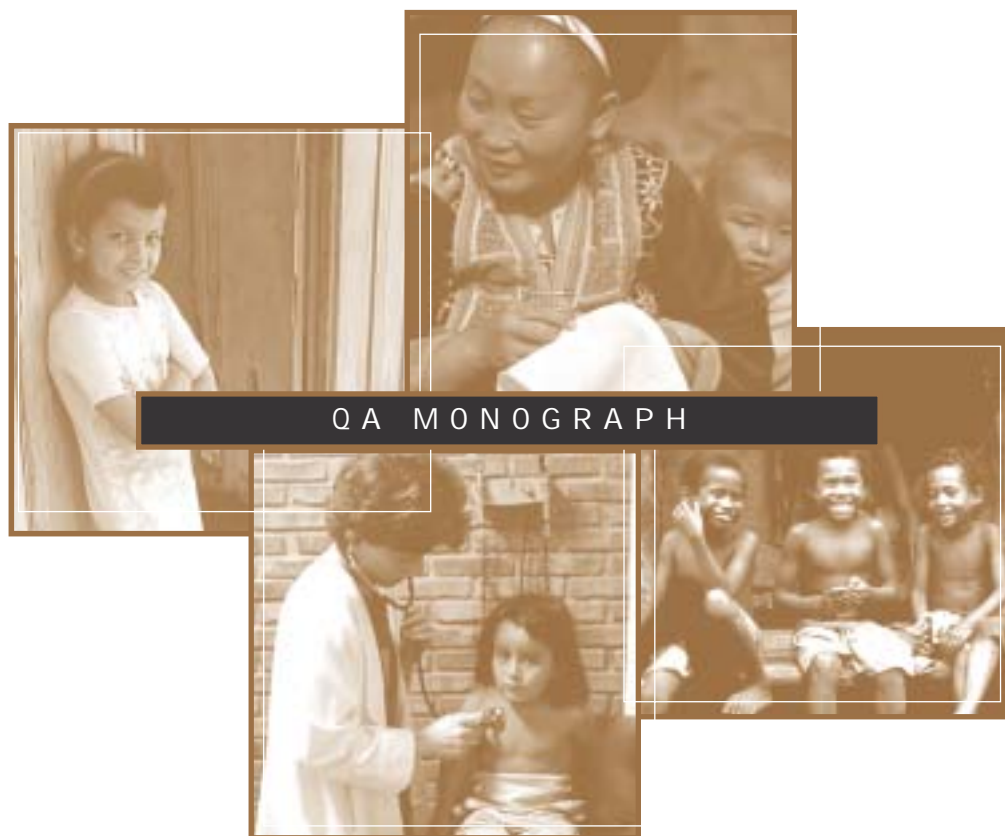


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QA MONOGRAPH

## Sustaining Quality of Healthcare: Institutionalization of Quality Assurance

September 2002





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# Sustaining Quality of Healthcare: Institutionalization of Quality Assurance

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September 2002



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# Table of Contents

List of Figures, Boxes, and Tables .....	v
List of Abbreviations .....	vi
Acknowledgements .....	vi
Executive Summary .....	1
1 Introduction to Institutionalization .....	5
1.1 What Is Institutionalization of Quality Assurance? .....	5
1.2 Objectives and Organization of the Monograph .....	6
2 Principles of Quality Assurance .....	9
2.1 What Is Quality of Care? .....	9
2.2 Principles of QA for Application in Developing Countries .....	10
2.3 The Core Activities of Quality Assurance: The QA Triangle .....	10
3 A Conceptual Model: What It Takes to Institutionalize Quality Assurance .....	13
3.1 Overview of the Model .....	13
3.2 The Internal Enabling Environment .....	14
3.2.1 Organizational Policies and Policy Implementation .....	14
3.2.2 Leadership .....	15
3.2.3 Core Values .....	16
3.2.4 Resources .....	17
3.3 Organizing for Quality: Developing a Structure to Support QA Implementation .....	18
3.4 Support Functions .....	19
3.4.1 Capacity Building .....	20
3.4.2 Information and Communication .....	20
3.4.3 Rewarding Quality Work .....	22
3.5 Conclusion .....	23

---

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4	Understanding the Process of Institutionalization: A Road Map .....	25
4.1	QA Institutionalization as a Process .....	25
4.2	The Phases of Institutionalization .....	25
4.3	Pre-Awareness .....	26
4.4	The Awareness Phase .....	26
4.5	The Experiential Phase .....	27
4.6	The Expansion Phase .....	27
4.7	The Consolidation Phase .....	27
4.8	Maturity: Sustained Quality of Care and a Culture of Quality .....	28
4.9	Conclusion .....	28
5	Moving towards Institutionalization: One Element at a Time .....	29
5.1	Policy .....	29
5.2	Leadership .....	34
5.3	Core Values .....	35
5.4	Resources for QA .....	37
5.5	Organizing for Quality: Creating a Structure for QA Implementation .....	39
5.6	Capacity Building .....	41
5.7	Information and Communication .....	43
5.8	Rewarding Quality .....	44
5.9	Bringing the Elements into Maturity .....	46
6	Epilogue .....	49
	References .....	51

## List of Figures, Boxes, and Tables

<i>Figures</i>			
Figure 2.1	Dimensions of Quality .....	9	
Figure 2.2	Quality Assurance Triangle .....	11	
Figure 2.3	Four Steps to Quality Improvement .....	12	
Figure 3.1	Essential Elements for the Institutionalization of QA .....	13	
Figure 3.2	Institutionalization of Quality Assurance .....	14	
Figure 4.1	The Phases of Institutionalizing Quality Assurance .....	25	
<i>Boxes</i>			
Box 3.1	Quality Policy in Mexico .....	15	
Box 3.2	Key Leadership Responsibilities for Successful QA Implementation .....	16	
Box 3.3	A Change in Values in Russia .....	16	
Box 3.4	A Change in Staff Attitudes in South Africa .....	17	
Box 3.5	Core Values that QA Project Experience Has Shown to Be Critical for Institutionalizing QA .....	18	
Box 3.6	Evolution of the QA Oversight Structure in Malawi .....	19	
Box 3.7	Key Roles and Responsibilities for a QA Structure .....	20	
Box 3.8	Capacity Building in Tahoua, Niger .....	21	
Box 3.9	The Three Types of QA Capacity Building .....	21	
Box 3.10	Sharing Data on Compliance with Standards in Ecuador .....	22	
Box 3.11	Facilitating Information Flow and Sharing of Lessons in Chile .....	22	
Box 3.12	Rewarding High Levels of Quality and Coverage in Ecuador .....	23	
Box 5.1	Evolution of Quality Policies in Malaysia .....	32	
Box 5.2	Top-Level Leadership Support for QA in Chile .....	34	
Box 5.3	Corporate Culture Building in Malaysia .....	36	
Box 5.4	Sustaining the Funding Base for QA Activities in Chile .....	38	
Box 5.5	Structures to Support and Implement QA in Malaysia .....	39	
Box 5.6	The Changing Challenges of Capacity Building in Zambia .....	41	
Box 5.7	Promoting the National Crusade for Health Quality in Mexico .....	43	
Box 5.8	Rewarding Quality in Malaysia .....	45	
<i>Tables</i>			
Table 4.1	Institutionalization Phase Characteristics, Strategies, and Indications of Readiness to Progress .....	26	
Table 5.1	Evolution of QA Essential Elements through the Phases of Institutionalization .....	30	
Table 5.2	Illustrative Example of an Organization's QA Institutionalization Status .....	32	
Table 5.3	Possible Activities to Develop the Essential Element <i>Policy</i> and Move to the Next Phase/State .....	33	
Table 5.4	Possible Activities to Develop the Essential Element <i>Leadership</i> and Move to the Next Phase/State .....	34	
Table 5.5	Possible Activities to Develop the Essential Element <i>Core Values</i> and Move to the Next Phase/State .....	37	
Table 5.6	Possible Activities to Develop the Essential Element <i>Resources for QA</i> and Move to the Next Phase/State .....	38	
Table 5.7	Possible Activities to Develop the Essential Element <i>QA Structure</i> and Move to the Next Phase/State .....	40	
Table 5.8	Possible Activities to Develop the Essential Element <i>Capacity Building</i> and Move to the Next Phase/State .....	42	
Table 5.9	Possible Activities to Develop the Essential Element <i>Information and Communication</i> and Move to the Next Phase/State .....	44	
Table 5.10	Possible Activities to Develop the Essential Element <i>Rewarding Quality</i> and Move to the Next Phase/State .....	45	
Table 5.11	Analysis of Each Essential Element in Zambia's Quality Assurance Program .....	47	

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## List of Abbreviations

CBOH	Central Board of Health
COHSASA	Council for Health Service Accreditation of Southern Africa
MOH	Ministry of Health
NGO	Nongovernmental organization
QA	Quality assurance
QD	Defining quality
QI	Improving quality
QM	Measuring quality
USAID	United States Agency for International Development

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# Executive Summary

**I**MPROVING quality has become a unifying theme across health programs and countries. Awareness of the importance of improving healthcare quality is seen in the rapid spread of evidence-based guidelines, growing attention to patient safety and reducing medical errors, and attempts to reduce waste and inefficiency to ensure that scarce resources for healthcare are used to derive their full impact.

Around the world, impressive efforts are underway in public and private organizations to improve the quality of healthcare, based on a systematic approach to ensuring that the details of healthcare are done right—an approach called quality assurance. The tools of quality assurance (QA) and quality management, born in manufacturing, have been successfully applied in healthcare in both developed and less developed countries, and there is growing acceptance that QA can improve program and health worker performance.

In developing country health systems, the need for higher quality care and health services that are responsive to clients is acute. QA activities have been successfully established in many developing country settings, but often falter in scaling up or sustaining their achievements. As more national ministries and other health organizations gain experience in applying QA approaches, demand has grown for guidance on the elements and processes that sustain the quality of healthcare.

## The Objectives of This Monograph

This monograph presents a conceptual framework to help healthcare systems and organizations analyze, plan, build, and sustain efforts to produce quality healthcare. The framework synthesizes more than ten years of QA Project experience assisting in the design and implementation of QA activities and programs in over 25 countries. That experience has shown that the key institutionalization question is often not so much a technical one—how to “do” QA activities—but rather, how to establish a culture of quality within the organization and make QA an integral, sustainable part of the health system.

As with any kind of organizational change, the road to institutionalizing QA can be long and complex. This monograph was written to provide practical information to

Ministries of Health and other health organizations in their quest for sustainable quality of care. It both describes the components necessary to inculcate a culture of quality and provides practical information on how to facilitate the process necessary to reach this goal. A framework of eight essential elements and a phased process for institutionalization of QA outline the critical aspects and a road map for creating a lasting program to improve the quality of healthcare. The institutionalization framework draws heavily on management literature and organizational change models, as well as QA program experiences in diverse countries.

## The Core Activities of Quality Assurance

At the heart of any effort to institutionalize the delivery of quality healthcare are three core QA activities: defining quality, measuring quality, and improving quality. These core activities are developed, scaled up, and made integral parts of an organization’s functioning through institutionalization. *Defining quality* means developing expectations or standards of quality, as well as designing systems to produce quality care. *Measuring quality* consists of documenting the current level of performance or compliance with expected standards, including patient satisfaction. *Improving quality* is the application of quality improvement methods and tools to close the gap between current and expected levels of quality by understanding and addressing system deficiencies (as well as enhancing strengths) in order to improve healthcare processes. These three sets of activities work synergistically to ensure quality care as an outcome of the system. Together they encompass the range of mutually supportive QA methodologies and techniques. No core activity alone is sufficient to improve and maintain quality; it is the interaction and synergy of all three that sustains high quality healthcare.

## A Conceptual Model of QA Institutionalization

Many factors affect a health organization’s ability to institutionalize QA and a culture of quality, but we have identified eight elements as essential for implementing and sustaining the core QA activities. The first four elements constitute the internal environment conducive to initiating, expanding, and sustaining QA within the organi-

<b>Essential Elements for the Institutionalization of QA</b>
<p><b>Internal enabling environment:</b></p> <p>Policy</p> <p>Leadership</p> <p>Core values</p> <p>Resources</p>
<p><b>Organizing for quality:</b></p> <p>Structure</p>
<p><b>Support functions:</b></p> <p>Capacity building</p> <p>Information and communication</p> <p>Rewarding quality</p>

QA Project 2000

zation. Such an enabling environment is comprised of (a) *policies* that support, guide, and reinforce QA; (b) *leadership* that sets priorities, promotes learning, and cares about its staff; (c) *core organizational values* that emphasize respect, quality, and continued improvement; and (d) adequate *resources* allocated for the implementation of QA activities. *Organizing for quality* refers to the mapping out of responsibilities and accountability for QA in the organization, including oversight, coordination, and implementation of QA activities. Three critical support functions sustain implementation of QA and improved quality of care: (a) *capacity building* in QA, such as training, supervision, and coaching for healthcare providers and managers; (b) *information and communication* for the purposes of sharing, learning, and advocating for quality; and (c) *rewarding* and recognizing individual and team efforts to improve quality. Each of these elements is described in depth in this monograph, and the descriptions are amplified by actual examples from developing countries.

## QA Institutionalization as a Process

While the end goal is to have each of the eight essential elements fully in place, in reality, the institutionalization of QA is a process through which an organization continu-

ously moves until QA is fully integrated into its structure and functioning. This process may be thought of as one where the organization progresses from having no formal or deliberate QA efforts, to initial awareness, to experimentation with QA activities, to expansion, and then consolidation of these efforts, until finally reaching a state of fully developed and institutionalized QA activities. At the state of QA maturity, QA is an integral part of day-to-day operations at all levels; and organizational values, leadership, and policies reinforce a culture of quality.

The *pre-existing* situation—before an organization begins to implement any formalized or deliberate QA efforts—is characterized by attempts to improve quality that are sporadic, individual, and informal, rather than part of a deliberate, formal QA intervention. The *awareness* phase is the first step on the road to institutionalizing QA; it is characterized by individuals (especially organizational leaders) becoming conscious of the need to improve quality of care and of the possibility of doing something deliberate and systematic about it. The *experiential* phase is characterized by the organization starting to implement QA on a small scale, trying out various QA approaches to learn from the experience, and developing evidence (documented results) showing that QA leads to improvements in the quality of care. At the end of this phase, sufficient momentum exists for an organization to move into the *expansion* phase, when there is an increase in scope of QA activities.

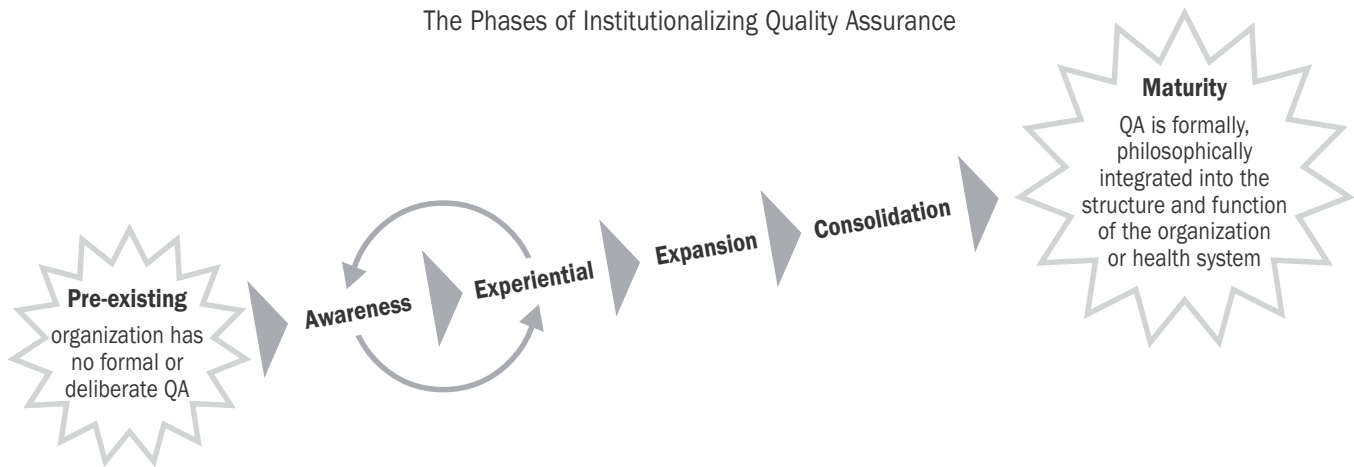
The expansion phase is not just a scaling up of QA activities, but also a signal of the strategic expansion of QA implementation, based on knowledge and experiences gained in previous phases. This expansion may be geographic, but could also relate to the types of QA activities, the range of facility types or departments involved, or the types of health problems being addressed. As expansion strategies are undertaken, they can precipitate or foster the need for “taking stock” of QA activities, ushering in a period of review, refinement, balance, and coordination. During *consolidation*, existing QA activities and programs are simultaneously strengthened and anchored into standard organizational operations, while at the same time being fortified by addressing lagging or missing activities.

