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Q.A. Brief

THE QUALITY ASSURANCE PROJECT'S INFORMATION OUTLET

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CONTENTS

QA Planning and Structure 3

Methods for Selection of Quality Problems 7

Monitoring Quality Improvements and Measuring Results 10

QA Forum: Interview with Dr. Richard Morrow and Dr. Gilbert Burnham 12

Other Project Activities 14

Documentation and Dissemination 20

Some Strategies for Managing Change 22

Institutionalization Issues for Quality Assurance Programs 24

*The **Q.A. Brief**, published twice yearly, shares with the international health community the methodologies, activities, and findings of quality improvement initiatives sponsored by the **Quality Assurance Project**.*

From the Director

As we progress through the fifth and final year of the Quality Assurance Project, it has become increasingly important to seek out, reflect upon, and share the important 'lessons learned' from our efforts. Unlike some vertical interventions with clear end points, quality assurance, quality management, and continuous quality improvement are distinguished by their continuity. Quality is an ever changing concept, as are the outputs and outcomes along the way. Because of the dynamic and changing nature of the world in which we live, and the great variation in circumstances among the developing countries with which we work, we will not attempt, at this point, to offer the reader some universal truths about the project and quality assurance but will focus on lessons learned by our staff in specific country settings. We have conducted a wide variety of quality interventions in an even greater variation of circumstances. These include activities at Ministries of Health, Provinces and Departments, hospitals, primary care settings in the field, vertical interventions such as cholera, vitamin A, and measles, and general technical assistance where requested.

This project has taught us that bringing personnel together from all levels of an activity (process) and helping them solve problems as a team using universally established TQM tools, has been a very successful intervention. Many positive results have been achieved using this approach. Thus, team problem solving has been widely accepted in

From the Director continued on page 2

those countries and situations where utilized. This issue of the *QA Brief* highlights this and other lessons learned to date in specific country interventions in QA planning, process improvement, training, dissemination, and institutionalization. More will come to light as we reach the end of the project.

William Jackman, M.D., Director, QAP

This issue of the QA Brief resulted from the contributions of almost all staff from the Quality Assurance Project. Each article was an attempt to consolidate their many viewpoints and experiences under the major headings or issues which emerged. Yet, this was by no means intended to be the definitive piece on 'Lessons Learned' for the project nor did we wish to present an overly idealistic view of our work in QA. Rather, we wished to feature some of the many experiences and reflections of our staff and colleagues over the past few years as they have worked to apply QA in their program.

The Editors

Quality Assurance Planning and Structure

Planning for the introduction, implementation, and conduct of quality assurance activities has been a key issue from the outset of the project. Of the many approaches to planning cited in current literature and as a result of QAP's experience, no single QA planning strategy can be said to be universally applicable to the developing country context. This is due in large part to variations in the socioeconomic, cultural, and political makeup of individual countries; the priorities of the Ministry of Health of each country and of other agencies with which we have worked and their capacity to carry out programs; the availability of financial, material, and human resources; and the influences of the USAID missions and other donors.

Despite the differences in approach to planning a QA program, QAP has learned a great deal from its experiences, some of which are summarized below.

Understanding organizational strengths and weaknesses

Knowledge about how an organization operates and what is possible within the organization is the foundation of a sustainable QA program. A good understanding of the organization is crucial for developing appropriate strategies for QA skills training and organizational change, and for determining what level of QA activity the organization can absorb. A general understanding of the dynamics and communication patterns within the organization is helpful in determining how to introduce QA and who might be an appropriate leader.

Also, in order to avoid duplication of effort, it is necessary to understand what already happens in the organization, as well as what works well. Such knowledge often provides insight about where and how to introduce QA to ensure its acceptance and success. QA programs in Jordan and Egypt began with full-scale organizational assessments. In Chile, a small-scale assessment which focused on quality-related activities was carried out. In other countries, knowledge of the inner workings of the organization came from a series of consultative planning meetings with key host country staff, as well as from prior experience in the region.

Building on existing systems or activities

QAP has learned that it is useful to build on existing systems or activities which both support the organization's objectives and provide an adequate foundation for the QA program. This is true regardless of whether the program is implemented on a national, regional, or local scale, within selected health facilities or departments, or for multiple or single PHC interventions.

For example, the Jordanian Ministry of Health chose QA as a means for achieving greater returns on its health investments through improved efficiency. QAP is providing technical assistance in improving the quality of family health services and is working to develop a sustainable local capacity for achieving continuous quality improvement. In Chile, QA activities are part of a comprehensive strategy for motivation and capacity building at all levels of the health system.

Elsewhere, quality assurance has been introduced through existing vertical programs. These include Vitamin A supplementation in Honduras, TB case management in the Philippines, cholera case man-

Quality Assurance Planning, Structure continued on page 4

 continued from page 3

agement in Ecuador, and measles immunization in Niger.

Assigning responsibility for quality assurance

Quality assurance requires an "owner," that is, an individual, group of individuals, or organization which has the responsibility and authority to foster, nourish, and support quality assurance activities. In several countries, this has been achieved through the creation of QA councils and committees, and the assignment of coordinators and other individuals.

In Chile, a QA Department has been established at the Ministry of Health to oversee and coordinate activities throughout the country's nine regions. Full-time Ministry staff members provide support for quality assurance activities. In addition, each region has a QA committee with full-time QA staff. At the facility level, participating hospitals and clinics have QA teams to undertake problem-solving activities.

Jordan has developed an extensive integrated QA structure involving all levels of the health system, from a Monitoring and Quality Control Directorate and a Quality Council within the ministry, to various councils and teams at the health directorate, hospital, and clinic levels.

In the Tahoua Department of Niger, a Quality Council has been established comprising the Regional Health Director, QAP's Resident Advisor, two District Medical Officers, and two Regional Health Services staff members. At the core of the QA effort are district level Quality Improvement Teams (QITs) operating within the medical center of each of Tahoua's seven districts.

For the QA micronutrient program in Egypt, QAP staff and Egyptian counterparts developed a country plan with an action-oriented strategy at three levels. A QA Board at the central MOH level was established to oversee QA micronutrient activities. QA Committees were created at the regional (governorate) level to provide administrative and organizational support to the QA efforts. At the operational (district) level, process improvement teams were formed to carry out on-going monitoring and quality improvement activities.

Securing top-level management support

An essential ingredient in the success of any program is the commitment of top-level management. This support is needed to legitimize any changes which may be introduced by the QA process. Moreover, while successful QA activities are cost-effective in the long run, they do require an initial commitment of resources which often must be authorized at a higher level.

While involvement by higher level MOH staff in day-to-day activities may not always be feasible or necessary, key MOH officials should at least endorse and be kept informed of the QA efforts being operationalized at the other levels of the health system.

Under the old "centralized" healthcare system in the Philippines, QAP operated under the auspices of the Department of Health (DOH) Undersecretariat for Public Health to assist one province with its vitamin A capsule program. Initial approval for project activities was obtained from the Undersecretary, who then facilitated contacts with those technically responsible at the regional and provincial level.

After health services were decentralized in 1993, provinces and municipalities were legally entitled to make decisions about receiving assis-

tance from external sources. For two new QAP activities undertaken at this time, there was now a sense of "informing" the Undersecretary rather than obtaining his formal concurrence for activities, which was given by local authorities. However, the DOH, given its broad knowledge of health system problems, was still helpful in identifying how best to use project resources, and moreover, was still seen to greatly influence local policy and practice.

Other examples of where the commitment of the MOH has helped to promote quality assurance:

In Egypt, the success of QA efforts being undertaken by pilot health facilities as part of the Cost Recovery for Health Project, and the outcome of activities which comprise the micronutrients initiative in two governorates, have created interest within the Ministry of Health in developing a National QA Program.

Support from the Ministry of Health, as well as USAID and other agencies in Ecuador, has helped to achieve significant improvements in the processes related to diagnosis, treatment, and overall management of Cholera within the region. Furthermore, it has helped to promote the expansion of QA activities to other health programs.

