A DESCRIPTIVE CROSS SECTIONAL STUDY ON FACTORS INFLUENCING THE QUALITY OF PRIMARY HEALTH CARE SERVICES PROVIDED BY MULTI PURPOSE HEALTH WORKERS IN TIRUVALLUR DISTRICT, TAMIL NADU

Dissertation submitted to
THE TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY
CHENNAI
In partial fulfillment of the requirements for the degree of

M.D. BRANCH XV
COMMUNITY MEDICINE

THE TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY
CHENNAI, TAMIL NADU.

MARCH 2007

CERTIFICATE

This is to certify that the dissertation entitled **"A DESCRIPTIVE CROSS SECTIONAL STUDY ON FACTORS INFLUENCING THE QUALITY OF PRIMARY HEALTH CARE SERVICES PROVIDED BY MULTI PURPOSE HEALTH WORKERS IN TIRUVALLUR DISTRICT, TAMIL NADU"** is the bonafide work done by **Dr. ARUN MURUGAN S.** Post Graduate student, in the Institute of Community Medicine, Madras Medical College, Chennai- 600003 under our guidance towards the partial fulfillment of the requirement for the degree of **"MASTER OF COMMUNITY MEDICINE"** branch XV, March 2007 under the Tamil Nadu Dr. M.G.R. Medical University, Chennai.

The Director I/C
Institute of Community, Medicine,
Madras Medical College,
Chennai - 600003

Place: Chennai

Date: 25/10/2006

The Dean
Madras Medical College,
Chennai – 600003

DECLARATION

I **Dr. ARUN MURUGAN S.** Post Graduate student, in the Institute of Community Medicine, Madras Medical College, Chennai- 600003 hereby declare that I carried out this dissertation entitled **"A DESCRIPTIVE CROSS SECTIONAL STUDY ON FACTORS INFLUENCING THE QUALITY OF PRIMARY HEALTH CARE SERVICES PROVIDED BY MULTI PURPOSE HEALTH WORKERS IN TIRUVALLUR DISTRICT, TAMIL NADU"** at Institute of Community Medicine, Madras Medical College, Chennai- 600003 during the period from January 2006 to June 2006.

I also declare that this bonafide work or a part of this work was not submitted by me for any degree or award to any university or board either in India or abroad.

This work is submitted towards the partial fulfillment of rules and regulation for the requirement of the degree "**MASTER OF COMMUNITY MEDICINE"** branch XV, March 2007 under the Tamil Nadu Dr. M.G.R. Medical University, Chennai.

Place: Madras Medical College,
Chennai - 600003.

[DR. ARUN MURUGAN S.]

Date: 25/10/2006

ACKNOWLEDGEMENTS

The completion of this dissertation would not have been possible without the support, contribution and encouragement of many people. Foremost in my mind are my family members who have stood by me throughout this process.

I gratefully acknowledge and sincerely thank Dr. Kalavathy Ponniraivan, Dean, Madras Medical College, Chennai, and Dr. Geethalakshmi, Vice Principal, Madras Medical College, Chennai, for providing me an opportunity to carry out the dissertation.

To my thesis supervisor Dr. Prince Prabhakar former Director in-charge, Institute of Community Medicine, Madras Medical College, Chennai , thank-you for being willing to work with me, for your words of encouragement, your challenges in what and how I was thinking, and your ability to get the best out of me.

My appreciation is extended to the technical advisors of my dissertation Dr. Paarivallal HRD Consultant and Trainer, Bangalore and Mr. Kartik Murugan, Manager, HCL Technologies, Chennai who have spend endless hours in helping me stretch my thinking and articulating my thoughts.

My sincerest appreciation and thanks needs to go to Dr. Bhavani Umadevi, former Associate and Dr. Nagarani, Assistant Professor, Institute of Community Medicine, Madras Medical College, Chennai, for the words of encouragement and support.

In particular I would like to thank Dr. V.V. Anantharaman, Dr. Kuberan, and Dr. A. Chitra for their outstanding and ongoing support, positive attitude and for instilling confidence in me. Thank you for listening, for being open and for giving me honest feedback.

A special thank you to Dr. Alphonse Selvaraj, Deputy Director of health services and preventive medicine, Institute of Public Health, Poonamallee, Chennai and Dr. Ravi Varma, Deputy Director of health services and preventive medicine, Tiruvallur Health Unit District for providing me the setting to do this dissertation.

I am also very grateful for the Village Health Nurses and Health Inspectors who were willing to participate in this study, and to share their perspectives. Your lives are filled with new experiences and challenges and I am very appreciative for the opportunity to listen and learn from each of you.

CONTENTS

INTRODUCTION

Primary health care was a new approach to health care that came into existence following an international conference in Alma Ata in 1978 organised by the World Health Organisation and the UNICEF. The Alma Ata conference defined primary health care as follows:

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination"

The approach has also been called as "Health by the people" and "placing people's health in people's hands." Primary health care was accepted by the member countries of WHO as the key to achieving the goal of Health for all

Essential components of primary health care

The Declaration of Alma Ata outlined the 8 essential components of primary health care.

1. Education concerning prevailing health problems and the methods of preventing and controlling them .

2. Promotion of food supply and proper nutrition.

3. An adequate supply of safe water and basic sanitation.

4. Maternal and child health care, including family planning.

5. Immunisation against major infectious diseases.

6. Prevention and control of locally endemic diseases.

7. Appropriate treatment of common diseases and injuries.

8. Provision of essential drugs.

Principles of primary health care

Equitable distribution

Health services must be shared equally by all people irrespective of their ability to pay. An example of equity is: if you had a loaf of bread and wished to share it with those in need you could do one of two things. Give everyone a piece of bread each. This is equality. Or you could give a piece of bread to those who need it or are hungry. This is equity or fairness. The same thing is done with the resourses of a country.

Community participation

There must be a continuing effort to secure meaningful involvement of the community in the planning, implementation and maintenance of health services, beside maximum reliance on local resources such as manpower, money and materials.

Intersectoral coordination

Primary health care involves in addition to the health sector, all related sectors and aspects of national and community development, in particular social welfare,panchayat raj institutions,agriculture, animal husbandry, food, industry, education, housing, public works, communication and other sectors.

Appropriate technology

Appropriate technology is technology that is scientifically sound, adaptable to local needs, acceptable to those who apply it and for those for whom it is used and can be maintained by the people themselves in keeping with the principle of self reliance with the resources the community and country can afford.

QUALITY OF PRIMARY HEALTH CARE IN INDIA

Historically, the quality of public services in developing countries has been neglected with little attention being paid to the quality of primary health care provided. In the years following the Alma Ata declaration, access was equated with adequate primary health care provision and priority was given to extending coverage by health care services. Considerations of the quality of care provided formed little or none of the primary health care or health systems discourse. During the 1980s concerns regarding the quality of care being provided emerged. The perceived lack of ability of primary health care workers to adequately treat common childhood illnesses such as diarrhoeal disease and acute respiratory infections, provided the impetus for a process whereby quality assurance

methods were applied to developing countries. The concept of quality of care in the field of public health services is yet to get its importance even now.

An extensive primary health care infrastructure provided by the government exists in India. Yet, it is inadequate in terms of coverage of the population, especially in rural areas, and grossly underutilized because of the dismal quality of health care provided. In most public health centers which provide primary health care services, drugs and equipments are missing or in short supply, there is shortage of staff and the system is characterized by endemic absenteeism on the part of medical personnel due to lack of oversight and control.

The quality of health care in India is an immensely neglected area of study, though recent efforts have begun to focus on it. Quality of health care services is a complex variable, encompassing as it does tangibles such as availability of drugs and equipment and intangibles such as courtesy and respect shown to patients during visits by providers. In India, the quality of health care services provided by the public health system is extremely low along almost all the criteria on which quality can be judged – infrastructure, availability of drugs and equipment, regular presence of qualified medical personnel and treatment of patients. Instead of being supportive and palliative of people's health, it will not be remiss to say that the health system itself poses a hazard to its intended beneficiaries, especially the poor who are often as reluctant to use public health services as the rich.

PROVIDERS OF PRIMARY HEALTH CARE SERVICES

Providers of primary health care and services are critical parts of the complex equation that determines quality of care. They are responsible for giving clients the information to make an informed decision about use of healthcare services and for ensuring that clients receive needed and competent medical attention.Yet providers' ability to provide high-quality care, their ultimate goal, is influenced by other factors, including local customs and traditions, medical culture, and the strength of the facility and health care system in which they work.

Providers are health workers, such as doctors, health aides, and midwives, who deliver primary health care care services in clinics, hospitals, and communities through outreach services and community-based activities. They work in both public and private settings and at various levels of the health care hierarchy, and may have different levels of education and supervisory responsibility. Providers are also clients of the health care system, in that their work requires the infrastructure, supervision, equipment, and physical setting that the system supplies. In addition, providers, like their clients, are influenced by the local culture, reflecting and often being constrained by local beliefs and biases regarding status, gender, ethnicity, and other social factors.

As the main point of contact between clients and the health care system, providers play a major role in identifying and meeting clients' health care needs. How well they respond to clients needs depends on individual providers technical and interpersonal skills, on the infrastructure of the health care system, and on clients' perceptions about what defines

high quality care. If providers' services and behavior do not meet clients' standards, clients may seek care elsewhere or go without care altogether. In some areas, clients may be forced to accept low quality care, simply because there are no other providers available.

Within the public health system, primary health care services provided through sub-centers and primary health care centers in rural areas. A subcentre is the first level of contact of the community with the health care system. Village Health Nurse's and Health Inspector's are collectively known as **MULTI PURPOSE HEALTH WORKERS [MPHW's]** are the principal functionaries at a subcentre. Since most of the health complaints are sorted out and attended to at the subcentre level or referred to next level of care they should be competent and optimal skills are needed. Several factors exist and influence the provision of quality primary health care. This study aims to examine those factors that influence and are experienced by VHN's and HI's in the rendering of quality primary health care in Tiruvallur district of the state of Tamil Nadu.

Quality health services in the developed world have been realized through an accumulation of improvements in the delivery of services as well as in the overall strengthening of medical education policies in terms of requirements for admission to medical school, curricula development and licensing. The Same concern for quality health services in developing countries has not yet fully emerged as a priority for policy makers due to competing demands on limited health care resources. Quality health care is equated with technical sophistication and thus considered expensive. Improving the

quality of primary health care services requires identifying the basic 'ingredients' of quality health care. In order to make improvements one must determine what constitutes quality and how it could be measured. The paper at hand addresses these issues in this paper; we offer a broad definition of quality and present a conceptual framework and methodological approaches for measuring quality of primary health care services.

DEFINING 'QUALITY'

Available literature on medical and health care research includes various formulations for defining and capturing the essence of 'quality'. Among the earliest and most prominent are Donabedian's explorations of a definition and of the process involved in the provision of quality care'. His pioneering work helped to systematize thinking on the multi-layered aspects of 'quality' in health services.

The concept of quality, as defined by Donabedian, is a 'property' or characteristic of medical care. This characteristic can range from one end of the spectrum to the other (e.g. low to high quality care) and can manifest itself through various elements or "attributes".

The first category of attributes includes the technical aspects of care and the human context in which it is provided. How medical science is applied technically to current medical problems and to promote human health falls under the technical domain. To complement the technical application of that science (cure) comes the equally important human setting (care) in which that science is applied. The "human setting" pertains to the nature of the client -provider relationship i.e. whether the client finds the provider

understanding, courteous, informative, and respectful of his privacy. If the client does perceive the provider as described above, and the provider is technically competent, the interpersonal aspects of care will blend with the technical ones to increase the probability of a positive outcome for client s' health.

The second category of attributes, according to Donabedian, goes beyond the technical/interpersonal frame and includes accessibility and continuity. Accessibility refers to the structure and location of care. It assumes clear and well-defined 'points of entry' and whenever possible round the- clock services; it also assumes that services can be provided at a reachable distance and affordable cost. Continuity implies a coherent pattern of services between and within various health delivery systems.

QUALITY IN THE CONTEXT OF PRIMARY HEALTH CARE SERVICES

The WHO definition of primary health care extends beyond the physical aspects of health to include mental and social well-being. A quality service attempts to capture all aspects of the definition. This means that primary health care service programs must take into account the social context in which client's live. . Especially relevant are client 's position in the hierarchy of family relationships, their role in the family, their workload, their contribution to decision-making, and their ability to pay for services, all of which affect client 's potential to seek care and to comply with the health care provided. Addressing the socio-cultural determinants of client's health" thus becomes a necessary part of any quality health service. Studying the components of quality must be sensitive to the social

context, such as the client-provider relationship and information exchange, can increase our understanding of the health services factors influencing health-seeking behavior, and can provide insight into the more successful preventive and curative approaches to primary health care. This understanding can help the health service manager formulate interventions to make their health facilities more socially acceptable and accessible to client users.

Assessing quality in primary health care services means measuring the gap between the qualities of care as perceived by the providers and as perceived by the clients. For instance, quality care to some providers may mean personal 'efficient' care, which reduces mortality and morbidity. Less attention is given to client's perception and experience of illness such as daily discomforts which are not identified as major problems. It is often precisely those daily discomforts which influence their health-seeking behavior. Thus a quality service ought to give special emphasis to client's experiences, expectations, and level of satisfaction with the service, to complement the views of the providers of care.