Dividing the institutionalization process into phases reflects the fact that there is a progression of organizational capacity and QA ability that must be developed to sustain the quality of healthcare. Each phase has specific organizational characteristics and a range of strategies and activities that organizations may use to foster progress to the next phase. Although it is tempting to assume that progress

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## The Phases of Institutionalizing Quality Assurance



QA Project 2001

towards *maturity* occurs steadily along a continuum, country and organizational experience indicates that this process is more complex: organizations may progress, regress, vacillate between two phases, or even stagnate. In some cases, organizations may be making progress in the awareness and experiential phases in a simultaneous or iterative manner.

Similarly, an organization will not necessarily have all eight essential elements aligned in the same phase of institutionalization. The development of each essential element may proceed at a different pace, although the ultimate goal is to bring all essential elements into alignment. The final chapter of the monograph provides a detailed road map of how each element develops during the course of the institutionalization process.

## Conclusion

QA institutionalization is an ongoing process where activities related to defining, measuring, and improving quality become formally and philosophically integrated into the structure and functioning of a healthcare organization or system. It is not a linear process, but rather a fluid one in which the essential elements may mature in sequence or in a less coordinated fashion. There is no one formula or set of steps an organization should or must follow to successfully institutionalize QA. The framework of eight essential elements and the phased process of institutionalization outline the critical aspects and road map for creating a lasting program to improve the quality of healthcare an organization or system provides.



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# 1 Introduction to Institutionalization

**H**EALTH systems worldwide are recognizing the need to improve quality. Such systems are increasingly adopting evidence-based guidelines, giving attention to reducing medical errors, and safeguarding patient safety. Concern with quality is also expressed in efforts to reduce waste and inefficiency, to ensure that scarce resources for healthcare are used to derive their full impact.

Why is quality of healthcare important?

Simply stated, healthcare organizations can't afford *not* to be concerned with quality and efficiency. Quality of care is not a luxury that only wealthy countries can afford; it is an imperative for healthcare organizations worldwide. Complex health problems that know no national boundaries, such as HIV/AIDS and antibiotic-resistant tuberculosis, demand careful attention to well-designed processes of care, based on clinical evidence of effectiveness. The very limited resources available for publicly funded health services in many low-income countries demand that those resources be channeled into effective processes of care and that wasteful or ineffective practices be eliminated.

Impressive efforts are underway to improve the quality of healthcare being offered to people around the world, based on a systematic approach to ensuring that the details of healthcare are done right—an approach called quality assurance. While the principles and methods of quality assurance are widely embraced, we know that re-orienting and reorganizing entire healthcare systems so that they can consistently offer quality care to all clients remains a challenge for many countries, especially in the developing world. Quality assurance (QA) activities have been successfully established in lower and middle-income countries, but often face significant hurdles in scaling up or sustaining their achievements. As more countries gain experience in applying the methodologies that lead to quality healthcare, demand has grown for guidance on the totality of the elements and inputs needed to sustain QA.

This monograph presents both a conceptual framework and a road map to help organizations create the capacity to plan, build, and sustain efforts to produce quality healthcare. We use the term framework to refer to (a) the essential elements an organization must have to institutionalize QA and (b) the phases an organization must pass through to reach mature institutionalization. The frame-

work incorporates more than ten years of QA Project experience assisting in the design and implementation of QA in over 25 developing country health systems. Other publications by the QA Project provide more general overviews of quality assurance in healthcare and technical guides to major QA interventions (Massoud et al. 2001; Bouchet Undated; Rooney and van Ostenberg 1999; Ashton 2001a). Most QA Project publications are available from the website and mailing address on the cover.

## 1.1 What Is Institutionalization of Quality Assurance?

The QA Project defines quality assurance as all activities that contribute to defining, designing, assessing, monitoring, and improving the quality of healthcare. While adequate drug distribution, financing, human resources planning and allocation, and technical and professional training systems contribute to and are necessary for quality care, quality assurance ensures that all processes work effectively and synchronously to achieve quality healthcare.

Our understanding of QA and its use to improve the quality of healthcare in developing countries has grown substantially over the last ten years. One lesson was learning that having the capacity to carry out technical quality assurance activities does not ensure that QA is institutionalized within an organization or that QA functions are sustained over the long term. The critical question now is not so much a technical one, how to “do” QA activities, but rather how to establish and maintain QA as an integral, sustainable part of a health system or organization, woven into the fabric of daily activities and routine. The process of achieving this state is what we term “institutionalization.”

Institutionalization is the process through which a set of activities, structures, and values becomes an integral and sustainable part of an organization. Institutionalization means that people know what needs to happen to provide quality care, they have the skills to make it happen, and they are committed to making it happen over time within the available resources. This notion encompasses a broader set of dimensions than financial sustainability alone.

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QA institutionalization can occur at any organizational level—individual healthcare facilities, health networks, intermediate health system structures (such as district or regional health units), national level health systems, or Ministries of Health. When QA is institutionalized into the structure and functioning of a health system or organization, QA activities are consistently implemented and supported by an organizational culture<sup>1</sup> of quality, as reflected in organizational values and policies that advocate and support quality care.

Quality assurance, as described in this document, is not viewed as a separate vertical program, working independently from other programs in the organization. The implementation of quality assurance activities does not take place in a vacuum, nor should its institutionalization be viewed in isolation. Rather, the goal of QA is to be integrated into all programs and activities. Sustaining QA requires an environment that enables the initiation, growth, and continuity of QA activities. For this reason, the monograph addresses the “enabling” environment internal to the organization necessary to sustain QA. We also examine potential opportunities to capitalize on factors or conditions in the organization’s environment that might facilitate the organization’s ability to produce quality healthcare services.

While quality assurance efforts interact with the larger external environment (health sector, as well as other sectors that affect health, such as private industry and public schools), it is beyond the purview of this monograph to discuss these influences in depth. However, we do point out opportunities to examine more closely the impact of the external environment, such as health sector reform initiatives in decentralization, financing reform, and re-engineering.<sup>2</sup>

As with any kind of organizational change, the road to institutionalizing QA can be long and complex. Achieving sustained quality healthcare requires organizational change to infuse the organization with a culture of quality. This monograph presents a framework of the essential elements and process necessary to reach the goal of QA becoming an integral, sustainable part of a healthcare organization. It also provides practical information on how to facilitate the process. We draw heavily on management literature and organizational change models, as well as QA program experiences in diverse countries.

## 1.2 Objectives and Organization of the Monograph

This monograph was written for people who are involved in the design or improvement of the quality of care in their organization or wish to be champions for the introduction of QA into their organization. The framework is valid for organizations ranging from individual healthcare facilities to national Ministries of Health. The monograph’s content and organization were designed to stimulate reflection and provide guidance on how best to plan, attain, and maintain quality healthcare.

The monograph has three objectives:

**Increase awareness and/or sensitize key stakeholders on what it takes to introduce and sustain quality assurance:** The monograph provides information for leaders, key decision makers, healthcare practitioners, and other stakeholders about what is involved in implementing and sustaining QA, both the important elements necessary to sustain QA and strategies for advancing the institutionalization process. A critical message is that the institutionalization of QA is a multi-factoral and continual *process* that requires sustained commitment from the leadership. Such commitment is worthwhile, as QA has been demonstrated to bring about lasting positive changes in the performance of healthcare providers, the satisfaction of users, and most importantly, the quality of healthcare.

**Guide self-assessment of the status of institutionalization of quality assurance in one’s organization:** The monograph can also be used as a guide for assessing the overall *status* or to monitor the *progress* of an organization with regard to institutionalizing QA. In addition, the detailed description of the phases of development for each essential element in the framework can be used to identify which elements may need further support in the organization. The monograph also contains practical examples of specific activities and strategies that might be of use during each phase of institutionalization and to advance each essential element along the road to maturity.

**Facilitate institutionalization of quality assurance in an organization:** The discussions of the process of institutionalization provide a variety of options an organization can consider as it moves through the various phases of institutionalization. While they are not meant to be pre-

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<sup>1</sup> *Organizational culture can be defined as the shared and behavioral expectations that characterize a corporate (or organizational) identity (Grindle 1997).*

<sup>2</sup> *In collaboration with the Pan American Health Organization (PAHO), the QA Project is developing a framework describing the interface between quality assurance and health sector reform. Publication is planned for fall 2002.*

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scriptive, these discussions provide guidance on major steps and indications of progress that have proven helpful in developing strong and sustained QA.

The structure of the monograph parallels these objectives. To provide a common background, Section 2 discusses the principles and activities that comprise QA efforts and that lead to improvements in the quality of healthcare. Section 3 presents the institutionalization framework, consisting of eight essential elements that address the internal enabling environment, organizing for quality, and the support func-

tions needed to sustain QA. This framework depicts what these elements look like when QA is institutionalized. Section 4 addresses the process of institutionalizing QA. It describes the phases an organization passes through on the road to establishing QA as an integral, sustainable part of the organization. Section 5 describes how each essential element of QA institutionalization moves through these phases. This section also illustrates how one can use this information to plan or improve progress toward institutionalizing QA in one's own organization.





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# 2 Principles of Quality Assurance

## 2.1 What Is Quality of Care?

The purpose of all quality assurance efforts is to improve and sustain the quality of healthcare. Quality healthcare is thus the ultimate goal of institutionalized QA activities. There are many different definitions for the term “quality” in the context of healthcare:

“...*Proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition*” (Roemer and Montoya-Aguilar 1988).

“*The quality of technical care consists in the application of medical science and technology in a way that maximizes its benefits to health without correspondingly increasing its risks. The degree of quality is, therefore, the extent to which the care provided is expected to achieve the most favorable balance of risks and benefits*” (Donabedian 1980).

“*Quality is doing the right thing, right, the first time, and doing it better the next time, with the resource constraints and to the satisfaction of the community*” (Ministry of Health and Population of Malawi 1997).

Quality is multi-dimensional, so the QA Project has identified nine dimensions of quality (Figure 2.1) that are important to a healthcare delivery system’s various internal and external stakeholders: individual clients, communities, providers, managers, and payers. Different stakeholders consider those dimensions of diverse importance.

*Technical performance*, one of the more commonly recognized dimensions of quality, refers to the degree to which tasks carried out by health workers and facilities accord with standards or meet technical expectations.

*Access to services* reflects a lack of geographic, economic, social, organizational, or linguistic barriers to services.

*Effectiveness of care* is the degree to which desired results or outcomes are achieved, whereas *efficiency of service delivery* relates to the use of resources to produce those services.

*Interpersonal relations* refers to effective listening and communication between provider and client; it is based on the development of trust, respect, confidentiality, and responsiveness to client concerns.

**Figure 2.1 Dimensions of Quality**

Technical performance
Access to services
Effectiveness of care
Efficiency of service delivery
Interpersonal relations
Continuity of services
Safety
Physical infrastructure and comfort
Choice of services

QA Project 1999

*Continuity of services* refers to the delivery of care by the same healthcare provider throughout the course of care (when feasible and appropriate), as well as timely referral and communication between providers when multiple providers are necessary.

*Safety*, the degree to which the risks of injury, infection, or other harmful side effects are minimized, is a critical dimension of quality care and is receiving increased attention due to the HIV/AIDS epidemic.

The *physical infrastructure and comfort* dimension is sometimes called “amenities”; it includes a facility’s physical appearance and cleanliness, and the comfort and privacy it affords clients.

*Choice of services* refers to client choice of provider, treatment, or insurance plan, as appropriate and feasible. Inherent in this dimension is client access to information that allows the client to make an informed choice.

Quality of care refers to the degree to which these nine dimensions of quality are present in the healthcare delivered to a client.

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## 2.2 Principles of QA for Application in Developing Countries

Much of the approach to quality assurance and its institutionalization presented in this monograph is built on the teachings and principles of established leaders in the field of healthcare quality (Deming 1982; Juran 1988; Donabedian 1980; Berwick 1995; Berwick et al. 1992; Langley et al. 1996). The QA Project has adapted the methods, approaches, and strategies of these leaders for use by healthcare systems in developing countries. The project's work includes both traditional QA methodology (e.g., accreditation, regulation, and standards) as well as newer methods, such as continuous quality improvement.

Our decade of work with hundreds of QA implementation efforts has brought to light a common set of principles that, despite variations among QA programs, lay the foundation for the institutionalization of QA in any health organization or system. These principles are the importance of client perspectives and needs, analyzing systems and processes, the use of data for decision making, and teamwork to solve problems. These four principles are interrelated and can be described as follows:

**Client focus:** QA stresses the fact that health services exist to meet the health needs of the clients who use them. By focusing on serving the needs of clients, healthcare providers and others involved in the delivery of healthcare perform better. Client focus means caring for the entire person rather than simply addressing an ailment; it means helping clients not only directly in seeing that they receive the treatment they should, but also in greeting them with respect, helping them find the room or person they need, reducing waiting times, handling their paperwork properly, and numerous other actions that may not be part of someone's job description but should be part of everyone's responsibility.

The principle of client focus distinguishes between "external" and "internal" clients. The former are generally the population served, including patients, patients' caretakers, their families, their communities, and even their society. An "internal client" is a particular person's colleague who may need assistance from the person in order to perform a job function. As an example, consider a nurse who needs to be able to access files in order to treat patients. He/she becomes an internal client to the file clerk when accessing a file. "Focusing on the client" directs our attention to serving clients—both internal and external. A client focus requires

knowing who the clients are while understanding and trying to meet their needs and expectations.

**Understanding work as processes and systems:** QA recognizes that unclear, redundant, or incomplete systems or processes may cause problems in the delivery of quality healthcare. Instead of blaming the people working in these systems for poor performance, QA activities involve them in the prevention, detection, and resolution of problems within processes or systems, in order to improve the quality of care.

**Testing changes and emphasizing the use of data:** QA emphasizes the need to improve processes by understanding how they function. This principle promotes decision making based on accurate and timely data rather than on assumptions. Understanding and using data also means understanding variation or differences in the output of a process or system and determining whether the variation is a normal part of the process or whether it indicates a real change (either as an indication of a problem or of an improvement).

**Teamwork:** QA focuses on participation and teamwork to solve problems and implement quality solutions, recognizing that the impact of QA activities is most powerful when team members draw on the participation, experience, and knowledge of major participants and stakeholders.

These principles serve as the foundation for QA and reflect that QA is not just a set of activities, but also a fundamental set of beliefs and values that should become a "way of doing things" in an organization. These principles are in accord with those espoused in the quality management literature (see for example, Berwick et al. 1992; Langley et al. 1996).<sup>3</sup> Introducing QA does not necessarily mean changing the whole way the organization is managed, but implementing QA according to these principles often brings about positive changes in the management of other components of the health system, such as logistics and financial management.

## 2.3 The Core Activities of Quality Assurance: The QA Triangle

The QA Project approach to improving health services performance encompasses three core quality assurance activities: *defining quality*, *measuring quality*, and *improving quality*. These three sets of activities work synergistically to ensure quality care as an outcome of the system and to-

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<sup>3</sup> The quality management literature often includes leadership as a fifth principle of quality. We include leadership in our framework for institutionalization.

**Figure 2.2 The Quality Assurance Triangle**



QA Project 2000

gether comprise the range of various QA methodologies and techniques used to assure quality healthcare. They are represented by a triangle (Figure 2.2) to indicate their mutually supportive, interactive nature. Each point of the triangle represents a set of core QA activities, and the unbroken triangle shape suggests that there is not one “correct” or even optimal entry point for initiating QA. One could start with making improvements in any problematic area. At the same time, however, no one core set of QA activities is sufficient on its own to improve and maintain quality. It is the interaction and synergy of all three that facilitate sustainable improvements in healthcare quality.

**Defining quality (QD)** means developing expectations or *standards* of quality. Standards are statements of expected performance that define for health workers what constitutes quality care. Standards can be developed for inputs, processes, or outcomes; they can be clinical or administrative; and they can be applied at any level of a system, from an individual provider to a national department of health.

A good standard is reliable, realistic, valid, and clear, and can be easily measured. Standards of quality should be based on the best scientific evidence available and can be developed in accordance with the nine dimensions of quality discussed above. Stakeholder perception and expectations of quality (including client and community,

provider, manager, and payer) should also be included in the definition of quality standards.

