Ministry of Health and Social Services

Final Report

Assessment of the National Quality Management Systems Used to Monitor and Improve Quality in Health Service Provision in Hospitals and Health Centres in Namibia

March 2014

Submitted to

The Permanent Secretary
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Submitted by

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FOREWORD

Ensuring the provision of quality health care is one of the most important goals of the Ministry of Health and Social Services (MoHSS). Lately there has been increased focus on how the quality of care in the public sector can be improved. Therefore, the assessment of the National Quality Management Systems could not have come at a better time as the Ministry is in the process of embarking on a restructuring exercise. This assessment will be a key source of information in tackling of quality care issues which are close to my heart, and indeed the hearts of many Namibians.

The MoHSS is committed to the provision of high quality, integrated, affordable and accessible health care and social welfare services. To date, my Ministry has, and continues to implement programmes and projects to provide quality health care to all Namibians and other people seeking such care in this country.

This Assessment was commissioned by my Ministry because it has taken note of past and present concerns about quality health care provisions for patients in our establishments. Some of the complaints were directly submitted to the Ministry while others were sent via the electronic Short Message Service (SMS) to the media. This then prompted an internal investigation which led to the assessment.

The assessment was made possible with the technical and financial assistance from the United States Government President's Emergency Plan for AIDS Relief (PEPFAR) through the US Department of Health and Human Services (DHHS), Centres for Disease Control and Prevention (CDC). The funding helped my Ministry to outsource the study to Baobab Research and Training Institute, a local institute based in Namibia.

This is the report. It is comprehensive and was conducted in 41 health facilities including all 34 public hospitals, 2 selected private hospitals and 5 health centres. It is the first of its kind in the country and is intended to critically assess the quality of health care across the entire Ministry, in a structured and systematic manner.

The Assessment Report provides a clear picture of the issues dealing with quality health services. It highlights the challenges facing the provision of quality health care. Notably, it identifies a general lack of a common standard understanding of what quality and quality assurance in health care means. The report reveals a high fragmentation of quality of care programmes and their poor coordination.

The Assessment Report provides constructive recommendations on how the MoHSS can improve the quality of its care through better quality management systems at all levels. It recommends strengthened policy and strategic plans on quality management, creation and use of standardized terms and terminology on what quality is and suggests the development of strengthened quality indicators to help standardize the monitoring of performance across various health facilities.

These efforts will create a culture of quality care provision, and extend quality monitoring to many other priority health care services whose quality has hitherto not been monitored systematically. Most importantly the report demands that the promotion of organisational values and their internalisation by staff should be the MoHSS leadership's core business and that leaders should create a quality care culture.

During the 2013 annual meeting with the Ministry's management cadre, I reiterated our commitment to support quality improvement programmes for all health professionals and most important the provision of quality health care to our key stakeholders, the patients.

The findings from this study highlight where we have done well, and point to the necessary systems in place. Despite limited human resources, most staff are trying their utmost to ensure that quality is adhered to at all times and at all cost.

The study also identifies our weaknesses and urges all key stakeholders to improve on core and essential health service elements through systematic and continuous quality improvement .The Assessment recommends several action items such as the creation of an enabling environment as well as support of relevant quality management related capacity building programmes for providers and health care managers. This report recommends enhanced communication on quality of care, strengthening information management and data use for quality improvement as well as rewarding quality work.

Drawing from these findings, I wish to pledge my commitment to ensure that the Ministry will continue to improve and provide high quality services to the public. My Ministry will use these findings and recommendations to inform the National Quality Management Policy and Strategic Plan to be launched soon. In addition, the Assessment Report will be used particularly by all health professionals to improve health services in Namibia.

Mr. Andrew Ndishishi
Permanent Secretary

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- Ms C S Gordon - Quality Assurance Manager, Quality Assurance Division, MoHSS
- Dr Apollo Basenero - Technical Medical Officer, Quality Assurance Division, CDC/MoHSS
- Dr Ndapewa Hamunime - Senior Medical Officer, HIV Case Management Unit, MoHSS
- Dr G Mutandi - Medical Advisor, HIV Care and Treatment, CDC
- Ms Sadhna Patel-Epidemiologist, CDC
- Ms Claudia Mbapaha - HIV Quality Improvement Officer, Quality Assurance Division, MoHSS
- Ms Z Kandjou –Finance manager, CDC
- Mrs A Beukes – Technical Advisor, CDC Laboratory

We also acknowledge the inputs obtained from the MoHSS Quality Assurance Technical Working Group during the designing and preparation of this study.

Our gratitude is extended to in-patients, out-patients and community members who participated in both the Client Exit Interviews and Focus Group Discussions. Their participation and insight enriched this assessment. Special thanks go to the health professionals in the 41 health facilities who took time to contribute to this assessment; their contribution to the study provided the much needed information and insight. Special thanks go to the Team leader Dr Pandu Hailonga-van Dijk and Deputy Team leader Mr Randolph Mouton as well the following researchers:

Mr Erich Afrikaner

Ms Jeany Auala

Ms Linda Nambudunga

Mrs Gladys Kamboua

Mrs Petrina Biwa

Ms Drusulla Hoeses

Mr Michael Mulunga

Mr Ndilipunje Israel

Mr Brandon Bock

Mrs Selma Ndjembo

Mrs Peter Mbango

Mr Jonas Kapanga

This research project was made possible with the technical and financial assistance from the United States Government President's Emergency Plan for AIDS Relief (PEPFAR) through the US Department of Health and Human Services (DHHS), Centres for Disease Control and Prevention Cooperative Agreement 1UGPS003014-01 with the MoHSS. The contents of this report are solely the responsibility of the authors and the MoHSS, and do not necessarily represent the official views of the CDC.

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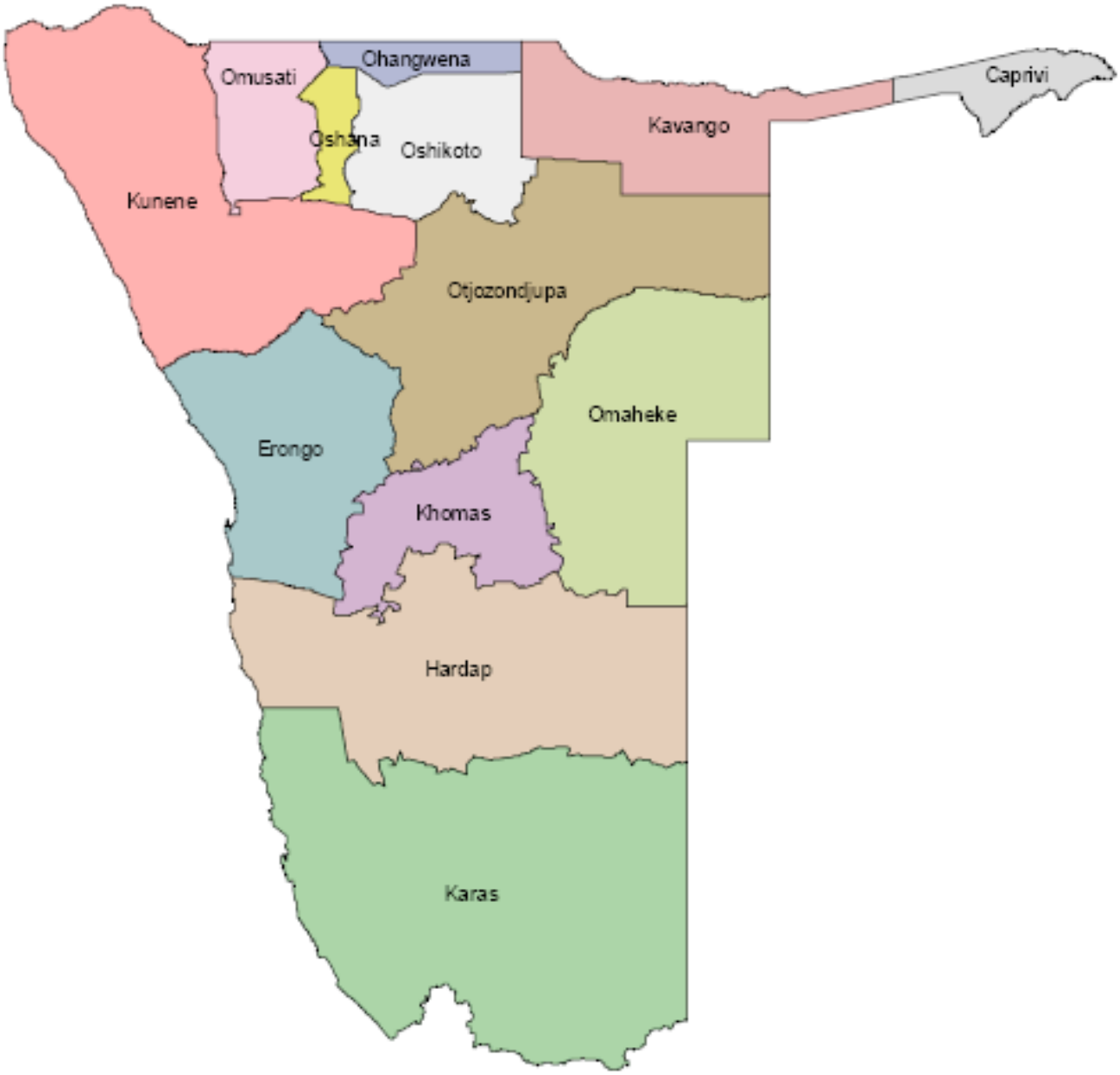
LIST OF ACRONYMS

ANC	Ante-natal Care
ART	Anti Retroviral Therapy
BARTI	Baobab Research and Training Institute
CDC	US Centres for Disease Control and Prevention
CMO	Chief Medical Officer
CHPA	Chief Health Programme Administrator
FH	Family Health
FBO	Faith Based Organisation
FGD	Focus Group Discussion
FOCUS	F: - Find a problem; O – Organize a team; C – Clarify the problem; U-Understand a Problem; S – Select an intervention
GRN	Government of the Republic of Namibia
HIV	Human Immunodeficiency Virus
HIS	Health Information System
HIVQUAL	HIV Quality Improvement Programme
IEC	Information, Education and Communication
IMAI	Integrated management of adolescent and adult Illnesses
IPD	In-patient Department
IPT	Isoniziad Prophylaxis Therapy
KPI	Key Performance Indicators
MCP	Maternal Child Health
MDGs	Millennium Development Goals
MGECW	Ministry of Gender Equality and Child Welfare
MoHSS	Ministry of Health and Social Services
NGO	Non-governmental Organisation
PDSA	Plan Do Study Act
PHC	Primary Health Care
PMO	Principal Medical Officer
QA	Quality Assurance
QI	Quality Improvement
RCN	Registered control Nurse
SADC	Southern African Development Community
SHPA	Senior Health Programme Administrator
SOP	Standard Operating Procedure
TB	Tuberculosis
TWG	Technical Working Group
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

INTRODUCTORY NAMIBIA MAP



EXECUTIVE SUMMARY

The main goal of the research was to conduct a formative assessment of the current health quality management systems in health facilities across Namibia. The following were the objectives of the study:

- Describe the quality management organisational structures that are currently used in the different healthcare facilities;
- Identify the current quality performance measurement systems and Quality Improvement (QI) activities in the different healthcare facilities;
- Explore the involvement of clients/consumers in QI activities in the different health care facilities;
- Assess how the Quality Management Programme is being evaluated;
- Identify the current clinical information systems in the different healthcare facilities and how the information is being used to improve quality of care;
- Explore issues of patient safety in the healthcare facilities;
- Assess how clients/consumers evaluate the quality of care in the different healthcare facilities.

The Assessment was conducted in all 13 regions; at national, referral, private, intermediate and district hospitals, and selected health centres. Field data collection was done over 12 days, between 18 June and 3 July 2012. The data was collected using four tools:

- Focus Group Discussion (FGD) with health professionals (40);
- FGD with inpatients (20) and Client exit interviews with outpatients (200)
- FGD with community members (8).

Complimenting data collection were the desk reviews of key documents.

The Assessment shows that Government has demonstrated a genuine commitment and interest in providing high quality service delivery through its provision of human and financial resources. This is reflected in the high degree of political will, the availability of different policies and guidelines and the creation of a Quality Assurance Unit at national level.

The findings suggest that QI activities are integrated into meetings; supervisory visits, ward rounds and auditing activities although not conducted in a systematic manner. The team approach is used to address problems in most facilities. However, this is often reactive rather than proactive.

The study found that there was a limited usage of common frameworks such as the FOCUS-PDSA model, but very little assessment of health workers' compliance with the process of care standards was done. The culture of quality care was not yet embraced by all. Generally there was not a unified understanding of what quality means.

While respondents indicated a wide range of quality improvement activities, the major areas of focus were on medication safety and infection control, with little attention on patient satisfaction. The findings therefore, suggested that there were no clear roles and responsibilities at the facility level regarding ensuring the quality of services. Quality assessments and evaluations were spearheaded by the national level, with limited inputs from the regions or districts.

Exit interviews with patients in public health facilities revealed that they were often treated as helpless human beings who did not know anything; consequently they were not involved in quality improvement activities.

There were various challenges facing quality health care in many of the health facilities such as:

- Lack of indicators for quality health care
- Lack of documentation;
- Limited Human and Financial resources;
- Lack of accountability from support staff e.g. cleaners and cooking staff and weak monitoring and evaluation systems.

The suggested recommendations, listed below, take into consideration that Government has a genuine interest, and is committed to improve the quality of care in health care settings.

Recommendations

Policies, guidelines & strategic plans

- Strengthen the development of policies, guidelines and strategic plans on quality management

Structure and management

- Strengthen the collaboration between technical experts, service delivery and administrative programmes and this should be reflected at different levels. It should also be interdependent and integrated
- Establish clear roles and responsibilities for each level i.e. national; regional, district and health centre levels

Quality tools and indicators

- Strengthen quality indicators (output and process indicators) i.e. validity, reliability, sensitivity and feasibility
- Have a definition of quality that is shared and understood by all stakeholders
- Create a quality culture which is part of the national agenda. All attempts should be made for health providers and users to internalise quality health care.

Human resources and competence management

- Strengthen measures to assess staff competence especially clinical competence. The following measures could be considered**:**
    - Application and selection procedures; validation of past history, current registration status and references
    - Recognition of individual performance (review or appraisals).
    - Systematic periodic review of clinical performance and appointments
    - Establish/strengthen programmes of supportive supervision which include supervisory field visits to primary care staff to evaluate performance
    - Clinical supervision should be a major component of ongoing performance management.
- Leadership should promote organisational values and set priorities to recognise and reward good performance.
- Capacity building in quality management should be part of staff empowerment and could be done through training, coaching, mentoring, self- and peer appraisals and supervisory activities
- Quality management should be a core component of staff performance
- Senior health managers should provide coaching and mentoring on ongoing technical and qualitative support to facilitate the behaviour changes needed to undertake and sustain quality assessment activities, while simultaneously encouraging the development of a “culture of quality”

Staff performance appraisal, recognition and rewards

- Establish a mechanism to reward staff for quality management as this will contribute towards their commitment and will motivate them to strive towards achieving excellence
- The MoHSS should introduce a process of peer review to provide a means of accountability and improvement of quality
- A peer review mechanism should be a major component of professional involvement in quality improvement

Consumers, users and clients

- Involvement of patients, their families and communities should be a core component of quality improvement
- Mechanism (e.g. customer care) should be established to solicit the views and opinions of patients with regards to services received, and also provide feedback to them on how their views and opinions were taken into consideration to improve the service

Training

- A standard curriculum for quality management should be developed and pre and in-service training of health professionals should have quality assessment as a core component
- Academic institutions i.e. the UNAM School of Medicine and Nursing and the National Health Training Centre (NHTC) should spearhead quality management training
- The MoHSS may consider outsourcing the quality management training to private training institutions with the requisite expertise and capacity. Leadership should create opportunities for staff to attend training in quality management at leading health care centres and/or bring in expertise to share their knowledge.

Monitoring and evaluation

- The MoHSS should establish key indicators for quality assessment which focus on inputs, processes, outcomes and impacts

Resources

- Resources for the required human, financial, communication, knowledge, coordination and infrastructural development should be committed to improve the quality of services

Enabling environment

- The MoHSS should create and sustain a conducive environment which will help providers to initiate, implement and if necessary expand and sustain quality assurance
- The environment should support, guide and reinforce quality management

1. INTRODUCTION TO THE PROJECT AND COUNTRY

1.1 Background and rationale for the study

The mission of the MoHSS, according to its2009 – 2013 Strategic Plan is "to provide integrated, affordable, accessible, quality health and social welfare services that are responsive to the needs of the Namibian population" (MoHSS, 2009, p. 5). The commitment in achieving this mission is reflected both in the national and international commitments such as Vision 2030, the Fourth National Development Plan (NDP-IV), MoHSS Strategic Plan 2009-2013 and the Millennium Development Goals (MDGs).

Five key factors have been identified in ensuring the health of the Namibian nation, and they include:

- Access to clinical services that are standardized and follow accepted protocols and guidelines
- Health services that are designed to support existing health systems, structures and providers
- Access to health services that are coordinated across agencies and sectors to achieve maximum impact
- Health services that are based on relevant primary health care principles
- Health services that are designed, developed and guided by the ongoing, coordinated collection, analysis and utilisation of relevant public health data (MoHSS, 2009)

In order to ensure the well-being of all Namibians, Government and other stakeholders should commit human, technical and financial resources. According to the World Health Organisation (WHO), Namibia doubled its health spending between 2001 and 2007, representing an 8.3% of the Gross Domestic Product (GDP). This was the second highest in the Southern African Development Community (SADC) region (Zere*, et al*, 2006). While the Government's health spending is put at 12.2% of the overall national budget, it still falls short of the Abuja Commitment where African governments pledged to increase their health spending to 15% by 2015 (WHO, 2009).

But despite Government's health spending, the prevalence of preventable/communicable diseases remains stubbornly high in Namibia. For example, the HIV prevalence rate among pregnant women is 18.8% and TB cases at 722 per 100,000 despite the success in Antiretroviral Treatment (ART) treatment at a coverage rate of 75% of those in need of treatment (MoHSS, 2009). Although reports indicate that the country by 1992 saw a decrease in the majority of communicable diseases, the reality is that the spread of communicable diseases is on the increase according to the Demographic and Health Survey (DHS) of 2006/7. It is suggested this may affect the country's ability to achieve the MDGs (MoHSS, 2008).

Research and anecdotal evidence implies that Namibia's public health facilities face several challenges related to governance, financing, resources, communication and coordination. Other findings show that unclear job descriptions, lack of proper maintenance programmes and lack of professionalism have contributed to the perceived poor health provision (Zere, et al, 2006). This is further complicated by institutional capacity gaps throughout the health service, duplication of structures, systems and functions and inadequate organisational development. The MoHSS is particularly concerned about the effectiveness and efficiency of quality management mechanisms across health facilities, and the effect that this might have on the provision of high quality health services.

In recognizing the above shortcomings and concerns, the MoHSS with technical and financial support from US Centres for Disease Control and Prevention (CDC) has started several initiatives aimed at strengthening quality management systems and structures at all health administrative levels. First on its list has been the research project to assess the current national quality management systems used to monitor and improve quality in health service provision in hospitals and health centres across Namibia. After a competitive bidding process, Baobab Research and Training Institute (BARTI) was selected to conduct the assessment.

1.2 **Background to Namibia's Health Sector**

Health services in Namibia were established in the 1890s and were exclusively of a curative nature, with preventative health care limited to childhood immunizations and maternal health checkups. By 1990, just before Namibia's Independence, health care was racially based and mainly urban-centred, with the rural areas, especially in the northern parts of the country, being served by churches, especially the Catholic and Lutheran denominations.

At Independence, deliberate efforts were made by Government to focus on primary health care and to transform the health care system from an urban-based curative service to a community based preventative service. Six key areas were identified in line with the Primary Health Care principles. These were preventative, curative, promotional, rehabilitative, accessible and affordable (MoHSS, 1998).

Currently, the country has a well-developed health infrastructure network consisting of 295 clinics, 47 health centres, 30 district hospitals, three intermediate hospitals and one national referral hospital, nine Sick Bays as well as various social welfare service points, private hospitals and clinics (MoHSS, 2011). The public health sector is structured in a three-tier hierarchy with national, regional and district levels.

Figure 1: National Health Sector Pyramid

The national level is responsible for policy formulation, regulation, planning, management development, and giving support for service provision to the entire health sector, while the regional directorates are responsible for regional level oversight and service delivery. Besides Government, Faith Based Organisations (FBOs) and Non-Governmental Organisations (NGOs) as well as the private sector, continue to play a key role in the provision of health services. The private sector is regulated by the Hospitals and Health facilities Act 36 of 1994), through the provision of licences for health care delivery to compliment the services of the public sector.

1.2.1 **Disease Burden**

The country is confronted with a burden of both communicable and non-communicable diseases, with communicable diseases accounting for the higher proportion. The main communicable diseases that contribute to the disease burden are; HIV and AIDS, Tuberculosis, and Malaria which is endemic to the northern parts of the country. Pneumonia, gastroenteritis and HIV and AIDS are among the causes of relatively high under-five mortalities. According to the Health Information System (HIS), non-communicable diseases are on the increase with reported cases of cancer, diabetes, hypertension and cardiovascular problems among the top causes of death. (HIS2009)

1.2.2 **Access to Health Services**

The population has access to three health services, which are namely public, private and not-for-profit healthcare systems. Most people, 85%, are able to access public and private not for profit health care, while 15%, mostly middle and high income levels of the population can access private profit-making health care systems. Given the geographical set up of the country, not all people have access to health facilities. It is reported that 40% live more than five kilometres from a health facility, and a considerable number more than 300km from a health facility (WHO 2009). Access is therefore challenged by distance, but in some cases by cost as well. Costs may include travelling costs and direct costs towards health consultation and medication.

1.2.3 **National Health Frameworks**

Namibia has political stability, a well-functioning democracy, high quality infrastructure and a high degree of political commitment for economic and developmental growth based on the country's long-term visions, "Vision 2030"and NDPs; all of which have been aligned to the achievement of the MDGs.

In addressing the challenges facing the global community, for example poverty, hunger, ill health, lack of education, inaccessibility to clean water, environmental degradation and gender inequality, 189 heads of states adopted the United Nations Millennium Declaration in September 2000 and endorsed a framework for development. Consequently, eight MDGs were established, with targets for 2015, and indicators to monitor progress toward their attainment. The MDGs are the first set of quantitative and time-bound goals shared by both developed and developing countries. They offer integrated goal oriented frameworks and form a basis for mobilizing resources and provide a platform to advocate change.

1.3 **Quality Assurance in the Health Sector**

The provision of quality health services, efficient and effective quality management systems were at the core of this assignment. The MoHSS is extremely concerned about the perceived lack of quality management across public health facilities in the country. Cases were reported, where clients entered a health facility with one problem, just to be discharged with an additional two other health problems due to overall poor quality management at a facility. The situation of poor public health services is apparent in the number of complaints sent through to local printed media.

There is a perceived high level of inefficiency at district hospitals, which negatively affects Government's ability to provide high quality health care and scale up interventions that are necessary to achieve the health-related MDGs (Zere, 2006). Hence, Government's interest in quality assurance programmes. What then is quality health care? Several definitions have been used to define quality, but this Assessment draws on three definitions:

> *...The quality of technical care consists of the application of medical science and technology in a way that maximizes its benefits to health without correspondingly increasing its risks. The degree of quality is, therefore, the extent to which the care provided is expected to achieve the most favourable balance of risks and benefits.*
>
> A. Donabedian (1980)

"Quality in Primary health care signifies: .proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition"

M. I. Roemer and C. Montoya Aguilar, WHO, 1988:58

"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the current professional knowledge"

United States Institute of Medicine, 2001

From these definitions, it is clear that quality assurance activities may address one or several dimensions, such as technical competence, access to services, effectiveness, interpersonal relations, efficiency, continuity, safety, and amenities among others. Quality assurance has been defined as a "set of activities that are carried out to set standards and to monitor and improve performance so that the care provided is as effective and as safe as possible" (Brown, Miller, Rafeh & Hatzell, 1990, p7). Thus, quality assurance promotes confidence in service provision and improves communications.

The Quality Assurance Unit in the MoHSS was established in 2003 as a subdivision in the office of the Undersecretary for Health and Social Welfare. However, quality assurance initiatives concentrating on nursing care were in place as early as 1993 when negligence and poor patient care were a public outcry. These initiatives were implemented by the Directorate Nursing Services with the assistance of a consultant.

The Quality Assurance Unit's' vision is to achieve acceptable levels of quality through development of a continuous mechanism for monitoring quality improvement; by setting standards, measuring performance, and improving quality.

The following are the overall functions of the Quality Assurance Unit:

- Ensure compliance with standards and norms at all levels
- Ensure services meet the expectations of the beneficiaries by carrying out client satisfaction surveys
- Carry out medical audits
- Develop and disseminate policy guidelines
- Identify training needs in quality improvement activities and carry out such trainings
- Communicate the Mission and Vision of quality assurance across the health sector
- Hold Health Units accountable for quality improvement activities
- Continuously evaluate quality improvement activities and assess the possibility of accreditation of healthcare facilities
- Guide pre-service training needs
- Prioritise and approve national performance measures (indicators)
- Analyse national data and produces benchmarking reports
- Initiate and conduct operational research
- Develop tools to assess the national capacity for quality improvement activities and design training materials targeted for every level described in framework
- Provide coaching and mentoring on; quality planning, data collection, and reporting on such activities
- Contribute to the pre-service curriculum for health related trainings

2. ASSESSMENT APPROACH AND METHODOLOGY

2.1 Overall Goal and Objectives

The goal of the project was to conduct a formative assessment of the current health quality management systems in facilities across Namibia. The overall objectives of the assessment were to:

- Evaluate the existing quality management infrastructure in all 34 public hospitals, five selected health centres and two selected private hospitals
- Identify gaps and best practices in the current quality management structures
- Make recommendations for an improved and sustainable quality management programme

The more specific objectives were to:

- Describe the quality management organisational structures that are currently used in the different health care facilities
- Identify the current quality performance measurement systems and quality improvement activities in the different healthcare facilities
- Explore the involvement of clients/consumers in quality improvement activities in the different health care facilities
- Assess how the quality management programme is being evaluated
- Identify the current Clinical Information Systems in the different healthcare facilities and how the information is being used to improve quality of care
- Explore issues of patient safety in the healthcare facilities
- Assess how the clients/consumers evaluate the quality of care in the different healthcare facilities

2.2 Approach

The overall approach and methodology (protocol) of the assessment was developed by the MoHSS (QA Unit) with technical support from the CDC and project consultants. Approvals were obtained from both the MoHSS and CDC Atlanta research committees. The approach of the assessment was participatory in nature, actively engaging health facility personnel, patients and the community. The assessment was termed 'formative' because the aim was to learn what works, and what does not work while quality activities were being implemented. An additional part of the formative research was to use the results of this formative approach to improve the said service while under implementation.

Due to the nature of the assessment, a mixed method research approach was used. Both quantitative and qualitative research data collection methodologies were employed, providing the opportunity to gather a 'thick description' of the situation on the ground, complemented by a statistical representative picture.

The following seven activities took place throughout the assessment:

Activity 1: Inception Meetings

Activity 2: Development of Data Collection Tools

Activity 3: Recruitment and training of researchers

Activity 4: Field arrangements and collection of primary data

Activity 5: Data entry and validation

Activity 6: Data analysis

Activity 7: Report writing

2.2.1 **Inception Meetings**

Three Inception Meetings were held between representatives of the Quality Assurance Unit MoHSS, CDC Namibia and the project consultants. The purpose was to gain mutual understanding of the approach, methodology and timelines of the consultancy. An inception report was prepared that served as an implementation guideline for the assessment.

2.2.2 **Development of Data Collection Tools**

The following four data collection tools were developed by the MoHSS Quality Assurance Unit with technical support from CDC Namibia and the consultants:

- Health Care Workers Quality Management Assessment Tool
- In-Patient Focus Group Discussion
- Community Focus Group Discussion
- Client Exit Survey Questionnaire

2.2.3 **Recruitment, Training and Selection of Data Collection Officers**

The Data Collection Officers were identified using existing contacts, and were then approached for their availability. A screening process was used to select the best Data Collection Officers, teaming qualified nurses with researchers. Fifteen researchers were invited for training.

Prior to conducting the assessment, it was imperative to conduct training for the Data Collection Officers. The training took place in Windhoek (13-17 June 2012) and was facilitated by Dr Pandu and Mr Mouton, supported by the MoHSS Quality Assurance Unit team.

The aims of the training exercise were to ensure all Data Collection Officers would:

- demonstrate adequate administration of the quantitative and qualitative data collection instruments;
- show adequate understanding of the issues to be covered in the research study;
- understand sampling, interviewee screening and interviewing processes;
- demonstrate adequate quality assurance techniques;
- demonstrate adequate understanding of proper data collection planning and implementation;
- show adequate understanding of 'reliability' and 'validity' in terms of social research; and
- show commitment towards proper, high quality and effective data collection in the best interests of the MoHSS and its Clients

Detailed training activities are included in the Training Agenda in Annex B.

During the training, trainees were observed and their ability to conduct research and their in-depth understanding of the objectives of the assessment, validity, reliability, planning, interviewing, working in a team and working under extremely tight schedules, was reviewed. Two lead consultants assessed the researchers' capability and chose supervisors/facilitators and note takers. Trainees who were not selected for fieldwork were asked to be on stand-by, just in case they were needed for fieldwork.

Five teams were then selected, with two data collection officers in each team. One team had an extra person to assist with note taking as it was felt necessary for this particular team. It was at first expected that a person with a health background would be the supervisor of a team, however, it was realised that this was not always possible. In addition, the consultants only secured four retired nurses, and one team was led by an experienced researcher instead of a nurse.