Multi Purpose Health Workers are the first level of contact with the community in the public health system of Tamil Nadu. They are the vital link of the entire system in implementing the primary health care programmes. Therefore they should be highly competent and skillful. If they do not perform up to the expected standards it will result in poor performance and lead to failure of achieving the programme objectives in their area.

A CONCEPTUAL FRAMEWORK FOR ASSESSING QUALITY IN PRIMARY HEALTH CARE SERVICES

Stages *of* the Health Care Continuum

The framework on quality of care views Primary health care service delivery within a continuum of services which begins with a structure and is fulfilled through a process. The end result of these services is outcomes.

Structure ⟶ **Process** ⟶ **Outcome**

Donabedian's definition of the continuum of medical care can be applied to primary health care services in the following manner:

1. **The Concept of 'Structure':** was considered to encompass the stable features of the providers of primary health care, the tools and resources at their disposal, and the physical and organizational settings in which they work. Thus, structure includes the human, physical and financial resources that are used to provide primary health care.

2. **The Concept of 'Process':** is defined as the set of activities that take place between the provider and client. It refers to the actual transaction in which the provider of care makes use of the available structural elements, described above, to manage the technical and personal aspects of health.

3. **The Concept of 'Outcome':** includes two elements: the direct impact of treatment on the current or future health of a client or her newborn, and the indirect impact on her satisfaction with the services offered and her health-seeking behavior.

It is obvious that these three components are interdependent and influence each other. Without infrastructure, no service can be delivered. Without service, a satisfactory outcome is impossible. Without outcomes measured, infrastructure and service delivery cannot improve

PROBLEM SATEMENT

There is no formal knowledge of the factors that influence the quality of primary health care given by Multi Purpose Health Workers in Tiruvallur district, state of Tamil Nadu. Before quality can be managed an in-depth study should be done to investigate factors that influence the quality of primary health care that is rendered

SIGNIFICANCE OF RESEARCH

No research findings could be found of that had been done locally in Tamil Nadu or nationally in India on factors that influence the quality of primary health care given by Multi Purpose Health Workers. Village health nurses and health inspectors are accountable to the community to provide quality and cost effective, and seek ways to improve that care. By doing these positive outcomes from primary health care system is ensured. This study is important because factors which are barriers to delivery of good service as well as those that enable delivery of good service will be identified. Solutions will be considered for identified barriers. Those factors that enable good service will be recommended to service deliverers.

Information about providers' perspectives on quality of care is surprisingly limited. Some providers acknowledge that their work environment could be improved, but feel that the situation is not under their control. For example, most of the 54 auxiliary nurse midwives (ANMs) interviewed for a study in India could not define quality services or suggest how family planning services could be improved. Medical officers in the same study focused mainly on inadequacies in the clinic infrastructure and on clinic equipment, supplies, and

medicines (Khan et al. 1995). But a study in Kenya found that providers and clients agreed on the importance of certain elements of care, including affordability, convenient location, good provider attitudes, privacy and confidentiality, and availability of supplies (Ndhlovu 1995). In some cases, providers may be reluctant to take steps that would improve the quality of care, feeling that such moves would increase their workload. Providers in Malawi, for instance, feared that making family planning services more convenient for clients would add to staff responsibilities (Tavrow et al. 1995).

RESEARCH QUESTIONS

The following research questions will direct this research:

- What barriers do Multi Purpose Health Workers identify that prevent them from rendering quality primary health care in Tiruvallur district, state of Tamil Nadu?
- What enablers do Multi Purpose Health Workers identify that help them to render quality primary health care in Tiruvallur district, state of Tamil Nadu?
- What support systems do the Multi Purpose Health Workers have in Tiruvallur district, Tamil Nadu to enable them to deliver a quality service?

OBJECTIVES OF THE RESEARCH

The objectives of this research therefore are as follows:

- To explore and describe barriers Multi Purpose Health Workers experience in delivery of a quality primary health care service in Tiruvallur district, state Tamil Nadu.
- To identify enablers to a quality primary health care service in Tiruvallur district, state Tamil Nadu
- To identify support systems for a quality primary health care service in Tiruvallur district, state of Tamil Nadu.

LITRETURE REVIEW

The majority of the Indian population utilizes public health services for their needs, starting at the first contact point, which is primary health care. This type of care is supposed to empower people to lead healthy lifestyles. Primary health care is therefore an investment in human potential and there is a desperate need for quality in delivery of this service.[1] Health departments are dependent on each other for the assurance of quality patient care.
The excellent performance of one department and the poor performance of other department results in an overall average performance.[2] When the overall quality is poor, with only islands of excellence, the profession should investigate all the internal and external factors that influence service delivery.

The purpose of this review has been to examine the concept of quality. Factors influencing quality of primary health care services, internationally and locally in India were studied. Focus was on studies in primary health care settings. Donabedian's theory of structure/process and outcome components of quality care has been used to explain these factors influencing quality care.

THE STATE OF QUALITY OF CARE IN DEVELOPING COUNTRIES

Early evidence of low quality of care

One of the first large-scale comprehensive efforts to provide detailed information on how primary health care services were delivered in developing countries was carried out by

the USAID-financed Primary Health Care Operations Research (PRICOR) project (1985-1992) whose studies spanned 12 countries. Using a direct observation of over 6000 patient provider encounters, this project uncovered severe deficiencies in the diagnosis, treatment, and counseling of patients as well as in the supervision of health workers for the following primary care activities: growth monitoring and promotion, immunization, case management for malaria, diarrhea and acute respiratory infections.[3]

Another study by Amonoo-Lartson et al. carried out in 1984 in rural clinics in Ghana assessed the process of providing maternal and child care.[4] They compared actual (observed) performance levels with expected levels for a number of diagnostic, therapeutic and counseling tasks. They found significant performance gaps, especially in the area of physical examination and in the counseling of clients.

Similarly, Sauerborn et al.[5] analyzed maternal and child health services in a rural district of Burkina Faso. They reported that especially the task of screening for risk factors in both under fives' clinics and antenatal clinics was carried out well below standard. They also found that communication in both curative and preventive clinics was poor, e.g. only 5% of mothers who brought their children to under fives' clinics received any kind of counseling during their visit.

Bjorck et al.[6] Observed 539 primary care visits and found that, according to local standards of care, only 65 (12%) of the patients were adequately diagnosed and treated.

The same weakness in the process of primary health care provision was reported by Gamer et al.[7] for managerial tasks, such as cold chain support and maintenance in 76 rural health centers in Papua New Guinea.

It is therefore no surprise that community satisfaction with primary health services is low, especially in the domain of interpersonal skills of health center staff, as Gilson et al. reported [8] from a qualitative study in Tanzania.

Why is quality of primary health care services in a bad state?

"Just give me more staff, more equipment, and more money and I will improve quality.[9] However obvious the scarcity of human resources, buildings, equipment and money to run health services may be in developing countries, we argue that there are other, more conceptual reasons, which delayed tackling the issue of quality of care in these countries:

(i) Overemphasis on quantity and access.

One of the documents which decisively altered health policies, especially in developing countries, was the Alma Ata Declaration of 1978 which put the concept of Primary Health Care (PHC) to the forefront of the health policy agenda.[10] The Declaration emphatically embraced community participation in health care and stressed the links between health and other sectors of society. As far as health care delivery was concerned, the key issues were access and affordability. Although the Declaration underlines the importance of improving the efficiency of service delivery and performance to recover costs, it does not mention quality, let alone provide any guidance of how the quality of

Primary Health Care could be achieved. Although some increase in the utilization of modern health care was noted, research from Ghana, Burkina, and Mali showed [11] [12] that the availability of primary health care in and of itself does not guarantee its utilization. In fact, household surveys revealed that the perceived low quality of health care was one of the main reasons why people did not attend primary health care services in cases of illness. [13]

(ii) Inappropriate focus on inputs.

Of the three elements in the Donabedian triad of structure, process and outcome, the focus in the assessment of quality has been clearly put on structure. The assumption was that document based analysis of the process of care was not feasible, given the low degree of documentation of care, and that observation of provider patient encounters was prohibitively expensive. Therefore, inputs, which could be assessed with ease and at low cost, were frequently used as proxies for quality. Such input indicators included the presence of drugs in health centers,[14] [15] staffing, and the availability of electricity or running water.[16] The reality in many developing countries made it tempting to equate lack of quality with the absence or shortage of inputs. The proposed policy consequence was to finance inputs to improve the quality of care. The assumption was that a minimal level of inputs is essential before one can focus on the process of health care delivery. The problem of improving process was mainly assigned to closer "supervision" of health care workers. However, supervisors were often viewed as people who inspect, affix blame and assign responsibility for system deficiencies. Moreover, doubts arose as to the validity of supervision in assessing the quality of care. Studies revealed that large

discrepancies exist between what supervisors believed health workers were doing and what independent observers found about how they actually spent their time. As an example, a study done in the Philippines [17] reported that supervisors thought that 82% of health workers explored a history of vomiting in children with diarrhea, while simultaneous observation of patient provider encounters revealed that only 11% did so in reality.

(iii) The new concern for quality of PHC.

In the late 1980's, several factors came together to put quality of care on the agenda: first, the recognition that the quality of many health services was, indeed, low (as shown above). Second, studies indicated that the low utilization of both community health workers and first line health services was, to a large extent, due to consumers' perceptions of low quality of care.[18] Patients voted with their feet and shunned health care which they perceived as low quality. Third, the crucial motivation to address the problem of quality came from a change in the financing of health care. Austerity policies under the banner of "structural adjustment" forced governments in the 1980s to cut subsidies to the health sector. Since in most developing countries the bulk of primary care was (and still is) provided by subsidized government services, policy-makers began to look for non-budgetary ways to finance health care. They turned to either user fees or some form of prepayment schemes. In both cases, patients/ consumers were asked to pay directly for health services. It became clear that consumers were only willing to pay for health services, and thus generate the necessary revenues to fund them, if they perceived these services to be of reasonable quality

Definitions

Quality has many definitions. The different role players in health define quality according to their need for it.

Quality in health care

For the health professionals, quality means excellence, perfection and technical expertise For receiver of care , the client, the humanistic dimensions of quality ar important, like social, personal and culturally acceptability and ethical care.

Health Managers want to ensure a quality and cost effective service and thus define quality as encouraging uniformity and reduction of variation in a continuous and dependable way. The reality definition of quality care is value for money.

Quality in primary health care

In primary health care context quality care is the ability of to meet the health related needs of the population consistent with local and national goals, as well as resource constraints. Access of the population, an adequate management system and commitment to priority health issues in the area are important concepts.

Donabedian's framework for quality

Quality is a composite concept that can be broken down into manageable components. These are designed to evaluate the quality of a product or a process. A product needs not excel in all the components, but the aim is to determine an optimum combination to ensure a quality product (Matzner

1991:22). Donabedian, the American father of quality control, broke quality down in three components, namely structure, process and outcome.[19]

Structure refers to the human and material resources and organizational framework that is necessary for the work to be done.

Process deals with how the service is carried out. This is the interaction between the multi purpose health workers and other health care workers and the client.

Outcomes are the end result of the care activities. Most people agree that the best measure of patient care is to look at the outcome.[20]

These components are interdependent, if the structure component is inadequate, this will influence service delivery in the process component. For instance if there is not enough staff or money to pay staff, fewer patients will be seen and more illnesses will prevail in the community. This means that the morbidity and mortality for the community will be high, which impact on the outcome component. If the outcome component is unsatisfactory, more work has to be done by less people, thus the outcome component influences the process component.

In this study, Donabedians's framework has been used to examine and explain the barriers and enablers of quality nursing internationally and locally, with special focus on primary curative health care.

FACTORS INFLUENCING QUALITY OF PRIMARY HEALTH CARE SERVICES

Structural components of health care

The structural components entail infrastructure, staffing and supplies. If shortages and problems exist here, it can negatively influence the whole process of nursing care, as well as the outcomes of care. Because of structural faults the possibility of medical errors exists and the patient can suffer or die.

Limited resources

A minimum level of service provision, physical infrastructure, staffing, supplies and time to do work effectively, is necessary for effective service delivery. Expanding services and increase demand for healthcare impact negatively on the quality of work they have to do. Multi purpose health workers find constraints imposed on achieving quality because of resource limitations.

Staffing

Adequacy of staffing is important for a positive client outcome. Governments with a limited budget are unable to compete for and retain the best qualified multi purpose health workers. For those left behind in the workforce,

dissatisfaction exists because of burnout and job-strain. There is intent and tendency to leave at high levels. Developing countries like India report the same tendency [21] (Khan 1999:173). There are problems of long working hours and poor working conditions for the remaining workforce.[22] This dissatisfaction results in an increase in client mishaps and medical errors. The patient's families are complaining and multi purpose health workers are more exposed to verbal abuse and thus even more job- strain. The working environment is not humane anymore and contributes to burnout. Multi purpose health workers feel that they are under siege and vacant posts can not be filled.[23]

The scenario sketched above is rather dark and somber for multi purpose health workers nationally and locally. These symptoms suggest a major flaw in the design of Primary Health Care and/or an inability to adapt to a changing world environment. Thus employers should realize the importance of personnel policies and benefits (Aiken et al 2001:43-53).

Finances

Financing of personnel and their benefits, as well as amenities and equipment are very important for personnel morale, job satisfaction and adequate patient care. As services expand and demands for health care increase, so does cost. In the effort to reduce cost, quality may be sacrificed (Khan 1999:173). A tension thus exists between quality and cost- effectiveness.[24] This inability to

finance health systems causes referral systems to collapse and limits outreach programmes and interaction with the community.