Early in the Jordan program, MOH officials visited the project sites often and participated in local activities on a regular basis. In addition, a member of the royal family expressed a genuine interest in the project which provided staff with additional incentive to work on project activities.

Top-down or bottom-up?

When introducing innovations into organizations, the relative advantages of top-down vs. bottom-up strategies are often debated. Introducing quality assurance is no exception. Some QA initiatives begin by introducing quality assurance to the highest levels of authority who in turn determine the actions to be taken at lower levels of the health system. Others begin with orientation and process improvement at the field worker level and later work toward securing positive endorsement and participation from higher up. (It should be noted, however, that no work can be started if high-level decision makers actively oppose the introduction of QA approaches).

"Knowledge about how an organization operates and what is possible within the organization is the foundation of a sustainable QA program."

In Jordan, a focused effort was made to initiate and develop a QA structure and function at the MOH level while less energy was directed at the field level.

In Niger, a mix of approaches was used. In keeping with the central MOH's recent policy to decentralize the Niger health care system, QAP has worked through an effective implementation process which emphasizes top-down and bottom-up simultaneously.

Quality Assurance Planning Strategies continued on page 6

Quality Assurance Planning: Strategies continued from page 5

Auxiliary nurse from the Vitamin A supplementation program, Honduras.

The MOH has been kept informed of all plans and activities. The regional level has been instrumental in designing strategies to build local QA capacity. Staff at all levels — departmental, district, and peripheral — have been trained in QA methods and tools, and are receiving financial and technical support for their work.

Though the impetus for quality assurance originally came from above, the program is currently being driven from the bottom up as problems are identified and solved at the district and peripheral level. This strategy to simultaneously inform, train, and support teams at the sub-national levels while keeping the central ministry informed, has helped to promote QA throughout the region.

Thus, although no single approach is the norm, field experience has borne out the effectiveness of a strategy which includes some mix of top-down and bottom-up approaches. In the end, however, the effort should work to foster an instinct for continuous quality improvement at all levels, from staff at the service delivery level to policy-makers at the national level.

Having well-defined priorities and objectives

The very nature of planning suggests that plans should be flexible, as projects will evolve and grow over time. However, planning for quality assurance requires that all those involved clearly understand the primary objectives of the proposed QA effort and agree on the steps which must be taken to achieve them.

Early in the project, Jordan QAP staff conducted a strategic planning workshop, including key MOH personnel, to identify and discuss program objectives and priorities. QAP has learned that it is critical to document and disseminate all resolutions and decisions made at such meetings, and should any changes be made to those decisions, to institute a systematic group process for amending them.

At the start up of a micronutrient activity in Honduras, staff from QAP and the International Eye Foundation met repeatedly before traveling to the field, to clarify the approach to implementation, define resource and time constraints, and discuss options for intervention. The result was a narrow and manageable scope of work which focused on Vitamin A supplementation activities in the capital city and surrounding communities.

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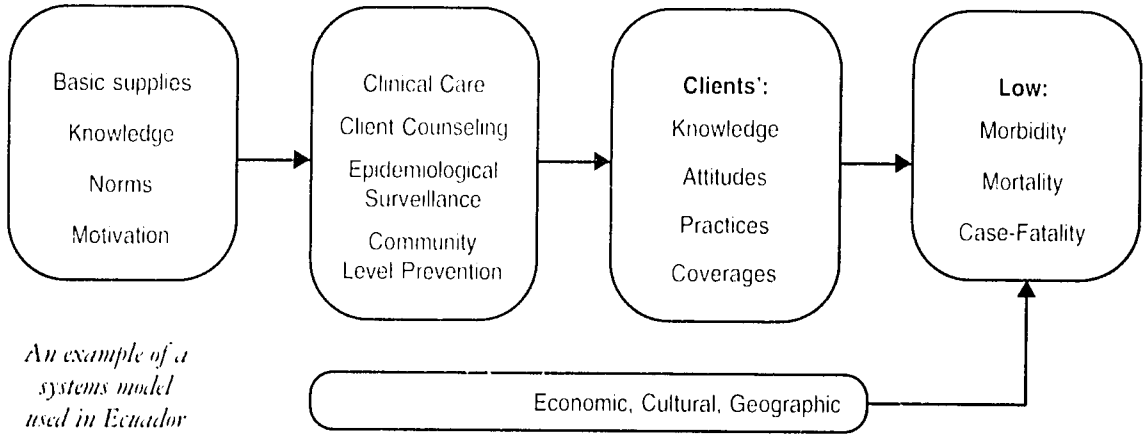
FIGURE 1

Systems Model for Control of Diarrheal Disease Activities at the Local Level



An example of a systems model used in Ecuador

Methods for Selection of Quality Problems

The Quality Assurance Project has employed a number of methods and techniques for identifying and measuring problems. These have ranged from quality methods such as soliciting suggestions from health workers, obtaining feedback from clients, and generating ideas through brainstorming or other group techniques, to quantitative methods such as analyzing outputs of existing information systems and conducting analyses of service delivery processes. The choice of method has been determined largely by the levels of skill and the resources of the teams or staff involved in the identification of problems.

From many of our experiences, we have learned that in the initial stages of a QA program, one of the most difficult tasks for QA teams is to select appropriate and well- defined quality problems. Frequently teams will arrive at a problem statement which is too vague or complex, and which may discourage team members early on in the QA effort.

A systems approach to identifying problems. To help prevent this problem, some programs have applied a Systems Model (Figure 1), which relates the different service components to one another, followed by a Systems Analysis which enables teams to identify and diagnose key problems in the way services are being provided through the collection of essential data. This approach relies on direct observations of service delivery, interviews with health staff, exit interviews with patients, record reviews, and or inventories of supplies and equipment. Some examples of where this ¸lesson learned¸ has been applied include:

> As part of an effort to improve cholera case management in Ecuador, QA teams began with a systems model and systems analysis to identify quality problems. This low cost "rapid assessment of quality" was carried out over a period of 2-3 weeks in a sample of health facilities. Consequently, QA teams were better able to identify and select quality problems, using data from the system analysis as well as from their own experiences. The end result was a much more structured and realistic definition of their problems.

> In Antique Province, Philippines, Regional Health Office staff and clinical supervisors in Rural Health Units were involved in implement-

[illegible] continued on page 8

ing a quality assessment for the Vitamin A capsule utilization program. They conducted observations, interviewed health workers and mothers, and reviewed the logistics systems. These same managers and supervisors joined other health workers in the process of reviewing data and identifying problem areas, thus enabling them to gain consensus on the problems to be addressed by their QA intervention.

Using other data sources for identifying problems.

In the above examples, a special data collection effort was undertaken to supply the needed information. In other country programs, existing information systems have provided a first source of data for the identification of problems. In Niger, however, a mix of these data sources was utilized.

FIGURE 2

Primary Health Care Service Quality Checklist

10: Acute Respiratory Infection

1. _____ Health Facility
2. _____ Service Provider
3. _____ Observer Supervisor
4. _____ Date

Name of child _____

Age _____

Take Medical History

Did the service provider:

5. YES ___ NO ___ Ask the age of the child?
6. YES ___ NO ___ Ask about symptoms of cough?
7. YES ___ NO ___ Ask about duration of cough?
8. YES ___ NO ___ Ask about activity level?
9. YES ___ NO ___ Ask about ability to drink?
10. YES ___ NO ___ Ask about any past history of respiratory problems e.g.(asthma)?
11. YES ___ NO ___ Ask about family history of TB or other respiratory illness?
12. YES ___ NO ___ Ask about any treatment administered?

