Summer Training at
National Health Mission, Haryana

Barriers and Facilitators in Implementation of National Quality Assurance Standards (NQAS) In Urban Primary Health Centres Of Ambala Division, Haryana

By
Shivani Bhandari

Under the guidance of
Dr. Mohan Lal Bairwa

MBA Hospital & Health Management
2017-2019

Institute of Health Management Research
The IIHMR University, Jaipur
2018

INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that **Dr. Shivani Bhandari** has undergone summer training at National Health Mission, Haryana from 2nd April to 1st June 2018.

The candidate herself completed the project assigned to her during summer training. Her approach to the project was sincere and proactive. This summer training is in partial fulfillment of the course requirement recommended for the award of MBA in Hospital and Health management.

I wish her success in all her future endeavors.

20/6/2018

Dr. Mohan Lal Bairwa
Assistant Professor
IIHMR University, Jaipur

for

(Col (Dr) Pramod Kumar) 22.6.18.

Col. (Dr.) Ashok Kaushik
Dean (Academic & Student Affair)
IIHMR University, Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141- 3924700, 2791431- 32, Fax: 0141 3924738, E-mail: iihmr@iihmr.edu.in, Web.: www.iihmr.edu.in

NATIONAL HEALTH MISSION

Paryatan Bhawan, Bays No. 55-58, Sector - 2, Panchkula, Haryana
Tel No. 0172-2560124, 2573922, 2570458, Fax : 0172 - 2580466
Web Site: nrhmharyana.gov.in, E - Mail: admn.nrhmhry@gmail.com

Ref.No: NHM/Admin/2018-19/ 1359 **Date: 04.06.2018**

TO WHOM IT MAY CONCERN

It is certified that Dr. Shivani Bhandari D/o Sh. Gulshan Bhandari has completed her summer training for the period from 02.04.2018 to 01.06.2018 in Urban Health division in the O/o National Health Mission, Panchkula, Haryana.

We wish her every success in her life.

Superintendent (Admin)
National Health Mission,
Haryana, Panchkula

Table of Contents

List of Tables

List of Figures

Acknowledgement

I would like to express my gratitude to everybody who upheld me over the whole span of this project. I am appreciative of the guidance, valuable feedback and friendly advice amid the project work. I am truly thankful to them for sharing their honest and illuminating perspectives on various issues related to the project.

Firstly, I would like to acknowledge my sincere thanks to our institute, Institute of Health Management and Research, Jaipur for providing me the platform to gain knowledge and skills in different aspects of health management.

I express my heartfelt gratitude to my University Mentor Dr. Mohan Lal Bairwa for his able guidance and useful suggestions which helped me in completing the project.

Special thanks to my Organization Mentor Dr. Nidhi Sharma, Programme Officer (Urban Health) for the faith shown in me and providing support in completing my project successfully as well as giving insight in to my operational issues which came across during the project at National Health Mission, Haryana.

I would like to thank the consultants Dr. Neha, Dr. Sonia and Dr. Chander Shekhar and all the field facilitators for helping me at various stages of my summer training.

At the end I would also like to thank my friends Kaavish, Dr. Rama, Dr. Divleen, Dr. Kanika and Anu without whom this project would have been a distant reality. My parents, seniors and colleagues hold a special mention here for their endless support for the successful completion of this training.

Regards,

Shivani Bhandari

HM-22nd batch

The IIHMR University

Acronyms

AFHC	Adolescent Friendly Health Clinics
AFHS	Adolescent Friendly Health Services
ARSH	Adolescent Reproductive and Sexual Health
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BMW	Biomedical Waste
DQAU	District Quality Assurance Unit
EDD	Estimated Date of Delivery
EDL	Essential Drugs List
HSHRC	Haryana State Health Resource Centre
IEC	Information Education Communication
ILR	Ice Lined Refrigerator
IMNCI	Integrated management of Neonatal and Childhood Illnesses
IUCD	Intrauterine Contraceptive Device
JnNURM	Jawaharlal Nehru National Urban Renewal Mission
LASA	Look Alike Sound Alike
LMP	Last Menstrual Period
MLC	Medico legal Cases
MoHFW	Ministry of Health & Family Welfare
NCD	Non- Communicable Disease
NVBDCP	National Vector Borne Disease Control Programme
NSSK	Navjaat Shishu Suraksha Karyakram
ORT	Oral Rehydration Therapy
QI	Quality Improvement
RBSK	Rashtriya Bal Swasthya Karyakram
RNTCP	Revised National Tuberculosis Program
ROP	Recording of Proceedings

SBA	Skilled Birth Attendant
SQAU	State Quality Assurance Unit
SOP	Standard Operating Procedure
STGs	Standard Treatment Guidelines
TQM	Total Quality Management
UHND	Urban Health Nutrition Day
UPHC	Urban Primary Health Centre
VDRL	Venereal Disease Research Laboratory
VED	Vital, Essential and Desirable

A. Internship Report

A.1. About Haryana

Figure 1: Map of Haryana

Haryana is a state in Northern India. It is located at 29.0588° N latitude 76.0856° E longitude. The state shares its boundaries with Rajasthan in the south and west, Himachal Pradesh and Punjab in the north, and the territory of Delhi in the east. The capital of Haryana is Chandigarh and it is also the capital of the neighboring state of Punjab. However, the biggest city of the state is Faridabad. The state was formed on 1st November, 1966.

DIVISIONS OF HARYANA

Revenue Divisions of Haryana

Division	Districts
Ambala	Ambala, Kurukshetra, Panchkula, Yamunanagar
Faridabad	Faridabad, Palwal, Nuh
Gurugram	Gurugram, Maheshnagar, Rewari
Hisar	Fatehabad, Jind, Hisar, Sirsa
Rohtak	Jhajjar, Charkhi Dadri, Rohtak, Sonipat, Bhiwani
Karnal	Karnal, Panipat, Kaithal

Figure 2: Divisions of Haryana

Table 1: Demographic profile of Haryana

Description	2011	2001
Actual Population	25,351,462	21,144,564
Male	13,494,734	11,363,953
Female	11,856,728	9,780,611
Population Growth	19.90%	28.06%
Percentage of total Population	2.09%	2.06%
Sex Ratio	879	861
Child Sex Ratio	834	819
Density/km2	573	478
Density/mi2	1,485	1,239
Area(Km^2)	44,212	44,212
Area mi2	17,070	17,070
Total Child Population (0-6 Age)	3,380,721	3,335,537
Male Population (0-6 Age)	1,843,109	1,833,655
Female Population (0-6 Age)	1,537,612	1,501,882
Literacy	75.55 %	67.91 %
Male Literacy	84.06 %	78.49 %
Female Literacy	65.94 %	55.73 %
Total Literate	16,598,988	12,093,677
Male Literate	9,794,067	7,480,209
Female Literate	6,804,921	4,613,468

Source: Census 2011

Table 2: Demographic Profile Details: Area Wise

Description	Rural	Urban
Population (%)	65.12 %	34.88 %
Total Population	16,509,359	8,842,103
Male Population	8,774,006	4,720,728
Female Population	7,735,353	4,121,375
Population Growth	9.85 %	44.59 %
Sex Ratio	882	873
Child Sex Ratio (0-6)	835	832
Child Population (0-6)	2,285,112	1,095,609
Child Percentage (0-6)	13.84 %	12.39 %
Literates	10,158,442	6,440,546
Average Literacy	71.42 %	83.14 %
Male Literacy	81.55 %	88.63 %
Female Literacy	51.96 %	65.98 %

Slums population proportion	Slum Household	Slum Population	Literacy
6.56%	332,697	1,662,305	75.8%

SLUMS	
Notified Slums	14,912
Identified Slums	16, 47,393

Source: Census 2011

Table 3: Urban profile of Haryana

	Number / Name
Million plus cities	2 (Faridabad and Gurgaon)
Cities (1 lakh to 10 lakh population)	16 (Ambala, Bhiwani, Hisar, Bahadurgarh, Jind, Kaithal, Karnal, Kurukshetra, Palwal, Panchkula, Panipat, Rewari, Rohtak, Sirsa, Sonipat and Yamunanagar)
Towns (50000 to 1 lakh population)	10 (Dadri, Fatehabad, Tohana, Hansi, Jhajjar, Narwana, Narnaul, Hodal, Dabwali and Gohana)
Urban Primary Health Centers (UPHC)	95
First Referral Unit (FRU)	2 in Distt Faridabad
Urban Health Centers (UHC)	11

Table 4: Key Health Indicators

Health Indicator	India	Haryana	Urban Haryana
Institutional Delivery	78.9% (NFHS 4)	80.5% (NFHS 4)	80.6% (NFHS 4)
Maternal Mortality Ratio (MMR)	130 (SRS 2014-16)	101 (SRS 2014-16)	--
Infant Mortality Rate (IMR)	34 (SRS 2016)	33 (SRS 2016)	27 (SRS 2016)
Neonatal Mortality Rate(NMR)	24 (SRS 2016)	22 (SRS 2016)	16 (SRS 2016)
Early Neonatal Mortality Rate (ENMR)	18 (SRS 2016)	16 (SRS 2016)	11 (SRS 2016)
Under 5 Mortality Rate (U5MR)	39 (SRS 2016)	37 (SRS 2016)	29 (SRS 2016)
Total Fertility Rate (TFR)	2.3 (SRS 2016)	2.3 (SRS 2016)	2.0 (SRS 2016)
Sex Ratio at Birth	898 (SRS 2016)	832 (SRS 2016)	824 (SRS 2016)

A.2. About the Organization

National Health Mission which encompasses the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) as its two sub-missions has the vision of universal access to equitable, affordable and quality health care services.

National Health Mission, Haryana is consistently working towards reducing the maternal, infant and neonatal mortality. Rigorous innovative and timely efforts have been rolled-out in the State to prevent the same.

A.2.1. About National Urban Health Mission

NUHM, as a sub-mission of National Health Mission was approved in 2013. NUHM is implemented in all cities with a population of over 50,000 and all District Headquarters, as per 2011 census. Thus, NUHM covers a population of around 30 crores across 1006 cities in India, so far.

Goal of NUHM

To improve the health of the urban population in general, but particularly of the poor and other disadvantaged sections/vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick & line kiln workers, sex workers and other temporary migrants by facilitating equitable access to quality health care through a revamped public health system, partnerships, community empowerment and active involvement of the urban local bodies.

Strategies of NUHM

NUHM has undertaken various strategies to improve the health indicators of urban poor.