Infrastructure

Infrastructural problems are also cause for poor quality care. Lack of facilities and unavailability of space and equipment can result in clients not receiving care in the time span that they need it or in a safer environment.

Tamil Nadu also has infrastructure shortages. Buildings are often in poor state and there is lack of necessary facilities. For the client health care services also need to be accessible and available and it is of no use for a community to have a service provided at hours that the majority of the population cannot attend to.

Time

The amount of time available for care depends on the number of staff and technology available. Willams and irunita [25] found time the most important condition necessary for the development of relationship between the provider and client and thus perceived quality of care by patients. Low levels of intimacy were found when time was limited. Staff members may experience more work satisfaction, while the clients will benefit from the open communication lines to communicate their needs while the care will improve. Greater work satisfaction, better communication of needs and open communication lines will result in effective continuity of care.

Training and education

Training should be an important enabler of quality health care. Unfortunately uncertain competencies, poor training opportunities, substandard education and lack of in-service programmes are still reported [26](Khan 1999:173). Training in the twenty-first century is still reactive and focused on care of individual patients, instead of being proactive with the focus on the population/community. In India a lack of clinical knowledge, inability to, and/or lack of motivation to integrate new knowledge and use it, is a known factor. Elgoni (2001:1)[27] states that training is haphazard and not related to needs and it is not evaluated in terms of applicability either. Continuous learning and recertification must be motivated so that knowledge will be increased and renewed instead of becoming stagnant. Social and organizational skills must also be taught as well as cultural sensitivity. This enables multi purpose health workers to solve problems, make group decisions and learn to communicate effectively. This way the multi purpose health worker will experience more job satisfaction because she will be able to make community level interventions and have a holistic approach to the patient, the family and the community (Carlson & El Ansari 2000:172)[28].

Disparity in equity

Equity is an important concept of a quality health service. In third world countries two medical systems are often in place one for those that can afford it and another for those that cannot pay. The latter often is not

available as people have to travel long distances to get to services and often have fewer infrastructures due to cost. Because of this Jewkes (1995:985)[29] reported a disparity in equity of services in favor of the rich and also between different parts of health system.

Information systems

An information system gives feedback about outcomes to the profession. Without seeing the results of their service provision multi purpose health workers can not plan and implement improved care. A good management information system will include the extent of the workload, comprehensive statistics, activities and audits for the appraisal of quality care (Khan 1999: 173)

Process components of health care

Lack of professionalism, low morale and productivity

In general lack of professional attitude results from inadequate qualifications, low motivation, staff indiscipline and poor knowledge of the objectives of the institution. Khan (1999:173) underlines the lack of motivation, poor staff discipline, and absence of knowledge about the philosophy of care as factors affecting quality primary health care

Organizational culture

Each organization has a certain culture, which influences the atmosphere positively or negatively for the employees as well as the patients. Lack of

communication and collaboration causes staff to feel not valued. Staffs who does not feel valued, has poor attitudes about clients. Clients feel unhappy around moody staff. They want to be shown empathy, compassion and to be treated as individuals. Multi purpose health workers communication skills, personality and willingness to go the extra mile are important attributes in the healing process (Williams and irunita 1998; elgoni 2001)

Supervision

Leadership, supervision and on-site management are key elements in the facilitation of quality activities even more than availability of money. Supervision influences work by reducing errors and increasing competence. Leaders can reduce errors by encouraging the staff to get it right the first time. Worldwide there is a lack of effective supervision and lack of policy, procedural and administrative manuals. Evaluation techniques, written job descriptions and job specifications in workplace can be seen as a major factor influencing the quality of healthcare provided.

Quality programs are to start at top, moving downwards through the entire organization to the grass root level. Valuable input from the actual grass root workers are necessary, as they are directly involved in the problem areas. This will make them more valued.

Client aspects

Client feature can make provision of quality care difficult, especially aspects like age, special needs, dependency, literacy , cultural and gender issues. It was found that

dependant patients are more exhausting, especially those with special needs like deafness and the aged. Cultural differences negatively affect communication (e.g. people not looking each other in the eye) (Williams & Irurita 1998: 36-44).Rural patients perceived receiving less care because they felt lonely and in need of support (Williams & Irurita 1998: 36-44).Male patients are reported to experience difficulty in communicating with female healthcare providers [30] and anxiety levels caused clients to be experienced as very unreasonable (Khan 1999:173).

Role modeling and management support

Health care providers have a high incidence of occupation-related stress. The support provided by supervisors has the potential to reduce illness, absence, misery and cost (Carlson & El Ansari2000:12). The heart of quality is not in technique, but commitment with persistence and passion by management to its people and product [31] (Carlson & El Ansari 2000:172). Health care providers must be role models and display good values and behavior, morality, intellectual honesty, dedication, generosity, forgiveness, genuineness, empathy and acceptance. Health care providers must analyze criticism, suggestions, bewilderment, fears, and compliments and have the highest ethical standards despite difficult working conditions (Moholo & Khoza 1999:34; Carlson & ElAnsari 2000:172). This is setting good examples for patient-centered care and putting the patient first. It is essential that nurses should believe that management desires and expect quality care (Mason 1997:7-10; Williams1998b:265). The above is to be realized only if a democratic approach is followed. Democracy brings autonomy in decision making and structuring of own work. Employee capabilities are built, power is shared and employees

are allowed to help shape the culture of the organization. It brings variety and facilitates learning. A democratic organization that shows these characteristics learns continuously and improves by analyzing, monitoring, developing and aligning.

Focus on client/family/ community and their needs

Care has to be client/family/community centered. It is important that the client is empowered to look after his own health. Equipping clients with knowledge, offering them information to make their own health decisions and thus make a difference in their lives is the goal of quality health care.

In primary health care the community is an important client. Community needs should be assessed, with the community part taking in assessment, setting of own objectives and monitoring its own progress.

Collaboration

Collaboration between different parties is essential for quality of care. Teamwork among different levels of staff members, health managers and clinical personnel is necessary to solve problems. For this staff must feel free to give their opinions. Sharing of experiences will increase knowledge and sympathy for each other. Contact between academia and Health care providers is necessary for reaching the gap between knowledge generation and application of it. It is obvious from above that multi-disciplinary planning and collective accountability will facilitate quality care more than individual responsibility (Maholo & Khoza 1999:34)

Professional development

Professional development is the process where the person accepts responsibility for changing own core attitudes and motivation in improved. This will be attained by continuous and in-service education (Williams & Irurita: 199836-44).The result will be multi purpose health workers whom will demonstrate confident leadership, delegate tasks to subordinates and solve problems adequately

Experience

Practical experience in primary care plays a positive role in the management of sicknesses. The more experience a person has, the more capable he/she is of making the right decisions.

Outcome components of health care

The outcome component is used to measure the result of the nursing care. The structural and procedural components have an effect on the outcome of the nursing care. If the structural input (lack of infrastructure, staff and money) and the procedural input (no compassionate and knowledgeable care, supervision, etc) is lacking, the outcome would be poor.

Inability to prove cost-effectiveness

For any service to be successful, it has to be shown as being cost-effective (Williams 1998b: 262-267). This is the same with the health care sector, whether it is privately run or by the state. Primary health care services include many qualitative activities like

listening, communication, counseling and support of emotional problems that is not easily measured (Mason 1997:6). Qualitative outcomes are often ignored because it is not as measurable as quantative outcomes. Data in the form of numbers of patients seen, amount of visits, episodes of services delivered, which are mostly quantitative have to be used to evaluate quality of care provided.

Medical mismanagement

The cost of quality can be expensive. This includes the failure costs, appraisal costs and prevention costs of which the failure costs includes 75-82% of the cost. When compared to the appraisal costs (15-20%) which includes monitoring and evaluation and prevention costs (0-10%) which are associated with activities designed to prevent problems

Patients have always been careful to choose a health care professional or facility, which they think will not harm them, or cost much to them. When there has been a choice, patients often decide not to use a health care facility or turn to alternative medicine.

Consideration of the needs of the client

One has to ask the question who the client is. The patient/community is the main reason for the existence of health care service. Therefore what the client wants is of utmost importance. Too often services become centered on the hustle and bustle of the care delivery, and the reason for the existence of the service (the client) is forgotten. If its needs are to be addressed, Health care providers need to get out there and find out what the community wants. This is the only logical way to satisfy clients/community and

include them in the improvement of their own health status. Clients need to be equipped with knowledge to make their own health care decisions that can positively impact on their lives. Satisfied clients use services and motivate others to use them. Satisfied clients lead to increased service provider job satisfaction and improve the health care facility reputation. Utilization and coverage will improve, as well as health status of the patient (Elgoni 2001:1; Williams 1998b: 265).

Examination of medical mistakes

Medical mistakes are easily blamed on the person making them, without considering the system's role in the making of the mistake. The smallest detail that caused them should be examined. Systems should be designed that will prevent medical mistakes having disastrous consequences, making errors predictable and thus preventable. At the same time introspection needs to be done by the Health care providers. A willingness to look at mistakes and faults is necessary, showing true accountability for their practice. Reporting and record keeping are important acts to safeguard the multi purpose health workers against penal and legal action.

Health care provider's participation

Moholo and Khoza (1999:34) plead for freedom of expression of staff, so that opinions can be given about care. Krairiksh and Anthony (2001: 16-23) [32] agree when they contend that enhancing Health care providers participation on all levels of clinical decisions, planning and structure should improve outcomes and staff satisfaction. Too

often decision-making are autocratic and made by those running the service, with no input from the persons with the direct contact with the client. It must be realized that the client has little contact with the policy makers. The persons delivering care are the ones that experience the clients' frustration with the service setup. The persons delivering direct patient care may feel that their hands are also being tied, because of resource constraints. This causes great frustration. An outlet for this bottled-up frustration is necessary, as this just leads to burnout and experienced personnel leaving the service for greener pastures

Summary of literature review

In this literature review it was established that overall and quality of care at primary health care level is necessary, because it is often the first and only contact the community has with the health system. Because the work of a health care provider being a responsible and accountable profession, and having an ethical and moral basis, it is necessary that practices have to be examined, altered, renewed, and aligned. .Definitions of quality care impresses the urgency on the reader to look at quality from the perspectives and needs of the role-players in the field: the client, the professional and the manager/employer. By studying the literature for the factors enabling provision of quality primary health care using Donabedian's structure/process/outcome framework, recurring problems and suggested solutions to them were found. Structural barriers mostly focused on the negative impact of change on institutions. Limited resources like staff, finances, infrastructure and time have the most limiting impact of all on already crippled services. Training is inadequate and our country still has not reached equity in services, no matter

how hard people have been working towards it, mostly because of the shortage of resources. Structural enablers to overcome these problems are and should be excellent education and training, accreditation, adequate information systems to give feedback about level of care delivered and a quality management program involving employees at every level. Process barriers are those found in the interpersonal process of provision of care. Lack of professional attitude, low morale and productivity, poor organizational culture, inadequate supervision by the supervisor/employer cause unhappy employees and in turn lead to unhappy clients. Care can be professional and expert, but if not delivered with compassion and moral integrity, it would not be valued. Process enablers of good primary health care are the availability of good role models and support by management, a focus on the needs of the client, collaboration between the role-players, professional development and experience of the Health care providers. Barriers to the outcome component are the inability to prove cost effectiveness and medical mismanagement. To be able to counteract these barriers, the enablers ask for input of the client and the service provider to democratically participate in management. Every single medical mistake must also be examined with care and acted upon to prevent further mistakes.

METHODOLOGY OF THE STUDY

RESEARCH DESIGN

The design of the study is quantitative, descriptive and cross sectional in nature as it is aimed at giving an accurate account of the characteristics of a particular group of primary health care providers, the Multi Purpose health Workers, as well as what quality services are delivered by them and the factors that affect the provision of quality primary health care.

STUDY AREA AND POPULATION

The population for this study was all the Multi Purpose health Workers working in Primary Health Center's in the district of TIRUVALLUR, state of TAMIL NADU. From this research population a sample was taken

STUDY PERIOD

The study was conducted during the period between January 2006 and June 2006

SAMPLING AND SAMPLING METHOD

Size of the sample

The sample size was calculated using the formula,

n = (t2pq/d2)

(Where t = 1.96 at 95% confidence);

p = population proportion;

q = 1-p;

d = allowable error.

For this study, we presumed maximum variability, hence p = 0.5; q = 0.5; d = as 20% of p i.e. 0.1 giving a power (1-d) of 80%.

Sample size thus yielded was of 100 respodents.

Sampling method

The sample was drawn through a cluster or area random sampling method. Through this sampling method the district of Tiruvallur was divided into clusters (based on geographic boundaries) of 14 development blocks. Then the clusters (blocks) are randomly sampled using lottery method and five blocks were chosen. The chosen blocks are Kadambathur, Minjur, Nemam, Periyapalayam and Tirutani. Data collection was done from all the Multi Purpose health Workers within the sampled clusters.

Criteria for inclusion of respondents

The criteria for inclusion in this research are:

- Respondents should be employed as either village health nurse or health inspector.

- Should be employed under the directorate of public health, government of Tamil Nadu.
- Should work in the district of TIRUVALLUR.
- Should have rendered primary health care service for a minimum of one year in that post in the district.