Activities other than developing standards that relate to defining quality include designing systems for quality outputs; strategic planning; communicating standards; and designing various forms of regulation, including accreditation, licensure, or certification standards.<sup>4</sup>

**Measuring quality (QM)** consists of quantifying the current level of performance or compliance with expected standards, including patient satisfaction. It involves defining indicators, developing or adapting information systems to provide data on performance related to the indicators, and analysis and interpretation of results.<sup>5</sup>

Activities related to measuring quality include routine collection and analysis of data on adherence to established standards through supervisory assessments; self-assessment; quality monitoring; and special studies or periodic assessments, such as audits. Measuring client satisfaction is one important form of quality assessment.

**Improving quality (QI)** refers to the application of quality management methods and tools to close the gap between current and expected levels of quality by understanding and addressing system deficiencies and strengths to improve, or in some cases, re-design healthcare processes. This core QA activity leads to improved performance according to defined standards of quality.<sup>6</sup>

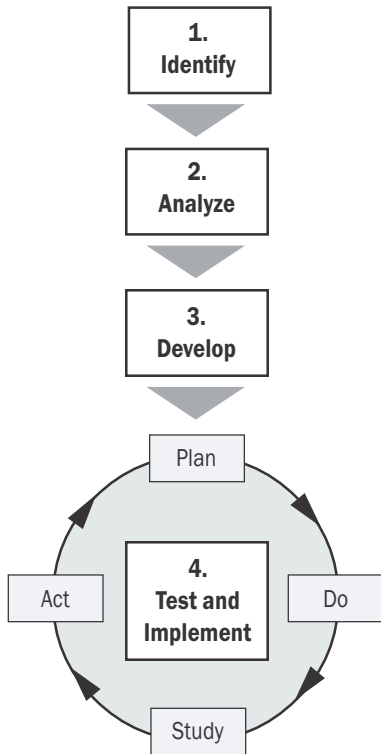
A variety of quality improvement approaches exists, ranging from individual performance improvement to redesign of entire systems/processes to organizational restructuring/re-engineering. These approaches differ in terms of time, resources, and complexity, but share the same four steps in quality improvement: (a) Identify what you want to improve, (b) Analyze the problem or system, (c) Develop potential solutions or changes that appear likely to improve the problem or system, and (d) Test and implement the solutions. Step 4 uses the “plan, do, study, act” cycle to determine whether the solutions under consideration would really yield improvement and whether they should be abandoned, modified, or scaled up. (Figure 2.3 presents this approach graphically.)

<sup>4</sup> More discussion of the uses and formats of standards in healthcare may be found in Ashton 2001b; more on regulatory approaches is in Rooney and van Ostenberg 1999.

<sup>5</sup> A systematic approach to measuring the quality of primary and in-patient care is described in Bouchet Undated and Ashton 2001a, respectively.

<sup>6</sup> A thorough presentation of approaches to improving quality is in Massoud et al. 2001.

**Figure 2.3 Four Steps to Quality Improvement**



1. Identify	Determine what to improve
2. Analyze	Understand the problem
3. Develop	Hypothesize about what changes will improve the problem
4. Test/ Implement	Test the hypothesized solution to see if it yields improvement; based on the results, decide whether to abandon, modify, or implement the solution

In summary of this section on the principles of quality assurance, the core QA activities, represented by the QA triangle, encompass the methods, tools, and approaches an organization uses to ensure quality care. The rest of this monograph focuses on how to support and sustain the implementation of these core QA activities.

# 3 A Conceptual Model: What It Takes to Institutionalize Quality Assurance

**B**EARING in mind that (a) our goal in implementing quality assurance is to improve the quality of healthcare; (b) QA and improved quality of care require not only a technical approach of tools and methods but also a change in attitude; and (c) QA is institutionalized when it is formally and philosophically integrated into the structure, functioning, and culture of an organization, we can examine institutionalization more clearly to identify its “essential elements.” These elements have been identified by the QA Project through its international experience in supporting QA activities and programs and from quality management literature (Baldrige National Quality Program 2001; Tenner and DeToro 1992; Marszalek-Gaucher and Coffey 1990; Brown 1995; Powell 1995; Shortell et al. 1995, among others).

## 3.1 Overview of the Model

Many factors affect a health organization’s ability to institutionalize a change in the way work is approached, especially the key, or essential, elements listed in Figure 3.1. We group them in three categories: internal enabling environment, organizing for quality, and support functions. These categories are briefly described in the next few paragraphs; then we describe the role each essential element plays in institutionalization and how each functions in a mature organization that can sustain QA.

**The internal enabling environment:** An internal environment conducive to initiating, expanding, and sustaining QA is necessary to institutionalize QA. Such a supportive/facilitative environment is comprised of: (a) *policies* that support, guide, and reinforce QA; (b) *leadership* that sets priorities, promotes learning, and cares about its staff; (c) *core* organizational *values* that emphasize respect, quality, and continued improvement; and (d) adequate *resources* allocated for the implementation of QA activities. The full impact of the internal enabling environment is achieved only through the synergy created among all four of these elements.

**Organizing for quality:** Institutionalization requires a clear delineation of roles, responsibilities, and accountability for the implementation of QA activities. We refer to this organization for implementing QA as the essential element, *structure*. However, in this context structure should not be

**Figure 3.1 Essential Elements for the Institutionalization of QA**



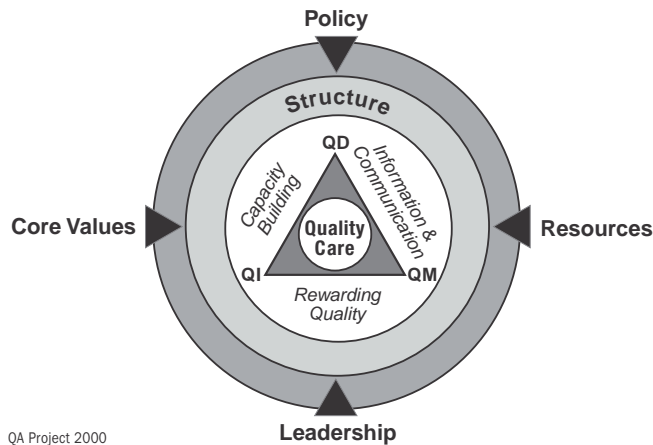
QA Project 2000

equated with an organization chart or reporting relationships. Instead, it refers to the mapping out of responsibilities and accountability for QA in the organization, including oversight, coordination, and implementation of QA activities.

**Support functions:** Several essential elements are needed to support sustained implementation of QA and improved quality of care. Three critical support functions are: (a) *capacity building* in QA, such as training, supervision, and coaching for healthcare providers and managers; (b) *information and communication* for the purposes of sharing, learning, and advocating for quality; and (c) *rewarding* and recognizing individual and team efforts to improve quality.

These three categories are represented in Figure 3.2 as a series of overlapping concentric circles that work together. At the center is quality healthcare, the desired outcome of QA. Surrounding the center is the triangle of core QA tech-

**Figure 3.2 Institutionalization of Quality Assurance**



QA Project 2000

nical activities for improving the quality of care: defining quality (QD), measuring quality (QM), and improving quality (QI). The impact of these core QA activities will depend on an enabling environment that encourages a culture of quality and facilitates continued implementation of QA, an appropriate organizational structure for framing effective QA implementation, and the presence and adequacy of support functions. Developing a culture of quality requires initiating or strengthening each essential element. Selecting where to begin depends on the situation, and each essential element—and each category where the essential elements reside—will progress at its own rate.

Each category of elements is important unto itself, but it is the combination of elements that facilitates and ensures institutionalization of QA. This model and the ensuing discussion of essential elements focus on those elements that operate within the organization's sphere of influence. At the same time, we recognize that every healthcare organization operates within a larger environment that influences its ability to implement QA. For example, some healthcare organizations approach the institutionalization of QA within a stable institutional context, while others operate in systems undergoing reform. External environmental factors create both constraints and opportunities for assuring quality and institutionalizing QA. Health sector reforms focused on decentralization or new financing mechanisms may provide opportunities for QA to contribute to better health outcomes. By the same token, external factors can negatively affect the institutionalization of QA, as is sometimes the case with civil service policies or resource flow to the health sector based on the country's financial situation.

While this model recognizes the influence of external factors, it emphasizes the more important role that the

categories of essential elements have in the institutionalization of QA. The sections that follow describe the role each essential element plays in institutionalization and how they function in a mature organization that is capable of sustaining QA. The elements are discussed by category.

## 3.2 The Internal Enabling Environment

The internal enabling environment includes those organizational features that encourage the growth of a sustainable QA program and that senior managers of an organization generally can control or change.

The key elements of the internal enabling environment for QA institutionalization are *organizational policies*, *leadership*, *core values*, and *commitment* to allocate necessary resources (human and material) to support QA activities. Regardless of an organization's level and complexity, these elements are necessary for sustaining QA and for the smooth functioning of the essential elements in the other two categories.

The internal enabling environment operates in the context of a broader external environment (economic status, political/administrative structure of the country, political stability, etc.) that may or may not be enabling. However, much can be accomplished to institutionalize QA by strengthening the essential elements in the internal environment. Such strengthening can assist the organization to persevere in sustaining QA activities despite hindrances from the external environment. For example, when external funding ended for Chile's National Quality Improvement Program, it was sustained largely by strong technical leadership and its strategy of decentralizing the planning, direction, and funding for quality improvement efforts to the level of the country's 27 health services (Gnecco 1999).

Although the internal enabling environment is critical, strengthening it to support QA need not precede efforts to develop other areas or essential elements. Each element may progress at a different rate. Section 5 describes the process of strengthening all of the essential elements and thereby moving toward the institutionalization of QA.

### 3.2.1 Organizational Policies and Policy Implementation

The term "policy" covers a wide range of organizational directives, from broad policies (like an organizational mission statement and human resource management) to narrow policies, such as standard operating procedures and clinical standards. Policy can be defined as a plan,



course of action, or a set of regulations adopted by a government, business, or institution that is designed to influence and determine decisions and procedures (Partnerships for Health Reform Project 2000). Policies reflect the decisions and actions of an organization's management. Policies written as laws, regulations, plans, and strategy statements constitute official statements of governing principles by which an organization operates and provides services.

To be effective, policies must be implemented and enforced. When written policies and their mechanism for enforcement incorporate a focus on quality and quality assurance, they provide sustained guidance for and reinforce the institutionalization of QA, particularly in organizations with high turnover at the leadership level.

Policies can be used to highlight an organization's commitment to quality and meeting client needs, to identify priority areas for improvement, and to provide flexibility and delegation of authority to make improvements (see example in Box 3.1). Policy development should be based on an orientation to results that reflect real changes in health status and community/client satisfaction.

For organizations embarking on QA, existing policies might hinder the institutionalization of QA. For example, policies that promote highly centralized decision making may limit staff initiative to make quality improvements. In contexts where decentralization reforms are being initiated, an opportunity may exist to modify current policies and shift the focus to emphasize quality assurance at the local level. In another instance, financing policies may be formulated to stress cost containment, imposing a culture of efficiency rather than a culture of quality, at the expense of patient care. In such a situation, policy dialogue and advocacy may be necessary to incorporate indicators of quality performance into financing mechanisms.

Policy is an important link to other enabling environmental elements. It is often set or influenced by leaders, may reinforce (or undercut) core values, and determines the resources allocated for QA activities.

### 3.2.2 Leadership

One definition of a leader is "someone you choose to follow to a place you wouldn't go by yourself" (Barker 1999). Leadership is the ability to motivate, enabling people to achieve results amid challenges and uncertainties (Management Sciences for Health 2002). Leadership is critical to the institutionalization of QA, because effective QA implementation requires a change in the way providers and managers work. In many places, health workers are demoralized after years of working with inadequate

### Box 3.1 Quality Policy in Mexico

Improving the quality of healthcare in public and private facilities is a major priority of the Government of Mexico. In the recently published *National Health Program 2001-2006*, the Secretariat of Health identified "Unleashing a Crusade for Quality" as one of its major strategies, with the following lines of action:

1. Define codes of ethics for health professionals
2. Define and make explicit the rights of health service users and healthcare providers
3. Establish a system of follow-up and response to complaints and suggestions
4. Establish systems to recognize good performance
5. Develop an information system to link hospital productivity and costs
6. Promote the use of clinical guidelines
7. Promote the certification of healthcare providers and facilities
8. Strengthen medical arbitration to resolve conflicts between patients and providers

Source: Secretariat of Health, Mexico 2001

resources, little response or support from higher levels of management, and little perceived authority to make changes. Making a shift to instill health workers with the desire to make improvements and empower them to do so clearly requires leadership.

In the context of QA, leadership relates to an individual's personal qualities and actions to support the staff's ability to ensure or improve the quality of healthcare. For example, in Honduras, "active leadership support" was found to facilitate the speed with which hospital-based quality design teams progressed. Such support was characterized as keeping up-to-date on the team's work, maintaining an open-door policy toward team members, and encouraging the search for creative solutions to overcome obstacles (Lin 2000). There is no single best leadership style: different styles are appropriate for different cultures or situations. However, effective leadership for QA involves creating and communicating a clear vision of what the organization is trying to achieve; developing the desire to reach that vision among staff; setting priorities to reach that vision; ensuring that staff have what is needed (flexibility, resources, etc.) to reach that vision; and showing care for staff, thereby building mutual trust (see Box 3.2).

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**Box 3.2 Key Leadership Responsibilities for Successful QA Implementation**

Develop and articulate to the staff a vision for quality of care—supported by core values and policies to guide standards development—and then allocate the resources to carry out quality assurance activities.

Continually advocate for quality with providers, staff, managers, and members of the community.

Create a synergy between quality words and actions. When leaders/managers advocate for QA in words but not in actions, they signal that quality is not a priority.

Practice and model the four principles central to QA: focusing on clients, systems and processes, decisions based on data, and teamwork.

Use change management strategies to reduce resistance to the changes inevitable when making improvements.

Provide resources for QA activities.

Ensure that all operational managers have a working knowledge of QA approaches and demonstrate a commitment to quality of care.

Empower staff to make improvements.

Ensure staff development to increase QA capacity.

Allocate staff time to participate in QA activities or make QA part of everyone's job description.

Adapted from Senge et al. 1994.

This discussion distinguishes between leaders and managers. Every organization has people in charge (managers) of making sure that things get done. Managers plan and organize activities, mobilize resources, and evaluate results. Leaders are individuals who have vision and can motivate people to follow and build that vision, who can set an example for others, and who promulgate the values and goals of the organization. Leaders see opportunities in the environment; develop a vision and direction for the organization; ensure alignment of vision, strategy, systems, and rewards; and motivate others to be creative and innovative.

Institutionalization of QA requires cultivation of leadership qualities among a range of managers at different levels in the organization. Not all managers will become leaders, nor will all leaders be managers. However, fostering leadership among managers will foster the institutionalization of

QA, since managers have the authority to establish QA as an organizational goal, devise other supporting policies, and allocate (or advocate for) resources to carry out QA activities. As leaders, these managers will start to model the behaviors necessary to achieve institutionalization and will communicate and support organizational core values. Capitalizing on informal leaders who “lead” by virtue of their personal strengths facilitates QA institutionalization.

In higher level organizations and more complex inter-organizational collaborations, leadership may come from more than one front. The vision and direction may come from one organization (such as a professional association), while the follow-through and resource allocation may come from another. In South Africa's KwaZulu-Natal Province, for example, the private Council for Health Service Accreditation of Southern Africa (COHSASA) provides individual hospitals with recommendations on how to improve their performance, while the QA Unit of the provincial government's Department of Health provides technical support to the hospitals to help them implement COHSASA's accreditation standards. For successful institutionalization the various roles of leadership must be assumed and played out in a coordinated fashion, avoiding competition for primacy.

### 3.2.3 Core Values

The culture of an organization reflects its core values. Ensuring sustained improvements in the quality of care within an organization requires shared values that emphasize quality healthcare and responsiveness to clients' needs. Organizational core values manifest themselves in how individuals in the organization behave individually and collectively. They are both a driver of behavior and a reflection of what people believe is most fundamental. To achieve optimal performance, organizational values and those held by the individuals working in the organization should be complementary and aligned to create a synergy of working together towards quality healthcare. Having

**Box 3.3 A Change in Values in Russia**

“...We are no longer talking about a project. We are talking about a whole new way of working.”

*Dr. Alesander Zoblin, Director of the Tver Oblast Department of Health, speaking at the launch of the large-scale implementation of redesigned systems of care, following the successful pilots*

For additional information, see Ethier Forthcoming.