Conduct Physical Examination

Did the service provider:

13. YES ___ NO ___ Assess general status (alertness, muscle tone)?
14. YES ___ NO ___ Count respiratory rate?
15. YES ___ NO ___ Take temperature?
16. YES ___ NO ___ Observe breathing for chest indrawing?
17. YES ___ NO ___ Listen for stridor, wheeze, and or hoarseness?
18. YES ___ NO ___ Auscultate chest?
19. YES ___ NO ___ Examine throat for discharge, enlarged tonsils, or inflamed pharynx?
21. YES ___ NO ___ Examine ears?

Brainstorming was initially used by teams to generate problems, but the problems identified were either too vague or could not be adequately addressed at the district level.

To get a better sense of the existing problems, the teams looked at service statistics produced by the national health information system. Though data were readily available on indicators such as dropout rates for tuberculosis and vaccination, coverage rates for growth monitoring and antenatal care, and rehabilitation abandonment rates for nutrition services, they were not being routinely used as a basis for problem solving or decision making.

These indicators reflected broader outcomes related to the case management of preventive services, denoting some possible problem areas in which teams could focus their problem-solving efforts. The teams later went on to conduct some observations of service delivery which resulted in the identification of patient waiting times as a major problem in the clinics, and the reorganization of patient flow as the appropriate intervention.

Advantages and disadvantages of conducting quality assessments.

The greatest advantage to doing a quality of care assessment at the start of a program is that it helps

health providers acknowledge problems and move beyond an initial denial of the need for quality improvement. The assessment also helps focus QA efforts on clinical and management issues related to 'high risk', 'high volume' or 'problem prone' areas, and serves as a baseline from which to measure improvements.

Yet in spite of these potential advantages, starting with such an assessment is not without risk. For example, identification of poor service quality can be harmful politically; results can be exaggerated or misused in the hands of the wrong people; conducting the assessment may be too costly; and providers may respond to the results with some degree of fear and resistance.

To offset some of these more negative aspects, QAP has involved key local staff in decisions concerning the design, development, and conduct of the assessment.

> In Indonesia, a systems analysis was used by health center staff to identify problems in the delivery of antenatal, immunization, and ARI services. The approach was well received in the field because it was seen as a practical and systematic means for assessing and defining quality, and provided a good starting point for QA problem-solving activities.
>
> In addition, the involvement of local staff in the assessment process generated considerable interest and support among the participants as well as Provincial and District level staff, helping to further advance the idea of a participatory team approach to improving quality.
> *(See Figure 2)*

In general, QAP has been flexible in its approach, utilizing and adapting various quality assessment approaches to the widely varying needs of developing country health systems. Field experience, however, has demonstrated the effectiveness of a systems approach in identifying and defining quality problems and has played a role in convincing senior management of the value of QA.

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Monitoring Quality Improvements and Measuring Results

Monitoring is "the periodic collection and analysis of selected indicators to enable managers to determine whether key activities are being carried out as planned and are having the desired effects..." Quality assurance emphasizes monitoring the processes that lead to outcomes, as outcome measures alone or other service statistics that are the traditional outcomes of monitoring systems may be of limited use in problem-solving.

The following are some lessons learned from our efforts to conduct quality monitoring as a component of QAP's approach in developing countries.

Collect only essential data for key indicators

This is an old problem, but always worth restating. There are limits to how much information can be collected and used effectively. Thus it is critical to use as few indicators as possible, paying close attention to the validity of the indicators which have been chosen.

> As part of the QA effort to combat cholera in Latin America, a lengthy list of indicators for clinical case management of cholera patients was developed by a team of national health authorities. When applied to the field situation, the number of indicators was substantially reduced based on the practicality of their use. Clinical records at hospitals were partially useful for constructing these indicators. Other essential information was gathered through the use of observation checklists and interviews conducted by local districts managers during routine supervisory visits to health facilities.

Keep data collection simple for staff with limited training

As part of the process of quality improvement, data collection may be indicated in essentially three places: identifying a problem and measuring its magnitude, verifying and measuring its causes, and monitoring the implementation and effectiveness of a solution.

Collecting data about a problem provides a basis from which to measure improvement; data on causes helps to determine the extent to which they contribute to a problem; and data on the effects of a solution (perhaps the same indicators) demonstrates whether a problem has been resolved, that is, whether a target or otherwise acceptable level of performance has been reached.

> For the cholera activity in Ecuador, routine supervisory visits to the health facilities made by local district management teams were strengthened to include data collection activities for measuring quality improvement interventions. District supervisors were trained in such methods as direct observations of service delivery, use of checklists, exit interviews, and focus groups.
>
> As a result, data is processed periodically to generate indicators which can be compared to previous figures, thus giving supervisors and health facility staff a sense of what results are being achieved and what additional efforts are needed to get better results. In addition, data analysis by both supervisors and facility staff has served to motivate QA teams to pursue new

[1] *Module 5: Monitoring and Evaluating Programmes. The Primary Health Care Management Advancement Programme.*

quality improvement cycles at higher levels of complexity and detail.

In some instances, the use of data for decision-making and problem-solving is a relatively new idea, requiring transfer of new skills and some degree of technical guidance external to the teams.

In Indonesia, during the first phase of QA training, less emphasis was given to the subject of indicators, data collection and analysis, and interpretation of results, because it was expected that external QA monitors would be on hand to provide teams with "just-in-time training" or assistance when the need arose. Workshops were then modified to include more direct training on the use of data at critical points in the process of problem-solving.

However, as evidenced by the difficulties experienced by some teams, there remains a strong need to provide more technical support in these areas, not only to improve the quality and the relevance of the data collected, but to interpret and apply the results.

Be prepared to improve the quality of data being collected

Although an indicator is a powerful tool for measuring health care quality and for triggering appropriate action, in some countries the use of indicators can present some problems, not the least of which has to do with the availability of data sources for constructing them. Clinical records and other data sources are often poorly maintained, incomplete, or nonexistent, and special data collection efforts are needed to supply the missing information.

In a study of clinical records for tuberculosis patients, only 1% of records were perfect. More than one quarter of the records showed at least one error which might have compromised effective treatment of the patients.

Use the information and provide timely feedback

It is essential to utilize the results of monitoring activities and feed them back in a timely manner to health staff and managers involved in the QA undertaking. When quality improvements can be demonstrated, it strengthens the confidence of QA teams, enhances institutional and political support, and provides some direction in planning for the continuation of an activity.

In Bolivia, the objective of a hospital-based quality assurance initiative was to demonstrate that by using QA methods, improvements in service delivery could be attained within the hospital's current budget or with cost savings. Activities included the collection of data to measure the magnitude of problems and causes related to management personnel systems, financial management and cost recovery, and patient satisfaction.

Additional data were gathered later to monitor the progress of solutions, and impact was assessed through a comparison of pre- and post-implementation data sets.

QA teams presented their successful results to hospital staff and then to representatives of public and private sector health organizations. The end result has been the continuation of QA activities within the hospital and the creation of a hospital-wide QA Committee, as well as expressions of interest by other institutions in initiating quality improvement activities in their hospitals.

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Decentralization Under Quality Assurance Programs

Lessons Learned From the Experience in Uganda

Martine H. Charles, M.P.H., Associate Scientist, Quality Assurance Project

Decentralization is the general transfer of authority in planning, management, and decision-making from higher (usually central) to lower (usually peripheral) levels of government. Decentralization of health system structures and management has become a key issue in the development of equitable and efficient PHC delivery systems. As various approaches to decentralization are tried, the lessons learned should be used to help guide future programs.

One such program began in 1993 in Uganda, where an ongoing overall decentralization of Government was occurring. A Quality Assurance program was introduced to the Ministry of Health (MOH) as part of a concerted effort to improve its capacity to provide better health services. A major emphasis was to help strengthen the district management teams in the process of improving their management skills to deal with these new decentralization realities. The Ugandan program began as a pilot in two districts in Western Uganda. Interest from all levels such as the Ugandan president, the MOH, UNICEF, and the World Bank pushed to introduce the program nationally in concert with the decentralization of all districts over a 5-year period. Now entering its second year of working with district political leaders and District Health Teams of the 27 decentralized districts (the remaining 12 will be decentralized in July 1995), the project has identified some lessons learned based on this work. The following is based on an interview by Martine Charles (MC) with Drs. Richard Morrow (RM) and Gilbert Burnham (GB) of the Johns Hopkins University School of Hygiene and Public Health.

