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Project

JAFPP Quality of Care Needs Assessment

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Executive Summary

Background and purpose

JAFPP currently provides 12% of family planning (FP) services in Jordan. While significant, this market share is less than one-half that of its high of 30% achieved in the 1990's. Likewise the number of IUDs inserted has dropped from approximately 16,000 to 9,800 per annum during the same period. In order to reverse this trend, JAFPP leadership has embarked on a program of robust and systematic changes to increase demand for JAFPP services as well as to improve service access and quality. This program of organizational change has been endorsed and encouraged by the Ministry of Social Development, JAFPP's regulating agency within the government of Jordan. USAID is providing financial and technical assistance to the Association, through the Strengthening Family Planning project (*Ta'ziz Tanzim Al Usra* in Arabic, or in short, *Ta'ziz*). One of the key areas of assistance provided by Ta'ziz is assuring the quality of care. Quality care is a key pillar of the revitalization of JAFPP, by assuring positive health outcomes, and keeping the reputation of the Association sound, thereby helping to increase demand. In order to plan and carry out systematic quality improvements, the JAFPP and Ta'ziz team conducted a thorough clinic-by-clinic situational analysis and assessment of what is needed to provide optimal quality of care. The assessment examined physical infrastructure, equipment and supplies, human resources, training, clinical guidelines, clinic processes, clinical supervision, clinic management practices, and client perception of the quality of services.

Findings

The most urgent needs are for the relocation, renovation, and construction of the clinics themselves. Current facilities are often too small for current patient load (to say nothing of hoped-for increased demand), poorly laid out in terms of patient flow and infection prevention, and unattractive to potential clients. Next, most equipment, instruments, and supplies are out of date or not functional and should be replaced within the next nine months. Of particular need is the replacement of all ultrasound machines: the availability of ultrasounds has a direct and immediate effect on demand for services. Of equal importance, but less urgency, the Association needs to focus on human resource development. The all-female staff of clinics is a key driver of clients choosing JAFPP. While turnover is relatively low, vacancies are barely covered by relief staff. In the past, two clinics were closed, not due to lack of demand, but to the inability to hire female physicians. Supervision within the clinics and from HQ to clinics is sporadic, unsystematic, and not always viewed as supportive. Further, roles, responsibilities, and reporting relationships are often unclear between various clinic staff and department heads at HQ.

Recommendations

JAFPP and the project will work together to plan and implement a five-year program of clinic relocation, renovation, and construction. Ultrasound machines will be prioritized for immediate procurement, followed closely by new instruments and other ancillary equipment. HR interventions will include an incentive system for performance and for service at less-desirable locations, refresher training on FP counseling and existing methods, training on new methods, and improved supportive supervision practices. All these interventions will be sustained by a coherent and purposeful system of governance within the clinics and between clinics and headquarters (HQ).

Introduction

As part of the larger overall effort to increase the utilization of its family planning (FP) services, JAFPP leaders are focusing on improving both demand for, and the quality of FP and reproductive health (RH) services. Taking a holistic approach to quality improvement, JAFPP, with support from the Ta'ziz project, is examining the clinical quality of service delivery, as well as client perception of quality. This report summarizes two primary needs-assessment efforts: a clinic-by-clinic survey of factors needed for good quality of care, as well as compilation and review of existing data on client satisfaction with services. During the survey, teams of JAFPP clinical staff from HQ, along with Ta'ziz project staff members, examined the situation concerning the following quality support factors:

- Physical infrastructure
- Equipment and supplies
- Human resources
- Clinical guidelines, checklists, and supportive supervision materials
- Client-related processes within the clinics
- Clinical supervision within the clinics and from HQ to clinics
- Clinic management practices
- Client perception of the quality of services

A description of the methodology used to conduct the survey, as well as the survey findings in each of these areas appear below. JAFPP and Ta'ziz will use the results of the assessment to build new, relocate, and renovate existing clinics; procure needed equipment; strengthen supply-management systems; refresh and provide training on up-to-date clinical care standards, guidelines, and supervisory checklists; renew operational policies and procedures; and update management skills.

