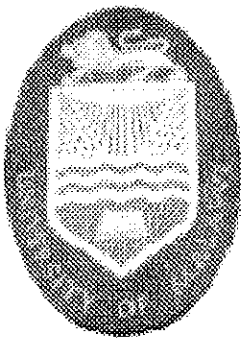

UNIVERSITY OF MALAWI

KAMUZU COLLEGE OF NURSING

FACTORS HINDERING PROGRESS OF PERFORMANCE AND QUALITY IMPROVEMENT IN REPRODUCTIVE HEALTH IN LABOUR AND POSTNATAL WARDS AT Q.E.C.H

A RESEARCH DISSERTATION SUBMITTED TO FACULTY OF NURSING IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR BACHELOR OF SCIENCE IN NURSING (POST BASIC).

SUBMITTED BY

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SUPERVISED BY

MR G. MASACHE

DATE 7TH OCTOBER, 2011

DECLARATION

I here by declare that this dissertation is as a result of my own work and effort.

It has never been presented for any degree. Where information from other people has been used, acknowledgement has been done as reference.

Candidate: VIOLET TALINDA KHONJE Date 18/10/11

Signature: .....

Supervisor: ..... Date .....

Signature: .....

DEDICATION

This dissertation is dedicated to my husband Eric Khonje, my beloved kids Kelvin and Kettie, my sisters Liness and Ivy and my brother Thokozani. Thank you for your prayers and support. May the good Lord bless you all.

ACKNOWLEDGEMENT

I thank the Almighty God for taking me to this far.

My sincere thanks should go to my supervisor ,MrMasache for his untiring support and guidance throughout the process of proposal development.

Thanks should go to the Librarian MrWela for his support in the process of literature review.

Lastly, I thank all my classmates for their mutual support and assistance.

ABSTRACT

Performance and quality improvement in reproductive health has been introduced to ensure skilled attendance and increase access to services thereby reducing maternal and neonatal morbidity and mortality. PQI/RH was introduced at Q.E.C.H in 2008. Since the initiation of PQI/RH, there has been progress in some of the departments while other departments have shown no progress at all. The study wanted to establish factors that are hindering progress to achieve quality performance in labour and postnatal wards at Q.E.C.H. The objectives of the study were to assess knowledge of providers on PQI/RH. To determine challenges faced by providers in implementing PQI/RH. Identify the availability of resources for implementing of PQI/RH and to assess whether departments have key players to facilitate quality achievement. The study was quantitative descriptive in nature and a semi structured questionnaire wasused to collect data from participants. Providers working in reproductive departments were the participants for the study. The study sample was 30 providers. Participants were purposively chosen from the departments in order to have a wider view of ideas. Results have shown that providers have inadequate knowledge on PQI/RH and are meeting several challenges to implement the initiative. Findings from the study will help providers, Quality Improvement Support Team(QIST) and management to develop strategies to achieve quality performance in reproductive health service. Findings of the study have been disseminated to Basic Studies Department and Q.E.C.H.

LIST OF ABBREVIATIONS AND ACRONYMS

ART : Antiretroviral Therapy

GTZ : German Technical Cooperation

HCI : Health Improvement Project

JHPIEGO : John Hopkins Program for International Education in Gynaecology and Obstetrics.

MoH : Ministry of Health

PMTCT : Prevention of Mother To Child Transmission

PPH : Post Partum Heamorrhage

PQI : Performance and Quality Improvement

PQI/IP : Performance and Quality Improvement in Infection Prevention

PQI/RH : Performance and Quality Improvement in Reproductive Health

QECH : Queen Elizabeth Central Hospital

QIST : Quality Improvement Support Team

RH : Reproductive Health

SBM-R : Standard Based Management and Recognition

USAID : United States Agency for International Development

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CHAPTER ONE

1.0 INTRODUCTION

Performance and Quality Improvement (PQI) is a technique used for achieving desired performance at service delivery sites and within communities. This is a strategy used by the maternal and neonatal health program to strengthen the components of skilled attendance system. The maternal and neonatal health program has used PQI to help facilities and their beneficiaries take a comprehensive look at their skilled attendance system to identify, implement and monitor a range of targeted interventions aimed at improving maternal and newborn healthcare services. The PQI process has guided maternal and neonatal health program to improve the quality of care, strengthen links between community and health facilities and empower individuals and communities to seek and demand for quality health services (Voet, 2003).

The Ministry of Health in Malawi through the Reproductive Health Unit with support from JHPIEGO, an affiliate of the Johns Hopkins University, a nonprofit corporation introduced PQI/RH in 2006 with the aim of reducing maternal and neonatal morbidity and mortality and increasing access to reproductive health services. According to MICS report 2007, the maternal mortality ratio is at 807 per 100,000 live births, neonatal mortality ratio is 31 per 1000 live births, contraceptive prevalence rate is 41.7% and total fertility rate is 6.3. JHPIEGO believes that improving performance at facility level will help to improve these health indicators. In its report of 2010, JHPIEGO has indicated that there is progress to achieving performance and quality improvement in places where the initiative has been introduced. Labour and postnatal wards at Q.E.C.H. have not shown any progress since 2009 hence the need to explore factors that are hindering progress to achieve quality performance.

1.1 BACKGROUND

Performance and Quality Improvement in Reproductive Health (PQI/RH) is not a new strategy. The initiative has been used in different countries in Africa with the aim of improving access to reproductive health services thereby reducing maternal and neonatal morbidity and mortality. Performance and Quality Improvement in Reproductive Health (PQI/RH) in Malawi dates back to 2006. According to Jhpiego report as cited by GTZ report 2009 the initiative was adopted in reproductive health after successful results in Performance and Quality Improvement in Infection prevention (PQI/IP). In 2006 PQI/RH was introduced in eight pilot districts of Balaka, Chikhwawa, Mangochi, Mulanje, Mzimba, Nkhotakota, Ntcheu and Ntchisi. In 2007 the initiative was extended to Chiradzulu, Machinga, Mchinji, Mwanza, Karonga and Rumphi. After progress was seen in the above districts, PQI/RH was taken to two districts hospitals of Dowa and Salima and to the four central hospitals, Kamuzu , Mzuzu, Queen Elizabeth and Zomba in 2008. Currently Mchinji, Mzuzu, Dowa hospitals have been accredited for performance quality improvement in reproductive health in 2009, 2010, and 2011 respectively.

Performance and Quality Improvement process uses Standard Based Management and Recognition, a system which starts with developing standards against which performance is to be measured. The standards show the provider and managers in detail not only what to do but also how to do it. The standards are included in an assessment tool that can be used for self, peer, internal and external assessment at the facility level. Application of the assessment tool leads to the identification of performance gaps that should be reduced or eliminated. This is the implementation stage. After implementation, there is monitoring of progress and rewarding of achievements made.

As already mentioned above PQI/RH was introduced at Queen Elizabeth Central Hospital (Q.E.C.H) in 2008. Q.E.C.H. is in southern region of Malawi and acts as a referral hospital for the southern region and district hospital for Blantyre. Chatinkha maternity unit is the main department offering reproductive health services at the hospital. In January, 2009 a base line assessment was conducted to measure performance against standards. The hospital got a score of 44%. In the first internal assessment done in March, 2009 the score was 51%. In the recent assessment that was done in August 2010, the hospital scored 64%. Though the scores seem to be rising, there are other departments that are not performing well since the introduction of the initiative. In the base line assessment labour and delivery and post natal wards scored 47% and 50% respectively. In the internal assessment the scores dropped to 40% and 35%. In the recent assessment there was a further drop to 14.3% and 25%. These scores have made the whole hospital to progress slowly towards achieving quality hence the need to explore factors hindering progress.

1.2 PROBLEM STATEMENT

Though standards have been developed to show providers what is expected of them to achieve quality in reproductive health services, little has been achieved in labour and postnatal wards at Queen Elizabeth Central Hospital. In all the assessments that have been done at the hospital labour and post natal wards have not shown any progress unlike other departments. Lack of progress in these departments has led the whole hospital to lag behind. The study wanted to establish from providers factors hindering progress in performance and quality improvement in reproductive health.

1.3 SIGNIFICANCE OF THE STUDY

The study results will help Quality Improvement Support Team (QIST), managers and providers to identify root causes that are hindering progress. The results will also help management to develop ways of supporting the initiative in the departments that are ragging behind. Finally, the results will motivate other researchers to conduct similar study in other hospitals that have not achieved quality.

1.4 BROAD OBJECTIVE

To explore factors hindering progress of Performance and Quality Improvement in Reproductive Health (PQI/RH) initiative in labour and postnatal wards at Q.E.C.H.

1.5 SPECIFIC OBJECTIVES

To assess knowledge of providers on PQI/RH.

To assess the availability of resources to implement PQI/RH

To identify challenges providers face to implement PQI/RH.

To identify roles of PQI/RH focal persons in the departments.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is an organized critique of the important scholarly literature that supports a study, and is a key step in the research process (Haber & Wood, 2006, p 79). According to Burns & Grove 2009, the purpose of the review is to convey to the reader what is currently known regarding the topic of interest. This section provides literature that is related to the topic of study.

In a study done by Choudhry 2005, there is evidence to prove that quality maternal care has a direct effect on maternal and neonatal mortality. A case control study of preventable and non-preventable perinatal deaths taking place between 1988 and 1991 at the National Institute of Perinatology in Mexico City suggested that the overall perinatal mortality rate of 24.8 per 1000 birth could have been reduced by 35% with better quality care and that 88% of the preventable deaths involved provider responsibility. In the same study by Choudhry, a review of evidence concerning maternal deaths attributable to service related factors at various levels of the referral system suggested that a substantial percentage of maternal deaths in more than 13 countries are due to inadequate supplies and equipment and poor client management.

In Malawi PQI/RH has started to show its impact on maternal and neonatal outcomes. According to JHPIEGO report 2009, Mchinji has been recognized as the centre of excellence in providing quality reproductive health services. At baseline in 2008 Mchinji District Hospital achieved only 34% of PQI/RH standards, and after only one year of dedicated implementation of PQI, the hospital achieved a final score of 89% in July 2009.