- Quality Healthcare services
- IT and E-Governance
- Community Participation: involvement of ASHA
- Maternal & child health services to urban poor
- Inter-sectoral convergence
- Synergy with JnNURM
- Capacity building of stakeholders

A.2.2. Urban Healthcare Facilities

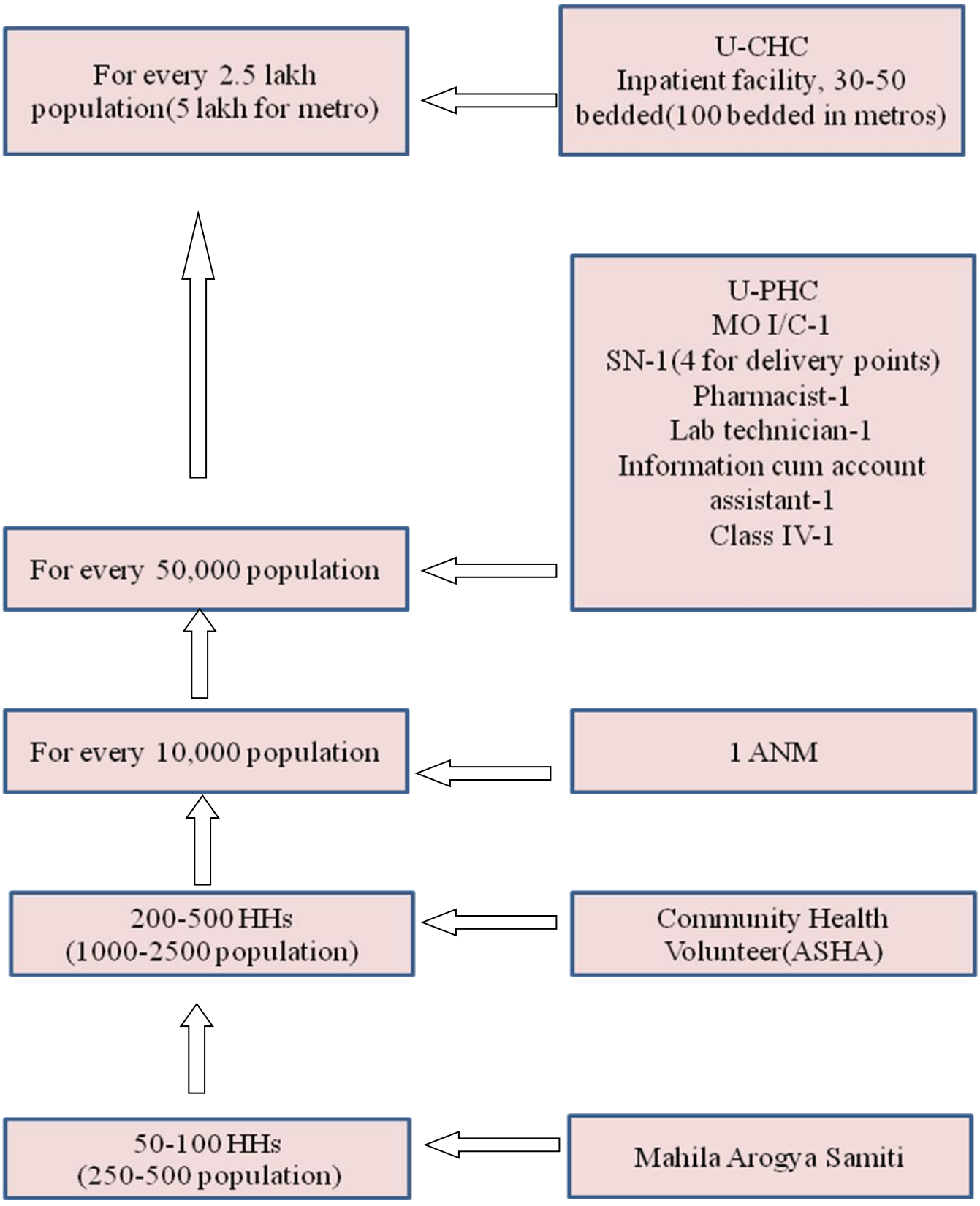

Figure 3: Urban Healthcare Facilities

A.2.3. Organogram of NUHM

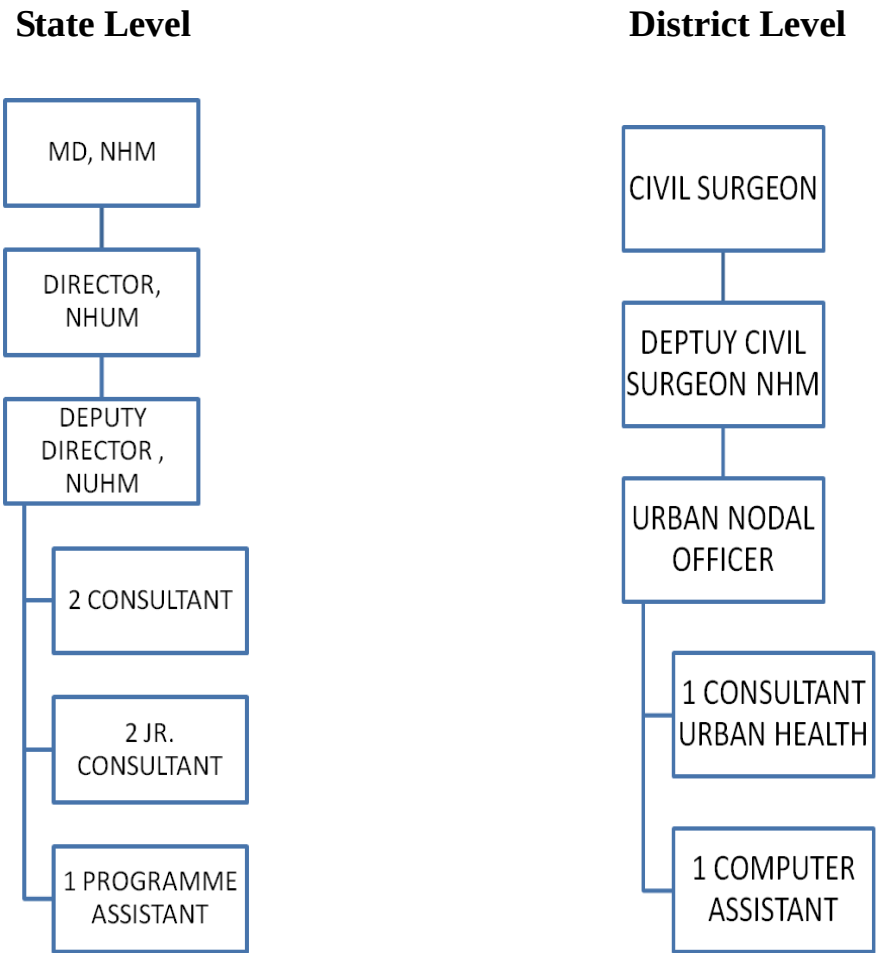

Figure 4: Organogram of NUHM

The Framework of the National Urban Health Mission (NUHM) includes the provision of primary healthcare to the slum dwellers and other vulnerable groups through targeted Outreach services.

Special Outreach Camps are organized in the Urban Primary Health Center (UPHC) catering areas. Specialist healthcare services through Gynecologists, Pediatricians, dermatologists, ENT specialists are provided to the urban poor population in these camps.

Inter-Sectoral Convergence with Urban Local Bodies (ULBs) for increasing service utilization at Urban Primary Health Centers (UPHC) and Conducting Special Outreach Camps under UPHCs.

A.3. National Quality Assurance Program

Quality is the degree of adherence to predetermined standards. Quality is tangible and can be measured. The measurement helps in creating a benchmark over a period. **N**ational Quality Assurance Standards for Urban Primary Health Centers were developed to measure the quality of services at UPHCs. These standards help the state in building an in-house quality management system which can fit into the design of UPHC.

A.3.1. Key features of the program:

1. Institutional Framework for the Quality Assurance
2. Adaptation of National Quality Assurance Standards
3. Creating pool of Assessors
4. Training on Quality Assurance
5. Selection of 'Priority Facilities' for Quality Assurance
6. Implementation of Quality Assurance at Facility Level
7. Implementation of Quality Assurance at System Level
8. Quality Certification of UPHC
9. Incentivizing and Sustaining Quality Assurance

Table 5: Quality assurance institutional structure

National Level	Central Quality Supervisory Committee
State Level	State Quality Assurance Committee
	State Quality Assurance Unit
District Level	District Quality Assurance Committee
	District Quality Assurance Unit
Facility	Quality Team

A.3.2. Measurement system for urban health facilities

It has been developed within the framework of existing Quality Assurance Program under National Health Mission. There are thirty-five Quality Standards for UPHC under eight areas of concerns. Each Quality Standard is measured through a set of measurable elements and checkpoints. One peculiar feature for Quality Assurance Standards for UPHC is that there are thematic checklists instead of Departmental checklists

1. **Assessment Protocols**

1.1 Assessment Method

a. Observation
b. Record Review
c. Staff interview
d. Patient Interview

1.2. Scoring Rules

a. 2 marks for compliance
b. 1 mark for partial compliance
c. 0 mark for non-compliance

Thus, using the scoring rules, assessment is done according to the checklist (Annexure 1).

Assessment activities are undertaken at different levels. Internal assessment is done within the facility by internal assessors. After the facility has been able to achieve a score as per the certification criterion, it is recommended for external assessment which is done by District Quality Assurance Unit (DQAU), followed by State Quality Assurance Unit (SQAU). Final assessment for certification is done by the assessors deputed by the MoHFW or an organization on behalf of the MoHFW.

A.4. Field observation

A.4.1. Aim

- To improve quality of services.

A.4.2. Objective

- To assess and identify the gaps in quality of services being provided at two different facilities according to Quality Standards.

A.4.3. Methodology

- The assessment of the facility was conducted based on the National Quality Assurance Standards checklists, under flagship of Ministry of Health & Family Welfare, Government of India.
- **Methods** used for assessment at facility:
  - Observation of the facility processes
  - Record Review at the Facility
  - Staff interviews: Discussion with MO I/C, Staff Nurse, Pharmacist, Laboratory Technician, ANMs, ASHA
  - Patient Interview

A.4.4. About the Facility: UPHC Ekta Vihar Chhabiyana, District Ambala

Figure 5: UPHC Ekta Vihar Chhabiyana, District Ambala

UPHC Chhabiyana is in the Gobind Nagar area (Near Gobind Nagar Gurudwara), Jagadhari road, Ambala Cantt. which is 2 km away from the Civil Hospital, Ambala Cantt.

The building of UPHC Chhabiyana was finalized in 2014 and became functional in April 2015. It is serving the slum areas namely, Ramkishan Colony (Muslim slum), Deha Mandi, Guwal Mandi, Left Tangri, Muslim Basti,Ekta Vihar and Chhabiyana.

Facility is a single-storied rented building with tenant occupying a room in the back-side of the UPHC. The building consists of 6 rooms, each of which is dedicated as specific departments which include Doctor's room (OPD cum dressing room), ANM room (Immunization and ANC check-up), Pharmacy, Laboratory, Family Planning room and Store.

Civil hospital is easily accessible in case of any emergency or other services.