Methodology

Under the leadership of the JAFPP medical director, Ta'ziz formed a team of experts to visit each clinic to carry out the assessment:

- JAFPP medical director or quality assurance advisor
- Medical doctor (at least one per clinic assessment) from Ta'ziz with specific advanced training in women's health and RH issues
- Infrastructure engineer(s) with experience in medical practice construction, maintenance, and renovation
- Other experts as needed, including the project organizational development specialist, and human resources development expert

Prior to beginning the assessment visits, an information-gathering instrument was adapted from previously validated instruments. The instrument was tested and refined by Ta'ziz and JAFPP staff. The instrument appears in Appendix A. The JAFPP medical director or quality assurance advisor contacted each clinic to explain the purpose and methodology for the assessment visits. Assessment staff scheduled visits to minimize disruption of client services, i.e., at the end of the day when the client load is lightest. The assessment was conducted for each of the 17 existing JAFPP clinics during November and December of 2010.

While the attached instrument provides the details of data collected, a summary of each area of investigation appears below.

- **Clinic physical infrastructure:** overall adequacy of space (square meters), room set-up to allow smooth patient flow and privacy, infection prevention conditions, access issues

(stairs vs. elevator etc.), signage, general cleanliness and attractiveness of exterior and interior, availability and reliability of electricity and water, communication infrastructure, and sanitary facilities for staff and clients.

- **Equipment and instruments**: the assessment team compared a standard checklist of equipment to what was available at each clinic, e.g., ultrasound machines and examination instruments. For each item, assessment staff noted the availability and functionality.
- **Supplies:** assessment staff noted the availability and expiration dates of family planning and infection prevention supplies.
- **Human resources**: the assessment team noted any clinic HR vacancies, as well as the qualifications and training needs of each clinic employee.
- **Clinic processes:**
    - Client registration, counseling, fee payment, clinical care, client care coordination and referrals
    - Financial procedures
    - Record keeping and reporting (to headquarters)
    - Infection prevention and control
- **Clinical guidelines:** the availability and currency of protocols, checklists, and clinical references
- **Clinical supervision:** assessment staff noted the frequency of and procedures used for clinical supervision within the clinic and for clinical supervision visits from HQ.
- **Clinic management:** procedures used within the clinic for everyday management of finances, human resources, and records
- **IEC (information, education and communication) materials:** brochures, posters, flipcharts, and other job aids

Findings

All clinics need at least some renovation. Eight of the clinics can be renovated in situ at reasonable cost. Nine of the clinic locations, however, present significant enough structural and ownership issues that we do not recommend renovating the current sites. The results are summarized below. A complete general assessment for each clinic appears in the *JAFPP Clinic General Assessment* report in Appendix B.

Physical infrastructure

We recommend renovating the following clinics in their current locations.

- **Ajloun** clinic is located on the first floor of the building which is located on the main road; it also has an adequate total space. It should be noted that the clinic does not have an appealing entrance, it does not have satisfactory patients flow, and the ventilation for the staff restroom is inadequate. The setup for infection prevention procedures is also suboptimal due to the location of the sterilization room.
- The owner of the current location for the **Al Hussein** clinic intends to discontinue rental to JAFPP. JAFPP intends to buy and renovate another suite very nearby. It should be noted though that the clinic location is ideal for the client base.
- Al **Mafraq** clinic is located on the first floor of the building and is also located on the main road and has an adequate area that suits the requirements of the clinic. The location of the sterilization room is not ideal, and the layout results in unsatisfactory patient flow.
- Al **Rusaifa** clinic is located on the main road and on the first floor of the building. It has an adequate space of about 200 square meters and has a clean and an appealing well-lit entrance yard. The appearance is quite good, as it is a relatively new building (2002). The

location of the sterilization room is not ideal, and the layout results in unsatisfactory patient flow.

- **Irbid 3** can be re-designed to achieve the ideal patient flow and ideal infection-prevention procedures. It is located on the first floor and has an adequate total area.
- **Madaba** clinic is located on the ground floor on the building and has an adequate total area with a clean and an appealing entrance yard. The renovation will result in an ideal patient flow and infection-prevention setup.
- Although **Sahab** clinic has a number of issues that need to be addressed to render it adequate in all ways: it has no signs to guide patients to the clinic, has an unsatisfactory patient flow, the patients' restroom is outside the clinic with no water, and the sterilization room is not close to the examination room which represents an unsatisfactory infection prevention setup. The clinic, however, has an adequate area and is located on the main road, hence renovation is recommended.
- **Sports City** clinic is already owned By JAFPP making it easy to go on with the renovation and reallocation of the rooms without any external permission. It is located on the ground floor and it has an adequate area. It also has an acceptable entrance yard. It is also located in the same building as JAFPP headquarters which allows for direct observation from the JAFPP management. The location of the sterilization room is not ideal, and the layout results in unsatisfactory patient flow.