At Mchinji District Hospital, the improved performance by service providers in offering quality RH services is now making an important impact on patient outcomes. The number of women who are treated for eclampsia, for example, has doubled while the number of women treated for postpartum hemorrhage has increased by 25% since 2005. Most importantly, the proportion of obstetric deaths from women who had emergency obstetric complications, had decreased since 2006 from 7.5% to 6.1%.

In a related report by JHPIEGO in December 2009, Mzuzu Central Hospital has also shown successes in quality improvement in reproductive health services. As part of PQI/RH program, a baseline assessment of hospital reproductive health services was conducted against which improvements would be measured. Three months after that assessment, Mzuzu Central Hospital conducted an internal review to check their progress. The hospital met the standards in 74% of the target areas, an increase from 50% at baseline. In October 2009, a mere six months after the baseline assessment, the hospital achieved a score of 91%. The hospital's performance drew the attention of the Ministry of Health (MoH), and in December 2009, a MoH team arrived in Mzuzu

to conduct an independent review of the hospital's 12 maternal health service areas. In this external assessment the hospital scored 89% which qualified Mzuzu as a center of excellence in reproductive health service delivery.

The successes achieved by Mzuzu's staff as facilitated through JHPIEGO's SBM-R approach had a direct impact on saving women's lives. Maternal deaths from direct causes at the hospital fell from 2.5% in 2004 to 1.6% in 2009. There were improvements in early diagnosis and correct management of eclampsia and postpartum hemorrhage (PPH).

JHPIEGO (2011), reported that obstetric complications at Dowa District Hospital has reduced from 23.2% in 2008 prior to PQI/RH to 16% in 2010 after the initiation. The journey to recognition started in December 2008 when six members of Dowa's Quality Improvement Support Team were trained as quality improvement coaches for RH under the then USAID/ACCESS program. During a baseline assessment in January 2009, Dowa scored 39% of the RH standards that encompass 12 clinical and support service areas. These include Focused Antenatal Care, Management of normal and complicated Labor and Delivery and Postnatal Care of Women and Neonates, Family Planning, Post Abortion Care, Cervical Cancer Prevention Services, Management of Sexually Transmitted Infections, Support Services (laboratory, blood bank and Pharmacy), Information Education and Communication (IEC) Services and Management.

A mere three months after the baseline assessment was completed Dowa Hospital conducted an internal review to assess progress made and achieved a score of 63%. Inspired by the dramatic improvement in only 3 months another internal assessment followed in July 2009, and the hospitals achieved a score of 86%. In February 2010 Dowa District Hospital requested for an external verification by a team of assessors where Dowa achieved 90% of standards and qualified as a Center of Excellence in Reproductive Health service provision.

2.2 KNOWLEDGE AND PERFORMANCE AND QUALITY IMPROVEMENT

In a study done in Uganda by Agha in 2010, it shows that training or orientation has some impact on quality improvement though effectiveness is more when training is combined with management support. In the study 123 midwives out of 248 were trained in the use of the quality improvement tool. 5% did not use the tool after training. 111 who managed to use the tool indicated that their performance improved greatly when they received supportive supervision from their supervisors.

JHPIEGO in collaboration with the Division of Reproductive Health in Kenya conducted a study whose aim was to investigate qualities associated with clinics that consistently exceeded expectations and that come highly recommended as a source of reproductive health care. In the study it was found that two of the most important characteristics of these highly performing sites were the presence of a well trained and motivated staff and capable and dynamic leadership and

management (Reynolds et.al 2007). In response to the study findings, JHPIEGO developed a supportive supervision training package for performance improvement to be used on site, in charge supervisors in Kenya. After implementation of the package an evaluation was done to see the effectiveness. In this evaluation two groups were used, supervisors and providers who were trained and a control group of supervisors and providers who were not trained. The results indicated that supervisors in the training group new significantly more techniques than supervisors in the control group to motivate staff and to communicate their expectations to staff. The supervisors gave examples of techniques they used to assess performance such as obtaining client feedback, obtaining client satisfaction data, seeking general impression from staff, observing skills and relying on service statistics. To motivate staff, supervisors included staff parties, time off, financial benefits, awards or certificates. They also held meetings, had one on one conversation with staff to improve performance.

The results also showed that providers in the training group had good interaction with clients than the control group. Providers in the training group were significantly more likely than the control group to improve communication techniques and respect confidentiality although these were post test measure only. It was observed that providers in the training group were able to tell clients about their treatment, dosage and side effects. In the sites where providers were trained in PQI, clients reported of the satisfaction they got from the services provided.

On the initiation of PQI/RH at Q.E.C.H providers were oriented / trained on the programme. Statistics have shown that 132 personnel were oriented. The table below shows the cadres that were oriented.

NURSES	CLINICIANS/DOCTORS	LABORATORY/PHARMACY TECHNICIANS	SUPPORT STAFF
64	2	6	60

Currently there are 60 nurse midwives in the department. Out of the 64 nurses that were trained 25 moved out of the department. Some went to school, others have gone to work in health centres under Blantyre District Health Office while others have retired from service.

2.3 CHALLENGES FACED IN PERFORMANCE AND QUALITY IMPROVEMENT.

Kerr and Fleming (2007), in their study on measuring quality through performance found that health care organizations have to confront the challenge of how to provide high quality care within a fixed budget. This was observed by the Veteran Health Administration which provides

care to over 5 million people within the largest integrated healthcare system in the United States as it was struggling to overcome a reputation for providing inferior and inefficient healthcare.

A study by Al-Qutab, Mawajdel, Nawar, Saidi and Raad (2001) in Jordan on assessing the quality of reproductive health services found that managers were not aware of the work load of the midwives in terms of number of pregnant women they see per unit time and the amount of resources to provide quality care. The study showed that high workload and inadequate resources compromised quality of care provided by the midwives. In the same study the researchers have reported of another challenge faced by providers in Egypt. Providers who were trained in performance and quality improvement thought that the process was more theoretical than practical. The study also indicates that lack of knowledge is another challenge in quality improvement. 74% of managers that participated in the study believed that providers who did not have training had problems to give appropriate health talks according to set standards.

According to Zulu and Chalanda, (1999) providers in Malawi have failed to adhere to quality improvement protocols in infection prevention due to lack of guidelines that they can follow. The study has also shown that where protocols exist, lack of enforcement by hospital authorities results in poor adherence to standards. Another challenge that the study indicate in adhering to standards in infection prevention is lack of resources. Chalanda and Zulu reports that there is perpetual lack of equipment and materials for basic aseptic techniques which is essential for provision of quality care.

2.4 IMPORTANCE OF RESOURCES IN PERFORMANCE AND QUALITY IMPROVEMENT

Resources are very important in implementing quality care. According to Werner, Koistand, Staurt, Polsky (2003) in their study on effect of pay for performance in hospitals found that hospitals can not achieve quality if they do not have resources despite the availability of incentives for staff. In the study quality performance was observed when adequate resources were available that is both human and material resources.

According to Zulu and Chalanda (1999), resources have been found to be essential in quality achievement in infection prevention and control practices as mentioned above. In their study providers failed to adhere to infection prevention standards due to lack of equipment and material resources.

2.5 AVAILABILITY OF A FOCAL PERSON OR SUPPORTIVE SUPERVISION AND QUALITY IMPROVEMENT

Reynolds (2007), found that supervisors have an important role to play to improve quality of reproductive health services. According to this study which was done jointly with JHPIEGO, results showed that supervisors can affect the quality by effectively managing existing resources, facilitating communication and feedback within a facility. Reynolds indicated that supervisors affect provider performance by improving provider motivation, promoting training opportunities and holding providers accountable for the quality of their services. Supportive supervision was seen to be effective since providers and supervisors engage in a two way communication and seek joint solutions to problems.

In the same study a report was done on quality of post abortion care services in Burkina Faso and Guinea. The services have expanded and improved due to continued support by management. On baseline assessment two teaching hospitals in Burkina Faso each met 355 while those in Guinea met 25% and 21%. After proper analysis of performance gaps and action plan to remedy the gaps were developed and implemented. Sites in both countries showed immediate improvement through recognition and implementation actions that required no external assistance. Follow up assessments three months later revealed improvement with facilities scoring 68% and 65% overall in Burkina Faso. In the next assessment the facilities achieved recognition by scoring more than 85%. Data collected in the facilities showed that over the past 5 years from 1998 to 2002 there is a greatly increased access to high quality post abortion care services. The average annual percentage of manual vacuum aspiration clients counseled about family planning for each of the five years at these two hospitals is extremely increasing between 91% and 100% and these levels are being sustained over time.

In Uganda a study was done to assess the impact of quality improvement on reproductive health services delivered by private providers. In this study done by Agha 2010, findings indicated that 85% of midwives improved in their performance with support from their supervisors.

Another study by Hungton et.al 2010 revealed that incentives given to providers had an impact on the quality of reproductive and child health services. This was a case control, quas experimental study in Egypt designed to investigate the effect of a performance based incentive payment scheme on behaviors of public sector service providers in delivering a basic package of maternal and child health services. The study showed significant improvements in the quality of family planning, antenatal care and child care services as reported by women seen in clinics where incentive payment scheme was introduced. In Menoufia clinic where incentives were introduced results showed that family planning clients had a complete history taken, asked about the date of menstrual cycle, previous contraceptive use and history of past illness among other indicators. Out of 116 women who attended the incentive scheme clinics 80.2% had complete history taken while 68.9% 0f the 61 clients had a complete history taken in the non incentive

On the child care services, results showed positive effects on the quality of child healthcare services which made more women to attend these clinics. The incentive scheme had an impact on the behavior of providers who were significantly less likely than colleagues in the non incentive scheme clinics to prescribe unnecessary medicines. They were more likely to take full history and record it in medical file and to ask clients if they had any questions and encourage them to return for follow up visit.