The team leader and deputy team leader provided key leadership for the management of the teams. They were allocated as follows:

- Mr Randolph Mouton oversaw data collection in Kavango, Caprivi, Ohangwena, Oshana, Omusati and Oshikoto regions.
- Dr Pandu Hailonga-van Dijk oversaw data collection in Erongo, Karas, Hardap, Omaheke, Otjozondjupa, Kunene and Khomas regions.

The distribution of teams is detailed in the table below.

Table 1: Distribution of Field Teams

Team	Region
Team 1: Mrs Gladys Kamboo and Mr Brandon Bock	1. Erongo
	2. Kunene
Team 2: Mrs P Biwa and Ms Drusulla Hoeses	3. Karas
	4. Hardap
Team 3: Mr Peter Mbango and Mr Michael Mulunga	5. Kavango
	6. Caprivi
Team 4: Mrs Linda Nambunduga & Mrs Jeany Auala	7. Ohangwena
	8. Oshikoto
	9. Omusati
	10. Oshana
Team 5: Mr Jonas Kapanga, Mrs S Ndjembo & Mr N Israel	11. Otjozondjupa
	12. Khomas
	13. Omaheke

A pilot-test was conducted. The purpose of the pilot-test was to test the data collection tools (content and structure) and the ability of data collection officers to administer and facilitate the tools. The pilot-test was conducted at the Khomasdal and Robert Mugabe Health Clinics in Windhoek. These were the only options for pilot-testing sites, as all other hospitals and health centres were already part of the assessment sample. These two sites created a few challenges for the pilot-test because they do not have in-patients and similar quality management structures as other health centres and hospitals. However, taking these limitations into consideration, the two clinics still provided sufficient opportunity for the tools and the data collection skills to be tested. The following lessons were learnt and used in order to strengthen data collection processes and skills:

- The FGD for community members were pretty clear and straight forward, hence no changes were needed.
- The FGD with in-patients could not be pretested as there were no in-patients at the clinics.
- The out-patient exit interview was also straight forward; however some interviews were done in a hurry resulting in concerns about the validity of the responses. It was recommended that exit interviewees be approached while inside the health facilities and not when they were outside already on their way home.
- The Health Worker Data Collection Tool was found to be a little bit complicated and also too long in facilitation length. One of the reasons for the complication was the collective understanding of terminology and objectives by data collection officers. After the pre-test, the team thoroughly re-examined the questions with the aim of clarifying any misunderstandings.

- During the pre-test, it transpired that when the questionnaire was shared or given to the clients, they tended to focus on the numbers/grades and failed to actively participate or contribute to the discussion. It was recommended that the data collection tool not be shared with the participants in advance, but that the data collection officers keep the tool to themselves and once the discussion was completed, they should then handout a summary on possible areas/status/grades they thought were applicable to the health facility.

Translations of the instruments were done during training by the data collection officers into the following languages: Afrikaans, Rukwangali, Khoekhoegowab (Nama/Damara) and Oshiwambo. Other languages could not be translated e.g. Silozi, as it was also felt that the people were likely to speak English as well.

2.2.4 **Fieldwork Arrangements**

Prior to the departure for field work, the MoHSS head office communicated with officials in the respective regions about the Assessment, the starting dates to ensure that hospitals and health centre personnel; in-patients, out-patients and community members were available on the suggested dates. Data collection was planned to start on 18 June and end on 29 June 2012. However, due to challenges experienced with the readiness of some health facilities to participate in the Assessment, data collection was only completed on 3 July 2012. Although all participating health facilities received MoHSS sensitisation letters, about 40% were not aware of the assessment exercise on arrival of the data collection teams. In such cases, it was a time consuming exercise to get the go-ahead; time that could have been used more productively. However, data collection teams were flexible and health facility personnel were accommodative once all approvals and protocols were in order.

In preparation for fieldwork, the teams were given the necessary resources such as tape recorders, logistic materials, MoHSS sensitization letters, contact details of MoHSS health facility management staff and funds (for fuel, communication, refreshments during Focus Group Discussion and for any other emergency).

All members signed contracts as data collection officers, while a separate contract was signed for the rent of vehicles. Teams were given 12-day contracts from 18 to 29 June for data collection. Supervisors served as the main facilitators for the FGD for health workers, while note-takers offered support and took notes. Both conducted the client exit interviewees and in-and-out-patient FGDs.

2.2.5 **Primary Data Collection and Quality Assurance**

During the Assessment, consultants acted according to standard ethical procedures. Confidentiality and anonymity was ensured, all research participants were asked to sign a consent form. In cases where respondents refused to sign a consent form, but agreed to participate, an Incident Reportable Form was completed.

Data collection took place in all 13 regions, covering four referral public hospitals (Oshakati, Rundu, Windhoek Central and Katutura Hospitals), 30 district hospitals, five public health centres and two private hospitals. It should be noted that the sample included all referral and district public hospitals in Namibia. The total number of people who participated in the Assessment is included in the table below.

Table 2: Formative Assessment Sample

Population	Site	Planned Tools	Actual Tools Completed
18 Health care workers	3 Referral Regional Hospitals	3 FGD	3 FGDs
166 Health care workers	30 District Hospitals	30 FGDs	29 FGDs
12 Health care workers	5 Health Centres	5 FGDs	5 FGDs
12 Health care workers	2 Private Hospitals	2 FGDs	2 FGDs
200 Out-patient Exit Survey	All facilities above	205 quantitative interviews	200 quantitative interviews
92 In patients	20 facilities	20 FGDs	20 FGDs
43 Community members	8 Selected facilities	8 FGDs	8 FGDs

For a more detailed breakdown of where and what types of data collection tools were used, please see Annex C. Based on this table, 40 out of 41 FGDs were conducted with health workers. A total of 200 out of 205 Client Exit Interviews were administered, 20 out of 20 FGDs were held with in-patients and eight out of eight FGDs with community members. The Health Workers FGD was not conducted at the Walvis Bay District Hospital because the contact person at the hospital did not organise the relevant health officers for the discussion, even after it was postponed twice. A set of five Client Exit Interviews were not conducted at the Roman Catholic Hospital in Windhoek because all patients used private doctors which made it structurally impossible to interview them.

The following quality management measures were put in place to ensure the integrity of data and the data collection process:

- Visits by lead consultants. They:
    - Checked for gaps, consistency of responses and procedures of data collection
    - Provided general support and guidance
    - Ensured that proper data collection protocols were followed
- Daily telephone conferences
    - Team leaders spoke to teams daily, collecting information and sharing lessons learnt
    - They used the Short Message Service (SMS) to send SMSes to all teams summarizing and sharing knowledge and information from within the groups
- Review of interview notes:
    - Teams sent their notes weekly, and were then given the necessary feedback. Each team was able to send its notes to the project managers, who provided the needed input.

In addition, there were frequent contacts with data collection teams and data spot-checks were done to ensure the integrity of data. Team leaders provided regular ongoing monitoring of data collection through scheduled contacts with the researchers. Representatives from the MoHSS Quality Assurance Unit also visited the teams and gave constructive feedback to improve the quality of the data collection.

2.2.6 **Data Entry and Analysis**

Collected data was incorporated into an Excel database. One hundred percent of data entry points were manually validated. Although the database for data entry was prepared while the teams were in the field, data entry only started when the teams returned. All quantitative data was exported from the Excel file into SPSS for the statistical analysis, while qualitative data was entered into Nvivo.

Thematic analysis was done using outputs from SPSS and Nvivo.

2.2.7 **Limitations**

- **Reluctance by some health workers to actively participate in discussions**
    - In some health facilities, not all staff actively participated in the discussions. This could possibly have been because some staff were junior in status while others were expatriate health personnel.
- **Refusal to be taped and to sign consent forms**
    - Some teams were challenged by in-patients and community members who refused to be taped and to sign consent forms.
    - The teams were advised to respect the clients' decisions and get oral consent where acceptable. They were also encouraged to only take notes in cases where respondents were uncomfortable with tape recordings. They were reminded to complete the Incident Reportable Forms.
- **Late receipt of assessment information**
    - In a number of regions, teams experienced situations where health workers were not aware of the assessment exercise because of none receipts of letters from head office. Nonetheless, in all such cases, they agreed to be interviewed.
- **Social issues**
    - Teams were confronted with poverty, and at times after interviewing clients, they were asked for money. The groups were encouraged to deal with the situation to the best of their ability. For example, in a few cases senior citizens asked for a N$20.00 for taxi, which was provided.
- **Previous experience with surveys**
    - Some health workers said they had provided similar information to the MoHSS in the past, but their inputs were not considered.
- **Inability to facilitate some tools**
    - The Khomas team was unable to conduct a focus group discussion with in-patients at the Roman Catholic Hospital. This issue was reported to the MoHSS, who advised that it be noted as a limitation.
- **Documentation**
    - The teams were not able to receive all the necessary supporting documents from the different health facilities.
- **Definitions of terminology**
    - The researchers faced some challenges as some participants had difficulties in understanding the word 'quality'.
- **Participation**
    - There was limited participation of in-patients at some sites. For instance at one of the sites, only four in-patients could be gathered for the FGD. Their responses were however sufficient enough, although they was not really active participation because of their medical conditions.

2.3 **Structure of the report**

The report is divided into eight categories aimed at assessing the current quality management situation and assurance at public and private hospitals and public health centres. Each category is divided into sub categories as per the list below.

1. Quality Management Organisational Structure:	Leadership and quality support programmes, quality work plans, quality management programme roles, staff resources, involvement, recognition and satisfaction.
2. Quality Performance Measurement:	Measurement of performance, quality indicators
3. Quality Improvement Activities:	Team approaches
4. Consumer Involvement:	Patients' involvement in quality related activities
5. Evaluation of Quality Programmes:	Evaluation
6. Clinical Information; Improvement Quality Care:	In-patient care, infection control, therapeutic committee, mortality meetings, cleanliness, health care staff attitude, information, communication and education, challenges in accessing health facilities.
7. Community Perceptions of Quality Care Mechanisms	Perceptions of health care environment, health care staff, utilisation and access to health service and patient's involvement
8. Conclusions and Recommendations	

3. QUALITY MANAGEMENT ORGANISATIONAL STRUCTURE

3.1 Introduction

One of the main findings, although not directly asked during the Assessment, was a common lack of understanding of what quality actually meant. Different participants defined quality differently and seemed to lack standardized quality management and improvement activities. A standard approach towards quality management across public health facilities seemed to be missing. This Assessment, therefore, strove to better understand the various ways in which quality was managed, monitored and improved. This section of the report will discuss main findings as they relate to quality management organisational structures including:

- leadership support of the quality programme;
- comprehensive quality management plans;
- annual quality goals;
- quality work plans for implementation;
- roles and responsibilities described in the quality programme;
- staff resources committed to support quality programmes;
- routine staff involvement in quality improvement activities;
- routine staff recognition for their improvement activities; and
- regular staff satisfaction

3.1.1 Organisational Structure

The assessment found that all health facilities had some sort of formal or informal organisational structure in place for quality management, control and improvement, even when integrated into other health structures or as standalones. In most cases, it was found that health facilities had different types of committees responsible for quality management, among other roles and responsibilities. These were within specific divisions and/or programmes, and not necessarily structures specifically focused on overall health quality management.

One of the major shortcomings relating to coordination between divisions was the fact that divisional committees did not meet to discuss quality management. Divisional committees such as the District Coordinating Committee, Hospital Advisory Committee, ARV/TB Committee, Therapeutic Committee, Employee Assistance Committee, Infection Control Committee, and others did not meet to discuss common issues related to quality management. Table 3 provides a general picture of the different committees and a brief summary of their responsibilities based on responses from health worker FGD participants.

Table 3: Divisional Health Facility Committees

District Coordinating Committee	It focuses on the management of the entire district, and looks at the management of facilities and patients, quality improvement, financial and human resources. Committee members are; Primary Health Care Supervisor, Nurse Manager, Environmental Health Officer, Control Officer and Principle Medical Officer (PMO). The Regional Health Director does not sit on this committee. The committee meets once a monthly.
Hospital Advisory Committee	It focuses on linkages between a hospital and the community. The committee is chaired by the PMO. Members include Nurse Manager, Primary Health Care (PHC) Supervisor; Control Officer, line ministries, Religious Leaders and Traditional Authorities. Some issues dealt with by this committee include; transport shortages; the lengthy hours spent at facilities, and staff establishment.
ARV/TB Committee:	It focuses on the management of Anti-Retroviral Treatment (ART) and TB services. The committee is chaired by the PMO. Committee members are the CDC clinic staff, PHC supervisor; control officer, pharmacist and Unit manager. The committee meets once a month.
Therapeutic Committee	It focuses on the management and provision of medicine, blood transfusions including transportation of blood. It ensures that correct medication and doses are prescribed, and monitors stock and expiry of medication. The committee consists of pharmacists, PMO, doctors, Unit managers and nurse managers. The committee meets once a month.
Employee Assistance Committee	It focuses on helping employees with counselling services and provides peer support.
HIV Quality Improvement (HIVQUAL)	It assess and improves HIV/AIDS services. The committee consists of a Medical Officer, nurse, patients and community members
Infection Control Committee	It focuses on the effects of various infections and the general cleanliness of the environment, safety of staff and that of the patients, as well as the safety of the public. It monitors and follows up on policies and training that are done to ensure that all procedures are followed. Members include the Medical Superintendent, Infection Control Registered Nurse; the laboratory; pharmaceutical services, the departments of Works and Environmental Health Services and heads of departments of the Nursing; Cleaning Services, Operating Theatre, Central Sterile Services and Intensive Care.
Maternal and Neonatal death review committee **(National level)**	The committee focuses on maternal and neonatal deaths, analyses and prepares reports on maternal and peri/neonatal deaths. Members include obstetricians and gynaecologists (2); Senior nurse manager (Quality Nursing Care 1); Paediatrician/ Neonatologist (1); senior midwives (2); a UNAM midwifery lecturer (1) a representative from the Medical School (1), a representative from the Medical and Dental Council (1), the Director of PHC (1); Director of THC and CSS, the Director of HRD Research (1); a representative each from a women's association (1) and the Namibia Planned Parenthood Association (NAPPA); the Undersecretary for Regional Coordination, the Director of Special Programmes, a representative each from of the bilateral partners, and men's organisation
Regional - Maternal and Neonatal death review committee	It focuses on maternal and neonatal deaths, analyses and prepares reports on maternal and peri/neonatal deaths. Members include the Regional Director, CMO; PMOs, RCN, CHPA–FH and special programmes; SHPA-FP and special programmes, HIS, Regional Pharmacist, HRM, Control Officer, the Councillor responsible for health, a Regional Health Training Centre midwifery/social worker, NAPPA and a representative from private hospital

All of the health facilities who participated in the assessment said they were implementing quality management measures, but the degree to which the quality management mechanisms or structures are in place varied greatly from one health facility to another. This was largely dependent on the type of facility (hospital or

health centre, private or public). In some instances there were differences within the same type of facility. Health centres had different structures in place than district hospitals while private hospitals had different structures than public hospitals.

One of the challenges was the absence of a national guideline for the establishment of a quality management structure, resulting in all health facilities using the overall MoHSS Strategic Plan 2009-2013 to formally or informally develop a structure around quality management. The lack of structures in some institutions could also be attributed to the absence of such a guideline.

One third of the health facilities assessed reported that a formal Quality Committee, note that this is the hospital wide committee, existed separately from all other committees and that it met more than four times a year. Written minutes of Quality Committee meetings were kept, as well as follow-up records.

The entire staff understood the quality structure and reporting mechanisms, while the quality control programme was actively supported by the overall facility. The district hospitals for example had a nurse within the Nursing Division who was primarily responsible for facilitating quality assurance, auditing and conducting inspection, across different divisions and helping improve quality. The described facilities excluded health centres, but included public hospitals and one out of two private hospitals.

However, FGD participants said that while 55% of the health facilities might not have a separate Quality Committee, they at least had four meetings per year where quality issues were purposefully discussed. These meetings included different disciplines, such as doctors, nurses, pharmacists, administrators and record clerks among others. They confirmed that staff knew about quality activities and committee meetings. Records of such meetings were kept, it was also reported. According to the FGD participants, the purposes of these meetings were to discuss different issues, although quality assurance was one of the components. It was noted, however, that in the hospital set-up, very few committees were active. The health facilities described here include all five health centres, one private hospital and all public hospitals.

Just over a tenth (13%)[1] reported that they had a quality management structure, but that it was 'loosely' in place. This was only in public hospitals and not in private hospitals or health centres. 'Loosely' in place meant that the facilities had a few meetings at which quality was purposefully discussed, but only some staff participated. It also meant that knowledge of the loose quality assessment structure was limited to only a few staff within the facility.

[1] Please note that the frequencies for all responses are included in tables in Annex E.

Figure 2: Organisational Structure (%)

Most of the health facilities have specific divisional meetings that deal with quality assessment, such as HIV Quality Improvement (HIVQUAL) meetings or the administrative committees, but not a separate quality management committee that deals with quality management and improvement across different disciplines. In some hospitals, such as the Ongwediva Medi Park, the process has already been initiated to establish a formal committee that will specifically be tasked with quality assurance and improvement. Health facilities not having such a committee, at the time of assessment, included both public and private health facilities. However, the Medi Park in Ongwediva had a hospital committee, which consisted of unit managers, administrators, medical doctors, pharmacists, and radiology technicians who met monthly and kept minutes and records of their discussions and follow-ups. But, this was not a separate Quality Management Committee.

The majority of the divisional committees faced several challenges with regards to quality management; especially the shortage of staff. In addition, available data at health facility levels were not used effectively to analyse quality challenges and their impact on patients. It was also unclear how the different divisional committees related to each other and whether they all strived towards one mutual goal of providing a high quality service to clients. A committee bringing representatives from different divisions together was missing in two thirds of health facilities, meaning that they operated in isolation from each other and in a non-coordinating fashion. Lastly, the assessment noted that the role of the Regional Director seemed to be missing in all this.

3.1.2 **Leadership Support for the Quality Programme**

Health Worker FGD participants were asked if the facility leadership supported the quality programme that they had in place, 5% said although health facility leadership reviewed quality data; provision of support for quality improvement was not consistent as the leadership was involved only when needed. Participants said leadership had limited experience in quality improvement activities. However, none of the FGD participants said there was no evidence of leadership involvement in the quality management of care programme/s.

One quarter, 25%, of all health facilities who participated in the assessment said their facility leadership was proactive with regards to quality improvement. They actively facilitated continuous education related to quality, and that quality improvement issues were regularly discussed in leadership meetings. However, some respondents said leadership “does not know what proactive means”, referring to the inability by some managers to prevent problems from happening and to solve problems that occurred in a timely manner.

The remaining 70%, said leadership regarded quality improvement as a priority as they supported staff and quality activities routinely. Respondents said leadership supported quality programmes through various ways, such as ensuring that staff under their supervision understood procedures and adhered to them; reviewed the daily mid-night census; were represented on most critical committees; did their supervisory visits and selected or nominating different individuals for different trainings. They confirmed that Unit managers also did spot-checks of other units not under their supervision for constructive criticism and advice.

Figure 3: Health Facility Leadership Support for Quality Programme (%)

Although the majority of the facilities received leadership support for quality management and improvement, the following challenges were mentioned by Health Worker FGD participants:

- Some leaders seemed to be reactive to a problem or respond to the number of SMSes in the daily newspapers complaining about the health system.
- In one health facility, staff expressed concern with the PMO who was not supportive due to competing priorities. They said that, "the support from the PMO is lacking as he is most of the time busy with his private practice". In light of this, and the perceived weak performance of some doctors, some participants felt leadership lacked the ability (including structures, guidelines and relevant tools) to measure the performance of medical doctors.
- While training was provided at some health facilities, it was unclear how the staff uses the knowledge gained from the different trainings. They also expressed dissatisfaction that only few people benefited from training as reflected in the following quotation. "The in-service training should be more diversified so that some departments are not left out and they do not see themselves to be less important because they did not attend training".
- Inability of leadership to attend meetings due to competing professional priorities.
- Lack of human resources is a huge concern. Many leaders in acting positions lack the authority to make decisions.

"The main challenge that we are facing is the non-existence of a tool or guide to assess the performance of doctors. This is crucial as it should form part of quality management to ensure that doctors are performing to the best of their abilities. I have been advocating to the national level to put in structures to assess the performance of doctors but up to now no response from the national office."

Although questions regarding the Quality Assurance Unit at MoHSS head offices were not specifically asked during the assessment, concerns were raised about the leadership role of the Quality Assurance Unit. The existence of a Quality Assurance Unit was identified as a positive development, where the following main activities were implemented:

- Implementation of projects, such as the Medical Injection Safety Project
- Tools such as the enrolment of the Infection Control Assessment in eight pilot sites
- Training such as in Waste Management; Effective Ward/Unit Management; Leadership and Management Workshops; Clinical Governance; Maternal Death Reviews for midwives; Team Guidance Workshops; Quality Improvement for managers, Record Keeping focusing on the nursing process; and in Decontamination, Disinfection and Sterilization Services.
- Development of guidelines such as Infection Prevention and Control; Post Exposure Prophylaxis; Waste Management Policy; Safer Blood Transfusion by nurses
- Forums such as Medical Doctors and Dentists Forums

Findings revealed that the Quality Assurance Unit was experiencing the following challenges:

- Inability to carry out effective and efficient audits,
- Inability to effectively consult and advice; and a
- Lack of clarity of expectations between the Unit and health facilities.

3.1.3 **Comprehensive Quality Management Plan**

Health Worker FGD participants were asked if their facilities had a comprehensive quality management plan in place. Most of the FGD participants said the hospital management plan was equal to the quality plan, because the hospital plan was inclusive of all operational, human resources, procurement, financial, management, and quality and community aspects. In addition, many FGD participants referred to their annual work plans as their quality plans. However, some annual work plans may or may not have included quality issues. Annual work plans were often confused with quality plans as reflected in the following quotations: “Our work plan is defined fully. Each division has its own work plan derived from the ministerial strategic plan, and this work plan includes timelines”. Another participant noted, “When it comes to quality, I’m not sure whether it is included in our work plans”. There were also individual divisional or programmatic quality plans such as the HIVQUAL[2], Public Health Unit Plan, Nursing Services Plan, Logistics Plan, Maintenance Plan, etc. that may or may not have included quality depending on the health facility. However, almost all health facilities did not have a separate comprehensive plan for quality planning, management, monitoring and evaluation.

Taking this into consideration, the Assessment found that more than two-thirds of the respondents reported to have quality plans, although these were not separate from hospital plans, annual work plans or in some cases individual divisional plans. One FGD participant said, “Indirectly there are quality plans, but just not called quality management plans. There are procedures such as nursing procedures and orientation and training procedures. There are also Standard Operating Procedures (SOPs) in place for each department. From the nursing side, there are procedures specific for this facility but there are also procedures from the MoHSS they need to follow”. Close to one-tenth, 8%, mostly health centres said there was no written quality plan in place. One fifth, 20%, of FGD participants said the quality programme had only a loose outline of a structured quality plan; a written plan that did not reflect routine quality improvement activities. Over a quarter, 27%, said their plans were updated and reviewed annually, while close to half, 45%, of the health facilities said their quality infrastructure included a written plan with a committee that oversaw the implementation of such a plan. However, this was not a separate comprehensive quality plan, but part of an overall management plan that dealt with quality among other issues. This response was from public and private hospitals and not health centres.

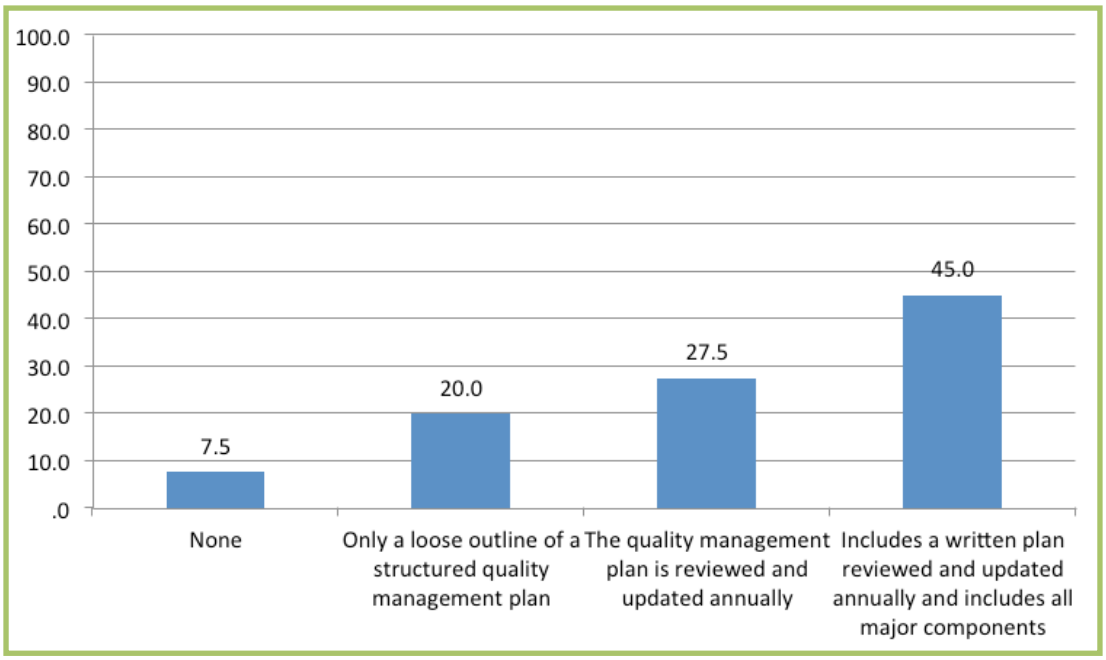
[2] HIVQUAL is a MOHSS led program coordinated by the Directorate of Special Programs, and supported by the CDC since 2007

It was found that private hospitals had work plans in place. According to one respondent "this is a private hospital and budget-orientated; thus timelines are a crucial part of the facility management. We have immediate, medium-term plans and long term plans; and timelines are set by managers. There are also activities done on a monthly, quarterly and annual basis and quality is continuously measured."

Concerns were raised by some FGD participants that in cases where quality management plans were in place, such plans were not comprehensive, and were known only by the top management of health facilities. The assessment noted that quality was assumed to be integrated into overall facility work plans. However, it was not clear how the current work plans measured quality. A work plan was also often associated with job descriptions, and often its evaluation was confused with staff performance evaluation.

Additional challenges mentioned were that some roles were over lapping; hence it became difficult to determine who was doing what, resulting in lesser quality improvement. While staff had daily, weekly, quarterly and annual work plans, it was unclear how they all fitted together and how they eventually fed into the national level strategic plan.

Figure 4: Existence of Quality Plan (%)



3.1.4 **Annual Quality Goals**

Overall annual goals at the majority of health facilities were found to be based on the MoHSS Strategic Plan with limited deviation by health facilities. Similarly, the donor funded health programme goals were based on the funders' requirements. Some programmes had specific quality goals, e.g. HIV and AIDS, Maternal Child Health, Maternal and Neonatal programmes. Divisional quality goals were also established. However, most quality goals were set to be included in the overall health facility goals or programme and divisional goals and not separately laid out.

Therefore, half of the facilities claimed to have facility specific quality goals while the other half did not. It was found that only one, 3%, of health centres indicated that the facility did not have any established annual quality goals.

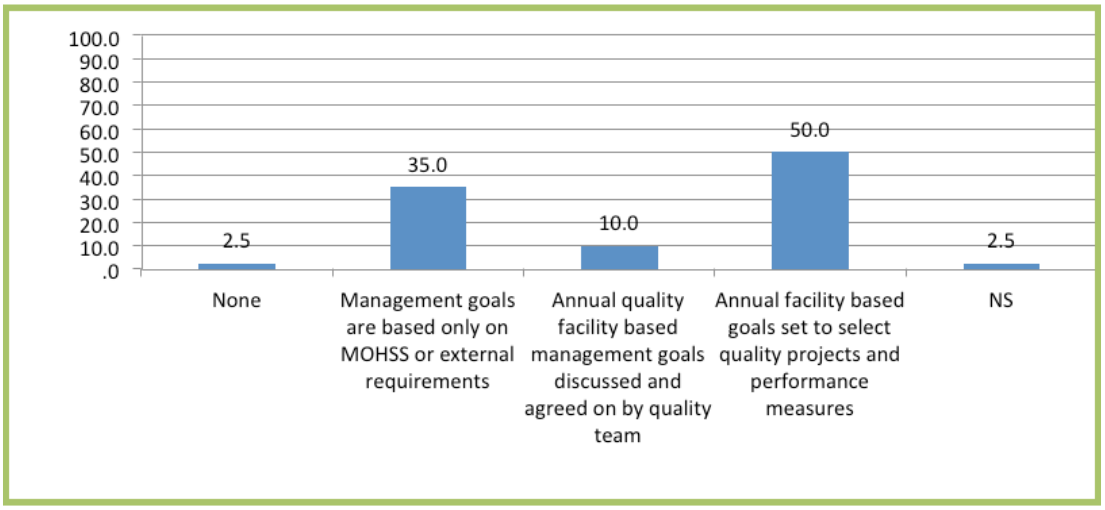
"Yes, we have goals. The goals are done on daily basis because it is a private hospital that works on strict budgeting. The unit managers have the responsibility of submitting unit proposals to the General Manager requesting what they need for their units to deliver quality service and care."

Just over one third, 35%, of the facilities had quality goals that were based mostly on MoHSS or external requirements, but not internal facility specific quality goals.

