	305	E	A	
3	8:05	8:50		154	14	140	Z	A	
4	8:07	11:14		192	18	174	Z	ANC	
5	8:06	8:46		141	19	122	Z	ANC	
6	8:06	10:10		183	20	163		ANC	
7	8:09	1:14		302	24	278	Y	ANC	labour
8	8:09	1:40		303	30	273	Y	ANC	labour
9	8:11	1:28		154	14	140	Z	ANC	
10	8:15	8:54		242	23	219	Z	ANC	
11	8:18	11:50		164	13	151	Z	ANC	
12	8:19	3:02		404	20	384	Y	ANC	
13	8:14	12:51		236	20	216	Z	A	
14	8:15	10:02		154	17	137	Z	ANC	
15	8:20	2:43		303	20	283	Y	ANC	
16	8:32	12:02		230	24	206	Z	A	labour
17	8:38	2:48		316	20	296	Y	ANC	
18	8:39	1:03		205	20	185	Y	ANC	
19									
20									

Method codes: A In-person, B Self, C Third assistance, D Clinician, E Telephone, F Surveys/implant, G PPO, H Counseling, I Other, Y First visit, Z Repeat.

*Use as many pages as necessary.

Figure 2. Example of Client-Flow Chart

planning clients (see example in Figure 2), 11 to 18 exit interviews (including acceptors, non-acceptors, and returning clients), one group self-assessment and three individual provider self-assessments.

Results: Analyzing and Using Assessment Findings

Tabulation of the quality of care data. Staff from each facility, with some technical assistance and using the structured compilation forms provided, tallied the data manually

and organized the problems identified by clients' rights (see example in Figure 3 of the compilation form completed by staff from one hospital based on the Family Planning Service Provider Self-Assessment).

Interpretation of findings. One month after the training in data collection, the teams regrouped for a 5-day workshop to discuss the results and use the assessment findings in team-based problem-solving. The workshop started with each team presenting its findings, highlighting information generated by the assessment that surprised facility staff. Figure 4 summarizes the findings presented by one health center team.

Figure 3. Example of Compilation Form Filled Out by Facility Staff

Family Planning Service Provider Self-Assessment

Number of providers completing form: 3

CLIENT'S RIGHT TO INFORMATION

1. % of FP providers providing FP information to non-FP clients	100% ¹
2. % of FP providers with skills to counsel:	
• adolescents	33%
• men	100%
• postpartum women	100%
• post-abortion women	100%
3. % of FP providers with private space for clients	67%
4. % of FP providers who ask clients to repeat information	33%
5. % of FP providers who feel they have adequate time for counseling	0%
6. List problems (if any) you have identified in the following areas and comment briefly:	
Individual counseling process:	<i>67% get it right, need training, shortage of staff, not enough time, one provider per clinic day</i>
Individual counseling skills:	<i>Need training in communication skills</i>
Information for assisting client choice:	<i>Done</i>
Examination of clients:	<i>Some parts missed</i>
Explanations related to method chosen:	<i>Done but not brief</i>
Provision of FP to men:	

¹ While the use of percentages for such a small sample size is unusual, this compilation form was tabulated for internal use by staff at their own hospital.

CLIENT'S RIGHT TO ACCESS

1. % of FP providers who do provide family planning to:
- adolescents 33%
 - divorcees 100%
 - widows 100%

CLIENT'S RIGHT TO CHOICE

1. List problems (if any) you have identified in the following areas and comment briefly:

Referral of clients: *Referrals done but no guidelines*

Clients' receiving method of choice: *Sometimes clients do not receive method of choice because method is out of stock*

Contraindications and alternative choices: *Clients are given enough information about any methods they are given*