Apart from supportive supervision, benchmarking and collaboration have shown to be effective in improving quality of services. In Tanzania a partnership for quality improvement was adopted in 2007 with the aim of improving Anti retroviral therapy and prevention of mother to child transmission (ART/PMTCT) services. In the initiative the Healthcare Improvement Project (HCI) and PharmAccess International (PAI) were providing technical leadership to facilitate shared learning among ART/PMTCT collaborative managed by implementing partners and regional health management teams in Tanga, Morogoro, Mtwara and Lindi. In the partnership teams were learning from successes from one team and implemented the issues in their teams. An evaluation was conducted in 2010 to see the effectiveness of the initiative. A cross-sectional evaluation which involved both quantitative and qualitative methods was done. Results showed that sharing ideas had an impact on the quality improvement. Across the region, the majority of ideas were borrowed from other teams, managers and coaches. Tanga and Morogoro had borrowed almost 70% of the ideas while Mtwara had 40% of the ideas borrowed. Teams attributed the quality improvement to the ideas gained from other teams (Wittcoff et. al, 2010)

Franco et.al (2010), did a similar study in Benin, Bolivia, Ecuador and Guatamala to improve family planning, malaria, maternal, newborn and child health and tuberculosis services. A collaborative improvement was adopted with the aim of improving health outcomes and compliance with health standards and to produce rapid significant improvement in targeted area of healthcare. The results showed achievements by over 1300 teams of healthcare providers who participated in the 27 improvement collaborative. There was improvement in compliance to health standards and health outcomes across all care areas addressed regardless of the baseline level of quality. Of the 135 analyzed time series data, 88% attained performance level of at least 80% and 76% reached at least 90% even though more than half had baseline level at 50% Or below. The data provide compelling evidence that collaborative improvement can achieve large increases in performance, regardless of baseline level and results can be achieved relatively rapidly. Teams reached performance levels of 80% in about 13 months on average when baseline levels were below 50% and in about 6 months when baseline were above 50%. The analysis also suggested that moving beyond 80.5% performance requires different efforts.

2.6 SUMMARY OF LITERATURE REVIEW

From literature review it has shown that knowledge on performance and quality improvement makes providers to adhere to standards though adherence is more when there is supportive supervision. Supervisors play a great role by explaining to providers what is expected of them as well as motivating them to work towards achieving quality. It has also shown that quality improvement needs adequate resources. There is need to have both human and material resources for performance and quality improvement to be achieved. In the course of achieving quality performance both managers and providers meet challenges. For example, there are budget constraints as well as work overload on providers.

CHAPTER THREE

3.0 THEORETICAL FRAMEWORK

3.1 INTRODUCTION

A theoretical framework is a structure of assumptions, principles and rules that holds together the ideas comprising a broad concept. It is a creative way of looking at the world or an aspect of it to describe, explain, predict, or control it (George 2010). This dissertation is influenced by the transtheoretical stages of change model.

3.2 DESCRIPTION OF THE MODEL

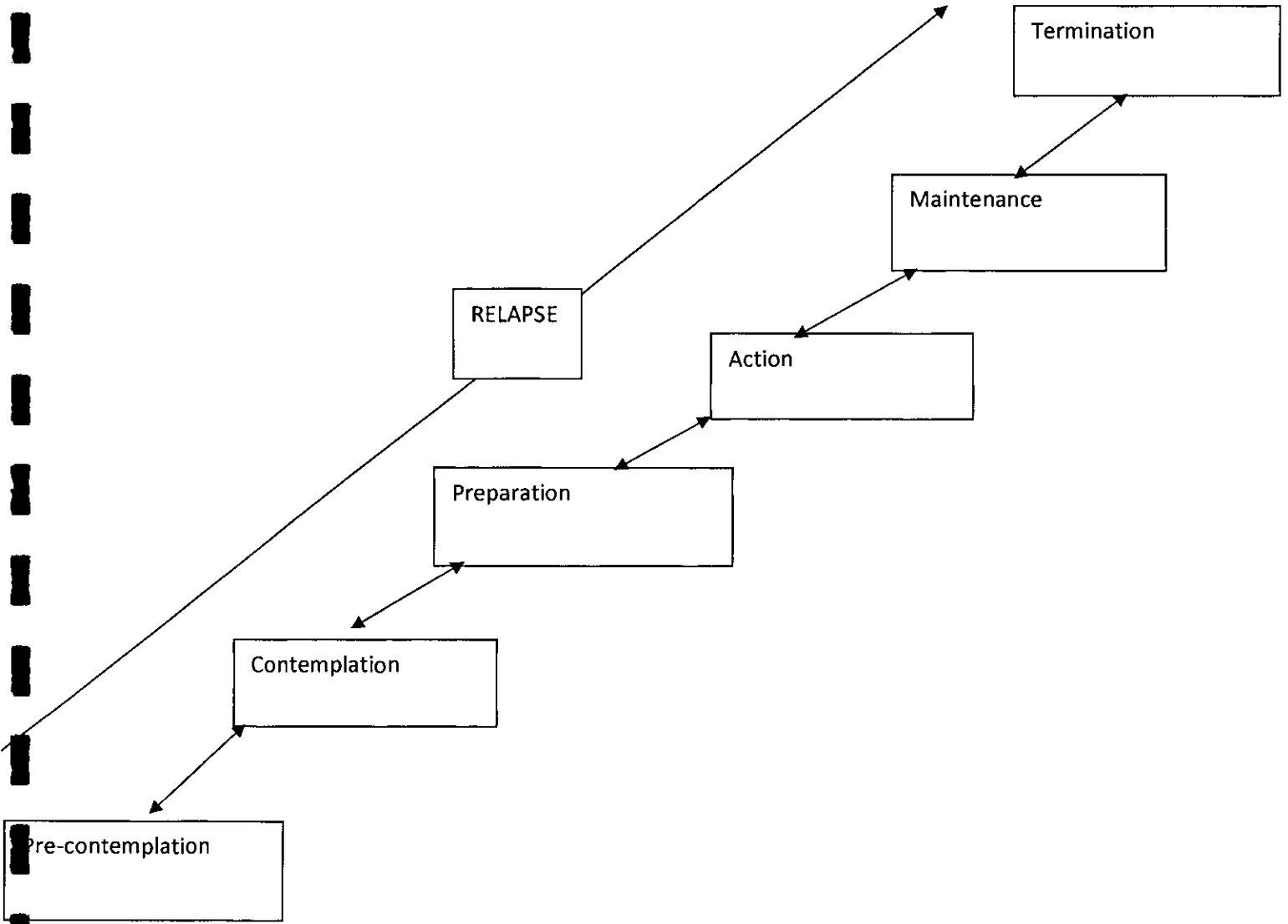
Prochaska introduced the change model as a framework to identify an individual's readiness to change behavior. The basic premise of the stages of the change model is that human behavior change is a process, with individuals at varying levels of motivation or readiness for change (Glanz 1997 as cited by Porche, 2004). The model accepts that individuals relapse in their behavior and recycle through previous stages of change. The model has six stages of change namely; pre-contemplation, contemplation, preparation or determination, action, maintenance and termination.

Individuals who are unaware of a health risk or problem and have no intention to change within six months are in the pre-contemplation stage of change. Individuals who are aware of the importance of the behavior change and intend to change in the next six months are in the contemplation stage. Those in preparation or determination stage have a plan of action for behavior change. Once the overt behavior modifications have taken place, the individual is considered to be in the action phase. The maintenance stage of behavior is not achieved until the individual has modified his/her behavior. In this stage the goal is to prevent relapse. Termination is the last stage in which the individual has no temptation to repeat the previous unhealthy behavior. As an individual progress through the stages of change, a decisional balance occurs after weighing the pros and cons of behavior change. The pros are instrumental gain to self, instrumental gain for others, approval of self and approval from others. The four categories of cons are instrumental cost for self, instrumental cost for others, disapproval from self and disapproval from others (Prochaska et.al. 2002 as cited by Porche, 2004).

The six stages of change are facilitated by ten processes of change. These are covert or overt actions or interventions that assist an individual to achieve behavior modification. The processes are consciousness raising, dramatic relief, self–reevaluation, environmental reevaluation, self-liberation, helping relationships, counterconditioning, contingency management, stimulus control and social liberation. Consciousness raising is an increase in awareness through facts and ideas that support behavior change. Dramatic relief is experiencing negative emotions associated with unhealthy behavior risks .Self –reevaluation is a cognitive or affective assessment of one's self

image. Environmental reevaluation is the cognitive or affective assessment of how ones environment affects health while self-liberation is the belief that one can change and the commitment to act on that belief. Helping relationships are social support for healthy behaviors while counterconditioning is learning healthy behaviors that substitute for unhealthy behaviors. Contingency management is a process of increasing rewards for healthy behavior and decreasing rewards for unhealthy behavior. In stimulus control, there is removal of reminders or cues to engage in unhealthy behavior and add cues that remind of healthy behavior. Finally, social liberation is the realization of social norms that support healthy behaviors.

3.3 DIAGRAMATIC REPRESENTATION OF THE TRANSTHEORETCAL STAGES OF CHANGE MODEL



Transtheoretical stages of Change (Porche 2004, p54).

3.4 APPLICATION OF THE MODEL TO THE STUDY.

PQI/RH has been introduced to improve access and quality of RH services thereby reducing maternal and neonatal morbidity and mortality. Standards have been developed to guide performance of service providers. There is need for providers to unlearn the old way of doing things and adopt what is stipulated in the standards. This requires a change process that providers have to go through in order to perform according to the standards if quality is to be achieved.

According to the transtheoretical stages of change, providers need to know why PQI/RH has been introduced and the need to perform according to the set standards. They need to realize how important their performance can affect quality. As providers go through the change process, they require support at different levels for sustainability of the new behavior.

CHAPTER FOUR

4.0 METHODOLOGY

4.1 INTRODUCTION

This chapter discusses the study design, setting, sampling, data collection, data analysis and presentation, reliability of results, ethical consideration, limitations and dissemination of results.