One tenth said they had annual quality based goals discussed and agreed upon by a team; but that these had loose processes in place to update goals and that goal selection and prioritization were not clearly defined. One FGD participant said, "We have different committees that have plans and we as a facility want to reach these goals. Even if we don't have them on paper at the end of the year one can see if we have reached it".

Close to 50% reported that health facilities had annual goals set to select quality projects and performance measures. The selection and prioritization processes were clearly defined and goals were relevant to facility needs. These facilities had an annual review and update of such goals. Please note that private hospitals fall into the latter 50%. Private health facilities have their own goals, which compliment MoHSS goals and are in line with their funding agents/mother bodies.

Figure 5: Annual Quality Goals (%)



Note: 'NS' refers to the percentage of facilities who did not respond to the questionnaire

3.1.5 **Quality Work Plan for Implementation**

Only two, 5%, of the 40 health facilities said they did not have work plans for implementation of a quality programme and that no specific timeframes were established. The remaining 95% of facilities had work plans ranging from informal processes,3%, to moderate planning for near future activities,38%, to a full work plan with timelines and individual roles and responsibilities in place, monitored and evaluated by a Committee,52%[3].

It should be noted that many of those with moderate to full work plans, mentioned that these plans were part of the overall facility plan or annual work plans, and not separate quality work plans. One health worker said, "Indirectly there are quality plans, but just not called quality work plans. There are procedures, such as nursing procedures, orientation and training procedures. There are also Standard Operations Procedures (SOPs) in place for each department. There are procedures specific for this facility, but also procedures from the MoHSS. But these are not necessarily called quality work plans".

[3] Please note that the remaining two were missing values.

3.1.6 **Roles and Responsibilities Described for the Quality Programme**

Overall, 53% of the Health Workers interviewed indicated that they had clear roles, responsibilities and accountability, while 15% felt that staff had vague ideas about roles and responsibilities for the quality management programme. Those who reported vague ideas worked at facilities with a loose quality organisational structure, an informal and formal structure, meaning that unclear roles and responsibilities were prevalent even when perceived structures were established.

"Yes, there are roles and responsibilities, but they are just not as transparent as it should be and they are not clearly documented. Some of the duties such as the clinical, nursing, administrative, and education duty are clear. Most of these roles and responsibilities are clearly engraved into their minds as professionals. There is a need for defining and put the roles and responsibilities in writing"

Close to one-third, 30% of the discussion participants felt that key roles and responsibilities were clearly described, but that follow-up responsibilities for quality services were not clearly defined.

However, it should be noted that many of those who said clear roles and responsibilities referred to their overall roles and responsibilities and not roles and responsibilities directly within the quality management structure per se. This was the case because many regarded quality management not as a separate activity, but as part of their overall daily roles and responsibilities. The high percentage for clear roles and responsibilities should therefore be regarded with caution. See Figure 7 for more details.

Concerns were raised that although most staff were aware of their roles and responsibilities, such roles and responsibilities were not always clearly documented. Two health facilities indicated that they were not given any job descriptions; the employment contract acted as the job description. The cleaning staff were not always seen as important when it came to quality management, hence their absence in meetings.

3.1.7 **Staff Resources Committed to Support Quality Programmes**

The assessment found that while some resources were committed to support the quality programmes, there was limited time to focus on quality improvement primarily due to staff shortages and competing priorities. Staff resources were not being committed to quality programmes per se, but existing staff were allocated quality management roles and responsibility in addition to other mandatory roles and responsibilities. At least 59% of the health worker FGD participants were of the opinion that key staff were assigned to focus on quality activities, but dedicated time was not allocated for such activities. The majority of health facilities, over 90%, said they had staff shortages, and hence little time was dedicated to quality activities.

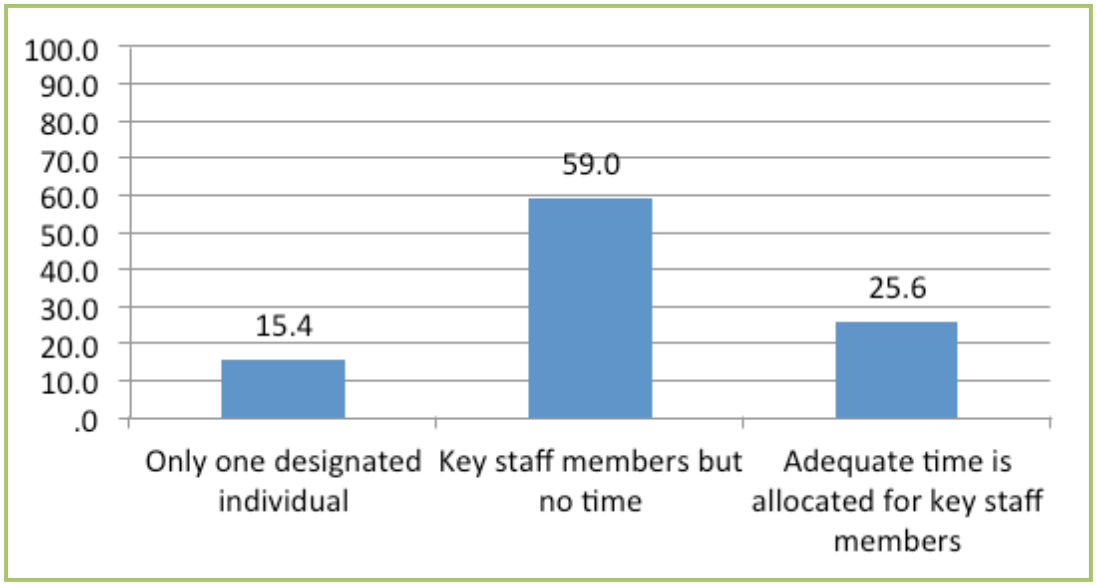
In the current environment of staff shortages, staff are expected to be multi-skilled in order to attend to all the activities and requirements of a respective health facility. Concerns were, raised about the number of programmes introduced and added on a regular basis, with no consideration for staff compositions. The statement below reinforces what was said about staff shortages: "Before the ARV programme, the clinic had three staff, it still has three staff. Consequently the quality care of the patient is lost; patients do not get enough attention as they should".

"I have been provided with training opportunities but I cannot attend because I am the only pharmacist, we are under staffed.
"In general one person is assigned to a maximum of three programmes
"Only one person is running the whole staff hospital, staff have also indicated that no dedicated times is allocated to members in committees to perform their functions"

Of those who participated in the health worker discussions, 15% said only one person was designated to perform or coordinate any efforts related to quality, but that quality was not part of that person's job description. One quarter, 26%,

of the respondents said adequate time was allocated for key members to perform routine quality related activities, in addition to being formally expected to conduct or participate in quality activities.

Figure 6: Staff Resources (%)



Staff shortages have resulted in health workers not attending extra related activities; be it training or meetings beyond their already hectic schedules. In addition, staff shortages have led to junior staff taking on additional responsibilities. For example, in some hospitals, enrolled nurses are doing the work of registered nurses, which is not part of their scope of practice and might have negative consequences should anything go wrong. This is further complicated by the language barrier between doctors and patients, because many doctors are expatriates. One Health Worker said "How can we appoint someone for quality management when we are busy translating for doctors who are unable to speak local languages, and nurses are committed to conduct translations? The doctors are switched every six months and the duration is not long enough for them to learn the languages; they should be assigned to the hospital for at least two years." A number of health professionals said their hospitals seemed to be dumping grounds for some doctors. A respondent said: "This hospital is a dump-site for foreign doctors, and this is very frustrating to everyone here."

It is very difficult for health personnel to execute mandatory roles and responsibilities and at the same time pay attention to quality issues when they are already overworked and understaffed.

3.1.8 **Routine Staff Involvement in Quality Improvement Activities**

Generally staff are sent for various training, not necessarily focused on quality, but including TB, Malaria and HIV and AIDS. Quality could be part of such training. Health worker participants said training in quality management was not provided per se, but as part of other training. They further pointed out that there was limited training specifically on quality management, as many managers did not especially search for it. Thus, 38% said staff received training in quality management and that they knew about quality improvement principles and were actively involved in quality planning and implementation. The same percentage reported that their health facilities did not have a formal process in place to routinely involve all staff in quality activities, but that some staff had attended external training while some participated in quality improvement project activities. At least 23% said only a few people had access to training opportunities, that no additional resources were available for quality training, and staff were not routinely included in quality improvement activities.

"Staff is routinely sent for trainings; however, it's only the same staff that attends workshops."

Figure 7: Staff Involvement in Improving Performance (%)

Some health facility workers complained that only some people were sent for training, and not all. Dissatisfaction was voiced against the selection criteria for those attending training, and the impact this had on those not selected. It was found that facilities did not have formal guidelines in place on who should attend workshops and training exercises. This was exacerbated by the fact that training is not decentralised to the regional level, resulting in management only inviting some facilities to attend. "Training is determined by the national level. We are often not invited and there are no resources (both financial and human) to attend those trainings".

Staff shortages made training attendance difficult at most health facilities, especially at health centres where there were only two nurses. Another challenge was the lack of feedback by those that attended training, which meant no further distribution of skills.

3.1.9 **Routine Staff Recognition for Their Improvement Activities**

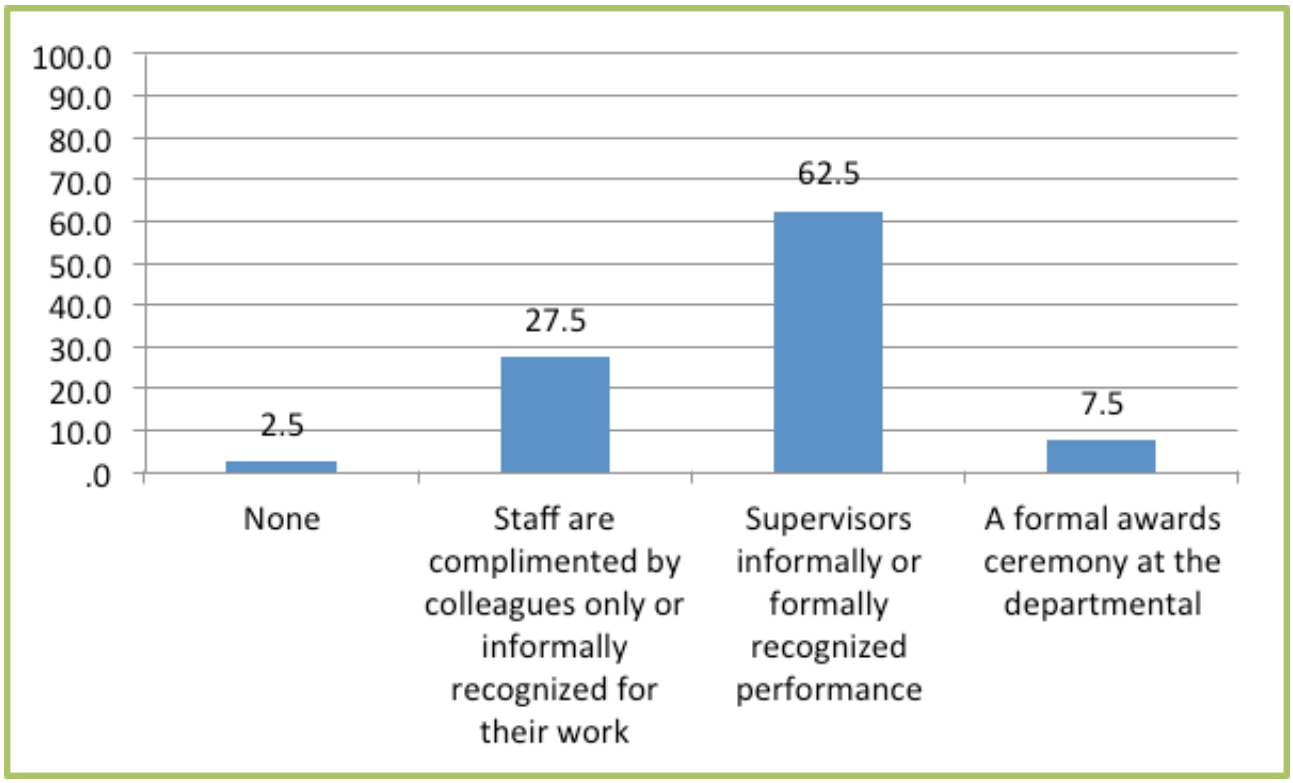
Sixty-three percent (63%) of all health facilities that participated in the Assessment reported that supervisors informally recognised them for their work. Close to one-tenth, 8% reported that a formal awards ceremony was conducted at facility level recognising staff that had exceeded expectations in their performance of quality improvement activities. The 8% included both public and private hospitals, but no health centres. Some examples of such recognition activities were listed as:

- A Nurses' Day where performing nurses are chosen by other staff
- Issuing of certificates, accompanied by a cheque for five years' dedicated uninterrupted services
- Christmas party for staff
- Incentives and living allowances
- End of year issuing of bags with goodies to cleaners

The public health hospitals, who are part of the 8% mostly issued certificates and organised Nurses' Day activities for outstanding jobs in general, which included quality improvement activities. Private hospitals organised similar activities to reward their staff.

At least 3% said health facilities had zero staff recognition for improvement activities, while 28% said they were complimented by colleagues only or informally recognised for their work.

Figure 8: Routine Staff Recognition (%)

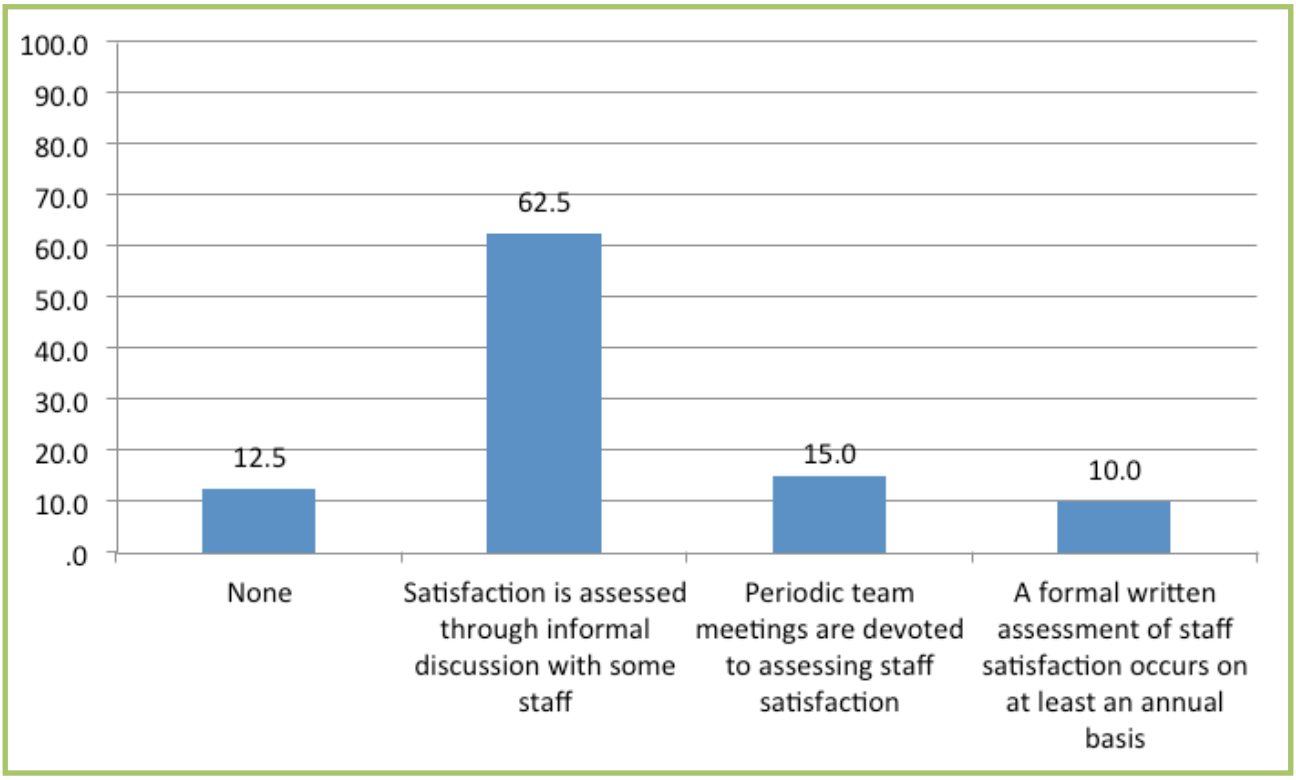


In the majority of public health facilities, the Assessment found that there is no formal recognition, no reward or incentives attached to good performance. It did not matter whether a person's performance was outstanding, mediocre or not, all receive the same salaries. Furthermore, the reward system seemed to focus on nurses and excluded other health workers and administrative staff, such as cleaners who provide an essential service. The lack of criteria and non-existence of a formal measure of outstanding performance made it difficult to implement a common programme in all facilities

3.1.10 Staff Satisfaction Regularly Assessed

The assessment found that a formal written assessment of staff satisfaction was done on an annual basis at one-tenth of all health facilities that participated in the study. At least15% of the facilities researched had periodic team meetings with some staff devoted specifically for assessing staff satisfaction. The majority of health facilities,63%, had informal discussions with some staff where staff satisfaction was assessed, while 13% of health facilities did not assess staff statisfaction at all.

Figure 9: Assessment of Staff Satisfaction (%)



Recommendations Quality Management Organisational Structure

- Departmental meetings should be held regularly with clear Terms of Reference
- Health facilities should strengthen current systems for quality management
- They should design and develop proper tools for quality management
- Leaders should take a proactive approach related to quality and not wait for an outbreak or a complaint from patients to act
- Sufficient resources, both in terms of financial, material and human resources, should be provided to support systematic quality management
- Programmes should be introduced with the assistance of regional and national offices to asses all health facilities
- There should be strengthening of all human resources in quality management
- There should be provision of annual ceremony/incentives for staff, health management teams and health facilities to recognise their progress and ensure that systematic QI processes are in place in all health facilities
- The leadership role of the Quality Assurance Unit should be strengthened at national level

4. QUALITY PERFORMANCE, IMPROVEMENT, PATIENT INVOLVEMENT AND EVALUATION PROCESSES

4.1 Introduction

This section of the report will look at quality performance measurements, quality improvement activities, patient involvement in quality management and evaluation of quality programmes.

4.2 Quality Performance Measurement

4.2.1 Routine Measurement of Quality of Care

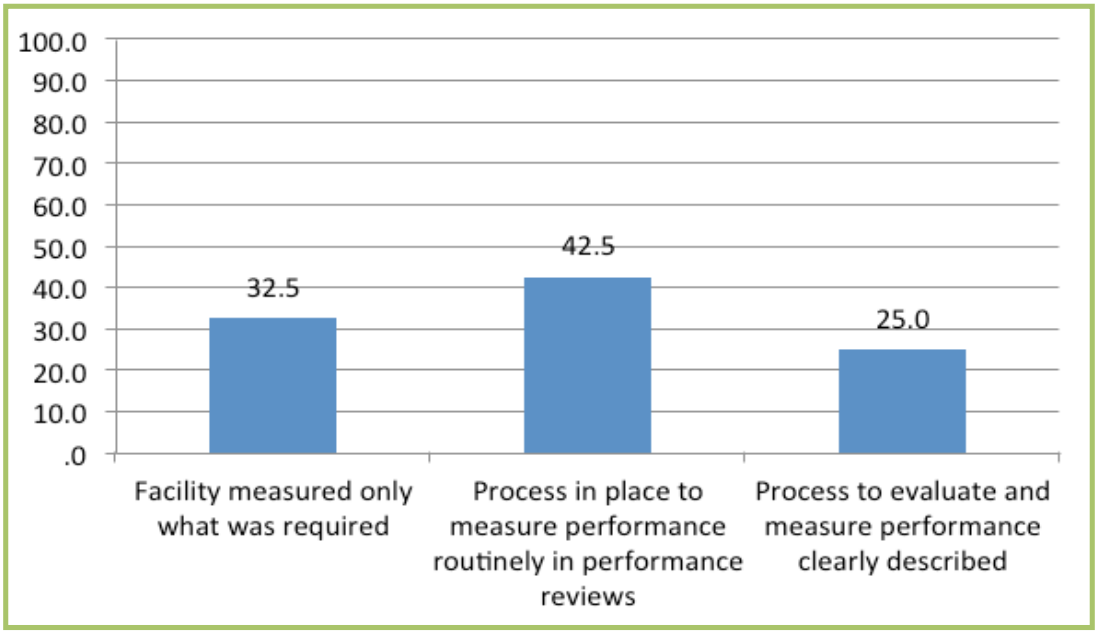
All of health facilities assessed measured the quality of care to different degrees. One-third, 32% of respondents said their health facilities measured only what was required, and that measurement only took place once in a while with the involvement of only a few staff. Close to half, 43%, of the health facilities had a process in place to measure quality of care performance routinely but lacked follow-ups based on results. At least 25% had a clearly described process to evaluate and measure performance, including indicators and annual measurements by facility leadership. Staff were also trained based on such reviews.

The following were identified as key quality care measurement activities:

- Audit of patient files by managers
- Maternal child health, maternal and neonatal death reviews
- Routine measuring of indicators
- Normal death review audits
- Therapeutic committee that looks at prescriptions and if guidelines are followed
- Infection control committee
- Supervisory visits by the staff from head office mainly from the Quality Unit, Directorate of Special Programmes and Primary Health Care Directorate
- Other tools include Nursing Care Plans, Nursing Assessment Forms and Patient Evaluation Forms
- Client questionnaires (private sector hospitals)
- Suggestions boxes (in some public facilities, but almost never looked at)
- Monitoring by donor fund managers

"There are no tools based on quality activities - we can rate it useless.... Some programmes have a check list, but we don't know we have never seen them."

Figure10: Routine Measurement of Quality of Care (%)



Although 25% indicated that there was a process to evaluate and measure quality of care, the Study found that half of the health facilities did not internally develop indicators, and that there was limited usage of such indicators where these were in place. As one respondent said, "some programmes have a checklist, but we don't know... we have never seen them". Although there are supervisory visits at all health facilities, some participants did not have a thorough understanding of their role and what was done during the supervisory visits. In addition, measurements often focused on in-patients and not on out-patients. Although they focused on in-patient, it was found that the voices of the patients were missing as the measurements were from the perspective of the provider only.

4.2.2 **Selection of Quality Indicators**

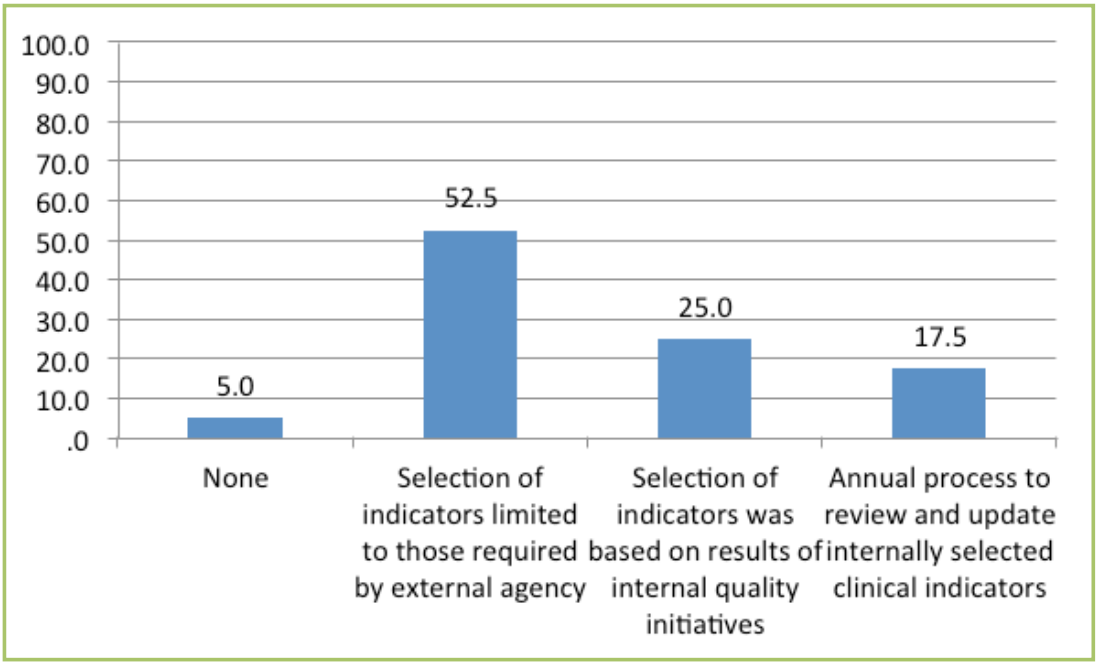
Five percent (5%) of health facilities did not select indicators to measure performance. Just over half, 52% of the facilities' selection of indicators were limited to those required by external agencies (i.e., MoHSS or donors). There were concerns regarding limited usage of such indicators in places where they were present, as they were only used to report to external agencies. One-quarter, 25%, reported that their selection of indicators was based on results of internal quality initiatives. The indicators had written definitions and frequencies for review. They said staff were aware of the indicators, which reflected the standard of care provided. They also collected indicators for national reporting. Some staff referred to the indicators in the strategic plan, but were not able to say what those indicators were.

Close to one-fifth, 18%, of health facilities that participated in the Assessment reported to have a process to review and update internally selected clinical indicators and that such indicators were clearly defined and understood by staff.

The Pharmacy was one department that had indicators that focused on the number and type of medicine; number and type of antibiotics prescribed by doctors. These indicators mainly helped to trace the prescription of medicine and the availability of medicine. Hospitals mostly used standard externally-developed guidelines as indicators, while two of the health facilities tried to develop their own indicators, but were not successful as they did not receive the necessary support from the national level.

"Indicators are selected but sometimes they are not well understood by all the staff. The whole staff needs to be involved in the whole process of planning so that they can give their input and suggestions. There is a need to create awareness and discuss indicators department-by department and give reasons why they have to be measured" – Katutura Central Hospital)

Figure 11: Selection Method of Quality Indicators (%)



Some of the indicators or sets of indicators that are currently used include:

- Key Performance Indicators (KPI) as defined by the MoHSS for all programmes
- HIV and AIDS indicators developed for donor requirements by donors, such as the number of patients receiving ART and types of ART, incidence and prevalence of HIV infections, AIDS related mortalities.
- The pharmacy with its10 indicators which are mostly from the MoHSS, e.g., performance prescription per day indicator: (how many medicines, number issued fully, issued some and don't have others), card balancing as per requirement, how much money was spent on medication and the number of anti-biotics prescribed by doctors
- Incidence of malaria
- Transportation indicators

While public health respondents were aware of several indicators, it appeared that indicators were mostly used for reporting to the national level or donors or ordering of medicines. A limited use was recorded for internal planning, monitoring and evaluation purposes. The assessment learnt that private health facility indicators were set by the board and based on the budget.

4.3 Quality Improvement Activities

4.3.1 Implementation of Quality Improvement Activities to Improve Quality of Care

The following were identified as structures in place to review the provision of services, including quality of services, although the entity could not be called a quality management committee. These were listed as review meetings; supervisory visits; patients review meetings; quarterly reports; patients auditing, ward rounds, and maternal and neonatal review meetings, amongst others.

"There is an infection control committee and the focal person ensures that everyone adheres to the policy. She distributes Information, Educational and Communication materials on infection control. She also conducts regular ward rounds to see if everyone is adhering to the rules. She also ensure that ward and offices are provided with masks, gloves, aprons, paper towels, soaps and disinfections such as spirits and others."

Based on the outcomes of the above meetings or structures, recommendations for improvements were made. However, other challenges such as limited staff and other resources, lack of quality management guidelines, confronted many health facilities as they tried to implement quality improvement activities.

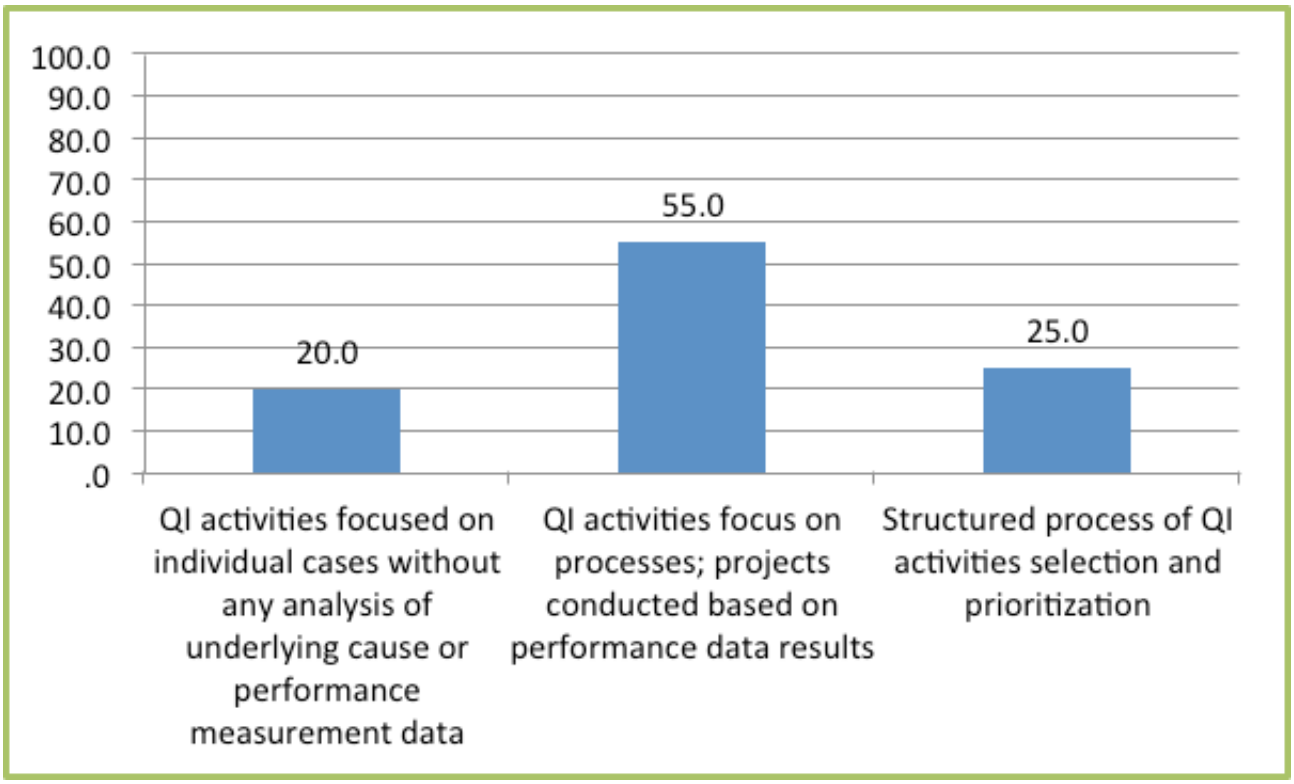
One-fifth, 20%, of health workers who participated in the FGD, said quality improvement often focused on individual cases without analysing the underlying causes or performance measurement data. Reviews were primarily used for inspection. More than half, 55% of the health workers said quality improvement activities focused on processes based on results from review meetings and/or routine checks. The remaining one quarter, 25%, said they used structured processes of quality improvement activity selection and prioritization, and these activities were data driven. They said they routinely turned patients' needs into quality improvement activities and that the majority of staff were involved in improvement activities.