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aligned values means that the core values of the organization and those of its employees are compatible and contribute to the same goals.

Core values do not operate independently within the enabling environment; they are directly connected to the elements of leadership, policy, and resources. Leaders often set the tone for organizational core values by modeling behaviors of respect, caring, and teamwork, and by communicating organizational goals of quality. Policy can establish, communicate, and reinforce the practice of QA as an organizational core value. The allocation of human and material resources to QA activities sends the message that quality is valuable to the organization. Core values that support QA promote the development of an environment where people feel they are doing something that matters, both to them personally and to others (see Boxes 3.3 and 3.4.).

However, core values are not the result of just leadership modeling or resource allocation. Every organization has values in operation, although they are often implicit or unspoken. Institutionalizing QA requires making explicit those desired values that foster quality care (see Box 3.5). Communicating values clearly and recognizing organizational accomplishments that reflect those values foster a culture of quality essential to sustainable QA.

### **Box 3.4 A Change in Staff Attitudes in South Africa**

“There has been a definite shift in attitudes. People who may in the past have been ignored in the chain of command are now being given a voice and they are being heard. This has resulted in a tremendous amount of professional and personal growth and has broken down the barriers that often exist between doctors, nurses and management. . . . There is more discussion between patients and staff, and patients are beginning to feel that their viewpoints are being taken into consideration. Nurses are looking more critically at their activities and at ways to improve their performance. Instead of grumbling about a situation, they are now beginning to understand that it’s better to identify a problem and think of ways to solve it.”

*Miss Joan Maher, Assistant Director of KwaZulu-Natal’s Quality Assurance and Accreditation Unit, speaking of the changes that have been noted in the hospitals involved in the COHSASA accreditation process*

Source: COHSASA 2000

Explicit core values also assist in the design of standards and interventions to improve the quality of care by stating what is fundamental to the notion of quality in a particular setting. For example, at the beginning of a national initiative in South Africa to provide adolescent-friendly healthcare, a panel of national and international experts formally talked with young people about their needs and expectations of clinic services (Dickson-Tetteh et al. Forthcoming). One outcome of the adolescent focus groups was the definition of a set of adolescent rights and responsibilities. As the standards were being introduced in pilot clinics, it became clear that some staff members had difficulty working with adolescents. Workshops to clarify values for clinic staff focused on the rights and responsibilities definition and helped staff understand how adolescents perceived healthcare quality.

In summary, organizational values, when explicitly stated in clear and concrete terms, can motivate change, provide direction, and energize staff. Values serve as a set of guiding principles upon which organizational members can build commitment to a shared vision of quality.

### **3.2.4 Resources**

Carrying out the daily tasks involved in implementing QA activities—be they quality improvement activities, designing and communicating standards, or monitoring results and measuring the success of improvements—requires human, material, and financial resources. Resources include staff time, office supplies, and transportation for QA activities, as well as resources for capacity building and communication to support QA implementation. The magnitude of needed resources may vary over time, with larger investments sometimes required initially while capacity is being developed. However, even when QA becomes part of everyone’s job, resources will be needed to undertake QA activities, i.e., staff time, designated funds, dedicated materials for data collection and interpretation, support to quality improvement teams, and continuing education of leaders in the science of QA.

Many health systems and organizations have severely limited resources for their programmatic needs. In these cases, the following question should be asked: Within the limits of the resources available, how can resources be maximized to achieve quality care? Without QA, can one be assured of efficient and effective use of current resources? Research suggests that increases in efficiency and effectiveness as a result of quality improvement initiatives may actually reduce implementation costs (Atkinson 1990; Abdallah et al. 2002).

### Box 3.5 Core Values That QA Project Experience Has Shown to Be Critical for Institutionalizing QA

- ◆ **Teamwork:** Quality is not the product of a sole individual, but a product of working together and valuing one's own work, as well as that of others.
- ◆ **Trust and respect:** One of Deming's principles is to "drive fear from the workplace." Trust and respect are critical for open and honest communication. This involves a commitment to openness, listening to each other, and valuing others' opinions.
- ◆ **Timely access to information:** Poor decisions often result from a lack of access to information. Organizational information sharing gives people the knowledge they need to make informed decisions about their work and enables "managing by fact." Practicing and modeling organizational information sharing will convince people that information is important.
- ◆ **Systems perspective:** Concentrate on ways to correct problems so people can do their work more efficiently, instead of blaming individuals. The problem is often in the system and not with a specific person.
- ◆ **Organizational and personal learning:** Staff must be encouraged to take risks in improving their work environment. Leaders and managers must trust staff to know how their job fits into the organization's values and empower them to act and respond as needed.
- ◆ **Patient-focused excellence:** A focus on the clients means open dialogue with them about what they want and need, what the organization is trying to achieve, and what can be done to make improvements.
- ◆ **Managing for innovation:** If an organization wants to improve quality, it must be willing to change the ways it works, not only in terms of processes, but also management and leadership styles.
- ◆ **Public responsibility:** This means focusing on the future and on the pursuit of the health of the community being served. Part of this value is visionary leadership.
- ◆ **Focus on results:** Create value in actions undertaken by measuring change and documenting that the change caused sufficient improvement.

Sources: Deming 1982; Ryan and Oestreich 1998; Baldrige National Quality Program 2001

Because institutionalization means that QA has become integral to the structure and functioning of an organization, a mature QA organization may not need to allocate resources to a separate QA function or department. QA will eventually become part of how people do their work and be supported by resources devoted to enhance overall work performance. Initially, however, specific resource investments may be needed to develop the organization's technical capacity in QA.

### 3.3 Organizing for Quality: Developing a Structure to Support QA Implementation

Although there is a strong tendency to equate the term "structure" with an organization chart or reporting hierarchies, organizing for quality refers to the delineation of responsibilities, authority, and accountability for both the quality of care and the implementation of QA.

Organizing for quality should not be equated to the creation of a vertical QA program with its own staff and resources that operates independently of other programs. *Structure* is not intended to reflect a physical sense of an office or department, but rather a mapping of roles and responsibilities that ensure quality care and the concomitant accountability for quality assurance.

Because every organization is unique in terms of its internal components and the political, technical, and economic environment where it operates, QA functions can be organized in more ways than one: no particular structure is correct or best. Organizations in more centralized environments will structure QA differently than those in more decentralized environments. Technological development, human resource development, and economic status will also influence decisions about how to organize for quality.

The appropriate structure for implementing QA could be a specialized QA unit within the organization, a quality improvement team based in a hospital or health center, a quality committee with representatives from various divisions or facilities, or a combination of these. Regardless of what form organizing for quality takes, it is important that roles, responsibilities, and accountability be formally defined for QA oversight, direction, and coordination with other activities in the organization.

The structure or manner through which QA is organized and implemented will likely vary over time, as the degree of institutionalization and maturity of the QA effort

increases (see example in Box 3.6). During the initial stage of QA institutionalization, some individuals may have to be assigned only to QA, working within a designated QA unit (i.e., a visible organizational location for QA), to boost awareness of QA and its importance to the organization. As QA becomes more integrated into the routine operations of the organization and accountability for quality results becomes more embedded, the type of coordination and oversight required may shift, as can its location. Routine management structures may assume daily oversight of QA

### Box 3.6 Evolution of the QA Oversight Structure in Malawi

Malawi's organization of QA demonstrates how the structure can change over time and how various stakeholders for quality have been involved. During the initial stages of developing a country-wide QA plan, a National QA Task Force formed to provide oversight and planning functions. Membership included representatives from the Ministry of Health (MOH), the regulatory boards (medical and nursing councils), the teaching institutions (medical schools, nursing schools, and allied health professional schools), professional associations, the Christian Health Association (mission facilities), and private practice. The Medical Council housed and provided support for this task force.

The success of several quality improvement pilot projects led to district initiatives in quality, including the formation of district and facility QA committees. The organizational locus of the country's QA activities shifted from the national to the district level. Measurable improvements in the quality of care in the seven pilot districts led to a decision to reconstitute the National QA Task Force and shift responsibility for its support to the MOH. The reconstituted task force included different members and new responsibilities.

In May 2001, the task force developed a vision for quality, a mission statement, Terms of Reference, and a one-year action plan, which senior MOH managers validated at a workshop in July 2001. The action plan clearly delineated the new roles and responsibilities of the task force and planned a transition of responsibility to a national QA committee. The plan also included capacity building for the task force and acknowledged the need for developing a cadre of QA experts who could provide coaching and mentoring to others.

For more information, see Reinke et al. 2001.

activities, and the role of a designated QA unit may become more narrow and technical in nature (such as focusing on development of standards). For example, in Chile, after QA structures in the decentralized health services had attained maturity, the role of the central level QA unit shifted from training and support of quality improvement teams to the development of national technical standards and quality monitoring tools (Gnecco 1999).

While QA can be implemented at any organizational level (facility, network, district, regional, national), three aspects of organizing for quality are important, regardless of the type or level of the organization: *oversight, coordination and support, and conducting QA activities* (see Box 3.7). For each of these aspects, roles, responsibilities, and accountability must be delineated and delegated within the organizational framework. The true structure for QA is manifested in how the roles and responsibilities for performing QA activities are divided and/or delegated within the organization, how they are implemented, and whether staff feel accountable for organizational results (high quality care). As QA becomes institutionalized, every individual becomes accountable for results and responsible for quality. Eventually, responsibilities for QA will be incorporated in job descriptions for every staff member, as well as in the scope of work for organizational units. However, specific individuals or groups must still be assigned responsibilities for oversight, coordination, and support of QA and for conducting QA activities.

## 3.4 Support Functions

As the name implies, support functions provide "support" for staff to initiate and continue technical QA activities, and to do them well. Those doing the day-to-day implementation of QA require specific types of support beyond those discussed previously in the context of the enabling environment or structure.

Systems to ensure *QA capacity building, communication of QA efforts, and reward for quality work* are critical for an organization to move beyond performing QA as isolated activities, to a state of continuously implemented QA, embedded in the organizational work ethic. There are many other support functions, such as logistics and financial management, but these three functions have particular importance to the institutionalization of QA.

### Box 3.7 Key Roles and Responsibilities for a QA Structure

**Oversight:** Any description of structure must address where the responsibility for oversight of QA activities lies. This oversight or stewardship for QA includes leadership and political support (developing strategic direction, setting priorities, follow-up, review of progress), as well as technical direction and monitoring of QA efforts. Effective oversight structures can vary from designating a senior manager who is well versed in QA to be responsible, to creating an independent body of major stakeholders for quality of care both within and outside the organization. Whatever the form, oversight responsibilities and accountability for results must be clearly defined to effectively implement and sustain QA.

**Coordination and support:** Responsibility for ensuring and coordinating the day-to-day implementation of QA activities must be assigned and accountability upheld. The structure must also define how the different components and levels of a QA program fit together and how they will be coordinated and synchronized. Issues of coordination will vary, depending on the type of organization. For smaller organizations, coordination across functional divisions may be key. In larger or national programs, coordination across geographic units as well as across broad technical programs will be important. In countries with a decentralized structure for healthcare administration, coordination becomes crucial for efficient use of resources.

**Conducting QA activities (defining, measuring, and improving quality):** Sustainable QA implementation requires clear delineation of specific duties, lines of reporting, and accountability for results, as well as allocating time for staff participation in QA. Eventually QA implementation should be part and parcel of each individual and team's job responsibilities and performance expectations. The nature of QA activities will vary, depending on the level and complexity of the organization. For organizations with more macro and strategic responsibilities, the focus of QA implementation may be on regulatory and monitoring functions, such as accreditation, development of quality standards, and monitoring of quality. For smaller organizations or organizational units, the focus may be on quality improvement and local adaptation of standards.

### 3.4.1 Capacity Building

Capacity building encompasses the whole range of activities that increase QA knowledge, skills, and ability: formal QA training, coaching and mentoring on the job, self- and peer appraisals, performance improvement, and supervisory activities. Ensuring that staff have the necessary knowledge and skills to carry out their QA responsibilities and that they know when and how to best use these skills is vital for the development of a critical repository of QA technical, managerial, and leadership expertise within the organization.

Doing QA is more than the simple application of technical methods. It often requires behavior change—learning to work differently. Traditional approaches to capacity building through one-time classroom training will probably be insufficient; innovative, alternative modes of learning are useful, including participatory, performance-based, and distance learning and mentored on-the-job practice.

Three main types of capacity building are needed for institutionalizing QA: basic QA expertise; coaching and mentoring of staff as they implement QA activities; and supervision and oversight of staff QA efforts. As described in the example of Tahoua, Niger, in Box 3.8, all three types are part of a continuum of support that should be provided to staff as they undertake QA activities. These three areas of capacity building are not mutually exclusive and may be carried out by a single individual or by a group of individuals working at different levels.

However they are performed, the ability to carry out these capacity-building activities needs to be developed and maintained in a critical mass of individuals working in the organization in order to sustain QA. (Box 3.9 details these main types of capacity building.)

### 3.4.2 Information and Communication

Information and communication are critical to efforts to expand QA and create a learning environment for the organization and the people working in it. "Information" in the context of support for QA refers to the gathering of experiences and results of QA initiatives. "Communication" is the two-way process of interaction in which available information is shared with various parts of the organization, with organization staff, with the communities being served, and with other stakeholders, including policy makers. Information and communication allow for the identification of priority areas for quality improvement efforts, reinforcement of core values, recognition of efforts, and demonstration of results for the purpose of advocacy, benchmarking, and change management.



### Box 3.8 Capacity Building in Tahoua, Niger

The QA Project provided long-term technical assistance to the Department of Health of Tahoua, Niger, to institutionalize QA in the decentralized management of health services in the region. Training and on-site coaching were the central strategies used to enable health workers at the regional, district, and facility levels to apply QA concepts and methods.

The Tahoua QA project first trained health workers who had been selected for the regional and district-level quality improvement teams in each of the region's seven districts. Training gave participants a framework and skills to systematically solve quality-related problems using methods adapted to local conditions. During the training workshops, participants chose a problem, drafted a definition statement, and began preliminary problem analysis before leaving training.

The QA Project's resident advisor gave the teams support, visiting each team regularly to motivate team members and help them apply the QA methodology. This follow-up support was found to be critical to teams' ability to move through the problem-solving cycle, since QA required very different attitudes and skills than what Tahoua health workers were accustomed to. Members of the district management teams and supervisors were also trained in coaching and team-building skills to enable them to train and support facility-level quality improvement teams.

Source: QA Project Undated

Ensuring the timely flow of information is critical to effective implementation of QA and thus to improvements in the quality of care. Formal mechanisms to assure the communication of new standards, policies, and improvement efforts increase the likelihood of acceptance and compliance with these QA activities. Communication reinforces the notion that QA is everyone's business, that successes should be publicized, and that lessons should be shared even when things do not go as planned.

Successful information and communication support for QA includes:

**Recording** improvements and changes, using both data to demonstrate results that have been achieved and stories about how these results were achieved (see example in Box 3.10).

### Box 3.9 The Three Types of QA Capacity Building

**Providing basic QA expertise:** Institutionalization of QA requires that health providers and managers receive initial and continuing knowledge and skill development in QA techniques and methods. As appropriate, the ability to manage QA activities might also be included. Developing basic QA expertise should ultimately be integrated into the pre-service and in-service training systems. Training activities can be on- or off-site, in the context of the job, or using distance learning. Staff needs will change over time, so training should be tailored to evolving QA responsibilities and related learning needs. QA Project experience has shown that training is most effective when it is "just in time"—i.e., when staff and providers need the information.

**Ongoing coaching and mentoring:** Coaching and mentoring provide ongoing technical and motivational support to facilitate the behavior changes needed to undertake and sustain QA activities in the routine working environment, while simultaneously encouraging the development of a "culture of quality." The term "coach" refers to an individual who is well versed in QA techniques and principles and can provide on-the-job technical support to staff implementing QA activities. In contrast, a "mentor" is someone who acts as a guide or advisor. A mentor does not need to be a QA expert, but must be able to know when additional intervention or expertise would be useful and facilitate connection with an appropriate resource person.

**Supervision:** Staff also need day-to-day support and correction as they undertake QA activities. Achieving supportive supervision of QA requires enhancing the supervisor's facilitative role; assuring that supervisors have a foundation of QA expertise; and teaching supervisors how to observe, assess a situation, and give constructive and immediate feedback for improvement.

**Sharing** what has been achieved and how it was done, with the organization's staff, the community it serves, and others who might learn from it and become motivated by it to improve their own services (see Box 3.11).

**Using the results** for advocating policy changes and resources: when activities are well documented with supporting data, it is easier to convince decision makers.