4.2 STUDY DESIGN

A design is a blueprint for conducting a study. It maximizes the researchers control over factors that could interfere with the validity of the findings (Burns & Grove, 2009). The study design was quantitative descriptive. Descriptive study designs are crafted to gain more information about characteristics within a particular field study. Their purpose is to provide a picture of situations as they happen (Burns & Grove, 2009). The researcher wanted to establish factors that are hindering progress in performance and quality improvement in reproductive health in labour and postnatal wards at Q.E.CH.

4.3 SETTING

The study was conducted at Q.EC.H in the reproductive health department. The department was chosen because PQI/RH initiative was introduced in the department in 2008. The other reason is that since the initiation of the program, data has shown that there is no progress to achieve quality performance especially in labour and postnatal wards.

4.4 SAMPLING

Haber & Wood (2006), defines sampling as the process of selecting representative units of a population for a study in a research investigation. Providers from the reproductive department formed a sample for the study with a large number of them drawn from labour and postnatal wards. The sample was drawn using purposive sampling methods. Streubert and Carpenter (1999) as cited by Rees 2003, states that using this method the researcher includes individuals or events on the basis of the researcher's knowledge of their relevance for the study. Although this seem to produce biased sample, the advantage of the method is that the sample is known to possess key characteristics felt should be included in the study.

4.5 DATA COLLECTION

According to Burns & Grove (2009), data collection is a precise, systematic gathering of information relevant to the research purpose or specific objectives of the study. Face to face interviews were done to collect data using a semi structured questionnaire. The questionnaire was prepared in English and the researcher administered it to collect data from participants.

Polit & Beck (2008), states that face to face interviews help to build rapport and clarification of questions by the researcher. This will be good because it ensures that appropriate data is collected.

4.6 DATA ANALYSIS AND PRESENTATION

Burns & Grove (2009), defines data analysis as a process of evaluating and organizing data to answer the research question. Data collected from questionnaires was analyzed manually and has been using pie charts, tables and in description form.

4.7 RELIABILITY OF RESULTS

To ensure reliability of results, the questionnaire was piloted at Chiradzulu District Hospital.The site was chosen because it is implementing PQI/RH initiative. From the pilot study some questions were revisited. Refer to appendices I & J.

4.8 ETHICAL CONSIDERATION

According to Burns & Grove (2009), research requires not only expertise and diligence but also honesty and integrity. Conducting research ethically stars with the identification of the study topic and continues through the publication of the study. The researcher sought permission from the Research Committee at Kamuzu College of Nursing for a go ahead in the study. Consent was also sought from relevant stakeholders namely; the Director, Queen Elizabeth Central Hospital, the District Health Officer, Chiradzulu district hospital as well as from participants. Participants read and signed a consent form before participation in the study. To ensure confidentiality, names of participants were not used instead code numbers were used. Participants were also assured that information provided will not be shared with parties not interested in the study. Refer to appendices E,F,G,H,I & J.

4.9 LIMITATION TO THE STUDY

Findings from the study will not be generalized because the study sample was small (n=30). The study was not at national level. The results give a reflection of Q.E.C.H not other hospitals who are implementing PQI/RH program.

4.10 DISSEMINATION OF RESULTS

A report of the study has been complied a copy of the dissertation have been submitted to Kamuzu College of Nursing since this study is an academic requirement for the course the researcher was undertaking. Other copies have been made to Queen Elizabeth Central Hospital management team and the management of maternity unit since they are responsible for decision making and overseeing processes in the unit.

CHAPTER FIVE

5.0 PRESENTATION OF FINDINGS

This chapter presents the findings on factors that are hindering progress in performance and quality improvement in reproductive health at QECH (labour and postnatal wards). Information was collected from 30 participants from the reproductive health departments and support services (laboratory and pharmacy). The data has been analyzed manually and is presented using charts, tables, graphs as well as in descriptive form.

5.1 DEMOGRAPHIC INFORMATION

This section presents the sample characteristics in relation to the participants age and sex.

5.1.1 AGE OF PARTICIPANTS

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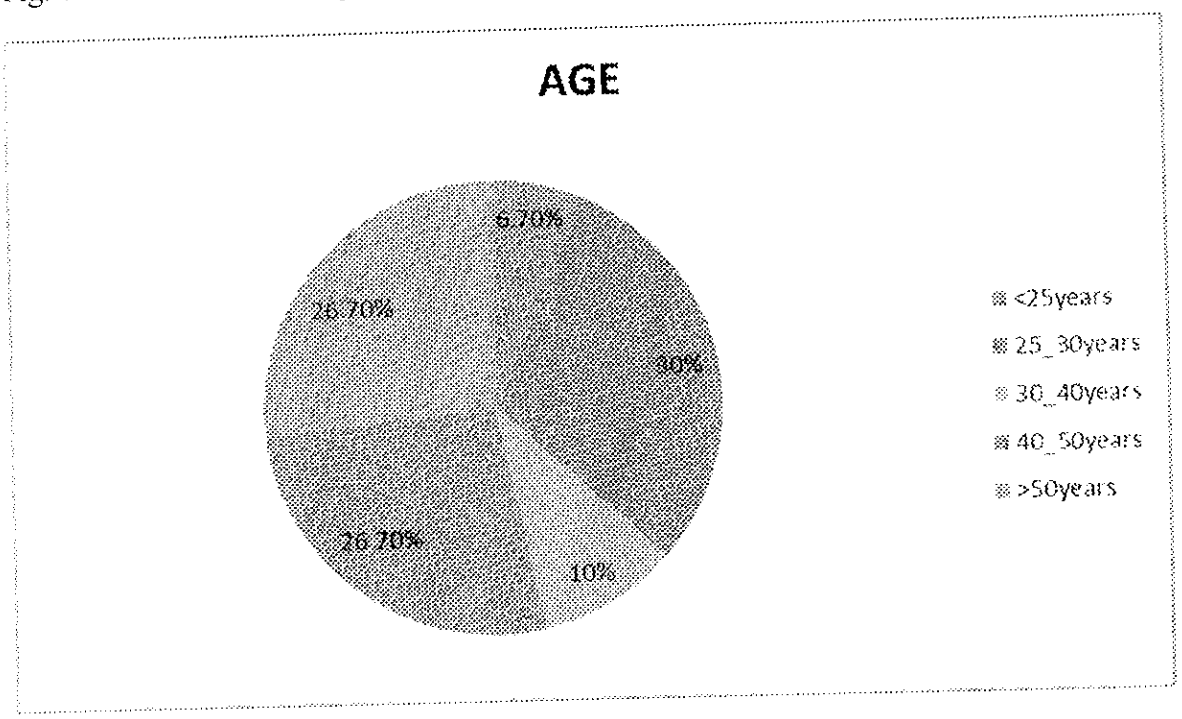
5.1.1 AGE OF PARTICIPANTS

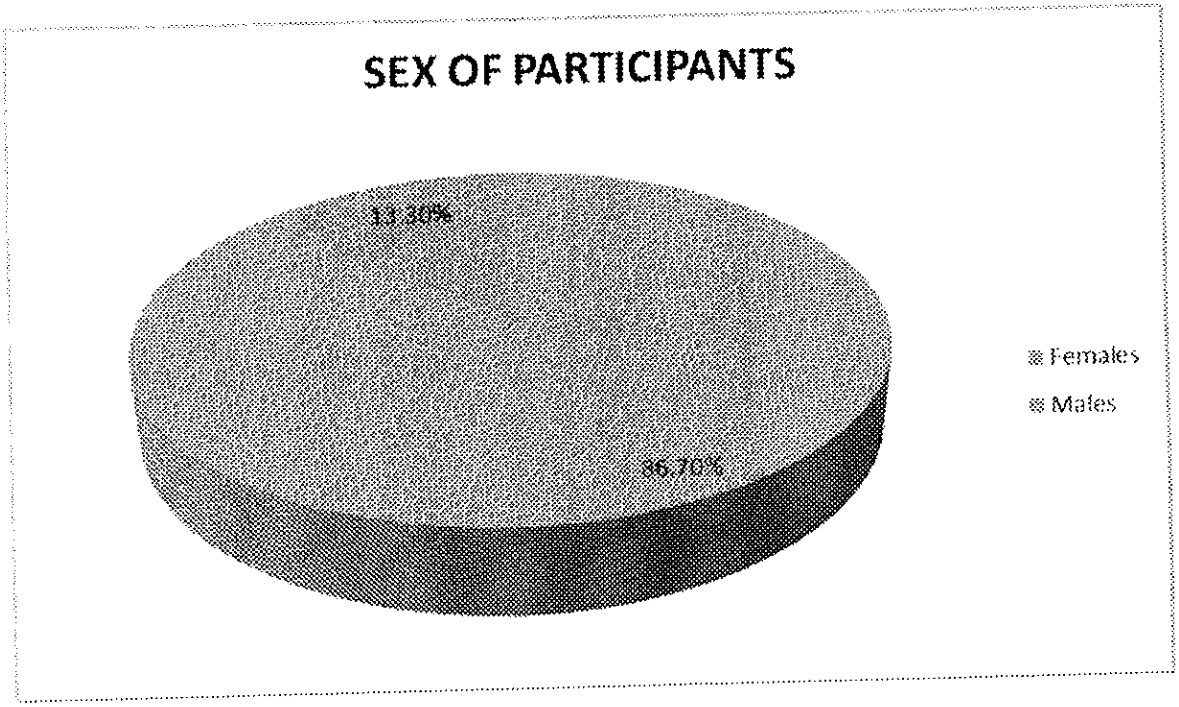
Fig. 1 A Pie chart showing age of participants



The majority of participants were in the age group of 25 -30 years representing 30% (n=9), followed by the age range of 40-50years and >50years which was 26.7% (n=8) respectively then those in the age group of 30- 40 years 10% (n=3) and finally those < 25 years which was 6.7% (n=2).