However, the above percentages need to be handled with caution as health care workers who participated in the assessment continuously equated facility based quality improvement activities with specific activities such as infection control of specific diseases. One respondent said, "There is a programme called Isoniazid Prophylaxis Therapy (IPT), a preventative treatment for TB in HIV patients, which is to ensure that the patients get the best quality of care".

In addition, when the above questions about quality improvement activities were asked, most, if not all public health facilities referred to activities taking place and driven by individual divisions, departments or programmes that did not necessary feed into the larger hospital quality management plan or quality committee, resulting in a fragmented approach to quality improvement and quality management.

Another challenge was a lack of guidance in quality improvement activities from the national level. Quality assurance at facility level was fragmented because of the absence of common guidance from the national level. This was coupled with other shortcomings, such as shortages of tools, resources, time and proper infrastructure.

Figure 12: Facility Quality Improvement Activities (%)



4.3.2 Team Approach Used for Quality Improvement

The assessment noted that there were limited team approaches in quality improvement as over 62% of health facilities were of the opinion that the same staff met to discuss quality improvements. This was broken down to 35% who felt that methodologies for quality improvement team approaches were not used, and 27% who reported that the same staff were always used, but that approaches included using established quality improvement methodologies, Plan Do Study Act (PDSA), fishbone and flowcharting. The remaining 38% reported that a team approach was routinely used and that staff had basic knowledge about quality improvement team approaches. As one participant said, "If an issue is brought from a certain department, this is shared with other departments and then approached as a team". Others felt that the team approach was problematic as it lacked cohesiveness. People at the top gave instructions instead of using participatory methods in decision-making and delegation. The Assessment found that Fishbone and Flowcharting approaches were often used by donor-funded programmes. For instance, the Infection Control Committee used the PDSA approach. Given the complexity of the health system, a team approach was found to be critical as it involved more than one discipline or work area, with solutions that require creativity and commitment from staff and a buy-in from patients. A team approach was said to harness the knowledge, skills, experience and perspectives of different individuals to make lasting improvements.

> *"The quality assurance is supposed to be in the management matrix, but it seems that quality assurance is just at a national level. When it comes to the regional level, people are just tasked with quality control instead of consulted with, no wonder why quality assurance is fragmented".*

4.4 Patient Involvement

4.4.1 Patient Involvement in Quality-Related Activities

Different mechanisms that have been put in place to get patients involved in improving health care were identified as:

- suggestion boxes,
- SMSes to print and electronic media and NBC's Open Line programme,
- Customer Care Officers, and
- client satisfaction survey questionnaires

Close to half, 45%, of the facilities assessed patients' needs. However this was mainly based on the patients' complaints through informal channels such an SMSes sent to a newspapers or a call to the call-in programmes on the National Radio service. Close to one-third, 30%, of the health facilities only discussed patients' concerns as they arose. Patient satisfaction was not measured routinely as there was no structure in place to gather patients' feedback. Just over one-fifth, 23% routinely integrated patients' assessment of the quality health service into their quality programmes. The quality improvement projects reflected results of issues identified by consumers. Two percent (2%) did not involve patients in quality related activities.

> *"The involvement of patients is a challenge. Suggestions boxes are there in place, but patients don't frequently use them. I don't understand why patients don't use the suggestion boxes, maybe they are not interested or they just lack knowledge, nurses did not advertise the box well":*

Some hospitals such as Rundu and Windhoek Central hospital have a Customer Care Officer who gives information to the public through the media. Suggestions boxes at out-patient departments were identified as a key activity involving patients in quality related activities.

The respondents attributed the non-use of suggestions boxes to high illiteracy rates in English. They said since the suggestion box was identified in English, and not all patients could read and write English, they tended to shy away from contributing. The situation was worsened by a lack of mechanisms to provide feedback to the patients. Only one hospital said they provide feedback through the Advisory Committee that consists of a Regional Councillor, the community and religious leaders. In one health facility in the Otjozondjupa Region, staff had meetings with patients on a weekly basis and provided health education, not necessarily feedback. In addition, the Regional Director in the Omaheke Region, tried to get first-hand experience of what the patients were experiencing by sitting with the patients to find out how it felt to wait, the length of time it took to get treatment and how it felt to sit the entire day on an uncomfortable chair. Some facilities also have regional meetings which include line ministries, regional offices as well as international NGOs with the focus on quality health care.

Donor funded programmes, such as HIVQUAL have patients as part of the committee members. The committee meets on a regular basis. In addition, the existence of a Health Advisory Committee was identified as a way of involving patients.

While in the public health facilities, the patient involvement seems to be on an *ad hoc* basis, in the private health facility patients were given a patient satisfaction questionnaire to help monitor and evaluate the services offered by the facility. This was reviewed on a monthly basis. The questionnaire included the following health key aspects:

- **The hospital**: general appearance, ease of access, parking, waiting time and noise level
- **Receptionists:** professionalism, friendliness, helpfulness and appearance
- **Nurses:** professionalism, friendliness, helpfulness, appearance and nurses response to call button
- **Doctors:** professionalism, friendliness, helpfulness and appearance
- **X-ray:** professionalism, friendliness, helpfulness and appearance
- **Caterers:** professionalism, friendliness, helpfulness and appearance
- **Food:** appearance and taste
- **Cleaners:** professionalism, friendliness, helpfulness and appearance
- **Communication:** the importance of introducing oneself to patients is emphasised, as it creates rapport between the staff and the clients

In addition, the private hospitals have e-mails and websites where patients can complain. Patients are asked to provide personal details on voluntary basis, and they are directly contacted if they have any complaints or concerns. The public relations officers of private hospitals act when a concern is received by calling the patient and talking to him/her directly. All these initiatives are from the leadership. They demonstrate proactiveness, full commitment and involvement.

4.5 Evaluation of Quality Programmes

4.5.1 Evaluation process of quality programme

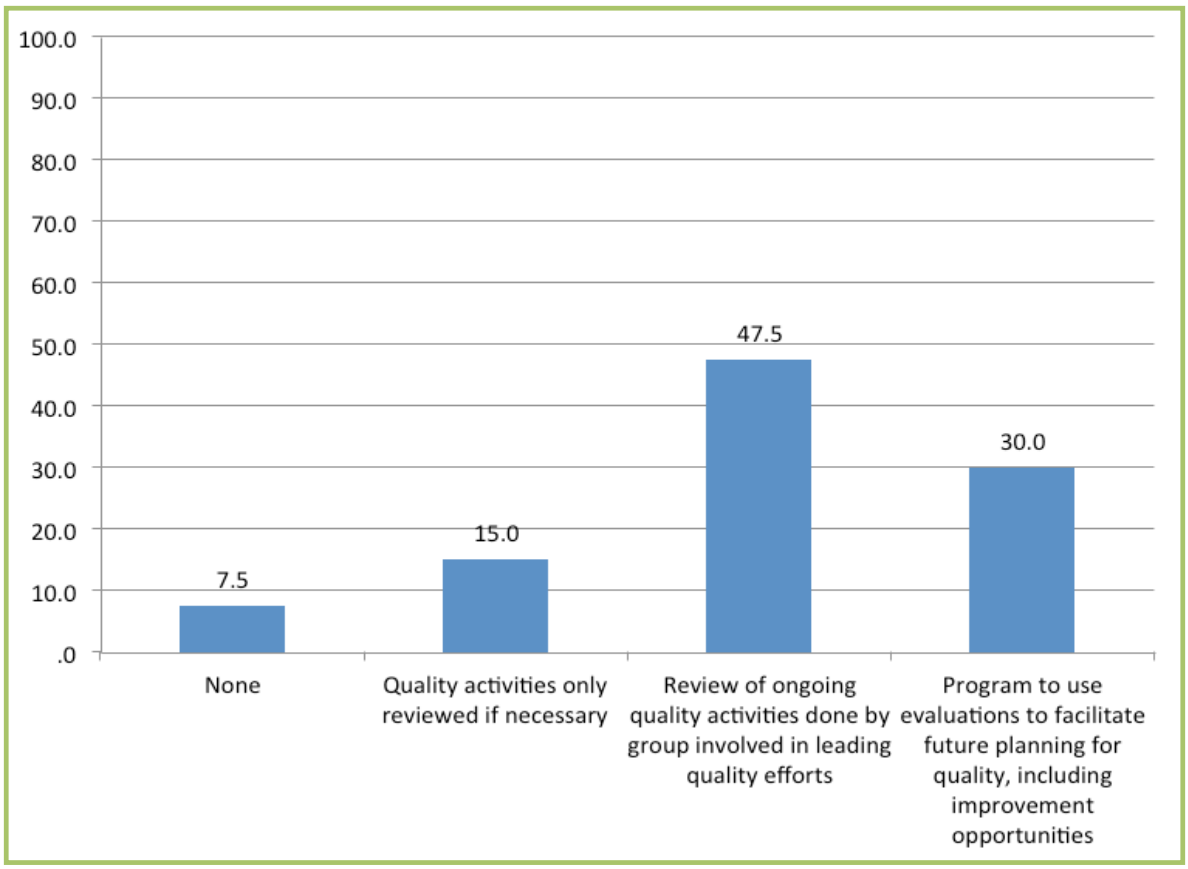
> *"Evaluation is done, but not a formalized process and there is a capacity lacking to do that on a formalized level."*

Close to a third, 30%, of the health worker FGD participants reported to have an evaluation structure in place to facilitate future planning for quality management, including identification of improvement opportunities. The assessment was told that quality committees, or management committees in most cases, were actively engaged in evaluations, and the results would be used to improve programmes. However, some of the health workers spoken to referred to programme specific quality evaluations and not overall facility evaluations. Programme specific evaluations included: IMAI, Maternal Child Health (MCH), Paediatric, HIV and AIDS, Family Planning, Immunization, IDP, Hand Wash Inspections, etc. The 30% facilities included mostly public hospitals, one private hospital and one health centre. The private sector facilities provide a different picture according to the respondents from the Medic Park who said, "The annual management plans, budgetary reports, auditing tools are all processes to evaluate quality of care. Evaluation is done on a quarterly basis and not on annual basis".

Close to half, 48%, of the participants said their facilities reviewed ongoing quality activities; where some results were used to plan ahead for future quality efforts, but not in a comprehensive manner, although summary findings of such evaluations were documented. This included one private hospital, one health centre and public hospitals.

Some 15% of the health facilities only reviewed quality health care when necessary, with no review of quality work plans, no annual review of quality goals and infrastructure. In many cases evaluations were done to some extent, although not formalized. Eight percent (8%) of the facilities did not do any form of evaluation. These were mostly health centres and one public hospital.

Figure 13: Quality Evaluation Process (%)



Some FGD participants said quality evaluations need to be led by the Quality Assurance Unit at the national level. However, concerns were raised that the Unit concentrated on nursing services only. The role of the Unit was unclear, as it was currently viewed as not inclusive.

Other concerns were about past evaluations and recommendations that were not taken into consideration by head office. One participant said, "Often when recommendations are made they seem to fall on deaf ears. We have told the Ministry time and again about the problems; they do not need outsiders (referring to the assessment team) to assess and tell them what is wrong".

Recommendation quality performance, improvement, patient involvement and evaluation process

- Develop a cohesive approach to quality improvement and management programme
- The Quality Assurance Unit should provide clear guidance to the region; who in turn should provide guidance to the district
- Develop national quality improvement guidelines to standardise continuous quality improvement practices and reporting across the health sector
- Strengthen facilities to use the team approach in addressing quality issues
- Create platforms which will help facilities to provide feedback to patients
- Redefine the Quality Assurance Unit and create awareness of its inclusiveness to dispel the perception that the Unit was created to address only nursing concerns
- Strengthen committees that are multidisciplinary in nature and not only limited to health professionals, to include cleaners, politicians, civil society and patients
- The title Suggestion Box should be in a local language and patients should be made aware of it and encouraged to write in a language they are familiar with.
- The MoHSS should strengthen or develop a culture of providing feedback to complainants be it patients or health providers, and there should be clear communication as to whom patient or health providers should direct their concerns to.
- The MoHSS should timely provide solutions to detected problems and offer recommendations on improving quality care
- Appoint monitoring and evaluation officers, or empower data clerks
- Use information generated in the planning processes
- Health facilities should analyse the data they generate to understand the status of their facilities, instead of collecting it and send it off to the national level without analysing it first
- Managers should be sent to relevant trainings that will add value to their health facilities"
- Comprehensive quality education tools should be developed to integrate or reflect on programme issues.
- Structures should be put in place, specifically focusing on quality assurance
- A position of a Quality Coordinator should be created at all levels
- Standard Operational Procedures should be available for each department
- The national level should recognise staff efforts and provide a standard questionnaire to assess staff and patient satisfaction. A routine system on patient satisfaction survey similar to the one used in private sector (text box on page 43) would be very helpful
- There should be provision of enough resources for training
- Supervisory visits should be encouraged to provide continued feedback on performance
- There should be a comprehensive quality management plan for each department and level of the health system
- Establish platforms to document, report, publish and show systematic continuous quality improvement activities at all levels of health system.

5. CLINICAL MANAGEMENT OF CARE

5.1 Introduction

This section of the report will look at clinical information systems and improvement in clinical care.

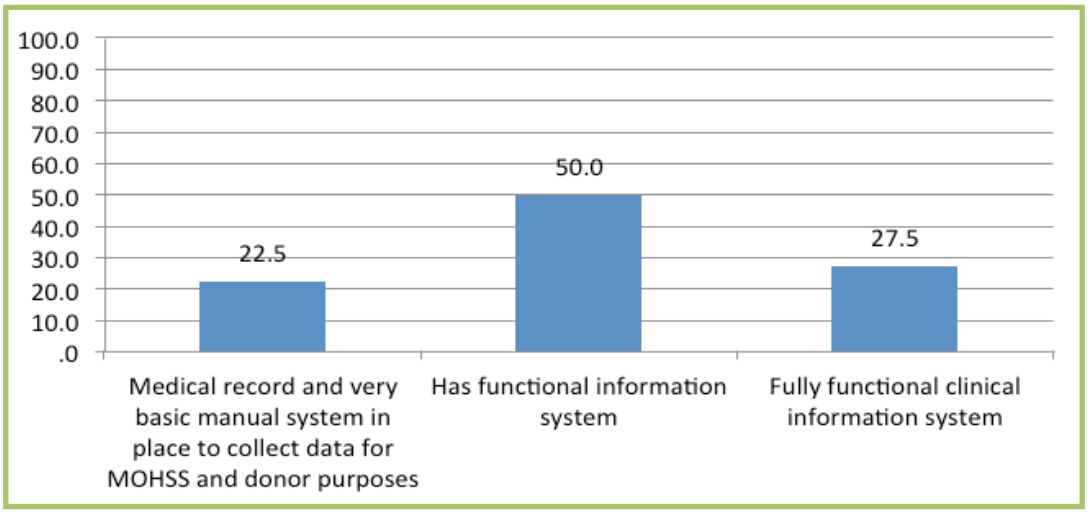
5.2 Clinical Information Systems

5.2.1 Existence of Clinical Information System to Track Patient Care and Measure Quality

Half of the facilities reported to have a functional information system (manual or electronic) to track patients and patient care. Some of the data collected was used for quality activities. However, the facilities reported limited capacity to manage quality measurements with current systems. These included one out of two private hospitals, three out of five health centres and public hospitals. The situation was described to be worse in 23% of the facilities where medical records and very basic manual systems were in place to collect data for MoHSS and donor purposes only. These included only public hospitals and two out of five health centres. Twenty seven percent (27%) reported to have fully functional clinical information systems in place to track patient care and produce useful quality of care information reports from an electronic database or health record. These included mostly public hospitals and one out of two private hospitals. Donor funded programmes such as HIVQUAL and Tuberculosis have electronic tools where all patients on treatment are added on the system. This is further complimented by the flow chart system. In the private health facilities, a patient's journey through the hospital was recorded manually while the symptoms and medication were computerized. Health facilities at the district level entered the data using a manual system while at the national level this was done both manually and electronically. Respondents said the current clinical information in public facilities was only recorded during admission with no provision made to track the patient's care. Recording of a patient's care was done manually and in some cases, it was difficult to read some people's hand writing.

Concerns were expressed about both the electronic and manual systems. Some respondents said it was difficult to extract data from the manual system, while others said data from the electronic system was not quite reliable as it did not contain all the relevant information. In addition, it seemed that only data entry occurred at hospital levels and not data analysis, resulting in little use of such data at the district and local level. The lack of a sufficient number of computers made data capturing even more cumbersome as expressed in this statement: "We are living in a highly digitalized world and the health facility should be equipped with the right technologies that would help improve quality care". This resulted in the Ministry being data rich, but information poor. While health facilities generated data they did not use the data as it was indicated. One health worker in the FGD said, "In most cases the data we generate is not used, it is just generated and handed over to the Ministry (Kavango Hospital)".

Figure 14: Clinical Information Systems (%)



5.3 Improvement in Clinical Care

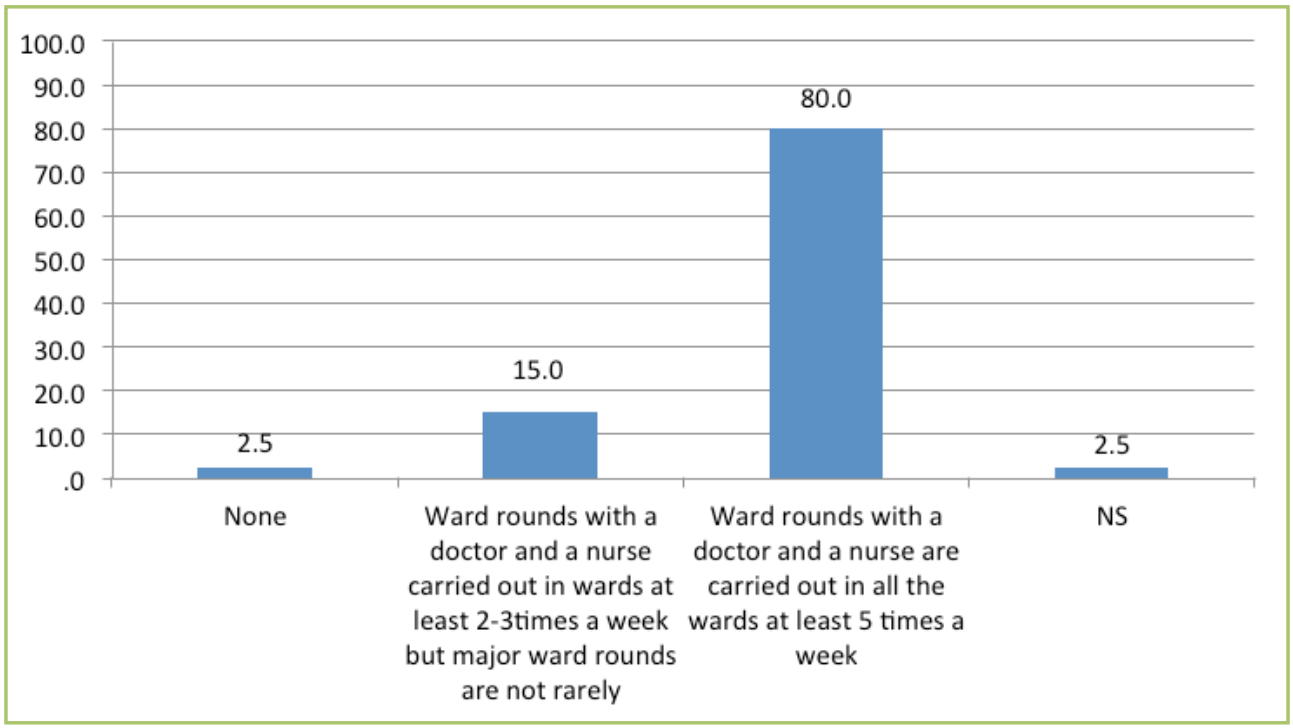
5.3.1 Types of Mechanisms in Place to Ensure Proper Inpatient Care

A large number of FGD participants felt that there was no mechanism of holding staff accountable for quality. As they put it: "People are just doing whatever they want and it is very frustrating for those who want to deliver quality care as per the oath they took". Some participants felt that there was a need to assess the performance of doctors as well as the administrative staff. The MoHSS has an attractive package to attract medical doctors; however, there were weak mechanisms in place to screen the qualifications of these doctors.

> *"If the Ministry wants to deliver quality of care to its maximum, they should urgently develop a tool or guideline to assess the performance of doctors. The absence of this process is really undermining and compromising quality of care. It also makes it difficult for the Medical Superintendents to be proactive in disciplining or releasing doctors who are not performing."*

Most health facilities, 80%, reported that ward rounds with a doctor and a nurse were carried out in all the wards at least five times a week. Major ward rounds with a team of doctors, nurses and pharmacists were also carried out at least once a week. The above includes both private hospitals, three of the five health centres and most public hospitals. Three percent (3%) noted that no ward rounds were done, which included health centres only as they did not have in-patient wards, resulting in the response being not applicable. At least 15% of public health facilities said ward rounds with a doctor and a nurse were carried out in the wards at least two to three times a week, but major medical ward rounds, which consist of key health professionals, were not done, or were rarely done.

Figure 15: Types of Mechanisms to Ensure Proper In-patient Care (%)

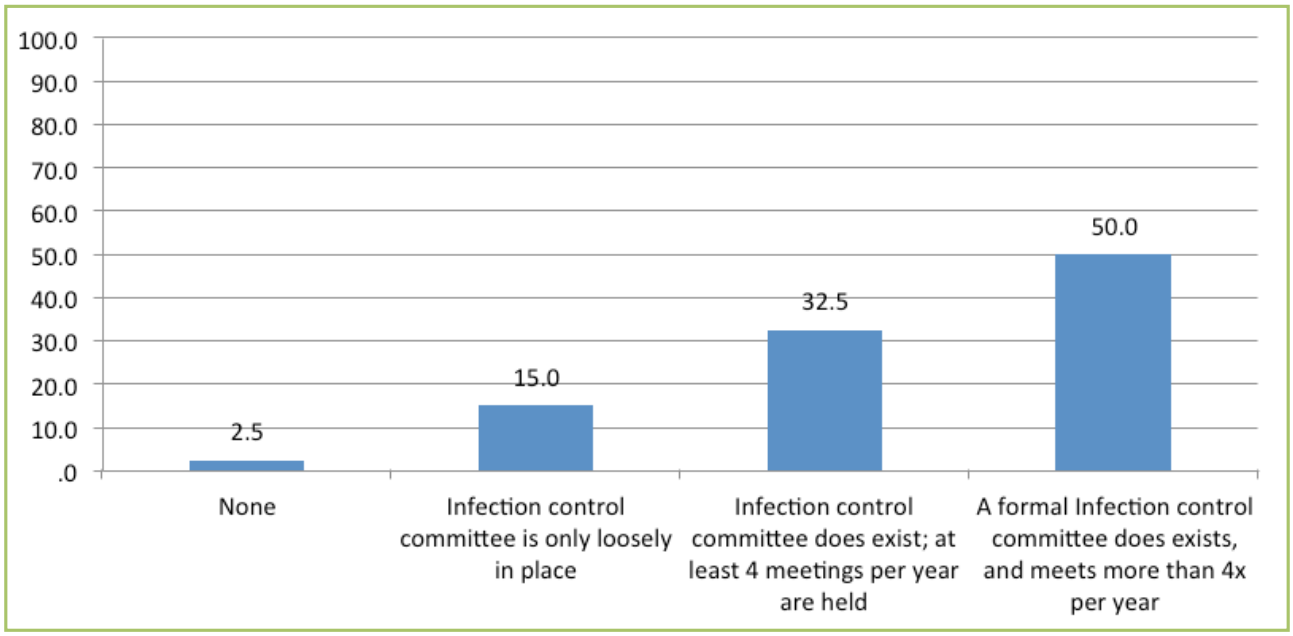


5.3.2 Functional Infection Control Committee

Only one facility, a health centre, reported not to have an Infection Control Committee or activities in place. Half of the facilities had a formal Infection Control Committee that met more than four times a year. These had written minutes and written follow-ups as well. The Assessment learnt that regular in-service training was provided with the entire staff understanding infection control practices.

The facilities researched included both private and public hospitals and one health centre. A third had a committee that met at least four times a year with staff being knowledgeable about infection control activities and committee meetings. All, documentation of such meetings were kept. However, the Assessment was told that only a few people were involved in committees while in-service training was lacking. Some people complained that only a selected few were sent for training, while some said certain administrative staff were not included. Fifteen percent (15%) of the facilities only had a loose infection control structure in place, which held a few meetings where some of the staff participated. Knowledge of infection control in such facilities was regarded as limited to only a few people. However, there was a focal point person assigned for infection control. This situation was found in two of the five health centres and public hospitals, but not private hospitals.

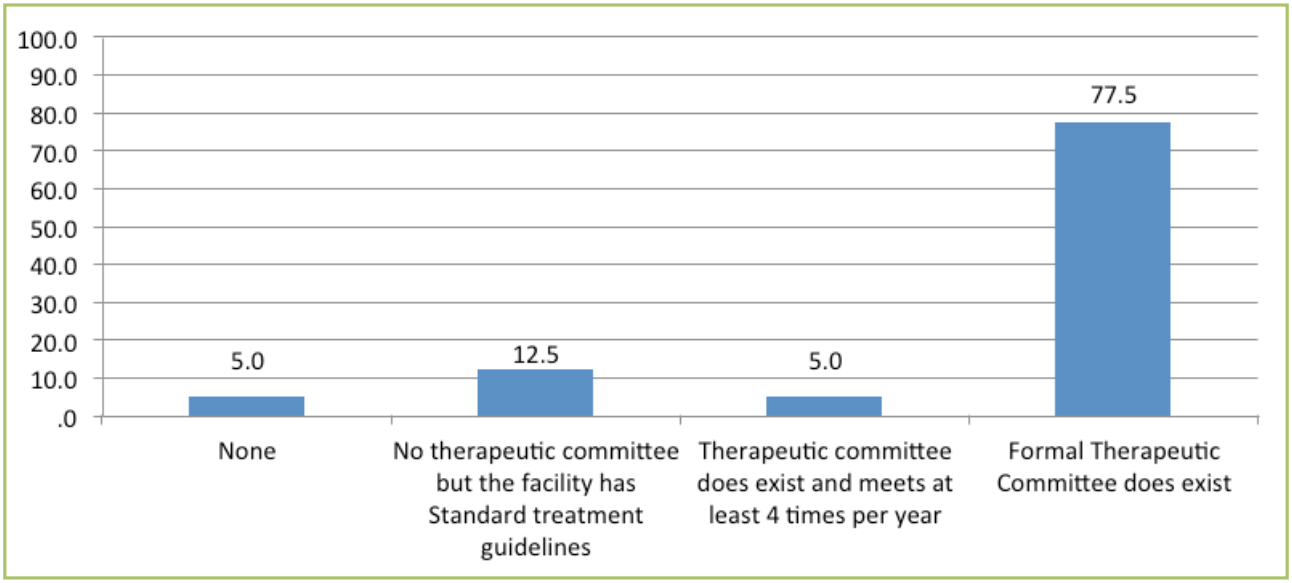
Figure 16: Functional Infection Control Committee (%)



5.3.3 Functional Therapeutic Committee

Three quarters, 77%, of all participating health facilities had a formal Therapeutic Committee that met more than four times a year. The Committee has written minutes and follow-ups. There was usually active support for the committee by facility personnel. Standard treatment guidelines were available and there were mechanisms in place to ensure that they were followed. It was considered one of the most effective committees with strong indicators, in all health facilities. At least 5% said a Therapeutic Committee did not exist, which included one public hospital and health centre. An additional 5% reported the absence of a committee as well, but they did have Standard Treatment Guidelines with no mechanisms in place to ensure that the guidelines were followed. The remaining 5% had a Therapeutic Committee that met at least four times a year, but it was not formal.

Figure 17: Therapeutic Committee (%)



Private Hospitals did not have therapeutic committees as they fully relied on the pharmacists.

There were some challenges identified with Therapeutic Committees such as the time of meetings. Some felt that meeting more than four times a year was too much; while others felt that it was sufficient because of the importance of the activity.