MC: Please describe the Ugandan program.

GB: A National Quality Assurance Committee (QAC) comprising top management and all program managers of the MOH was appointed and a Quality Assurance Unit (QAU) was established to act as a secretariat. There was close collaboration with the secretariat of the Ministry of Local Government. The program began when JHU teamed up with a Ugandan doctor who was working for the German foreign assistance organization, GTZ, and who was interested in QA issues. He had put together some early QA programs on his own in two districts of Western Uganda. With some support from UNICEF, the team began to develop a pilot QA program . After barely a year, the MOH became very interested in this program. One of its major concerns was that district health teams were ill equipped to take on the responsibility of decentralizing health care systems. Both the MOH and the World Bank saw QA as an approach to help strengthen the district management teams by improving their management skills. From the beginning, the MOH set up a QA unit. This came about in the context of decentralization. The central government, I would imagine mainly with pressure from the president, decided that the health system and the entire government assistance in Uganda were going to be decentralized. Quality assurance management is an excellent complement to decentralization.

MC: What do you think are some of the required components of a successful decentralization program?

GB: For QA management to succeed, there needs to be a strong commitment from the central level,

coupled with involvement at all levels. The push for decentralization in all sectors came from the very top. The importance of involving both the periphery (the district level) and the center, and both at the same time, has emerged as a significant lesson learned. In Western Uganda, we have started with the districts because that was being managed by the GTZ, the German aid organization. But it was frustrating to them because this was all being done separate from the national system. At the same time, when we became involved at the national level, we could see very clearly that without strong emphasis on leadership from the top, it wasn't going to take off.

RM: Another extremely important component in introducing QA management is the district workshops. Right from the beginning, it was decided to involve local government groups. The district development committee, the district health committee, the head politician (RCI), and the district executive secretary, who is the head of local government, have been involved with the health team in the workshops. They have come to the initial workshops and have participated. In the first general meeting of all decentralized districts, they discussed their experiences with decentralization, with the QA management, and their lessons learned. In some respects, the involvement of the district executive and the RC chairman have been critical in the input from the community to the PHC work. There is genuine community representation by those who have authority as well as responsibility.

GB: One of the essential aspects of a decentralized system is the political will to do it, from the highest levels. Often, one finds a decentralization of responsibility but not authority. And when the decentralization is done, you have to let the people get on with it. Mistakes will be made. It is very important to have an open and transparent accounting system which will make a shift from what it was in the past in most countries. Even with strong political will, you will find very substantial resistance from some sectors because many have been doing very well under the old system and they will not wish to see an open and transparent accounting system. Coupled with decentralization, it almost has to be that way because the central authority needs the accounting from the districts and the districts are going to demand it of the people.

MC: What were your experiences in training?

GB: The continuous reinforcement of the QA management approach is very important. Another lesson is that the training and the awareness and the use of QA management methods must be continued for quite a while, a number of years. This is not something where you do a couple of workshops and people automatically start using the methods. The workshops need to be followed up with supervision, continuous support from people who know something about QA and can help the district teams in solving their problems using QA mechanisms.

MC: Did you start your training and awareness courses at the central or peripheral level, or both, and what would you consider to be the better approach?

RM: We did the training and awareness courses at the central and peripheral level almost simultaneously. We did the one for the central level and went to the districts within a few days. Then started the second round of workshops in the districts before we got to the second round at the center. The center has had regular monthly meetings to provide support to the districts. They organized themselves so that two members from the central headquarters visit each district now every other month. Everybody has taken part in good spirit. I had anticipated all sorts of resentment but that has not happened. This represents a commitment of 20-25% of the time of the central senior MOH staff, spending a full week every other month in the districts. If noth-

Lessons Learned From the Experience in Uganda continued on page 16

Other Project Activities

Jordan

As a result of the enthusiasm growing out of the success of the pilot Family Health Services (FHS) Center in the Balqa'a Health Governorate, the program has been expanded to the Ma'adaba and Irbid Health Governorates at both the primary and secondary care levels.

The model Family Care Center in Salt was inaugurated in April by the Minister of Health and the Ambassador of the United States. Several Jordanian dignitaries were in attendance.

The Ministry of Health is hosting a Health Care Quality Certification Program which will include a test preparation workshop in August, followed by a certification examination in November. The Program will be open to Jordanian health professionals.

Egypt

Egyptian Society for Quality Assurance

In response to a proposal to the Ministry of Health in Egypt, the Minister agreed to establish the first national society for QA in Egypt. The Egyptian Society for Quality Assurance (ESQA) will be headed by the Minister himself. A list of 50 potential founding members has presented to the Minister for approval. The Minister has agreed to the proposed members and has issued invitation letters requesting their participation in founding the Society. Once the founding body is established, formal procedures to register the Society with the Ministry of Social Affairs will take place.

Micronutrients

Through the use of QA tools, process improvement teams have reached positive results in their efforts to improve micronutrient services in Egypt. Examples include a 75% improvement in patient satisfaction at Etsa Clinic in Al Fayoum Governorate and a significant improvement in mother's knowledge of nutritional needs at the Luxor clinic. The QA micronutrient assistance to Egypt has been recognized by MOH officials as an "action-oriented model" for technical assistance.

Niger

The Project received national recognition from the Niger Health Information Service (SNIS). In helping to mobilize an emergency response to the meningitis outbreak by supporting immunization campaigns, the project made it a point to remind health workers to simultaneously check measles immunization status and to immunize for measles as needed. This idea was promoted nationally.

Nigeria

Dr. William Jackman, QAP Director, was a featured speaker at the Nigerian General Medical Practitioners Annual Conference held in Abeokuta, Nigeria in March. The presentation offered the providers some insights into the role modern quality assurance methods might play in the context of a private practice. It also allowed the development of QAP contacts in the private healthcare sector of the country.

Philippines

Iodine Deficiency Reduction

During Dr. Stewart Blumenfeld (QAP/Bethesda)'s visit in February, he found that salt production had ceased entirely because Tuba had not been conforming to the Commission on Audit rules in procuring raw salt. All procurement was halted until a set of operating rules could be devised that would both meet the Commission's requirements and allow for procurement of salt in sufficient quantity and acceptable quality. A meeting with the Provincial Governor led to a decision to essentially privatize the salt manufacturing and distributing system by placing it in the hands of the Benguet Barangay Health Workers' Association. QAP worked with the Tuba staff to finish the indicators and work out a plan to collect data on the

QAP Resident Advisor, Nigeria (JHU), Dr. Stella Gongs, a distinguished Nigerian physician and QAP Director Dr. William M. Jackman at the Nigerian General Medical Practitioners Annual Conference.

variables required for the indicators. UNICEF, which is helping two other provinces in the region with their iodized salt programs, has asked to use the QAP indicators.

Honduras

Vitamin A

QAP has been collaborating with the International Eye Foundation (IEF) in Honduras to help build QA problem-solving capability for the Vitamin A capsule distribution program. Based on an initial assessment of quality, teams trained in the tools and techniques of quality assurance are currently working to address inadequacies in the health education provided to patients about the benefits of Vitamin A, as well as weaknesses in the delivery of Vitamin A to post-partum women. Success of this effort will be determined by measuring selected indicators of effectiveness via pre- and post-intervention assessments.

Middle East

Quality Management Training Course

This course was held in Dahab, Egypt May 14-25 and sponsored by the Brookdale Institute in collaboration with a number of sources, including the Institute for Health Care Improvement and the Quality Assurance Project. Participants from Egypt, Jordan, Lebanon, Morocco, Tunisia, Israel, the West Bank, and Egypt were present. Dr. Walid Abubaker (QAP Bethesda) participated as a faculty member.

