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Identifying Barriers and Facilitators in Implementation of Quality Improvement (QI) Program in Private Sector Health Facilities: An Interstate Qualitative Study

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ABSTRACT:

Aims and objectives:

1. To identify facilitators and barriers faced by CSE(Centre for skill Enhancement) personnel during implementation of Manyata program activities in the two states of Maharashtra and Uttar Pradesh.
2. To provide actionable recommendations for enhancing the implementation and sustainability of the Manyata Program.

Material and methods: The trainers and health care providers of the CSEs across two states: Uttar Pradesh and Maharashtra were interviewed for qualitative data, their audio-recorded transcripts read and thematic analysis done

Observations: The feedback of trainers for effective reception at staff level and practical issues in implementation of clinical standards and adherence to protocols to enhance quality maternity care were analysed.

Conclusion: The study provides a nuanced perspective of the facilitators and barriers in implementing the Manyata Program's CSE activities.

Based on the findings, the study proposed evidence-based recommendations for CSEs as well as for private health facilities to develop strategies so as to enhance the QI training programs for capacity building of private nursing homes

Keywords: Manyata, Quality health care, Clinical standards, Nursing staff, Nurses trainers, Respectful maternity care, private maternity nursing homes

Introduction:

The WHO's Safe Motherhood Initiative brought maternal and child health to the forefront of public health concerns, aiming to decrease maternal mortality by 75% between 1990 and 2015[1]. Around the same time,

Manyata was launched in 2016 by the Federation of Obstetrics and Gynecological Societies of India (FOGSI) [2]
Manyata is an accredited program towards quality improvement and certification led by FOGSI, supported by Jhpiego, and focuses on private maternal care facilities [1]
It promotes evidence-based clinical and respectful maternity practices through the training of staff nurses, their mentorship, and certification of the facility for three years, followed by periodic assessments before renewal.
To facilitate its implementation on a wider scale, Manyata has partnered with 17 Centres for skill enhancement (CSEs), and reached out to more than 2800 facilities and over a million women all over the country

Role of CSEs:
These are led by FOGSI champions, who anchor the rollout in their regions at Manyata.
They support:
- Facility onboarding
- Training and mentoring
- Gap assessments and certificate facilitation

Review of Literature:
In India, the private sector delivers up to 80% of outpatient care. Yet the data on quality of care in private facilities in India is lacking. Patients perceive better service in private facilities (e.g., shorter wait times, higher availability), but studies show clinical quality remains suboptimal in both public and private sectors[8]. NABH certification is widely recognised as a national quality certification, yet has low coverage, especially amongst smaller facilities. Here, it is even challenging to get the center owners enrolled with Manyata; despite FOGSI's strategies for popularizing the concept [2]
To complement ongoing government efforts to advance quality of care (QoC) in maternal health as well as to bridge the gap between public and private nursing homes, the Federation of Obstetric and Gynecological Societies of India (FOGSI) initiated the Manyata (meaning "accreditation" or "recognition" in Hindi) program to improve the quality of maternal health care in India's private sector. [1]
Of late, there has been a marginal rise in institutional deliveries by 10% above the baseline from 79% in 2015-16, and maternal mortality ratio (MMR) has decreased significantly from 130 in 2015 to 97 in 2019[9]
In an attempt to facilitate institutional deliveries, few organisations have implemented conditional cash transfer programs, also known as Demand-Side Financing (DSF)[4], in developing countries besides the other quality improvement programs introduced by our Government like *Janani Suraksha Yojana(JSY), Pradhan Mantri Surakshit Matritva Abhiyan(PMSMA), LaQshya, SUMAN-Surakshit Matritva Aashwasan Yojana*[9] *and* IGMSY (which covers all childbirths by a woman, and cash transfer was paid for only the first two live births of women aged 19 and older) .
Through the JSY (April 2005) and JSSK (Janani Shishu Suraksha Karyakram, June, 2011), trained birth attendants called ASHA workers are empowered to provide safe maternity care whereas the PMSMA(June 2016) elevated the benchmark of the quality care by involving the private care practitioners as volunteers to provide specialist care in Government facilities[5]
The JSY, launched in 2005, as a nationwide flagship program, under the umbrella of the NRHM, for providing monetary incentives INR 1400 for institutional delivery and INR 500 for home deliveries to

women in rural areas of low performing states, proved to improve the rates of institutional deliveries by 50% only [11]

