MAQ PAPERS

Managing Programs to Maximize Access and Quality: Lessons Learned from the Field

INTRODUCTION

Great strides have been made in the last decade in awareness of and commitment to quality of care in reproductive health and child survival programs. More and more countries are adopting the Programme of Action of the 1994 International Conference on Population and Development (ICPD) held in Cairo. Managers are learning that emphasizing quality leads to results: it makes programs more effective and efficient, helping to attract and retain clients and to reduce costs. Today there is broad consensus about the importance of quality. Instead of explaining quality's importance, we are able to focus on the lessons that have been learned about how to build quality improvement into service delivery programs.

In this paper, we are speaking to the program leaders and donor agencies that are responsible for allocating resources for service delivery programs. We provide guidance on the actions that must take place to improve the quality of reproductive health and child survival programs. This guidance is based on the field experiences of members of the Management and Supervision subcommittee of USAID's Maximizing Access and Quality (MAQ) Initiative. It results from multiple discussions, including a moderated electronic forum, held over the past three years. While we acknowledge that much remains to be learned about strengthening quality through management and supervision, we are heartened by the increased attention being paid worldwide to these important issues.

This paper concentrates on quality of care as it affects the entire population of persons in need. Access to services is a vital dimension of quality: a program that provides excellent care to individual clients but presents barriers to others or fails to reach all those in need cannot be considered of high quality. A quality program must provide both its current and potential users with access to a range of services that reflect their reproductive health goals. Thus, the issues and strategies discussed in this paper with relation to quality improvement apply also to the question of access.

The paper begins with an overview of the key principles of program quality that must be understood at all levels. We then focus on the actions that must occur at the national program leadership, district, facility, and community levels in order to improve the quality of reproductive health and child survival programs. Finally, we discuss incentives that can recognize or motivate quality initiatives.

MAQ PAPERS

Managing Programs to Maximize Access and Quality: Lessons Learned from the Field

AUTHORS

Wayne Stinson
Management Sciences for Health

Lynn Bakamjian
AVSC International

Sallie Craig Huber
Family Planning Management Development Project,
Management Sciences for Health

Diana Silimperi
Quality Assurance Project,
Center for Human Services,
University Research Corporation

This MAQ paper was produced for the MAQ Initiative by the Family Planning Management Development project of Management Sciences for Health.

The development of this paper was supported by the Center for Population, Health, and Nutrition of the United States Agency for International Development. This paper does not represent official statements of policy by USAID, or the position of the organizations represented by the authors.

MAQ PAPER VOL. 1, NO 3 · 2000

KEY PRINCIPLES OF QUALITY

Quality in programs does not just happen; leaders at all levels must promote it continuously through word and deed. Doing so requires investing in quality improvement and taking a customer orientation.

Quality improvement requires that the program invest in its staff and systems, improve its use of existing resources, and use a "customer orientation" both with clients and staff.

Investing in Quality Improvement

To improve program quality, those in charge must provide for developing appropriate policies and systems at every programmatic level. Investing in such changes must be done systematically and over the long term, in order for the resulting improvements to be sustained.

Investments in quality have traditionally focused on material inputs and training of staff members. We have learned that investments must also focus on processes—the *ways* in which resources are used. Namely, leaders must not only provide verbal commitments to improve

This paper is a publication of the Maximizing Access and Quality (MAQ) Initiative—an initiative of the United States Agency for International Development (USAID), collaborating agencies, country partners, and other collaborators to apply state-of-the-art methods to maximize access to and the quality of family planning and other selected reproductive health services.

The four authors of this paper are current or past chairs of the Management and Supervision subcommittee of the USAID MAQ Initiative. The views and experiences represented in this paper reflect deliberations from a series of subcommittee meetings over a two-year period (1997-1999), as well as discussions occurring via an Internet listserv on supervision. Participants have included quality specialists from most USAID reproductive health and child survival cooperating agencies, including John Snow International (especially the SEATS Project); Management Sciences for Health (FPMD Project); University Research Corporation, Center for Human Services (Quality Assurance Project); AVSC International; Pathfinder International; the International Planned Parenthood Federation; JHPIEGO; the Johns Hopkins Center for Communication Programs; and INTRAH. Drafts of this paper have been widely circulated within the MAQ community and reflect extensive comments and suggested revisions.

quality; they must follow up their commitments with actions to make the entire system support quality. Actions that count include:

- investing in effective supervision and in-service training;
- providing systemic support for service delivery needs, including pharmaceutical supplies and contraceptives, transport for referral and supervision, and facilitation for problem-solving;
- encouraging effective use of information for identifying and resolving problems and making services more client-friendly;
- recognizing staff members for quality improvement.

These quality improvement efforts must focus not only on technical standards of care, but also on the individual client's needs and wants.

In committing themselves to quality, leaders may need to recognize and resolve inconsistencies in what they promote. Managers at all levels must balance their desire for quantitative outputs with their focus on quality. They must pay attention to ways in which quantitative goals, when expressed as targets for service providers, may introduce inappropriate pressures or may conflict with quality. They must express confidence that quality, as perceived by users, will increase effective access to services, appropriate utilization, and continuation rates. Full commitment to quality will result in expanded access and responsiveness to users, which are factors that contribute to longer-term demographic objectives.