A.4.4.1 SWOT Analysis

Table 6: SWOT analysis

STRENGTHS	**WEAKNESS**
• Team Work • Patient Load (60-70 OPD/day) • Coordination b/w Departments • Dedicated and courteous staff • Large slum coverage (5 areas) • Regular Outreach activities • Well maintained pharmacy (Skilled and competent pharmacist) • Immunization coverage • Accessibility Signages like Directional Signage from Main road to facility were adequate.	• Rented Infrastructure • Congested pathway from the main road • Difficult for the ambulance to access in case of emergency • BMW management inadequate • Inadequate Hygiene & Sanitation • No power back-up
THREATS	**OPPURTUNITIES**
• Sudden Patient load / Management of the Outbreak of any disease. • Emergency	• Opportunity of OPD's for Gynecology & Obstetrics, geriatric, AYUSH. • Augmentation of Lab services • Trainings for the staff

A.4.4.2. Thematic checklist gaps

A. GENERAL CLINIC

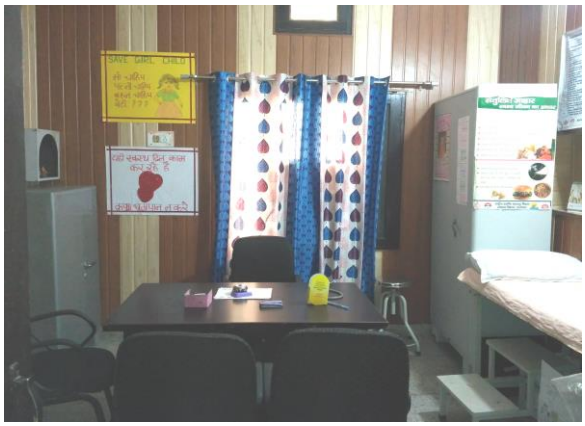

Figure 7: Doctor's room

General Clinic is operational from 10.00 AM to 06:00 PM. Medical Officer was present in the clinic and was attending the patients in serial number. There is proper seating arrangement for the doctor and patient and ample amount of space available in the waiting area for the patient's attendants. Privacy of the patient is respected.

Gaps observed as per the checklist were:

- AYUSH clinic was not included in the facility
- Adolescent friendly clinic was on priority basis, no fixed days for AFHC
- Non-availability of IEC material for AFHC
- Patient's consent was taken verbally, no written consent form was available
- No AFHC training of the Medical Officer In-charge or the staff
- Sanitation and Cleanliness of the facility including toilets was a major concern due to non-availability of regular housekeeping services
- No follow up of the referred patients.
- Time was not mentioned in the OPD slip.
- STGs and SOPs were not available at the facility
- Counseling services on "Menstrual Hygiene" was not done in the clinic
- Infection control practices regarding Biomedical Waste – bins were not closed, no proper place for the bins, management protocols were not followed
- Facility does not provide curative ARSH services

- 0.5% Chlorine solution was not available for disinfection and sterilization of equipments, betadine is used for disinfection.
- Quality management and Outcome checkpoints were severely non-adherent.

Table 7: General clinic score card

	General Clinic	**72.12**
	Area of Concern Wise Score	
A	Service Provision	**70**
B	Patient Rights	**100**
C	Inputs	**88.24**
D	Support Services	**58.33**
E	Clinical Services	**79.72**
F	Infection Control	**65.63**
G	Quality Management	**0**
H	Outcome	**11.11**

B) MATERNITY HEALTH: -

Figure 8: ANM room

The facility has six ANMs. Each ANM covers around 10,000 to 15,000 population including outreach sessions.

Gaps observed as per checklist were:

- IEC material was not available at the facility as per checklist.
- No provision for warmer during cold
- No training was conducted for the Medical Officer or staff regarding IMNCI or SBA
- Hygiene and cleanliness was compromised due to lack of housekeeping
- Policy for removal of condemnation items was not present at the facility.
- Calculation of expected pregnancy in the area was not done by the staff
- The knowledge of the staff regarding calculation of LMP or EDD was not up to the mark
- Urine test for every ANC visit was not done
- Incompetency of staff to identify pre-eclampsia cases.
- Pregnant women were not counseled for danger signs of pregnancy and no arrangement of vehicle for dropouts.
- No proper decontamination of instruments after use.
- SOPs were not available at point of use
- BMW management was compromised
- Quality management and Outcome checkpoints were severely non-adherent.

Table 8: Maternity health score card

	Maternity Health Score	**83.33**
	Area of Concern wise Score	
A	Service Provision	**100**
B	Patient Rights	**84.38**
C	Inputs	**88.24**
D	Support Services	**90**
E	Clinical Services	**98.96**
F	Infection Control	**61.76**
G	Quality Management	**50**
H	Outcome	**25**

C) NEWBORN & CHILD HEALTH: -

The newborn and child health services at facility are performed at the General Clinic by Medical Officer In-charge and ANM which needs improvisation as per thematic checklist of Newborn & child Health.

Gaps observed as per the checklist were:

- No IEC corner available – Immunization, Family planning, HIV protection etc.as per the checklist
- Staff nurse/ ANM were not trained by NSSK, RBSK, SBA, Skill lab
- Staff was not skilled in identifying & managing complication.
- Resuscitation equipment was not available.
- No advance communication was done to the higher centre in terms of newborn & child health
- No screening and referral of children with 4Ds under RBSK
- Management & Referral of Severe Dehydration as per clinical protocol was inadequate
- Non-availability of ORT corner
- SOPs were not available
- Quality management and Outcome checkpoints are severely compromised.

Table 9: New Born & Child Health Score Card

	New Born & Child Health Score	**62.07**
	Area of Concern Wise Score	
A	Service Provision	**95.83**
B	Patient Rights	**65**
C	Inputs	**70.83**
D	Support Services	**100**
E	Clinical Services	**66.67**
F	Infection Control	**73.08**
G	Quality Management	**0**
H	Outcome	**14.29**

D) IMMUNIZATION: -

Immunization services were provided by the ANM on every Thursday. A specific corner was dedicated for the same. The staff is competent and enthusiastic which was evident from the improved immunization status of the area covered by the facility.

Gaps observed as per thematic checklist were:

- Formats for First Information Report & Preliminary Investigation Report were not available
- Staff was not aware of Cycle time for reporting First Information Report.
- No proper emergency drug tray was available in immunization room
- Staff was aware of shake test.
- Vaccine recipient was not asked to stay for half an hour after vaccination to observe any adverse effect following immunization
- Non-availability of hand washing facility at the Point of Use
- BMW management was compromised
- Internal Assessment of immunization clinic was not done at periodic interval
- Disposable gloves, masks, caps and aprons were not available at point of use
- Non-availability of post exposure prophylaxis regimen
- Staff does not know what to do in condition of needle stick injury
- Indicators under Outcome area of concern were not recorded

Table 10: Immunization score card

	Immunization Health Score	**73.42**
	Area of Concern Wise Score	
A	Service Provision	**100**
B	Patient Rights	**100**
C	Inputs	**80.77**
D	Support Services	**83.33**
E	Clinical Services	**94.74**
F	Infection Control	**50**
G	Quality Management	**0**
H	Outcome	**20**

E) FAMILY PLANNING: -

Figure 9: Family planning room

There was a dedicated room for family planning services, but it falls behind the quality standards as per the thematic checklists. So, the facility has to start working on Quality Management and Outcome checkpoints.

Gaps observed as per thematic checklist were:

- Abortion facility was not available
- No follow up of referred cases
- List of Family Planning services was not available at the facility
- IEC material regarding benefits of family planning was not displayed
- Education material for counseling was not adequate
- Procedures and counseling area were not properly ventilated
- Hygiene and cleanliness was an issue
- Staff was not aware of general principles of counseling
- Non-availability of drugs for Medical Method of abortion
- Compliance to MTP (Medical Termination of Pregnancy) Act for abortion Procedures were not available
- Procedure surfaces were not wiped with 0.5% solution after every procedure
- Decontamination of Instruments was not done after use
- Sterilized instruments were not stored as per specification

- Non- availability of SOPs for family planning and abortion services
- Protocols for family planning counseling were not displayed
- Protocols of IUCD insertion and removal were not displayed
- Quality management and Outcome checkpoints were not up to the mark

Table 11: Family planning score card

	Family Planning Health Score	**77.06**
	Area of Concern Wise Score	
A	Service Provision	**91.67**
B	Patient Rights	**83.33**
C	Inputs	**88.24**
D	Support Services	**92.86**
E	Clinical Services	**89.47**
F	Infection Control	**87.5**
G	Quality Management	**0**
H	Outcome	**14.29**

F) COMMUNICABLE DISEASES:

The facility rarely provides services for communicable diseases as per the National Health Programs. Most of the patients are referred to nearby civil hospital (2kms) for diagnosis and treatment of the respective disease.

Gaps observed as per thematic checklist were:

- The facility does not provide services under National Leprosy Eradication Program, National AIDS control Program as per guidelines.
- Non-availability & display of IEC material for RNTCP, NVBDCP, HIV/AIDS
- The facility does not provide services under Integrated Disease Surveillance Program (IDSP)
- Quality management and outcome checkpoints are severely compromised

Table 12: Communicable disease score card

	Communicable Disease Score	**33.33**
	Area of Concern Wise Score	
A	Service Provision	**34.09**
B	Patient Rights	**71.43**
C	Inputs	**31.82**
D	Support Services	**0**
E	Clinical Services	**32.98**
F	Infection Control	**77.27**
G	Quality Management	**16.67**
H	Outcome	**12.5**

G) NON-COMMUNICABLE DISEASE: -

The facility attempts to provide NCD services but due to lack of resources the services were not in line with the guidelines.

Gaps observed as per thematic checklist were:

- No survey for prevalence of various eye diseases & Health Education for prevention of various eye diseases were conducted by the facility.
- Poor referral service for screening and correction of refractive errors, no records were maintained
- The facility did not provide services under National Program for the health care of the elderly as per guidelines
- No fixed days for conducting geriatric health counseling, assessment and treatment
- Services regarding National Tobacco Control Program like counseling, promotion of quitting tobacco in the community, IEC activities were lacking behind
- Doctor/ Staff were unaware of 5A's & 5 R's tobacco cessation counseling
- No linkage with any tobacco cessation facility
- Non-Availability of IEC material under National blindness control program, Mental health program, National deafness control program.