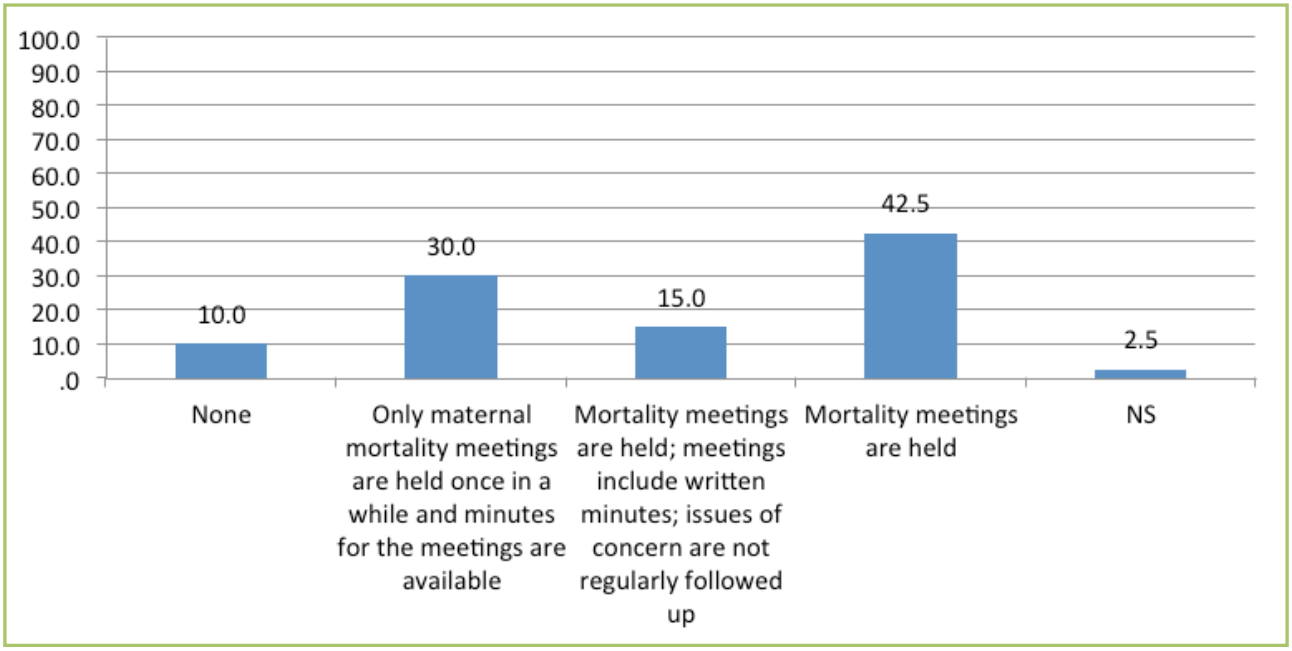
In addition, participants were of the opinion that the MoHSS many a times released new policies/guidelines without withdrawing the old ones. There were usually no instructions prohibiting the use of the older policies or guidelines.

5.3.4 Mortality Meetings

At least 42% of health facilities held mortality meetings either on a monthly or weekly basis and submitted reports to regional and national levels. Issues of concern from such meetings were regularly followed up and feedback was given in subsequent meetings. This was in addition to the normal mortality audits conducted on a daily basis. But, private hospitals did not have formal meetings on maternal mortality, but had case meetings to critically review what had happened.

One tenth of the facilities said that they did not hold mortality meetings. Close to one-third, 30% said they only held maternal meetings once in a while and minutes for such meetings were kept. An additional 15% held mortality meetings. These ones had written minutes although issues of concern were not regularly followed-up. The findings suggested the lack of follow-ups on critical issues identified. This meant that although issues were identified due to the lack of follow-up, they were never addressed

Figure 18: Mortality Meetings (%)



Recommendations

Clinical Management of Care

- Implement electronic tracking systems in all health facilities
- Train staff in the usage of the electronic systems. Include this in the pre- and in-service training of all health care cadres
- Increase staff capacity in data management and data use for quality management and quality improvement
- Provide internet, printing facilities and other information resources for quality management and quality improvement.
- Staff should be computer literate. Data capturing and analysis through computers should become a norm
- Standardise data analysis and strengthen data use for quality management and quality improvement
- Create an electronic system that integrates all relevant quality indicators at health facility, district and national levels
- Develop a comprehensive information system to track patient care and monitor quality over time
- Provide detailed medical electronic information on all patients to all health facilities. The details should include the history, diagnosis, treatment/medication and discharge.

Infection Control

- Strengthen infection control practices and provide clear guidance
- Provide in-house training
- Provide sufficient health workers and they should be assigned specific duties only (e.g. infection control only)
- Provide proper infection control commodities for the hospital e.g. hand hygiene materials, colour-coded bags, durable incinerator machines etc
- Refresher trainings should be given to keep health providers as well as cleaners, potters up to date with infection control and quality management
- Improvement of health facilities, especially renovations should be given attention. One cannot provide quality services when there is no water, toilets are out of order and there is no soap to wash hands or clean floors with for that matter.
- Infection control needs its own separate meetings, and a focal person
- Provide sluice machines where needed

Therapeutic care

- Hospital staff should be actively involved
- Treatment guidelines should be provided for all critical clinical areas
- More staff such as pharmacists and pharmacy assistants are needed
- All recommended medications should always be available in all hospitals

Mortality management

- The importance of analysing, reviewing and reporting mortality data at the health facility should be emphasized
- District hospitals should be strengthened to provide high quality care at their facilities and avoid unnecessary patient complications and transfer to other hospitals. A health provider at a regional hospital remarked, “They refer their patients who are in a bad state and die in our facility, which gives our facility a bad image”.
- Where feasible committees should be streamlined as there are too many
- Where feasible, private doctors should be members of the mortality meetings

6 COMMUNITY PERCEPTIONS OF QUALITY AND CARE MECHANISMS

6.1 Introduction

Overall, most respondents, 85%, from the Client Exit Survey reported that they were satisfied with the health services that they received on the day of the survey, while a slightly lower proportion, 76%, felt that they were usually satisfied with the service. Satisfaction decreased considerably when individual attributes were assessed such as the health environment, perceptions of health care staff, access to facilities and client participation.

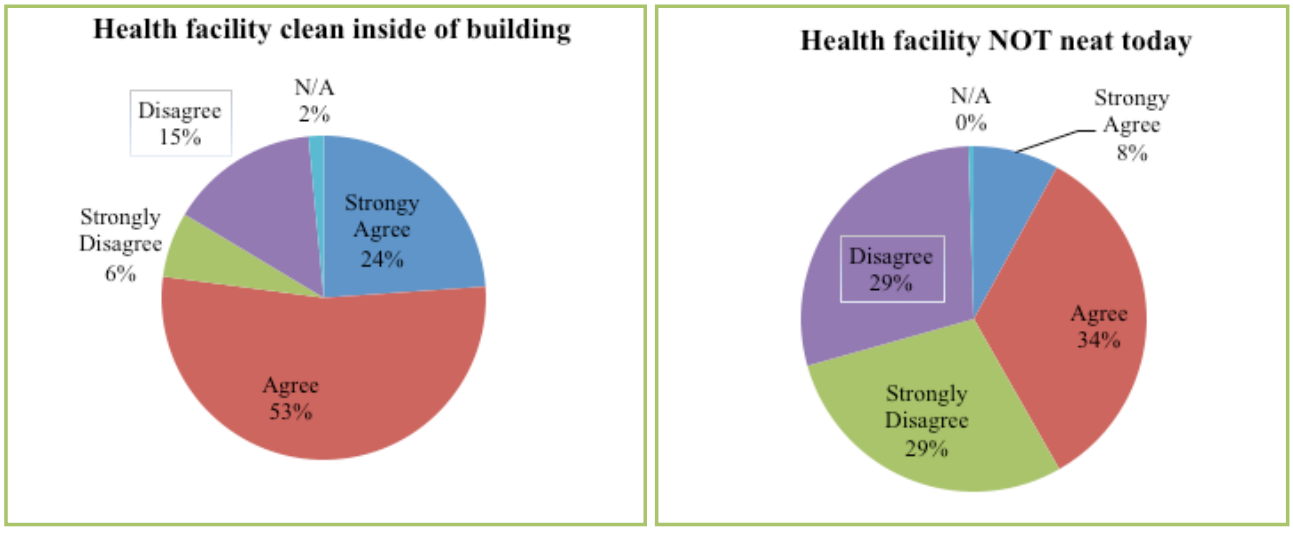
6.2 Perception of Health Care Environment

Three quarters, 77%, of clients at exiting health facilities that participated in the survey reported that health facilities were usually clean on the inside of the building. But, 48% felt the facilities were clean on the day of the visit. **Many expressed concern about the perceived lack of cleaning materials, especially strong detergents. They felt that there was a need to use cleaning detergents to improve the smell in the hospital as it seemed that water was the only thing used to clean. A respondent in Opuwo said, "They only use water to clean".**

"There is only two toilets in the ward that are functioning and times, if they are occupied we have to use the bush, which is forbidden and nurses get angry if we do so. If you are very sick you have no choice, there is nothing you can do with the environment."

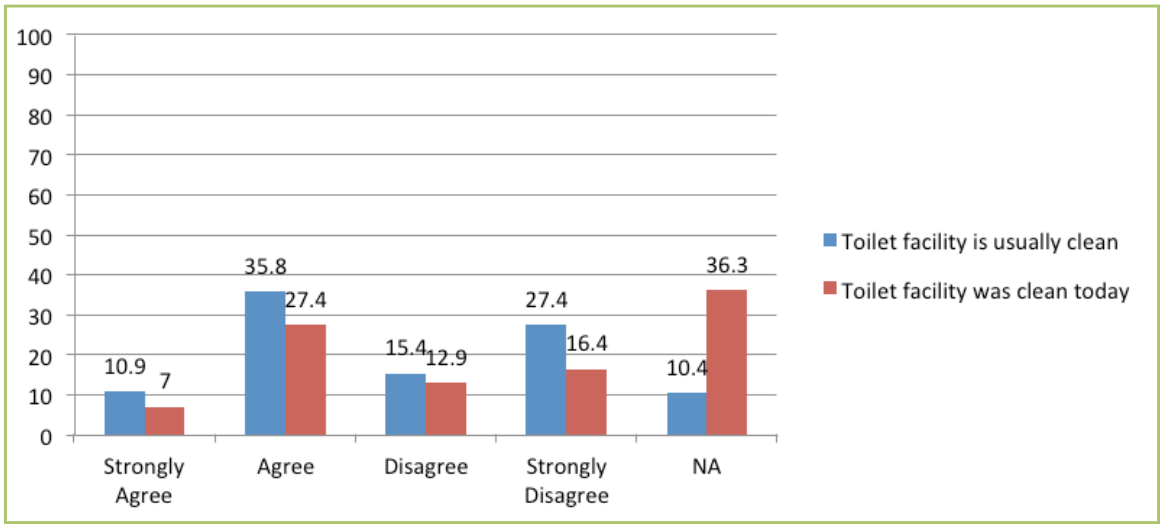
There was also a stench at the Katutura Hospital that smelt like a broken sewerage. Concerns were raised about the perceived reluctance of cleaners at health facilities to clean. Close to half of the respondents regarded facilities to be clean on the day of the survey, 42% complained about cockroaches; apparently as a result of food left by patients in their lockers. Although the place was regarded to be clean by half of the respondents on the day of the survey, 42% felt that it was not neat. However, more respondents, 74% said the facilities were usually neat. Just over half, 55%, felt that it was relatively clean outside the health facility buildings as well, while 45% disagreed.

Figure 19: Cleanliness of Health Facility



Close to half of the respondents, 36%, agreed while 11% strongly agreed that toilet facilities at health facilities were usually clean. However, 7% strongly agreed and 27% agreed that toilets were clean on the day of the survey. Although many toilets were reported to be clean, concerns were raised of many broken toilets. In at least three health facilities, participants complained about toilets not flushing in the entire ward. They said that some people with urgent need continued using these toilets, which was regarded as very unhygienic.

Figure 20: Cleanliness of Toilets at Health Facilities (%)



The situation worsened with only one-fifth of the respondents reporting availability of soap in toilets, and a reduced percentage of 15% reporting having soap for hand washing on the day of the survey. The same situation was found with regards to the lack of toilet paper. Other issues of concern included roaming cats eating patients' food, some patients not receiving food, and some patients being asked to wash dishes at the facility.

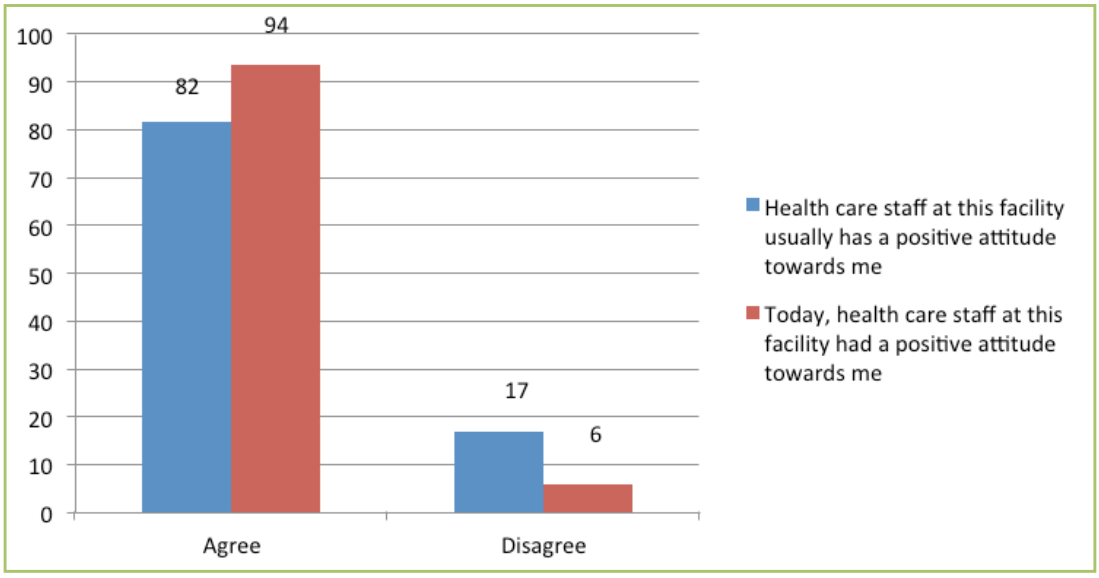
Table 4: Perceptions of Health Care Environment

Health Care Environment	Strongly agree	Agree	Strongly disagree	Disagree	NA
	%	%	%	%	%
Satisfied with health care service received TODAY	35.3	49.3	7.5	7.5	.5
Satisfied with health care service received USUALLY	27.9	48.8	9.0	12.9	1.5
Health facility usually clean inside of building	23.9	53.2	6.5	14.9	1.5
Health facility not clean inside building	7.5	43.8	28.4	19.9	.5
Health facility usually clean outside of building	16.4	46.3	18.4	16.9	2.0
Health facility not clean outside building	6.5	37.8	30.8	23.9	1.0
Health facility is usually neat	20.9	53.2	8.0	15.9	2.0
Health facility is not neat today	8.0	33.8	28.9	28.9	.5
Toilet facility is usually clean	10.9	35.8	27.4	15.4	10.4
Toilet facility was clean today	7.0	27.4	16.4	12.9	36.3
Toilet in this facility usually have soap to wash hands afterwards	2.5	16.4	51.7	18.9	10.4
Today, toilet had soap to wash hands afterwards	1.0	14.4	33.8	15.4	35.3
Toilet in this facility usually have toilet paper	6.0	23.9	41.3	18.4	10.4
Today, toilet facility had toilet paper	3.0	15.4	32.3	13.9	35.3
No cockroaches in this facility	18.9	38.3	23.4	18.4	1.0

6.3 Perception of Health Care Staff

Findings suggest that there were mixed feelings from respondents about staff attitudes. Almost all participants, 82% felt that health workers had a positive attitude on the day of the survey while 53% agreed and 29% strongly agreed that they usually had a positive attitude. However, when it came to some of the actions of health workers, the picture changed for the worse. Three quarters of the respondents strongly disagreed (56%) and 18% disagree that the health workers introduced themselves. Close to half, 44% felt that health care workers were rude to other patients. Health care workers, regarded as rude were said to speak to patients as if they were children. They shouted and listened to patients in a disrespectful manner. In some instances, it was reported that cleaners and food handlers sometimes shouted at patients. Lack of respect was also shown by some food handlers and nurses who would just place food before patients, without helping those who could not help themselves to eat.

Figure 21: Perception of Health Care Staff (%) (Summary)



Two thirds, 67%, of respondents said that health care workers explained a health examination before it was actually done, while 72% said they fully understood the explanation. Seventy nine percent (79%) of the respondents agreed, while 53% strongly agreed that the health workers were knowledgeable about the subject at hand. This was however worrisome as all health workers need to speak in such a manner that patients should feel that they are knowledgeable about the subject at hand. Some noted that senior nurses were more knowledgeable, while the new graduates gave the impression that they were not interested in the job – they were relaxed with little urgency. Others were of the opinion that some nurses had lost their passion, and as a result were 'not serious' when dealing with patients. However, some respondents noted that they could not judge the knowledge of nurses as they did not know what health workers were supposed to know or not, especially since many of them were in the low and often illiterate quartiles of society. FGD participants stated their concerns about some permanent staff that seemed complacent in their interactions with patients, but felt that temporary staff did a better job. Some expressed their opinion as follows: "Some health workers are just after the pay cheque". Another one said, "Because doctors do not check or touch patients, they only look in your card and send you away".

"There are only two doctors and a few nurses so it takes them some time to attend to all patients as quick as possible"
"If you ask assistance from health workers sometimes they don't' come at the time when you request their services, it depends mostly on the person themselves. If you find a nurse for example with a bad attitude they will not come and attend, if you find a kind person they mostly attend to you, sometimes if health workers are busy they will not attend to you on time " (Tsumeb)

Communication seemed to be a challenge as only one third of the respondents noted that they were not told how to use their medicine by the health care worker, while 42% were given written materials on how to prevent the 'condition' from happening again, and such material was explained as well. However, the challenge was the language barrier. Some respondents were illiterate and many of the pamphlets and leaflets were in English. Concerns were raised again on limited communication between doctors and patients at public facilities, because some doctors would just look in the health passport and prescribe medicine. One of reasons could be the time constraints resulting from the many patients at public facilities needing medical attention. Just over one third of the health care workers asked the respondent if they had questions during consultations.

Almost all, 86% of the respondents felt that their consultation was confidential, although 40% felt that the consulting room did not provide sufficient privacy. However, concerns were raised about limited respect for patients' rights at some facilities as other health workers and cleaners would enter consulting rooms unannounced. The bed space in public hospitals did not provide sufficient privacy even when curtains were drawn, due to the proximity to adjacent beds.

Table 5: Perceptions of Health Care Staff (Detailed)

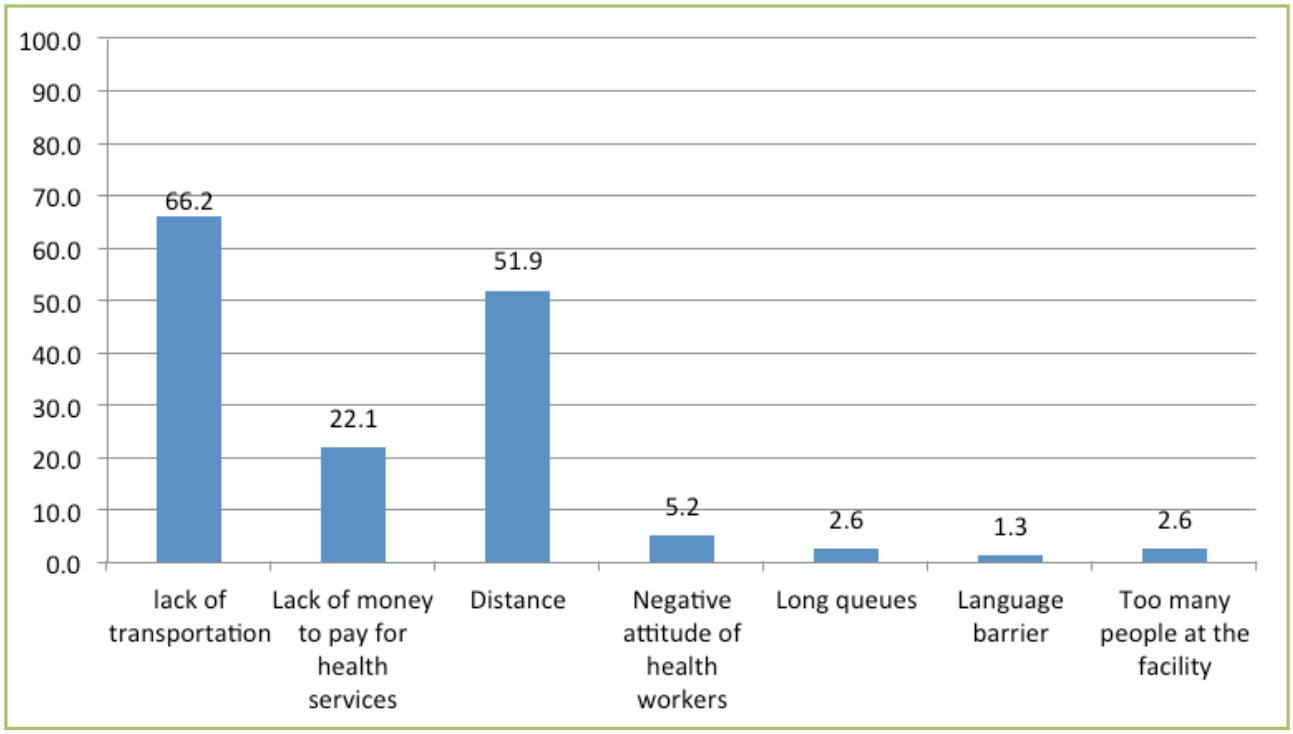
Health Care Staff	Strongly agree	Agree	Strongly disagree	Disagree	NA
	%	%	%	%	%
Health care staff at this facility usually have a positive attitude towards me	28.9	52.7	4.0	13.4	1.0
Today, health care staff at this facility had a positive attitude towards me	36.8	56.7	2.0	4.5	.0
Health care worker introduced herself/himself to me today	3.0	23.4	55.7	17.9	.0
Health care worker at this facility is rude to other patients	16.4	27.9	33.3	21.4	1.0
Health care worker explained the examination before it was actually done	20.4	46.3	18.4	8.5	6.5
Fully understood the explanation that health care worker gave today with regards to my condition	23.4	48.8	9.5	10.0	8.5
Health care worker seemed to know what she/he was talking about	26.4	52.7	3.5	6.5	10.9
Health care worker did not explain how to take medicine received today	3.5	28.4	46.3	17.9	4.0
Health care worker provided me with written materials on how to prevent my condition	3.5	38.3	40.3	11.9	6.0
Health care worker explained written material to me	3.0	35.3	16.9	13.9	30.8
Health care worker wanted to know whether I had any questions	7.0	31.3	34.8	16.9	10.0
Discussion between patient and health worker was confidential	47.8	37.8	10.9	3.0	.5
Consultation room did not provide sufficient privacy	11.4	28.4	38.3	19.4	2.5

6.4 Utilization and Access to Health Services

When asked, what types of services can be accessed at health facilities, more than half of the respondents, 66%, noted communicable disease services, , while slightly more than half, 51% noted maternal health services, followed by child health services, 46%, followed by provision of care, 44%, and non-communicable disease services, 33%. Other services that received percentages lower than 3% included HIV testing, physiotherapy, orthopaedics, family planning, optometry, blood testing and those who indicated that they did not know.

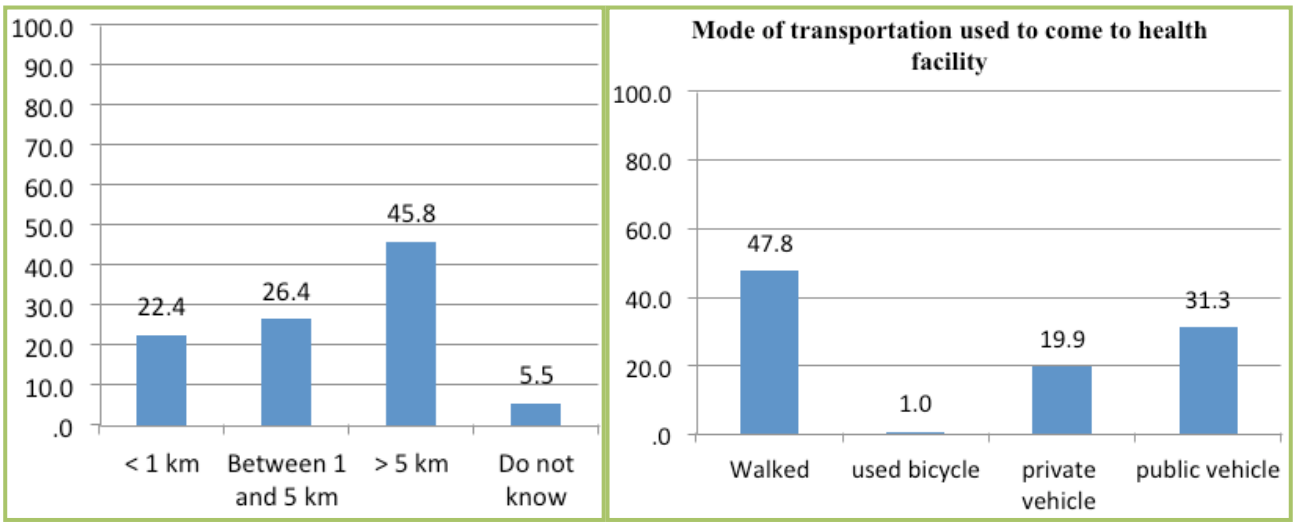
Close to two-thirds, 62% of respondents who participated in the Client Exit Survey said they did not experience challenges in accessing health facilities, while more the one-third, 38% did experience challenges. On lack of transportation, 66% of respondents said it was the biggest challenge, followed by distance, to and from health facilities 52% and a lack of money, 22%, to pay for health services. FGD participants said some of them stayed very far from the health facility, with no cars coming from the village to the main settlements/ towns where the health facilities were located. As a result, they first had to walk to the main road, while sometimes being very ill, to catch a ride from a Good Samaritan to the health facility. On some days they would return home walking as there was no available transportation from the main road. Poor treatment by health workers also resulted in patients not wanting to revisit health facilities. Some FGD participants in the Kunene and Caprivi (Zambezi) regions indicated that traditional health practices also hampered people from visiting health facilities.

Figure 22: Challenges Experienced with Accessing Health Facilities (%)



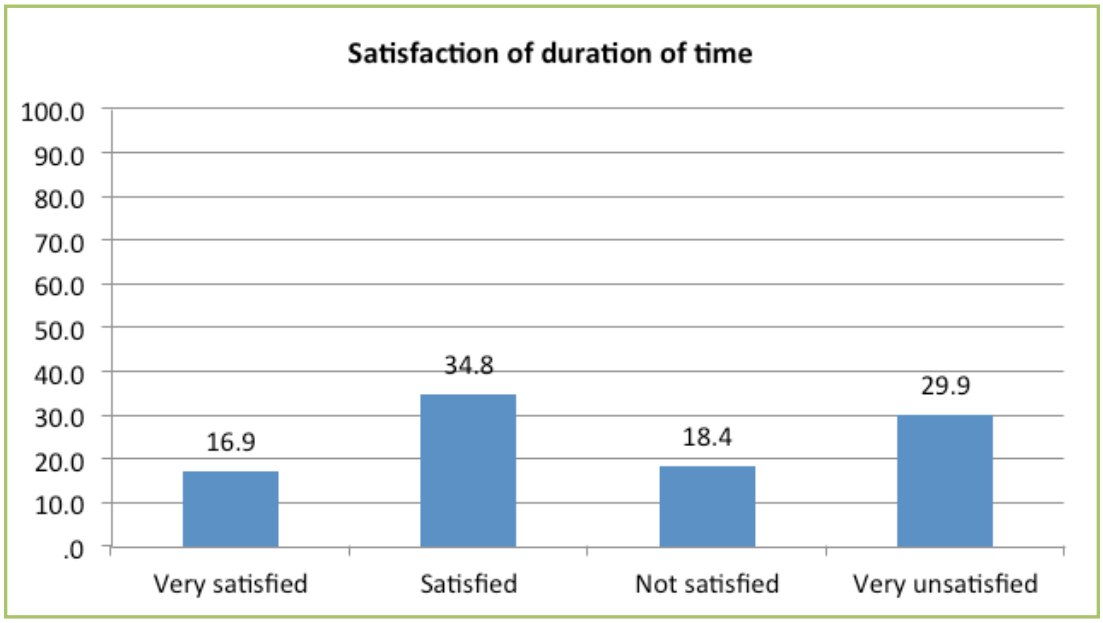
Most of the respondents, 48%, had to travel more than five kilometres to the closest health facility, while almost half of them walked. Just under one third, 31%, of the respondents used public transportation, followed by private vehicles, 20% and bicycle, 1%. Most of the respondents, 55% spent less than one hour to reach the facility on the day of the survey, while 28% spent between one and two hours, 9% between two and three hours, 4% between three and four hours and 4% between four hours and more hours. Almost all, 91% of the respondents spent less than N$50 on transportation to and from the facility on the day of the survey, followed by 8% who spent between N$51 and N$100, and 1% who spent N$101 plus. Most respondents said they had to pay N$4 for consultation and medicine at public facilities. Most of them regarded this amount as acceptable.