Currently the Manyata program is in implementation in 22 in India, benefitted by over 2000 facilities [9]. As per 2015 census, over 70% of maternal deaths and about 85% of neonatal deaths are attributed to complications in the peripartum period namely due to postpartum haemorrhage, hypertensive disorders, sepsis and birth asphyxia and low birth weight babies, respectively[6]

Manyata, is a FOGSI initiative that aims at reducing the maternal and neonatal mortality rate by teaching staff nurses twenty clinical standards namely: Respectful maternity care, Essential newborn care, as well as Resuscitation, Care of the low birth weight babies and handling emergency conditions like Postpartum hemorrhage and Eclampsia[3] as well as arrange for timely transfer of complicated cases

It is a first-of-its-kind initiative that has been building the capacities of healthcare workforce by providing certification, through periodic training and assessment as well as regular upgradation during renewal of certificate.

This program, reinforcing quality assurance, is being implemented by Jhpiego, an affiliate of Johns Hopkins University, with support from MSD for Mothers and in collaboration with the Federation of Obstetric and Gynecological Societies of India (FOGSI). Baseline assessments conducted under Manyata program provided an opportunity to measure the existing quality of care at childbirth in participating private healthcare facilities.

According to a study in resource-scarce settings by Ndola Prata, Amita Sreenivas et al, the most cost-effective interventions were family planning and safe abortion and antenatal care as well as preventing postpartum complications,[7] which are all an integral part of Manyata training.

Before the COVID-19 pandemic, all activities conducted by the Centre of Skill Enhancement (CSE) initiative were delivered through physical training sessions. The COVID-19 pandemic led to a transition to virtual training. However, there is limited evidence comparing the efficacy of these two modes. Given this gap, it becomes essential to explore how the shift has impacted the delivery and uptake of quality assurance programs and assess how CSEs have adapted to the challenges in the new training format.

According to data, about 200 Manyata training sessions by NMOGS CSE (Navi Mumbai Obstetrics and Gynec Society) in Maharashtra and 126 Manyata training sessions by KMC CSE in Uttar Pradesh, have been conducted till date, and certification to facilities has been provided across India. This achievement makes it an ideal setting to explore the facilitators and barriers faced by the CSE team during various steps of the certification process. Understanding these factors is critical to enhance the effectiveness and sustainability of the program.

This study seeks to identify the

- operational,
- managerial, and
- systemic

challenges as well as enablers, encountered by the CSE team during the certification process. By doing so, it will provide valuable insights into improving the implementation of the Manyata Program and inform potential revisions to CSE guidelines to better address current needs and challenges.

3. OBJECTIVE

Purpose of this Study

1. To examine the operational, managerial, and systemic barriers and facilitators experienced by CSE te-

ams.
2. To utilize observations to improve the effectiveness, sustainability, and policy alignment of Manyata for future implementation.

Objectives:
1. To explore the barriers and facilitators of trainers and healthcare providers in improving the quality control process in the Manyata Program.
2. To provide actionable recommendations for enhancing the implementation and sustainability of the Manyata Program.

4. Methodology

4.1. Study Design – This study adopts a **Qualitative Case Study Design**, which is suitable for in-depth exploration of the implementation and functioning of the Manyata Program's Centre of Skill Enhancement (CSE) activities. This design allows for a comprehensive understanding of the operational, administrative and management facilitators and barriers across selected healthcare facilities.

4.2. Study Area Population

The CSE Lucknow (KMC) and
The Navi Mumbai Centre for Skill Enhancement from Maharashtra have been selected as the sample population of CSE.
Considering its comprehensive involvement and extensive experience, these two centres have had a robust exploration of both operational and managerial aspects of the Manyata Program's implementation in Uttar Pradesh and Maharashtra

4.3 *Study Sample definitions:*

CSE heads: of the two states **of Uttar Pradesh and Maharashtra**
Manyata trainers: provide training to all facilities on board (**have worked in collaboration with FOGSI and Jhpiego so as to be well versed in the system**)
Health care providers (senior staff/Facility owners who train within their facility)
Manyata implementors: Those in the technical team of onboarding to certification

Institution	Stakeholders	Sample Size
Centre of skill enhancement	Manyata trainers	15
	CSE Lead	2
Private healthcare facilities	Total facility owners	5
	Healthcare Providers	7
Implementing Agency	Manyata Program Implementers	2

- **Inclusion Criteria:**

1. CSE Heads

a) CSEs operating in Uttar Pradesh (UP).
b) CSEs operating in Maharashtra

2. Healthcare Facilities:

Facility owners that have provided training to their own nursing staff after having received Manyata certification

3. Healthcare Providers/Manyata trainers:

a) Providers working in the facility for at least 1 year.

b) Providers who had been working at least for a year, received and imparted training were included in the Manyata program.