CLIENT'S RIGHT TO SAFETY

1. List problems (if any) you have identified in the following areas and comment briefly:

Warnings and follow-up for complications: *No problems*

Clinic hygiene: *Sterile and hygiene techniques done*

CLIENT'S RIGHT TO PRIVACY AND CONFIDENTIALITY

1. List problems (if any) you have identified in the following areas and comment briefly:

Discussion of clients with others: *No problem*

CLIENT'S RIGHT TO DIGNITY, OPINION AND COMFORT

1. List problems (if any) you have identified in the following areas and comment briefly:

Courtesy of other staff: *Clients not provided with information*

Providers' handling of clients: *People are handled nicely but are not given chance to say how service can be improved*

CLIENT'S RIGHT TO CONTINUITY

1. List problems (if any) you have identified in the following areas and comment briefly:

Supplies: *Inadequate supplies at times*

Return appointments: *Not all providers give return dates*

Following the presentations, the three-person team from each facility selected one problem to use during the workshop to practice the steps in the problem-solving cycle. The teams also discussed the difficulties they had encountered during data collection and analysis.

The assessment found that many of the facilities had performance problems in similar areas. Not only were waiting times long, but family planning services were not well coordinated with the delivery of antenatal care services, possibly causing more delay in the process. On the provider side, they lacked family planning counseling skills, did not mention sexually transmitted diseases or HIV, did not adequately employ infection prevention measures, and many general facility staff did not know when family planning services were provided. On the client side, providers felt that men were not comfortable

Figure 4. Findings Presented by Namitambo Health Center¹

CLIENT'S RIGHT TO INFORMATION

- Individual counseling of clients was not done (as low as 25%).
- Clients feel the discussion was not done in confidentiality (50%).
- Providers did not ask the clients to repeat information (0%).
- Providers do not have individual counseling skills.
- Many staff (45%) of health center do not know where family planning is conducted within the health center.
- Only 64% of health center staff know the family planning methods available at the health center.

CLIENT'S RIGHT TO ACCESS

- Clients feel schedule is convenient and the providers used language they understood.
- The health center has no catchment area map nor information on population of reproductive age in the catchment area.
- Client flow: average waiting time was 244 minutes and the average contact time was 19 minutes. Time consumed was too much.
- Provider was overloaded with work—doing antenatal, postnatal clinic, labor ward and family planning, which made it difficult for her to work effectively.

¹ The assessment at Namitambo Health Center included observations of 6 client-provider observations of 2 providers, 3 provider self-assessments, and 13 family planning interviews (including new, return, and non-accepting clients).

going in for family planning services. In most facilities, Depo-Provera supplies were inadequate.

Use of quality assessment findings in systematic team problem solving.

Upon return to their facilities, the assessment teams engaged both family planning and non-family planning staff in the problem-solving process they had learned at the workshop. These expanded teams then selected priority problems to address and within a month of the second workshop, had initiated the problem-solving process. Four facilities focused on long client waiting time, a critical issue for both staff and clients. The fifth team chose to address the problem that both non-family planning staff and patients knew little about: the availability of family planning services. The remaining facility, a hospital, focused on increasing access to family planning services through the Outpatient Department clinic.

CLIENT'S RIGHT TO CHOICE

- Providers did not provide enough information on STD/HIV symptoms and prevention.
- Providers did not provide enough information on whether the client could stop or change methods.
- Providers did not give enough information on reproductive choices.
- Providers did not give enough information on all available methods.
- Shortages of contraceptives such as Depo Provera, and at times shortages of staff, limited choice.

CLIENT'S RIGHT TO SAFETY

- Providers did not dispose of needles/syringes properly.
- Providers did not decontaminate equipment correctly.
- Providers did not wash hands before and after seeing patients.

CLIENT'S RIGHT TO PRIVACY AND CONFIDENTIALITY

- Less than 50% of clients felt there was privacy during counseling and examinations.

CLIENT'S RIGHT TO DIGNITY

- Clients felt that they were treated with dignity.