Taking a Customer Orientation

A fundamental principle of managing for quality is that programs must concentrate on the needs of both the women and men who use their services and those who might use their services in the future. These actual and potential users should be viewed as "customers": individuals with their own quality expectations, needs, and rights to decide for themselves whether or not to seek and use reproductive health services.

Customers—both internal and external—are the heart and soul of quality programs.

IPPF Framework: Clients' Rights and Providers' Needs[1]

Clients' Rights

- *Information* about family planning
- *Access* to all service delivery systems and health care providers
- *Choice* of adopting, switching, or discontinuing methods
- *Safety* in the practice of family planning
- *Privacy* during discussions and physical examinations
- *Confidentiality* of all personal information
- To be treated with *dignity*, courtesy, consideration, and attentiveness
- *Comfort* while receiving services
- *Continuity* of care for as long as the client desires
- To express their *opinions* about the quality of services

Providers' Needs

- *Training* on technical and communication skills
- *Information* on technical issues, updated regularly
- *Infrastructure,* including appropriate physical facilities and efficient organization
- *Supplies* of contraceptives, equipment, and educational materials
- *Guidance* from service guidelines, checklists, supervision
- *Back-up* from other providers and levels of care
- *Respect* and recognition from co-workers, managers, clients, and community
- *Encouragement* to provide good quality of care
- *Feedback* from managers, supervisors, other service providers, and clients
- *Self-expression*, so that managers consider their views when making decisions

This customer orientation provides a new perspective for program management as well: front-line providers are also seen as customers of the overall service delivery system. As *internal* customers, service providers require supportive management and supervision, readily available and appropriate supplies, and regular development and updating of skills.

The customer orientation is embodied in IPPF's Clients' Rights/Providers' Needs framework (see previous page), which addresses the needs of both internal and external customers. This framework is a basic reference document on managing for quality in reproductive health and child survival programs.

Professionals play a key role by developing technical definitions of quality. These definitions add technical specificity to clients' otherwise imprecise expectations of safety and efficacy, informed choice, and even privacy. The definitions must be codified and communicated through norms and standards, which must clearly state the quality expectations of individual workers and service sites.

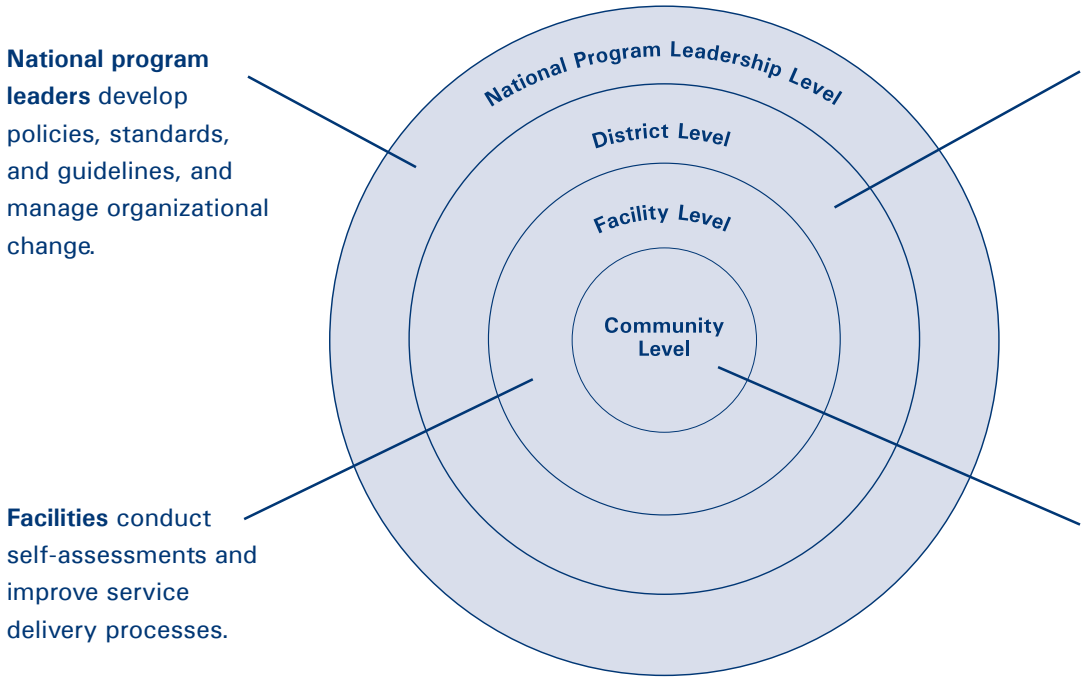
In operational terms, quality means consistently delivering the services that best meet both client and professional expectations within prevailing resource constraints. Acceptance of resource constraints is essential. Even the poorest program in the world can advance toward quality using its existing resources, as long as the program ascertains, records, and communicates both its clients' needs and its professional standards.