- Facility does not provide early detection & treatment of common mental disorders in OPD
- Facility was not providing early detection of hearing impairment
- The staff had not been imparted with necessary trainings as per National Health Program.
- No system for follow up of referred cases

Table 13: Non-communicable disease score card

	Non-Communicable Disease Score	**54.22**
	Area of Concern Wise Score	
A	Service Provision	**68.42**
B	Patient Rights	**64.29**
C	Inputs	**20.83**
D	Support Services	**16.67**
E	Clinical Services	**50**
F	Infection Control	**83.33**
G	Quality Management	**57.14**
H	Outcome	**87.5**

H) DRESSING ROOM & EMERGENCY: -

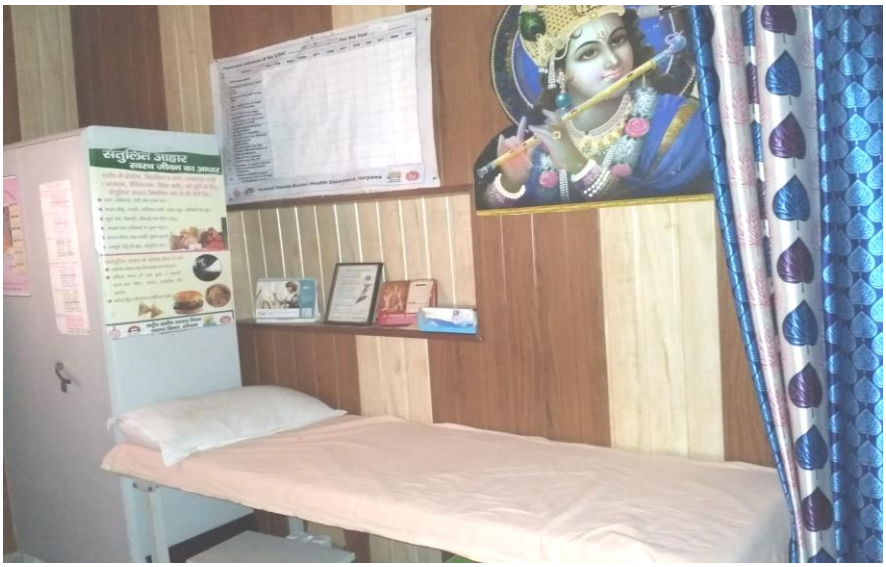

Figure 10: dressing & emergency room

The dressing room is shared with the OPD which is separated by curtain. The space is fair enough for single patient but would be difficult to manage in case of emergency or sudden increase in patient load.

Gaps observed as per thematic checklist were:

- No training of staff for handling Emergencies
- Emergency drug tray was maintained but few drugs were not available as per the checklist
- Splints were not available for bone injury cases
- No Emergency protocols were available at point of use
- No procedure for informing police in case of Medico Legal Cases.
- Decontamination of surface of procedure and instrument was not adequate
- Emergency services were not present like for trauma, bone injuries, life threatening conditions, patients were referred to Civil Hospital.

Table 14: Dressing room & emergency score card

	Dressing Room & Emergency Score	**56.77**
	Area of Concern Wise Score	
A	Service Provision	**50**
B	Patient Rights	**100**
C	Inputs	**71.43**
D	Support Services	**83.33**
E	Clinical Services	**45.45**
F	Infection Control	**66.67**
G	Quality Management	**0**
H	Outcome	**6.25**

I) PHARMACY: -

Figure 11: Pharmacy

The facility had a competent and dedicated pharmacist with well-equipped pharmacy meeting the needs of the patients with satisfactory outcomes.

Few gaps observed as per thematic checklist were:

- Alternative medicines were not available due to non-functional AYUSH clinic
- Vaccines were collected from Civil Hospital on priority basis by the ANM
- Cold Storage equipment was present but not functional.
- Only chloroquine was available under NVBDCP guideline

- Temperature control at Pharmacy & medical store would get compromised in summer season as AC was not available
- Pharmacy had no plan for safe storage and handling of potentially flammable materials
- No Training on Inventory Management and Drug Storage but the pharmacist was aware it
- Following drugs were not available in pharmacy / facility store- Antidotes and other substances used in Poisoning, Anticonvulsants/ Antiepileptic, Antianginal medicines
- LASA policy was known and practiced in the department
- VED drug list was not available
- Work instructions for storage of vaccines were not displayed at point of use
- Conditioning of ice packs was not done prior to transport
- SOPs were not available at the point of use
- Percentage of drugs available against EDL were not recorded
- Antibiotic prescription rate was not recorded
- Trends analysis of Indicators was not done

Table 15: Pharmacy score card

	Pharmacy Score	**71.56**
	Area of Concern Wise Score	
A	Service Provision	**92.86**
B	Patient Rights	**100**
C	Inputs	**82.35**
D	Support Services	**68.48**
E	Clinical Services	**100**
F	Infection Control	**0**
G	Quality Management	**14.29**
H	Outcome	**40**

J) LABORATORY: -

Figure 12: Laboratory

The space provided was not appropriate for the proper functioning of the laboratory. Although the lab technician was qualified and committed, only blood and urine tests are being performed and blood smear for malaria is prepared in the lab. Investigations covered under various National Health Programs must be strengthened at the earliest.

Gaps observed as per thematic checklist were:

- Non-availability of common pathology & Serology Tests viz. VDRL, Malaria tests, Routine hematology tests, Rapid blood test for HIV, water quality tests, dengue, swine flu tests, tuberculosis etc.
- No linkage with outsourced laboratory
- Demarcated sample collection testing area was not evident
- Laboratory space was inadequate for carrying out activities
- Work benches were not provided, shelf was used as work bench
- Trainings for Lab technician were inadequate.
- Floors, walls, roof, sinks in laboratory were not very clean
- Instruments for hematology, biochemistry, and microscopy were not adequate.
- Proper storage space for sample and reagents were not available
- There was no system of timely corrective break down maintenance of the equipments.
- No adequate illumination in the laboratory.

- The facility does not provide monitoring and reporting service for Integrated Disease Surveillance Program, as per guidelines
- No standard formats for requisition and reporting were available
- Disinfection and sterilization of instruments was not as per the guidelines
- Compromised BMW management and Quality Outcome indicators

Table 16: Laboratory score card

	Laboratory Score	**52.72**
	Area of Concern Wise Score	
A	Service Provision	**50**
B	Patient Rights	**75**
C	Inputs	**59.62**
D	Support Services	**73.53**
E	Clinical Services	**46.15**
F	Infection Control	**61.3**
G	Quality Management	**21.43**
H	Outcome	**22.72**

K) OUTREACH SERVICES: -

Figure 13: Outreach session

Outreach services were being conducted on a regular basis by a dedicated & committed ANM (8-10 per month) including special outreach sessions like UHND, deworming, polio etc. ANM was accompanied by one mobilizer on per day basis (Rs.150/day). The sessions were conducted with a prior micro plan under the guidance of Medical Officer. Outreach sessions mainly targeted slums and vulnerable population. Co-ordination and co-operation with the nearby Anganwadi center exists.

Due to non-working ILR at the facility, the ANM had to collect vaccines from Civil Hospital first. The transport facility was not available for the ANM.

Gaps observed as per thematic checklist are:

- Community based newborn screening was not done during the home visits as per the thematic checklist
- No provision of services under National Health Programs as per the checklist
- The facility does not provide services under Integrated Disease Surveillance Program as per the guidelines
- No system of grievance redressal for the beneficiaries.
- ANM was not skilled for diagnostic services
- Dressing material and Sanitary Napkins were not available
- Incentives and Transport Allowance/Dearness Allowance to ANM were paid on time.
- No system for taking feedback from ANM about the outreach activities
- The facility has not established procedure for supporting and monitoring activities of Mahila Arogya Samiti.
- Staff was not competent to identify Pre-Eclampsia
- ANM was not skilled enough for recognizing birth defects.
- Staff was unaware of eligibility, Limitation and Benefits of Lactation Amenorrhea Method (LAM)
- ANM was unaware of how to calculate the no. of beneficiaries (pregnant women & Infants for every vaccination)
- Hand sanitizer was not available for outreach session and home visits
- No provision for segregation of biomedical waste was present, only one black bag was provided to the ANM for collection of the waste
- Quality indicators were highly compromised, and no trend analysis was done

Table 17: Outreach services score card

	Outreach Score	**61.59**
	Area of Concern Wise Score	
A	Service Provision	**67.07**
B	Patient Rights	**83.33**
C	Inputs	**61.90**
D	Support Services	**50**
E	Clinical Services	**68.75**
F	Infection Control	**50**
G	Quality Management	**0**
H	Outcome	**66.7**

L) GENERAL ADMINISTRATION: -

The facility falls behind the General administration processes as per the checklist. Although the Medical Officer and the staff were committed towards their roles and responsibilities, the quality standards and implementation were quite weak due to lack of resources and basic amenities.

Gaps observed as per thematic checklist were:

- Medical Certificates were not issued at the facility
- Facility lay out with directions to different departments were not displayed
- Non-availability of at least one Disable friendly toilet
- Danger sign was not displayed at high voltage electrical installation
- No training of staff on infection control, Biomedical Waste Management, Basic Life Support.
- Cleanliness was the issue due to non-availability of regular housekeeping
- Unidirectional method and outward mopping technique was not followed
- No defined schedule for change of linen
- Facility does not periodically test the quality of water from the source (municipal supply, bore well etc.) for bacterial and chemical content.
- The facility had no system to ensure the proper utilization of fund provided to it

- Only half of the staffs were immunized
- No demarcated area for secure storage of BMW before disposal
- No Log book /Record of waste generated was maintained
- Bio Hazard sign was not displayed at the point of storage and generation
- Quality and outcome indicators were severely non-adherent

Table 18: General administration score card

	General Admin Score	**70.35**
	Area of Concern Wise Score	
A	Service Provision	**60**
B	Patient Rights	**70.59**
C	Inputs	**78.43**
D	Support Services	**87.23**
E	Clinical Services	**100**
F	Infection Control	**33.33**
G	Quality Management	**44.32**
H	Outcome	**10**

A.4.4.3. Assessment Summary

The assessment was based on the thematic checklist. The facility NQAS score did not cross 70% and thus, there is a need for quality-oriented practices to be included in their functioning as per the guidelines of NQAS.

Overall Score of facility as per Quality Standards for Urban Health Centre was **63.89%**.

Thematic wise score card is given below:

<table>
<tr><th colspan="4">UPHC Quality Score Card</th></tr>
<tr><td>Dressing Room & Emergency</td><td>General Clinic</td><td>Maternity Health</td><td>New Born & Child Health</td></tr>
<tr><td>56.77083333</td><td>72.11538462</td><td>83.33333333</td><td>62.06896552</td></tr>
<tr><td>Immunization</td><td colspan="2" rowspan="2">UPHC Score</td><td>Family Planning</td></tr>
<tr><td>73.41772152</td><td>77.05882353</td></tr>
<tr><td>Communicable Disease</td><td colspan="2" rowspan="2">63.89459274</td><td>Non-Communicable Disease</td></tr>
<tr><td>33.33333333</td><td>54.21686747</td></tr>
<tr><td>Outreach</td><td>Pharmacy</td><td>Laboratory</td><td>General Administration</td></tr>
<tr><td>61.58536585</td><td>71.55963303</td><td>52.72108844</td><td>70.34883721</td></tr>
</table>

Figure 6: UPHC quality score card

As per the assessment based on Thematic Checklists of UPHC Quality Assurance guidelines the performance of the UPHC is comparatively better in Immunization, Pharmacy, General clinic, Family Planning, Maternity Health and General Administration.

Highest scoring areas is for Maternity Health services with score 83.33% followed by Family Planning with score of 77.06%. Lowest scoring areas are services related to Communicable diseases 33.33% as most of the patients are being referred to Civil Hospital for the treatment. Quiet similar situation exists with the Non-Communicable diseases with the score of 54.22%. Lab facilities were inadequate, thereby leading to the scoring of 52.72%.