Figure 23: Distance to Health Facilities and Mode of Transportation (%)



In addition to the time that it takes to travel to and from health facilities, FGD participants were not happy with the waiting time at health facilities. A quarter of the respondents said they waited between an hour and two hours to be attended to on the day of the survey. Another quarter were attended to between 30 minutes and an hour, and close to one third, 29% were attended to within 30 minutes. Close to one-quarter were seen between one and a half hours and three hours and 10% were attended to within three hours and more. Close to half, 48% of the respondents were unsatisfied while 30% were very unsatisfied with the waiting time to be attended to at health facilities.

Figure 24: Satisfaction with Duration of Waiting Time (%)

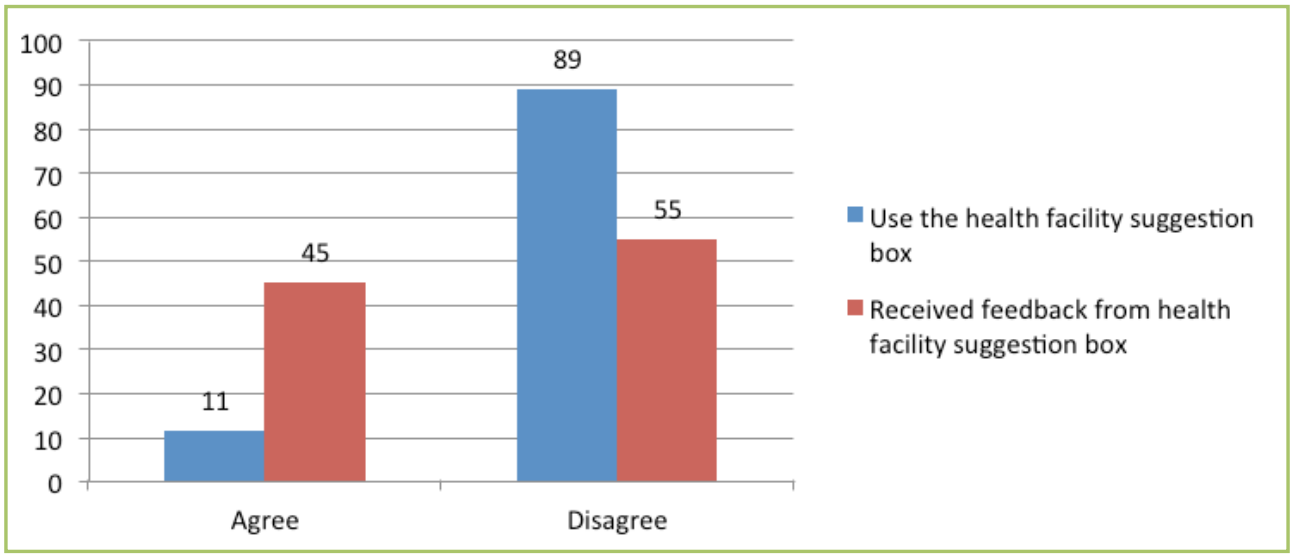


While many were dissatisfied with the waiting duration, they acknowledged that the staff tried their utmost best; however, due to limited numbers of health staff, especially medical doctors, the situation was the way it was. A small number indicated that sometimes the nurses did not attend to them as fast as they should because they were sitting around, or chatting on their cell phones, and only attended to patients when they felt like it. Others expressed concern that health professionals did not get out of their examining rooms in order to assess which patients were in need of urgent assistance and which ones were not. One respondent gave an example of a boy in Rundu who allegedly died while waiting to receive medical attention. The boy was said to have been bitten by a snake, but his medical situation was not regarded as an emergency while he sat in the waiting room.

6.5 Patients' Involvement

There were small numbers of respondents who suggested and contributed towards better quality health services but the majority said there were limited opportunities to do this at health facilities. One tenth of the respondents said they had used the Suggestion Box at health facilities before, while 90% said they had not. Encouraging was the finding that close to half, 45%, of the respondents reported receiving feedback from comments made in the Suggestion Box. One of the challenges was that patients did not know about the Suggestion Box or if they did, the requests to participate were in English. A few who made use of the Suggestion Box said they were discouraged because they rarely received feedback about their requests, complaints or recommendations.

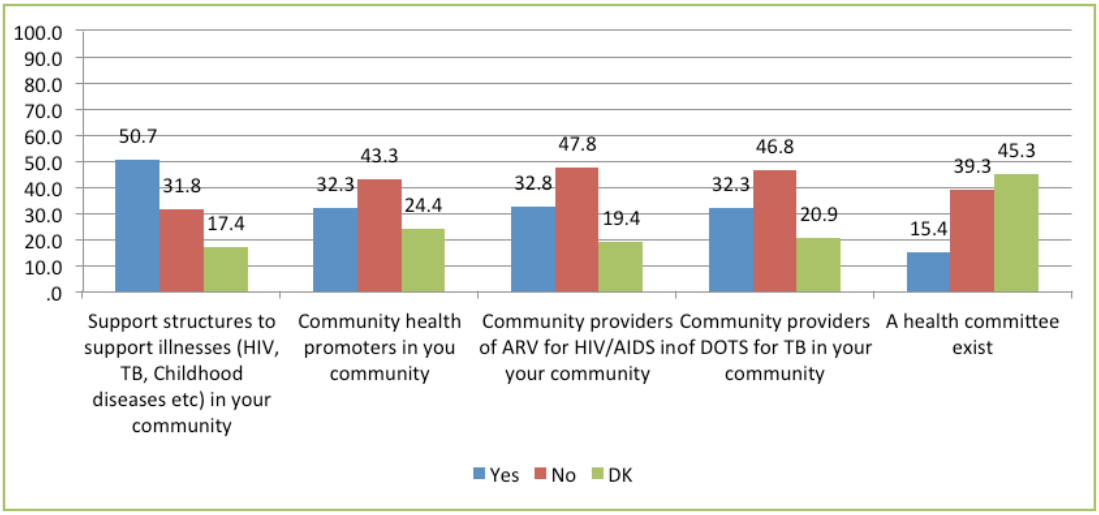
Figure 25: Use of the Suggestion Box (%)



When health workers were asked about patients and community involvement in health care, they referred to the SMSes in print media. Some local newspapers have created a page for community members to write about issues that affect society, and many a time, they have used these pages to complain, raise concerns and make suggestions on health related issues. At one health facility, when the staff were asked about the quality of their health facility, their response was "There is nothing about our health facility in the newspaper", meaning that everything was okay when not reported in the SMS sections of local newspapers.

Half, 51% of the respondents were aware of support structures for certain illnesses such as HIV and AIDS, TB, childhood diseases and others in the community, while more than two-thirds, 68% reported not having heard of community health promoters, or they did not know about them. Interestingly, the same percentage also said that there were none, or they did not know of HIV and AIDS and TB health promoters in their community. Only 15% said they knew of a Community Health Committee, but many of those who heard about such a committee did not know its roles and responsibilities. It also seemed that respondents actually referred to other types of committees, such as the ELCIN church volunteers, when referring to Community Health Committees, meaning that the above 15% is likely to be lower.

Figure 26: Community Participation (%)



Recommendations on community perceptions of quality and care mechanisms

- Improvement of hygiene should be prioritized
- Sufficient resources e.g. cleaning materials, toilet papers etc should be provided
- MoHSS staff should forge a relationship with Society for the Prevention of Cruelty towards Animals (SPCA), so that they can get rid of animals roaming the health facility e.g. cats that have been identified in some health facilities.
- The role of environmental health officers should be strengthened because they seem to be invisible.
- Communication between patients and health providers should be strengthened with the provision of an interpreter where needed.
- Provision should be made to have doctors trained in basic understanding of the local languages. Simple booklets should be developed that would make it easy for them to ask questions such as “Where is the pain?” ”How do you feel?” and “How are you?”
- Programmes should be put in place to improve the attitude of health providers towards patients
- In view of the fact that 45% of the clients live more than five kilometres from health facilities there is a need for the MoHSS to strictly look into either building clinics close to the patients or providing mobile clinics on a weekly or monthly basis
- Involvement of patients, their families and communities should be a core quality improvement criteria
- Customer care programmes with the sole responsibility of dealing with customers’, users’ and clients’ needs should be developed and implemented
- Cleaners, potters and clerks who are often the first people patients come into contact with should be trained in customer care services
- Facilities should use continuous quality improvement processes to improve efficiency in service delivery and minimize patient waiting times
- The use of suggestion boxes should consider use of local languages and ensure that clients are systematically provided with feedback on issues raised through suggestion boxes
- Routine systematic and standardised client exit surveys should be implemented, reviewed and reported at all health facilities

7 CONCLUSIONS AND OVERALL RECOMMENDATIONS

7.1 Conclusions

The MoHSS has committed to provide effective and efficient health services to all Namibians. It has well established policies, strategic plans, and has an enabling environment for prevention, treatment and management of health care. Although great strides have been made in reducing the prevalence of certain epidemics such as HIV and AIDS, various concerns remain in relation to the MoHSS' ability to continue to provide quality services, and more specifically quality management structures to monitor the provision of quality services. One of the MoHSS's main weaknesses, according to the 2009-2013 Strategic Plan, is the lack of standardisation and equity of service provision and the weak reward system for its human resources and challenges in information management systems (MoHSS, 2009). The mentioned weaknesses were echoed throughout this Assessment as well.

Fundamental to the issue of dealing with quality health service and managing such a quality is the common understanding of what it means, and how it needs to be managed. Coupled with a common understanding of quality is a common understanding of quality assurance. There seem to be a wide range of opinions of what quality and quality assurance are. Brown et al, 1990) defined quality assurance as a "set of activities that are carried out to set standards to monitor and improve performance so that the care provided is as effective and as safe as possible" (p.7).

Following on a common definition across health facilities for quality and quality assurance, was the absence of set standards for quality assurance and the monitoring thereof. Limited guidelines and standardised tools on quality assurance were available to health facilities across the country. The Quality Assurance Unit also did not have such tools or guidelines available.

The absence of quality goals was a good indication that challenges would be experienced towards quality management, as quality management could not be done in a vacuum. Specific health facility goals for quality assurance were absent in more than half of the facilities. Without clear goals and objectives for quality assurance and improvement, development of quality assurance activities was a challenge. It was learnt that the overall MoHSS Strategic Plan was used as goals by many health facilities, but this was too broad. Something more focused needed to be developed for each facility. Without such goals, one could not prepare an effective and efficient work plan, commit resources, measure performance, select indicators, develop activities, involve patients or carry out monitoring and evaluation activities. Most of the health facilities, except for some private hospitals, and around one third of the public health facilities, were found in this situation.

According to Donabedian (1980), one can measure the quality of health care by evaluating its structure, processes and outcomes. A good structure increases the likelihood of a good process, and a good process increases the likelihood of a good outcome. Several newspaper articles, SMSes and concerns by Government suggest that the quality of services at Namibian health facilities has decreased over the years. This is confirmed in the findings of this assessment as it shows weak institutional structures designed for quality management and improvement. It also shows weak processes that have been fashioned to facilitate capacity building for quality improvement implementation and undesirable outcomes of quality health at many of the facilities.

7.2 Recommendations

Since a good quality health service is at the heart of the MoHSS, the following recommendations were made to support the achievement of these goals.

In light of the findings, the following recommendations were developed from the Assessment and literature review. They focus on core and essential elements in quality improvement i.e. definition, ability to measure quality care, creating an enabling environment, which includes leadership, policy, core values and resources; capacity building, communication, information and rewarding quality.

7.2.1 Quality strategies/guidelines and policies (regulatory framework)

Quality of care is expressed in various documents, for example, as policies, standards and guidelines, which are developed by different programmes and units mostly at the national level, including donors and bilateral organisations. These documents partially cover health care quality, such as access, equity and effectiveness in general statements. It is imperative that quality is incorporated into all national health policy programmes and strategies. Most important, is the role of management in not only providing vision and definitions but in setting clear standards and expectations that are ultimately linked to certification/accreditation that can incorporate improvement as well as other strategies to assure quality and compliance with regulations. In addition, the, MoHSS should:

- Develop a national quality policy that reflects the key elements of quality assurance including core organisational values. The document should include explicit statements as they relate to:
    - Laws and regulations concerning quality;
    - Equity, affordability, sustainability and efficiency;
    - Factors that influence quality of care, whether medical, technical or organisational;
    - Indicators and standards for quality assurance in health care;
    - Consumer involvement, patient empowerment;
    - Rewards/incentives for quality improvement;
- Develop a comprehensive Strategic plan for quality health care, which reflects a well-articulated vision on quality and a clear definition of quality and quality assurance approaches. As well as scope and depth of quality assurance and infection control activities required of hospitals.

Quality improvements systems should be a requirement when providing licences to private and public health facilities.

7.2.2 Structure and management

7.2.2.1 Coordination:

Lack of or limited coordination was identified as one of the weakest links, thus there is a need to strengthen collaboration and coordination between different divisions and departments.

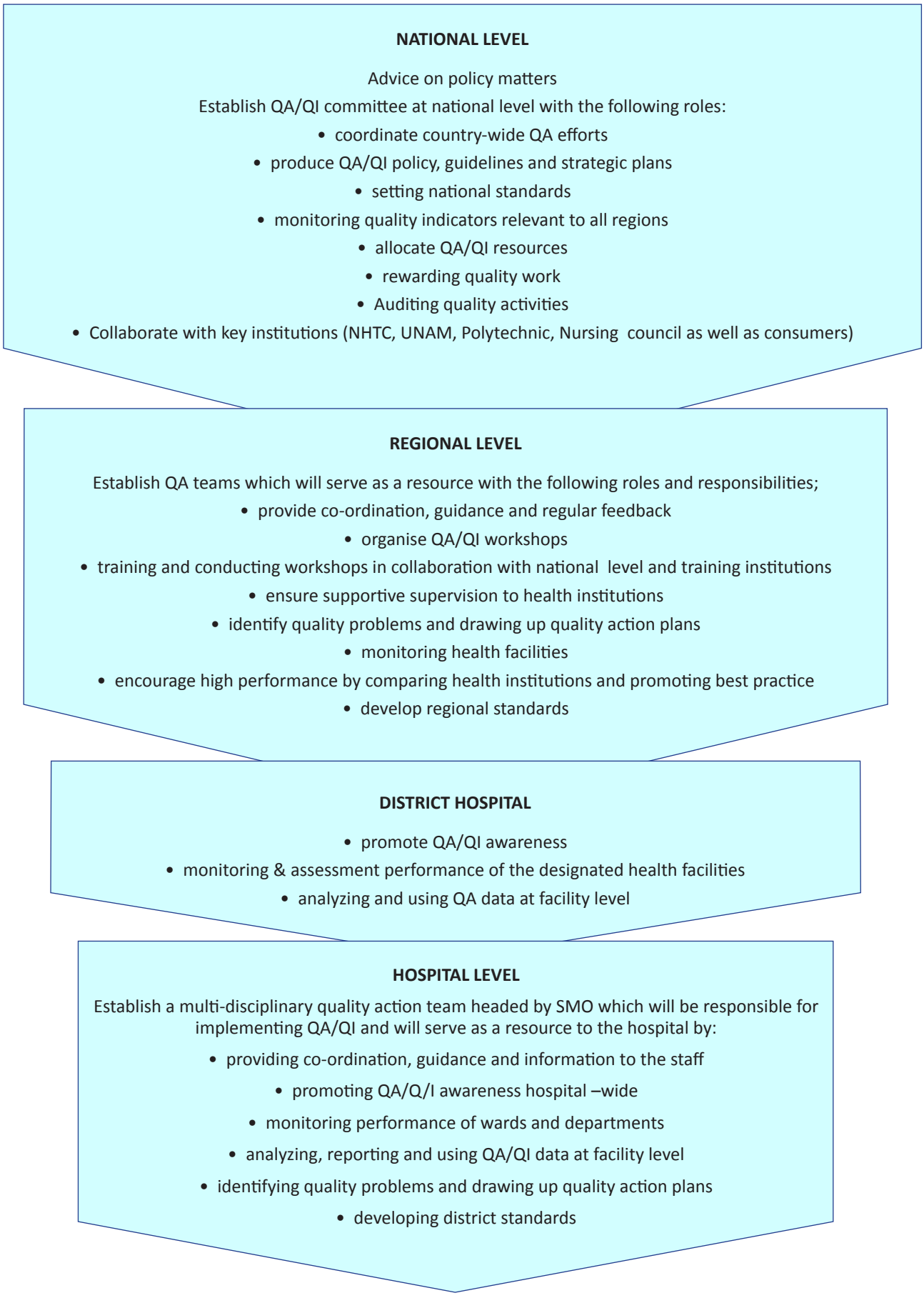
Coordination between technical experts, service delivery and administrative programmes is critical, as this will provide clear delineation of tasks as to who is responsible for what, when and how. If possible, there should be a reduction in the number of committees within health facilities; instead they should strive to concentrate on the roles and responsibilities of committees. The Quality Assurance Unit has a key role to play in ensuring coordination.

Clear roles and responsibilities should be developed and established at all levels that support policy making, executive functioning and information dissemination from the hospital level to the national level as reflected in Figure 27.

7.2.2.2 Roles and responsibilities

The assessment noted the lack of clear roles and responsibilities in health facilities and that activities that were taking place were driven by individual divisions, departments or programmes and did not necessary feed into the larger hospital quality management plan and quality committee. This, it was observed, resulted in a fragmented approach to quality improvement and management. In addition, the quality issues were addressed by taking a top down approach as they were spearheaded by the national level, with limited input from the regions and districts. It is imperative that the MoHSS develop and establish clear roles and responsibilities at all levels that support policy making, executive function and information dissemination from the hospital level to the national level as reflected in Figure 27.

Figure 27: Quality Management Structure



The structure reflects quality management at different levels and should be seen as interdependent. In addition, the structure should consist of multidisciplinary teams e.g. administration officers, logistics officers, nurses, doctors, social workers, pharmacists, etc., as they all have an essential contribution to make towards quality management.

Key to effective quality management is the management process. The structure should include: designated leadership, who will provide organisation with a vision, strategic direction as where the organisation wants to go and create and promote the core values for quality management. It should allocate responsible persons for accountability, supervision, monitoring and communication at all levels.

Establish an enabling environment for quality improvement, monitoring and evaluation by creating quality assurance and improvement policies, plans, structures and guiding tools. The Quality Assurance Unit needs to take the lead to guide and not implement. It needs to facilitate and be seen as a Unit that can provide support and guidance to all different departments and divisions involved in quality issues at facility level. It therefore needs to take the leading role at the national level, while supporting leadership at the regional and local levels.

7.2.3 Organisational cultures that support and sustain quality in health facilities

- A culture of quality needs to be created for the provision of health services and should be part of the national agenda. A culture of quality care can only be harnessed through the active involvement of leadership and supported from the national level. There are various strategies that can be implemented to promote a culture of quality care, for example:
- Instituting a Quality Health Care Month where health professionals share successes and learn from each other
- Introducing a Quarterly Quality Assurance Newsletter or website

Most important a culture of quality care should be integrated into the pre-service training and reinforced through in-service training and on job training of staff. Complementing an understanding of quality is a positive attitude and commitment to improvement.

One of the definitions of quality care reads as follows: “Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (IOM, 1990, p. 21). The Ministry needs to develop its own definition that is shared and understood by all stakeholders.

7.2.4 Quality tools, indicators and methods

These should strengthen the health information systems where quality of care indicators are included and they are reliable, valid, useful, which will help the user to interpret them correctly. Quality indicators should address the key dimensions of quality such as safety, access, appropriateness, efficiency, effectiveness and consumer participation in health care. Added to these are the five cross dimensional issues such as competence, continuity of care, accreditation, information management, education and training for quality. (Maxwell, 1992 &Donabedian 1980).

7.2.5 Human Resources and competence management

7.2.5.1 Staff competence

Appropriate staff should be recruited and resources allocated for human resource development. Irrespective of limited human resources, all efforts should be made to ensure that appropriate staff are appointed and organisations should avoid adopting the mentality that an “incompetent practitioner is better than no-one at all”.

Clinical competence is a critical component of quality management and various measurements have been identified, which should be implemented to assess clinical competencies and they include among others the following:

- Application and election procedures; validation of past history, current registration status and references
- Individual performance review or appraisal
- Systematic periodic review of clinical performance and appointment
- Establishing and strengthening programmes of supportive supervision which include supervisory field visits to primary care staff to evaluate performance. Clinical supervision should be a major component of ongoing performance management
- Mechanisms should be put in place to assess the professional qualifications prior to recruiting new staff
- There should be a clear national policy that draws distinctions between individual licensing and certification, accreditation and improvement work.

7.2.5.2 Leadership and supervision

- Health facility leadership needs to be empowered to take the lead in quality assurance and improvement by setting priorities, recognising and rewarding good performance. They should continuously promote learning; take a genuine interest in quality assurance mechanisms and structure, review data regularly to monitor hospital performance, as well as staff and patients wellbeing. Leadership at facility level needs to create an enabling environment where staff respect each other, and more importantly where all staff respect patients. Certain values and norms need to be established in a participatory manner, and serious disciplinary action should be taken against those that violate the core values and norms of the facility. Thus the promotion of the organisational values and internalization of these values by the staff should be the leadership's core business.

7.2.5.3 Continuing education and capacity building

In view of the high staff attrition and relocation, there is a need to implement diverse capacity building strategies. It is a known fact that the majority of the continuous professional trainings lack the key ingredients in quality care, for instance, QA knowledge, skills, and supervisory activities. There is a need to identify local quality management coaches and trainers, and should they not be there, it is imperative that a core group of health providers should be identified and trained as coaches and trainers. There is a need to ensure that staff have the necessary technical, managerial and leadership knowledge and skills to carry out their quality management responsibilities.

Coaching and mentoring:

Senior health managers should provide coaching and mentoring, and on ongoing technical and qualitative support to facilitate the behaviour changes needed to undertake and sustain QA activities. Those who carry out supervisory visits should be trained in providing feedback should they identify an issue.

Capacity building:

There should be support to national, regional, district hospitals and health centres in upgrading the skills and knowledge of their staff in quality management. Capacity building can be done through training, coaching and mentoring, self and peer appraisals and supervisory activities. Health workers should be empowered to take ownership and responsibility for the quality of care being delivered.

7.2.5.4 Staff performance appraisal, recognition and rewards

- Quality management should be a core component of staff performance. There should be a built-in mechanism to not only measure performance of people and structures, but also to complement and reward those that are meeting expectations.

7.2.5.5 Peer Review:

Implementing a peer review process will provide a means of accountability and improvement of quality. Peer review should be a major component of professional involvement in quality improvement and it should be linked to the broader quality improvement processes. This should be addressed in the strategic plan focusing on issues such as who should participate? What course of action should be taken when the reviewers identify an issue?

7.2.5.6 Rewarding

Research conducted globally in Europe and Asia, particularly in Singapore, shows that rewarding for quality care has contributed to staff's commitment to quality and motivated them to strive towards achieving the best. In order to provide a reward there is a need to develop a mechanism to evaluate best performance. Rewards are offered to individuals, groups (ward) and specific health facilities.

Quality awards could include a price, a trip, featuring the work of the teams in a newsletter or conference, this could be Government sponsored or independently funded. An award takes an integrated approach to performance management, and assists organisations in improving their organisational capabilities and effectiveness, recognizing the value of customers including patients in this case; addressing organisational and staff learning challenges and contributes to organisational sustainability. Namibia could consider developing its own local award system. Thus in developing its own local award system, the country could draw on the Baldrige Model, or could draw lessons from Singapore where they formed strategic alliances with centres of excellence overseas and adopted their best practices (Lim, M 2004). The Baldrige model has the aim of:

i) **improving organisational performance practices, capabilities, and results**

ii) **facilitating communication and sharing of information on best practices**

iii) **serving as a tool for understanding and managing performance and for guiding planning and opportunities for learning (Young, 2002)**

7.2.6 Consumers, users and clients

- According to the Patient Charter of Namibia, health facilities should recognise and protect the integrity and dignity of patients and clients. Also the World Health Report of 2000 emphasises responsiveness to population and individual needs. Consequently, the involvement of patients and their families should be core to quality improvement. Customers should be involved in their own health care for they have responsibilities as well as rights. There is a need to introduce Customer Care programmes in all health facilities. In developing this programme, customers should be involved in its design and monitoring. Lessons on customer care could be drawn from private companies.

A customer care programme's sole responsibility is to deal with customers, users and clients. This system should regularly solicit the views and opinions of patients, not only with regards to the services they received, but also provide feedback to them on how their views and opinions were taken into consideration to improve the service. In addition to the suggestion box found at some health facilities, it is recommended that a Help Desk or Customer Care Desk be established at hospitals where patients can go for information and share comments where needed. The effectiveness of a Help Desk or Customer Care Desk will largely depend on the participation of the customers.

7.2.7 Training

- Strengthen curriculum development for quality management. The pre and in-service training of health professionals should have quality as a core component.
- Academic institutions such as the UNAM School of Medicine and Nursing and the NHTC should spearhead quality management training. Alternatively, the Ministry should consider outsourcing quality management training to private training institutions with the requisite expertise and capacity. In addition, funds should be made available for staff to attend training in quality management at leading health care centres and if possible bring in experts in the country to share their knowledge.
- There should also be tailor-made quality training programmes for staff in the lower ranks such as cleaners, clerks, security guards and porters, who are often the first point of contact with patients.

7.2.8 Quality Management Information System and communication

Information systems should be strengthened to help monitor quality improvement and quality assurance activities. These should then be integrated within the national systems. Information needs to be shared with all staff, ensuring that all staff are aware of the strengths and weaknesses of quality improvement activities and identify areas where remedial action is needed.

One of the key issues in quality management is information. One way is to address the information flow between clients and service providers and between different stakeholders in the health facilities. The following recommendations are however made:

i. The Quality Assurance Unit at national level should play a key role in coordinating and disseminating information;

ii. Health facilities should institute a customer care section in their respective facility;

iii. Annual conferences on quality health care should be conducted regularly and academic institutions could take the lead in this;

iv. A quality culture should be encouraged by establishing a Quality Health Care Month, where health professional share successes and learn from one another. Participants in this type of activity should include customers who are also members of the review team.

v. The participation and contribution of customers in quality care programmes will contribute towards the improvement of the client-centred services as they will be able to provide the much needed information services.

7.2.9 Monitoring and evaluation

Quality improvement programmes which monitor clinical performance and customer satisfaction should be established. Key indicators should be created and there should be built-in review and evaluation processes, which include common trends such as patient compliance with heath advice; common patient complaints and protocols. In addition, customer satisfaction should be evaluated on a regular basis. Most importantly health facilities need to ensure that issues raised are followed-up and the patient or customers who raised the issues are given feedback.

Monitoring and evaluation is crucial. Evaluation of quality assurance activities needs to carry the same weight as monitoring. Many times, one finds that institutions concentrate on monitoring more than evaluation. Monitoring systems need to ensure that compliance with quality standards is regularly reviewed and that remedial actions are implemented where necessary. Monitoring and evaluation procedures need to be well developed and must support the facility in achieving its quality goals and objectives.

7.2.10 Resources

In order to implement quality assurance programmes, there is a need to commit resources for the required human and infrastructural development. Services offered should continuously be monitored and evaluated. Staff should be given enough time to participate in quality management activities.

The MoHSS should ensure that health facilities are within reach of the patients, and should that not be the case, they should strengthen mobile clinics so that they can provide the necessary health care to rural communities. In that way they would be addressing the transportation challenges rural communities face.

7.2.10.1 Enabling environment

The MoHSS should create an enabling environment which would help health providers to initiate, implement, and if necessary expand and sustain quality assurance. Hence the need to have a policy environment that provides, supports, guides and reinforces quality management.

7.2.10.2 Integrating quality in the health sector

Quality should be integrated at all levels. It should not be seen as the responsibility of one sector, for example, nursing, as is the current situation. It should be accorded the necessary power.

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9. Interesting Quotes from Assessment Participants

"If providers do not offer quality services, they will fail to earn the populations trust, and clients will turn to the health system only when in dire need of curative care"

"I suggest it is best if the doctors speak the same language who can ask the patients directly so that the patients can express themselves better

"If we are to receive quality service, doctors and nurses are supposed to change their attitudes. Doctors are also supposed to listen to the patients more, if they cannot treat the patients they should seek advice from other doctors

"We must pray very loud, this is a very serious problem"

"There should be proper information systems in place to trace services offered by different Doctors"

"WE thank the facility for the wonderful service and encourage the facility to continue doing a great work

"I have never come across any management of the hospital seeking the opinion from in-patients"

"Community members can play a role by going on strike against bad service"

"We feel that the nurses are enough they just need to be trained on how to treat patients; they treat you and leave for more than 30 minutes before they come back and we find it unprofessional"

"We would like to thank you for coming to talk to us, as we have never come across such a platform to give our inputs"

Annex A: Terms of Reference

Ministry of Health and Social Services

Quality Assurance Division

QUALITY MANAGEMENT INFRASTRUCTURE ASSESSMENT

TERMS OF REFERENCE FOR ASSESSMENT OUTSOURCING

Contents

INTRODUCTION

The MOHSS with support from Centres for Disease Control and Prevention (CDC) has commenced several initiatives that are aimed at strengthening Quality Management systems and structures at all health administrative levels. This will result in enhanced provision of sufficient budget support and regular sharing of knowledge and experience of quality management activities among health care providers in both public and private health sectors.

The two main components of the initiatives are:

i. Assessment of the prevailing national quality management infrastructure in both public and private health sector

ii. Establishment of an improved national quality management programme through development of Quality management policy and strategic plan. This will be based on the results of the national infrastructure assessment.

OBJECTIVES OF THE INFRASTRUCTURE ASSESSMENT

- To evaluate the existing Quality management infrastructure in all 34 public hospitals, 5 selected health centers and 2 private hospitals.
- To identify gaps and best practices in the current quality management structures.
- To make recommendations for an improved and sustainable quality management programme.