HOW TO IMPROVE QUALITY AND ACCESS

Program staff members at all levels, as well as customers, must agree on the quality objectives of the program. They must then engage in continuous efforts to improve the program's quality—without becoming disappointed if their quality expectations are not achieved immediately. As shown in the graphic below, everyone from the national program level to the community plays a role. In this section, we address how to manage for quality, emphasizing the actions needed by national program leaders, middle managers, facility staff members, and consumers.

Manage quality holistically, through integrated services and systematic managerial improvements.

Quality Management Responsibilities at Multiple Program Levels



Isolated quality interventions, however strong individually, will not create organizational change and a system-wide customer orientation. Quality improvement requires:

- systematic action, addressing the root causes of problems and simultaneously strengthening related management processes;
- integration of technical interventions (such as family planning, women's health, and child health), because quality cuts across vertical service delivery programs;
- management of change, because improvement usually necessitates both individual and organizational commitment to new or different behaviors, attitudes, and (in some cases) values.

There is no single route to quality. Some common approaches to quality improvement (some of which are associated with specific cooperating agencies) include:

- continuous quality improvement or CQI, which focuses on gradual but sustained improvements in service delivery through team-based problem solving;
- Client Oriented, Provider Efficient or COPE, which focuses on self-assessment and self-improvement at the clinical level;
- medical monitoring (or quality control) of clinical services, which emphasizes inspection of quality at the output level;
- facilitative or supportive supervision, which seeks to change one of the most influential quality support systems—supervision—from its traditional form of inspection to the more appropriate facilitation and coaching role;
- quality assessment or situation analysis, sometimes in the form of peer review or self-assessment, other times managed by external groups;
- accreditation or certification, a process to verify that a particular institution, service, or individual has met clearly defined standards;
- performance improvement or PI, a step-by-step process to evaluate the factors needed for good performance, to reveal the root causes of problems, and to identify potential solutions, which may or may not include training;
- quality assurance or QA, which includes definition of standards, the design of optimal processes to achieve quality, routine assessments in relation to standards, and continuous efforts to bridge the gap between standards and actual performance.

These approaches are not mutually exclusive, in fact several (for example, quality assurance) include elements of more than one approach. The commonalities of the different approaches are greater than their differences. As such, practitioners can apply a single approach or elements from several approaches, as seems most appropriate and feasible in their setting. Uncertainty about how to apply or combine approaches should not be used as an excuse for inaction.

There is no single or preferred place to begin working on quality. Some programs start at the national program leadership level, while others start with a few districts or clinics, depending partly on motivation and financing. Decentralized systems may proceed differently than highly centralized systems. In the end, the best thing to do is to launch the quality effort, at whatever programmatic level or levels seem most prepared for action. Below we enumerate the actions that must be taken throughout the system, by leaders at the national program level, middle managers at the district (or regional) level, providers and staff members at the facility level, and consumers in the target community.

What to Do at the National Program Leadership Level

At the level of the overall program, leaders have the important role of creating a climate focused on quality. They must do this by articulating the vision through policies

Program leaders set the tone, provide the resources, and reward those who promote quality.

and standards, developing guidelines, and providing recognition for quality improvements. These tasks also require leaders to define the organizational structure of the quality improvement effort. We discuss each of these responsibilities below.

Articulating the Vision. Leaders must provide both moral leadership and material support to the quality effort. This dual role involves articulating a vision of quality and championing that vision throughout the institution (or program) at all levels and across all functions. Specific actions leaders should take include:

- setting a national or system-level health policy that fully incorporates a quality focus;
- allocating adequate resources for managing the quality process;
- developing national standards and guidelines;
- promoting mechanisms for communicating standards through the system;
- setting the agenda for managing change and focusing on quality throughout the system.

Developing Guidelines. The MAQ Initiative has provided much guidance on the process of guidelines development (for a summary of the May 1998 conference on this topic, see http://www.intrah.org/quality/guidelines/index.html).[2] Once developed, technical standards and guidelines must be disseminated at all levels and through multiple channels, including training and supervision. An important lesson learned is that standards and guidelines should serve as the basis for training and supervisory activities. Leaders should ensure that standards and guidelines are communicated through:

- consistent and up-to-date training curricula;
- technical reference sheets (job aids);
- supervision tools and procedures;
- individual job descriptions;
- indicators used for monitoring and evaluation;
- rewards for positive behavior.

Providing Recognition. Leaders must pay particular attention to local-level improvements, not simply to reward the hard work of individuals and teams, but also to identify promising improvements that should be replicated. Their behavior should demonstrate to everyone throughout the system that:

- quality—and particularly a client focus—really matters;
- good quality (as well as efforts to improve quality) will be rewarded;
- poor quality will be remedied as quickly as possible.

Later in this paper we provide examples of ways to reward both quality and efforts to improve quality.