A.4.4.4. Suggestions

The Quality Assurance Standard for Urban Primary Health Centre is a versatile tool to assess the UPHC as per their status. Assessment is an approach of Quality Assurance that will help in improving the quality standards of UPHC Chhabiyana, Ambala Cantt., Haryana. These suggestions can be divided into two groups –

a.) One where gaps will be covered by the support from concerned State level authorities; and

b.) Secondly gaps will be covered by the interventions at the facility level only.

a.) State Level:

- HR status must be improved like deputation or replacement of staff on long leave.
- Provision of transport facility and other relevant support to the staff for outreach activities.
- Urgent need of regular housekeeping services.
- Change of timings i.e. from 10AM-6PM to 9AM-5PM for increased coverage of slum population, as stated by the staff.

b.) Facility Level:

- The facility should initiate a Quality Assurance Program within the Facility; Quality Team for the same should support and supervise Quality Assurance Program.
- The staff must make sure that all the IEC material is available and should be displayed properly and distributed to the beneficiaries.
- The Medical Officer should conduct regular meetings with the Quality and Urban Health Consultants holding responsibility for the concerned facility.
- The Medical Officer should check periodically the functioning of various departments, review and assess the staff performance.

- Personal protective equipments should be made available at all points of care.
- Toilets should be cleaned at specified time and some toilets should be disabled friendly.
- Bio Medical waste bins should be present at the point of generation and proper segregation with its final disposal should be made as per BMW Management & handling rules.
- Departments should display their Scope of the Services and Contact details of deputed staff.
- Infection control program should be initiated with surveillance of some of the department like Laboratory.
- Patient satisfaction survey and employee satisfaction survey must be conducted at regular interval with an active mechanism to redress patient complaints.
- The Medical Officer should arrange regular meetings with the district Chief Medical Officer regarding the status and performance of the facility and attain the support of district/state for improvisation of services at their respective facility.
- Staff should be trained on latest quality initiatives and best practices of medical world.

A.4.5.Delivery Hut, Urban Slum Dispensary, Sector-19, Panchkula

Figure 14: Labor room at urban slum dispensary, Sector 19, Panchkula

Accompanied by District urban health consultant a visit to assess labor room in Urban Slum Dispensary as per NQAS to find the gaps was done.

A.4.5.1. Labor Room Quality Assessment

Gaps observed as per checklist were:

- No assisted vaginal deliveries were done.
- No management of pregnancy induced hypertension was been done.
- There was no display of service provision and entitlements at the entrance of labor room.
- The space in the labor room was inadequate with no attached toilet.
- Compromised hygiene.
- No provision of fire extinguishers.
- Emergency tray was not fully maintained.
- Non- availability of radiant warmer.
- Temperature was not maintained due to non-availability of provision of AC.
- Several vials were found which had same month expiry.
- No follow up of referred patients.
- Non-adherence to the sterilization protocol and no SOPs were available.

Table 19: Labor room score card

Labor Room Score Card		
	Labor Room Score	**66.50485437**
	Area of Concern Wise Score	
A	Service Provision	**75**
B	Patient Rights	**42.86**
C	Inputs	**71.57**
D	Support Services	**50**
E	Clinical Services	**70.75**
F	Infection Control	**75.53**
G	Quality Management	**63.64**
H	Outcome	**0**

A.4.5.2. SUGGESTIONS:

- The MO should check periodically the functioning of labor room, review and assess the staff performance
- The staff nurses need a retraining on infection control and sterilization.
- The facilitator should raise the issue to resolve infrastructure related issues.
- Internal Assessment of all services to be done at periodic interval and record of the same need to be maintained.

B. Project Report

B.1. Project Title: Barriers and Facilitators in implementing National Quality Assurance Standards (NQAS) in Urban Primary Health Centers of Ambala Division, Haryana

B.2. Background

Health sector is one of the fastest growing sectors. With the growing population, there is a need for improvement in healthcare system. Rapid urbanization exceeds the capacity of health systems to serve efficiently and effectively; thus, leading to poor health outcomes and increase in disease burden. The National Urban Health Mission (NUHM) was approved in May 2013 as a sub-mission of National Health Mission (NHM) with the aim to improve the health status of the urban population, especially the urban poor and other vulnerable sections by facilitating the access to quality primary health care.(1) Urban Primary Health Centers (UPHCs) are the first point of contact between the Public Health System and targeted beneficiaries which help to reduce the burden at secondary and tertiary level health facilities. Every individual regardless of rural or a slum area is entitled to get basic primary healthcare. It is the responsibility of the public healthcare system to ensure accessible and affordable primary healthcare services of acceptable quality. Government of India has been making efforts to promote health through various initiatives. One such initiative was launching of National Quality Assurance Program by the Ministry of Health & Family Welfare in November 2013. Using similar framework, new guidelines & assessment tools were devised in 2015 specifically for urban healthcare facilities as "Quality Standards for Urban Primary Health Centers".(2) Adhering to the quality standards, the tool ensures that the health facilities play their expected roles in a uniform manner. These standards also help the health systems to develop and assess elements such as governance, leadership, infection control, biomedical waste management, etc. which affect the quality of patient services. These standards create a better health care system, on which the public, providers and policy makers can rely upon. The key reason to bring up such quality standards in healthcare is to enhance health outcomes. Adapting these standards in a healthcare setting involves not only streamlining the processes, but also adhering to it for the long run.

Haryana has made a progress in increasing the proportion of institutional delivery, but still the state has not been able to achieve a significant improvement in indicators i.e. fully immunized children, children breastfed within one-hour of birth, exclusive breastfeeding for first six months of the child etc.

All these indicators are poor in urban areas than in rural areas. One of the contributing factor being inadequacies in the quality of care provided in healthcare facilities. It has been seen that, improved quality has a positive impact on patient`s willingness to accept and effectively use the services. The state of Haryana initiated this program in the year 2016 for the UPHCs. The state has been able to achieve certification for only one of the UPHC in Kurukshetra district of Ambala division in the year 2018. The state is working towards achieving certification for all the UPHCs.

The assessment activities for NQAS certification are undertaken at different levels- internal assessment within the facility by internal assessors, external assessment by District Quality Assurance Unit (DQAU) and State Quality Assurance Unit (SQAU), and a final assessment for certification by the assessors, deputed by the Ministry of Health & Family Welfare or an organization on behalf of the MoHFW.

B.3. Literature Review:

For any of the healthcare provider, according to a NQF consensus report, the choices of practices that has top priority will depend on the provider`s circumstances, including what practices have been implemented already, resources availability, environmental and physical constraints and various other individual factors.(3) The philosophy of doing things right must be implemented with enthusiasm and commitment throughout the organization – from top to bottom and the little steps forward (called "Kaizen" by the Japanese) must be viewed as "a race without a finish".(4) There are some opinions that, quality assurance or control implementation in a healthcare facility can create anxiety, fear, doubts and high expectations among staffs. Various reasons why people oppose change are because they want to guard their own interests, have lower level of understandings and lack of trust.(5). The implementation of quality system is not a simple task to do and in contrast, bring a major challenge for the managers and professionals in seeking to adapt their work processes to excel in the health care. In a process of quality improvement, a system of rewards and recognition of the efforts of people who contribute to the service excellence should be considered. These efforts in future stimulate and motivate people after reward, renewing the commitment to the quality and excellence of the services provided by the facility.(6) For accreditation to be implemented and maintained in the organization, difficulty in establishing an organizational culture oriented toward quality is encountered and thus reducing staff turnover.(7) Quality Improvement (QI) initiative in primary care has the potential to improve receiving of evidence-based practices but it used to be difficult to implement and difficult to sustain too. (8) The challenges of the assessor training were of various kinds i.e. though participants were from different professional background related to primary health care but they were not directly assigned for quality of care; organizations where field exercise was conducted had other priorities e.g. continuing routine patient care services.(9) Common barriers reported in a study to assess the impact of continuous QI/TQM were participants' attitude against implementation of quality standards were followed by staff resistance and deficient knowledge and resources as well as lack of leadership support to them. (10) Also, organizations having success in fostering patient-centric care have gone beyond the mainstream frameworks for quality improvement based on clinical measurement and audit and most of them have adopted a organizational approach for strategic patient focus.(11) Staff availability is always critical for better performance and health-related outcomes at any health facilities in developing countries. Health facilities manned by skilled, committed and satisfied staff perform to deliver high quality services far better than those, which have staff shortages.(12) Most of Primary Health Care

providers and directors believe that research can also help to improve the quality and effectiveness of services given. In some cases, research can assist to improve the effort to develop step-wise empirical models that will guide countries with limited resources to consider local strengths and find solutions to overcome major limitations and challenges. (13) To improve the quality of care, various factors and combination of various methods are influential, such as evidence-based measurement from different perspectives, extensive and effective feedback to staff and prioritized improvement activities.(14)

B.4. Rationale

UPHCs are expected to deliver quality services. Quality standards were launched for UPHCs, intended to strengthen the quality of health services. Everyone in the healthcare set up, from a doctor to a support staff needs to be aware of the importance of quality in healthcare. Their knowledge, skills, attitude, motivation, communication, and other soft skills can make a lot of difference in the final delivery of health care. Not only at the facility level, but regular review at state and district level is crucial for quality outcome. Keeping in mind the importance of healthcare professionals holding leadership positions in context of National Quality Assurance Standard Certification, it becomes essential to investigate their understanding regarding the barriers and facilitators that arise during the implementation process of NQAS in UPHCs.

It was a good opportunity for me to conduct this research during preparation period of various UPHCs to achieve NQAS certification; especially when no similar research has been conducted in Haryana before to learn about the various barriers and facilitators in implementation of quality standards and its sustainability after implementation in UPHCs. The results of such investigation may be helpful for the quality implementation team, the trainers and other relevant stakeholders for bringing about effective implementation and later sustainability of NQAS in UPHCs. It may help in making more assertive decisions and creation of strategies, oriented towards proper implementation of the program at a large.

B.5. Research Question

1. What are the various barriers and facilitators in the implementation of National Quality Assurance Standards in Urban Primary Health Centres of Ambala division, Haryana?

B.6. Objective

1. To assess the barriers and facilitators in implementation of National Quality Assurance Standard guidelines in Urban Primary Health Centres.
2. To learn various strategies that would ensure sustainability of quality practices after implementation.

B.7. Methodology:

Study Setting: In Ambala division, three districts (Ambala, Kurukshetra, and Panchkula) were selected. UPHCs taken up by the state for NQAS certification in the selected districts were included in the study.

Study Design: Exploratory study using qualitative approach

Study Participants

1. State Urban Health consultant
2. District Urban Nodal Officer
3. District Urban Health Consultant
4. District Quality Consultant
5. MO I/C at the facility level

Study Sample: 14 concerned officials/implementers

Inclusion Criteria: Persons holding responsibility or working at the selected UPHCs for NQAS implementation were taken as sample.

Exclusion Criteria: Participants who did not consent were excluded.

Study period:

- The study was conducted between April - May 2018.