We **do not** recommend renovating the following clinics. They should be moved or expanded prior to renovation.

- Al **Aqaba** clinic is currently under construction and will be evaluated once the construction works are over.
- Al **Bayader** clinic is a small rented venue located on the second floor of the building. There is no sterilization room in the clinic.
- Al **Karak** clinic is rented. Also, we recommend looking for better alternatives (location wise), with acceptable total area.
- Al **Mahatta** clinic is rented, and a new owner has not made a final decision whether he wants to keep the clinic or not. Also, the building is very old with very bad electro-mechanical systems. There is no room for filing; all files are kept in the waiting area instead. The two examination rooms are not private. The sterilization procedures are not satisfactory due to the location of the sterilization area.
- Al **Qeishmah** clinic has a very small area with only one available restroom for patients and staff. Also, the infection prevention control is unacceptable due to the location of the sterilization room.
- Al **Zarqa** clinic is located on the ground floor of the building. It has an adequate area of about 160 square meters. It has a separate room for filing as well as two examination rooms. The current owner, however, intends to discontinue rental to JAFPP. JAFPP owns an alternative site that it is using as a storage facility. This owned site could be renovated in order to be used as a clinic. Due to the probable cost of these extensive renovations, however, we recommend buying or renting a third location more suitable to use as a clinic.
- **Irbid 1** clinic is located on the second floor with high step riser. The building is very old and is rented. The owner is refusing to allow any modifications to the area which is very small. The entrance of the clinic is neither clean nor appealing and infection-prevention procedures are suboptimal due the location of the sterilization room.
- **Jerash** clinic is located on the second floor of the building. The entrance is not well-lit. There are no floor traps, which makes the cleaning process more difficult. The clinic is poorly ventilated; given that it is open only from one side and closed from all the other

sides. There is no filing room; the files are kept instead in the waiting area. Also, the infection prevention procedures are not satisfactory due to the location of the examination room and the sterilization room.

- **Sweileh** clinic is very small and it is rented. There are no signs to guide patients to the clinic and the patient flow and the control of the infection prevention procedures is not satisfactory.

Equipment

The availability and condition of all equipment at all clinics is compiled in the table in Appendix C and is summarized below.

Medical equipment

Medical equipment availability and condition varied from clinic to clinic, with the exception of ultrasound machines. Staff at most clinics we visited emphasized the need for new ultrasound machines. Clinic managers discussed the impact of poorly or non-functioning ultrasound machines on patient desire to visit the clinic.

Item	# clinics that need replacement
Examination couch No clinics have a regular examination couch; rather they rely on a gynecological examination couch alone. Regular examination couches are necessary for examinations such as during antenatal care and clinical breast exams.	**17**
Gynecological couch	**6**
Adult scales	**7**
Examination light	**8**
Sphygmomanometer	10
Stethoscopes for measuring blood pressure	5
Stethoscope for doctors to perform physical examination	17
Equipment trolleys	5
Double basin for infection prevention	6
Step for examination bed	5
Examination stool for physician	1
High capacity hot oven	2
Timer/alarm for instrument cleaning	17
Ultrasound machine (with printer)	13
Ultrasound probes/vaginal	13
Sonic aid for fetal heart monitoring	17
Implanon kit (sterilized gauze, bandages, syringes, lidocaine, sodium bicarbonate, blades, blade holders, mosquito forceps for removal)	17 (wherever service is provided)
Sharps box	17
Cover sheets—more needed per clinic	17

Non-medical equipment

The following non-medical equipment is needed to support medical services and is missing or non-functional at some or all clinics. (For detailed equipment needs, see Appendix C.)

- Computer (needed at five clinics)
- Printers (2)
- Fax machines (17)
- TVs with DVD player (17)
- Fans (2)
- Heaters (1)
- Cooler for drinking water (1)
- Phones (at least two per clinic) (5)
- Furniture and desks (all)

Instruments

Because of the large number of patients seen and the repeated sterilization of instruments in highly concentrated chlorine solution, many instruments are rusted and therefore unsanitary, yet still in use. The following instruments need replacement at all clinics.

- Speculums of various sizes
- Tenaculums
- Sounds
- Forceps
- Ovum forceps (sponge holder)
- Shettle forceps
- Scissors
- Alligator forceps
- Instrument containers
- Jars long and short

Supplies

The Ministry of Health (MOH) provides JAFPP with contraceptive supplies for free. The Association buys other supplies from local vendors. The procurement of these other supplies is not systematic: at times they are purchased centrally and other times purchased locally.