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### Box 3.10 Sharing Data on Compliance with Standards in Ecuador

As part of a QA intervention to improve compliance with maternal and child care standards in hospitals in Ecuador, data on monthly compliance with the standards are posted in each hospital's public areas for staff and clients to see. Monthly staff discussions of the trends in compliance with standards have generated collective self-supervision, creating the opportunity to discuss causes for problems and potential interventions and heightening awareness among staff of their role in quality improvement.

Hermida and Robalino. Forthcoming

When QA is institutionalized, the organization has been transformed into a learning environment. Yet, without access to information, it is difficult to learn, so gathering and communicating information are essential support functions.

#### 3.4.3 Rewarding Quality Work

In addition to having the capacity to do QA and having information available about what can be achieved, staff also need to see that their QA efforts are important to the organizational leadership and the communities served. Providing individual, group, or organizational recognition or rewards can reinforce interest in QA endeavors and help to align staff values with organizational values relating to quality.

Every organization has implicit, if not explicit, incentives that influence staff behavior. Institutionalization requires developing mechanisms to stimulate and reward workers for striving to provide quality services. Incentives can be material—such as in Zambia, where some districts rewarded their best staff with bicycles or sewing machines—or non-material—such as public recognition of staff. In Costa Rica and Niger, the best QA teams were selected to attend a conference, thus serving the dual purpose of rewarding staff while continuing their skill development. These practices boost employee self-esteem and encourage continual efforts.

There are many ways to recognize and reward individuals and teams for QA efforts that do not necessarily require additional resources: featuring the work of quality improvement teams in meetings or newsletters, publicly recognizing an “employee of the month” for outstanding client focus, posting displays on QA efforts in healthcare facili-

### Box 3.11 Facilitating Information Flow and Sharing of Lessons in Chile

The national quality unit in Chile's Ministry of Health (MOH) has played the lead role in coordinating the dissemination of information on QA interventions and results from quality improvement activities carried out in the Health Services. Approaches used include:

**National “Quality in Healthcare Month”:** Since 1994, the MOH has designate October “Quality in Healthcare Month” to stimulate health professionals throughout the country to come together to share successes and promote quality through special events.

**Bi-monthly newsletter:** In the first three years of the program, the quality unit published and distributed throughout the country a newsletter reporting on advances by local quality improvement projects, training activities, and formation of quality committees. The newsletter ceased publication in 1995 because circulation had become too large and funds ceased. Instead, the central team now contributes QA information to bulletins published by the health regions.

**National Resource Center:** The quality unit houses a resource center on QA methods and experiences. The materials are available to quality monitors and teams throughout the country and to self-organized QA study groups.

**National Quality Assurance Conference:** Since 1995, the MOH has sponsored an annual conference featuring presentations of quality improvement projects, regional quality plans, and technical discussions of QA issues. The average attendance is 250 participants, drawn from the health services, universities, and the private sector.

Gnecco et al. 1999

ties, and honoring individuals and teams with symbolic awards. Quality improvement efforts, commitment to QA goals, or quality work can also be recognized in the regular performance appraisal system.

Rewarding quality work can also be done through higher level interventions, such as changes in financing systems or in civil service human resource management policies (see example in Box 3.12).

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**Box 3.12 Rewarding High Levels of Quality and Coverage in Ecuador**

In 2000, the Ministry of Health of Ecuador (MOH) introduced a new program, called “Free Maternity,” to improve maternal and child health care. An important feature of this program was to change the mechanism by which health districts would be funded and to introduce a financial incentive for districts to provide targeted maternal and child services, such as prenatal consultations, normal deliveries, management of obstetrical complications, family planning, and care for children under five.

Besides assigning funds through annual budgets, under the new program the MOH pays participating health districts based on the number of priority services provided and on meeting quality standards in the provision of those services. The terms of payment and quality standards are defined through formal management agreements between the national Free Maternity Coordination Unit and the municipality in which the district lies. Quality teams in the facilities monitor and continuously improve their compliance with approximately 30 maternal and child health clinical standards on a monthly or bimonthly basis, under the supervision of the district management teams and provincial MOH office. The facilities also regularly measure client satisfaction through exit interviews conducted by community members.

In 2002, the Free Maternity program proposed two new elements in the payment scheme to reward quality, client-focused care. First, the MOH would pay a 2 percent premium above the agreed-upon payment amount to districts that achieve particularly high levels of quality, coverage, and client satisfaction. Data on compliance with clinical quality standards and coverage levels would determine eligibility for the premium. Second, users’ committees (made up of clients of facilities in the district) would review quality of care information, including client satisfaction, and advise the program on paying the premium.

After more than a year of pilot testing in eight districts, the QA component of the program is being progressively extended to the entire country. One-third of Ecuador’s 217 municipalities have signed management agreements. Introduction of the proposed premium and users’ review is expected in 2003.

Source: Jorge Hermida, personal communication with L. Marquez, September 2002

Staff also find rewards and gratification when managers remove disincentives or barriers to quality. For example, quotas on the number of patients a provider must see may discourage adherence to guidelines or adequate patient counseling. Lowering such quotas gives employees an opportunity to experience the satisfaction of providing quality care. Similarly, lack of responsiveness by management to staff suggestions for quality improvements will discourage staff from making such suggestions. Rewarding quality requires managers to identify and reduce or eliminate barriers to quality at every level of the organization.

### 3.5 Conclusion

These eight essential elements—policy, leadership, core values, resources, structure, capacity building, information and communication, and rewarding quality—are key to understanding what is needed to sustain QA interventions and continuous improvement in the quality of care delivered.

The framework presented here describes the internal elements around which an organization must focus its efforts to institutionalize QA. These elements do not appear spontaneously; they must, each in its own right, be developed and nurtured. Institutionalization of QA requires a long-term vision, because it can be a lengthy and sometimes complex process. Section 4 describes the dynamic process that organizations go through as they embark on the road towards QA institutionalization and continuous quality of care.





# 4 Understanding the Process of Institutionalization: A Road Map

## 4.1 QA Institutionalization as a Process

The preceding section focused on the eight essential elements for institutionalizing QA and what they look like when QA is institutionalized; in other words, it was a static depiction of their “end state.” In reality, the institutionalization of QA is an evolving process, where organizational changes take place continuously while QA becomes formally and philosophically integrated into an organization’s structure and functioning. This section examines this process of institutionalizing QA within an entire organization without looking at each individual element (as noted earlier, an organization may be a facility, a network of health centers, a district, or a regional or national system). The next section presents the process for each element separately.

The process of institutionalization can be described as a passage through a series of phases, between an initial state of pre-awareness of QA and the end state of mature QA functions and structure. The QA Project has identified four main transitional phases: awareness, experiential, expansion, and consolidation. The phases and their descriptions were derived from QA Project experience in developing country health systems and are consistent with concepts in the organizational development literature (Renzi 1996; United States Agency for International Development 2000). The characteristics, strategies, and activities depicted for each phase are illustrative and are not meant to be prescriptive.

Although institutionalization is a continuum, subdividing it into four distinct phases helps to map out the process that

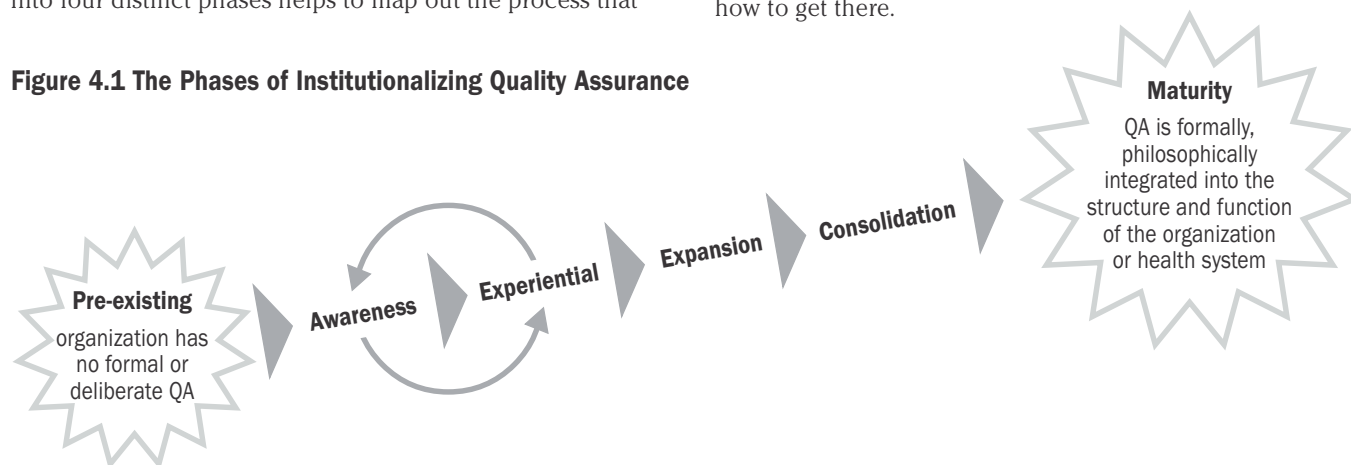
organizations are likely to experience. Such a road map can assist healthcare organizations to assess their own level of QA development and to make decisions (human resource, financial, and technical) on how best to further their organization’s advancement toward incorporating QA as part of day-to-day operations.

## 4.2 The Phases of Institutionalization

The phases of institutionalization reflect the degree of organizational commitment and capacity to do QA and the extent to which QA activities are implemented within the organization. Figure 4.1 depicts the phases an organization passes through as it moves towards QA maturity, when QA is formally and philosophically integrated into the way the organization functions. Although the figure depicts progress through the phases as linear, different reasons may cause actual progress to include reverting to an earlier phase. Furthermore, some phases (e.g., awareness and experiential) often occur simultaneously or in an iterative fashion, as suggested by the curved arrows.

Table 4.1 lists the characteristics, strategies, and indications of readiness to progress for each phase. Organizational leaders and managers can use this table to determine their organization’s location on the institutionalization continuum, either as a whole or at the level of each essential element. The description of potential strategies and activities in each phase provides guidance for planning how to most efficiently move toward QA maturity by helping leaders visualize where the organization should go and how to get there.

**Figure 4.1 The Phases of Institutionalizing Quality Assurance**



QA Project 2001

**Table 4.1 Institutionalization Phase Characteristics, Strategies, and Indications of Readiness to Progress**

Phase	Illustrative Characteristics	Potential Strategies or Activities	Indications of Readiness to Progress
Awareness	Decision makers become conscious of need to systematically address improvements in quality of care.	Demonstrate need for improvements (using quality data, community surveys, media). Create QA awareness through formal and informal benchmarking. Communicate to stakeholders that there cannot be improvement without some change.	Deliberate decision by the organization to explore QA as a mechanism to improve quality of care
Experiential	Organization tries QA approaches to learn and document that QA leads to improved care.	Implement small-scale QA activities or experiments. Develop mechanisms for diffusion of QA results and lessons learned.	Leadership support for and/or formal decision to develop an organizational strategy for QA
Expansion	Organization strategically expands QA activities in scale and scope. Organization increases its capacity to conduct QA activities.	Develop strategy for QA expansion (e.g., define priorities, set goals, plan implementation). Build capacity and develop leadership for QA. Share results and innovation.	Existence of demonstrated improvements in quality as a result of QA activities Consensus among decision makers that QA merits continuation
Consolidation	Organization simultaneously strengthens and anchors existing QA activities into routine operations, while addressing lagging or missing activities.	Identify missing essential elements or lagging QA activities and take corrective action. Enhance coordination of QA strategy and activities. Support establishment of a learning environment.	Full implementation of a balanced set of QA activities, integrated into routine responsibilities throughout the organization

The following sections describe in more detail the state of pre-awareness, the four transitional phases, and the ultimate state or goal, maturity. For each phase, possible strategies and indications of readiness to move on to the next phase are presented.

### 4.3 Pre-Awareness

As the term suggests, “pre-awareness” is not a phase of QA institutionalization; rather, it is the organization’s pre-existing state before it begins to implement any formalized or deliberate QA efforts. Isolated attempts to improve quality occur commonly in this state: it is hard to imagine a health organization where no one has made any attempts to improve the quality of care (e.g., a district health officer’s attempts to improve the quality of care by sending staff for in-service training). Pre-awareness is characterized by activities that are sporadic, individual, and informal, rather than part of a deliberate, formal QA program. Isolated QA successes often become known, building momentum within an organization to consider QA; thus, the organization enters the awareness phase.

### 4.4 The Awareness Phase

The awareness phase is the first step on the road to institutionalizing QA. Influential individuals (especially key decision makers) become conscious of the need to improve the quality of care and of the possibility of doing something deliberate and systematic about it. The impetus for this awareness could come from personal experience with quality problems, an isolated QA success during pre-awareness, discussions with key stakeholders, participation in training or conferences, complaints and pressure from communities or clients, or other sources. During this phase, senior managers, policy makers, and key stakeholders (including providers) gain knowledge of and interest in QA, while becoming increasingly dissatisfied with the current care.

Strategies for building organizational awareness of QA aim to increase exposure to perceived needs for better quality of care and to extend familiarity with quality assurance approaches. Examples include but are not limited to:

- ◆ Using comparative data to demonstrate the need for improvement, i.e., comparing health status indicators for the population served by the organization with regional, national, or international statistics
- ◆ Examining and discussing a critical incident, such as an avoidable death or other tragedy in the organization
- ◆ Conducting formal or informal QA sensitization sessions for a variety of stakeholders and organizational leaders to introduce QA approaches in health
- ◆ Benchmarking (through site visits to other organizations or countries) to increase awareness of “other ways of doing things” that may be more effective
- ◆ Assessing the level of quality to demonstrate the current state of care provided by the organization

The main indication for organizational readiness to move on to the experiential phase is the deliberate decision by the organization or system to explore the use of QA as a means to improve quality of care.

## 4.5 The Experiential Phase

This phase is characterized by the organization undertaking specific QA activities and trying out various QA approaches to learn from the experience, while it develops evidence (documents results) that QA does make a difference and leads to improvements in the quality of care.

Strategies of most use during the experiential phase include:

- ◆ Implementing small-scale QA activities or experiments to demonstrate results and “learn by doing”
- ◆ Documenting experiences from these small-scale efforts in terms of results and establishing processes for organizational learning
- ◆ Developing or strengthening mechanisms for the diffusion and exchange of QA experiences and knowledge

The awareness and experiential phases often overlap. In some organizations, these phases may happen concurrently in different parts or levels of the organization, rather than sequentially. The combined result of these two phases is the organization’s decision to embrace QA as an organizational strategy and expand its implementation. In Malawi, awareness strategies were implemented and followed by a period of experimentation at nine pilot sites, but certain stakeholders still needed additional awareness to be ready to support broader organizational strategies to institutionalize QA.

At the end of the experiential phase, sufficient momentum exists for the organization to move into the expansion phase. Indications of such readiness include increased leadership support and a formal decision to develop an organizational strategy for QA. This decision indicates that the organization has enough knowledge and experience with QA to be convinced of its benefits and is committed to extending QA in the organization.

## 4.6 The Expansion Phase

As the name implies, the most obvious characteristic of this phase is expanding implementation of QA activities. This phase is not simply a scaling up of activities or straightforward replication of positive results across the organization but rather the strategic expansion of QA implementation, based on knowledge and experiences gained in previous phases. Expansion may be geographic, but could also be an expansion in scope (engaging in more types of QA activities) or in coverage (covering a wider range of facility types or departments). Other characteristics of this phase are an increasing organizational capacity to conduct QA activities and the development/use of a formal QA strategy that includes priorities and implementation plans. Learning and trying new things continues in the expansion phase.

Strategies of most use during the expansion phase are those that facilitate expanded implementation, such as capacity building in QA, diffusion of innovation and results, and leadership development. Two key indications of organizational readiness to move into the consolidation phase include the existence of demonstrated improvements in the quality of care as a result of the QA strategy/activities and a consensus among decision makers and stakeholders that QA merits continuation and further consolidation.

## 4.7 The Consolidation Phase

The boundary between the expansion and the consolidation phases is a fine one. As expansion strategies are undertaken, they can precipitate or foster the need for taking stock of QA activities, ushering in a period of review, refinement, adjustment, and coordination. During consolidation, the organization is simultaneously strengthening and anchoring existing QA activities and programs into routine operations, while making its QA effort more comprehensive by addressing lagging or missing activities.