Defining the Organizational Structure. A very common debate at the leadership level concerns the appropriate organizational structure to support quality assurance. Specifically, does quality require a dedicated program unit with an identified director and staff members, or is it better managed as a universal responsibility without its own structure? While there is no scientific way to answer this question, we found consensus that quality does require special leadership and visibility, along with clear assignment of roles and responsibilities for carrying out quality assurance interventions.

Commonly, leadership emanates from an inspired individual (regardless of organizational affiliation) rather than from a bureaucratic unit. However, the most effective organizational structure for quality assurance seems to evolve over time. For example, during the early stage of initiating quality improvement, some managers find that creating a special unit is useful (see the example from Uganda on the next page). As programs mature, maintaining quality often becomes a shared responsibility, which is incorporated into existing job descriptions and roles. Throughout this process, it is crucial for leaders to institute and support change management efforts that will facilitate the adoption of new ideas and behaviors.

What to Do at the District Level

The job of district management teams is to help service providers do *their* jobs better. This requires supportive management systems as well as facilitation for problem solving. Like the national program leaders, district teams must also recognize and reward both good quality and efforts to improve quality. In particular, the district team's role is to serve as the liaison between the national or program level and the facility level, and to strengthen four support systems: supervision, logistics and supply management, referral, and monitoring and evaluation. These responsibilities are discussed below. District teams must also assist facility teams to play *their* roles in quality management, as explained in the section, "What to Do at the Facility Level."

District teams must manage systems for quality, especially supervision, logistics, referral, and information systems. Facility teams can only be as strong as the management systems that support them.

The Role of a QA Unit: Example from Uganda[3]

The Ugandan MOH established a Quality Assurance Unit in 1994 to express the government's great interest in quality. The Unit's role was to coordinate national standard setting, supervision, and process improvement activities. The Unit worked with programmatic departments to ensure that standards were updated and that supervision from national levels to districts was properly guided, and to facilitate problem solving at the national and district levels. In 1998, the MOH further expressed its commitment by upgrading the Unit to a Department and promoting its head to become the Director General for Health—the highest civil service position within the Ministry.

Serving as Liaison Between the Program and Facility Levels. District teams play a major role in integrating quality improvement into the ongoing work of the service site and its management support team. They serve as the glue linking the policies and expectations set at the central level with the reality of service delivery at the local implementation level. As a result, the district office is often one of the best places to begin quality improvement activities.

Many district managers have the responsibility of operationalizing and communicating national technical standards. Typically, operationalizing the standards requires making decisions about which facilities have the resources to perform which services; allocating resources to ensure adequate manpower and supplies; developing systems for referrals among facilities; and even distributing responsibilities within individual clinics. Communicating the technical standards may occur through reference tools and supervision, but district teams most effectively demonstrate their commitment to standards when they ensure that guidelines are achievable and that facilities have the necessary resources and other support.

For district teams, health care providers are internal customers whose specific needs must be met if the program as a whole is to move towards quality. These customers' needs include supportive management and supervision from the district teams. Specifically, the district should provide:

- clear, practical, and achievable standards for health worker performance;
- appropriate and well-maintained equipment;
- readily available supplies;
- communications support for behavioral change;
- effective referral systems;
- staff development opportunities and technical updates;
- sympathetic (facilitative) assistance in solving problems;
- appreciation for a job well done and, conversely, reminders when performance is below standard.

Region-District Collaboration in Support of Services: Example from Niger[4]

In Niger, the Tahoua Regional Health Director's Office applied a quality management approach to newly decentralized management and control functions. The Regional Office worked with all eight District Management Teams to redesign service delivery processes and to set standards considering client, community, and provider needs and expectations. The District Teams measured and monitored performance and facilitated continuous process improvement and problem-solving activities. Regional and District Management Teams developed a supervision guide to assess health worker performance and implement an improved supervision strategy based on problem solving and supporting facility-level quality improvement teams. An assessment by the Quality Assurance Project found that those health facilities with active quality improvement teams performed significantly better on a variety of quality indicators, including compliance with sick child care standards and general management and cleanliness of facilities. The Tahoua experience shows that measurable gains in the quality of services are possible by motivating and empowering local health workers even when health system resources are severely limited.

Strengthening Supervision. Supervisors of service providers play two critical roles in improving quality. In one role, they are the essential program communicators: they disseminate information about the importance of quality and the content of specific standards from senior leaders to service providers, and they disseminate information from service providers to planners and senior leaders about quality expectations and support requirements. In the other role, they are essential facilitators of change, since they are the people best placed to train local teams in self-assessment and process improvement. They are, in other words, key promoters of facility-level changes.

The key function of modern supervisors is to support facilities and communities in managing local quality improvement efforts.

Few supervisors are equally proficient in both functions. Fewer still have the material and moral support they need from program leaders to do their jobs. They cannot meet the quality needs of their supervisees unless they themselves receive appropriate technical updates from the training department, timely data from the information system, and prompt per diem payments from financial managers. As a result, the supervision system should be a primary focus for systematic quality improvement efforts.