DATA COLLECTION

Research instrument

This study made use of questionnaires as method of data collection. A questionnaire was constructed for this study to elicit responses from the Multi Purpose health Workers to explore the factors influencing quality of primary health care services. The information gained from the literature was used to develop the questionnaire. The questionnaire consisted of problems those problems especially in the Indian context.

Administration of questionnaire

A letter of introduction was given to the Multi Purpose health Workers. This letter explained the purpose and importance of the study to the field of practice, and encouraged them to participate in the completion of the questionnaires. Confidentiality was guaranteed. Informed and written consent was obtained before administration of questionnaire.

Format of the questionnaire

The questionnaire had several sections, with biographical data about the respondent as the first (A) section. The following B section covered the structural/process and outcome factors influencing the quality of care provided according to the theoretical framework.

The available possible answer (each with a number value) had to be chosen, and the particular number had to be entered in a block provided on the right-hand side. This coding ensured that the information could be entered with ease into a computer.

Pre-testing of the instrument

Pre testing was done on 15 Multi Purpose health Workers from kancheepuram district who were attending ISM training at IPH poonamallee. Several ineffective questions were eliminated to decrease the time taken to complete the questionnaire. Generally all the questions were well understood and only small corrections were needed to enhance the better understanding of the questions.

RELIABILITY AND VALIDITY

The questionnaire was developed after an extensive literature study was done. The concepts identified as factors influencing provision of quality primary health care services were translated into questions in the questionnaire. To determine whether the

same factors were experienced by the respondents the instrument was given to experts for assessment and then it was pre-tested on a group of Multi Purpose health Workers. The factors identified through the literature review and those identified by the pilot study correlated.

RELIABILITY

The reliability of an instrument refers to the degree of consistency which the instrument measures the attribute. The pretest earlier mentioned tested for reliability. Questions were clearly worded and simple language was used so that all the respondents clearly interpreted and understood the questions in the right manner.

VALIDITY

Content validity was obtained from two sources, namely the literature studied and experts consulted.

Internal validity was difficult to obtain in this study, as the respondents had to respond on their own and when they had time, thus the same situation could not be provided or ensured to each respondent.

Construct validity examines the fit between conceptual and operational definitions. Examination of construct validity determines whether the instrument actually measures the theoretical construct. The following factors could influence construct validity in this study:

- Respondents could have behavioral changes when guessing the hypothesis (Hypothesis guessing).

- Respondents might have wished to be seen in a favorable light, as competent and psychologically healthy (Evaluation apprehension). Anonymity was assured, thus this factor would play a minimal influence.
- The expectancies of the researcher might bias the sample(Experimenter Expectancies).

External validity is the extent to which study findings can be generalised beyond the sample used in the study. The following influenced this type of validity:

- **Interaction of selection and treatment of individuals**. If a large portion of respondents decline to participate, or only certain respondents, the study cannot be generalized. In this study none of respondents refused to take part in the study. So the external validity could be judged.
- **Interaction of setting and treatment**. Some organizations often do not encourage participation in studies. All authorities and supervisors involved in this research have been contacted and they gave their permission for the study to take place and for their members of staff to take part. A few in turn contacted to ask what the study entails, and requested feedback.
- **Interaction of history and treatment**. The changes taking place in the politics of the state of Tamil Nadu needs to be taken in consideration when research was done because it was carried out just before, during and after the elections for the state assembly.

ETHICAL CONSIDERATIONS

Permission to conduct the study was obtained from appropriate authorities. A letter of introduction was given to the Multi Purpose health Workers. This letter explained the purpose and importance of the study to the field of practice, and encouraged them to participate in the completion of the questionnaires. Confidentiality was guaranteed. Informed and written consent was obtained before administration of questionnaire. Name of the participants and their institutions are not mentioned in the dissertation to ensure anonymity. Care was taken to ensure the rights of the people taking part in the research were protected.

DATA ANALYSIS AND DISCUSSION

Section A consists of the biographical data of the Multi purpose health workers

Section B contains the data from client- provider relationship components

SECTION- A:

Biographical characteristics of MPHW's:

Age:

The age distribution of the respondents indicate that 33 percentage of the sample consisted of people in the age group30-39 years while 24 percentage of the sample consisted of people in the age group 20-29 years (Figure – 1).

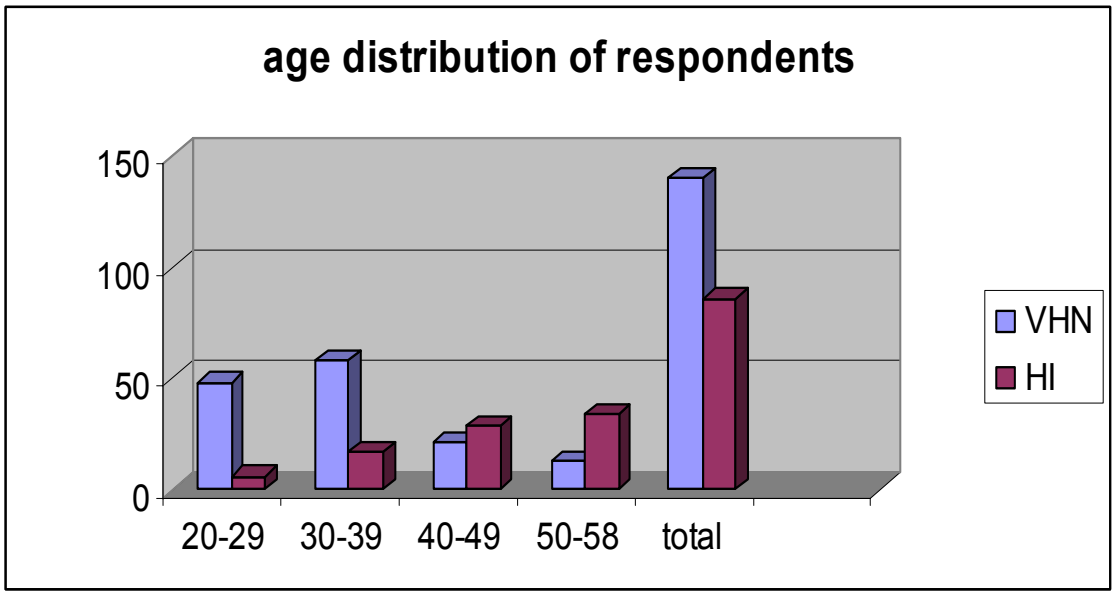

Figure – 1: age distribution of respondents

Gender:

Among the multi purpose health workers 66 percentage were females (n=149).Among the health inspectors among the total(n= 76) 12 percentage were females. All the village health nurses were females

SECTION B:

CHANGES/INSTITUTIONAL TENURE

Stress endured by multi purpose health workers in rendering primary health care services:

Most of multi purpose health workers indicated that they experienced stress as totally unendurable while rendering primary health care services.

Factors causing stress in service:

Different factors that could cause stress in the service were explored and the results were analyzed. Multi purpose health workers blamed lack of experience and lack of training of self and colleagues, patients being too demanding, too many changes, not enough support from personnel in service, not enough staff and not enough time for clients as stressors (Table – 1).

Table – 1: effect of factors causing stress in service

Stressors in service	No effect	Some effect	Serious effect
Lack of training of self / colleagues	20.4%(46)	67.7%(153)	11.9% (27)
Lack of training of supervisors	32.3% (73)	46.9%(106)	20.8% (47)
Lack of experience of self / colleagues	31.5% (71)	56.6% (128)	11.9% (27)
Too much responsibilities of self /colleagues	6.2% (14)	54% (122)	39.8% (90)
Too much responsibilities of supervisors	26.1% (59)	50.9% (115)	23% (52)
Too many patients	3.1% (7)	41.6% (94)	55.3% (125)
Not enough resources	13.7% (31)	42.5% (96)	43.8% (99)
Not enough support from authorities	13.3% (30)	29.2% (66)	57.5% (130)
Not enough support from personnel in service	27.5% (62)	57% (129)	15.5% (35)
Long working hours	46.5% (105)	45.1% (102)	8.4% (19)
Patients too demanding	10.1% (23)	39% (88)	50.9% (115)
Too many changes	21.7% (49)	59.7% (135)	18.6% (42)
Not enough staff	15.5% (35)	23.9% (54)	60.6% (137)
Continuous turnover of staff	59.3%-(134)	31.4% (71)	9.3% (21)
Not enough time for patients	88.1% (41)	26.1% (59)	55.8%-(126)

RESOURCES

Operating hours and days of service:

The majority (188; 83.2%) of the respondents worked in services functioning 5 days a week providing services mostly between 8.00 AM and 2.00 PM (155: 68.6%) (Table - 2).

Table -2: Frequency of days of service

Number of days	N= 226	%
1 day	7	3.1
2 days	11	4.9
3 days	4	1.8
4 days	4	1.8
5 days	188	83.2
6-7 days	12	5.2

Visits of supervisors to services:

About 40.3 %(n=91) respondents indicated that the supervisors visited the services once in three week and 35%(n=79) indicated that they visited once in a month.

Referral of clients:

Multi purpose health workers refer patients to: Medical officer at Primary Health Centre (142 or 62.84 %) and Private medical general practitioners (46 or 20.35%).

Traditional healers, midwives, private nurse practitioner and alternate medicine practitioner were referred to minimally, but 40-60% of respondents indicated that their patients did consult them directly (Figure – 2).

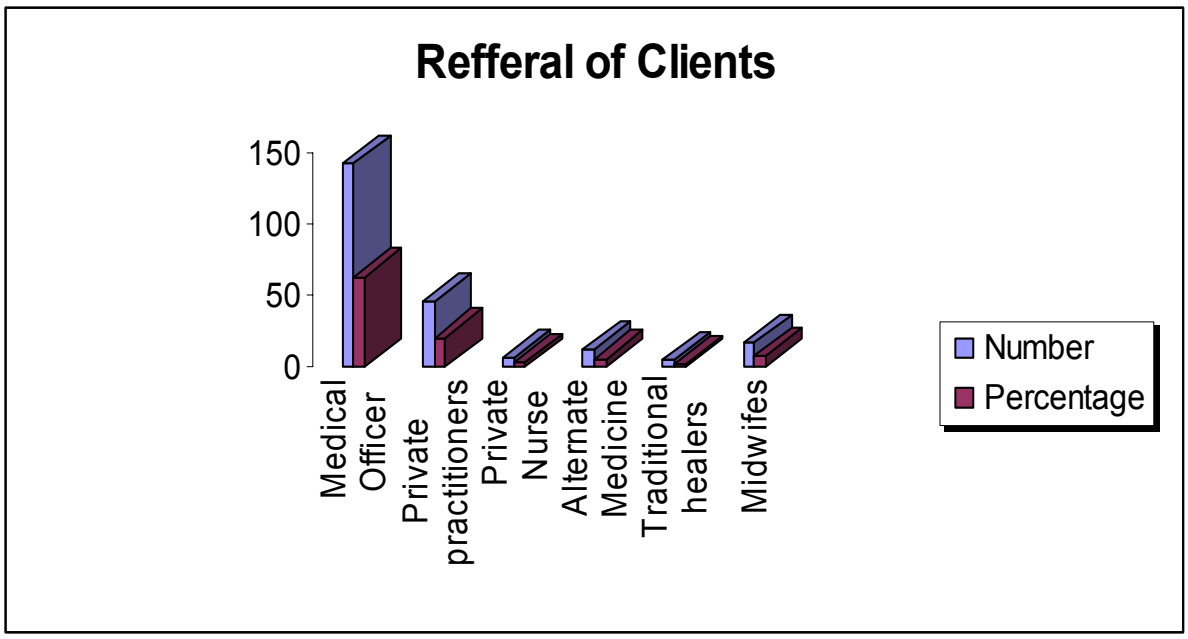

Figure – 2: referral of clients

Complaints of clients

The only complaint the clients reported to 'always' have is the long waiting time. In all other cases clients reported the complaints as 'often' than 'always'. Respondents gave the following data about complaints of clients;

- Have to wait too long to be seen (68: 30.0%)
- Not enough medicine (18:8.0%)
- Nurse is not as good as the doctor (18:8.0%)
- Medicine is not of a good quality (13:5.7%)

- Quality of service is poor (28:12.4%)
- The hours are inconvenient (15:6.6%)
- Personnel are unfriendly (11:4.9%)
- Clinic is too far from home (10:4.4%)
- Gender insensitivity (4:1.8%)
- Cultural insensitivity (4:1.8%)
- Unavailability (11:4.9%)
- Not being examined properly(9:4.0%)
- Health problem not being managed properly(2:0.9%)
- Treatment did not work properly and had to return to VHN for same complaint (15:6.6%)

Adequacy of budget

Figure demonstrates the view of the respondents regarding the adequacy of budget to cover the needs of the whole service. Only 15% of the respondents indicated that they felt that their budget is adequate to cover the needs of the whole service (Figure -3).