Data Collection Method:

- Telephonically appointments were scheduled for the interview. In-depth face-to-face interviews were carried out using an interview guide. Audio taping was done during the interview which was later fully transcribed in Microsoft Office Word. Each interview lasted for 30 min on an average (20 min to 1 hour).

Analysis plan

- For analysis, the transcriptions were used. Analysis was done using thematic content analysis. Firstly, primary content analysis was done by reading the transcriptions of the interviews with progressive development of themes, subthemes and codes accordingly.

Result

In the presentation of results, the verbatim were edited for possible grammatical mistakes, without changing their basic content. In addition, few terms between brackets were added wherever necessary to facilitate the understanding of content by the reader.

B.8. Ethical Consideration

The study was conducted in accordance with the ethical principles after taking permission from the Director (NUHM, Haryana). Interviews were scheduled according to the availability of the participants. At the time of scheduling, the objective of the study was made clear, as well as its mode of conduction was explained well to the participant. Prior to the interviews, which were carried out in the place of work of each participant, an informed consent was taken. The participation was completely voluntary. They could quit the interview or answer to any specific questions at any time. It was explained that the identity would remain hidden and they could get any statement deleted from the record made. When transcribing the recorded interview, all identifiers were replaced with codes like letter R (for Respondent) with a different numerical value (1, 2, 3 and so on) for each respondent following the code.

B.9. Results

Sixteen people were telephonically invited to participate in the study. Although when contacted, two of the participants reported of not looking after the NQAS implementation process in the UPHCs, thereby reducing the sample size to fourteen.

Profile of the respondents is listed in below table.

Table 20: Profile of respondents

State Level	District Level	Facility Level
Urban Health Consultant-2	Urban Nodal Officer-3	Medical Officer Incharge-4
	Urban Health Consultant-3	
	Quality consultant-2	

Information on years of work experience was available for all the respondents. Mean years of work experience was 14 years. Talking about the area of responsibility four respondents were implementer and internal assessor (28.6%), three respondents were planners at district level (21.4%), three were district coordinator (21.4%), two were state coordinator (14.3%) and two were district facilitator (14.3%).

The results were divided into **three categories** keeping in mind the objectives of the study. For each category, themes were identified. The themes were further divided into subthemes which are described below:

General barriers to and facilitators for implementing Quality Standards

Theme 1: Need for Quality Assurance

Visualization

If our patient becomes aware about all this, our quality will be bound to improve because our patients are not aware about quality; whatever we are doing is right for them. Nobody is challenging whatever you are doing, so, if we teach our patients what is quality then they will demand quality services. Once they demand quality services, we will have to provide. So, it will get implemented on its own. (R2)

The scenario is very common with public facility as people carry a perception that, 'it's a government hospital and here you won't find any good services, medicines and so on'. (R10)

For people who reside in the urban areas, there will always exist a comparison with the private healthcare setup. In the private healthcare setup as the OPD load is less, so they can provide better

quality of services. Once they are comparing these 2 setups, we must be in the same race, so quality is very important. (R14)

Public health facilities have been recognized as being error prone with compromised quality care. Limited public awareness about quality often leads to leniency among the healthcare providers towards delivering quality care. Several participants felt that in urban areas there is always a comparison with the private setups, which facilitates their morale to upgrade their facilities so as to achieve more patient coverage. They worked with a vision to bring about a change which would strengthen UPHCs, ultimately leading to deviation of people from private setup to public setups. It was also mentioned that there has been growing awareness among people due to active role of government which again makes it necessary to deliver quality care in the public setups as well.

Privacy

I think, the most important thing other than the services is privacy and the confidentiality. Patient will only come when they have faith in you. In a single room where other people are also sitting, there is no privacy. If a male comes and he wants to undergo vasectomy, he will hesitate to ask you. If a person, irrespective of female or male needs condom, he will hesitate to ask you. (R2)

The participants expressed concerns about the effect of the deficient space on the quality of the UPHC services. It is difficult to get an infrastructure in the urban areas, so it becomes rather very hard to organize and deliver services keeping the privacy and confidentiality of the patients intact. All this ultimately leads to hesitant behavior among the patients.

Privacy was one issue emphasized a lot by few interviewees which would lead to decreased patient footfall. The interviewees understood that quality is necessary for patient satisfaction which would ultimately lead to an increased health seeking behavior.

Theme 2: Insights on Quality Assurance

Benefits /Advantages in practice

Quality is important in public sector as it caters huge chunk of population. Government is catering this huge population by outreach activities; private is not giving anything like that. Private is only providing services to those who come to them be it Fortis or any other big brand. Added benefit in public sector is

that, you are reaching to the community. So, if we give quality services to maximum population, it will help in economic growth. (R10)

It is possible to observe from the statement that the benefits arising from Quality Assurance ultimately serves to decrease the economic burden of the country. Not only this but one of the interviewee did mention about how this project is helpful for the personal growth as well. Increased patient footfall is the result of NQAS certification, although the count for urban poor did not show much improvement as reported by one of the interviewee. Quality Assurance largely contributes to the streamlining of the processes, thus the ease of rendering services. Thus, quality is beneficial for the public as well as the staff.

Attractiveness

Since there are many constraints in UPHCs, as it is located in the slum. Hence, infrastructure is a problem and NQAS has thematic areas, so, much is not required to be changed in the infrastructure. We just need to streamline the processes. Secondly, the checklist is in a very simplified form based on same methods as in rural i.e. compliance, partial compliance, no compliance. So, it is very easy that wherever there is no compliance or partial compliance those gaps have to be filled. (R14)

Interviewees commented that Quality Assurance guidelines made for UPHCs are well designed keeping in mind the scenario of urban healthcare settings. UPHCs face a big challenge of infrastructure and space constraint, but still the Government has provided complicit checklists that make it possible to have successful implementation and easy adoption. It is based on thematic areas with focus more on the streamlining of the processes. The assessment method, as reported by one of the interviewee was thought to be quiet efficient to understand various gaps. Although staff would find it difficult to adapt to the changes that take more time and so were difficult to fit into their routine.

Record Keeping

Sometimes it is felt that, we have so many registers already i.e. outreach camp, outreach sessions, non-communicable disease, communicable disease, ANC, PNC, etc. So, it is sometimes felt as a burden as we have shortage of staff. In the beginning we face this problem but gradually we get into a habit of doing this. (R6)

The challenge of record review was the most predominant point emphasized especially by the participants who had a direct role in implementation process of the only certified UPHC. Although, all

the interviewees understood the importance and benefit of maintaining documents, but still record keeping was felt as a burden. They very well understood how records are helpful in planning and also in referring back when a mistake is made. The participants reported how the staff felt just responsible for the practical aspect of the work and not record keeping. Another issue reported was of the Standard Operational Procedures which was not readily provided to the in- charges.

Theme 3: Work environment

Work Culture

The challenge is that these are taken as dispensaries. They are not given much attention. If we have to give lab services according to quality standards, the kits are not maintained at standard temperature. In labor rooms temperature is not maintained. These are the small things which are challenges which nobody pays attention to. Vaccines are in the vaccine carriers only. These small things nobody pays attention to. (R13)

Suppose I go to the Laboratory Technician and ask him to dispense LASA and choose a dispensing method so that chances of error get reduced. They say that we don't make mistakes. We already know the medicine as we have been working on these things for last 20 years. So, this kind of attitude is there, they are not ready to change sometimes. (R11)

In view of the above statements and as per stakeholders interviewed, who had the responsibility of putting into practice a complex quality management system, based on the standardization of processes mentioned work culture as a barrier to the implementation of Quality Standards. Informants explained that staff resistance to change is the most significant barrier to the adoption of quality standards. Staff, particularly older staff, is likely to resist more because they have been in a practice of doing things their way. Although when made to understand logically, the staff did accept the change.

As, reported by several interviewees UPHCs are given the status of a dispensary, being paid less attention by the senior management. Therefore, quality policies must be common elements for the entire system, beginning with senior management, which will have an impact on the attitude regarding the culture of quality.

Team Work

At the state level there are two kinds of involvements; one from the urban health team, and the major part from the Quality Assurance cell in HSHRC. Since we know the major constraints in urban health setups, and they know the quality part, so, there is team effort. It is the same at the district level. Our district urban health consultant and quality consultant work together. The most important part is at the facility level, Medical Officer and his team. (R14)

Team work seemed to have an important role to play in supporting the implementation process. At the state level combined efforts, knowledge and experience of urban health team and HSHRC was of utmost importance. At the district level also a combined input from members of both the organization seemed to drive the cause. At the facility level, it was vital that a team made up of different categories of health workers is formed to be responsible for implementation of Quality Assurance. As mentioned by few participants the team is likely to function better since the Executive director was quiet effective, thus it penetrated into the system. Another set of participants felt very little contribution from the state level though.

Theme 4: Change champions

Leadership

Sometimes we say, "Lead with Example". If the leader is committed to work, the subordinates get motivated. Till the leader is not setting any example, the staff remains reluctant towards their part. But when the in- charge supports his/her subordinates, they reciprocate. So, leadership is important to achieve any target. (R11)

The successful implementation of Quality Standards depends on rational, proactive, empathetic, determined and a positive approach of the leader to work unceasingly to achieve continuous improvement. The commitment of Medical Officer In-charge was among the most mentioned facilitator contributing to the adoption of Quality Standards. All interviewees believed that leaders' ability to communicate and commit to the initiative was an essential first step toward establishing and promoting quality. Participants mentioned several actions that leaders must take to facilitate such projects.

First, the leader must have self interest, should be enthusiastic about the change and signal that the project is important for the service. Also, he/she should talk with the staff to identify the areas with the greatest need for improvement. The leader should play the role of a coach and educator. Few participants

felt a breach in leadership at the district level, as according to them there was lack of interest of seniors at the district level. It seemed that they had superficial knowledge about the various ongoing programs.

Innovation

When the assessor would ask, things should not be haphazard. Quality is also the reproducibility of the things in the earliest possible time. So, we did the file indexing. Assessors appreciated that, the moment he says the name of the report it was in front of us. (R10)

I repeatedly say this in the meetings also, that once we determine that we have to do this, we will find a solution. The point is, when we say this can't be done, we accept that. We never had this type of mentality. Some points were there which were not applicable in urban settings, so we did a lot of brainstorming for that. Finally, we generated customized points. (R10)

Interviewees described how conversations were valued among various team members. The experiences of the participants in implementing quality standards in UPHCs showed how small innovations such as indexing of files for better reproducibility was done. The participants mentioned extensive brainstorming as one important facilitator to find out solution to the points which otherwise seemed to be unachievable.