5.1.2 SEX OF PARTICIPANTS

Fig 2. A pie chart showing the percentages of participants as regards sex.



The majority of the participants were females representing 86.7% (n=26) of the total sample while 13.3% were males (n=4).

5.2 PROFESSIONAL INFORMATION

This part presents the professional cadre, qualification of participants and period they have worked in the department.

Fig 3. A table showing the professional cadre and qualification of participants

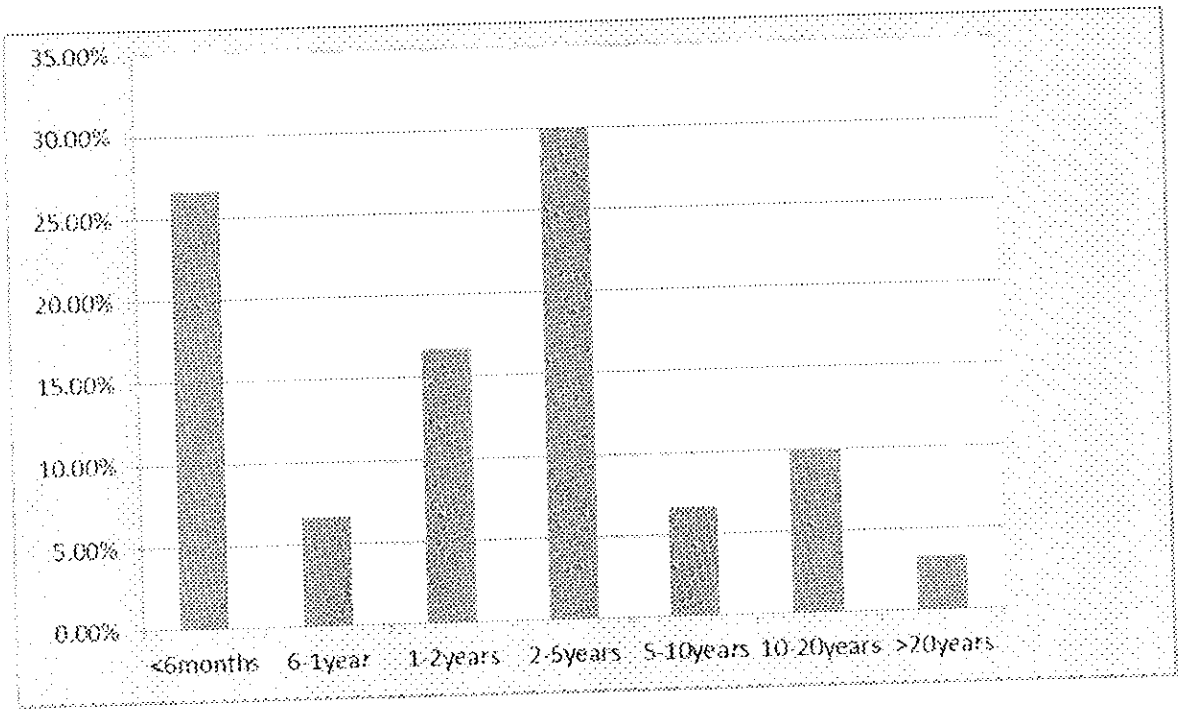
PROFESSIONAL CADRE	PROFESSIONAL QUALIFICATION	FREQUENCY (N=30)	PERCENTAGE %
Enrolled Nurse Midwife (ENM)	Certificate	14	46.7%
Nurse Midwife Technician (NMT)	Diploma	10	33.3%
Registered Nurse Midwife (RNM)	Degree	3	10%
Laboratory Technologist	Degree	2	6.7%
Pharmacy Technician	Diploma	1	3.3%

A Table showing the professional cadre and qualification of participants.

The majority of participants were Enrolled Nurse Midwives (ENM) who made 46.7% of the sample (n=14). Nurse Midwife Technicians (NMT) came second (n=10) representing 33.3% of the total sample. Thirdly were Registered Nurse Midwives making 10% of the sample (n=3) followed by Laboratory Technologist who formed 6.7% of the sample (n=2). Finally, pharmacy technician (n=1) making 3.3% of the sample.

5.3 PERIOD PARTICIPANTS HAVE WORKED IN THE DEPARTMENT

Fig 4. A bar graph showing length of period participants have worked in the department.



A bar graph showing how long participants have worked in their various wards/departments

26.7% of the participants (n=8) had worked < 6months in their department, 6.7% (n=2) had worked between 6months to 1 year, 16.7% (n=5) had worked between 1to 2 years, 30% (n=9) between 2 to 5 years, 6.7% (n=2) had worked between 5 to 10 years, 10% (n=3) between 10 to 20 years and 3.3% (n=1) had worked more than 20 years.

5.4 KNOWLEDGE ON PERFORMANCE AND QUALITY IMPROVEMENT IN REPRODUCTIVE HEALTH (PQI/RH)

When participants were asked if they had heard anything about PQI/RH, 73.3% (n=22) said had heard about PQI/RH while 26.7% (n=8) did not. Those that had heard about PQI/RH were further asked on how the knew PQI/RH. The study has shown that providers knew PQI/RH from different sources. Below is the table showing how the participants knew PQI/RH initiative.

Fig 5 - A table showing how participants knew about PQI/RH

TRAINED	FROM SCHOOL	FROM COLLEAGUES	ON PLACEMENT TO THE WARD	NO KNOWLEDGE ON PQI/RH
10	4	5	3	8

The data shows that only 33.3% (n=10) were trained on PQI/RH while the remaining percentage 66.7% (n=20) did not have a formal training on PQI/RH. Out of the 20 participants who were not trained, 20% (n=4) knew about PQI/RH from school, 25% (n= 5) heard from colleagues, 15% (n=3) on placement to the ward while 40% (n=8) had no knowledge on PQI/RH.

When asked to give reasons why PQI/RH was introduced, 80% (n=24) were able to give some reasons why PQI/RH was introduced. Although only 22 participants had heard about PQI/RH as mentioned above, 2 participants who were among those who said they did not know anything about PQI/RH gave views on reasons for initiating PQI/RH out of their own understanding of the word PQI/RH. Out of the 24 who gave some reasons for the introduction of PQI/RH, 37.5% (n=9) said it was introduced to improve performance of providers, another 37.5% (n=9) mentioned to reduce maternal and neonatal mortality. 20.8% (n=5) said PQI/RH was introduced to reduce complications while 4.2% (n=1) said it was introduced to improve access to reproductive health services.

When asked whether they know what is assessed during PQI/RH assessments, 56.7% (n=17) of the sample said they know what is assessed while 43.3% (n=13) did not know what is assessed. Most of the participants who said they knew what is assessed during PQI/RH assessments said what is assessed is similar to what is assessed in infection prevention assessment. Of the 17 participants who said they know what is assessed, 64.7% (n=11) mentioned procedures, 23.5% (n=4) mentioned infection prevention practices while 11.8% (n=2) said assessment is on availability of resources. None of the providers were able to mention attitude of providers, documentation of care, quality of care provided, management support and information education and communication. Those that did not know what is assessed (n=13) attributed their lack of knowledge to lack of orientation or training on PQI/RH.

Providers were asked whether they had seen the tools /RH standards. Out of the 30 providers interviewed, 40% (n=12) had seen the tools /standards that are used to assess performance while 60% (n=18) had not seen the standards. Of the 12 who had seen the standards, only 7 had used

the tool to assess their performance against the set standards. The 5 participants who had not used the tool to assess their performance, 3 said they had no time to use the tool while 2 said did not know how to use the tool to assess their performance. The 60% (n=18) who had not seen the tools said they had no access to the tools and doubted if their wards/departments had a copy of the standards. During the study the interviewer had seen the RH standards in Labour ward, Antenatal clinic and Family planning clinic. Management reported that each ward was provided with RH standards at the initiation of the programme.

Below is a table showing participants' use and accessibility to RH standards.

Fig- 6 Use and access to RH standards

SEEN THE TOOLS	NOT SEEN THE TOOL	USED THE TOOLS	NOT USED THE TOOLS
40% (N=12)	60% (N=18)	7 (58.3% of participants who had seen the tools)	5 (41.7% of participants who had seen the tools)

5.5 AVAILABILITY OF RESOURCES TO IMPLEMENT PQI/RH

When the participants were asked if they have necessary resources for the implementation of PQI/RH, 60 % (n=18) said they have the resources while 40% (n=12) said they do not have the necessary resources for the implementation of PQI/RH. The 60% who said have necessary resources, mentioned material resources as the ones available for the implementation of PQI/RH.

Of the 18 participants only 33.3% (n=6) said have constant supply of the resources while 66.7% (n=12) said sometimes the resources are out of stock. When asked what resources should be available for easy implementation of the initiative, 63.3% (n=19) of the total sample suggested material resources, 16.7% (n=5) suggested material resources, human resources and drugs, 13.3% (n=4) suggested human resources and 6.7% (n=2) mentioned drugs only. Providers said lack of resources make them not to follow RH standards. Vital signs are not checked due to lack of vital signs equipment. Providers tend to improvise materials for doing procedures which is not in line with what the standards require of them. Providers said quality can not be achieved if resources are not adequate or not in constant supply.

5.6 CHALLENGES FACED IN IMLEMENTATION OF PQI/RH

When the participants were asked if they have met challenges in the implementation of PQI/RH, 93.3% of providers (n=28) had faced challenges in the implementation of PQI/RH, 3.3% (n=1)

had not faced challenges and the remaining 3.3% (n=1) said was not sure because had no knowledge of what PQI/RH is about.

Of the 28 participants who had faced challenges, 42.9% (n=12) mentioned human resources as a challenge, 39.3% (n=11) mentioned material resources, 10.7% (n=3) said lack of knowledge while 7.1% (n= 2) all of the above as challenges met in the implementation of PQI/RH. Participants who faced challenges on human resources said the department has high work load. Inadequate numbers of staff make them not to follow what the standards require them to do. For example providers said a midwife can have 6 labouring women to admit at a time or 30 post natal mothers who need post natal checks. To ensure that clients receive minimum care on time providers opt not to do systematic assessments as stipulated in the standards. This makes them feel that to achieve quality there is need to have adequate staff without which no progress will be made. Providers mentioned that inadequate human and material resources and lack of knowledge on PQI/RH are making the initiative to lag behind.