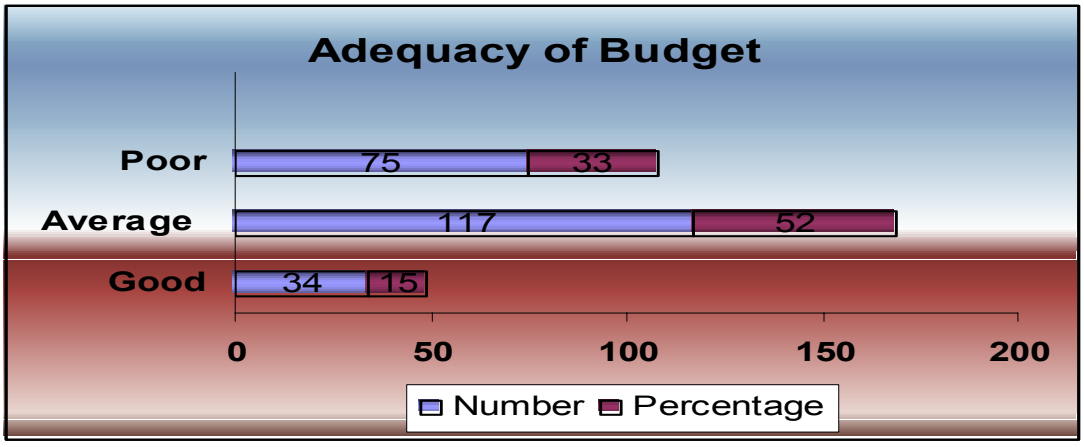

Figure -3; Adequacy of Budget

Building facilities

It was found that 68% of the sample was of the opinion that the building is inadequate, that there were not enough waiting rooms for clients and toilet facilities for staff and clients.

Material resources (equipment and supplies)

Figure- 4: shows how often staffs were unable to obtain stock, such as Blood pressure apparatus, stethoscopes, bandages, linen, disposable needles, syringes, gloves and medicine. Most of the respondents (120:53%) reported that they often experienced problems when receiving stock from stores (Figure – 4).

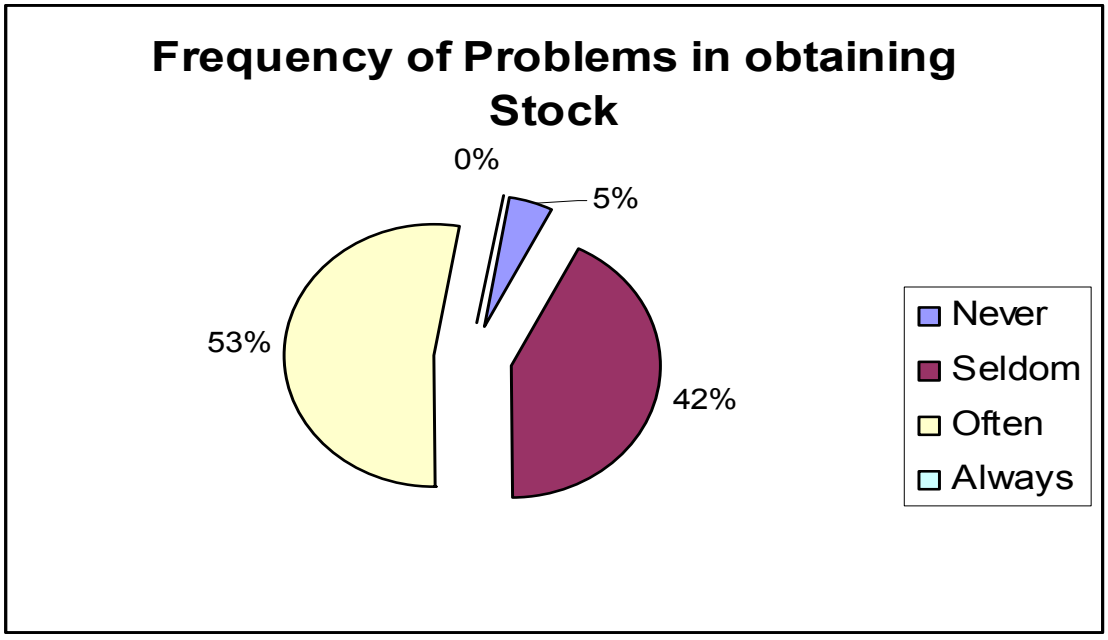

Figure – 4: Frequency of problems in obtaining stock

Human resources

The staff of a health service is its most valuable. All the primary heath care services are rendered to the community free of charge. This increased the workload of the staff rendering these services. Of the multi purpose healthy workers 89.4 percent (n=202) already indicated that they did not have enough staff members for the facility and 84 percent (n=190) reported no staff increases to meet the increased workload. This caused a severe workload

PROFESSIONAL TRAINING:

Educational characteristics:

The qualifications of the respondents are portrayed in Figure 4.2. All of the respondents had a basic qualification of 10^{th} standard pass before entering service. Later many of them acquired under graduate and post graduate degrees through distance education mode. But these additional qualifications did not help them to get additional financial benefits or promotions. All the respondents received their training in primary health care in various training institutes across the state (Figure – 5).

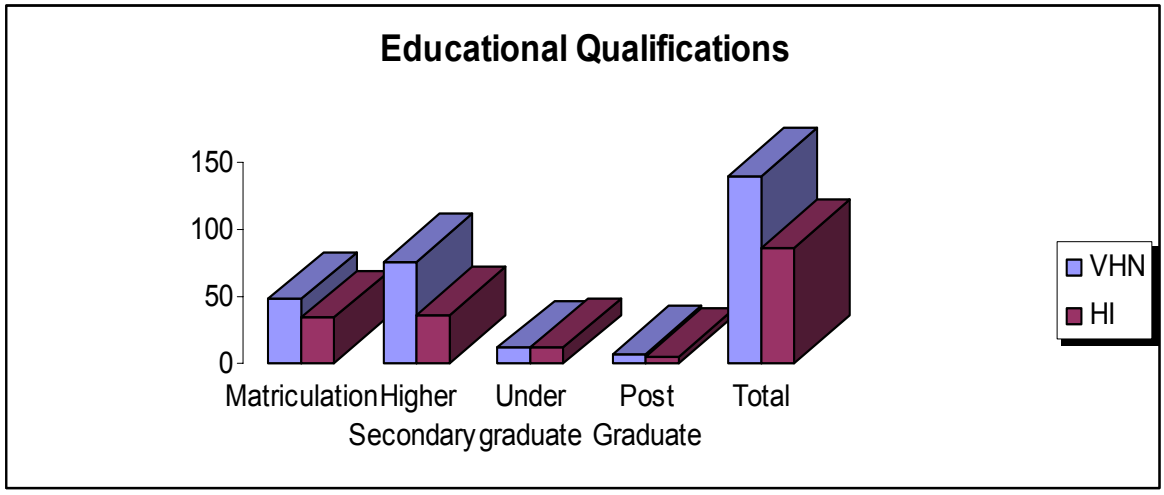

Figure – 5: Educational Qualifications of Respondents

SUPERVISION:

Supervision and feedback received by MPHW's:

Many of the respondents (82:36.3%) indicated that they never or seldom receive any feedback about their service from their supervisors. This shows a serious lack of communication from the supervisors. Those that reported regular feedback (63:27.9%), received it on in 1-3 months.

Factors indicative of safe functioning of MPHW's:

Twenty-one (34%) respondents only reported complete and orderly notes with 81-100% of their patients. Accurate documentation on all records is essential in order to protect the patient, the MPHW and the institution from litigation process. The number not to comply with complete record keeping is too large to ignore

Most of the MPHW (67.3%) state the main complaint of patients in the notes at least 81-100% of the time. The same amount (67.5%) also indicated that the systems examined is relevant to the complaints of 81 to 100 % of patients

The diagnosis is clearly stated and relevant to the main complaint and systems examined for half of the respondents (58%).(69% respondents reported that their prescriptions are relevant to the main complaint, systems examined and diagnosis with 81-100% of the patients, and 71.2% indicated that the MPHW prescribes according to the EDL with 81-100% of the patients

It is indicated by 57% respondents that they use medical terms most of the time. Most of the respondents 80.5% examine about eighty to hundred percent of their patients; and only forty nine (21.7%) respondents said that less than eighty percent of their patients do not receive medicines for their complaints (Table -3).

The causes of unsafe practices:

The MPHW's (162:71.7%) blamed the number of clients that each MPHW has to see, as well as lack of time to see the patients(168:74.3%) as the cause of unsafe practices. The third important factor is knowledge that is not kept up to date(106:46.9%). Thorough examination not being done is also given as a factor by a large number of respondents

(84:37.2%). Poor communication with clients (75:33.2%) was also cited as a factor by a sizeable group of respondents

Table -3: Factors indicative of safe functioning of MPHW's.

Factor	With 1-20% of patients	With 21-40% of patients	With 41-60% of patients	With 61-80% of patients	With 1-100% of patients
Patient notes are complete and orderly	15	2	39	93	77
The main complaint of the patient is stated	14	3	5	52	152
The systems examined are relevant to the main complaint	0	0	31	47	148
Diagnosis is clearly stated, relevant to main complaint and systems examined	0	9	12	74	131
The prescription is relevant to the main complaint, systems examined and the diagnosis	5	0	14	51	156
The MPHW prescribes according to the Essential Drug List	0	0	23	42	161
The MPHW use medical terms	3	0	13	81	129
Patients not examined	182	21	13	10	0
Patients not receiving medicines for their complaint	177	34	11	2	2

.EXPERIENCE AND UPTO DATE KNOWLEDGE:

Most of the multi purpose health workers had more than 16-25 years of experience (50; 22%), closely followed by the group having > 25 years of experience(49; 21%).This reflects positively on the excellent experience of multi purpose health workers, but could negatively cause an impact due to their set ways of functioning (Table – 4).

Table – 4: Work Experience of Respondents

Respondents	less than one year	1-3 years	3-7 years	8-15 years	16-25 years	>25 years	Total
VHN	11	29	35	27	22	16	140
HI	0	4	6	15	28	33	86
Total	11	33	41	42	50	49	226

Refresher courses reflect on up to date knowledge. To keep updated with recent trends in primary health care, MPHW's need to attend in service education and training sessions on a regular basis. It is a reason for great concern to note that according to most of the MPHW's refresher courses were done 3 years ago(119:52.7%)

the respondents seemed to be well informed about the benefits of furthering their studies. 59.1% MPHW's admitted that it would increase their knowledge when they study further, while 33.3% MPHW's acknowledged being out of touch with recent developments

SERVICE DELIVERY:

Time spent by MPHW's rendering curative primary health care:

Curative services occupied most of the MPHW's time as one hundred and thirteen (50%) indicated that they delivered curative care 33- 40 hours per week, while a little more than quarter (26%) delivered curative care for 25-32 hours per week. The remaining (24%) only delivered it 1-24 hours per week, as Figure – 6 shows

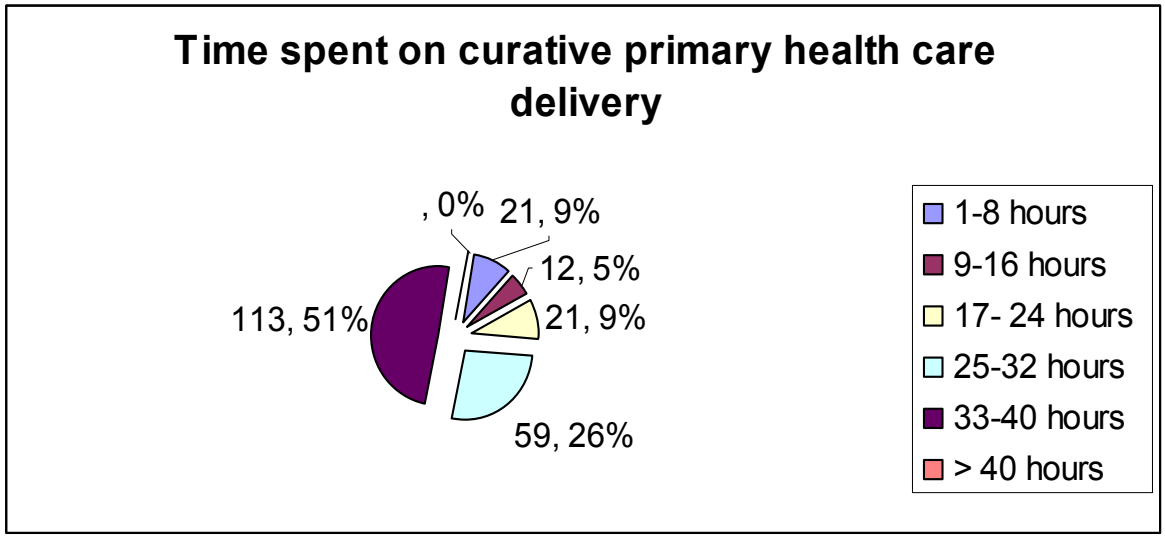

Figure – 6: Time spent on Curative Primary Health Care Services

Other services rendered by MPHW's:

The other services MPHW's are involved apart from curative services are (Figure – 7)

- Reproductive and child health service
- RNTCP
- Malaria control
- Leprosy control

- Blindness control
- HIV counseling
- Sanitation and preventive measures
- IEC
- School health