SCOPE OF WORK FOR THE ASSESSMENT

COVERAGE OF THE ASSESSMENT

The assessment will cover all the 13 regions (34 district hospitals), 5 selected health centers and 2 private hospitals.

CATEGORIES OF STAFF TO BE INTERVIEWED

The following categories will be interviewed: Medical superintendents; Chief Medical Officers (CMO); Principal Medical Officer (PMO), Nurse Managers; Chief Control Officers or Control Officers; infection control nurses and patients/consumers.

TABLE SHOWING THE FACILITIES WHERE THE ASSESSMENT WILL BE CONDUCTED

REGION	DISTRICT HOSPITAL	HEALTH CENTRE	PRIVATE HOSPITAL
CAPRIVI	KATIMA MULILO **(FGD)**		
ERONGO	OMARURU		
	SWAKOPMUND		
	USAKOS		
	WALVIS BAY		
HARDAP	MARIENTAL	ARANOS	
	REHOBOTH		
KARAS	LüDERITZ		
	KARASBURG		
	KEETMANSHOOP **(FGD)**	BETHANIEN	

KAVANGO	ANDARA		
	NANKUDU		
	NYANGANA		
	RUNDU		
KHOMAS	WINDHOEK CENTRAL	KATUTURA	ROMAN CATHOLIC
	KATUTURA **(FGD)**		
KUNENE	KHORIXAS		
	OPUWO		
	OUTJO		
OHANGWENA	ENGELA	ODIBO	
	EENHANA		
	OKONGO		
OMAHEKE	GOBABIS		
OMUSATI	OKAHAO		
	OSHIKUKU		
	OUTAPI **(FGD)**		
	TSANDI		
OSHANA	INTERMEDIATE HOSPITAL OSHAKATI **(FGD)**		Medi- park (Ongwediva)
OSHIKOTO	ONANDJOKWE		
	TSUMEB		
OTJOZONDJUPA	GROOTFONTEIN	MANGHETTI DUNE	
	OKAHANDJA		
	OKAKARARA		
	OTJIWARONGO		

FGD (Focus Group Discussions) will be conducted with the patients in the above selected district hospitals.

METHODOLOGY

TOOLS FOR THE ASSESSMENT

The tools for the assessment have already been developed**.** A Questionnaire will be used to interview the healthcare workers and Focus Group Discussions for the patients/consumers. The categories of health care workers will be interviewed jointly as a team at the facilities. There will be need of showing evidence for some questions e.g. minutes of previous meetings where quality related issues were discussed. All interview sessions will be recorded.

The staff conducting the national quality management system assessment will ensure that information gathered from participants is kept confidential.

TRAINING OF THE INTERVIEWER TEAMS

The consultant with the assistance of Quality Assurance MoHSS will conduct trainings of the interviewer teams on the use of the assessment tools.

LETTERS INTRODUCING THE INTERVIEWERS TO THE FACILITIES

Quality Assurance Division will send introductory letters of the interviewer teams to all the selected health care facilities. Copies will also be sent to the regional and district health administrative levels.

DELIVERABLES

The output of the exercise will be a dataset both qualitative and quantitative plus a Quality Management System Assessment Report.

The structure and content of the report are indicated below:

Executive Summary

Introduction

Background

Programme justification

Programme objectives

Methodology

Assessment objectives

Data collection strategy

Data collection tools

Field work arrangement

Data management

Data analysis

Results

Programme implementation

Programme evaluation

Effectiveness

Impact (unintended effects)

Relevance

Sustainability

Gaps identified

Challenges

Lessons learnt

Conclusions& Recommendations

References

Appendences

TIME FRAME

Total duration for the assessment and report writing is 8 weeks.

ACTIVITES	WEEKS							
	1	2	3	4	5	6	7	8
Pre testing of the tools and making modifications								
Training of the interviewer teams on the assessment tools								
Data collection								
Data analysis and processing								
Compiling Assessment Report								
Disseminating assessment results								

MONITORING AND EVALUATION

The consultant is expected to work based on these terms of reference.

DEBRIEFING ON THE ACTIVITIES

The consultant is expected to debrief the QA Technical Working Group Members on the methods that will be used before the start of the assessment. Thereafter debriefing will be done at one month (midway through the assessment) and at two months (the end of the assessment).

QA team will closely work with the consultant and hold meetings every two weeks to discuss the activities and progress. These meetings may be held by teleconferencing.

There will be need for documentary evidence on the activities done. This will necessitate the use of attendance sheets and having all people interviewed sign.

The consultant will present the Assessment to the Quality Assurance Technical Working Group for review and endorsement.

SUPERVISORY VISITS

Quality Assurance team will visit selected regions to evaluate how the assessment is conducted.

Annex B: Training Agenda

BAOBAB

"Making a Difference"

Reg. No. 2005/2095; VAT Nr. 4066-450; P.O. Box 25720, Windhoek, Namibia: Tel: (+264) (0) 813253515; E-mail: info@baobabinstitute.com

Training Programme Schedule

Assessment of the national quality management system used to monitor and improve quality in health service provision in hospitals and health centers in Namibia

Day 1: Wednesday, 13 May 2012

Time	Activities	Who
8:30 - 8:45	Registration	BARTI
8:45 - 9:00	Welcoming and Introductions and Agenda	Dr Hailonga-van Dijk
9h00-9h15	Training Objectives	Mr Mouton
9:15 – 10:30	Logistics, Training Contracts: Explanation, Comments, Questions and Answers, and Signing of Contracts	Dr.Hailonga-van Dijk
10:30 - 11:00	*Tea Break*	
11:00 – 11:30	Background to the National Health Quality Management System and importance of this assessment including its objectives	Dr Basenero A
11:30 – 12:00	Introduction to Research (quantitative & qualitative & validity and reliability)	Mr Mouton
12:00 – 13:00	Introduction to Data Collection Tools	Mr Mouton
13:00 - 14:00	*Lunch Break*	
14:00 - 15:30	Familiarisation with Health Facility FGD	DrHailonga-van Dijk
15:30 - 15:50	*Tea Break*	
15:50 - 16:50	Familiarisation with Health Facility FGD	DrHailonga-van Dijk
16:50 - 17:00	Recap	Mr Mouton

Time	Activities	Who
Day 2: Thursday, 14 May 2012 Dr.Basenero A - pre-test site		
8:30 - 9:00	Recap of lessons learned previous day	Team
9:00 - 10:30	Familiarisation with In-patient FGD	Mr Mouton
10:30 - 11:00	Tea Break	
11:00 - 13:00	Familiarisation with Community FGD	Dr Hailonga-van Dijk
13:00 - 14:00	*Lunch Break*	
14:00 - 15:30	Familiarisation with Client Exit	Mr Mouton
15:30 - 15:50	*Tea Break*	

Time	Activities	Who
Day 2: Thursday, 14 May 2012 Dr.Basenero A - pre-test site		
8:30 - 9:00	Recap of lessons learned previous day	Team
15:50 – 16:50	Ethical Protocol	Mr Mouton
16:50 - 17:00	Recap	Dr Hailonga-van Dijk
Time	**Activities**	**Who**
	Day 3: Friday, 15 June 2012	
8:30 - 9:00	*Pretesting (Robert Mugabe &Khomasdal health Clinic*	*Team*
9:00 – 13:00	Pre-test in Windhoek (Khomasdal& Robert Mugabe Clinic)	Team
13:00 - 14:00	*Lunch Break*	
14:00 - 15:30	Discuss pre-test and make changes to the tools where necessary	Mr Mouton/Dr.Pandu
15:30 - 15:50	*Tea Break*	
15:50 – 17:00	Allocation of teams to respective regions & Translations	Team
Time	**Activities**	**Who**
	Day 4: Saturday, 16 June 2012	
09h00	Finalise field schedule Review Checklist and all necessary documents	DrvHailonga-van Dijk
9:00 – 13:00	*Teabreak and final review , Pack for the regions*	Team

Annex C: List of Data Collection Tools per Health Facility and List of Data Collection Team

REGION	DISTRICT HOSPITAL	Health Workers FGD (41)	In-Patient FGDs (20)	Community FGD (8)	Client Exit Interviews (205)
CAPRIVI	KATIMA MULILO	1	1		5
ERONGO	OMARURU	1			5
	SWAKOPMUND	1	1	1	5
	USAKOS	1			5
	WALVIS BAY	0	1		5
HARDAP	MARIENTAL	1			5
	REHOBOTH	1			5
	ARANOS HC	1	1		5
KARAS	LüDERITZ	1	1	1	5
	KARASBURG	1			5
	KEETMANSHOOP	1	1		5
	BETHANIE HC	1			5
KAVANGO	ANDARA	1			5
	NANKUDU	1			5
	NYANGANA	1			5
	RUNDU	1	1	1	5

KHOMAS	**WINDHOEK CENTRAL**	1	1		5
	KATUTURA	1	1	1	5
	KATUTURA HC	1			5
	ROMAN CATHOLIC (Private)	1	0 (not done hosp.policy		5
KUNENE	**KHORIXAS**	1		1	5
	OPUWO	1	1	1	5
	OUTJO	1			5
OHANGWENA	**ENGELA**	1			5
	EENHANA	1			5
	OKONGO	1			5
	ODIBO (HC)	1			5
OMUSATI	OKAHAO	1			5
	OSHIKUKU	1	1		5
	OUTAPI (FGD)	1	1		5
	TSANDI	1	1		5
OSHANA	INTERMEDIATE OSHAKATI (FGD)	1	1	1	5
	MEDI-PARK	1			4 Not possible
OSHIKOTO	ONANDJOKWE	1	1		5
	TSUMEB	1	1		5
OTJOZONDJUPA	OKAHANDJA,	1	1		5
	OKAKARA	1			5
	OTJIWARONGO	1	1	1	5
	GROOTFONTEIN	1	1		5
	MANGETTI DUNE	1			5
OMAHEKE	GOBABIS	1	1		5
TOTAL TOOLS COLLECTED		**40/41**	**20/21**	**8/8**	**200/205**

[1] Not able to do CEI as the patients were private and as such was difficult to get them

Team	Region	Hospital & Health Centre
Team 1: Mrs Gladys Kamboo& Mr Brandon Bock	Erongo	Omaruru
		Swakopmund
		Usakos
		Walvis Bay
	Kunene	Khorixas
		Opuwo
		Outjo
Team 2: Mrs P Biwa & Ms Drusulla Hoeses	Karas	Luderitz
		Karasburg
		Keetmanshoop (FGD)
		Bethanien HC
		Aranos
	Hardap	Mariental
		Rehoboth
Team 3: Mr. Peter Mbango& Mr. Michael Mulunga	Kavango	Andara
		Nankudu
		Nyangana
		Rundu
	Caprivi	KatimaMulilo
	+Oshikoto	Tsumeb
		Grootfontein
Team 4: Mrs Linda Nambunduga& Mrs JeanyAuala	Ohangwena	Engela
		Eenhana
		Okongo
		Odibo HC
	Oshikoto	Onandjokwe
	Omusati	Okahao
		Oshikuku
		Outapi (FGD)
		Tsandi
	Oshana	Intermediate Oshakati (FGD)
		Medi-Park
Team 5: Mr Jonas Kapanga, Mr. S. Ndjembo& Mr N. Israel	Otjozondjupa	Okahandja
		Mangetti Dune
		Okakarara
		Otjiwarongo
	Khomas	Windhoek Central
		Katutura (FGD)
		Katutura HC
		Roman Catholic
	+Omaheke	Gobabis

Annex D: Data Collection Tools

AP.1: HEALTH CARE WORKERS QUALITY MANAGEMENT ASSESSMENT TOOL (110 minutes)

Facility Name:	
Facility Type:	Hospital (fill in type) _____Health Center _____Other (please fill in)_____
Primary Contact Person at site:	Name and Title:
Completion Date	
Where Completed	On-site ____Off-site____ If off-site note where OA was completed _____
Individuals present by name and position	Name _____ Position _____ Name _____ Position _____ Name _____ Position _____
Completed by	Name_____ Title and organisation

√ score in left hand column

ADMINISTRATIVE AND MANAGEMENT

A) Quality Management organisational structure		
A.1. Does the facility have an organisational structure to assess improve the quality of care? If so, for which programmes (HIV, MCH, IMAAI, etc.)?		
Describe the structure you have and provide examples for each programme, if available:		
	0	No quality management structure or activities in place
	1	Quality management structure is only loosely in place; a few meetings at which quality is purposefully discussed; some staff participate; knowledge of quality assessment structure is limited to only a few people in facility.
	2	Separate quality committee may not exist but at least 4 meetings per year where quality activities are purposefully discussed; meetings include different disciplines in quality discussions (e.g. nurse, doctor, pharmacist, administrator, records, other); staff knows about quality activities and committee meetings; documentation records of meetings are kept.
	3	Formal quality committee does exist; and meets more than 4x per year; quality meetings include written minutes and written follow-up; entire staff understands quality structure and reporting mechanism; active support by overall facility.

A.2. Does the facility leadership support the quality programme? If so, for which programmes (HIV, MCH, IMAAI, etc.)?		
Describe and provide examples, if available or any other comments: e.g. minutes of management meetings		
	0	No evidence of leadership involvement in quality of care programme.
	1	Facility leadership reviewed quality data; support for Quality Improvement (QI) is not consistent; involved only if needed; leadership had limited experience in QI activities.
	2	Leadership sees quality improvement as a priority, supports staff and quality activities routinely; leadership involved in setting quality priorities.
	3	Facility leadership stresses being proactive; leadership actively involved in ongoing education about quality; QI issues discussed at leadership meetings in the facility
A.3. Does the facility have a comprehensive quality plan? If so, for which programmes (HIV, MCH, IMAAI, etc.)?		
Describe and provide examples, if available or any other comment: *e.g. Quality Assurance programmes included in annual work plan*		
	0	No written plan in place.
	1	Quality programmes has only a loose outline of a structured quality plan; a written plan does not reflect routine quality improvement activities.
	2	The quality plan is reviewed and updated annually; the quality plan describes the quality committee structure and its frequency of meetings; key quality principles and objectives are outlined; the quality plan does not include all major components and is not routinely shared with staff.
	3	The quality infrastructure includes a written plan reviewed and updated annually and includes all major components; the quality committee oversees and provides feedback to quality improvement activities; staff is aware of the plan; staff is actively involved in reviewing and updating the quality plan.
A.4. Are annual quality goals established for the facility? If so, for which programmes (HIV, MCH, IMAAI, etc.)?		
Describe and provide examples, if available or any other comment:		
	0	No annual quality goals established for the facility.
	1	Goals based only on MOHSS or external requirements.
	2	Annual quality facility based goals discussed and agreed on by quality team; goals selected based on past performance; a loose process is in place to update goals; goal selection and prioritization process not clearly defined.
	3	Annual facility based goals set to select quality projects and performance measures; selection and prioritization process clearly defined; goals relevant to facility needs; at least annual review and update of goals.

A.5. Is there a document in place (i.e.workplan) to specify timelines for the implementation of the quality plan? If so, for which programmes (HIV, MCH, IMAAI, etc)?		
Describe and provide examples, if available or any other comment:		
	0	No work plan utilized for quality programmes and no specific timeframes established
	1	No formal process for quality findings in place; follow-up of quality findings only as needed;work plan may be in place but is not reviewed and updated periodically.
	2	Quality activities include moderate planning for the near future; work plan in place and reviewed and updated periodically.
	3	Full work plan with timelines and individual roles and responsibilities in place; monitored by quality committee; staff aware of timelines and work plan activities.
A.6. Are there clearly described roles and responsibilities for the facility's quality programmes? If so, for which programmes (HIV, MCH, IMAAI, etc)?		
Describe and provide examples, if available or any other comment:		
	0	No roles and responsibilities described in quality structure.
	1	Staff has vague idea about roles and responsibilities for quality programmes; no written documentation or activities described in job descriptions.
	2	Key roles for quality programmes are clearly described; leadership and governance is established; staff is informed about different roles; QI team roles are described; follow-up responsibilities for quality activities are not clearly defined.
	3	The staff responsibilities are clearly described regarding involvement in team structure, performance measurement, and quality activities; follow-up responsibilities for quality activities are clearly defined; roles and responsibilities are noted in job descriptions.
A.7. Are staff resources committed to support the facility's quality programmes? If so, for which programmes (HIV, MCH, IMAAI, etc)?		
Describe and provide examples, if available or any other comment:		
	0	No designated resources are committed to support facility's quality programme.
	1	Only one designated individual responsible to perform or coordinate any efforts related to quality; quality not part of other staff's job expectations
	2	Key staff members are formally expected to conduct or participate in quality activities, but no dedicated time is allocated.
	3	Adequate time is allocated for key staff members to perform routine quality related activities in addition to being formally expected to conduct or participate in quality activities.

A.8. Is the staff routinely involved in quality improvement activities? If so, for which programmes (HIV, MCH, IMAAI, etc)?		
Describe and provide examples, if available or any other comment:		
	0	No staff routinely educated about QI; staff do not participate in quality activities.
	1	Only a few people have access to training opportunities; no additional resources for quality training available; staff are not routinely included in QI project activities.
	2	No formal process in place to routinely involve all staff in quality activities; some staff members attend external quality trainings; some staff participate in QI project activities.
	3	Almost all staff members are involved in quality activities; all attend an annual quality training; staff knows about QI principles; staff are involved in the review and updating of the quality plan and routinely participate in quality project activities; resources in place to ensure education of new staff and updates for all staff.
A.9. Is the staff routinely recognized for their improvement activities?		
Describe and provide examples, if available or any other comments:		
	0	No staff recognition for improvement activities.
	1	Staff are complimented by colleagues only or informally recognized for their work.
	2	Supervisors informally or formally recognized performance. Acknowledgement of contributions made by staff by senior leaders occurs regularly.
	3	A formal awards ceremony at the departmental, facility, or national levels recognizes staff that have exceeded expectations in their performance of quality improvement activities. A formal process exists to identify staff that performs beyond expectation with privileges granted to support their work.
A.10. Is staff satisfaction regularly assessed?		
Describe and provide examples, if available or any other comments:		
	0	No effort is made to assess staff satisfaction.
	1	Satisfaction is assessed through informal discussion with some staff.
	2	Periodic team meetings are devoted to assessing staff satisfaction.
	3	A formal written assessment of staff satisfaction occurs on at least an annual basis.
Quality Programme Recommendations:		

B) Quality Performance Measurement		
B.1. Does the facility routinely measure the quality of care?		
Describe and provide examples, if available or any other comments: E.g. Is there a process for reviewing patient care, medication use etc.		
	0	No routine measurement of quality of care in place.
	1	Facility measured only what was required; only few staff members involved in measurement process or measurement is done once in a while.
	2	Process in place to measure performance routinely in performance reviews; implementation steps have defined timetables; most relevant staff involved in measurement process; results reviewed in quality discussions.
	3	Process to evaluate and measure performance clearly described; performance reviews for internally developed indicators conducted by the facilities leadership at least annually, action taken on the results; staff trained in review process.
B.2. How are quality indicators selected at this facility?		
Describe and provide examples, if available or any other comments:		
	0	No indicators selected to measure performance.
	1	Selection of indicators limited to those required by external agency (i.e. MOHSS or donor).
	2	Selection of indicators was based on results of internal quality initiatives; indicators had written definitions and frequencies of review; staff was aware of indicators; indicators reflected standard of care; required indicators for national reporting collected.
	3	Annual process to review and update internally selected clinical indicators; indicators clearly defined and understood by staff.
Quality Performance Measurement Recommendations:		
C) Quality Improvement (QI) Activities		
C.1. Does the facility conduct QI activities to improve the quality of care?		
Describe and provide examples, if available or any other comments:		
	0	No quality improvement activities in place or initiated.
	1	QI activities focused on individual cases without any analysis of underlying cause or performance measurement data; reviews primarily used for inspection.
	2	QI activities focus on processes; projects conducted based on performance data results; findings presented to quality committee; QI principles (consumer focus, staff involvement, team approach) applied; at least one project completed.
	3	Structured process of QI activities selection and prioritization; QI activities are data-driven; consumer needs routinely identified and incorporated in quality improvements; majority of staff involved in QI activities; findings shared with entire staff.

C.2. Is a team approach used for quality improvement?		
Describe and provide examples, if available or any other comment:		
	0	No team approach for quality improvement conducted.
	1	Mostly the same staff members meet to discuss improvements; methodologies for quality improvement team approach not used.
	2	Team approach to QI introduced; basic staff knowledge about QI team approach; results presented at quality committee; team approach includes using established QI methodologies (PDSA, fishbone, flowcharting).
	3	Team approach used routinely to address complex quality issues; members educated about their roles; continue to monitor changes; results shared throughout the facility or openly displayed in the facility.
Quality Improvement Activities Recommendations:		
D) Consumer Involvement		
D.1. Are consumers/patients involved in quality-related activities?		
Describe and provide examples, if available or any other comment:		
	0	No consumer/patients involvement in quality-related activities.
	1	Patient concerns are only discussed as they arise; patients' satisfaction is not measured routinely; no structure in place to gather patients' feedback.
	2	Patient needs and/or satisfaction are assessed; patient feedback is discussed in quality committees.
	3	Findings of consumer/patient assessments routinely integrated into the quality programme; QI project reflects results of issues identified by consumers; structured input from consumers such as patients, family members, advocates, etc is obtained.; consumer feedback is incorporated in setting quality goals; results of quality activities are routinely communicated with patients and other consumers; patient centred quality activity is launched.
Consumer Involvement Recommendations:		
E). Evaluation of Quality Programmes		
E.1. Is a process in place to evaluate the facility's quality programmes? If so, for which programmes (HIV, MCH, IMAAI, etc)?		
Describe and provide examples, if available or any other comment:		
	0	No formal process is established to evaluate the quality programmes.
	1	Quality activities only reviewed if necessary; no review of quality work plan; no annual review of quality goals and infrastructure.
	2	Review of ongoing quality activities done by group involved in leading quality efforts and includes routinely evaluating improvements achieved through a team approach; some results from evaluations used to plan ahead for future quality efforts, but not in a comprehensive manner; summary of findings are documented.
	3	Structure in place to use evaluations to facilitate future planning for quality, including identification of improvement opportunities; past results of performance measurements and improvement activities are used to update work plan, annual goals, and timelines; the quality committee is actively engaged in the process of evaluation; evaluations are used to review annually the quality infrastructure.

Evaluation of Quality Programmes Recommendations:		
F) Clinical Information System		
F.1. Does the facility have an information system in place to track patient care and measure quality? If so, for which programmes (HIV, MCH, IMAAI, etc)?		
Describe and provide examples, if available or any other comments:		
	0	No system established to use data to assess quality of care. Has basic paper medical record but no system in place to collect data for quality purposes; routine reporting to external governing body may exist but data is difficult to obtain through chart extraction.
	1	Medical record and very basic manual system in place to collect data for MOHSS and donor purposes;
	2	Has functional information system (manual or electronic) to track patients and patient care; some data is collected and used for quality activities. Limited capacity to easily manage quality measurements with current system.
	3	Fully functional clinical information system to track patient care and produce useful quality of care information reports from an electronic database or health record.
Clinical Information System Recommendations:		

G. IMPROVEMENT IN CLINICAL PRACTICE		
G.1. What mechanisms are in place to ensure proper inpatient care?		
Describe and provide examples, if available or any other comment:		
	0	No ward rounds are carried out by the doctor and a nurse.
	1	Ward rounds with a doctor and a nurse are carried out in the inpatient wards at least once a week. No major ward rounds are conducted.
	2	Ward rounds with a doctor and a nurse are carried out in the wards at least 2-3times a week but major ward rounds are not done or rarely held.
	3	Ward rounds with a doctor and a nurse are carried out in all the wards at least 5 times a week. Major ward round with a team of doctors, nurses and pharmacists' is also carried out at least once week.
Inpatient care Recommendations:		

G.2. Does the facility have a functional infection control committee?		
Describe and provide examples, if available or any other comments:		
	0	No infection control committee or activities in place.
	1	Infection control committee is only loosely in place; a few meetings are held; some staff participate; knowledge of infection control is limited to only a few people in facility. There is a focal person is assigned for infection control activities.
	2	Infection control committee does exist; at least 4 meetings per year are held; meetings include different disciplines in infection control discussions (e.g. nurse, doctor, pharmacist, administrator, other); staff knows about infection control activities and committee meetings; documentation records of meetings are kept.
	3	A formal Infection control committee does exists; and meets more than 4x per year; the meetings include written minutes and written follow-up; regular in -service training of staff is carried out; and entire staff understands infection control practices.
Infection Control Recommendations:		

G.3. Does the facility have functional a therapeutic committee?		
Describe and provide examples, if available or any other comments:		
	0	No therapeutic committee and no Standard Treatment Guidelines at the facility.
	1	No therapeutic committee but the facility has Standard treatment guidelines. No mechanisms in place to ensure that the guidelines are followed.
	2	Therapeutic committee does exist and meets at least 4 times per year; meetings include different disciplines in quality discussions (e.g. nurse, doctor, pharmacist, other); documentation records of meetings are kept. Standard treatment guidelines are available but no mechanisms in place to ensure that they are followed.
	3	Formal Therapeutic Committee does exist; and meets more than 4 times per year; meetings include written minutes and written follow-up; there is active support by overall facility. Standard treatment guidelines are available and there are mechanisms in place to ensure that they are followed.
Recommendations therapeutic committee:		

G.3. Does the facility hold mortality meetings?		
Describe and provide examples, if available or any other comments:		
	0	No mortality meetings are held.
	1	Only maternal mortality meetings are held once in a while and minutes for the meetings are available
	2	Mortality meetings are held; meetings include written minutes; issues of concern are not regularly followed up.
	3	Mortality meetings are held; meetings include written minutes; issues of concern are regularly followed up; and feedback is given in subsequent meetings.
Recommendations for mortality meetings:		

AP:2: FOCUS GROUP DISCUSSION TOOL FOR IN-PATIENT HEALTH CARE CLIENTS (60MINUTES)

1) Facility Name	___ 1) Omaruru ___ 2) Swakopmund ___ 3) Usakos ___ 4) Walvis Bay ___ 5) Khorixas ___ 6) Opuwo ___ 7) Outjo ___ 8) Grootfontein ___ 9) Tsumkwe ___ 10) Mangetti Dune ___ 11) Lüderitz ___ 12) Karasburg ___ 13) Keetmanshoop ___ 14) Bethanien	___ 15) Mariental ___ 16) Rehoboth ___ 17) Gobabis ___ 18) Andara ___ 19) Nkankudu ___ 20) Nyangana ___ 21) Rundu ___ 22) KatimaMulilo ___ 23) Windhoek Central ___ 24) KatuturaHosp ___ 25) Katutura HC ___ 26) Roma Catholic ___ 27) Engela ___ 28) Eenhana	___ 29) Okongo ___ 30) Odibo ___ 31) Onandjokwe ___ 32) Tsumeb ___ 34) Okahao ___ 35) Oshikuku ___ 36) Outapi ___ 37) Tsandi ___ 38) Intermediate Oshakati ___ 39) Medi-Park
2) Type of Facility	___ 1) Private Hospital ___ 2) Public District Hospital ___ 3) Health Centre ___ 4) Clinic ___ 5) Other (specify) _____		
3) Primary contact person at site	Name:_____ Title: _____		
4) Questionnaire completion	Completed by: _____ Date: _____ Checked by: _____ Date: _____		
5) Duration of interview	Start time: _____ Finish time: _____ Total time: _____		

I. WELCOME/INTRODUCTION (10 minutes)

[Facilitator Read]

I would like to thank you for volunteering your time to be part of this important discussion. My name is

_____, and I work for _____. I will be moderating our discussion today.

We asked you to join this discussion today to get your thoughts about the quality of health care services that are being offered in this facility. You being the clients of this facility, you know better the quality of services that are being offered. Your responses and suggestions will help the MoHSS in identifying areas in health care delivery that need improvement.

In this group, we will talk for about one hour. I'm a facilitator, and that means that I will ask questions and lead the discussion. My partner, _____, is the recorder. S/he will take notes during our discussion and help me summarize what we talk about today.

A discussion among a group of people like you, sometimes leads to a better understanding of a given issue because then we get to hear many different opinions at the same time. Please share openly and honestly about the questions that will be asked. We want to hear everyone's point of view, even if it is different from what others have said. Although, you might have different experiences, we can learn from all of you.

Discussion Guidelines

To make sure that we make the most of our time together, there are some instructions or guidelines that we would like you to keep in my mind so that our discussion goes smoothly.

- What is said in this room stays in this room. Please do not discuss the thoughts shared in the group outside of the group.
- Place all mobile phones on vibrate. If you must answer your phone, please leave the room and return shortly.
- Only one person speaks at a time. Feel free to disagree, but do so with respect for others' thoughts. Also, feel free to add to someone else's point or thought.
- Share only what you're comfortable sharing. You do not have to discuss every topic and you do not have to talk about yourself or your own situation unless you want to.
- There is no right or wrong answers to these questions. We want your honest thoughts and opinions.
- We would like to hear from everyone.

Do you have any questions about these instructions?

Before we begin, I want you to be fully aware of what we will be doing today and the possibilities associated with this discussion.

Consent

[Facilitator Instructions]

- Read the consent form for the participants.
- Make sure that the participants understand the risks and verbally agree to be interviewed and audio taped in the focus group.
- Give one copy of the consent form to each participant to keep.

Confidentiality

As I stated earlier, we will be recording the discussion because we don't want to miss any of your important thoughts and opinions. But, we will only be using unique identifiers and there will not be any names attached to the comments on the final report. You may be assured complete confidentiality.

On that note, please introduce yourselves. Say your first name only and one thing about yourself that you would like to share with the group. I'll start….

2. TOPIC GENERATION

Again, this group was organized to discuss the quality of health care services that are being offered in this facility. Your opinions and thoughts will help the MoHSS to identify the gaps in the quality of services and improve on them. If there is some confusion during the discussion and you need me to clarify any question please ask.