Consolidation is thus the natural successor of expansion. For example, during the expansion phase, there may be disproportionate emphasis on certain essential elements,

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while others are neglected. Similarly, one QA activity (e.g., setting standards) may be very successfully expanded in scope or geography, while another (e.g., measuring compliance) may be lacking. During consolidation, the organization seeks to initiate any previously undeveloped core QA activities and bring the weaker essential elements up to speed. Thus, key strategies for the consolidation phase focus on refinement and equilibrium to ensure that all essential elements and core QA activities are fully developed and scaled up throughout the organization. Consolidation strategies ensure the full implementation of QA plans and the continuity of the gains made during expansion. Indications that an organization has reached maturity are the full implementation of a balanced set of QA activities covering the entire organization and integrated into the responsibilities of all personnel.

#### 4.8 Maturity: Sustained Quality of Care and a Culture of Quality

Maturity is not a phase, but rather a state where QA is formally and philosophically integrated into the structure and function of the organization. With maturity, QA is an integral part of day-to-day operations at all levels. Organizational values, leadership, policy, and resources reinforce a philosophical and practical culture of quality. Other indica-

tions of maturity are the full implementation of a balanced QA plan that includes all three core QA activities (defining quality, measuring quality, and improving quality). In addition, each essential element has also reached a state of maturity, ensuring that the organization can sustain the quality of healthcare provided.

#### 4.9 Conclusion

QA institutionalization is a process through which an organization integrates a focus on quality into how it defines itself and its mission. The preceding pages describe the various phases of QA institutionalization in which an organization or health system might find itself. The important organizational elements necessary for institutionalization also progress through this same series of phases. Just as institutionalization itself is not a linear process, the development and maturation of each of the eight essential elements may or may not evolve in a synchronized fashion. The overall level of QA institutionalization within an organization depends on how well each of the eight essential elements has been developed. Section 5 discusses the process of institutionalization for each essential element and suggests strategies to facilitate progress through each phase.

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# 5 Moving towards Institutionalization: One Element at a Time

THE institutionalization of QA is a complex process, as is institutionalizing any change in how an organization operates. The eight essential elements of QA all contribute to an organization's ability to institutionalize QA, yet the degree of development of each essential element will vary within an organization and will vary over time. Each element must go through the same series of transitional phases as QA institutionalization itself: it is unlikely that an organization embarking on QA will develop all the policies, leadership, values, structure, and support functions all at once. This section discusses how each element can progress from its current status to maturity, to fully contribute to the organization's overall efforts to institutionalize QA. Just as the aggregate view provides guidance for overall planning and assessment, looking at each element individually provides concrete ideas on how to facilitate its development.

Table 5.1 describes, for each element, the conditions that signal an organization's readiness to move on to the next phase of institutionalization. Organizations can use this table to help gauge where they are in the continuum for each element with respect to each phase of QA development and identify where QA institutionalization efforts should focus next.

Table 5.2 provides an illustration of how the status of each essential element might look for a hypothetical organization. The shading in each cell shows, at a particular point in time, the phase that the hypothetical organization has reached in the institutionalization process for that essential element. Looking at the progress of each element relative to the others would enable the organization to understand the extent to which its QA development is balanced and complete. In this example, it would be appropriate for the organization to now focus relatively greater efforts on developing the essential element of rewarding quality as its highest priority and then to strengthen policies, core values, and information and communication. With time, the organization should reassess the strength of each element, revise the table, and act to strengthen the weakest elements.

The next few pages discuss each essential element individually, describing its role in facilitating the institutionalization of QA and how each element develops on the road to maturity. A table suggests possible activities that an organization might undertake to develop each element and

move the whole organization closer to QA institutionalization. These strategies should not be seen as prescriptive; they are illustrative and meant to encourage new ideas. The abundance of information is meant to serve as a comprehensive reference, rather than as a "how-to" manual; readers may find it useful to refer to the specific phases and essential elements that are most relevant to them at the moment, based on a self-assessment using Table 5.1.

## 5.1 Policy

Organizations have internally set policies at every level to guide organizational efforts. QA policies provide a framework and goals for the development of QA efforts within an organization. They define the organization's QA mandate and guide the setting of objectives, allocation of resources, and implementation of activities to ensure quality healthcare.

While the essential element *policy* can lend vital direction to an organization's QA efforts, the development of policy statements about QA are not necessarily effective in initiating QA activities in a country. Policy statements alone, without supportive structures and staff empowered and motivated to undertake QA, are not sufficient to make quality assurance happen. Similarly, efforts to legislate or decree quality, without creating the conditions to undertake and sustain QA activities, are doomed. Consequently, the development of explicit national QA policies, as illustrated in the case of Malaysia in Box 5.1, often occurs years after major QA efforts are underway, thus allowing the organization to develop policies based on its own experience.

It is also important to keep in mind that every healthcare system/organization operates in a larger national policy environment that may influence organizational QA efforts but over which the organization may have little influence. For example, national health policies may constrain what a regional health office can do to implement QA. Alternatively, the larger policy environment can facilitate the development of QA policies. Such facilitation occurred in Chile in 1989 when its newly elected democratic government made improving the population's health status a top priority in its social policies. This emphasis gave rise to the Ministry of Health's quality improvement initiative in 1991 (Gnecco et al. 1999).

**Table 5.1 Evolution of QA Essential Elements through the Phases of Institutionalization**

Phase of Institutionalization	Essential Element			
	Policy	Leadership	Core Values	Resources for QA
Awareness	Key decision makers are willing to allow experimentation outside existing policies for learning about QA.	Senior decision makers approve the start of QA experiments.  Key leaders emerge who are willing to support QA in the organization.	Key decision makers are aware of the advantages of explicit organizational core values.  Decision makers indicate a willingness to create mechanisms to reinforce core values.	Resources are allocated to support initial QA experiences.
Experiential	Consensus exists among key stakeholders and decision makers about the importance of putting quality and support for QA clearly into organizational policies (and any reform agendas).  Quality and QA are included in sector reform agenda.	Several operational and senior managers display leadership qualities.  Authority to expand QA activities has been delegated and the necessary resources committed.	Core values that reflect a culture of quality are made explicit and accepted by the organization's leadership.	Resources are committed to finance QA expansion costs.  Budget lines are added for QA activities or resources are allocated for QA within existing budgets.
Expansion	Policies that support QA capacity building are developed.  Policies exist that encourage measurement and continuous improvement.	A critical mass exists of operational and senior managers who display leadership qualities.  Organizational, unit, and individual worker goals are aligned.	Staff can articulate organizational core values.  Core values guide program development and strategic decisions.	Realistic budgets for QA activities are developed based on awareness of the true costs of doing QA.  Decision makers demonstrate a willingness to consistently allocate adequate resources for QA.
Consolidation	Policies supporting measurement and continuous improvement have been written and fully communicated.  Resources are available and core values are aligned with policies.	Operational and senior managers feel accountable for quality, provide leadership to QA activities, and advocate for QA.  The organization demonstrates a sustained commitment of resources for QA.	Staff and leaders' daily performance reflects core values.  Rewards and programs are in place to support core values.	Sufficient resources are allocated to support ongoing quality initiatives.  Estimated QA resource needs are incorporated into annual operating budgets.
Maturity	Organizational policies identify quality as an explicit goal and QA as an important mechanism for reaching that goal.  Organizational policies are fully communicated and actively used by leaders to set goals and guide implementation.	QA is supported throughout the organization at all levels.  Staff feel ownership of results and empowered to make improvements in collaboration with others.	Explicit core values are reinforced by policies, rewards, and leadership styles.  Managers use core values to guide program development and their own and their staff's behavior.	QA resource needs are routinely identified, quantified, and incorporated into annual operating budgets.  Resources for QA are consistently made available.



Essential Element				Phase of Institutionalization
Structure	Capacity Building	Information and Communication	Rewarding Quality	
<p>Organizational leaders have decided to further explore QA.</p> <p>Responsibility is assigned for oversight, technical support, and implementation of initial QA experiences.</p>	<p>Key leaders, decision makers, and stakeholders express a need for QA and are interested in exploring it for their organization.</p> <p>The organization sponsors QA awareness or training events.</p>	<p>Key stakeholders are committed to exploring QA.</p> <p>Information about problems with quality of care and possible approaches to improve quality is disseminated within the organization.</p>	<p>The organization's leadership recognizes the need to develop mechanisms or processes for rewarding quality work and QA efforts among staff.</p>	Awareness
<p>Leaders recognize the need for clear oversight, coordination, and accountability for QA expansion.</p> <p>Consensus exists within the organization as to appropriate and effective structures for QA expansion.</p>	<p>The organization has supervisors, coaches, and leaders with knowledge and skills to support and expand QA efforts.</p> <p>Consensus exists on capacity building strategies for expansion.</p>	<p>Those experimenting with QA regularly document their activities and share this information with others, both inside and outside the organization.</p>	<p>Managers understand what impedes quality work and what motivates workers and teams to pursue quality.</p> <p>Incentive packages to motivate quality work are developed and tested.</p>	Experiential
<p>Responsibility for QA activities is formally assigned within the organization.</p> <p>QA strategies are refined based on an assessment of QA "structure."</p>	<p>There is a critical mass of competent staff to support ongoing QA efforts.</p> <p>Leaders and managers model QA values and processes.</p>	<p>Mechanisms and systems are established for routine documentation and sharing of results and lessons learned.</p> <p>Documentation information is continually used for QA advocacy.</p>	<p>Organizational leaders express commitment to rewarding quality.</p> <p>Incentive packages that passed testing are in place.</p> <p>Staff are knowledgeable about incentive and performance management systems.</p>	Expansion
<p>All staff can accurately describe their own responsibilities to contribute to quality of care.</p>	<p>QA content is integrated into other training curricula.</p> <p>A mechanism exists to sustain a critical mass of QA expertise within the organization.</p>	<p>Systems for documentation, sharing, and advocacy operate routinely.</p>	<p>Staff believe that reward systems are fair and meaningful.</p> <p>Mechanisms exist for community input into the reward/incentive package.</p>	Consolidation
<p>QA is integrated into job descriptions.</p> <p>Roles, responsibilities, and accountability for QA are clearly delineated and operational.</p>	<p>QA capacity building is integrated into pre-service and continuing education and supported continuously by coaching, mentoring, and supervision.</p>	<p>Mechanisms exist for regular documentation and sharing of experiences.</p> <p>Information about improvement areas and better practices is used for decision making at policy and operational levels.</p>	<p>Formal or systematic processes exist for recognizing staff and managers who perform high quality work.</p> <p>Incentive systems that reward continuous improvement are integrated into the personnel system.</p>	Maturity

**Table 5.2 Illustrative Example of an Organization’s QA Institutionalization Status**

Transitional Phase in the Institutionalization Process	Essential Element							
	Policies	Leadership	Core Values	Resources	Organizing for Quality	Capacity Building	Information and Communication	Rewarding Quality
Awareness								
Experiential								
Expansion								
Consolidation								

Key policy issues that an organization faces in each phase of institutionalization are described below. Table 5.3 has suggestions on activities that an organization may undertake in each phase to develop the essential element of QA policy.

**Box 5.1 Evolution of Quality Policies in Malaysia**

Malaysia has a well-developed national QA program in the health sector, under the leadership of the Ministry of Health. Centralized planning characterizes government activities in all sectors. Shortly after Malaysia became independent in 1955, the country’s first five-year development plan (1956–60) was defined and has since been followed by a continuous succession of five-year plans. Although the Ministry launched the program in 1985, objectives related to improving the quality of healthcare did not appear in the Health Sector Plan until ten years later in the Seventh Malaysia Plan (1996–2000). With the growth of private sector delivery systems, privatization, corporatization of public hospitals, and increasing pressure to optimize the relationship between health sector expenditures and outcomes, the Ministry now recognizes the need for legislation to regulate healthcare distribution, quality, standards, and cost in all agencies operating in the sector.

Source: Suleiman and Jegathesan 2000

**Awareness:** As an organization embarks on QA, a common first step is to analyze how current organizational policies may help or hinder the delivery of quality healthcare and the implementation of QA activities. For example, if policies focus on cost containment without providing explicit criteria for quality, their implementation may negatively affect the quality of care. Countries that are initiating broad health system reforms should review policies related to financing, decentralization, purchaser-provider cost sharing, etc. to determine their potential impact on the quality of care and how QA could enhance the reforms’ positive effects and mitigate their negative effects. In addition to looking at current policies, those interested in pursuing quality will start to identify the key stakeholders in policy discussions on quality and consider how these stakeholders can be included in policy dialogue and how to increase their awareness of QA’s potential role in improving organizational performance. If the policy environment is rigid and offers little flexibility for experimentation and innovation within the system, study tours to organizations or countries with strong QA efforts may stimulate favorable conditions for QA demonstration projects. Although policies are generally created at higher management levels in an organization, the experiential phase provides the opportunity to try out different policies for innovation at lower levels in the organization. One indication of readiness to move on to the experiential phase of policy is the willingness of decision makers to allow experimentation outside of existing policies as the organization starts to learn about QA, as well as willingness to use “simple rules.”<sup>1</sup> Such a decision may be prefaced by

<sup>1</sup> “Simple rules” refers to using the concept of complexity to work out solutions: where it is difficult to control all aspects of a situation (which probably accounts for most work situations), it may be best to provide a vision and some basic guidelines, and then simply allow people to try out things. “Complexity science suggests that we would be better off with minimum specifications and general senses of direction, and then allow appropriate autonomy for individuals to self-organize and adapt as time goes by” (Plsek 1997).



discussions with various stakeholders (leaders, providers, clients, and communities) about the kinds of policies needed to support core values and advance quality initiatives.

**Table 5.3 Possible Activities to Develop the Essential Element Policy and Move to the Next Phase/State**

Awareness	<p>Analyze existing health policies in terms of addressing quality and supporting or constraining QA</p> <p>Assess impact of proposed healthcare reforms on quality</p> <p>Review and catalog existing quality standards to identify gaps</p> <p>Visit other organizations/countries to study their QA policies</p>
Experiential	<p>Convene stakeholders to elicit their perspectives on quality and generate consensus on the need to include quality within organizational policy</p> <p>Develop standards for priority areas where clear performance expectations are lacking</p> <p>Disseminate and discuss findings from analysis (from awareness phase) of the impact of existing policies on healthcare quality; make recommendations for amending or changing policies that hinder quality</p> <p>Develop an ongoing mechanism for reviewing new policies and analyzing impact on healthcare quality and QA activities prior to their approval</p>
Expansion	<p>Review human resource policy for impact on quality of healthcare services</p> <p>Analyze staffing patterns to delineate feasible, realistic QA implementation plan</p> <p>Set up a process to update or adapt existing standards and assess the need for new standards and related indicators for monitoring the quality of organizational performance (in terms of healthcare results)</p> <p>Implement communication plan to inform all stakeholders of policy</p>
Consolidation	<p>Refine existing QA written policy and institute mechanism to assure regular review/updates</p> <p>Review policy to assure that it is addressing resources for QA; amend if needed</p> <p>Analyze resources (human and financial) needed for supporting QA</p>

**Experiential:** During the experiential phase, the content of policies is often built from the bottom up, based on local experiences and needs to support QA implementation and improvements in the quality of care. For example, a quality policy or plan developed by a pilot region might serve as a model for the development of a national quality policy. Key indications of readiness to move on include consensus among key stakeholders and decision makers in the organization about the importance of putting quality and support for QA clearly into organizational policies and into any reform agendas.

**Expansion:** As an organization moves towards expansion, the need for more specific, operational policies increases. With expansion comes increased scope and coverage of QA activities. This requires clarity but also flexibility in the implementation and delegation of authority to make improvements. During this phase, the organization may modify existing policies that hinder quality (or cause disincentives for quality). The organization may need to develop policies related to capacity building, communication, and rewards that support core values. In particular, if the organization is involved with health sector reform, organizational leaders can ensure that quality and QA are included in reform policies and plans. A key indication of readiness for consolidation in the policy arena is the presence of policies encouraging measurement and continuous improvement.

**Consolidation:** As the organization moves into consolidation, it is important to review policies and their impact on staff's sense of direction, motivation, and ability to perform. This is also the time to ensure that mechanisms are in place to regularly review policies and to make changes as needed to maintain the quality of care. During consolidation, increasing alignment between formal and informal policies takes place, especially with regard to desired results, core values, and mechanisms to implement QA. Indications of moving to maturity include the existence of a written QA policy that is widely communicated throughout the organization, leadership support for QA policy, and alignment of resources and core values with policies.

**Maturity:** An organization that has reached the state of policy maturity has specific policies supporting quality healthcare as an explicit goal of organizational performance and QA as an important mechanism for reaching that goal. In addition, these policies are fully communicated throughout the organization and to stakeholders.