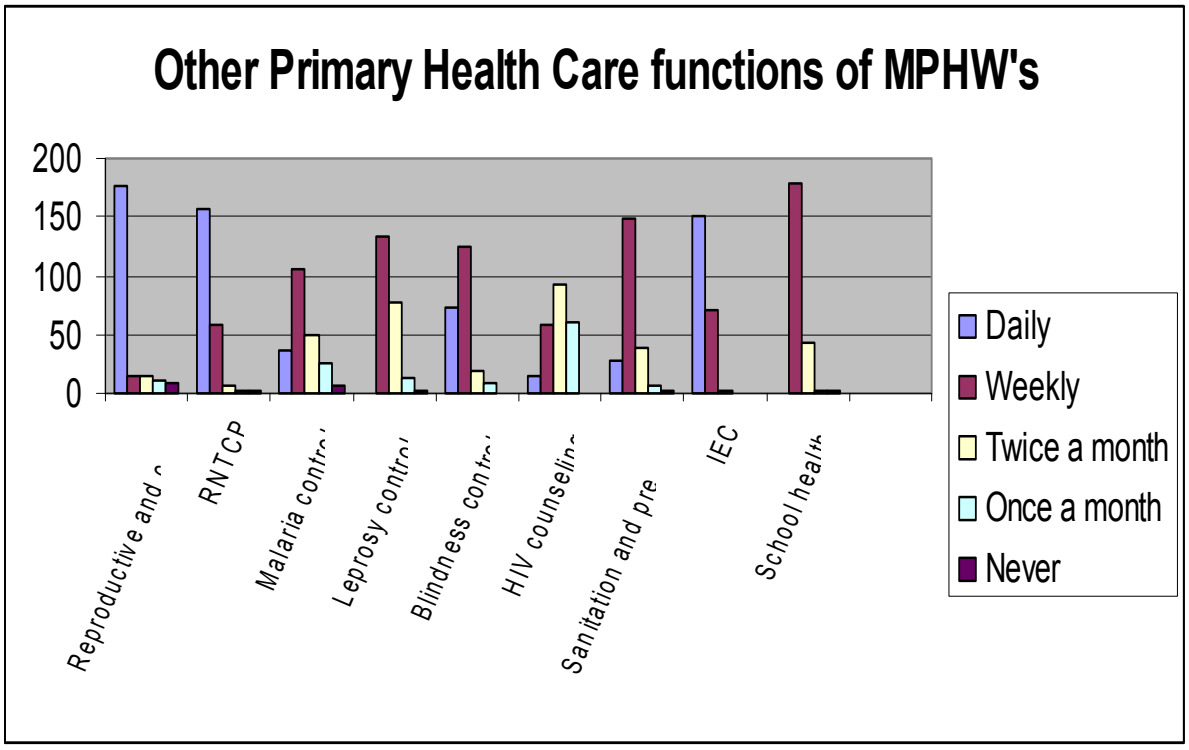

Figure – 7: Other Primary Health Care Functions of MPHW's

Referral of patients to primary health centre:

Most of the time the MPHW's were capable of rendering the necessary services to the patients on their own without reference to the primary health centre r. This is demonstrated in Figure where most MPHW's (134 or 59.2%) only refer 1-10% of their patients to the primary health centre.

The extent of consultation time of MPHW's:

The average time spent on consultation per patient is in 46.5 percent of cases is 6-10 minutes. Ten minutes is very short to interview, examine, diagnose patients, and these MPHW's function under tremendous pressure. This state of affairs can also be very annoying to patients who waited for 2-4 hours for consultation. A large number of MPHW's (37.6%) indicated that they take a bit longer to consult the clients , namely 11-15 minutes (Figure – 8).

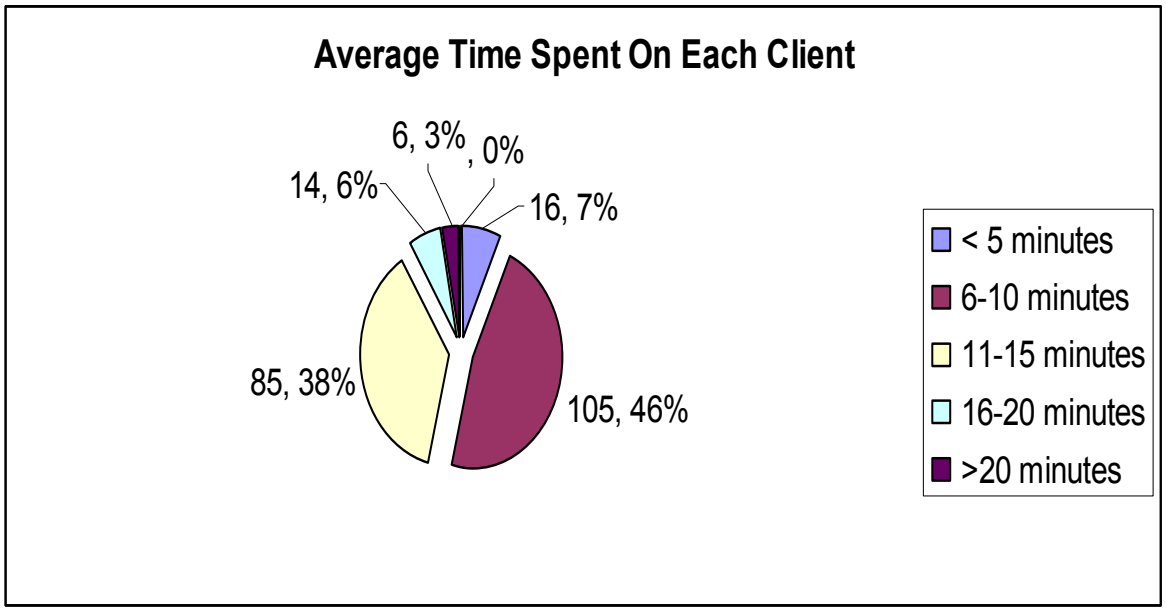

Figure – 8: Average Time spent on Each Client

The extent of full physical examination of clients by MPHW's and reasons for overlooking it:

Most MPHW's indicated that they do a full physical examination on a client

- Always (121: 54%)
- Often (90: 39%)
- Sometimes (11: 5%)

- Never (4: 2%)

When asked for the reasons for not doing full physical examination on all clients, an alarming number (117: 51.8%) indicated that they felt it was unnecessary. The majority (156: 69%) said that they did not have the time to do it. Regarding explaining condition to the patient and advising them about treatment the MPHW's said that most of the time the follow this rule (159: 70.3%).

Handling of patients when there is lack of time:

When the MPHW's were asked what they do when they do not have enough time to handle all the patients, the following was reported:

- They felt stressed (163; 72.1%),
- They worked faster and leave out less important detail (127; 56.2%).
- They send patients away (usually to another health center) (63; 27.8%),
- They become impatient and cross (23or 10.2%).

MOTIVATION AND MORALE:

Communication between you and your supervisors:

Communication channels were perceived as generally open between the MPHW's and supervisors, as reported by one hundred and fifty three(67.7%) of the respondents. There is large number of MPHW's reporting no follow up

of problems, leaves everything for you resolve, delegate work but no authority to carry them out and poor supportive supervision.

Attitudes of colleagues:

The MPHW's were asked to rate attitudes of their colleagues on the following: Attitude towards work, morale, independent thinking, productivity, self-drivenness (ability to do things out of own motivation instead of being motivated by external forces), compassion and empathy towards patients and professionalism. Most thought that their colleagues scored average or poor, as demonstrated in Figure – 9.

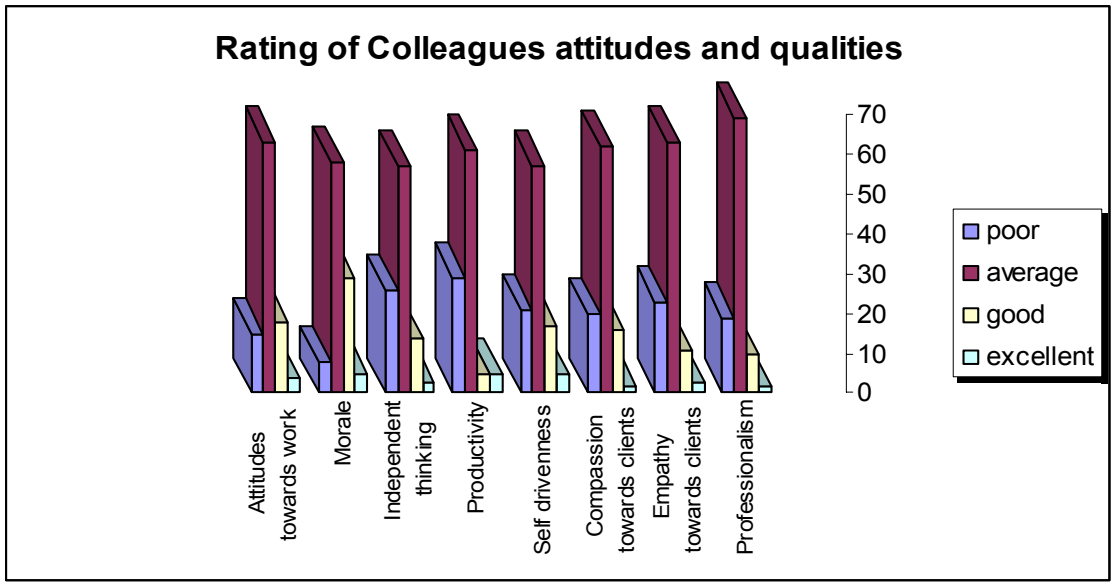

Figure – 9: Respondents Rating of Colleagues Attitudes and Qualities

Own attitudes towards working conditions were reported to be good by most (163: 72.1%) and excellent by thirty seven (16.4%)

The MPHW's experienced clients as follows. They were often

- Demanding (161: 71.2%)
- Unreasonable (97: 42.9%)
- Aggressive (49: 21.7%)
- Thankful (165: 73%)
- Collaborative (153: 67.7%)

Conflicts and clashes amongst personnel occur often (97; 43%) as mentioned by the respondents and generation gaps are experienced quite often between personnel (83; 36.7%).

Reasons why MPHW's work in other places:

More than a half of the MPHW's reported that they do not work in other places (122; 54.0%). MPHW's (77; 34%) in this study indicated that the they work in other places because of a lack of money,

Self-worth of MPHW's:

The thought processes of MPHW's were explored in order to establish how they value themselves in the service.Generally MPHW's feel that they are not remunerated enough for what they do and that their supervisors do not listen to their problems. The habit of not being valued and motivated and listened to are carried over from supervisors to their MPHW's (Table – 5).

Table – 5: Feelings of Self Worth of MPHW's

Factors	Number	Percentage
I feel valued as a worker	128	56.6
I am recognized for my contribution	99	43.8
I am paid enough for what I do	54	23.9
My pay relates to my qualifications	83	36.7
I feel that my supervisor always listens to me	133	58.8
I am motivated by my supervisor to work harder	99	43.8

COMMUNITY INVOLVEMENT/COLLABRATION:

Influences on communication between MPHW's and patients:

Communication between MPHW's and patients is very important and can contribute to the well being of the client and community. Lack of privacy (34.5%) and cultural differences (33.3%) were reported by a third of the respondents as the biggest problems. The low literacy levels (30.3%) of clients and impatience of the MPHW (27.3%) are the next largest reasons given for poor communication between MPHW's and patients. Physical disabilities of clients (19.7%) were reported by of the respondents as being a problem.

Do community members have the opportunity to participate in the service:

Community involvement in services as experienced by the MPHW's are that ninety five (42%) of the respondents reported that health committees were a way for the community to participate. One hundred and forty three (63.3%)

respondents believed community members could present themselves as volunteers.

Rate the effectiveness of your contact with principal role players in your community:

The most effective role players in the community are teachers (131: 58%) and women groups (81: 35.8%). Contact with members of local council was only reported by thirty five (15.5%) to be effective. This is disappointing, as one would want local council members to be informed and active in their communities' health care needs. Traditional healers do not play such a great role in the study.

The role the communities have in the service:

It seems as if the MPHW's were not in agreement about the value of members of the community in the health service. Fifty nine (26.1%) of the MPHW's reported that the involvement of the community improved the health care while the same percentage (26.0%) reported that the involvement of the community never improved healthcare.

OUTCOME:

Most of the respondents (149 :65.9%) perceived themselves generally as having good to excellent skills in the qualities mentioned on the questionnaire. Doing a full physical examination is rated excellent or good by one hundred and forty-three (63.3%). More MPHW's also rated themselves

good or excellent on safety, competence, interpersonal relationships, compassion, taking a comprehensive history, proper record keeping and giving health education. Most gave themselves excellent to good marks for continuity, work ethics, accountability, and diagnosis of the condition, prescribing treatment and knowledge when to refer

SUMMARY

The research population was the Multi purpose health workers and their supervisors in the Curative Primary Health Care setup. The sample was the Multi purpose health workers in Tiruvallur district of Tamil Nadu.

Data was gathered by applying questionnaires to both groups. Data was entered in Microsoft excel and Epi info 2000 and presented visually with the aid of graphs and tables.

Barriers to a curative PHC service seem to be multifactorial, with scarce resources causing great stress for the workforce. This have a negative impact on relationships between employer and employee, Multi purpose health workers and their patients, the type of managing that take place, and the quality of the examination and treatment of patients. Slow changes frustrate workers, causing more stress and poor attitudes, feelings of not being valued, and not being motivated (internally and externally).

Enablers examined showed that although the workforce may be discontented and overworked, they still try to deliver their best, with few errors. Clients still have a lot of respect for their health care deliverers, but this trend may not continue much longer. Clients are already returning more often to avail primary healthcare service, causing even more stress for MPHW's.

LIMITATIONS

- The MPHW's were very busy , and the questionnaires were lengthy and took some time to complete
- Questionnaires were set only in English since the basic educational qualification was 10^{th} standard. But some respondents commented that they would have preferred to answer it in Tamil.
- Only MPHW's in Tiruvallur district of Tamil Nadu state were part of the study and thus it cannot be generalized beyond this area. For this we need a bigger study with financial resources and a bigger sample from all over Tamil Nadu.