All the 93.3% (n=28), said that the challenges were existing at the time of interview. Out of the 28 participants who had met challenges in the implementation of PQI/RH, 96.4% (n=27) said that the problems were reported to management while 3.6% (n=1) was not sure if management was aware of the challenges or not.

Of the 27 participants who said a report was given to management on the challenges faced, 70.4% (n=19) said nothing was done to solve the challenges while 29.6% (n=8) said that resources were provided to deal away with the problems. Those who had met challenges (n=28), gave the following suggestions as means that will solve the challenges. 42.8% (n=12) suggested increase in human resources in the departments, 28.6% (n=8) said constant supply of material resources, 14.3% (n=4) suggested training of providers in PQI/RH while the remaining 14.3% (n=4) mentioned all of the above as solutions to challenges met. Participants said management had financial problems while others said that priority on resource allocation is not made to RH departments hence persistence of challenges.

5.7 IMPORTANCE OF FOCAL PERSONS IN THE IMPLEMENTATION OF PQI/RH

When participants were asked if they have a focal person for PQI/RH in their departments, 33.3% (n=10) said have a focal person in their departments, 40% (n=12) said have no focal person while 26.7% (n=8) had no idea on whether they have a focal person or not.

Of the 10 participants who said have a focal person, 60% (n =6) mentioned that the focal person remind them on the reproductive health standards, 20% (n=2) said the focal person reports problems to management, 10% (n=1) said the focal person is responsible for training staff on PQI/RH while the remaining10% (n=1) did not have knowledge on what the focal person does.

Those that had no focal person and had no idea if their department had a focal person (n=20) explained that it was necessary to have a focal person in their departments. 50% (n=10) said the focal person will be supervising to see that standards are followed, 20% (n=4) said the focal person will orient staff to standards. Another 20% (n=4) said the focal person will channel problems to management while 10% (n=2) said the focal person will facilitate achievement of quality performance.

CHAPTER SIX

6.0 DISCUSSION OF FINDINGS

6.1 INTRODUCTION

This chapter aims at discussing findings from the study. The discussion includes demographic data, professional information, knowledge about PQI/RH, availability of resources, challenges met in implementing PQI/RH and importance of having a focal person.

6.2 DESCRIPTION OF DEMOGRAPHIC DATA

The study findings have shown that demographic data which includes age and sex have no much significant in the study. Finding on age just signifies that a lot of providers are adults and can make decisions that positively influence the achievement of quality performance in the department.

6.3 PROFESSIONAL INFORMATION

Professional information has shown that 90% of providers were nurse midwives while 10% were from support services laboratory and pharmacy (Refer to figure 3).This indicates that providers in the department have a pre-service education on reproductive health services. The knowledge providers have can facilitate achievement of quality performance if most of the providers had an in service training or orientation on PQI/RH. The study has shown that only 10 providers out of 30 participants had an in service training on PQI/RH. According to Porche (2004), people change behavior when they understand the reason why. If given the necessary information about PQI/RH, it will be easy for providers to adopt the new behavior expected in their work performance. There is need for continued support throughout the process.

The results have shown that 26.7% of the participants have worked in the reproductive department less than 6months while the rest have worked in the department between 6months to 20 years. If providers who have worked in the department for long had the necessary knowledge, they would have been used to mentor, supervise and orient new staff deployed in the department on PQI/RH.

6.4 KNOWLEDGE ON PERFORMANCE AND QUALITY IMPROVEMENT IN REPRODUCTIVE HEALTH (PQI/RH)

The findings from the study showed that 73.3 % of participants had heard about PQI/RH while 26.7% did not. The knowledge about PQI/RH was form training, pre-service education and colleagues Data has also shown that out of the 30 participants, only 33.3% had in service training while 66.7% did not. Though at the start of the initiative many providers were trained it shows that due to transfers, school and retirement most of them have moved out of the department. The

report from Q.E.C.H indicated that 64 nurse midwives were trained and 25 of them have moved out of the department. According to findings from the study, a bigger percentage of providers currently working in the department are not trained on PQI/RH. Lack of trained providers can affect the achievement of quality performance negatively. These providers will not be practicing according to set standards hence quality will not be achieved. From the study findings some participants indicated that lack of knowledge was one of the challenges hindering quality improvement. According to the study done by Agha (2010) training or orientation to performance and quality improvement is essential if quality is to be achieved. There is need for all providers in the department to have a formal training or orientation to PQI/RH. In the study by Agha (2010) providers were able to achieve quality performance because of the training they had as well as the supportive supervision they received from managers. Due to lack of training providers have different views on why PQI/RH was introduced as well as what is assessed during PQI/RH assessments. Though 80% of all participants were able to give reasons on why PQI/RH was introduced, the reasons were different. Similarly on the knowledge of what is assessed during PQI/RH assessments, diverse reasons were given. Performance and quality improvement in reproductive health standards require all providers to perform according to set standards hence the need for an orientation or training that will form a common ground for all. In the same study done by Agha (2010), emphasis has been made that knowledge on performance and quality improvement can change perception of providers on aspects of service provision which they feel are not a priority. In a study done by Reynolds et.al (2007), findings have also shown that qualities of clinics that achieved quality performance were the presence of well trained and motivated staff.

The findings have also shown that the majority of providers (60%) have not seen the standards which stipulate the required performance and only 7 have used the tools to assess their performance against set standards. During data collection standards were seen in labour ward, antenatal and family planning clinics. Management had also reported that each ward was provided with the standards at the time PQI/RH was initiated. Though this is the case, providers said had no access to the standards. This can be a contributing factor to why providers have no knowledge on PQI/RH and what it involves. When providers have access to information they can use it to inform their practice Access to information is another way one can learn without having formal training. The standards are part of management tools hence the need to be communicated and made available to staff as is done with procedure manuals in nursing practice. When the standards are made accessible, providers will have knowledge of what is required of them as well as using the tools to assess their performance. According to JHPIEGO (2010), the standards not only show the provider what to do but also how to do it hence very essential to be readily available to all providers. The standards are meant for self, peer, internal and external assessment. Keeping the tools accessible to providers will help to achieve the intended objective.

6.5 AVAILABILITY OF RESOURCES TO IMPLEMENT PQI/RH

The findings have shown that 60% of participants have necessary resources for implementation for implementation of PQI/RH though the resources are not in constant supply. All participants, those who said have resources and those who said had no resources for implementation of the initiative, suggested that constant supply of material resources and availability of human resources can help in achievement of quality performance. Participants lamented most of the times they improvise in order to carry out procedures. Some providers said that essential assessments such as vital signs monitoring are not done due to lack of vital signs equipment. Inadequate resources can hinder achievement of quality performance. This is in line with findings from a study done by Werner, Koistand, Staurt & Polsky (2003), which showed that hospitals that had inadequate resources failed to achieve quality performance despite availability of incentives for staff. Availability of resources has an impact in achieving quality performance. In a related study by Zulu and Chalanda (1999) on infection prevention practices in hospitals of Malawi, it was discovered that resources were essential in quality achievement in infection prevention and control practices. The study showed that providers failed to adhere to infection prevention standards due to lack of material resources. In Malawi, PQI/RH was introduced after progress was seen in performance and quality improvement in infection prevention (PQI/IP). In hospitals where resources have been available achievement of quality improvement has been easy. This shows that availability of resources can facilitate achievement of quality in reproductive health.

6.6 CHALLENGES FACED IN IMLEMENTATION OF PQI/RH

The findings from study have shown that 93.3% the participants have met challenges in the implementation of quality improvement in reproductive health. The challenges include shortage of human and material resources and lack of knowledge on performance and quality improvement in reproductive health. Providers reported that due to workload it is difficult for them to follow what the RH standards require them to do. Examples were given on situations where one midwife is supposed to attend to 6 labouring women in the admission room or 30 postnatal mothers. Providers said that systematic assessments are not done in these situations and due to continued high workload, the standards are neglected. To effectively implement and achieve quality, there is need for adequate human and material resources as well as knowledge as already mentioned above.

The findings have also indicated that much of the problems were reported to management. Though a report was given to management, 70.4% said nothing was done to deal away with the current challenges. Providers said that management was facing financial problems that made it not to meet the demands for the wards. Some felt that priority in resources allocation was not made to the department. These could be some of the factors hindering achievement of quality performance. When providers report to management problems faced in performing work, an

expectation is that something will be done. If nothing is done providers' morale for work is decrease hence affect quality performance. According to Kerr and Fleming's study(2007), hospitals have to confront the challenge of how to provide quality care within a fixed budget. There is need for commitment from managers to ensure that challenges faced by providers are dealt with accordingly within the limited budget. It is also good that most of the challenges were communicated to management. This gives an opportunity for management to find means of helping out. This is contrary to the situation in Jordan in study done by Al-Qutab, Mawajdel, Nawar, Saidi & Raad (2001) where managers had no knowledge of the challenges providers were facing in the implementation of quality improvement programme. Managers need to be resourceful and vigilant in dealing with issues that affect their organizations. Failure of subordinates to perform may reflect the type of management within the organization.