## 5.2 Leadership

Leadership—having a vision and the ability to generate commitment to that vision—is key to institutionalizing QA. Leadership for QA is both necessary to begin and sustain institutionalization and an evolving part of the institutionalization process at both the national/policy and operational levels (see Box 5.2).

Leadership involves examining the environment; identifying opportunities for change; giving direction; and motivating others to learn, act, and innovate. As an organization moves from awareness toward maturity, it needs to encourage the development of leadership skills at all staff levels as a means to empower them to make quality improvements and to promote ownership of results. Table 5.4 gives examples of activities that can help develop leadership for QA during each phase of the institutionalization process.

**Awareness:** As an organization gains awareness of QA, leadership for quality often manifests itself by a few champions (individuals who work proactively to effect change

### Box 5.2 Top-Level Leadership Support for QA in Chile

The strong support of the top leadership of Chile's Ministry of Health for quality was critically important for the early development of the National Quality Assurance Program. During the program's first three years, the MOH changed three times. Yet in each case, the new Minister reviewed the program, recognized its value, and decided to continue support. Continued leadership support was helped by the fact that the central level QA team made an effective case for the program, based on the broad base of activities it generated early on throughout the country.

As the program expanded in the regions and local health areas, the central level team made a concerted effort to identify and train local health professionals who would lead local QA efforts, train others in QA, and coach quality improvement teams. These individuals, called quality monitors, have been drawn not only from MOH regional and area offices but also universities and nongovernmental organizations (NGOs). The quality monitors proved to be a vital strategy for rapidly extending QA activities throughout the country, especially given the small central level QA team. The program has developed a training module on leadership skills and team building specifically for quality monitors.

Source: Gnecco et al. 1999

for improved quality) with a vision and the ability to bring other key stakeholders to support that vision. In some cases, key decision makers and leaders realize they need more information before they will champion such change. Even if quality champions do exist, "QA leaders" are

**Table 5.4 Possible Activities to Develop the Essential Element Leadership and Move to the Next Phase/State**

Awareness	<p>Identify leaders and champions and create opportunities for them to share their views about the importance of QA for the organization</p> <p>Create learning opportunities about QA for leaders and key decision makers</p> <p>Visit other organizations to see what QA implementation looks like and analyze the role of leaders in that implementation</p> <p>Organize formal and informal sessions about the need for leadership and an awareness of leadership styles among key decision makers in the organization</p>
Experiential	<p>Share results from QA experiments with top management to nurture commitment to QA</p> <p>Develop additional QA leaders through leadership training among senior management and operational managers at QA pilot implementation sites</p> <p>Encourage experimentation with leadership styles and evaluate the impact of different styles on the development of QA activities</p> <p>Encourage self-assessment of leadership styles and leadership behavior consistent with core values</p> <p>Develop appropriate capacity-building materials for QA leadership skills based on experiences</p>
Expansion	<p>Articulate the relationship between the organization's core values and desired leadership style</p> <p>Provide continued training and capacity building in leadership development for functioning and emerging leaders</p> <p>Coach and mentor senior and operational managers to nurture new leadership skills</p> <p>Create opportunities for QA leaders to share experiences, results, and lessons with each other to reinforce commitment to quality improvement</p> <p>Create opportunities for leaders to share and assess the effectiveness of leadership styles in achieving quality</p>
Consolidation	<p>Incorporate leadership development into the core curriculum for health professionals</p> <p>Incorporate the evaluation of leadership styles and their consistency with core values into performance assessment/appraisal systems</p>

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needed throughout the organization to begin institutionalizing QA. Thus, an important set of activities during the awareness phase is to generate awareness of what leadership is, why it is important, and how it can be further developed. Indications of leadership readiness to move on to the experiential phase include the existence of several key leaders (beyond the initial champions) willing to support QA in the organization and the approval of senior decision makers to start experimental QA activities.

**Experiential:** During the experiential phase, leaders support staff who are implementing QA by facilitating identification of opportunities for improvement, providing guidance and feedback, ensuring the flexibility for innovation, and rewarding achievements (demonstrated results). At the same time, these QA experiences offer opportunities to develop leadership skills and new QA leaders. Such leadership development might include skills in change management, exploring how current management/leadership styles inhibit or facilitate the achievement of quality, working with/empowering teams, and strategic planning. The experiential phase also provides an excellent opportunity to experiment with different leadership and management styles even while trying out various technical components of QA. Indications of readiness to move on to the expansion phase include a growing number of individuals at the operational and senior management levels who display leadership qualities, are aware of leadership styles, and delegate authority for quality improvements.

**Expansion:** During expansion, leadership is critical to articulate and communicate the quality vision the organization is trying to achieve and to motivate more of the organization to move towards that vision. Thus, not only must leadership continually support expansion, but the number of leaders must continually expand as well. Training and cross-fertilization among managers is especially important during this phase. Training in leadership skills will broaden to new areas of expansion (geographical, scope, etc.) and focus heavily on change management and alignment with core values as increasing parts of the organization take on new roles related to QA. Cross-fertilization can be achieved through the creation of communication opportunities for leaders to share and assess their strategies to support and inspire quality improvement. Indications of readiness to move on to consolidation are a significant portion of managers throughout the organization who display leadership qualities and the increasing alignment of organization, unit, and individual worker goals.

**Consolidation:** Creating an ongoing pool of leaders who can support QA efforts over time can be achieved by incorporating leadership development into core curricula at health professional training institutions. During this phase,

leaders continue to model behaviors and practice quality management, inspiring others to become leaders in quality healthcare. They help assess how well the organization is achieving its quality goals and have developed the habit of looking for changes needed in strategies for QA implementation. Indications of readiness to move forward to leadership maturity include the presence throughout the organization of senior and operational managers who feel accountable for quality within their area of responsibility, who advocate QA, and who ensure continued commitment of resources for QA. Management accountability would also be reflected in staff accountability for quality.

**Maturity:** In an organization that has reached maturity, a critical mass of leaders exists who embrace a quality culture. The vision and commitment to quality endure, despite turnover among managers or decision makers, because staff feel ownership of organizational results (quality of care) and feel motivated to make improvements to achieve desired results.

### 5.3 Core Values

Every organization has values that are reflected in organizational behavior. While many organizations do not have explicitly formulated core values, implicit organizational values influence management decisions, management-staff interaction, and provider-client interaction. For QA to truly spread and become integrated into the structure and functioning of an organization, organizational values must foster attention to the needs of the client and facilitate efforts to make improvements in the way things are done to improve quality. As seen in the case of Malaysia (see Box 5.3), core values provide a very important foundation for the institutionalization of QA by promoting a positive work culture that emphasizes quality. Positive core values become a source of pride and a guide to action when they are explicit (i.e., written and communicated) and are reinforced by policies, rewards, and leadership styles. Although the core values in an organization that has institutionalized QA may vary from one place or culture to another, there will be striking similarities between them: teamwork, trust and respect, support of learning, and openness to change. Table 5.5 suggests activities that may be appropriate to help an organization develop core values to support quality at each phase of institutionalization.

**Awareness:** A key to developing organizational values that can foster improvements in quality is the examination of current organizational values, whether implicit or explicit. Are they in alignment or in conflict with those necessary for achieving high quality care and the implementation of QA? Formal exercises to examine organizational values and compare them with those of other organizations that

have embraced a culture of quality may be useful, as would be other efforts to raise leadership's awareness of the benefits of defining and communicating quality values. Indications of readiness to move on include key stakeholders, especially decision makers, who are aware of the advantages of explicit core values and of their importance to QA and who are willing to facilitate the formulation and reinforcement of core values.

### Box 5.3 Corporate Culture Building in Malaysia

In 1991, Malaysia's Ministry of Health embarked on a formal national effort at building a culture of excellence and quality, spurred by a general government movement and led by the Prime Minister, to create a "culture of work excellence" in the public sector. After studying factors underlying the success of various corporations, the MOH leadership recognized that a prerequisite for a quality-mature organization is to have a vision and mission that describe the organization's goals and objectives. The following statement was developed:

*"The Vision is of a nation of healthy individuals, families and communities enjoying an enhanced quality of life. In its corporate Mission, the Ministry of Health strives to provide quality health care to all of its customers through high Quality services, continuing education and research."*

Three core values related to this statement were then identified: caring services, teamwork, and professionalism. Various means were used to communicate these values and inculcate them in both professional and nonprofessional staff, including special training modules on core values and reinforcement of the concept of a quality culture at all opportunities where staff met with senior management, such as at assemblies and meetings. Pledges, wearing of uniforms, and singing of quality-related anthems are also widely practiced.

The national quality evaluation, conducted in 1997, found that staff knowledge of the core values was good, especially among the professional group and that the main sources of information about the core values of the MOH were meetings and briefings. The majority of staff said that they believed the initiative had helped them to improve the quality of their work and patient satisfaction.

Source: Suleiman and Jegathesan 2000.

**Experiential:** During the experiential phase, an organization needs to develop mechanisms to facilitate the internalization of core values. This could be done within the context of teams that are working on QA experiences (e.g., quality improvement, standards development, monitoring of quality), which will become microcosms for developing and testing positive core values. They can then demonstrate the kinds of results (organizational behavior) that emerge from these values. The range of values examined should reflect the various levels of interpersonal interactions: management-staff, staff-clients, and staff/management-community. One indication of core value readiness to move onto the expansion phase is the presence of an initial set of explicit core values that reflect a culture of quality and are accepted by leadership.

**Expansion:** During this phase, the challenge is to broaden exposure to the newly developed core values among members of the organization and to reward behaviors that reflect those values. Managers and leaders need to discuss core values with staff and explain how these values influence daily work. One mechanism to reinforce core values is their inclusion in formal performance appraisals, i.e., to evaluate how well individual behavior and performance reflect such values. This is also valid for performance appraisals at the organizational level: How well has the organization met the needs and expectations of its clients? Indications of readiness to move on to consolidation are that a large number of staff can articulate the organization's core values and that these values guide program development and strategic decisions.

**Consolidation:** During the consolidation phase, a system must be developed to assure that organizational standards and priorities are based on and continually aligned with core values supporting both high quality healthcare and QA implementation. Indications for readiness to move on to the state of maturity include leaders, staff, and stakeholders who can articulate organizational values and whose daily performance reflects those values. In addition, rewards and other programs that support the core values are in place.

**Maturity:** Maturity is reached when the organization has explicit core values that reflect multiple dimensions of quality and when those values are aligned with efforts for quality improvement. Leaders and managers use the organization's core values as the foundation for program development and to guide their own behavior, and staff throughout the organization are conscious of the core values and apply them in their daily work. Incentive programs express the organization's recognition that values-based performance contributes to its worth. Disincentives to such performance are continuously sought out and eliminated.



**Table 5.5 Possible Activities to Develop the Essential Element Core Values and Move to the Next Phase/State**

Awareness	<p>Initiate discussion with key policy makers and stakeholders about the importance of core values and the kinds of core values that the organization might want to consider adopting</p> <p>Study or visit organizations that have successful QA programs and study their core values</p>
Experiential	<p>Develop a plan to work with quality teams to formulate relevant core values, as pertinent to the successful institutionalization of their work</p> <p>Write out core values and discuss them with health personnel, clients, and other stakeholders</p>
Expansion	<p>Promote information sharing and education about explicit core values for all staff and organizational units</p> <p>Facilitate inclusion of core values in policy statements, performance systems, etc. and reinforce them at every opportunity (staff meetings, trainings, ceremonies, etc.)</p> <p>Assess barriers to change and develop strategies to reduce resistance and overcome barriers</p>
Consolidation	<p>Assess organizational units and staff to verify whether they are aware of the organization's core values and apply them in daily work</p> <p>Work with human resources and policy makers to incorporate core values into job descriptions and performance assessments</p> <p>Eliminate any remaining disincentives that prevent the organization's core values from being reflected in every staff member's daily work</p>

## 5.4 Resources for QA

When an organization has institutionalized QA, the resources necessary to optimize quality (within the fiscal constraints of the organization) are available. Although allocation of some resources for QA is essential for its institutionalization, it is how the organizational leaders make use of these resources—rather than the level of resources—that drives the institutionalization process. Resource requirements for QA will vary as the organization goes through the various stages of institutionalization, as a variety of investments is needed to reach maturity (e.g., capacity building, experimentation, and the time of organizational leaders to support the institutionalization process), and the magnitude of these investments changes over time.

An important issue during institutionalization is the source of resources for QA. QA programs that are entirely dependent on donor resources tend to contract after outside funding ends. Committing the organization's own resources for QA activities by incorporating funding for QA into operating budgets is thus a key milestone on the road to institutionalization. Box 5.4 describes how the Chilean MOH addressed this problem with its national quality assurance program. Table 5.6 suggests other ways to ensure that adequate resources are available for QA at each phase of institutionalization.

**Awareness:** Senior healthcare decision makers may believe that improvements in quality are unaffordable, because they see advanced technology as the most promising source of improvement. In fact, QA can lead to many improvements in clinical and organizational quality without necessarily using more resources. It commonly saves money or reduces costs through the elimination of errors, duplication, and inefficiency. Initiating QA activities will require some additional resources, but the actual costs related to QA will depend on how much staff time is free for such endeavors and how much capacity for QA already exists in the organization. In the awareness phase, resources are needed for capacity building, advocacy and communication, and learning about what others have done. During this phase, it is useful to hold discussions with leaders, decision makers, and stakeholders regarding the costs (and savings) of QA, as well as exploring the link between policies supporting QA and resource allocation. Indications of readiness to move on to the next phase include allocation of resources to support initial QA experiences.

**Experiential:** Resources needed for the experiential phase include capacity building efforts, time for staff to work on QA activities and documentation, and resources for measuring results, as well as resources to support any QA structures (oversight and coordination) in place. Resource use for this phase should be evaluated for estimating future costs of QA activities, costs related to improvements, and cost savings related to demonstrated results. Indications of readiness to move to expansion include readiness to add budget lines for QA activities or allocation of existing budgets to QA and the investment costs of expansion.

**Expansion:** Resource needs in the expansion phase include capacity building, communication mechanisms, reward systems, and leadership development. Many of these expansion costs are related to initial investment, so they will be reduced over time. For example, the allocation for QA capacity building will decline as it becomes

integrated into pre-service curricula, ongoing coaching, and supervision. Throughout this phase, it is especially important to document costs and cost savings related to QA activities, as such information is needed for both planning and advocacy purposes. Indications of readiness to move on include adequate allocation of resources for QA activities in the expansion phase, budgets for QA activities, and awareness among decision makers of the true costs of doing QA.

**Consolidation:** A system for monitoring QA implementation costs should be refined and fully functioning in order

#### Box 5.4 Sustaining the Funding Base for QA Activities in Chile

The MOH of Chile initiated its national quality assurance program in 1991, supported by a two-year grant from USAID. A team of four central level staff was designated to direct the program, provide QA training, and initiate quality improvement activities in the health regions and areas. Yet the four members of the central team realized that they were too few to provide the level of coaching and training needed to support QA implementation in the country's 29 health areas. They soon adopted a strategy of stimulating the creation of local quality committees to direct all QA activities and train local quality monitors to provide hands-on technical support.

In 1993, when external funding ceased, the MOH shifted funding for the central team's salaries, travel expenses, and other direct costs to its regular budget. The MOH decided that all other costs of QA training and implementation, including training materials, participant travel, and per diem expenses, would be borne by the health regions and areas themselves, out of their decentralized operating budgets. A 1999 study found that the health areas were allocating an amount totaling US\$ 85,000 (around US\$ 3,000 per health area) to support QA efforts. In addition, over 500 quality monitors were volunteering technical support.

In 1996, budget cuts led the MOH to reduce staffing of the central QA team to one full-time professional, who works closely with the heads of major technical programs and units in the MOH to develop quality standards and monitoring tools that are implemented throughout the country.

Sources: Gnecco et al. 1999; Legros et al. 2000

to assure that resources allocated for QA are efficiently and appropriately used. During this phase, more attention is directed to process improvements to save costs. A monitoring system should thus be in place to capture cost savings as well as expenditures. The ability to document and analyze costs with effectiveness measures or costs with outcome improvements is increasingly important as more QA resources are budgeted for sustaining quality care. An indication that the organization is moving toward maturity is the availability of sufficient resources to support ongoing quality initiatives and the explicit incorporation of these resources for quality in the annual operating budget.