CONCLUSIONS

The conclusions will be explained with the aid of Donabedian's structure/process/outcome model as barriers and enablers.

Structure:

Barriers:

- Resources are more limited than ever. Staffing levels are unrealistically low, vacant posts are frozen and staff have to cope with increased workload and increasing demands of the community, as well as expectations from the health department and government. Obtaining stock and equipment is a major problem, and most Primary health centers functions with a deficient budget. Buildings are inadequate and not close enough to patients.
- Convenient hours for the public to use the service were not even to be considered, because of lack of staff and facilities
- Time spent with patients was less because of staff limits. More time was spent on curative services and less on preventative projects
- Training sessions and development opportunities are greatly lacking particular in in-service training, mostly because of inability to spare staff to go on these ventures. Rather new courses have been discontinued because of lack of finances. Refresher courses have

not been organized or attended for a couple of years by most of the sample

- Furthering their studies in their chosen career field did not seem to be an interest of MPHW's and their supervisors in Tiruvallur district of Tamil Nadu.
- Autocratic decisions were made by management, with little input from nurses on grass root level. This caused stress and lack of job satisfaction, and lack of problem solving skills, because nurses were not expected to think for themselves. Information systems by the way of computers were absent or not used to their potential, thus continuous and relevant feedback about the service is nearly impossible

Enablers:

There seems to be few structural enablers present in Tiruvallur district of Tamil Nadu. Training, information systems and quality management programmes was identified in the literature study as enablers, but in this study it was identified as lacking, and thus barriers to the structural component of the Tiruvallur district of Tamil Nadu

- *Good referral systems* with a large multidisciplinary team existed in the region

Process:

Barriers:

- lack of professionalism, low morale and productivity: MPHW's identified poor attitude amongst their colleagues, and supervisors as having an effect of low morale. Stress levels influence productiveness.
- Supervision and leadership: this seems to a problem in this area. Some excellent management methods like performance appraisal and upkeep of job descriptions were not used, probably because of lack of time or lack of knowledge. The MPHW's reported a general lack of support from their superiors. Lack of communication channels was also reported between them and superiors.
- Client aspects identified that influenced quality primary health care were culture, literacy levels, physical attributes of patients and therefore communication problems.
- Role modeling and support by the health organization: the MPHW's generally felt that the organization did not follow up reported problems, left MPHW's to solve their own problems while duties are delegated without authority to carry them out. Feedback is not given often and also seems to be a problem in this category. Lack of listening skills and communication were two other problems reported in employee-organization relationships that were unsatisfactory. Motivation by superiors was lacking.

- *Focus on the patient/family/community and their needs:* While attention to individuals was given in a curative consultation, this is not true of family or community needs. Little time was left for meetings with the community through forums or contact with local role-players. Staff was not doing surveys or requesting community membership/patients to complete questionnaires. No interest was shown in having letterboxes for complaints
- *Professional development* was not given serious consideration by most of the respondents, who replied that they are not furthering their studies or keeping up dated with refresher courses

Enablers:

Lack of role modeling and support from management, lack of professional development and lack of focus on the individual/family community seem to be barriers in this study. These are factors that can contribute to a good service, but because of the lack of these, it is barriers in the Tiruvallur district of Tamil Nadu

- *Collaboration* between team members was possible, especially since there was such a large team. Because of staff not studying, lack of collaboration existed between academic institutions and the workers in the field. There was also a lack of collaboration between other sectors of the community and health services.

Teamwork seemed to be present, although incidences of clashes due to culture and generation gaps were also reported

- *Experience* is a great enabler in these services. Most of the supervisors had extensive experience, and the respondent who replied with the least experience, already had two years of working experience. This was probably the reason for the reported low incidence of medical mistakes

Outcome:

Barriers:

- *Inability to prove cost-effectiveness:* A significant amount of patients were reported to return to the clinic, often with the same complaint. Although not all patients were given medication for their complaints (reported to be unnecessary), one wonders whether this would be the reason for patients' return to clinic with the same complaint. MPHW's also gave free advice and support as well as counseling to patients. As patients receive these services free, there is a tendency to return to counselors whom understand them. This might overload the service, and are not reflected as cost effective.
- *Medical mistakes also occurred, but surprisingly little was reported in this study, with only a slight increase in substantiated complaints by clients*

about improper care. According to the reported services rendered by MPHW's , most do not do a thorough physical examination. Experience had also taught MPHW's to do work quicker and do an assessment of the clients fast.

Enablers:

- Effectiveness was compromised by the number of return visits reported, but substantiated by the small amount of problems reported by the community.

- Efficiency of the general curative primary health care services were questionable, as PHC was built on the premise of prevention and promotion, and curative services infringe on this preventive services.

- Appropriateness and accessibility. The services were not absolutely appropriate, as still an amount of patients reported inability to avail services, due to hours open and lack of staff rendering services. MPHW's reported having to send patients away at times, or working faster, which means that the clients may not be thoroughly examined and served.

- Continuity seems not to be a problem, as the client is served and provided consultation by the same provider again and again.

- Participation of clients and community was a problem, as they did not have much input via health committees or letter box complaints as mentioned earlier.

- Examination of mistakes was done by those supervisors and superiors who received the complaint. They mostly heard the client out, some of them might consider the opinion of the staff member involved, but very few got both the parties together for a problem solving session. Less use was made of auditing to identify problems and correct them by giving feedback to staff and proactive ways of preventing them

RECOMMENDATIONS

Structure:

- Resources needs to be re-assessed and budgets accordingly reallocated. Human resources are being depleted because material and equipment are unavailable. MPHW's have to be creative and innovative, but at the expense of their own time and those of the patients, because of lack of resources. Human resources should be developed and not taken advantage off, to squeeze the last ounce of productivity out of them.

- When resources have been supplied, health services must look at the needs of the community they serve, by adapting consulting hours to be convenient to the public, by implementing health committees and having letterbox complaints, and acting on requests from these areas. Management of health services needs to become more democratic. A health committee in name that is not really functioning, is of no use whatsoever to the service.

- Managers need to be knowledgeable about all facets of the service, latest management principles, should attend regular training sessions for this, should keep contact with academia and professional organizations, and should give feedback about these

events and information received to their employees. It is of no use to send one person to an expensive symposium and not organizing for that person to give feedback. That would be throwing money in the water.

.

- Managers and practitioners should keep up to date about the newest trends in their chosen career field, and strive to be part of renewal that these initiatives (for instance adolescent-friendly initiative, district health information systems) bring. Excuses of not having time will negate the amounts of time that could be saved by initiating these programs. Some of these programs provide advice and support to initiate them, services are not expected to do this on their own.

- Accreditation should be a sought after as an achievement by all health services as a basic standard

Process:

Managers on top level should address lack of motivation, poor morale, and bad attitude. One of managers' most important functions is motivation of their staff. Covey said that employees are the golden goose that lays the egg. If you kill the golden goose, you rid yourself of your source of income, work, and your employees' loyalty. That would be too high a price to pay, as the workers

of the Tiruvallur district of Tamil Nadu are still amazingly productive, even with all the odds against them, with little union problems. But for how long?

- Communication and feedback to employees are a great issue and needs to be looked at as soon as possible. It is a crime to let people work and not let them have goals, give them feedback about how they are progressing, show them where they should change direction

- Democracy is also needed in the hierarchy of the health services. Middle managers and top managers of services are not only the employees of the state, but are also the advocates of those supervised by them, as the Multi purpose health workers are the advocates of the client. These managers must be able to realize what problems are faced on grass root level from input from those working at this level, and be able to actively influence politicians and those above them.

- Contact with academic institutions is necessary, so that feedback can be given about research results and practices found to be worth sharing.

Outcome:

- Medical errors should be examined. Regular audit and performance appraisal sessions are necessary. Complaints from clients should not be seen as a session where you deny all responsibilities, but as a learning situation for staff and the clients. This way the client learns about health system culture and the MPHW about clients and community, so that their needs can be identified and addressed in a far more efficient and effective manner.

Recommendation for further research

- The replication of this study in other areas will yield interesting results, weather to ascertain in other geographical and cultural areas MPHW's experience the same problems.

- The actual practice of MPHW's would be interesting to pursue, to be able to compare between different ways they might be addressing the same problem, to compare accuracy and to improve practice.

BIBLIOGRAPHY

[1] Crisp,N. 1997 standards, sophistication and quality: the health balancing act. Indicator south Africa. 14(1): 46-49

[2] Matzner, L. 1991. The definition and measurement of quality in primary health care. Port Elizabeth: Universiteit Port Elizabeth.

[3] Nicholas D D, Heiby J R and Hatzell T A, The Quality Assurance Project: introducing quality improvement to primary health care in less developed countries. *Quality Assur Health Care* 3: 147-165, 1991.

[4] Amo~mLartsonR , Alpaugh-Pjennark M and Neumann A, An approach to evaluating the quality of primary health care in rural clinics in Ghana. J *Trop Ped* 31: 282-285,1985

[5] Sauerborn R, Nougtara A, Bidiga J, Sorgho G, Tiebelesse L and Diesfeld H-J, Assessment of MCH-services in the district of Solenzo, Burkina Faso II) Acceptability. J *Trop Ped* 35(Suppl): 1&U, 1989

[6] Bjorck M, Johansson R and Kanji N, Improving the quality of primary care senices in Angola. *Health Pol Plan* 7: 290-295, 1992.

[7] Gamer P, Thomason J and Donaldson D, Quality assessment of health facilities in rural Papua New Guinea. *Health Pol Plan 5:* 49-59, 1W.

[8] . Gilson L, Aliolio M and Heggenhougen K, Community satisfaction with primary health care services: an evaluation undertaken in the Morogoro region of Tanzania. *Soc Sci Med* 39: 767-780, 1994.

[9] Palmer H, Editorial: quality of care and health care resources. *Int* J *Qua1 Health Care* 7: 79, 195.

[10] WHO Alma-Ata 1978, *Primary health care.* World Health Organuation, Geneva, p. 24,1978.

[11] IDS Health Group Health needs and health services in rural Ghana. *Soc Sci Med* 15: 1981.

[12] Chabot H T J and Bremrners J, Government health services community: conflict or harmony. *Soc Sci Med 26:* 957-962, 1988.

[13] Donabedian A, Promoting quality through evaluating the p b s s of patient care. *Med Carc* 6: 181-2M,1%8

[14] Litvack J I and Bodard C, User fees plus quality equals improved access to health care: results of a field experiment in Cameroon. *Soc Sci Med* 37: 36%383,1993.

[15] . Akin J S, Guilkey D K and Denton H, Quality of services and demand for health care in Nigeria: a multinomial probit estimation. *Soc Sci Med 40:* 1527,1!395

[16] Lavy V and Germain J M, Quality and cost in health care choice in developing countries. *World Bank Living Standards Measurernea Series No. 105,34* pp., 1994.

[17] PRICOR Child sunival r e p t - r e s u l t s from system analysis in the Philippines. *Pricor Child Survival Reports* (May 89), p. 2,1989.

[18] Sauerborn R, Nougtara A and Diesfeld H J, Low utilization of community health workers-results from a household inteniew survey in Burkina Faso. *Soc Sci Med* 29: 1163-1974,1989.

[19] Lancaster, D. R. & King, A. 1999. The spider diagram nursing quality report card: bringing all the pieces together. Journal of nursing administration. Vol 29 No7/8 (43-48).

[20] Shongwe, NT. 2000. Quality Assurance: An evaluation of the quality of Nursing Care in Swaziland. Pretoria: Unisa

[21] Khan, Y. 1999. Factors affecting quality assurance in nursing care. Nursing Journal of India. 90 (8): 173-174

[22] Chirwa, ML, 2000. What specific problems do nurse managers in Malawi report they experience in ensuring quality care. Africa Journal of Nursing and Midwifery Vol. 2 (2) 7-9

[23] Aiken, LM, Clarke, SP, Sloane, DM, Sochalski, JA, Busse, R, Clarke, H, Giovannetti, P, Hunt, J, Rafferty, AM & Shamian, J. 2001. Nurses' Report on Hospital Care in five countries. Health Affairs, 2 0(3): 43-53

[24] Clark, JM& Maben, J. 1999. Health promotion in primary health care nursing:the development of quality indicators. Health Educational Journal, 5892):99-119.

[25] Williams, AM & Irurita, VF. 1998. therapeutically conducive relationships between nurse and patients: an important component of quality nursing care. Australian Journal of Advanced Nursing. 1692) 36-44

[26] Carlson, CL & El Ansari , W. 2000. Squaring the circle: Developing public health competencies in primary care. NT Research. 5 (3):165-176

[27] Elgoni, A. 2001. developing a client satisfaction tool.

[28] Moholo, MM & Khoza, P.1999. Total quality management in public health services. Nursing Update. (12) 34-35

[29] Jewkes, R. 1995 Quality improvement in health services time for appropriate managerial technology. South African Medical Journal, 85(10):985-6.

[30] Tornkvist, L, Gardulf, A& strender, L.2000. paient's satisfaction with the care given by district nurses at home and at primary health care centres. Scandinavian Journal of Caring sciences. 14: 67-74

[31] Mason C. 1997 Achieving quality in community health nursing. Hampshire: Macmillan Press Ltd.