All clinics were found to have adequate quantities of contraceptive supplies (COC, POP, injectables, IUDs, and condoms) and consumable supplies such as alcohol and iodine solution. No clinics reported stock outs in recent memory. Doctors use disposable gloves when examining the patients; it is recommended that they use latex and surgical gloves for pelvic exam and IUD insertions. Further, the spatula for pap smears should be disposed of after one use and not disinfected and sterilized for repeated use. In light of these recommended practice changes, the following supplies are needed:

- Sterile gloves
- Latex gloves
- Cotton swab sticks for high vaginal swab culture and sensitivity
- Spatula
- Brush for pap smear

Human resources

Clinic human resources, particularly the all-female medical staff, are perhaps JAFPP's most attractive feature to existing and prospective clients. At the time of the assessment, there is one physician vacancy. Because of the Association's policy of maintaining two fill-in physicians, however, there were no clinics without a doctor. While physician turnover is relatively low, discussions with clinic doctors and HQ managers suggest that clinics distant from Amman have problems in attracting and retaining doctors. This topic will be addressed in the forthcoming employee incentive system.

Clinic staff was questioned about their qualifications, and about training they had received during the last two years. Complete findings appear in the table in Appendix D, and are summarized here. Most doctors and some nurses have received training on FP methods and counseling for specific conditions at the Jordan Medical Council with assistance from PSP. These staff members also underwent quality assessments on their FP counseling skills and received certificates. Other staff members have received no refresher training since their hiring. For example, no physician had received training on Nuva-Ring, and only one doctor was qualified to use implants (Implanon). Most physicians need overall ultrasound training, and all will need specific training on how to use new ultrasound machines when they are procured. The following are additional training needs that were identified during the assessments:

- Early detection of breast cancer and the proper clinical breast exam
- Early detection of cervical cancer and proper interpretation of pap smear results
- Sexual health and sexual dysfunctions
- Reproductive tract and sexually transmitted infections
- Other reproductive health topics:
    - Dysfunctional uterine bleeding
    - Polycystic ovaries
    - Infertility
    - Menopause
    - Antenatal care
    - Acute complications of pregnancies (e.g., ectopic and hypertension)
- Management of chronic diseases
- Violence against women
- Infection prevention
- Communication skills
- Computer skills

Guidelines, protocols, and checklists

Clinics have a wide variety of guidelines and protocols, many of which have been superseded or are otherwise out of date. Most clinics have both IPPF and WHO FP guidelines in Arabic and English. Again, out-of-date guidelines are kept on clinic bookshelves and could easily be mistakenly used by staff members. Association clinics and HQ offices hold a bewildering array of clinical checklists. None, however, appear to be in use within the clinics. (See more about supervision, below.)

In terms of IEC materials the clinics have brochures from JAFPP, the ministry of health, and from previous USAID projects. The JAFPP brochures are old, however, and the contents may be out of date. Likewise old posters need to be replaced with those containing more up-to-date information.

The small uterine and breast models used to demonstrate IUD insertion and clinical breast exam should be replaced with more up-to-date and easier to use models.

Clinic processes

Clinical path and client flow

Clinical path and flow refer to client registration, counseling, fee payment, clinical care and client care coordination and referral within the clinic.

Reception: Registration of **new clients** is initiated by the social worker and consists of the following steps

1. Open a new file and assign a patient number (clinic code and client serial number)
2. Record the client's demographic, social, medical, and reproductive history

For **returning clients** the client file will be drawn by the receptionist who will direct the client to the social worker for additional counseling or directly to physician for care provision.

Fee payment: performed by the receptionist according to the service/method preliminary identified by the social workers for the new clients and by the client herself for returning clients. Fee adjustment will be made in case of mismatch between the preliminary estimate and the actually received service.

Counseling: If appropriate, FP and other counseling are provided by the social worker. (JAFPP social workers do not have a medical background but have been trained on reproductive health counseling upon employment with JAFPP.) In the case of family planning counseling, the social worker usually goes beyond general counseling to the identification of the method. In the case of non-FP healthcare services, many social workers provide medical information or advice from the social worker often well beyond their qualifications, and in some of the interactions we observed the information given was not medically accurate. As well as putting patients at some medical risk, possible mis-information may cause confusion for the client, especially if the information or advice doesn't match that provided by the physician. When the social worker is absent, the receptionist substitutes to provide counseling. The receptionist is not trained to provide such services, and they take place at the reception desk, causing privacy concerns.