The National Workshops for Quality of Health Care in Palestine

Sponsored by the Ministry of Health-Palestine National Authority, the Palestine Council of Health, and in collaboration with WHO and UNICEF, this workshop was held April 29-May 9. Dr. David Nicholas and Dr. Walid Abubaker (QAP Bethesda) presented the session "Quality of Health Care: Concepts and Applications" and offered case studies drawn from the experiences of the Quality Assurance Project.

Latin America

Conference on Quality in Healthcare Services

Due to the increased enthusiasm and support for expanding QA in the region, it was decided to organize the first Latin America Conference on Quality of Healthcare Services to enable Latin American representatives to exchange experiences, strengthen their capabilities, and make contacts. The conference will be held in Quito, Ecuador on August 1 through 5, 1995, and is being jointly sponsored by the Latin America and Caribbean Health and Nutrition Sustainability Project (a USAID contract) and the Quality Assurance Project.

ing else, it has provided the opportunity for the people in the center to see what the real problems are at the district level and it provides the district people a chance to interact.

There is still a very strong sense from the center that these visits are to give directives to the districts to tell them what they should be doing and to give them forms to fill out and get information back to the center. But in fact, these views are shifting and the basic notions that the center exists in order to support the districts is beginning to take hold. Some of the people who are particularly sensitive to this are beginning to make it clear that the purpose of the central divisions is really to provide support and to answer questions and to get information that the districts need, not vice-versa. It would be interesting to see how much further this progresses but it seems right on course. Among other things, the divisions in the central ministry have begun requesting QA management sessions of their own. They now have become quite caught up with the whole idea of TQM. There are interesting spin offs in that way.

> *"The training and the awareness and the use of QA management methods must be continued for quite a while, a number of years."*

MC: Tell me about the teams and the kinds of problem solving they chose to look at. Did the process require much outside direction once the teams were formed?

GB: Peripheral health centers and dispensaries are operated by one to four trained personnel. The lack of communication and reliable transport make networking and interchange fundamentally difficult. In districts with 50 to 100 units, hundreds of people are involved so the logistics of getting them involved in making decisions on their own are mind boggling.

Every health unit has established a health unit management committee. They view teamwork as one of the main principles under QA management. When the program started in Uganda, rather than trying to establish other kinds of teams, we worked with the existing district health management team and the health unit management team from the hospital by building on their teamwork concepts. So it's just a question of how to do everything at the same time. Yet I think one of the strengths to decentralization is that, at least in some of the districts, the district health management teams have actively been working with the GO groups. It is quite variable from district to district. The policy now is clearly to direct the involvement in all their activities in primary health care.

QA played an important role in getting things going even though that wasn't, perhaps, the initial intent in setting up the program. One of the things that we have done in the problem statements is to encourage people to select problems that they thought they could solve in a fairly short period of time. We set an arbitrary length of six months. A very widespread problem was that people tackled problems that were far more complex than they thought or the problems that ended in their front yard but the tail of it was way off somewhere else that they didn't have ownership or control over. I think that, on the subject of lessons learned, that's something that we probably didn't emphasize enough in the beginning. That is the selection of problems, the problem statement, and the ownership of problems.

GB: One of the QA tools that has worked very well is the use of scattergrams, where the district health team plot number of patients seen against revenues received. They saw a big spread and started asking why is this over here, and so forth. Another one people have used at least in two districts has been the allocation of new motor vehicles. When we started flowcharting this, it became apparent that in most places, there is no standard method. This is important when there are a number of programs, donor-supported or otherwise, that are going on at the same time. There are never enough vehicles to go around and people need vehicles on short notice. What the district did was flowchart the process of requesting vehicles, cancellations, changing plans, and vehicle repairs. In the two districts that I worked with that had the flowcharting, it was a real eye opener to them to see what was happening with the vehicles. It proved to be a big problem. I don't know if there is a permanent solution to this but I think it has helped people think more rationally about allocation of vehicles.

Another problem selected by the districts that was worked out quite well right in the beginning was that people weren't getting paid. It wasn't only the fact that people were getting paid every 3 or 4 months, but some people weren't getting paid at all. They flowcharted the process by which employees are being hired and they found there were three separate processes for hiring. One of them ended up that your name was entered into the payroll and you were getting a salary and the other two sort of disappeared up in the air someplace because they didn't seem to follow a standard pattern. So on the basis of that, they established a standard pattern so people went through this process and actually ended up on the payroll.

RM: At the first General Conference of District Health Teams held in Kampala in December, 1994, district after district related the problems they had identified and then described briefly how they had gone about solving them. There were about approximately 20 districts represented and about 300 people came to the meeting and it was remarkable. They really felt that they had made measurable progress in solving some of their major problems.

MC: If they came up with problems or solutions that you felt were not what you'd like to see, did you try to guide them toward a better problem identification or a better solution or did you let them do it anyway?

RM: No, they were reporting about what they had done, I think that the one general deficiency was that it would have been helpful to have better documentation of exactly what had been done. They identified problems and, working with teams using QA tools, they developed generally sensible solutions. They had impressions about what the results were but to relate one to the other was a bit problematic. Actually, members of the QA Unit are following up on some of the more dramatic changes that have occurred, particularly in health care. For example, they are looking at maternal complication referral patterns and the shift in approach of transporting the women having problems to the hospital.

MC: Where does the program go from here?

GB: This is a country that has been destabilized by 15-20 years of war. It's been making good progress but we still have a very long way to go. Several big challenges lie ahead. One is how to keep the educational process going because the experiences in this country show that five years or so is reasonable for getting something going in a hospital. As someone who's done this before in developing countries, I'd say probably five years is the bottom end of the scale--how to keep people excited about it, how to keep encouragement up, how to keep the process going for five years, or whatever period of time it takes. That's one challenge.

Lessons Learned From the Experience in Uganda continued on page 18

The next challenge that we have is how to move the concepts of QA and QA management below the district health management team to the health centers themselves because we've looked at the whole issue of QA management as really methods of management, management culture. We have not looked at it as a series of checklists and a series of standards to which everybody has to adhere. So we've been very much in the management problem-solving mode. The issue is getting this down to the health units so they can start taking a lot of the responsibility for what they do themselves rather than thinking the supervisor or the district health team is going to solve their problems for them. In the whole concept of the quality improvement team, these are the key players.

RM: There needs to be continued training. As time goes on that with the idea of continuing workshops every six months, with introduction of a new theme at each is probably going to be useful. Clearly, there are certain specific skills that the districts health teams need to have. The next main theme is the development of clinical and managerial standards and that will be an ongoing activity.

There are certain other issues that need to be addressed. One that has been started but hasn't gotten very far is to develop a self-assessment instrument for the districts to assess the quality in their districts, not to use this for comparison between districts but for districts to use as a benchmark for themselves. An instrument has been developed but is not yet ready to be put into place. That is something that people have been thinking about: how to assess your own quality of services. The instrument looks at the actual plan of the district management teams. What do they select as indicators for quality in their districts. The unit has made some suggestions. Among these is to measure user satisfaction and also something to measure morale or health worker status. There's something that people can do consistently to see how their services are.

GB: Another thing that has started is a small grants program. If the districts want to do operations research on QA, how to improve quality in their district, and they don't have enough resources, they can apply to the competitive grant program. It's not very much money but it's enough to help them with transportation, somebody's time, or materials. That was started just a few months back.

RM: Two more important topics. One is the importance of the information system, which needs a lot of work. Our feeling is that an MIS should grow from the needs of management. Much better morbidity and mortality information will be needed and rationality requires a linkage between health programs and changes in health status. But we're a very long way from having such an information system. It's an important topic and shouldn't be separated from the other things. I think that doing anything sophisticated is not particularly appropriate.