Quality Assessment Insights

Some lessons learned from this assessment are as follows:

Using self-assessment to conduct a facility-level quality assessment not only built staff capacity but also led to increased ownership of the results and the lessons learned from the assessment.

In conducting the self-assessment, the Malawi facility staff faced the challenges of low educational level among some nurses, poor roads, and limited communication by telephone and radio. Despite these challenges, staff demonstrated that they could carry out all stages of the quality assessment process: providing input on survey design; collecting, compiling and analyzing data; and identifying problems or barriers to quality.

In addition, the new perspective gained from the assessment was reflected in attitudes toward problems. For example, at the first systematic team problem-solving meeting at one facility, the first task was to select a priority problem using the quality assessment results. The facilitator cautioned that evaluation of alternative problems should consider such questions as *What level of effort will be needed for implementation? Is the problem under the sphere of influence of the team? What resources will be required?* A nurse who had not participated in the assessment declared that waiting time was not a problem the team could focus on, since to speed up the process, the facility needed more nurses to absorb the great demand for services. Upon hearing this, a nurse who *had* participated in the assessment disagreed: “We may not need to hire more staff. We might be able to change some other things, like the patient flow, to cut down on the waiting time.” This attitude was based on insight garnered from the assessment process.

The process of self-assessment also facilitated team problem solving as well. For instance, in the Chiradzulu District Hospital, the team chose to work on the problem of long waiting times. Because the self assessment had involved client-flow analysis, staff knew that the long waiting time of over two hours was largely due to the fact that the group health education talks took place only once a certain number of patients had arrived. The nurse saw individual clients only after the group health talk was given. After a quick analysis, the

team decided to eliminate the group health talk. Instead, clients would be seen starting at 7:30 am, and each provider would give individual health talks to patients. As a result, this team was able to decrease waiting times to a third for family planning clients and to an eighth for antenatal care clients, while actually increasing individual client-provider contact time by more than 800%.

Using staff from peer facilities to conduct client interviews and observations created an opportunity to increase staff awareness of quality of care.

While the teams used the assessment to systematically tackle a priority problem at each facility, the assessment gave individual staff a new perspective on their practices. When staff observed their peers, it helped to reinforce the quality of care criteria in their minds, since they had to judge the client-provider interaction they were observing. The act of being observed by peers drew each provider's attention on quality of care criteria as applied to their own habits and practices, naturally focusing on changes that could improve quality. Eliciting the clients' perspective gave staff a glimpse of clients' knowledge of family planning, their opinion on the quality of services, and it helped to gain insight on provider-client communication gaps. All these activities helped providers become aware of the opportunities to increase access to quality family planning services that are sensitive, confidential, efficient, and client empowering.

Lessons learned for those who want to adapt this method.

In some facilities, staff who were not involved in the training were initially reluctant to participate in the assessment process (ie, being observed). Since staff who help to conduct the assessment gain double benefit in awareness of quality of care issues, participation in the assessment should be strongly encouraged. Strategies to increase participation in quality assessment and subsequent problem-solving activities need to be considered in assessment design.

In addition, the eight days of training time per quality assessment participant was workable on a small scale but might be difficult to sustain if carried out as a large-scale intervention. The training organizers estimate that only two days of training would be needed to just learn how to apply the quality assessment instruments, without training in problem solving.



Assessing Facility-Level Family Planning Services in Malawi: Summary

In 1996, with support from Malawi's national Family Planning Quality Improvement Steering Committee and the Quality Assurance Project, staff at six health facilities in Mchinji and Chiradzulu Districts (two district hospitals and four health centers) assessed the quality of family planning services at their own and neighboring facilities. Eighteen local staff members assisted by six representatives of the regional and central Ministry of Health and Population participated in the quality assessment. Local staff collected, compiled, analyzed, and interpreted the data, which were organized around the concept of the rights of clients. Following the data collection, participants in the assessment joined with other staff in their facility to apply team-based problem-solving methods to resolve priority problems highlighted by the assessment.