

*Quality Assurance Methodology  
Refinement Series*

***Internal Quality  
Assurance: Lessons  
Learned From the  
PKMI Hospital  
Pilot Program in  
Indonesia***

***By:***

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The PKMI Internal Quality Assurance Hospital Pilot Program was a collaborative effort between the Indonesian Association for Secure Contraception (PKMI) and the Private Sector Family Planning (PSFP) and Quality Assurance (QAP) projects, sponsored by the United States Agency for International Development. PSFP was funded through contract No. 4970355-C-00-0126-00 with University Research Corporation and carried out in collaboration with the National Family Planning Coordinating Board (BKKBN) in Indonesia. QAP is funded under Cooperative Agreement No. DPE-5992-A-00-0050-00 with the Center for Human Services.

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## *Acronyms*

BKKBN	National Family Planning Coordinating Board
FP	Family planning
IEC	Information, education and communication
IUD	Intra-uterine device
KAP	Knowledge, attitudes and practices
PDCA	Plan-Do-Check-Act Cycle
PKMI	Indonesian Association for Secure Contraception
PKBRS	Hospital Family Planning Program Units
PSFP	Private Sector Family Planning Project
QA	Quality Assurance
QAP	Quality Assurance Project
USAID	United States Agency for International Development

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## *Executive Summary*

**A**s part of its activities under the Private Sector Family Planning (PSFP) Project, the Indonesian Association for Secure Contraception (PKMI) developed and conducted a pilot test of an internal quality assurance program in the family planning units of 16 hospitals between May 1992 and March 1995. The internal quality assurance program was intended to complement an existing external quality assurance system which PKMI had been supporting since 1984, consisting of periodic meetings to review monthly activity reports submitted by clinics and site visits to clinics experiencing difficulties. The internal quality assurance program was intended to motivate hospital staff to assume greater responsibility for the quality of the services they provide.

The internal quality assurance program was pilot-tested in several district-level hospitals in Jakarta and West Java, areas where most hospital-based family planning services are provided. The primary objective of the pilot test was to determine the feasibility of implementing a quality assurance approach to problem-solving, which consisted of six steps: 1) build a quality assurance team, 2) identify a problem, 3) identify the causes of the problem, 4) identify a solution, 5) implement the quality assurance solution (essentially the Plan-Do-Check-Act cycle), and 6) evaluate the outcome.

PKMI played a dual role in the internal quality assurance pilot test, serving as both the manager of the study and the principal source of training and technical assistance for the hospitals. Technical assistance was also provided to PKMI by international consultants from the Quality Assurance Project and the Project Support Group of the PSFP Project, both funded by the U.S. Agency for International Development.

PKMI and the international consultants spent the first year of the project developing, testing and revising a reference manual in Bahasa Indonesian on quality assurance for long-term contraceptive methods. The manual served as the basic tool for the internal quality assurance program. In April 1993, hospital and family planning unit directors attended one-day Quality Assurance Awareness workshops to develop their understanding of and support for the program. Each of the hospital directors then appointed an internal multidisciplinary team (averaging 8-13 members) to

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participate in the pilot program. Three members of each team attended a five-day Quality Assurance Basic Skills Course conducted by PKMI. These participants were supposed to train the other members of their team when they returned to their hospitals. It was expected that they, together with the hospital director, would conduct a one-day Quality Assurance Orientation seminar for the entire hospital staff.

The PKMI program focused on problem-solving and did not seek to establish an institutional structure in each hospital to sustain quality assurance activities in the long-term. Once the training was completed, the teams were expected to implement the quality improvement cycle, starting with team meetings to identify, prioritize and analyze problems. PKMI provided on-site technical assistance during the entire cycle, making an average of 10 visits to each hospital.

Of the 16 hospitals which received orientation and training, 13 initiated quality improvement activities, and 9 completed an entire problem-solving cycle of problem identification, solution development and implementation. The teams formed spent from 8 to 15 months to complete a problem-solving cycle.

Although the teams were able to apply many of the concepts and techniques they learned in training, most of the hospital teams had difficulty with the steps in the quality improvement process, particularly identifying and understanding problems. This was due, in part, to a lack of analytical skills and in part to lack of participation by key staff. In some cases, the problems identified and solutions proposed were overly simplistic. In other cases, however, causes and solutions were impressive and led to measurable improvements in the coverage of family planning services and the performance of key tasks. Examples of quality improvements obtained by the teams include a reduction from 50% to 0% of potential family planning clients leaving the hospital without receiving family planning services or referrals; reduction of post-operative infections among tubectomy clients, from 6.6% to 0%; reduction in the proportion of incomplete medical records from 40% to 10%; and an increase in the proportion of clients aware of sterilization from 70% to 93%.

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Personnel issues were seen to have an important effect on team performance. Support from the Hospital Director was a key factor in the overall success of team efforts. If the director was supportive, it was more likely that the team would complete the problem-solving process; when the director was not overtly involved or interested, the team stopped functioning or did not start at all.

The PKMI manual proved to be a popular and useful reference for the internal quality assurance activities. The training program, which provided basic skills training for only 3 members of each hospital team and relied on onsite technical guidance from PKMI monitors to support the teams throughout the problem-solving cycle, was found to impart insufficient skills to the teams in the areas of data collection and analysis, interpretation of results, and linkages between the steps—skills which are essential to effective problem analysis. While the visits of the PKMI monitors provided valuable assistance, the need was identified for training an individual within each hospital who could serve as an ongoing facilitator and source of motivation and support for quality assurance teams.

PKMI has been successful in promoting a great deal of interest in quality assurance in Indonesian hospitals. The quality assurance activities which were implemented as part of this pilot program are not, however, well institutionalized within the hospitals, and only a few of the teams were able to realize significant and sustained improvements in service quality as a result of the quality assurance activities. The quality assurance programs initiated were also limited because they focused only on family planning services limited to one or two units. Hospital directors may have been reluctant to embrace quality assurance programs which were not immediately beneficial to the entire facility.

The pilot test results suggest that, to enhance the effectiveness and sustainability of internal quality assurance efforts, internal hospital quality assurance programs should encompass all aspects of the facility (not just one type of service) and aim from the outset to construct a self-sustaining quality assurance system that does not depend on external support. The pilot test found that this requires a systematic, yet flexible approach to quality assurance; an overt and visible commitment from the facility's leadership; the creation of a dedicated cadre of qualified quality assurance

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coaches and staff within the hospital; and the development of an adequate organizational structure for quality assurance. Documentation and internal dissemination of results is needed to better communicate accomplishments, build support for instituting similar reforms or improvements in other departments, and strengthen advocacy for quality assurance throughout the hospital.