At the district level, quality improvement programs commonly do the following for supervision:

- ensure that the supervisors themselves understand and support the program's technical standards as well as the mandate for responding to client needs;
- review and clarify supervision policies and procedures, to ensure that supervision occurs when needed and involves the most appropriate people;
- assess how supervisors currently do their field work, attempting to bridge the gaps that frequently exist between supervision policies and typical practices;
- design checklists and other job aids;
- develop coaching and facilitation skills among supervisors, to reduce the use of typical "policing" or inspection approaches and increase support for local problem solving.

Improving Supervision to Improve Quality of Care: Example from Uganda[5]

The Ugandan Quality Assurance Department has collaborated with technical program units to develop quality standards and train district teams in quality management. They assessed reproductive health supervision practices in 10 districts, revised supervision policies, and developed checklists and other tools for flagging significant problem areas. They are currently developing strategic supervision approaches, such as using "flag" indicators to identify the key facilities in which technical supervisors are most needed.

Strengthening Logistics and Supply Management. The importance of dependable supply systems cannot be overemphasized. Without supplies, health care providers cannot treat sick children, contraceptive users risk significant gaps in coverage, children thought to be immunized may receive ineffective vaccine (due to cold chain problems), and potential clients may simply stay at home because they lack confidence in clinics.

Problems in supply management may involve the commercial sector, national warehouse, or other entities beyond the influence of district teams. Even in these cases, however, the district teams should:

- assist providers to prescribe appropriate medications and ensure their appropriate use;
- train and supervise facility staff members in procedures for managing available stocks and reordering promptly;
- identify and analyze system breaks between the district and clinical levels;
- respond as promptly as possible to requisitions;
- promptly communicate district and facility needs to higher levels, following up and at times even applying pressure on regional and national authorities when needed to get results.

Improving Logistics to Improve Quality of Care: Example from Niger[6]

The Tahoua Regional Health Director's Office in Niger noted that gas bottles used to sterilize equipment and keep refrigerators working were frequently unavailable for periods of up to three months because empty bottles were not promptly refilled and returned to service. Focusing on a few select measures (number of gas bottles lost, number of cold chain interruptions) as well as client needs, the regional team designed an efficient management system for the region that will ensure the distribution of essential vaccination materials including gas bottles, and improve the quality of health services provided to patients.

Strengthening Referral. Referrals from one facility to another for specialized care are an important element of any health care system. There are likely to be two significant problems with referrals: individuals in dire need may not obtain appropriate higher-level care; and individuals who should start with lower-level care may bypass it and overburden the specialized facilities. Both problems affect the quality of patient care; in the first case, untreated conditions often worsen and may lead to death, and in the second case, specialized facilities may become distracted from managing the serious cases for which they were intended.

To support quality improvement in referral systems, district teams should:

- develop and disseminate technical guidelines that indicate clearly which services may be provided in which facilities, and which require referral;
- ensure (through supervision) that service providers identify, refer, and facilitate transport for those in greatest need;
- strengthen district communication and transportation systems;
- assess reception and case management practices at referral centers;
- organize and facilitate teams—including community, facility, and hospital representatives—to analyze and consider solutions to referral problems;
- reduce unnecessary self-referral, to enable reference facilities to concentrate on the most urgent cases.

Increasing Referrals to Improve Quality of Care: Example from Zimbabwe[7]

The Zimbabwe National Family Planning Council (ZNFPC) discovered that community-based distribution agents (CBDs) rarely referred clients to clinics. In response, ZNPFC undertook a four-year effort to revise training, hold joint workshops for CBDs and nurses, and publicly recognize CBDs with high referral rates.

Strengthening Monitoring and Evaluation. Quantitative information about health worker performance, compliance with technical standards, and clients' perceptions of quality is vital for developing and monitoring quality improvement strategies, yet district teams often depend on personal impressions, rather than data. Assessments by the PRICOR Project and the Quality Assurance Project have shown that these impressions are often too optimistic.[8]

District teams must support quality improvement by making efforts to strengthen the information base. They should:

- assess and strengthen (or support efforts to strengthen) the routine information systems;
- analyze information at the district level and provide feedback to facilities;
- support periodic (at least annual) quality assessments;
- develop the skills of facility staff members to assess their own work;
- encourage providers to seek client feedback.

District teams can work with representative service providers to perform a local quality assessment.[9] Typically, assessment teams spend three to five days identifying local priorities and developing simple data collection tools. They then spend approximately two weeks interviewing and observing service providers in order to compare technical norms with actual practice. In a follow-up workshop, they use the information to develop district-wide quality improvement strategies.

District data-collection efforts can make use of a variety of model tools that are available and intended for local adaptation. These include tools designed to help health programs assess quality, analyze problems, redesign processes, and improve quality. The following USAID Cooperating Agencies not only provide ideas through their periodic publications but also make tools available on their Web sites:

- Management Sciences for Health—the Electronic Resource Center (http://erc.msh.org);
- Johns Hopkins University—Reproductive Health Online (REPRO-LINE) (http://www.reproline.jhu.edu);
- AVSC International (http://www.AVSC.org);
- the Quality Assurance Project managed by the Center for Human Services, the non-profit affiliate of University Research Co., LLC (http://www.qaproject.org);
- John Snow, Inc. (http://www.jsi.com);
- the Population Council (http://www.popcouncil.org).