The second topic is continuing education and the introduction of the quality improvement management methods into ongoing training programs at all levels in medical system training, nursing training, and university training. It is being introduced in the newly developed school of public health for advanced health training. Perhaps a good lesson that we've learned is the importance of the Ministry Continuing Education Center which is a very well run center. The Director, Dr. Vincent Ojoome, has from the beginning been a member of the QA Unit and they are about to introduce QA into all their continuing education programs. Institutionalization requires that the ideas of TQM be part of the fundamental training of all cadres.

GB: One overall lesson— we've not only been involved in PHC activities based in district hospitals but also the central hospital, the National Hospital. One of the basic lessons is that the more complex the structure, the more vested interests there are, and the more difficulties. The QAC is full of enthu-

siastic and fairly flexible people but when you move up the line, the defenses set in and everybody has already established a system in their best interest. Of course, this is where a large amount of the budget goes, a large amount of money goes into the services of the larger hospitals and so it really does become important to look at how these resources are being used

One of the biggest hurdles we found was that people believed that if you're going to have quality, you've got to have more resources. The first response you have when talking about improving quality is we need more resources, what are you going to do for us? In some cases, you're not going to do better unless you have more resources. You can't do a good EPI program if you don't have a cold chain. So there is that component to it but I think that one of the main emphases of the program, or at least what we have encouraged the unit to look at is to improve the quality with the existing level of resources because the chances of getting much more in the way of resources is not very great. One emphasis has been trying to close the gap between what's being achieved now and what could be achieved with the same amount of resources and then identifying those areas where specific kinds of resources need to be addressed. But it has not been a resource oriented kind of program at all.

MC: Would you consider the program a success?

GB: Overall, the program has been a success, but there have been many problems. I guess it depends on how you define success but if you define success in terms of doing what they said they would do and following through with it and making adjustments as needed, that has certainly been so. It is from nearly every point of view a success.

That's not saying that everything is going the way we would like it. I think many people in the center don't have as deep a concept of QA as we would like and hopefully these recent meetings we've had will help strengthen that. But I think it's coming along and one of the major messages of QA in Uganda has been coordination, pulling things together. I think in that way, it has done a spectacular job.

QA Forum

Each issue of the QA Brief features the QA Forum. This column provides our readers the opportunity to share their experiences in implementing quality improvement measures in LDC primary health care systems. We wish to hear about methods, results, or even unresolved issues related to LDC quality assurance initiatives. Our goal is to foster an exchange of ideas about successful quality improvement measures, such as:

- innovative methods for monitoring the quality of care
- team approaches to successful problem-solving
- supervision techniques which ensure quality of care
- tools used for quality assessment

If you have an experience to share, please send a summary (1,000-word maximum) to:

QA Forum
Center for Human Services
7200 Wisconsin Ave., Suite 500
Bethesda, MD 20814

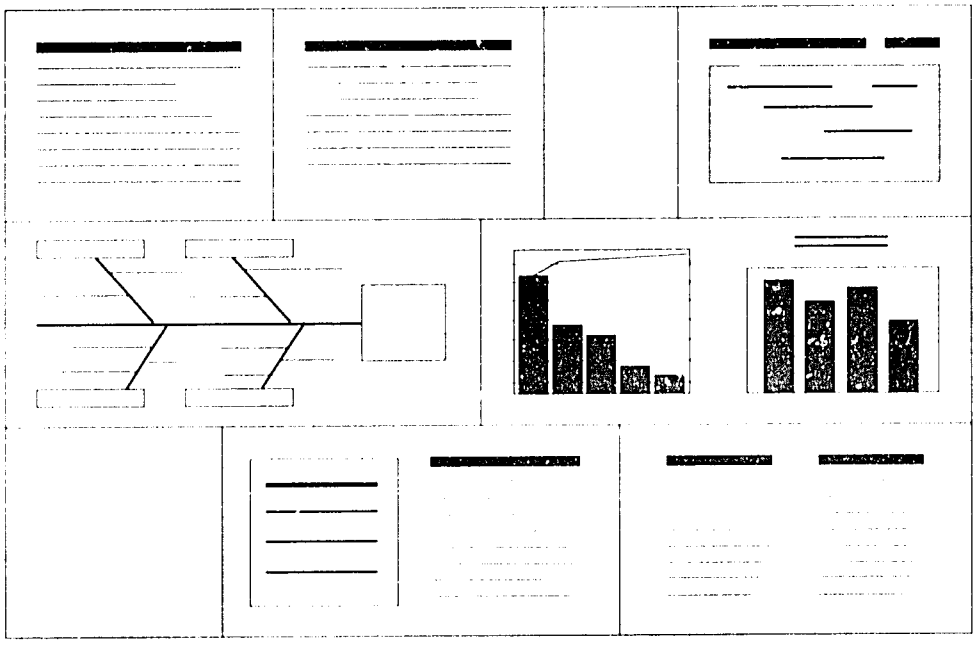
If appropriate, please indicate how readers may obtain further information. We will feature submissions in future issues of the QA Brief.

Documentation and Dissemination

ver the past year, QAP has boosted efforts to gather concrete evidence demonstrating the association of QA approaches with improved service quality. Documentation from the field has been provided by quality teams as part of their problem-solving activities or been produced through a special effort on the part of QAP staff to ensure that results are chronicled, summarized, and made available for local as well as international dissemination and advocacy.

Local dissemination strategies have become an integral part of many QAP country programs and include the development of regional newsletters, participation in national conferences, and publication of articles in magazines and journals. Successful experiences have also been disseminated through presentations given to Ministries of Health and donor agencies, as part of formal QA training workshops conducted for local health staff, or through interpersonal networking. Of the many experiences and lessons learned from these efforts, a few are highlighted below.

> In Jordan, dissemination is perceived to be an active method of communication. Dissemination does not require merely producing a written guideline or other product and distributing it to all concerned, but actively communicating the work through focus group meetings, conferences, training workshops, and direct personal contacts.
>
> The Jordan project has had an active dissemination campaign from the start. Every lecture, workshop, and meeting conducted has fostered the objective of having participants duplicate the QA effort and pass it on to others. Lectures and workshops have been conducted not only for Ministry of Health officials, but for universities, the military health service, and management training institutes. In addition, several Jordanian journal, newspaper, and magazine articles have called attention to the start-up of the project, the various training courses held throughout the year, and related developments in quality assurance.
>
> For Jordan, the lesson has been to develop from the outset of the program an active dissemination and communication strategy which designates target groups, defines objectives and methods to be used, and considers the resources needed to optimize the effort.
>
> In Tahoua, Niger, the creation and quarterly distribution of a regional health care newsletter has greatly served QAP's and the Tahoua Department's dissemination objectives. The quarterly newsletter, Ader Santé, is published by the Departmental Health Office and routinely includes news about QA activities, particularly the work of process improvement teams. Departmental staff have benefited from the process of preparing the information bulletin; moreover, it has filled a communication void existing among the districts of the region and between the Departmental Health Office and the districts.
>
> The bulletin has also served to keep central MOH staff and the general public informed of health sector problems in Tahoua. In helping to mobilize an emergency response to the meningitis outbreak by supporting the immunization campaigns, the newsletter helped to inform people about the nature of the outbreak, and reminded health workers to check measles



QA Storyboard. A helpful tool to show the progress of a process improvement team.

immunization status and give vaccines as needed. The approach is now being promoted on a national scale.

Local media networks are very useful in calling attention to the activities of QA teams. For example,

> At the May 15 Hospital in Cairo, Egypt, news of the hospital's effort to improve customer relations by establishing an efficient reception desk was publicized in one of the most widely read information magazines in Cairo. As a result, response and praise from multiple sectors of the community were directed at the hospital, and internally, staff are continuing to improve interpersonal skills in all areas of the hospital.

The sponsorship of local conferences has also helped to propagate the achievements of quality assurance work.