- **Exclusion Criteria:**

1. CSEs, that are inactive and not involved in delivering Quality Improvement (QI) activities.

2. Healthcare Facilities and Providers:
Who have not received Manyata certification and/ or adequate training to contribute towards our research questionnaire.

4.4. Study Tool –

4.4 Methodology

TABLE 1: SAMPLE POPULATION

Definitions:

Terminologies	Basic functions		
CSE Heads under FOGSI supported by Jhpiego	Baseline gap assessment and Onboarding	Planning and coordinating	Logistics and funding support by the Manyata (M) team
Manyata trainers	Training strategies: scheduled sessions, simulation models	Pre-test and post-test assessment	Working on documentation, soft skills, assigning activities, homework for drills
Manyata mentors	in-person and virtual support	Exam preparation with fine touch and mock test	Procuring dates for final exam
Manyata assessors	FOGSI 'peer assessors'	Initially, on-site Now online	Double-blinded, unbiased online assessment for one hour

CSE: Centre of Skill Enhancement

- **Qualitative data collection:**

TABLE 2: DATA COLLECTION TOOL

Institution	Stakeholders	Methods	Tool	Major Area of Inquiry
	Centre of Skill Enhancement (CSE) Lead (1)	Offline	Semi-structured, in-depth interview	• Program Implementation experience • Quality improvement mechanism

				• Systemic challenges & enablers • Feedback & suggestions
Private Health Facilities	Health care providers (Doctors and nurses)(10)	Offline	Semi- structured, in- depth interview	• Knowledge of QI practices • Changes in clinical practice • Barriers to implementation • Feedback & Suggestions
Jhpeigo	Manyata Program Implementers (1)	Offline	Semi- structured, in-depth interview	• Program design and delivery • Challenges in implementation • Results achieved or outcome • Suggestions

4.5. Data Analysis -

- Thematic Analysis: The information was analysed using a thematic analysis approach, involving coding, identifying themes, subthemes and interpreting the findings.
- Software: Manual coding was preferred to facilitate data management and analysis over any expensive software
- Triangulation of qualitative information to ensure validity.
- Results were reported in narrative form.

Approach Used:

- Qualitative Inductive Approach
- Thematic Analysis

Transcription & Familiarization:

- Audio-recorded interviews were transcribed verbatim.
- Transcripts were read multiple times for familiarization.

Code Generation:

- Initial line-by-line manual coding was done.
- Meaningful segments of data were labeled with descriptive codes.
- Codes were both in-vivo (participants' own words) and researcher-driven.

4.6. Study Duration –

The study was conducted over 5 months, encompassing data collection, data analysis, and report writing.

Developing Categories & Themes:

- Similar codes were grouped to form sub-categories.

- Sub-categories were clustered into broader themes.
- Themes reflected patterns in **perceptions, challenges, promoters and suggestions.**

Software Used:

- Manual coding done in Word/Excel; reviewed and refined iteratively.
- Frequency and relevance of codes considered in theme development.

Validation:

- Peer review and triangulation with trainers, providers and implementers for credibility.

MANYATA TRAINERS N-13

Theme	Sub-Themes	Key Codes / Examples	Illustrative Quotes	Frequency
1. Barriers in Implementation	Staff-related	Turnover, resistance from seniors, language barriers. Little laziness on part of staff towards documentation as they compare with their peers in other non-Manyata hospitals	"Old staff refuse to learn; younger ones adapt but leave often" 'Paperwork is exhaustive"	6
	Doctor-related	Rigid mindset, low engagement, weak coordination, esp. if the facility owner is not a Gynecologist Poor acceptance to the new norms and comfort with old, creating resistance to change Lack of constant pursuit/motivation from facility owners	"Doctors don't attend sessions; nurses are left to implement."	5
	Infra/Resources	Lack of kits, poor infrastructure, no BMW segregation, unavailability of colour coded bags in a few centres	"Many nursing homes still use phenol and don't follow protocols."	4
	Tech & Program Issues	Digital illiteracy, Zoom/ID issues, long forms, paperwork, internet glitches…range issues	"They don't know how to join Zoom or log in with their ID."	5
	Onboarding Resistance	Fee issues, low perceived ROI, symbolic accreditation. Few facilities are NABH accredited or yearning for NABH accreditation, which is a deterrent to choosing Manyata, which lacks recognition at par.	"They think it's just for certification, not actual improvement."	3