Assessing Quality Improvement: Example from Tanzania[10]

The Ministry of Health and Uzazi no Malezi Bora Tanzania or UMATI (the International Planned Parenthood affiliate) in Tanzania developed simple data collection instruments to evaluate changes in quality. These instruments, called the Quality Improvement Quotient (QIQ), were designed with easily observable indicators of quality organized within the familiar "clients' rights/providers' needs" framework, to enable the use of participatory data collection and analysis by clinic staff members with assistance from "facilitative supervisors." Both providers and supervisors reported that the QIQ complemented COPE and helped them to pinpoint various aspects of quality that required remedy in their sites and in the program as a whole.

What to Do at the Facility Level

Quality of care is most critical at the facility level, where health care providers serve community members directly. There is abundant evidence even from clinics without adequate resources that providers can do much to improve the quality of services.[11]

Service providers and staff members should feel that quality is their personal and group responsibility. They should apply proven quality management tools and approaches.

Providers and other staff members in service facilities—the facility team—need to focus on identifying quality concerns and determining the source of problems related to compliance with standards, as described below. Above all, they need to "own" quality: to acknowledge and take responsibility for quality. These ideas lie at the heart of modern quality management, and even managers of under-staffed, poorly-equipped facilities need to pursue them.

Specifically, facility teams can work with supervisors or facilitators to identify problems and opportunities for improvement by:

- ensuring compliance with national standards and guidelines;
- conducting periodic self-assessments and peer reviews of quality to identify any problems;
- encouraging colleagues to identify deficiencies in quality and suggest specific improvements, through staff meetings, suggestion boxes, and other means, some of which may be anonymous;
- encouraging both clients and those in need but not yet clients to articulate their needs;
- asking clients what they think about services, through informal questions and/or formal exit interviews;
- meeting periodically with community leaders and others able to articulate the needs of eligible but non-participating clients;
- setting up process improvement teams whose role is to analyze and resolve problems, using data to diagnose causes and test solutions.

When quality problems arise from non-compliance with standards, it is important to identify the reason for the non-compliance. Staff members may be unable to comply; may be unaware of the norms and standards they should be following, or may be reluctant to follow those guidelines. Each reason requires a different solution.

In those cases where the problems derive from staff inability to comply with official norms, the root cause may be that managerial support is inadequate or management processes are poor. Since such problems are often systemic, the search for solutions must be systemic as well. When waiting times are long, for example, the root cause may lie anywhere from the reception desk, to the health education unit, to the pharmacy. Causes at all levels must be considered, just as solutions must be sought both within and outside the normal hierarchy: a village mother may be as likely to offer a solution as a senior staff member. These cases generally require team-based problem solving. Teams should bring together all those individuals who affect or are affected by a particular problem. The group membership should vary in accordance with the nature of the problem.

In other cases, problems derive from ignorance of standard guidelines and procedures. For example, providers may fail to follow a malaria treatment protocol because it was poorly communicated and is misunderstood. Such cases are best managed through training and internal communication methods, such as supervision, job aids, and technical references.

Other problems result from weak motivation. It may be a provider's attitude that difficult tasks can be skipped, that efficient time management is not required, that clients' need for quality does not count. (A common and urgent example is the need for infection control within family planning clinics.) Providers' level of motivation may depend on how well their own quality expectations have been met. Providers' reluctance to comply with standards may also be due to inadequate reinforcement by supervisors. Health workers may know the technical standards and have the necessary support to comply, but sense that supervisors and managers do not find the norms important. Supervisors and managers must continuously reinforce norms. They may also use incentives to motivate staff members, as described in "Incentives for Quality," beginning on page 13 of this paper.

In all cases, supervisors need to remind providers of quality requirements and insist that they follow norms. They should also help to build a sense of responsibility and ownership for quality among service providers.

Supervisors can help providers appreciate that quality can make their professional careers more rewarding and also benefit others.

Clinic staff members who observe poor quality among their colleagues should:

- call their colleagues' attention to the problem and remind them of official norms;
- encourage clients to insist on receiving quality care from their providers;
- work with quality improvement teams to identify and resolve underlying problems.

As a necessary step for quality improvement, facility teams may have to accept difficult changes. They may find it necessary to reorganize the clinic or redistribute the workload in response to the problems they identify. For example:

- Quality assessments very often find that clients wait long periods for service and then receive only cursory attention because of apparent staff overload. As a result, clients may receive inadequate diagnoses and counseling because there is "too little time" for individualized care. The common solution is to hire additional staff members, when in fact the underlying problem may be inappropriate clinic organization and management. The actual problem may be that workers arrive late or that they concentrate their services in the morning and use the afternoon hours to complete data forms.
- "Integrated" family planning clinics may not even resupply existing clients when the formally trained worker is absent, because of a refusal to share responsibilities.