Staff Engagement

If we show the staff that, they are very important part of the organization, they will work. If we keep scolding them and take everything to our credit, they will not work. We must make them feel that they are the main and important part of this institution and this institution belongs to them. (R2)

When we tell them that you have to do this work, the staff resistance increases. But if you ask for their suggestion like how we can do this so that you don't feel a burden. It's just the way of saying things differently, although the work must be done. Then they give input, can we make it like this, does that solve your purpose. (R10)

The biggest issue was the language problem, as it is not in Hindi. ANM, Laboratory Technician has their basic education in Hindi. Each word was translated and discussed with them, asked to speak in their own language. When they understood this, they knew what is being expected out of them. So, from this they picked, internalized it and started working. (R8)

Participants recognized that the staff is overburdened and therefore it was important to make strategies to overcome this barrier. Two interviewees out of thirteen cited staff involvements, staff centrality and

staff internalization as critical strategies for overcoming this barrier. Changing the mind-set of staff was another barrier most consistently mentioned. Staff sensitization, according to three out of 14 participants who had a role in implementation of quality standards in the certified UPHC was identified as one of the key facilitator for not only NQAS implementation but also its sustainability. One of the participant had trouble in implementation as not all staff members could understand the language used in the guidelines. This barrier was very well overcome by mentoring done by the leader during frequent short meetings with the staff, which lead to good reciprocation of work. Most of the participants mentioned that the staff was very cooperative and supportive. As pointed out by one of the participant, status quoits are one general mentality, but progressive realization of real-time benefits came with time.

Responsibility

Sharing of work load was the only way we achieved our desired objective. Understanding responsibility in HR shortages may help to avoid such situations. In some cases, we didn't even follow our work hierarchy. We divided the tasks on a similar basis and started working on it. (R11)

For medical officer in-charges, Quality Assurance came as a huge responsibility. This was often overcome by sharing the ideas and responsibility between the facility and district team members which reduced the feeling of being overwhelmed by the workload, thereby resulting in easier implementation. As reported by one of the participant the stakeholders themselves shared the responsibility of tasks which otherwise had to be allotted to the staff.

Availability

The doctors are involved too much into meetings, training, and outreach session supervision. So, due to this there is no availability of the MO at the facility. Therefore, patients develop a perception that no doctor is available in the UPHC. (R4)

Another barrier regarding the implementation of NQAS in UPHCs was that only one Medical Officer was responsible for the clinical as well as administrative work. A participant commented that she thought it would have been easier to implement Quality Standards if at least two doctors were available at the facility. One of the interviewee talked about how sometimes the pharmacist had to face angry patients due to non-availability of Medical Officers who is involved in attending meetings and trainings.

Coordination

As sir had duty somewhere else, he started calling the staff at his duty place. The staff was coordinated with sir and he called them as per their convenience. They understood his problem. (R10)

Interviewees acknowledged coordination between Medical officer and his staff and noted that this coordination and understanding was critical for working towards achieving standardization. A good coordination between the district and facility heath workers was also mentioned as one significant facilitator. Although, one of the interviewee believed that there was lack of coordination between the departments which acted as a barrier.

Theme 5: Organizational context

Resources

Infrastructure can be managed but if HR is not there or skilled HR is not there, it is very difficult. Unfortunately, this one aspect no one is paying attention. (R8)

Deputation is another major barrier faced. If supposedly an ANM gets deputed somewhere else, who will do her part of work. The person who does will get burdened. (R3)

In interior areas doctors usually do not prefer to go. So, a lot of problem is faced during recruitment of doctors. (R1)

Since the facilities are in the interior areas, doctors usually do not prefer such areas to work. Secondly, the timings of the UPHCs was said to be not very satisfactory for the patients as well as the staff. Maybe because of this difficulty, interviewees mentioned staff attrition (especially Medical Officer) as another challenge inherent to implementation of quality standards. Most of the staff in the UPHC was reported to be contractual, thus making people less keen to work towards quality. Deputation was one big barrier reported by most of the participants. Not only this, expressing frustration, one of the interviewee mentioned about no substitutes for staff on leave for long durations, thus causing a hindrance in the working of the facility work. There was considerable concern regarding the shortage of medicines and equipment shortages. Such shortages occurred as a result of unnecessarily time-consuming procurement procedures. It was a challenge to work in irregular supply of essential commodities. This resulted in obvious patient dissatisfaction.

Structure and Facilities

The main barrier is that we do not have our own building. We can't change much according to our will. Mostly are on rent. We need to do things within defined limits. (R3)

If we work hard and get grade A. Further, if we must shift to a new place later and there we do not find a good infrastructure; we will again come to zero. This is a major point. (R6)

No proper infrastructure, space constraint was mentioned as a barrier for making changes as per required standards. Since most of the health facilities were in rented houses, changes could not be made without the involvement of the landlord. Although it notified by most of the interviewees regarding the tremendous support provided by the urban local bodies for the only certified UPHC. Several participants expressed major concern about the availability of limited routine investigations leading to higher rates of referrals to the civil hospitals. Another issue mentioned was regarding lack of mobility support for the medical officer and his staff.

Barriers to and facilitators for using various implementation strategies

Theme 1: Implementation strategy

Motivation

Every week keep asking casually, send me a picture of the work you have done. Saying you have done superb, I wouldn't have been able to do it. You have done so well. This is the way I get NQAS done. (R2)

One activity that we planned was appreciation of the staff. We had star performer of the month who would be appreciated from any doctor or any senior. That played a very good role. In other districts too, MO I/C liked the idea. Word of appreciation in front of other counterparts, even if you don't give a certificate, one handshake or say something about him, that thing will remain in his memory and will keep motivating. We saw the results. (R10)

All interviewees emphasized that staff members' motivation was an important factor for successful implementation of the program. Several factors could help motivate them. Appreciation was one of the most emphasized facilitator which motivated the staff members. Motivating change through incentives, felicitation programs, positive reinforcement, and staff recognition were strategies employed by most of the implementers. A sense of competition with the other UPHCs also facilitated the staff to work towards quality. As mentioned by two of the participants, there was lack of seriousness at the facility level, which acted as a barrier.

Trainings

We must train our staff. We gave demo like for spill management. We marked a motto, that if the staff practices it with his hands, he will remember. "What the hand does, the mind always remembers that". (R10)

The importance of regular monitoring to reinforce compliance was a recurring theme in almost all the interviews. As clear from the above statement, the implementers focused on making quality a routine activity through live demonstrations and role play. It was mentioned that no proper induction or trainings for the new joining were practiced. No previously scheduled meetings to disseminate information were emphasized on by one of the interviewee. It was commented that the staff were not properly trained for the program which made it difficult to make them understand things in due time. Site visits and observation were mentioned to be quiet valuable to bring about effectiveness to implementation. Experienced interviewees consistently mentioned about lack of systematic running of other national health programs which lead to less awareness at the district and facility level about them. Review meetings to monitor the progression acted as a facilitator. Although varying attendance rates at the trainings had been a challenge for the stakeholders.

Task Allotment

For the resistance, if we go for the visit, that is quite valuable. If we have a target to get ten works done, but we find that the person is not sensitized and is showing resistance, we must change our strategy. Just give him one work out of the decided ten. Make your speed slow accordingly. (R10)

Then comes work distribution, few things are very simple like immunization will obviously go to the ANMs, but then there are many other things where work distribution had to be done. So, we had to analyze who is the most suitable person for that work. That was also a challenge. Challenge in the sense i.e. everything was very time consuming and we were not experienced. (R9)

Especially in the context of quality management systems, slow dissemination of work as per staff capacity to minimize burden was mentioned as a facilitator. Decisions on work distribution although was found to be tough as this required a good judgement from the leader. Staff tends to lose focus on quality due to other programs running simultaneously. According to one of the interviewee, staff failed to understand that quality is an ongoing process. The basic principles of mapping processes to ease work were also considered as a challenge.

Timing

Timelines they should follow, which they are not able to because there are many more programs that run simultaneously. (R14)

Interviewees referred to lack of working according timeline as one the barrier. As per the experiences shared by three out of fourteen interviewees, working beyond the duty hours on part of the medical officer in-charge and his staff helped achieve certification so early. Staff was therefore highly motivated to spend extra time. Although, all the interviewees recognized the project as time consuming and felt time constraint due to several other simultaneously running programs.

Funding

Funds are another issue. The funds are released quite late. Recording of Proceedings (ROP) comes late. (R3)

Our main barrier that time was of budget, which she solved for us. Now we do not have any problem regarding budget after we received help from HSHRC. (R7)

Since the implementation of Quality Standards requires large investments of a wide range of resources, including financial ones, funds were one important theme discussed with the interviewees. Funding was mentioned in all interviews as an important factor for implementing improvements. Getting extra funding from the urban local bodies in one of the UPHC was therefore a key facilitator for establishing quality standards. A second financial facilitator was that of monetary help from the HSHRC. Several participants mentioned that monetary constraints caused delay in procurement of important commodities. Delay in release of funds forced spending from their pocket. Majority of the interviewees felt budget constraint, delay in release of funds as one major barrier while others saw no problem with funds. Delayed ROP was one important factor contributing to delay in release of funds.

Strategies for sustainability of change

Theme 1: Sustainability of Quality

Ownership

Our aim is not just one-time implementation but implementation during each service delivery process. We want all these things to become a part and parcel of our system. All this has to come from within. All of us should own this project. (R2)

Until they own the project, it won`t be sustainable. If they have simply prepared documents and records to clear nationals, the program will not sustain. But if they have grasped and taken the ownership it will sustain. (R11)

In view of the above statements, it can be mentioned that perceptions of the participants indicate the importance of ownership for the sustainability of the program. Involvement of all the stakeholders leads to greater ownership for the program during implementation. Ownership comes with understanding the responsibility and seeing the program throughout from inception to implementation at the grass root level making it a part of the system.

Strategic Planning

With this number of Human Resources if it is expected to maintain the same quality with increasing patients and services, that won't be possible. (R8)

Keep monitoring even after implementation. State should ask for feedback. After every three months scoring should be done. External and internal assessment should be done even after certification. By this a fear to maintain things would be there. If this check is not kept, there would be a leniency at various levels and change would not sustain. (R 1)

Strategic planning largely contributes to successful implementation and sustainability of the programs. By means of reassessments (internal as well as external), constant hammering, retraining, reorientation, continuous skill development, performance-based incentives and capacity building would help seek sustainability once certification is achieved as suggested by the interviewees. Although few of the interviewees showed a high concern about increasing patient footfall and demand once quality is achieved. Human Resource, time and motivation available for working according to the achieved quality were still limited. This seemed to be big challenge for them.

B.10. Discussion

This assessment study allowed identifying barriers and facilitators that arise in implementing National Quality Assurance Standards in Urban Primary Health Centers from the point of view of various stakeholders and implementers. An understanding of the factors, that influence the implementation of quality standards, is essential for the success of the program, so that, there is an assertive decision making and problem-solving technique can be used. The interviewees identified various significant factors that resulted in adoption and non-adoption of quality standards in the facility.

Quality is a continuous process; the participants were pleased with the project, but anxious regarding implementation and its sustainability. This study identified factors by focusing on three levels of the health system namely, the service providers (core implementers), district level healthcare workers and state level healthcare workers. The common facilitators mentioned were, the value of leadership, motivation and sensitization of the staff etc. The leader provides an environment full of energy and enthusiasm where he recognizes the highly motivated and influential subordinates, who would be willing to go beyond other subordinates to accomplish organizational goals.