Clinical care is provided mainly by the physician with the assistance of the nurse. Some services such as provision of hormonal contraception pills, condoms, and breast examinations may be performed by the nurse without the supervision of the doctor.

Recordkeeping and reporting (to headquarters):

Client files are maintained by the receptionist. She enters daily records of clients and services into the clinic database, as a duplicate of the paper records maintained at the clinic. In addition, daily records of services provided and contraception methods dispensed are kept by the nurse. The receptionist's and nurse's records are compared daily and discrepancies are investigated immediately. Service delivery records are transferred from the clinic database to a CD and hand-carried to HQ on a monthly basis.

Infection prevention and control

Infection prevention oversight is the responsibility of the clinic's nurse. While there are thorough infection prevention (IP) and control procedures in place, they are not followed consistently, and the following IP problems were observed in all clinics:

- The chloride solution concentration is estimated roughly and in most instances is far greater than the recommended 0.5%.

- Instruments are kept in the chloride solution for more than the optimal 10 minutes indicated in the policy which is causing rusting of the instruments.
- The appropriate brushes are not used for instruments cleaning, which is contributing to instrument scratching and roughness.
- The temperature and the time duration of sterilization in the hot ovens are more than indicated.
- In most clinics the location of the infection prevention area in not optimal: it is either in the service provision area or it is moved out through an open area. In many clinics the sinks used for instruments cleaning are too small for that purpose.

Clinical supervision

Clinical supervision is done by the physician on a day-to-day basis within the clinic. In addition, the Association's medical director and quality assurance advisor travel to clinics to provide supervision to the doctor as well as all other staff as needed.

For **headquarters supervision** the medical director is responsible for the overall performance of clinics. She coordinates staff training offered by external parties, personnel issues such as vacations, and fill-in staff where needed. She also responds to help with solving problems or conflicts at the clinic level. The quality assurance advisor has the primary responsibility for making supervision visits to clinics. As mentioned above, there exist at JAFPP HQ and clinics a plethora of clinical guidelines, protocols, standards, and supervision checklists. None of these, however, is used during HQ supervision visits to the clinics. According to written Association policy, supervision from HQ should happen at least every quarter. Timing of actual visits, however, is sporadic and is affected by the convenience and expense of making visits (i.e., clinics in Amman receive many times the supervision visits of those in more remote areas).

Clinic supervision: The clinic supervision role is neither well-structured nor documented and the clinic physician is by default the clinical supervisor, clinic business manager, and main provider of clinical care. Each physician is left to conduct clinical supervision according to her own style. Within-clinic supervision is informal; the assessment team could find no evidence of the use of any of the many supervision checklists available at HQ and the clinics.

Clinic management

As mentioned above, the physician is the default clinic manager, and she makes many of the day-to-day decisions that affect the staff and the running of the clinic. Functional reporting lines from clinic staff to HQ department heads are well documented in the recently completed human resource development assessment. In summary, however, department heads from HQ exert management control over clinic staff. These competing demands from HQ managers and the site manager (physician) often create conflict as a given staff member may feel that she has more than one direct supervisor, and may not know how to prioritize competing tasks. This is especially true for the social workers, who are expected to provide counseling in the clinics as well as do outreach in the community. Finally, while JAFPP has an impressive health management information system (HMIS), clinic data are not used to make management decisions at any level. Training will be provided for clinic managers and HQ department heads on using data for decision making and problem identification. By using HMIS data to focus supervision where it is needed most the Association can better husband human and financial resources that are in short supply.

Patient satisfaction (perception of quality)

JAFPP clinics have in place a system to collect patient reactions to the services they receive. The form used captures a useful range of client perceptions. These data could be an important tool in

assessing and improving the quality of services. The implementation of the client-feedback system, however, is paper-based and inconsistent at best. In examining clinic-by-clinic availability of client feedback data, no clinics had data available for the entire time the system has been in place (approximately four years). Most clinics were missing data for at least ½ the reporting periods. The method of survey application is also inconsistent and may discourage client veracity. In some cases providers interview clients and fill out the forms, thus discouraging criticism of the clinic or especially of the staff. While the quality of the data is suspect, the aggregation of the data may, however, provide some at-least-marginally useful insights into client perceptions. The data are summarized in figures 1 and 2 below.