Changing such practices as these may be hard for clinic staff members to accept, but must be encouraged. Strong moral leadership is required from supervisors and other senior managers. Occasionally, technical support from outside the facility (for example, from specially trained facilitators) may also be required.

Process Improvements: Example from Kenya[12]

Since 1986, the Family Planning Association of Kenya (FPAK) has used a simple quality assessment and problem-solving process to enable providers to determine how care can be improved. This process, known as COPE, views clients as critical to the improvement process. At FPAK clinics today, service providers talk about their desire to relate better to clients, about wanting to hear clients' views, and about creating the kinds of services clients will want to recommend to their friends. Improvements have broadened the range of information provided to clients, adjusted clinic hours to more convenient and accessible times, reduced waiting times, and strengthened client flow and organization of work.

What to Do at the Community Level

The most important thing for health program managers and providers to do at the community level is to get community members engaged. Program staff members must encourage community members to articulate their needs routinely. They must listen as intently as possible to what people want and what they think they are getting, and above all they must act on the community feedback they receive.

Communities and individuals must articulate their needs and respond to educational messages.

A fundamental principle underlying quality efforts is that programs must focus on each client as an individual with unique needs. (See Clients' Rights/ Providers' Needs Framework on page 3.) The literature shows that improving quality offers practical benefits to both clients and programs; clients are more satisfied, and programs see an increase in the use of their services. However, many programs still rely on a

medical model of service delivery, in which clients are considered to be patients rather than customers, and services are driven by providers' schedules and abilities rather than by clients' needs and conveniences.

Quality improvement initiatives must therefore support providers and develop service delivery systems to treat clients as customers. Providers should:

- bear in mind that their "patients," as customers, have rights to information, to respectful and dignified treatment, and to autonomy in making decisions about their own health care;
- recognize that they may differ from their clients in terms of class, educational level, gender, and socioeconomic status;
- seek training and support from their supervisor to build the skills and behaviors to bridge these gaps through attention to better client-provider interaction and the supporting processes.

Increasing Client and Provider Awareness: Example from Nepal[13]

The Nepali government uses radio to create higher expectations of quality among both clients and providers. Through two complementary radio programs, a soap opera aimed at the public, and a distance education serial targeting health workers, the Radio Communication Project depicts providers as respectful and caring and shows clients participating in their own care. The programs have significantly improved providers' counseling skills but also—perhaps more importantly—heightened client awareness and led to user reminders to providers. Clients now know more about what providers should do and are thus able to reinforce the messages of the health worker programs.

Program staff members should always ask individual clients and communities what quality of care means to them. They should never rely exclusively on documents written by international experts or even drawn from other programs. To solicit input, they can:

- organize focus groups;
- conduct clinic exit interviews;
- support community surveys;
- do comparative analyses of service use and continuation.

INCENTIVES FOR QUALITY

Many programs assume that quality is its own reward, but this assumption is not always true. Individuals and teams who work for quality must be recognized and encouraged. Community and supervisory recognition, as well as professional satisfaction, provide strong incentives for further quality. By the same measure, those who implicitly or explicitly discourage quality need to be brought into quality improvement teams in order to change.

Those who embrace error and learn from it should be rewarded. Those who strive to improve quality should be recognized.

Examples of ways to recognize individuals or facilities for excellent quality include:

- logos or accreditation for clinics that meet specified quality standards;
- organizational newsletters with feature articles that highlight high-quality performance by individuals or teams;
- praise for good performance, provided during supervisory visits and preferably in the presence of other health workers.

Recognizing High Quality: Example from Egypt[14]

In 1992, Egypt launched a major effort to implement standards of quality with the goal of increasing client satisfaction and demand for services and reducing maternal mortality. This "Gold Star" program developed technical guidelines and step-by-step performance standards, implemented an extensive supervision system, and established 101 quality indicators. Almost 1,500 facilities have now met these standards, achieving "Gold Star" status; another 1,450 facilities show success on 90–99% of indicators. Client demand for services has increased at facilities that achieve at least 90% of indicators. In addition, the program has created a spirit of competition among facilities to achieve their performance objectives.

While individual rewards for quality improvement are rarely harmful, the opposite tactic—blaming individuals or groups for poor performance—can actually discourage quality efforts. The fact is that even an individual whose performance is very poor is probably not solely responsible. Individuals do not work alone; they operate within a system, and it is that system that determines the program's overall quality. The individual health worker who does not follow the latest technical guideline may never have been trained in it or may face strong peer pressure against doing things differently from the established practice. The clinic that records high levels of client dissatisfaction may be unable to meet clients' needs due to lack of essential supplies, rather than poor provider skills. The supervisor who makes only half as many supervisory visits as scheduled may lack fuel for transportation or may not have been reimbursed for past visits.

In these cases, it is critical to determine why the problems occur and to respond to staff members' support requirements. To foster an environment in which quality problems are discussed and resolved sensitively, managers and providers should:

- seek out and address the underlying reasons for poor performance (see the list of reasons for non-compliance in "What to Do at the Facility Level," on page 10);
- identify those who implicitly or explicitly discourage quality improvement efforts, and integrate them into quality improvement teams where their needs and ideas can be addressed;
- create teams whose role is to examine problems and errors, identify the contributing factors, and develop solutions.