[32] Krairiksh, M & Anthony, M K. 2001 Benefits and outcomes of staff nurses' participation in decision making. Journal of Advanced Nursing Administration. Issue 31: 16-23

OTHER REFERENCES

Identifying predictors of high quality care in English general practice: observational study BMJ 2001;323;784.

ASSESSING THE QUALITY OF REPRODUCTIVE HEALTH SERVICES
The Policy Series in Reproductive Health, Reproductive Health Working Group housed in the Population Council, Regional Offce for West Asia and North Africa,

Technical Report # 46, Reproductive Health Care at the Primary Level in Armenia: Assessment of Providers Services and the Factors Affecting Performance Final Report August 2003

QUALITY IMPROVEMENT IN PRIMARY HEALTH CARE, A PRACTICAL GUIDE, WHO PUBLICATIONS, Eastern Mediterranean series 26

QUALITY OF CARE IN FAMILY PLANNING SERVICE DELIVERY IN KENYA: CLIENTS' AND PROVIDERS' PERSPECTIVES, Lewis Ndhlovu, The Population Council's Africa OR/TA Project, Nairobi, Kenya: January, 1995

Performance Assessment in Primary Health Care, Summary of Background Information, Views and Debate at an APHCRI Forum, Canberra, July 4-5, 2005

www.who.int

www.bmj.com

www.highwirepress.com

www.pubmed.org

www.tn.gov.in

www.nihfw.org

QUESTIONNAIRE

BIBLIOGRAPHIC INFORMATION

1. Name

2. Age
   Key: (20-29=1),(30-39=2),(40-49=3),(50-58=4)

3. Gender
   Key:(male=1),(Female=2)

CHANGES/INSTITUTIONAL TENURE

4. How much stress do you endure in rendering primary health care services?
   Key: (no stress=1), (Normal stress=2) ,(Unbearable at times=3),(Totally unbearable=4)

5. Rate the extent that the following have on your stress levels:
   Key: (no effect=1) ,(Some effect=2), (Serious effect=3)

   Lack of training of self / colleagues
   Lack of training of supervisors
   Lack of experience of self / colleagues
   Too much responsibilities of self /colleagues
   Too much responsibilities of supervisors
   Too many patients
   Not enough resources
   Not enough support from authorities
   Not enough support from personnel in service
   Long working hours
   Patients too demanding
   Too many changes
   Not enough staff
   Continuous turnover of staff
   Not enough time for patients
   Others (Please specify)

RESOURCES

6. How many days per week does your service operate?
   Key:(1 DAY=1),(2 DAYS=2),(3 DAYS=3),(4 DAYS =4),(5 DAYS =5),
   (6-7 DAYS =6).

7. What is the service's operating hours?
   Key: (08:00-17:00 = 1),(08:00-14:00 = 2), (07:00-12:00 = 3), (07:00-10:00 = 4),(07:00-09:00 = 5)

8.	How often dose your supervisor visits your service? Key: visits once a week=1, Visits once in two weeks=2, Visits once in three weeks=3, Visits once in a month =4, Dose not visit=5	
9.	To whom you refer clients to? Key: Yes = 1 No = 2)	
	Medical officer at PHC	
	Private medical general practitioners	
	Private nurse practitioner	
	Alternate medicine practitioners	
	Traditional healers	
	Traditional midwifes	
	Other (Specify)	
10.	Are you aware that any of your clients use the service of the following persons? Key: Yes = 1 No = 2)	
	Private medical general practitioners	
	Private nurse practitioner	
	Traditional healers	
	Traditional midwifes	
	Other (Specify)	
11.	Which of the following are generally the aspects your clients complain about your service? Key: Always complain about this = 1, Often complain about this = 2, Sometimes complain about this = 3, Never complain about this = 4)	
	Have to wait too long to be seen	
	Not enough medicine	
	Nurse is not as good as the doctor	
	Medicine is not of a good quality	
	Quality of service is poor	
	The hours are inconvenient	
	Personnel are unfriendly	
	Clinic is too far from home	
	gender insensitivity'	
	cultural insensitivity	
	unavailability	
	not being examined properly	
	health problem not being managed properly	
	treatment did not work properly and had to return to MPHW for same complaint	
	Other (Specify)	
12.	How adequate is your budget to run the service? Key: (Good = 1),(Average = 2),(Poor = 3)	

13. Dose the building allotted to you comply with the requirements of the service?
Key: (Yes = 1),(No = 2)

14. How often do you experience problems in obtaining equipment/stock?
Key :(Never = 1),(Seldom = 2),(Often = 3) ,(Always = 4)

15. Are there enough staff members in your primary health centre?
Key: (Yes =1),(No =2),(Don't know = 3)

16. Are there increases in staffing levels to meet the increased workload?
Key: (Yes = 1),(No = 2) ,(Don't know = 3)

PROFESSIONAL TRAINING

17. Where did you obtain your training in primary health care?

18. Which of the following educational qualifications do you have?
Key:(matriculation=1),(highersecondary=2),(undergraduate=3),(postgraduate=4).

SUPERVISION

19. How often do you get feedback from supervisors about quality of your service / service point?
Key: Weekly = 1, Monthly = 2, 1-3 months=3, 4-6 monthly = 4, 7-12 monthly = 5, never=6

20. How often does the following take place in the clinic?
Key: With 1-20% of patients = 1, With 21-40% of patients = 2, With 41-60% of patients = 3, With 61-80% of patients = 4, With81-100% of patients = 5

Patient notes are complete and orderly
The main complaint of the patient is stated
The systems examined are relevant to the main complaint
Complaint and systems examined
The prescription is relevant to the main complaint, systems examined and the diagnosis
The MPHW prescribes according to the Essential Drug List
The MPHW use medical terms
Patients not examined
Patients not receiving medicines for their complaint
Others (please specify)

21. Which of these are the causes of unsafe practices in providing primary health care?
Key: yes=1, No=2

Lack of time to see client
Too many clients per nurse
Lack of practical experience
Not enough hands on training knowledge

Not Updating knowledge

Not enough communication skills

Personal characteristics of VHN like laziness, uncaring attitude etc,.

Others (please specify)

EXPERIENCE AND UPTO DATE KNOWLEDGE

22. Years of field experience
Key: (less than one year=1),(1-3 years=2) ,(3-7 years=3),(8-15 years=4),(16-25 years=5),(>25 years=6),

23. When did you last attend a refresher course in primary health care?
Key: less than one year=1, Within 2 years=2, Within 3 years=3
, > 3 years=4

24. Why do you feel a need to update your knowledge in primary health care
Key: I do not feel it is necessary = 1, I am out of touch with relevant developments = 2, I need more knowledge = 3, Others (please specify

SERVICE DELIVERY

25. How many hours per week do you spend on rendering a curative service?
Key: 1-8 hours = 1, 9-16 hours = 2, 17- 24 hours = 3, 25-32 hours = 4 , 33-40 hours = 5, > 40 hours=6

26. How often are you as MPHW involved in other Primary Health Care functions?
Key: daily=1, Weekly=2, Twice a month=3, Once a month-4, Never-5

Reproductive and child health service

RNTCP

Malaria control

Leprosy control

Blindness control

HIV counseling

Sanitation and preventive measures

IEC

School health

Others (please specify

27. What percentage of your clients do you refer to the primary health centre?
Key: 1-10%=1
11-20%=2
21-30%=3
31-40%=4
41-50%=5
51-60%=6
61-70%=7
71-80%=8
81-90%=9
91-100%=10

28. How much consultation time do you take per patient?
Key: < 5 minutes =1, 6-10 minutes=2, 11-15=3, 16-20=, >20 minutes=5

29. How often do you do full physical examinations of clients?
Key: always=1, Often=2, Sometimes=3, Never=4

30. What is the reason a full physical examination is not done on all patients?
Key: Yes = 1 No = 2)

Do not have the time
Do not have enough experience
Do not have enough theory
It is not necessary
Other (please specify

31. Do you always explain condition to the patient and advise him about treatment?
Key: Never =1, Sometimes =2, Most of the time = 3, Always = 4)

32. What do you do when there are too many clients and too little time to consult everyone?
Key: Yes = 1 No = 2)

Send patients away
Become impatient and cross
Feel stressed
Work faster and leave out less important detail
Other (please specify

MOTIVATION AND MORALE

33. Rate the communication between you and your supervisors?
Key: Yes =1 , No = 2)

- Open communication channels exist
- your supervisors does not follow up reported problems
- your supervisors leaves everything for you resolve
- no supportive supervision
- they delegate work but no authority to carry them out

Other (please specify

34. Please rate the following of your colleagues
Key: poor=1, Average=2 , Good=3, Excellent=4

Attitudes towards work
Morale
Independent thinking
Productivity
Self drivenness
Compassion towards clients
Empathy towards clients
Professionalism

35. Rate your own attitude towards your working conditions
Key: poor=1, Average=2, Good=3, Excellent=4

36. What are your experiences with your clients?
Key: always=1, Often=2, Sometimes=3, Never=4
Demanding
Unreasonable
Aggressive
Thankful

COLLABRATIVE

37. Are there any conflicts and clashes amongst personnel?
Key: Always = 1, Often = 2, Seldom = 3, Never = 4

38. Do you experience generation gaps between personnel?
Key: Always = 1, Often = 2, Seldom = 3, Never = 4

39. What are the reasons why MPHW's in your facility work in other places besides their full-time job?
Key: They do not like the full time job = 1, Lack of money = 2, More stimulation = 3, Plan to change jobs = 4, Other (please specify)

40. Which of the following statements are applicable to your position?
Key: Always = 1, Most of the time = 2, Sometimes = 3, Never = 4

I feel valued as a worker
I am recognized for my contribution
I am paid enough for what I do
My pay relates to my qualifications
I feel that my supervisor always listens to me
I am motivated by my supervisor to work harder

COMMUNITY INVOLVEMENT/COLLABRATION

41. To what extent may the following influence communication between MPHW and clients?
Key: very high=1, High=2, Low=3, Very low=4

Caste difference	
Literacy level of patient	
Physical disability of clients	
Lack of privacy whwn examining	
Impatience of VHN	

42. Do community members have the opportunity to participate in the service through
Key: Never =1, Sometimes =2, often = 3, Always = 4)

health committees	
volunteers	
letter box complaints	
questionnaires	
no complaints	

43. Rate the effectiveness of your contact with principal role players in your community
Key: Never =1, Seldom =2, often = 3, Always = 4)

Teachers	
Members of local council	
Religious leaders	
Village elders	
Women groups	
Youth forums	

44. Dose contact with role players improves care?
Key: Never =1, Seldom =2, often = 3, Always = 4)

OUTCOME

45. Rate the quality of service you render
Key: poor=1, Average=2, Good=3, Excellent=4

Safety	
Competence	
Interpersonal relationships	
Compassion	
Continuity	
Work ethics	
Accountability	
Taking comprehensive history	
Doing full physical examination	
Diagnosis of the condition	

Proper record keeping	
Prescribing treatment of diagnosed condition	
Giving health education	
Know when to refer patient to the next level of health care	

THANK YOU FOR PARTICIPATING IN THE RESEARCH

DEFENITIONS

Quality health care

Quality means different things to different people. The professional practitioner sees quality in professional performance. The client regards accessibility and compassionate care as quality. Managers look for efficiency and fiscal stability. In this research, quality of care is seen as a combination of abovementioned factors, namely knowledgeable, compassionate, professional, efficient, safe care. It means that the MPHW knows how to interview, diagnose, treat a condition or emergencies and refer the client when necessary, and what health education to render. It means that they are able to gain adequate support from their supervisors and have enough resources available to perform their duties. It means that their supervisors as well as her clients are satisfied with services provided.

Primary health care

Primary health care is the health care delivered to the client at first level of contact. The care is preventive, promotive, curative and rehabilitative and aims to keep the client out of secondary and tertiary health care institutions, as these are quite expensive for the client , as well as the state.

Stress

Stress can be defined as the sum of physical and mental responses to an unacceptable disparity between real or imagined personal experience and personal expectations. By this definition, stress is a response which includes both physical and mental components.

Supervisor

A Supervisor is an employee of an organization with some of the powers and responsibilities of management, occupying a role between true manager and a regular employee. A Supervisor position is typically the first step towards being promoted into a management role

Communication

Communication is the process of sharing information. In a simplistic form information is sent from a sender or encoder to a receiver or decoder. In a more complex form feedback links a sender to a receiver.

Attitude

Attitude is a concept in psychology. Attitudes are positive, negative or neutral views of an "attitude object": i.e. a person, behaviour or event. People can also be "ambivalent" towards a target, meaning that they simultaneously possess a positive and a negative attitude

Morale

Morale is a term for the capacity of people to maintain belief in an institution or a goal, or even in oneself and others.

Empathy

Empathy commonly is defined as one's ability to recognize, perceive and directly experientially feel the emotion of another

Conflict

Conflict is a state of opposition, disagreement or incompatibility between two or more people or groups of people, which is sometimes characterized by physical violence

Role Player

A role player is a player who fulfills an important function for a team.

Competence

Competence is the ability to perform some task

Accountability

Accountability is a concept in ethics with several meanings. It is often used synonymously with such concepts as answerability, responsibility, blameworthiness, liability and other terms associated with the expectation of account-giving.

Work ethic

Work ethic is a set of values based on the moral virtues of hard work and diligence. It is also a belief in moral benefit of work and its ability to enhance character.

MAPS OF TIRUVALLUR DISTRICT AND TAMIL NADU