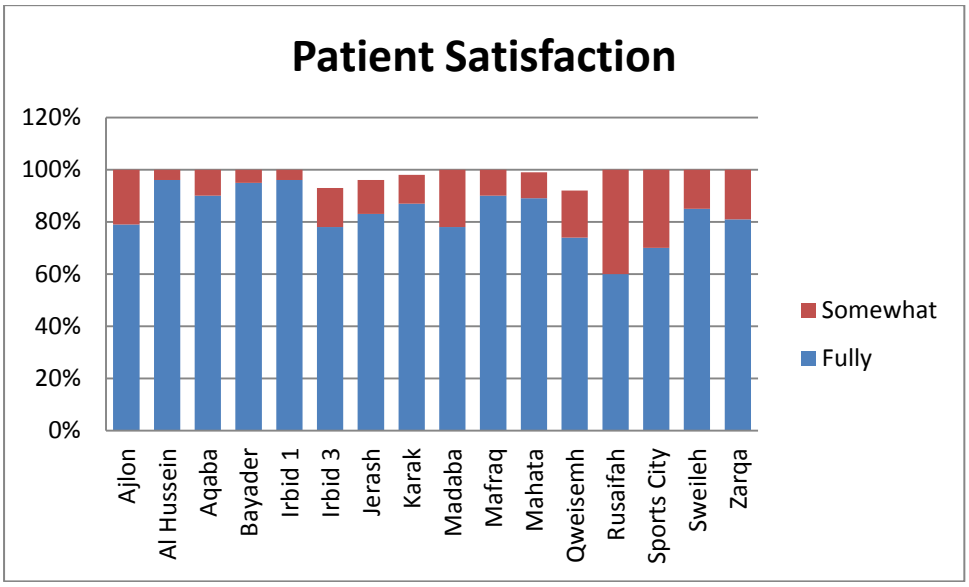

Figure 1. Patient satisfaction by clinic

Figure 2. Percent satisfaction by factor

While patient responses to questions about satisfaction are generally high, the main point of dissatisfaction is with clinic equipment. This point agrees with the clinic staff self-assessment of needs, as well as the observations of the JAFPP/project assessment teams.

Recommendations

The assessment highlighted several needs at clinics in order to provide the best quality of service. Most of these needs are systematic in nature. Interventions will be developed in detail under the leadership of the CEO, medical director, and quality assurance advisor. Ta'ziz and JAFPP staff will work as a team to plan, develop, implement, and measure interventions. While detailed planning and interventions will take place over the months and years to come, some initial recommendations are listed below.

- Streamline patient data recording so that the receptionist is the one to initiate both paper and computer files.
- Create a formal list for clinic relocation (rental or purchase), renovation, and construction. The Association and the project will work together to agree on a timeline and funding sources.
- Develop and communicate clear job descriptions for clinic staff with defined roles and responsibilities.
- Clarify procedures for fill-in during staff absences. For example, when the social worker is absent, the nurse or doctor should provide counseling, rather than the receptionist.
- Clarify reporting relationships within the clinic as well as between HQ managers and clinic staff members. In the end, each clinic staff member will have one clear supervisor.
- Develop incentives for service in rural or remote clinics.
- Create a clinical supervision post at headquarters to assume the routine supportive supervision activities.
- Establish supportive supervision and quality improvement systems and procedures.
- Update and provide clinics with a single set of clinical standards and guidelines, along with the resulting clinical supervision checklists. Assist in the removal of out-of-date materials from the clinics.
- Update the quality assurance manual based on the updated guidelines and procedures and identify performance indicators to be monitored by the quality assurance coordinator.
- Establish an ongoing training program to upgrade and expand providers' capacity regarding RH/FP information and services focusing on the following priority training topics:
    - FP counseling
    - FP methods COC, POP, and new long term hormonal methods such as implants and injectables
    - Ultrasound, general and machine-specific operation
    - Infection prevention
- Finalize and develop procurement and preventive maintenance plan for the identified equipment and instruments. Prioritize ultrasound purchases.
- Update and implement policies for expired files disposal and broken instruments/furniture removal.
- Review the content of IEC materials and make sure all clinics have the same materials in enough quantities.
- Formalize and automate the client-feedback process to provide clinics and Association managers with information about areas of needed attention.

Appendices

A: Instrument evaluation table
B: Full engineering report
C: Equipment findings table
D: Training needs table