> As part of the quality effort in Chile, a national conference attended by over 100 local health professionals was held in Santiago to present the results of QA work and discuss regional QA plans. The principal sponsor of the conference was the Chilean Ministry of Health, with QAP and Panamerican Health Organization (PAHO) serving as co-sponsors.

Finally, an important lesson learned has been the need to concurrently gather information about project activities and retain it in documented form. In many of QAP's subprojects, storyboards have been used to exhibit the operational statement of a problem; demonstrate the use of tools such as process flowcharts, cause-and-effect diagrams, and matrices; present the results of data collection activities; describe the solution; and display results which show improvements in performance.

> As an example, storyboards have been used in the Rural Health Units (RHUs) of Antique Province, Philippines, as a means of disseminating the work of problem-solving teams. In creating the storyboards, the teams reviewed the process they undertook to resolve their problem and were encouraged to apply the methodology to address other problems. These storyboards were then prominently displayed on the walls of the clinics so that the public could see the steps being taken to improve the quality of services. The storyboards also served as a continuous reminder to the workers that skills they had used to resolve one problem could be applied again to other problems in the RHU.

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Some Strategies for Managing Change

by Elizabeth Marriani, M.S., Training Manager, QAP

QAP recognized early on that simply providing new knowledge and skills would not address the feelings of tension and anxiety experienced by many managers and staff during the transition to QA. To manage this process of change, QAP has been integrating the "change strategies" of coaching, team building, and rewards and recognition, into much of its technical support.

Coaching

When implementing quality assurance, the Quality Assurance Project has frequently found there is little pre-existing institutional infrastructure to support implementation of newly learned skills and knowledge when trainees return to their work setting. In some cases, a "coach" is utilized to not only help a team to apply and adapt the various skills and techniques of QA, but to provide the emotional support needed to bring about behavior changes. For example,

> A training plan in QAP/Egypt included not only a training needs assessment and a training curriculum, but also a plan for supporting the implementation of new knowledge and skills into every day practice.
>
> After training was given to Operating Room nursing staff and supervisors to improve their technical and supervision skills, QAP employed an experienced full-time consultant, or coach, to work with the nurses in their home hospital for a period of 6 months. The consultant provided a role model for the supervisors and nursing staff as they implemented new skills and knowledge, and gave continuous on-the-job training when needed.
>
> This approach served to re-enforce correct implementation of newly learned skills by the nurses and helped supervisors to assume responsibilities in training staff and maintaining technical standards.

Similarly, in Tahoua, Niger, QAP has learned that resources for post-training support must be identified as part of any QA change strategy. In the case of Tahoua, coaches are individuals within the health care system who were selected for their demonstrated aptitude with the new material and who subsequently received special training to provide technical support to active Quality Improvement Teams (QITs) throughout the region.

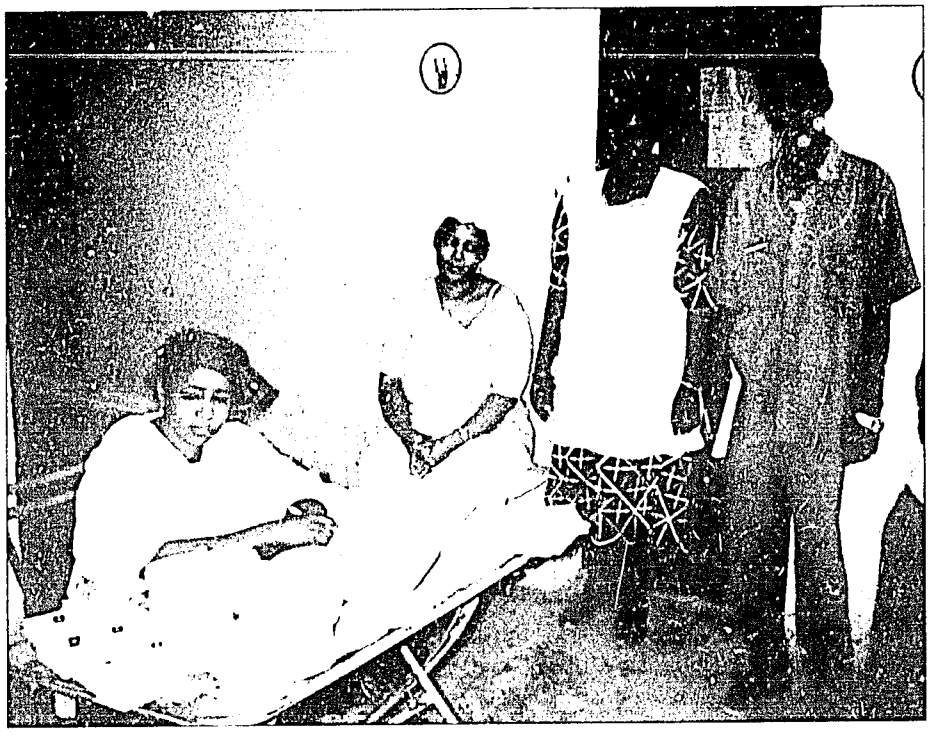
The purpose of the coaching visits were to encourage the QITs to pursue the problem solving initiated in their training, to lend technical support, or to clarify the use of the problem-solving tools.

Most team members have commented that the coaching visits were indispensable in encouraging the members as they follow the problem-solving process. They felt that the coaching helped them overcome their feelings of helplessness when the solutions seemed beyond their control. They also helped to adapt the QA approach to the Tahoua experience. The team members felt that the techniques of QA were important and the problem-solving was logical, but change in behavior could only come with adequate coaching support after their training.

Team-building

Team building, a process of working with team members to create an effective team, may be required to help team members identify and overcome obstacles to effective performance.

For both the Micronutrients Initiative in Egypt and the Jordan QA Program, a special training course was developed for the purpose of enhancing teamwork. The course enabled participants to better understand the importance of teams in quality management, acknowledge the roles of individual team members, apply effective meeting skills, use effective communication techniques, employ appropriate decision-making strategies, and manage conflict.



Routine coaching visit in Tahoua, Niger.

Rewards and Recognition

Rewards and recognition for those who are implementing quality assurance are also important. Such recognition can be as informal as letting a person know that he/she is doing a good job, or it could take the form of certificates or public and professional recognition.

> **In Jordan,** it was felt that a recognition and reward system for people working in QA should be designed and instituted early in the process. This would include an incentives system to encourage people to be involved in QA, but which doesn't necessarily include monetary incentives.

QA staff in Jordan introduced the idea of giving out certificates of achievement to QA workshop participants. Also, they began recognizing teams with plaques, newspaper announcements, letters of gratitude from the general directors, certificates of excellence given to deserving individuals by a special committee, and authorship of articles in the local newsletter.

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Institutionalization Issues for Quality Assurance Programs

Lori DiPrete Brown, M.S.P.H., Deputy Director, QAP

In order to achieve and maintain all the potential benefits of quality assurance, it must become a routine activity within health care organizations. Moreover, a structure which assures quality must be integrated into the overall health system. The following discusses lessons learned during efforts to institutionalize QA programs in Chile, Jordan, Costa Rica, Niger, and Egypt.

What is Institutionalization?

Institutionalization of QA is achieved when essential and appropriate QA activities are carried out effectively on a routine basis throughout an organization, health system, or health sector. Quality assurance activities can be said to be fully institutionalized and sustainable when expertise, commitment, and resource allocation are sufficient to apply, adapt, sustain, and further develop the QA approach.

The following are five important elements in a fully developed QA program:

1. *QA Structure*
2. *Standard Setting Activities*
3. *Monitoring Activities*
4. *Quality Improvement*
5. *Culture of Quality*

A "culture of quality" is the most intangible, and arguably the most important element of a QA program. While the culture of quality engendered in each organization will vary a great deal, there are several common characteristics. The achievement of quality should be seen as possible and feasible within the system. While this assumption may be realistic in many developed country settings, instilling this confidence in developing country health systems is often a big challenge. Quality care should be explicit and be understood as a central objective of the system by all. Furthermore, each member of the health team should feel that "quality is my responsibility." Finally, some belief in the use of teams and teamwork should be present.