Theme	Sub-Themes	Key Codes / Examples	Illustrative Quotes	
2. Implementation Enablers	Leadership & Ownership	Active owners, zero sessions improve compliance.	"When owners attend zero session, they ensure full staff participation."	7
	Trainer Innovation	Storytelling, phone follow-ups, screenshot attendance	"I teach while cooking or take surprise screenshots and post them to ensure presence."	8
	Hybrid Model & Teamwork	Online + one physical session, peer learning	"Hybrid model helps—one physical session clears all doubts.	6
	Digital Support & Assessment	WhatsApp mentoring, mock tests, pre-post assessments	WhatsApp groups and mock tests help clarify doubts post-session."	5
	CSE support	Back up from the clerk to manage minute things like permissions, coordination for food and stay during onsite training; to posting zoom meet link, taking attendance, allotting mentees and sending reminders to them for online sessions. As well as paying trainers on time without delay from CSE side	We have a real pillar of support who is a personal assistant/reminder and digitalized! Gifted to our CSE, whom we can always bank upon	2

Theme	Sub-Themes	Key Codes / Examples	Illustrative Quotes	Frequency
3. Suggestions to Improve	Incentives & Recognition	Rs.500 bonus, individual certificates as motivation for passing staff	"Give Rs.500 and certificate to passing staff—it motivates others."	4
	Policy & Linkages	Govt./NABH recognition improves enrollment	"It should be linked with NABH, then hospitals will take it seriously."	3

	Simplification & Outreach	Reduce documentation, local language, focus on remote areas	"Give materials in Hindi-English and reduce the heavy paperwork."	4
4. Knowledge & Practice	Teaching Strategy	Simulation-based drills, dummy practice, visual aids	"We use dummies to show delivery, PPH, eclampsia drills."	6
	Protocol Focus	Partograph, AMTSL, checklists for emergency	"I stress on partograph usage and AMTSL with step-wise clarity."	6

Healthcare Providers N=13

Theme	Sub-Themes	Key Codes / Examples	Illustrative Quotes	Frequency
1. Knowledge and understanding	Awareness of Manyata	Purpose of Manyata, goals of certification	"We are doing Manyata to improve staff knowledge in the hospital."	9
	Clinical Knowledge Gained	ANC, PPH, eclampsia care, partograph, respectful maternity care, newborn hygiene	"Manyata taught us how to use the partograph and manage PPH."	11
2. Training Experience	Mode & Structure	Offline training, hybrid sessions	"Some things are better understood in physical training."	7
	Trainer Effectiveness	Clear explanation, helpful trainers	"Sir taught us very well. Whatever he taught is still in our minds."	6
	Attendance & Discipline	Timely updates, advance notice	"We were already informed a day before about the session."	5
3. Barriers in Training	Logistical Barriers	Patient load, session missed	"Sometimes patient came during the session and we had to leave."	9
	Cognitive Challenges	Technical terms, content overload	"There are some technical words that we don't understand."	4

4. Barriers in Implementation	System-level Barriers	Staff shortage, emergency cases	"If staff is on leave, managing delivery alone is difficult."	5
	Skill Transfer Barriers	Forgetting content, no demos	"We forget things over time; training should happen yearly." – HP2	6
5. Implementation of Learnings	Practice Adoption	PPH kits, trays, protocols	"We made PPH kits and emergency trays after training." –	11
	Quality Care Actions	Hygiene, counseling, monitoring	"We advise mothers on breastfeeding and hygiene." Now we advise post-delivery contraception without shying away.	8
6. Enabling Factors / Facilitators	Peer & Supervisor Support	Helpful colleagues, senior support	"Our Madam helps and explains when we don't understand."	7
	Empowering feel to see our colleagues perform well	Juniors are receptive when leader is from within, as they too will get the opportunity to lead when junior staff are recruited and they become responsible, experienced seniors.		5
	Getting recognition as a trainer Trainer Engagement Free hand	Recaps, open doubt clearing Trust by facility owner	"If we don't understand anything, she tells us very well." You are well experienced now, so decide the sequence/ number of mentorship visits	6
7. Perceived Impact of Manyata	Staff Motivation	Confidence, clarity of roles	"We are more confident and ready to handle emergencies."	5
	Clinical & Operational Improvements	Fewer emergencies, better workflow	"Patient care has improved. We feel better prepared now."	6

8. Suggestions for Improvement	Training Delivery	More physical sessions, hybrid model	"Offline sessions are better. Practical is easier to understand."	6
	Program Structure	Refresher sessions, simplified content	"If we revise every 6 months, it will be remembered."	5