6.7 IMPORTANCE OF FOCAL PERSONS IN THE IMPLEMENTATION OF PQI/RH

The study has also revealed that 40% of participants said had no focal person for PQI/RH in their department. 26.7% had no idea whether their department had a focal person or not. Availability of a focal person in the implementation of PQI/RH is of great importance as the study has shown that participants who have a focal person are supported. Participants who had focal persons in their departments said that a focal person is essential in implementing quality performance. Providers said that focal persons are able to orient staff to the initiative and report issues to management. Those who had no focal person in their department expressed the need to have one for them to be helped in the achievement of quality performance. A focal person will indeed supervise and assess to see if standards are being followed and offer support where necessary. The need to have focal persons in every department is in line with a study done by Reynolds (2007) which found that supervisors have an important role to play to improve quality of reproductive health services. The supervisors were able to manage resources, facilitate communication, motivate providers, promote training opportunities give feedback and seek joint solutions to problems. If this is applied to reproductive department at QECH achievement of quality performance will be easy. Providers will channel their concerns appropriately, supervision will be intensified and morale will be high among providers. The same study has also indicated that apart from support from a focal person or supervisor, management support is important. Departments can progress quickly in achieving quality performance when fully supported by management morally and with resources. This is also in line with what Agha (2010) identified in his study that providers did well in achieving quality due to the support they got from their supervisors. In the transtheoretical model of change, Porche (2004) says that new behavior can be sustained if support is given. Providers need to be reminded now and again on PQI/RH. There is need to put cues that will remind providers of the standards. There should be continuous monitoring of how they are performing and giving them positive feedback.

6.8 CONCLUSION

The findings of the study have shown that providers have diverse knowledge of what PQI/RH is all about. Findings have also indicated that most providers have not been oriented nor trained in PQI/RH. Lack of knowledge can negatively affect the progress to achieve quality in the department. Apart form lack of knowledge, the study findings have also shown that providers have a lot of challenges to implement PQI/RH. The challenges include inadequate human and material resources and lack of supportive supervision. Though management is aware of the challenges being faced, little has been done to counteract the challenges.

CHAPTER SEVEN

7.0 IMPLICATION OF THE STUDY

The study has helped to highlight factors that are hindering progress in performance and quality improvement in reproductive health at Q.E.C.H. The factors are lack of knowledge on PQI/RH, inadequate human and material resources and inadequate supportive supervision. The study finding will help develop means to deal away with current challenges so that progress can be made. These findings can also be used to improve nursing in all its fields of education, management, practice and research.

7.1 NURSING EDUCATION

Nurse educator in all nursing school should teach midwifery students on the quality improvement in reproductive health. Students should have access to the standards that have been developed and use them while in training. When doing assessments with students, educators should ensure that the tools used have been developed in line with RH standards. This will help to have no gap in performance once the students qualify. There is also need to incorporate the issue of quality performance in the midwifery curriculum.

7.2 NURSING MANAGEMENT

The Ministry of Health and its partners through the Reproductive Health Unit should support hospitals that are implementing PQI/RH initiative with adequate material and human resources to be used for the initiative. Management at Q.E.C.H. should support PQI/RH as it has done with other programmes so that quality is achieved and maintained at every level of the hospital's development.

7.3 NURSING PRACTICE

Nurse in charges should use management tools to orient staff to ward activities and requirements. Management tools should be made accessible to be referred to by providers in their course of work. Providers should have a habit of using management tools to inform practice. There is need for nurses to have a habit of doing peer assessments as a means to identify gaps in performance. Nurses in the clinical area should have a habit of learning things from colleagues who have undergone any kind of training since not all nurses can have an opportunity to go for a similar training.

7.4 NURSING RESEARCH

There is need to conduct research in other hospitals who are implementing PQI/RH initiative to identify factors that are hindering progress in those hospitals. It is also necessary to find out

factors that have made other hospitals to achieve quality performance within 1or 2 years of adopting the initiative.

7.5 RECOMMENDATIONS

Management at Q.E.C.H. should plan to orient or train staff who have not been trained on PQI/RH in the reproductive health department.

Management at Q.E.C.H should priorities resource allocation in the reproductive health department.

Quality Improvement Support Team (QIST) at Q.E.C.H should ensure that each ward has two focal persons to provide support to providers.

QIST and Nurse- in- charges should intensify supportive supervision to ensure that RH standards are being followed.

QIST should ensure that each ward in the reproductive unit has the RH standards for reference.

Nurse- in -charges should make sure that new staff is oriented to RH standards on placement to the wards.

Providers who have been oriented to RH standards should take an active role to orient others to the standards.

7.6 AREAS OF FURTHER RESEARCH

There is need to conduct a similar study in hospitals who have taken long to achieve quality performance in reproductive health.

Another research can be done on effectiveness of orientation to nurses on new initiatives that are being introduced in nursing practice.

A study can be conducted to identify factors that hinder nurses from learning from those that have undergone training in a certain programme.

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APPENDICES

A. TIME TABLE FOR ACTIVITIES

Activity	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
Topic selection and formulation												
Formulation of objectives and planning of methods												
Literature review												
Proposal development												
Proposal submission												
Pre-testing and data collection												
Data collection												
Data analysis and interpretation of results												
Report writing and submission of dissertation												
Dissemination of results												

B. RESEARCH BUDGET

A budget is a plan for forth coming period which is expressed in monetary terms. It is a statement of how much money will be required and allocated to accomplish planned tasks (Burns and Grove, 2009). The following was the detailed budget of the study.

ACTIVITY	ITEMS REQUIRED	MULTIPLYING FACTOR	SUB-TOTAL	GRAND TOTAL
SECRETARIAL SERVICE				
Printing of letters	5 letters	@K10 each	K500-00	
Printing of proposal	3 copies	@K500 each	K1500-00	
Printing and photocopying of: questionnaire	35copies	@ 70 each	K2450.00	
Consent forms	35 copies	@K10 each	K350.00	
Binding of the proposal	3 copies	@K200 each	K600-00	
Photocopying and binding of the report	6 copies	@K1000 each	K6000-00	
Photocopying papers	2 reams A4	@ k900 each	K1800.00	
Writing materials	10 pens	@ 35 each	K350.00	
	5 lead pencils	@ 20 each	K100.00	
River arch file	2 files	@ 600 each	K1200.00	
Memory stick	1	@ 4000 each	K 4000.00	
SUB TOTAL			**K18,850.00**	

COMMUNICATION AND TRANSPORT				
Use of internet	Airtel air time	K2000.00	K2000.00	
Phone call bills	Air time	K2500.00	K2500.00	
Internet Dongle	Airtel type	K5500.00	K5500.00	
Delivery of letters	Transport	@ k1500.00 one way	K3000.00	
Data collection Other travel expenses	Transport : Lilongwe-Blantyre. Home to QECH	 @k1500.00 one way K350 per day/5days 3500.00	 K3000.00 K1750.00 K3500.00	
SUB TOTAL			**K21,250.00**	
MEAL EXPENSES				
Lunch	For 5 days	@ k800.00 per meal	K4000.00	
Contingency 10%			K4450.00	
SUB TOTAL			**K8450.00**	
GRAND TOTAL				**K48550.00**

JUSTIFICATION OF THE BUDGET.

The drawn budget consist of costs that have been used in this proposal development as well as those expenses to be incurred in whole research process till submission of reports. The costs include secretarial work, transport and communication, food allowance and contingency.

Secretarial work has taken 38% of the total budget and this carters for all writing materials, printing and photocopying of all documents needed in this research process.

Communication and transport expenses have taken 44% of the total budget. This has been so because a lot of travelling has and will be made to collect necessary information. The other expenses have been on internet and phones.

Meals have taken 8% of the budget. This will be used during the time of data collection.

Contingency is 10% of the total budget which will carter for any unforeseen circumstances.

C. QUESTIONNAIRE

TITLE: STUDY ON FACTORS HINDERING PROGRESSPERFORMANCE AND QUALITY IMPROVEMENT IN REPRODUCTIVE HEALTH LABOUR AND POSTNATAL WARDS AT Q.E.C.H.

CODE NUMBER: **DATE:**

INSTRUCTION: Tick the correct response in the blankets and where explanation is needed write partcipants response in the space provided.

DATA SECTION: DEMOGRAPHIC INFORMATION

1. AGE
   - i. less than 25 years [ ]
   - ii. 25-30 years [ ]
   - iii. 30- 40 years [ ]
   - iv. 40-50years [ ]
   - v. 50 years and above [ ]

2. SEX
   - i. Female [ ]
   - ii. Male [ ]

DATA SECTION: PROFESSION INFORMATION

3. What is your professional cadre?
   - i. Nurse Midwife Technician [ ]
   - ii. Enrolled Nurse Midwife [ ]
   - iii. Registered Nurse Midwife [ ]
   - iv. Registered Nurse [ ]
   - v. Laboratory Technician [ ]
   - vi. Pharmacy Technician [ ]

vii. Other specify.....

4.What is your highest professional education qualification?

i. Degree [ ]

ii. Diploma [ ]

iii. Certificate [ ]

5. How long have you worked in the department?

i. less than 6 months [ ]

ii. 1- 2 yrs [ ]

iii . 2-5 yrs [ ]

iv. 5-10 yrs [ ]

v. 10-15 yrs [ ]

vi. 15- 20 yrs [ ]

vii. 20 yrs and over [ ]

DATA SECTION: KNOWLEDGE ON PQI/RH

6. Do you know anything about performance and quality improvement in reproductive health?
Yes [ ] No [ ]

7. How did you know about performance and quality improvement in reproductive health(PQI/RH).

i. From bulletin boards [ ]

ii. During job orientation [ ]

iii. During in-service training [ ]

vi. From colleagues [ ]

vii. Before being employed [ ]

8. Have you been oriented or trained in PQI/RH?

Yes [ ] No [ ]

9. Why was PQI/RH introduced?

i. improve provider performance [ ]
ii. improve access to services [ ]
iii. reduce complications [ ]
other specify.....

10. Do you have knowledge on what is assessed PQI/RH?

Yes [ ] No [ ]

11. If yes, what are the things that are assessed in PQI/RH?

12. Have you seen the tools that are used for assessment?

Yes [ ] No [ ]

13. Have you used the tool to assess your performance against the set standards?

Yes [ ] No [ ]

14. If the answer is no, why have you not used the tool?

i. have no access to it [ ]
ii. have no time [ ]
iii. have no idea on how to use [ ]
iv. It is not necessary [ ]

DATA SECTION: AVAILABILITY OF RESOURCES TO IMPLEMENT PQI/RH

15. Do you have the necessary resources to implement PQI/RH?

Yes [ ] No [ ].