Below are some of the lessons learned from our many experiences. Though many of them will reiterate lessons learned in other sections of this issue, they underscore the need for a comprehensive approach to effectively institutionalize a QA program.

A QA structure should be developed gradually.

Efforts to define a QA structure often err on the side of completeness, trying to anticipate all the committees and structures that will be needed to implement QA in an organization. As a result, too many committees may be formed at the outset, leading to an excessive number of meetings and to unfocused QA activities.

It is often better to develop the QA structure gradually as needs arise, so that committees and working groups have clearly understood functions and concrete tasks. Letting the QA structure evolve slowly helps to develop the program in a more efficient way, and avoids setting up systems that have to be corrected or discontinued later.

Defining a flexible, but standardized methodology for QA is important. In defining a methodology for a QA program, it is important to strike the correct balance between standardization of the methodology to insure quality, and flexibility to allow for local adaptation.

Close alliance with the existing Ministry of Health (MOH) structure is essential.

Developing an effective partnership with and basing QA efforts in existing structures can lead to successful institutionalization of QA in even the most difficult circumstances.

In Niger, our partnership with the Departmental Health Director and his staff have been critical to initiating QA in the region. This alliance has also ensured that our efforts to introduce QA methods and tools through existing health support systems have been appropriate and effective.

The Niger QA program has since been working to improve supervision and management information systems. The results have been the establishment of trust and local support for the project, rapid integration of QA methods, and fundamental changes to key management systems.

Gain and sustain political support from various actors in the health sector.

Regardless of whether the QA program aims to work only in the public sector, or throughout the health sector, support will be needed from senior MOH Officials, leaders in the non-government sector, medical associations, universities and clinical experts, health clinic and hospital directors, health providers, and members of the health team who provide support services.

This support is needed because medical practitioners look to these sources as authoritative voices about what constitutes state-of-the-art medical practice. Physicians and nurses are more likely to accept and practice QA if they feel accountable to their peers as well as to senior managers in the system.

Be prepared to deal with frequent changes in personnel at all levels.

Turnover of personnel, from the Minister of Health to the doctors and nurses who direct rural health centers are real impediments to developing a culture of quality and sustaining political advocacy.

This frequent turnover is common among developing countries. For QA activities to be successful, it is probably best to expect this and develop appropriate strategies. For example, when planning training activities, they should be carried out close to the time of implementation, so that most of the trained staff will be able to participate in the implementation.

Awareness of the QA program must be sufficiently widespread and include the higher management levels. In this way, newly appointed officials (ministers, etc.) can be held accountable for the pursuit of quality, and cannot easily dismiss the quality initiatives that have taken place. In many institutions, there is often a core of senior technical staff less vulnerable to turnover. Leadership and technical skills must be developed in their ranks if QA programs are to survive staff turnover, reorganization, and political change.

Making extra funds available to QA programs has implications for financial sustainability.

A strategic issue that arises during the course of QA start-up planning, especially in settings where resources are scarce, is whether or not the organization or an external agency should make extra funds available for the development of QA projects or special activities such as orientation seminars and training. Such funding can provide incentives to test the introduction of QA. It could be argued that once it has been proven successful, health professionals will be willing to do QA without external financial incentives.

On the other hand, a QA program may be less sustainable if it is predicated upon additional funding. The available budget may be insufficient to continue support. It is possible from the outset to negotiate future funding, by making clear the purpose of the initial funding and its temporary nature.

Institutionalization Issues for QA Programs continued on page 26

Institutionalization Issues for QA Programs continued from page 25

The amount of funding is also important; it should be high enough to provide incentives, and low enough to avoid causing imbalances in the prevailing health system. Even if the issue of sustainability can be addressed adequately, financial incentives may detract from the message that better quality does not always require additional resources.

In Chile, small-scale quality improvement projects and training courses were funded during the first 2 years of the project. Also, during the first year, the QA project paid for some staff support for the MOH quality unit. Over time, however, these costs were taken on by the Ministry of Health and the local health systems. Thus, the program was financially self-sustaining after 2 years.

After only one year of the QA micronutrient effort in Egypt, the Egyptian contribution covers approximately 80% of the costs of both financial and human resources contributed to these QA activities. The MOH and the Health Directorates have developed a plan to sustain the program by maintaining teamwork and expanding similar QA work in other governorates.

In the QAP program in Tahoua, Niger, a QA approach has facilitated the design and implementation of more efficient processes which have reduced waste and ultimately cost. However, given the resource-poor health management system, some activities require continued financial support. It is likely to stay this way for some time to come.

At present, the QAP is supporting activities such as quarterly staff meetings and supervision visits. Unfortunately, the MOH is unable to absorb the costs for current activities, and expansion to other Departments is not likely. In Niger, institutional and financial sustainability are particularly difficult because of the country's extreme economic dependence on donor assistance for most of its healthcare.

In the last year, responsibility for the delivery of public health care in Costa Rica has been transferred to the Social Security Administration. With essential support from the head of the Human Resources Department, a central Quality Assurance Committee has been formed and a budget allocated. This committee has taken charge of all local costs associated with training and implementation of hospital process improvement activities in two regions of the country.

The idea of quality is powerful.

The definition of quality in all its dimensions might be mystifying to some, dry to others. But in fact, it has proven to be a very powerful tool for creating a culture of quality. Our QA activities have clearly demonstrated success in creating this culture when people at all levels are given a chance to define quality for themselves and to understand what it means for their work.

Once ideas about quality are internalized, it produces a profound transformation. The dimensions of quality become a lens through which health providers can see everything that they do. It gives them a common vision and a shared language with which to discuss their work and set about making improvements.

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Organizational Conditions That Favor Institutionalization of a QA Program

Some organizations or health systems possess characteristics that make it easier to launch a successful QA program. While the absence of these characteristics does not mean it will be impossible to start a program, program development and expansion may be slower when these conditions are not met. In some cases, the establishment of a fully developed QA program may not be possible until these characteristics are present.

There is top-level support for QA.

Top-level leaders must provide ongoing support for the QA effort. While they need not be involved in day-to-day activities, it is important that they send a consistent message about the importance and seriousness of QA.

There is a quality assurance "champion".

In addition to top level support, it is also helpful to have a "champion" within the system who will lead the QA effort and be personally identified with the effort. The champion should have leadership qualities, enjoy the respect of colleagues, and have the ability to motivate others.

Organizational systems are relatively developed and stable.

Mature management and administrative systems within the organization or system will greatly enhance the likelihood of success of the QA effort. Systems that are stable at their base are more able to develop and sustain new programs and activities.

QA supports the organizational or health system mission.

Establishing a direct and visible link between the QA program and an organization's raison d'être is a prerequisite for institutionalization. This link needs to be clearly established so that all members of an organization understand that QA serves their overall mission.

There is an existing system or activity that provides a foundation for the QA program.

It is much easier to build on existing systems rather than developing systems from scratch. If QA activities are already ongoing in the organization through supervision, monitoring, day-to-day management or special committees, QA programs can be developed around these activities so that they have more impact and increased prominence in the organization. In the case of national programs, QA programs may be built around existing expert bodies (i.e. accreditation bodies or governmental groups) or professional organizations.

Adequate time and resources are available.

Staff must have the flexibility to shift some of their regular activities to spend time on the QA effort. QA activities may also incur some financial costs related to data collection, documentation, and transportation. Without the commitment of staff time and modest financial resources, it will be hard for the team to get started. Furthermore, members of the organization may doubt the commitment of top-level leaders if allocations of time or money are not made.

The Q.A. Brief is available free of charge to health professionals worldwide. Those interested in receiving future issues of the Q.A. Brief or any other Quality Assurance Project publications should contact:

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