CONCLUSION

This paper has outlined broad strategies for approaching persistent quality problems in reproductive health and child survival programs, as recommended by members of the Management and Supervision subcommittee of USAID's Maximizing Access and Quality Initiative. It has been written for those best able to influence broad strategies, particularly funding agencies, senior government officials, and program managers. The many tools, techniques, and detailed technical approaches that exist for managing quality have not been described here, but should be referenced as quality improvement efforts proceed.

Our subcommittee's work over the last several years makes clear that there are no magic bullets for quality improvement. Many technical approaches exist; there is no single route to quality, no one best place to get started, and no ideal approach to improvement. There are, though, two best practices for quality improvement: namely, to start on it now and to plan for the long term. Sustainable levels of quality cannot be achieved overnight. They must be worked toward, with expectation of slow but continuous improvement over the long term. Quality can be improved, at an affordable expense, but programs should look for gradual and sustainable processes rather than quick fixes. ■

NOTES

1. C. Huezo and S. Díaz, "Quality of Care in Family Planning: Clients' Rights and Providers' Needs," in P. Senanyake and R.L. Kleinman, eds., *Family Planning: Meeting Challenges, Promoting Choices: The Proceedings of the IPPF Family Planning Congress, New Delhi, October 1992* (Pearl River, New York: Parthenon Publishing Group, 1993): 253–244.
2. See also USAID and PRIME Project, "MAQ From Guidelines to Action: Report of a USAID-Sponsored Conference, May 12–13, 1998" (Chapel Hill, NC: Program for International Training in Health [INTRAH], University of North Carolina, 1998).
3. W. Stinson, personal notes from field visit, 1998.
4. S. Legros, Y. Tawfik, et al., "The Niger QAP/BASICS Project: Final Evaluation" (Bethesda, MD: The Quality Assurance Project and BASICS Project, 2000). E. Kelley, C. Geslin, et al., "The Impact of QA Methods on Compliance with the Integrated Management of Childhood Illness Algorithm in Niger," *Operations Research Results* 1, no. 2 (Bethesda, MD: Quality Assurance Project, 2000).
5. G. Burnham and W. Stinson, "Assessing the Quality of the Supervision of Reproductive Health Services in Uganda," *QA Brief* 7, no. 1 (Bethesda, MD: Quality Assurance Project, 1998).
6. L. Winter, M. Boucar, et al., "Niger Country Report: Tahoua Project" (Bethesda, MD: Quality Assurance Project, 1998).
7. A.J. Kols and J.E. Sherman, "Family Planning Programs: Improving Quality," *Population Reports* series J, no. 47 (Baltimore: Johns Hopkins University School of Public Health, Population Information Program, November 1998): 16.
8. Ministry of Health and Quality Assurance Project, "Report on Quality of Care in the Muhima and Ruanagana Districts of Rwanda" (Bethesda, MD: Quality Assurance Project, 1999). J.J. Burns, L.M. Franco, and J.S. Newman, "Oral Rehydration Therapy in Diarrheal Disease Control," *Service Quality Assessment Series* (Bethesda, MD: Primary Health Care Operations Research, 1990). L.M. Franco, "Malaria Treatment," *Service Quality Assessment Series* (Bethesda, MD: Primary Health Care Operations Research, 1991).
9. M. Francisco, "A Comparative Analysis of QA Assessments" (Bethesda, MD: Quality Assurance Project, 2000). J. Hermida, D. Nicholas, and S. Blumenfeld, "Comparative Validity of Three Methods for Assessment of the Quality of Primary Health Care: Guatemala Field Study" (Bethesda, MD: Quality Assurance Project, 1994).
10. J. Bradley et al., "Quality of Care in Family Planning Services: An Assessment of Change in Tanzania 1995/6 to 1996/7" (New York: AVSC International, 1997).
11. Kols and Sherman, "Family Planning Programs: Improving Quality."
12. J. Bradley, "Using COPE to Improve Quality of Care: The Experience of the Family Planning Association of Kenya," *Quality/Calidad/Qualité* no. 9 (1998).
13. Kols and Sherman, "Family Planning Programs: Improving Quality": 12.
14. Ministry of Health and Population, Arab Republic of Egypt, *Summary Country Profile on Population and Development: Egypt* (Cairo: Population and Family Planning Sector, Ministry of Health and Population, December 1998).

MAQ PAPERS

This paper is a publication of the Maximizing Access and Quality (MAQ) Initiative—an initiative of the United States Agency for International Development (USAID), collaborating agencies, country partners, and other collaborators to apply state-of-the-art methods to maximize access to and the quality of family planning and other selected reproductive health services.

Copies of this MAQ paper may be obtained by contacting the MAQ fellow at:

Office of Population/
Research Division
USAID
Washington, DC 20523-3601
Phone: 202-712-4548
Fax: 202-216-3404