16. If yes, what resources are available?

17. Do you have constant supply of resources mentioned above?

Yes [ ] No [ ]

18. What resources would you suggest should be readily available for easy implementation of PQI/RH?

20. If yes, what problems have you encountered so far?

21. Do these problems exist right now?

Yes [ ] No [ ]

22. If yes , were the problems reported to management?

Yes [ ] No [ ]

23. If yes, what was done to solve the problem?

24. Were you satisfied with the solution?

Yes [ ] No [ ]

25. If no, what in your opinion would have solve the problem?

DATA SECTION: ROLES OF FOCAL PERSONS

26. Do you have a focal person for PQI/RH in your ward/ department?

Yes [ ] No [ ]

27. If yes, what roles do they play?

28. If no, do you think it is necessary to have a focal person?

Yes [ ] No [ ]

29 . Explain your answer in 28 above?

THANK YOU FOR TAKING PART IN THIS STUDY

D. PARTICIPANT'S INFORMED CONSENT FORM

Principal investigator: Violet Khonje

Supervisor : Mr G. Masache

I am a second year student at Kamuzu college of Nursing a constituent college of the University of Malawi pursuing a Bachelor of Science in Nursing (Post Basic). In partial fulfillment of my studies I am supposed to conduct a research that will contribute to body of knowledge and benefit nursing and midwifery profession as well as clients. The title of my study is factors hindering progress in performance and quality improvement in reproductive health. You are therefore being invited to participate in this study. In particular, you have been chosen because you meet the criteria of targeted participants. The study will help to understand from the providers perspective things that are preventing to meet reproductive health standards in some departments . The knowledge will guide the Management, Quality improvement team and providers on what strategies to take to achieve quality performance in reproductive health. Apart from this stated significance, there are no direct benefits and no monetary reward to you as the participant.

When you take part in the study there are no any harm except that you will spend about thirty minutes responding to the questions to the best of your knowledge. All study information will be identified by code number not with names to protect your identity. In addition, all the information given will be kept confidential, and soon after report writing data will be destroyed. Your participation is completely voluntary and you can withdraw from the study any time you feel like doing so . For more information you may contact the researcher on cell phone number **0888705749.**

If you have understood the purpose of study as well as your rights to participate and withdraw but voluntarily determined to participate, please sign in the space below.

Participant's Signature---------- Date _____

Investigator's Signature..... Date _____

E. LETTER TO RPC SEEKING APPROVAL FOR THE RESEARCH PROPOSAL

FROM: Violet Talinda Khonje

TO : The Chairperson,

Research and Publications Committee,

Kamuzu college of Nursing,

Private Bag

Lilongwe.

SUBJECT: REQUEST FOR PERMISSION TO CONDUCT A STUDY ON FACTORS HINDERING PROGRESS IN PERFORMANCE AND QUALITY IMPROVEMENT IN REPRODUCTIVE HEALTH IN LABOUR AND POSTNATAL WARDS AT QUEEN ELIZABETH CENTRAL HOSPITAL.

I write to request for permission to conduct a study on factors hindering progress in performance and quality improvement in reproductive health (PQI/RH) in labour and postnatal wards at Queen Elizabeth Central Hospital.

I am a second year Bachelor of Science in Nursing (post basic) student here at Kamuzu college of Nursing, a constituent college of the University of Malawi. I am intending to conduct this study as a requirement in partial fulfillment my degree programme.

Enclosed is the full proposal of the intended study for your scrutiny and approval. I will be grateful if you process the proposal within the work plan so that I can meet the programme timetable.

Yours Sincerely

Violet Khonje

F. APPROVAL CERTIFICATE FROM RESEARCH AND PUBLICATIONS COMMITTEE

University of Malawi
KAMUZU COLLEGE OF NURSING

RESEARCH AND PUBLICATIONS COMMITTEE

APPROVAL CERTIFICATE

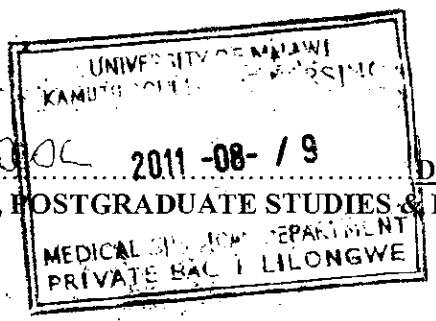
TITLE: Factors Hindering the Progress of performance and quality improvement in reproductive Health in labour and postnatal wards at QECH

INVESTIGATORS: Violet Talinda Khonje

DEPARTMENT/YEAR OF STUDY: Basics Department/ Year 2

REVIEW DATE: 11TH JULY, 2011.

DECISION OF THE COMMITTEE: APPROVED



SIGNATURE: ..... DATE: 11/07/2011.....

DEAN, POSTGRADUATE STUDIES & RESEARCH

cc Supervisor:

DECLARATION OF INVESTIGATOR(S)

I/we fully understand the conditions under which I am/we are authorized to carry out the above mentioned research and I/we guarantee to ensure compliance with these conditions. In case of any departure from the research procedure as approved, I/we will resubmit the proposal to the committee.

DATE....9/8/11.....SIGNATURE(S).....

G. REQUEST TO CONDUCT A STUDY AT Q.E.C.H

Kamuzu college of Nursing,

Private Bag 1,

Lilongwe.

Cell phone: 0888705749

Date: June, 2011.

TO: The Hospital Director

Q.E.C.H.

P.O Box 95.

Blantyre

CC : The Chief Matron, Q.E.C.H.

Dear Sir,

SUBJECT: REQUEST TO CONDUCT A STUDY ON FACTORS HINDERING PROGRESS IN PERFORMANCE AND QUALITY IMPROVEMENT IN REPRODUCTIVE HEALTH IN LABOUR AND POSTNATAL WARDS

I write to request for permission to conduct a study at your hospital in the reproductive health departments on the above topic. I am a student at Kamuzu college of Nursing pursuing Bachelor of Science in nursing course. I intend to do this research in partial fulfillment of the programme requirements.

Participants to the study will be providers working in the reproductive health departments . The results will be communicated to interested parties, including your office.

I will be grateful if my request is honoured.

Yours sincerely,

Violet Khonje.

H. LETTER OF APPROVAL FROM Q.E.C.H

Telephone: (265) 01 874 333 / 677 333
Facsimile: (265) 01 876928
Email: queenshosp@globemw.net

All communications should be addressed to:
The Hospital Director

In reply please quote **No.**

QUEEN ELIZABETH CENTRAL HOSPITAL
P.O. BOX 95
BLANTYRE
MALAWI

Ref No QE/10

12th August 2011

Kamuzu College of Nursing
Private Bag 1
LILONGWE

Dear Sir/Madam

RE: PERMISSION TO CONDUCT A STUDY AT QUEEN ELIZABETH CENTRAL HOSPITAL

I write to inform you that management has no objection for you to conduct a study at Labour Ward and Postanatal wards entitled " **FACTORS HINDERING PROGRESS IN PERFORMANCE AND QUALITY IMPROVEMENT IN REPRODUCTIVE HEALTH**"

You are advised to show this letter to concerned departments as appropriate.

All the best in your studies

Yours faithfully

E. Nkangala
PRINCIPAL NURSING OFFICER

I. REQUEST TO CONDUCT A PILOT STUDY AT CHIRADZULU DISTRICT HOSPITAL

Kamuzu college of Nursing,

Private Bag 1,

Lilongwe.

Cell phone: 0888705749

Date: June, 2011.

TO: The District Health Officer

Chiradzulu District Hospital,

P.O Box 21

Chiradzulu

CC : The Matron, Chiradzulu Hospital

Dear Sir,

SUBJECT: REQUEST TO CONDUCT A PILOT STUDY ON FACTORS HINDERING PROGRESS IN PERFORMANCE AND QUALITY IMPROVEMENT IN REPRODUCTIVE HEALTH IN LABOUR AND POSTNATAL WARDS.

I write to request for permission to conduct a pilot study at your hospital in the reproductive health department on the above topic. I am a student at Kamuzu college of Nursing pursuing Bachelor of Science in nursing course. I intend to do this research in partial fulfillment of the programme requirements.

The main study will take place at Q.E.C.H. Participants to the study will be providers working in reproductive health department.

I will be grateful if my request is honoured.

Yours sincerely,

Violet Khonje.

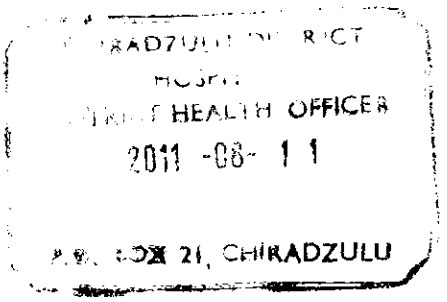
J. APPROVAL FROM CHIRADZULU DISTRICT HOSPITAL

Kamuzu College Of Nursing,

Private Bag 1,

Lilongwe.

Date: June, 2011.



TO: The District Health Officer

Chiradzulu District Hospital,

P.O Box 21

Chiradzulu

CC : The Matron.

Dear Sir,

SUBJECT: <u>REQUEST TO CONDUCT A PILOT STUDY ON FACTORS HINDERING PROGRESS IN PERFORMANCE AND QUALITY IMPROVEMENT IN REPRODUCTIVE HEALTH IN LABOUR AND POSTNATAL WARDS.</u>

I write to request for permission to conduct a pilot study at your hospital in the reproductive health departments on the above topic. I am a student at Kamuzu college of Nursing pursuing Bachelor of Science in nursing course. I intend to do this research in partial fulfillment of the programme requirements.

The main study will take place at Q.E.C.H. Participants to the study will be providers working in reproductive health departments.

I will be grateful if my request is honoured.

Yours sincerely,

Violet Khonje.