3. Manyata Implementors N=1

Theme	Codes	Illustrative quotes
1. Establishment and Value of CSEs	Sustainability of QI program, FOGSI-led model, Reduced donor dependency, CSE as a trust builder.	"The CSE lead is a renowned person… if that person says… trust is built and engagement starts."
2. Facilitators to Implementation	Word-of-mouth promotion, Independent CSE functioning, CSE credibility, Staff skill improvement Government alignment with SDGs	"Some hospitals… seeing improvement… are interested in enrolling." "Ultimately, it will reduce the IMR."
3. Barriers to Implementation	Lack of dedicated data personnel, Partial dependence on Jhpiego, Facility onboarding difficulty without personal follow-up.	"They are dependent on maintaining the data… they don't have any specific person."
4. Recommendations for Program Strengthening	Integration with NABH/JCI, State or national recognition, Dedicated data officer in CSE.	"It should be recognized by the state government or central government… this will increase enrollment."

3. CSE LEAD

Theme	Codes	Illustrative quotes
1. Demand Generation Challenges	- Limited outreach capacity - Reliance on conferences and CME - Virtual engagement is less effective	"As CSE lead and practicing Obstetrician, it is difficult for us to create demand generation. It is mainly through conferences and CME that we spread information." "Virtual engagement has its demerits. The level of seriousness and involvement drops down considerably."
2.Facility Assessment & Owner Involvement	- Owner's commitment crucial - Disoriented staff reflects poor leadership	"At the time of assessment we generally get the vibes of the facility... How involved is the facility owner?" "If we find there is lack of involvement of the facility owner, we do not clear facilities."

	- Assessment includes facility vibe	
3. Human Resource Constraints	- Shortage of qualified staff - High turnover in small nursing homes - Reliance on ANMs or assistants	"It is difficult to get Qualified staff for small nursing homes. Usually, they move ahead at the first opportunity." "Most of the times, small nursing homes are working with ANM and sometimes, even with patient assistants."
4. Need for Continued Training	- Skills degrade over time. - Reinforcement necessary. - Staff motivation depends on leadership	"It is important that there be regular training sessions to reinforce good practice guidelines."
5. Quality Improvement Barriers	- Staffing shortages - Financial constraints - Lack of monitoring & motivation	"Challenges in quality improvement mechanisms: Manpower, Finances, Monitoring, Motivated and dedicated Healthcare force."

5. Expected Outcome

- The study provides a nuanced perspective of the facilitators and barriers in implementing the Manyata Program's CSE activities.
- Based on the findings, the study proposed evidence-based recommendations for CSEs as well as for private health facilities to develop tailored strategies to enhance the QI training programs and strengthen the capacity of health care provider as well as private health facilities to deliver quality maternal care, so as to improve patient outcomes and trainers' satisfaction.

Discussion:

- The study highlights how quality improvement (QI) programs like **Manyata** contribute significantly towards achieving **SDG targets** related to maternal and newborn health. While trainers showed strong motivation and creativity in delivering the sessions, implementation at the facility level was often limited by real-world constraints such as **staff shortages, emergency patient loads, and inconsistent participation by doctors**.
- This matched with the findings of RE-AIM framework study conducted by Spiegel and Pallipamula [9] which also reflected decreased self-motivation and compliance of health care facilities
- One key insight was the positive impact of **hybrid training models,** where virtual sessions were supplemented with physical demonstrations. This format was appreciated by both, trainers and healthcare providers for its flexibility and hands-on reinforcement—consistent with global best practices emphasizing interactive, adult-centered learning [12]

6. Dissemination Plan-

- The findings of the study were shared with relevant stakeholders, including healthcare providers, pro-

gram managers, and policymakers, through presentations.

- The research was approved for publication in a peer-reviewed journal, to ensure broader dissemination and academic contribution.

7. Ethical Consideration-

- **Informed Consent:** Written informed consent was obtained from all participants before enrolment in the study. A participant information sheet in the local language was ~~will be~~ provided.
- This contained the description of the purpose of the study, procedures, intervention details, duration, potential risks and benefits of participating in the study, and contact information of the study investigators.
- It also informed the participants of their right to refuse or withdraw from the study at any stage without any consequences or impact on their routine medical care.
- Privacy and confidentiality were strictly maintained, and study findings reported in an anonymous and aggregated manner.
- Any concerns1q and queries were addressed before obtaining the consent. Those who expressed willingness to participate in the study were asked to sign on the informed consent document prior to the study enrolment.
- Approval*:* Ethical clearance has been obtained from our Institutional ethics committee before data collection.

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