Active involvement of the staff in decision making was being motivated by the medical officers and district consultants towards the cause of achieving quality. Coordination between the MO I/C and his staff; between facility and district level healthcare workers was necessary and of paramount importance to the implementation process. Such an initiative was easier to adopt because of strong commitment of the medical officer at the facility level.

Several participants reported that the adoption of quality standards was most successful with the help of champion such as Executive Director. On the other hand, implementing change can be a difficult process, with various identified financial and professional barriers. Lack of focus on urban healthcare facilities harbored dissatisfaction and demotivation which eventually led towards negative impact. Lack of infrastructure and human resources demotivated not only the medical officers but also the healthcare workers at the district level. The result of this study is consistent with the findings in projects implemented in South Africa which showed that shortage of staff, demotivation, poor attitudes were some of the quality shortfalls.(15) Results from this study were consistent with other studies, which also explained that shortage of medicines is a source of annoyance and anger among patients which, in turn affects the staff motivation level.

A study done in Pakistan suggested that health workers perform better when essential commodities and equipment are available to them. The same study pointed that healthcare staff has consistently shown to be dissatisfied as the health system struggles to cope with the challenge of catering to the needs of the

growing number of patients and one of the reasons has been cited to be inadequate supplies available to health staffs.(12)

According to a technical report on quality published by the Health Systems Trust showed that, political commitment to provide high quality primary health care is an important initial which often create a gap between the intended role of primary health care services and their real capacity to deliver; chiefly because of lack of resources and management capacity.(15)

World Health Organization (WHO) report cited that shortage of resources for urban health is a problem everywhere. The study group in this report noted that, there was some evidence i.e. if reference health centres offer services of an appropriate quality, they would not only enjoy support from the communities

they serve but also be in a good position to stimulate the generation of resources.(16) Several respondents identified various strategies used to overcome these barriers that may assist other implementers facing the same challenge. These strategies include sensitization of staff and providing positive reinforcement by the leaders. On the other hand, for achieving sustainable changes, difficulty in establishing same quality with increasing patient footfall was a major concern for the study participants.

Thus, the study contributes to more assertive decision making, especially to those who aim to implement quality standards in urban health facility throughout. The positive attitudes of health providers should be reinforced by overcoming the pre-identified barriers, while the highlighted concerns on sustainability of quality standards should be taken into consideration to enhance health outcomes.

The main strength of this study is that it is the first qualitative study in Haryana trying to explore the views of stakeholders and implementers in the NQAS implementation process. The study presents the in-depth views of the participants. Inclusion and analysis of perspectives of healthcare workers at all three levels (facility, district and state) strengthens this study. However, this study includes evidence from only three districts; henceforth reporting limited perspectives. Therefore, more studies should be done which can include more districts to have a better opinion on the barriers and facilitators being faced in the implementation of the quality standards in UPHCs.

B.11. Conclusion

The present study concluded that strong leadership commitment, active staff involvement, and sharing responsibility were the important facilitators for the implementation of Quality Standards in Urban Primary Health Centres.

Lack of proper infrastructure, shortage of staff, budget constraint and non-availability of medical officer due to meetings and training were the top barriers pointed out in the study. However, considering the qualitative nature of the study, the findings should be generalized cautiously.

B.12. References:

1. Ministry of Health and Family Welfare. Annual Report 2016-2017 Chapter 2 National Health Mission [Internet]. 2016. Available from: https://mohfw.gov.in/annual-report-department-health-and-family-welfare--2016-17

2. QualityStandardsforUrbanPrimaryHealthCentre.

3. Blake SC, Kohler S, Rask K, Davis A, Naylor DV. Facilitators and barriers to 10 national quality forum safe practices. Am J Med Qual. 2006;21(5):323–34.

4. Adinolfi P, Affairs H, Hope P, Road OG, Hope P, Health TP, et al. Critical Factors of Total Quality Management and Its Effect on Performance in Health Care Industry : A Turkish Experience. BMC Res Notes [Internet]. 2013;19(February 2014):37–41. Available from: http://www.biomedcentral.com/1756-0500/4/566

5. Offei AK, Bannerman C, Kyeremeh K. Healthcare Quality Assurance Manual for Sub-Districts. 2004;(July):1–77.

6. Manzo BF, Brito MJM, Corrêa A dos R. Implicações do processo de Acreditação Hospitalar no cotidiano de profissionais de saúde. Rev da Esc Enferm da USP [Internet]. 2012 Apr [cited 2018 Jun 10];46(2):388–94. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342012000200017&lng=pt&tlng=pt

7. Oliveira JLC de, Matsuda LM. Benefits and difficulties in the implementation of hospital accreditation: The voice of quality managers. Esc Anna Nery - Rev Enferm [Internet]. 2016;20(1):63–9. Available from: http://www.gnresearch.org/doi/10.5935/1414-8145.20160009

8. Hespe C, Rychetnik L, Peiris D, Harris M. Informing implementation of quality improvement in Australian primary care. BMC Health Serv Res. 2018;18(1):287.

9. Hiv M, Programme A. Baseline Assessment : Quality Management in selected Urban Primary Health Care facilities in Sylhet. 2010;(August).

10. Shortell SM, O'Brien JL, Carman JM, Foster RW, Hughes EF, Boerstler H, et al. Assessing the impact of continuous quality improvement/total quality management: concept versus implementation. Health Serv Res [Internet]. 1995 Jun [cited 2018 Jun 10];30(2):377–401. Available from: http://www.ncbi.nlm.nih.gov/pubmed/7782222

11. Luxford K, Safran DG, Delbanco T. Promoting patient-centered care: A qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. Int J Qual Heal Care. 2011;23(5):510–5.

12. Shah SM, Zaidi S, Ahmed J, Rehman SU. Motivation and Retention of Physicians in Primary Healthcare Facilities: A Qualitative Study From Abbottabad, Pakistan. Int J Heal Policy Manag [Internet]. 2016;5(8):467–75. Available from: http://ijhpm.com/article_3181.html

13. Sbarouni V, Tsimtsiou Z, Symvoulakis E, Kamekis A, Petelos E, Saridaki A, et al. Perceptions of primary care professionals on quality of services in rural greece: A qualitative study. Rural Remote Health. 2012;12(4).

14. Marx M, Nitschke C, Nafula M, Nangami M, Brodowski M, Marx I, et al. If you can't measure it- you can't change it - A longitudinal study on improving quality of care in hospitals and health centers in rural Kenya. BMC Health Serv Res. 2018;18(1).

15. Health Systems Trust. Initiative for Sub-District Support. Technical Report N°Health Systems Trust. University of Cape Town. Durban. South Africa. [Internet]. 1997. Available from: http://www.who.int/entity/management/district/WhatReallyImprovesQualityPHC.pdf

16. Who. The Role of Health Centres in the Development of Urban Health Systems. 1992.

17. Sommerbakk R, Haugen DF, Tjora A, Kaasa S, Hjermstad MJ. Barriers to and facilitators for implementing quality improvements in palliative care - Results from a qualitative interview study in Norway. BMC Palliat Care. 2016;15(1).

ANNEXURE

Annexure 1: Sample Checklist

CHECKLIST FOR GENERAL CLINIC → a					
Reference No.	**Measurable Element**	**Checkpoint**	**Compliance**	**Assessment Method**	**Means of Verification**
Area of Concern - A: Service Provision → b					
Standard A1	Facility provides Promotive, preventive and curative services → c				
ME A1.1 → d	The facility provides treatment of common ailments → e	Availability of Consultation services for common illnesses → f	→ g	RR/SI → h	Common Cold, Fever, Diarrhoea, Respiratory tract infections, Bronchial Asthma, conjunctivitis, foreign body in conjunctival sac, etc. → i

Annexure 2: Consent Form

CONSENT FORM

Research title- Barriers and Facilitators in implementing National Quality Assurance Standards in Urban Primary Health Centres of Haryana

Date:_____

Researcher: **Dr. Shivani Bhandari**
University: Institute of Health Management Research, Jaipur
Stream: MBA Hospital and Health Management
Intern, Urban Health (NHM Haryana)
University Mentor: Dr. Mohan Lal Bairwa
Organization Mentor: Dr. Nidhi Sharma
Email: shivani.j17@iihmr.in
Phone: 8968264694

I invite you to take part in a research study. Before you decide to participate in this study, it is important to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please do ask the researcher if there is anything that is not clear or if you need more information.

The purpose of this study is to understand about your experiences in implementing National Quality Assurance Standards in Urban Primary Health Centers of Haryana. We will recognize barriers and facilitators in implementing NQAS in UPHCs from the perspectives of the various stakeholders/ implementers. In addition, we would want to know how changes made as per NQAS can be made sustainable. Your valuable inputs can be helpful for the quality implementation team, the trainers and other relevant stakeholders for bringing about effective implementation and later sustainability of NQAS in UPHCs.

The interview should take less than an hour. I will be audio taping the session so as to be sure of capturing the thoughts, opinions and ideas. Although I will be taking some notes during the session. I will be compiling a report which will contain all interviewee comments without any reference to individuals. I assure you that all your comments will remain confidential.

If you have any questions now or after the discussion, you can always contact the researcher.

Signature of Participant

Annexure 3: Interview Guide

Interview Guide

The intent of this study is to explore the barriers and facilitators to the implementation of National Quality Assurance Standards in Urban Primary Health Centers of Haryana. The results can be helpful for the quality implementation team, the trainers and other relevant stakeholders for bringing about effective implementation and later sustainability of NQAS in UPHCs. I will use NQAS in place of National Quality Assurance Standards and UPHCs in place of Urban Primary Health Centers during the interview.

This interview will be recorded for analysis purpose and will not be shared with anybody except interviewer. All the unique identifier will be removed from the results including name of individuals and places. You are free to quit the interview or answer to specific questions if you do not wish to respond.

Identification details

A. Name.....
B. Age.....
C. Work Experience (in years).....
D. Position/Area of responsibility in NQAS implementation.....
E. Date/Time.....

Start audio recording

1. What do you think are the various problems faced in seeking primary care in urban settings? (Probe: Quality of care)
2. What do you think about the importance of quality in urban health?(probe: perceived error-prone, not patient centric, compromised quality, etc)
3. What is your personal experience and views (in general) on NQAS?
4. How has leadership been exercised at various levels for the implementation of NQAS?(kind of leadership-centralized or decentralized)
5. NQAS entails a change. Is the UPHC staff generally open to change? (If not, then how do you manage them?)
6. What do you feel are the factors which pose challenges/barriers to implementation of NQAS in UPHCs? Please elaborate.(Probe: work culture, documentation, staff resistance etc)
7. Do you have any suggestions as to how can we overcome the various barriers? Please share.
8. Would you like to tell the potential factors which facilitate the NQAS implementation?(Probe: key actors)
9. How do you think we can achieve sustainable changes as per NQAS?(educational sessions, periodic re-assessments, incentives)
10. What efforts can be taken to enhance the success of NQAS at the facility level?
11. Is there anything more you would like to add?

Thank you so much for participating in interview, giving me valuable time, and sharing your opinions.