Let's started!

Today we are here to talk about the quality of health care services that are being offered in this facility.

Health care staff Attitude (8 minutes)

1) How would you describe the Health care staff Attitude/conduct in this facility ?

   » Probe: *(How do the health care staff behave in this facility? Are they rude to you, do they treat you with sympathy? E.t.c)*

Respect for patients and their rights (6 minutes)

2) Do the health care staff respect you and your rights?

» Probe: (*do they give you enough time to explain your complaints? Do they listen to your views?*)

Promptness of attention or service (6 minutes)

3) Do you think the health care staff attend to you as fast as they could?

» Probe: *(given the number of patients in this facility and staff numbers do you think they tried as much as possible to attend to you fast enough?)*

Provision of adequate information (6 minutes)

4) Are you provided enough information about your condition or any other thing you need to know in this facility?

Probe: *(are there health education activities in the facility? Are your questions always answered?)*

Health care environment (6 minutes)

5) How do you describe the environment where the health care services are being delivered?

Probe: *(Is the environment clean? Do you feel comfortable as you wait to be seen by the health care workers?)*

Provision of privacy and confidentiality (6 minutes)

6) When you are being asked questions and examined by the health care worker, do you feel there is privacy?

Probe: (*when you are being examined or asked questions, are you in a place where only the health care workers see you and not other patients?)*

Overall Reactions/Impressions to national quality management system **(10 minutes)**

7) What do you think can be done to improve the quality of services?

» Probe:

- What can the community do to help improve the services
- Would you like to take part in improving the quality of services and how?

CONCLUSION (2 minutes)

[Facilitator Read]

We are now at the conclusion of our group discussion. Thank you for your participation in this focus group discussion today.

8). Are there any short final comments that anyone would like to make?

You shared some really important information and your responses will be very helpful to us in identifying the gaps in the quality of health care services and try to improve. Once we have compiled all of the responses from the various focus groups, the presentation of the findings will made available in different forums.

AP:3 OUTPATIENT CLIENT EXIT QUESTIONNAIRE TOOL

1) Facility Name	___ 1) Omaruru ___ 2) Swakopmund ___ 3) Usakos ___ 4) Walvis Bay ___ 5) Khorixas ___ 6) Opuwo ___ 7) Outjo ___ 8) Grootfontein ___ 9) Tsumkwe ___ 10) Mangetti Dune ___ 11) Lüderitz ___ 12) Karasburg ___ 13) Keetmanshoop ___ 14) Bethanien	___ 15) Mariental ___ 16) Rehoboth ___ 17) Gobabis ___ 18) Andara ___ 19) Nkankudu ___ 20) Nyangana ___ 21) Rundu ___ 22) KatimaMulilo ___ 23) Windhoek Central ___ 24) KatuturaHosp ___ 25) Katutura HC ___ 26) Roma Catholic ___ 27) Engela ___ 28) Eenhana	___ 29) Okongo ___ 30) Odibo ___ 31) Onandjokwe ___ 32) Tsumeb ___ 34) Okahao ___ 35) Oshikuku ___ 36) Outapi ___ 37) Tsandi ___ 38) Intermediate Oshakati ___ 39) Medi-Park __ 40) Roman Catholic
2) Type of Facility	___ 1) Private Hospital ___ 2) Public District Hospital ___ 3) Health Centre ___ 4) Clinic ___ 5) Other (specify) _____		
3) Primary contact person at site	Name:_____ Title: _____		
4) Questionnaire completion	Completed by: _____ Date: _____ Checked by: _____ Date: _____		
5) Duration of interview	Start time: _____ Finish time: _____ Total time: _____		

Guide: A semi-structured questionnaire to explore client satisfaction.

Interviewees: client exit for outpatients to explore the quality of the services being provided and to find out client satisfaction/dissatisfaction.

Introduction to the Respondent

I would like to thank you for volunteering your time to be part of this important discussion.

My name is ....., and I work for.....

We are here to ask for your assistance in providing your views on the quality of health care services. I will be asking you questions about the quality of services that you have received at this facility. Your responses and suggestions will help the MOHSS identifying areas in health care delivery that need improvement. This interview is confidential, and all information will be kept as such.

We will not share your identity or your individual responses with the staff at that facility or with anyone else. Only the survey organizers and the committee monitoring the ethics aspects of this study will be able to see the data. The responses you provide will be kept strictly confidential and will not be shown to other persons.

There are no risks involved in participating in the study. Participation in this study or refusal to participate will not affect your ability to access health services or any other services.

The interview usually takes between 10 and 20 minutes to complete. Participation in this survey is voluntary and you can choose not to answer any individual question or all the questions. However, we hope that you will participate fully in this survey since your views are important.

At this time, is there anything you would like to ask me about the survey?

By consenting, you indicate that you understand the information I just read about the study and that you are willing to participate.

Do you agree to be interviewed: ___ 1) Yes ____ 2) No

Introductory Questions

Health Care Environment (SA – Strongly agree; A-agree; SD – strongly disagree; D-disagree; NA – Not applicable)

		SA	A	SD	D	NA
6)	I am satisfied with the health care services that I received today.					
7)	I am satisfied with the health care services that I usually receive at this facility.					
8)	This health facility is usually clean on the inside of the building.					
9)	This health facility is not clean on the inside of the building today?					
10)	This health facility is usually clean on the outside of the building?					
11)	This health facility is not clean on the outside of the building today.					
12)	This health facility is usually neat.					
13)	This health facility is not neat today.					
14)	The toilet of this facility is usually clean.					
15)	The toilet of this facility was clean today.					
16)	There is usually soap in this facility to wash my hands after I use the toilet.					
17)	Today, there was soap to wash my hands after I used the toilet					
18)	The toilet in this facility usually has toilet paper.					
19)	Today, the toilet in this facility had toilet paper.					
20)	I did not see any cockroaches in the facility.					
21)	I am aware of the health facility suggestion box.					
22)	I always use the health facility suggestion box.					
23)	I have never received any feedback from the health facility suggestion box.					

Health Care Staff (SA – Strongly agree; A-agree; SD – strongly disagree; D-disagree; NA – Not applicable)

24)	The health care staff at this facility usually has a positive attitude towards me.					
25)	Today, the health care staff had a positive attitude towards me?					
26)	The health care worker introduced herself to me today?					
27)	I have seen that the health care staff at this facility is rude to other patients.					
28)	The health care worker explained to me the examination before it was actually done?					
29)	I fully understood the explanation that the health care worker gave me today with regards to my condition?					
30)	The health care worker seemed to know what s/he was talking about.					
31)	The health care worker did not explain how I should take the medicine that I received today?					
32)	The health care worker provided me with written materials on how to prevent my condition.					
33)	The health care worker explained the written material to me.					
34)	The health care worker wanted to know if I had any questions.					
35)	I felt that the discussion between me and the health care worker was confidential.					
36)	The room where the consultation took place did not provide sufficient privacy.					

Utilization and access to services

37) What services are available at this facility? [tick more than one response]
___ 1) Maternal health

___ 2) Child health

___ 3) Communicable disease

___ 4) Non-communicable disease

___ 5) Provision of care

___6) others, specify_____

38) Have you experienced any challenges in accessing this health facility?
___ 1) Yes
___ 2) No

39) (If yes to 37) What were these challenges? [tick more than one response]
___ 1) lack of transportation [including lack of money for transportation]
___ 2) Lack of money to pay for health services
___ 3) Distance
___ 4) Negative attitude of health workers
___ 5) Lack of facility for disabled people to access
___ 6) Other (specify): _____

40) How far do you live from this health facility?
___ 1) < 1 km
___ 2) between 1 and 5 km
___ 3) > 5 km
___ 4) do not know

41) What mode of transportation did you use to come to the health facility today?
___ 1) Walked
___ 2) used bicycle
___ 3) used donkey/horse cart
___ 4) sledge
___ 5) wheel barrow
___ 6) private vehicle [includes own, friend, relative's vehicle]
___ 7) public vehicle

42) How long did it take to come to this facility today?
___ 1) < 1 hour
___ 2) between 1 and 2 hours
___ 3) between 2 and 3 hours
___ 4) between 3 and 4 hours
___ 5) between 4 and 5 hours
___ 6) more than 6 hours

43) Including all costs, how much did you spend on transportation to and from this health facility?
___ 1) 0 – N$50

___ 2) N$51 – N$100

___ 3) N$101 – N$200

___ 4) N$201 – N$300

___ 5) N$301+

44) Were you required to pay for the following services at this facility today?
___ 1) Consultation
___ 2) Medicine
___ 3) Other (please specify): _____

45) If yes to 43, how much did you pay? _____

46) Did you find the payment to be too high, acceptable, too low?
___ 1) too high
___ 2) acceptable
___ 3) too low

Timeliness

47) How much time did it take at this facility before one of the health care staff attended to you today?
___ 1) 0-30 minutes (up to thirty minutes)
___ 2) 31 -60 minutes (thirty-one minutes and up to an hour)
___ 3) 61 – 90 minutes (between one hour and one half an hour)
___ 4) 91 – 120 minutes (between half an hour and two hours)
___ 5) 121 – 160 minutes (between two hours and two and a half hours)
___ 6) 161 – 190 minutes (between two and a half hours and three hours)
___ 7) 191+ minutes (three hour and more)

47b) How satisfied were you with the above duration of time?
___ 1) Very satisfied
___ 2) Satisfied
___ 3) Not satisfied
___ 4) Very unsatisfied

Community Participation

	Yes	No	DK
48) Are there peer to peer support structures to support illnesses e.g. HIV, TB, childhood diseases, etc in your community?			
49) Are there community health promoters in your community?			
50) Are there community providers of Anti retroviral for HIV/AIDS in your community?			
51) Are there community providers of DOTS for TB in your community?			
52) Is there a community health committee (probe for possible contribution of this committee to the quality committee) in your community?			

Recommendations

If you had a chance to improve anything at this health facility, what would be three most important things that you would like to improve and how.

_____
_____
_____
_____
_____
_____

Thank you very much for talking with us today, do you have any questions for us.

Explain what happens next:

AP: 4: COMMUNITY FOCUS GROUP DISCUSSION TOOL (60 minutes)

WELCOME/INTRODUCTION (10 minutes)

[Facilitator Read]

I would like to thank you for volunteering your time to be part of this important discussion. My name is _____, and I work for _____. I will be moderating our discussion today.

We asked you to join this discussion today to get your thoughts about the quality of health care services that are being offered in this facility. You being community members, you know better the quality of services that are being offered. Your responses and suggestions will help the MoHSS in identifying areas in health care delivery that need improvement.

In this group, we will talk for about one hour. I'm a facilitator, and that means that I will ask questions and lead the discussion. My partner, _____, is the recorder. S/he will take notes during our discussion and help me summarize what we talk about today.

A discussion among a group of people like you, sometimes leads to a better understanding of a given issue because then we get to hear many different opinions at the same time. Please share openly and honestly about the questions that will be asked. We want to hear everyone's point of view, even if it is different from what others have said. Although, you might have different experiencesw, we can learn from all of you.

Discussion Guidelines

To make sure that we make the most of our time together, there are some instructions or guidelines that we would like you to keep in my mind so that our discussion goes smoothly.

- What is said in this room stays in this room. Please do not discuss the thoughts shared in the group outside of the group.
- Place all mobile phones on vibrate. If you must answer your phone, please leave the room and return shortly.
- Only one person speaks at a time. Feel free to disagree, but do so with respect for others' thoughts. Also, feel free to add to someone else's point or thought.
- Share only what you're comfortable sharing. You do not have to discuss every topic and you do not have to talk about yourself or your own situation unless you want to.
- There is no right or wrong answers to these questions. We want your honest thoughts and opinions.
- We would like to hear from everyone.

Do you have any questions about these instructions?

Before we begin, I want you to be fully aware of what we will be doing today and the possibilities associated with this discussion.

Consent

[Facilitator Instructions]

- Read the consent form for the participants.
- Make sure that the participants understand the risks and verbally agree to be interviewed and audio taped in the focus group.
- Give one copy of the consent form to each participant to keep.

Confidentiality

As I stated earlier, we will be recording the discussion because we don't want to miss any of your important thoughts and opinions. But, we will only be using unique identifiers and there will not be any names attached to the comments on the final report. You may be assured complete confidentiality.

On that note, please introduce yourselves. Say your first name only and one thing about yourself that you would like to share with the group. I'll start….

3. TOPIC GENERATION

Again, this group was organized to discuss your views on the quality of health care services that is being offered in this facility. Your opinions and thoughts will help the MoHSS to identify the gaps in the quality of services and improve on them. If there is some confusion during the discussion and you need me to clarify any question please ask.

Let's started!

Today we are here to talk about the quality of health care services that are being offered in this facility.

Health Care environment

Quality of health care services (SA – Strongly agree; A-agree; SD – strongly disagree; D-disagree; NA – Not applicable)

	SA	A	SD	D	NA
6) I am satisfied with the health care services that I usually receive at this facility.					

Please comment on the quality of the health care services at this facility

Probe(treatment, accommodation & meals)

……

……

……

……

Health care staff

7) How would you describe the health care staff's attitude.& knowledge?
Probe; knowledge, Attitude, confidentiality & provision of information especially health education

……

……

……

Suggestion boxes

	SA	A	SD	D	NA
8) I am are aware of the health facility suggestion box					
9) I always use the health facility suggestion box.					
10) I have never received any feedback from the health facility suggestion box					
Please comment on the effectiveness of suggestions boxes;					
Utilization and access to services	SA	A	SD	D	NA
11) What services are available at this clinic? [tick more than one response] ___ 1) Maternal health ___ 2) Child health ___ 3) Communicable disease ___ 4) Non-communicable disease ___ 5) Provision of care ____6)others, specify_____					
12) In your view what are some of the reasons why people do not access heath services **(Probe: transportation; finances; distance; staff attitude; facility for disabled people**					
Timeliness/promptness	SA	A	SD	D	NA
13) How do you feel about the time patients spend before they are attended to by a health professional? Are you satisfied					
Kindly elaborate:					

Cleanliness (How do you view the cleanliness of the health facility

	SA	A	SD	D	NA
14) This health facility is usually clean on the inside of the building.					
Please comment on the general cleanliness of the facility (probe cleanliness inside and outside the building, availability of soap, presence of cockroaches etc).					

Community participation

15) What role does the community play in the provision of health services? Kindly elaborate …… ……			
	Yes	No	DK
16) Are there peer to peer support structures to support illnesses e.g. HIV, TB, childhood diseases, etc in your community and are they effective? Give examples: …… ……			
17) Are there community health promoters in your community and are they effective? Give examples; …… ……			
18) Are there community providers of Anti retroviral for HIV/AIDS in your community and are they effective? Give examples; …… ……			
19) Are there community providers of DOTS for TB in your community and are they effective? Give examples: …… ……			
20) Is there a community health committee (probe for possible contribution of this committee to the quality committee) in your community and are they effective? Give examples: …… ……			

Recommendations

If you had a chance to improve anything at this health facility, what would be three most important things that the community could do to improve and how?

_____

_____

_____

_____

_____

_____

Thank you very much for talking with us today, do you have any questions for us.
Explain what happens next:

Annex E: Data Tables

E.1 Health Care Worker Focus Group Discussion Frequencies and Percentages

Quality management structure in place	Number	Percent
No quality management structure or activities in place	0	0%
Quality management structure is only loosely in place; a few meetings at which quality is purposefully discussed; some staff participate; knowledge of quality assessment structure is limited to only a few people in facility.	5	12.5%
Separate quality committee may not exist but at least 4 meetings per year where quality activities are purposefully discussed; meetings include different disciplines in quality discussions (e.g. nurse, doctor, pharmacist, administrator, records, other); staff knows about quality activities and committee meetings; documentation records of meetings are kept.	22	55%
Formal quality committee does exist; and meets more than 4x per year; quality meetings include written minutes and written follow-up; entire staff understands quality structure and reporting mechanism; active support by overall facility.	13	32.5%
Total	40	100%

Leadership support	Number	Percent
Facility leadership reviewed quality data	2	5%
Leadership sees quality improvement as a priority	28	70%
Facility leadership stresses being proactive	10	25%
Total	40	100%

Comprehensive quality management plan	Number	Percent
None	3	7.5%
Only a loose outline of a structured quality management plan	8	20%
The quality management plan is reviewed and updated annually	11	27%
Includes a written plan reviewed and updated annually and includes all major components	18	45%
Total	40	100%

Establishment of annual quality management goals	Number	Percent
None	1	2.5%
Management goals are based only on MOHSS or external requirements	14	35%
Annual quality facility based management goals discussed and agreed on by quality team	4	10%
Annual facility based goals set to select quality projects and performance measures	20	50%
NS	1	2.5%
Total	40	100%

Work plan exist	Number	Percent
None	2	5%
No formal process for quality findings in place	1	2.5%
Quality management activities include moderate planning for the near future	15	37.5%
Full work plan with timelines and individual roles and responsibilities in place	21	52.5%
NS	1	2.5%
Total	40	100%

Quality management programme role	Number	Percent
Staff has vague idea about roles and responsibilities for quality management programme	6	15%
Key roles for quality management programme are clearly described	12	30%
The staff responsibilities clearly described w.r.t team structure, performance measurement and quality	21	52%
NS	1	2.5%
Total	40	100%

Committed staff resources	Number	Percent
Only one designated individual	6	15.4%
Key staff members but no time	23	59%
Adequate time is allocated for key staff members	11	25.6%
Total	40	100%

Routinely involvement of staff to improved performance	Number	Percent
Only a few people have access to training opportunities	9	22.5%
No formal process in place to routinely involve all staff in quality activities	15	37.5%
Almost all staff members are involved in quality activities	15	37.5%
NS	1	2.5%
Total	40	100%

Staff routinely recognized	Number	Percent
None	1	2.5%
Staff are complimented by colleagues only or informally recognized for their work	11	27.5%
Supervisors informally or formally recognized performance	25	62.5%
A formal awards ceremony at the departmental	3	7.5%
Total	40	100%

Assessment of staff satisfaction regularly	Number	Percent
None	5	12.5%
Satisfaction is assessed through informal discussion with some staff	25	62.5%
Periodic team meetings are devoted to assessing staff satisfaction	6	15%
A formal written assessment of staff satisfaction occurs on at least an annual basis	4	10%
Total	40	100%

Routine measurement of performance	Number	Percent
Facility measured only what was required	13	32.5%
Process in place to measure performance routinely in performance reviews	17	42.5%
Process to evaluate and measure performance clearly described	10	25%
Total	40	100%

Method to select quality indicators	Number	Percent
None	2	5%
Selection of indicators limited to those required by external agency	21	52.5%
Selection of indicators was based on results of internal quality initiatives	10	25%
Annual process to review and update internally selected clinical indicators	7	17.5%
Total	40	100%

Does the facility conduct QI activities to improve the quality care	Number	Percent
QI activities focused on individual cases without any analysis of underlying cause or performance measurement data	8	20%
QI activities focus on processes; projects conducted based on performance data results	22	55%
Structured process of QI activities selection and prioritization	10	25%
Total	40	100%

Use team approach used for quality improvement	Number	Percent
Mostly the same staff members meet to discuss improvements	14	35%
Team approach to QI introduced	11	27.5%
Team approach used routinely to address complex quality issues	15	37.5%
Total	40	100%

Involve patients in quality-related activities	Number	Percent
None	1	2.5%
Patient concerns are only discussed as they arise	12	30%
Patient needs and/or satisfaction are assessed	18	45%
Findings of patient assessments routinely integrated into the quality programme	9	22.5%
Total	40	100%

Have evaluation process	Number	Percent
None	3	7.5%
Quality activities only reviewed if necessary	6	15%
Review of ongoing quality activities done by group involved in leading quality efforts	19	47.5%
Programme to use evaluations to facilitate future planning for quality, including improvement opportunities	12	30%
Total	40	100%

Information system in place to track patient care and measure quality	Number	Percent
Medical record and very basic manual system in place to collect data for MOHSS and donor purposes	9	22.5%
Has functional information system	20	50%
Fully functional clinical information system	11	27.5%
Total	40	100%

Proper inpatient care mechanisms	Number	Percent
None	1	2.5%
Ward rounds with a doctor and a nurse carried out in wards at least 2-3times a week but major ward rounds are not rarely	6	15%
Ward rounds with a doctor and a nurse are carried out in all the wards at least 5 times a week	32	80%
NS	1	2.5%
Total	40	100%

Functional infection control committee	Number	Percent
None	1	2.5%
Infection control committee is only loosely in place	6	15%
Infection control committee does exist; at least 4 meetings per year are held	13	32.5%
A formal Infection control committee does exists, and meets more than 4x per year	20	50%
Total	40	100%

Functional therapeutic committee	Number	Percent
None	2	5%
No therapeutic committee but the facility has Standard treatment guidelines	5	12.5%
Therapeutic committee does exist and meets at least 4 times per year	2	5%
Formal Therapeutic Committee does exist	31	77.5%
Total	40	100%

E.2 Client Exit Interview Frequencies and Percentages

Health Care Environment	Strongly agree		Agree		Strongly disagree		Disagree		NA		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Satisfy with health care service received TODAY	71	35.3	99	49.3	15	7.5	15	7.5	1	.5	201	100.0
Satisfaction with health care service received USUALLY	56	27.9	98	48.8	18	9.0	26	12.9	3	1.5	201	100.0
Health facility usually clean inside of building	48	23.9	107	53.2	13	6.5	30	14.9	3	1.5	201	100.0
Health facility not clean inside building	15	7.5	88	43.8	57	28.4	40	19.9	1	.5	201	100.0
Health facility usually clean outside of building	33	16.4	93	46.3	37	18.4	34	16.9	4	2.0	201	100.0
Health facility not clean outside building	13	6.5	76	37.8	62	30.8	48	23.9	2	1.0	201	100.0
Health facility is usually neat	42	20.9	107	53.2	16	8.0	32	15.9	4	2.0	201	100.0
Health facility is not neat today	16	8.0	68	33.8	58	28.9	58	28.9	1	.5	201	100.0
Toilet facility is usually clean	22	10.9	72	35.8	55	27.4	31	15.4	21	10.4	201	100.0
Toilet facility was clean today	14	7.0	55	27.4	33	16.4	26	12.9	73	36.3	201	100.0
Toilet in this facility usually have soap to wash hands afterwards	5	2.5	33	16.4	104	51.7	38	18.9	21	10.4	201	100.0
Today, toilet had soap to wash hands afterwards	2	1.0	29	14.4	68	33.8	31	15.4	71	35.3	201	100.0
Toilet in this facility usually have toilet paper	12	6.0	48	23.9	83	41.3	37	18.4	21	10.4	201	100.0
Today, toilet facility had toilet paper	6	3.0	31	15.4	65	32.3	28	13.9	71	35.3	201	100.0
No cockroaches in this facility	38	18.9	77	38.3	47	23.4	37	18.4	2	1.0	201	100.0
Aware of the health facility suggestion box	16	8.0	35	17.4	113	56.2	18	9.0	19	9.5	201	100.0
Always use the health facility suggestion box	2	1.0	21	10.4	100	49.8	20	10.0	58	28.9	201	100.0
Never receive feedback from health facility suggestion box	19	9.5	20	10.0	75	37.3	16	8.0	71	35.3	201	100.0

Health Care Staff	Strongly agree		Agree		Strongly disagree		Disagree		NA		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Health care staff at this facility usually has a positive attitude towards me	58	28.9	106	52.7	8	4.0	27	13.4	2	1.0	201	100.0
Today, health care staff at this facility had a positive attitude towards me	74	36.8	114	56.7	4	2.0	9	4.5	0	.0	201	100.0
Health care worker introduced herself to me today	6	3.0	47	23.4	112	55.7	36	17.9	0	.0	201	100.0
Health care worker at this facility is rude to other patients	33	16.4	56	27.9	67	33.3	43	21.4	2	1.0	201	100.0
Health care worker explained the examination before it was actually done	41	20.4	93	46.3	37	18.4	17	8.5	13	6.5	201	100.0
Fully understood the explanation that health care worker gave today with regards to my condition	47	23.4	98	48.8	19	9.5	20	10.0	17	8.5	201	100.0
Health care worker seemed to know what she/he was talking about	53	26.4	106	52.7	7	3.5	13	6.5	22	10.9	201	100.0
Health care worker did not explain how to take medicine received today	7	3.5	57	28.4	93	46.3	36	17.9	8	4.0	201	100.0
Health care worker provided me with written materials on how to prevent my condition	7	3.5	77	38.3	81	40.3	24	11.9	12	6.0	201	100.0
Health care worker explained written material to me	6	3.0	71	35.3	34	16.9	28	13.9	62	30.8	201	100.0
Health care worker wanted to know whether I had any questions	14	7.0	63	31.3	70	34.8	34	16.9	20	10.0	201	100.0
Discussion between patient and health worker was confidential	96	47.8	76	37.8	22	10.9	6	3.0	1	.5	201	100.0
Consultation room did not provide sufficient privacy	23	11.4	57	28.4	77	38.3	39	19.4	5	2.5	201	100.0

Type of services	Number	%
Maternal health service	103	51.2
Child health service	93	46.3
Communicable disease service	132	65.7
Non-communicable disease service	67	33.3
Provision of care service	89	44.3
HIV testing service	2	1.0
Physiotherapy service	2	1.0
Orthopaedics service	2	1.0
Family planning service	5	2.5
Follow up on correct medicine usage service	1	0.5
Eye clinic service	2	1.0
Blood testing service	2	1.0
Do not know	5	2.5

Experience any challenges in accessing this health facility	Frequency	Percent
Yes	77	38.3
No	124	61.7
Total	201	100.0

Type of challenges in accessing this health facility	Number	%
lack of transportation	51	66.2
Lack of money to pay for health services	17	22.1
Distance	40	51.9
Negative attitude of health workers	4	5.2
Long queues	2	2.6
Language barrier	1	1.3
Too many people at the facility	2	2.6

Distance from health facility	Number	Percent
< 1 km	45	22.4
Between 1 and 5 km	53	26.4
> 5 km	92	45.8
Do not know	11	5.5
Total	201	100.0

Mode of transportation used to come to health facility	Number	Percent
Walked	96	47.8
used bicycle	2	1.0
private vehicle	40	19.9
public vehicle	63	31.3
Total	201	100.0

Travel time to facility today	Number	Percent
< 1 hour	111	55.2
between 1 and 2 hours	57	28.4
between 2 and 3 hours	18	9.0
between 3 and 4 hours	8	4.0
between 4 and 5 hours	4	2.0
more than 6 hours	3	1.5
Total	201	100.0

Amount spend on transportation to and from this facility	Number	Percent
0 – N$50	183	91.0
N$51 – N$100	15	7.5
N$101 – N$200	2	1.0
N$301+	1	.5
Total	201	100.0
Required to pay for consultation	**Number**	**Percent**
Yes	85	42.3
No	116	57.7
Total	201	100.0
Required to pay for medicine	**Number**	**Percent**
Yes	44	21.9
No	157	78.1
Total	201	100.0
Required to pay for other	**Number**	**Percent**
Yes	15	7.5
No	186	92.5
Total	201	100.0

Amount paid for service	Number	Percent
2	1	.5
4	26	12.9
6	8	4.0
8	33	16.4
9	1	.5
10	6	3.0
12	1	.5
15	2	1.0
20	4	2.0
30	1	.5
70	1	.5
Total	84	41.8
System	117	58.2
Total	201	100.0

Acceptability of payment	Number		Percent
too high	11	5.5	6.5
acceptable	63	31.3	37.5
too low	10	5.0	6.0
Total	84	41.8	50.0
NA	117	58.2	168
Total	201	100.0	

Time of arrival until time treated by the health care staff today	Number	Percent
0-30 minutes (up to thirty minutes)	58	28.9
31 -60 minutes (thirty-one minutes and up to an hour)	46	22.9
61 – 90 minutes (between one hour and one half an hour)	29	14.4
91 – 120 minutes (between an hour and a half and two hours)	18	9.0
121 – 160 minutes (between two hours and two and a half hours)	18	9.0
161 – 190 minutes (between two and a half hours and three hours)	11	5.5
191+ minutes (three hour and more)	21	10.4
Total	201	100.0

Satisfaction of duration of time	Number	Percent
Very satisfied	34	16.9
Satisfied	70	34.8
Not satisfied	37	18.4
Very unsatisfied	60	29.9
Total	201	100.0

Support structures to support illnesses (HIV, TB, Childhood diseases etc) in your community	Number	Percent
Yes	102	50.7
No	64	31.8
DK	35	17.4
Total	201	100.0

Community health promoters in your community	Number	Percent
Yes	65	32.3
No	87	43.3
DK	49	24.4
Total	201	100.0

Community providers of ARV for HIV/AIDS in your community	Number	Percent
Yes	66	32.8
No	96	47.8
DK	39	19.4
Total	201	100.0

Community providers of DOTS for TB in your community	Number	Percent
Yes	65	32.3
No	94	46.8
DK	42	20.9
Total	201	100.0

A health committee exist	Number	Percent
Yes	31	15.4
No	79	39.3
DK	91	45.3
Total	201	100.0

Community Participation	Number	Yes	Number	No	Number	DK	Number	Total
Support structures to support illnesses (HIV, TB, Childhood diseases etc) in your community	102	50.7	64	31.8	35	17.4	201	100.0
Community health promoters in your community	65	32.3	87	43.3	49	24.4	201	100.0
Community providers of ARV for HIV/AIDS in your community	66	32.8	96	47.8	39	19.4	201	100.0
Community providers of DOTS for TB in your community	65	32.3	94	46.8	42	20.9	201	100.0
A health committee exist	31	15.4	79	39.3	91	45.3	201	100.0

Notes