**Table 5.6 Possible Activities to Develop the Essential Element Resources for QA and Move to the Next Phase/State**

Awareness	<p>Present examples to stakeholders and policy makers of the costs of poor quality and the potential cost savings through reduction of waste or inefficiency, as well as QA implementation costs</p> <p>Document existing resource allocations for QA</p> <p>Identify existing policies that support or could be used to support resources (human, material, and financial) for QA</p>
Experiential	<p>Try out different approaches to measuring the costs and savings of QA activities</p> <p>Analyze broad staffing requirements and staff time needed to implement QA activities</p> <p>Set up an expenditure tracking system for all QA material investments</p>
Expansion	<p>Based on results from trial costing methods, expand their implementation</p> <p>Analyze staffing requirements to implement expanded QA activities</p> <p>Identify capacity building needed to enable staff to undertake expanded QA</p> <p>Identify sources for additional staff or expertise</p> <p>Identify resource needs for new QA activities being implemented (e.g., adding self-assessment or monitoring of performance according to standards, after having developed standards)</p>
Consolidation	<p>Refine the cost-monitoring system for capturing QA expenditures as well as cost savings</p> <p>Develop annual and long-term human resources plans to address staffing requirements to undertake and sustain expanded QA</p> <p>Broker partnerships or intersectoral collaborations as additional resources to sustain QA activities</p>

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**Maturity:** As QA becomes a “way of doing business,” certain costs will be reduced. Nevertheless, for QA to be fully institutionalization, resources to support quality initiatives must be routinely identified, quantified, and incorporated into annual operating budgets.

## 5.5 Organizing for Quality: Creating a Structure for QA Implementation

As Chapter 3 points out, organizing for quality refers to the creation of structures or mechanisms to provide oversight, coordination, and technical support for QA and to implement QA activities. No single QA structure or organization is appropriate for all organizations; rather, each organization must define the structure that best meets its needs and situation. Regardless of what the structure looks like, when QA is fully institutionalized, the oversight, coordination and support, and implementation functions will be integrated into the job descriptions and behaviors of staff throughout the organization. At such point, roles and responsibilities for QA, as well as accountability for quality of care, are clearly delineated for all staff, so that continual improvements are made to meet the needs of clients.

Organizing for quality is both a goal and a means to that goal, and in this light, it must be flexible over time, as staff become increasingly accountable for the quality of their work and their quality assurance efforts. The QA structures that are developed will change as the organization proceeds through the various phases of institutionalization, as the organization’s needs, capabilities, and staff change and develop. Box 5.5 describes the creation of QA structures in Malaysia, and Table 5.7 identifies steps to facilitate the development of this essential element through the phases of institutionalization.

**Awareness:** During awareness, two types of activities related to QA structure are taking place: (a) raising awareness of the need to structure or organize for quality, and (b) building structures to facilitate awareness of the need for quality care and for QA. Although a single individual or small group may initially champion QA awareness activities, involvement of a wider group of stakeholders will facilitate commitment over time. At this stage, these concerned stakeholders can be an informal group or a formal task force. Their role is to provide oversight and coordinate various communication and capacity-building activities.

Stakeholders should realize that the need for structure does not necessarily mean that a vertical program must be created; furthermore, the appropriate structure for quality will probably change over time. The awareness phase is also a good time to examine other structural changes or

### Box 5.5 Structures to Support and Implement QA in Malaysia

The MOH of Malaysia began experimenting with structures to assure quality even before the creation of a formal QA program. Quality control circles were introduced throughout the civil service in the early 1980s. When the national QA program was launched in 1985, a national level steering committee was established for the program. All service divisions and technical programs within the MOH eventually developed their own QA program committees on a staggered basis. Also, each state and district has created a QA committee, as have many hospitals. The hospital and district QA committees develop standards and undertake quality initiatives to address locally identified areas of concern. Lastly, quality control circles—problem-solving teams of 6–10 workers from the same unit or facility—are widespread in the Ministry.

Source: Suleiman and Jegathesan 2000

reforms that may be occurring in the health sector, such as decentralization. QA can be built into such health sector changes, and appropriate opportunities to do so may arise at this point. A key indication of readiness to move to the next phase is that organizational leaders have decided to further explore QA and have assigned responsibility for implementation, technical support, and oversight of pilot QA experiences.

**Experiential:** This phase presents two structural issues: creating structures to facilitate experimentation with QA and trying out various possible ways to organize for quality. Assigning responsibility for QA implementation, coordination of experiential activities, and oversight becomes more urgent as the organization experiments with QA. As QA technical activities are implemented experimentally on a small scale, the various roles and responsibilities for QA at the local levels, as well as mechanisms for coordination and accountability for results, can be explored. Such exploration may be done through the structures established during the awareness phase, but these structures will likely become larger and more inclusive in this phase. Expansion of stakeholder involvement ensures support for the initial QA experiences and for establishing a learning environment.

In this phase, it becomes even more important to understand the relationship of QA efforts to other organizational changes that may be occurring in the health sector. Understanding those relationships will help QA champions find



opportunities to integrate QA into other managerial responsibilities at both the central and local levels, rather than creating separate organizational structures.

A key indication of readiness to expand QA structures and efforts is the explicit recognition of the need for clear oversight, coordination, responsibility, and accountability for the expansion of QA implementation. By the time an organization is ready to move on to expansion, an appropriate and effective structure for QA within the organization is clear.

**Expansion:** As an organization moves into the expansion phase, the manner of organizing for quality becomes explicit, with clear delineation of structure at all levels. Decisions made during this phase about structure for QA implementation have implications for other essential elements because the expansion requires a concerted effort to build QA capacity, broaden communication, refine reward systems, and strengthen leadership to support a broader, larger-scale implementation of QA. In many cases, expansion of QA may require short-term assignment of individuals solely devoted to carrying out the supportive functions for expanding QA implementation. At the same time, the need continues for a clear assignment of technical oversight and leadership, stakeholder involvement, and coordination of QA activities throughout the organization.

During expansion, the long-term vision of QA roles, responsibilities, and accountability among all staff in the organization becomes more fully developed. This includes designing staff performance measures that reflect their QA involvement and responsibilities, and orienting staff to those roles. As time goes on, the effectiveness of the structures for ensuring ongoing use of information for decision making, involving stakeholders, and getting results should be evaluated. A key indication of readiness for consolidation is the formal assignment of QA activities and responsibilities within the organization. Another indication is conducting a formal assessment of the QA structure to refine QA strategies.

**Consolidation:** As the organization moves towards consolidation of structure, people feel increasingly accountable for organizational goals. The need for an array of individuals solely responsible for QA activities will diminish, because in this phase, QA is part of daily operations, the “way things get done.” However, there will be continuing need for oversight, coordination, and ensuring a learning environment related to QA. The QA structure undergoes refinements or modifications based on experience and assessment. During this phase, mechanisms are fully implemented to ensure that all staff receive training and orientation to their QA roles, responsibilities, and new

**Table 5.7 Possible Activities to Develop the Essential Element QA Structure and Move to the Next Phase/State**

Awareness	Identify key stakeholders to participate in initial QA awareness activities
	Create a working group or task force to provide oversight of QA awareness activities in the organization
	Visit other organizations to see how they have organized themselves to implement quality assurance activities
	Develop consensus on appropriate structures to try as the organization embarks on experiences with QA implementation
Experiential	Examine broader health system or organizational reforms to see where QA could be integrated
	Test out different models for organizing at the operational level
	Advocate the need for clear oversight, coordination, implementation, and accountability for QA
	Review how well the structure for oversight and coordination is working
Expansion	Ensure adequate information sharing with stakeholders
	Develop consensus on appropriate structures for expansion
	Outline the structural elements at all levels as part of the strategic plan for QA implementation
	Delineate and communicate specific QA roles and responsibilities for all staff
Consolidation	Outline staff performance measures that include or reflect involvement in QA
	Ensure adequate orientation and capacity building for new roles and responsibilities at all levels (and for oversight, coordination, and implementation)
	Assess the effectiveness of QA structures at all levels of the organization
	Refine or modify QA structures in light of assessments of how well they facilitate achieving quality care
Consolidation	Continue to work with staff on change management and communicating their roles and responsibilities
	Reinforce roles and responsibilities through rewards and recognition
	Ensure that QA responsibilities are incorporated into all job descriptions

QA techniques and approaches. All staff have QA responsibilities, and as such, QA training is integrated with general training and orientation for any position. An indication that the organization is moving toward structural maturity is that each staff member can accurately describe his or her responsibilities for achieving quality care.

**Maturity:** Maturity finds less need for specific vertical or other structures to support QA. However, some independent structures may still have a role, as certain functions—such as QA oversight and coordination within the organization and with outside stakeholders—remain prominent, even at maturity. Thus, the evolution of the QA structure reflects the increasing integration of quality into the daily operations of the organization. Nonetheless, even in maturity, the QA structure may continue to change, responding to changes in the environment and vision of the organization.

## 5.6 Capacity Building

Capacity building plays a very important role in facilitating the institutionalization of QA by ensuring knowledge and skill development in the technical implementation (standards development, process improvement, etc.) and management (leadership, planning, monitoring, etc.) of QA activities. Expansion and consolidation require a critical mass of QA expertise, and organizations may use many different strategies to build and sustain this capacity. Box 5.6 describes the challenges Zambia has faced in building and sustaining QA capacity. Table 5.8 lists activities that may strengthen QA capacity building at each stage of institutionalization.

**Awareness:** To raise awareness among key decision makers about QA as a general strategy to improve quality of care, capacity building activities focus on providing knowledge about quality and QA. Such activities may even include site visits or study tours to other organizations that have already implemented QA. The key to capacity building during QA awareness is to prepare the ground for change by identifying problems with the current situation and effective, feasible alternatives that could be implemented. A key indication that awareness has been achieved is

### Box 5.6 The Changing Challenges of Capacity Building in Zambia

In the early 1990s, Zambia's political and health sector reforms focused on improving the quality of healthcare. The health ministry became aware of QA during an international conference and made the commitment to explore QA. Two senior staff were sent for special QA training and study tours; in 1993, these staff constituted the QA Unit within the Health Reforms Implementation Team. The unit developed sensitization materials—for district and provincial staff—to foster awareness about problems with quality of care and the need to address client needs. The unit quickly realized they could not be the sole entity disseminating this information and began encouraging district and provincial staff to use these materials to more broadly conduct sensitization training. They also soon recognized that a single exposure to QA sensitization materials could not build an individual's capacity to guide healthcare improvements at the facility level. They developed consensus around a comprehensive training and mentoring plan that included awareness, standards setting, problem solving, coaching, and QA committee development. QA coaches were developed among those already sensitized to QA; they became responsible for further dissemination and for guiding local QA work. External assistance then provided mentoring to the QA Unit to increase its capacity to lead the QA effort.

As Zambia's QA program entered the expansion phase, coaches showing skill in this role received instruction as QA trainers. They independently identified groups needing QA training and started QA work without involving the QA Unit. QA capacity building expanded from districts to hospitals, and new coaches and trainers were developed specifically for hospital work. Thus, Zambia created a critical mass of trainers and coaches competent to lead QA work, while at the same time creating a critical mass of staff who could define, measure, and improve quality care. Meanwhile, the QA Unit has downsized, causing increased reliance on the QA trainers and coaches to continue capacity-building activities.

As the Central Board of Health (CBOH) moves QA toward consolidation, QA capacity is being integrated into pre-service training for many technical cadres and post-basic training for clinical officers and nurses involved in specialized training. Also, plans must be made to reliably provide ongoing capacity building to create more coaches and QA trainers, and to address staff reassignment and attrition at all levels, from facility to top leadership. The consolidation phase will also require the CBOH to consider how it will continue to provide capacity building for its most experienced QA staff: getting them additional learning experiences through international conferences, courses, professional materials, or other means is becoming an important challenge.

Source: Askov et al. Undated

**Table 5.8 Possible Activities to Develop the Essential Element *Capacity Building and Move to the Next Phase/State***

Awareness	<p>Undertake QA awareness and sensitization sessions for selected stakeholders and decision makers</p> <p>Explore various perspectives about quality healthcare (manager, provider, client, payer, community)</p> <p>Perform site visits to facilities reputed to be high quality</p> <p>Arrange study tours to other countries or regions to broaden perspectives on quality</p> <p>Hold workshops on best practices</p> <p>Study adverse events</p> <p>Implement quality assessments, including measurement of client satisfaction</p> <p>Review existing health statistics and epidemiological data</p>
Experiential	<p>Establish skill development training for supervisors and coaches, including on-the-job mentoring and evaluation</p> <p>Introduce self-assessment and monitoring exercises</p> <p>Conduct leadership training</p> <p>Develop performance indicators and performance-based evaluation of training</p> <p>Test alternative training modalities (e.g., computer-based learning, problem-based learning, mentoring)</p>
Expansion	<p>Develop a formal QA capacity-building plan</p> <p>Develop a system for tracking staff training in QA and ongoing, performance-based evaluation of training effectiveness</p> <p>Develop a formal training program for QA mentors and coaches that includes on-the-job learning</p> <p>Validate the competence of QA mentors, coaches, and supervisors</p> <p>Explore whether computer-based learning could expand access to QA information to private practitioners and remote staff</p> <p>Develop and implement a leadership training curriculum</p>
Consolidation	<p>Develop a mechanism for an annual QA capacity-building needs assessment, strategic planning of specific QA topics, and development of appropriate training strategies to address each</p> <p>Refine the performance-based evaluation system</p> <p>Refine the process for maintaining a critical number of competent coaches and mentors</p> <p>Implement a training strategy to maintain critical mass of QA practitioners and champions</p>

when leaders, decision makers, and stakeholders express the need for QA and are interested in exploring what it means to implement QA within their organization.

**Experiential:** Capacity building also has a key role in successful experiences with QA implementation that demonstrate results, i.e., that show that change is possible and beneficial. During this phase, capacity-building activities focus on developing (a) specific QA technical skills in a critical mass of practitioners, and (b) the necessary leadership and support skills (planning, coaching, etc.) among those implementing QA activities. At the end of this phase, a key indication of successful capacity building is that the organization has a group of supervisors, coaches, and leaders with the knowledge and skills not only to support the current level of QA, but also to expand it. In addition, the organization has an understanding of what kinds of capacity-building approaches are most appropriate and consensus on strategies for expanding QA capacity building within the organization.

**Expansion:** When the organization is ready to expand the scope of QA implementation, capacity building is again critical by providing and reinforcing QA knowledge and skills to an even broader group of individuals. During expansion, QA capacity building might include training, on-the-job learning, mentoring, coaching, computer-based learning, and other forms of learning. For maximal effectiveness, capacity-building activities for QA must be integrated with other organizational capacity-building activities. During this phase, QA training and support materials must be compiled or revised as necessary. Capacity must be developed at several levels: staff with QA leadership skills that can facilitate the work of QA teams, QA experts who can foster the continuous development of QA strategies and techniques, and staff with QA coaching and mentoring skills who can provide ongoing support to the expanding QA implementation. These QA staff are not a small group of exclusive QA experts, but rather a growing proportion of staff with QA skills. The skills of the expanding pool of QA coaches, mentors, and master trainers should be validated at this point and the effectiveness of QA training evaluated. A key indication of readiness to move on to the next phase is the creation of a critical mass of competent staff to support ongoing QA efforts. Another indication is the presence of leaders and managers modeling QA values and processes.

**Consolidation:** At this phase, capacity-building plans are integrated into ongoing staff training and development plans. The content and methods of training and other capacity-building efforts are monitored for their effectiveness. Competency and performance are evaluated on a regular basis, and the results are used to direct improvement or enhancement of capacity. Diverse approaches to

capacity building are used, such as self-assessments and on-the-job learning. Additional indications of consolidation include having a QA curriculum that is being integrated into other training curricula, such as pre-service training at health professional schools and universities, and including QA in in-service training for specific health interventions. Finally, a key characteristic of this phase is the existence of a process or mechanism to maintain a critical mass of QA capacity. Once a critical mass of QA practitioners and supporters exists along with a strong system to maintain both numbers and skills, maturity is close at hand.

**Maturity:** At maturity, capacity building for QA is fully integrated into the pre-service and continuing education curricula for healthcare providers and managers, and is supported on a continuous basis by coaching, mentoring, and supervision. Thus, the organization has a mechanism to develop and update QA capacity at all levels, including the maintenance of a critical mass of experts, coaches, and practitioners.

## 5.7 Information and Communication

Information and communication play a key support role in each phase of the QA institutionalization process. This role encompasses gathering all relevant information about direct QA activities and the other essential elements (such as policy development) and sharing it with all those who can learn from it or who need it to further the institutionalization effort. Information and communication are thus important not only to facilitate QA implementation but also for advocacy and to boost awareness and recognition of the value of QA. Whether defining, measuring, or improving quality, documenting and sharing results are crucial. Working in teams can successfully take place only if team members share (communicate) the information they have with others on their team. This information is part of the data collected and used to make decisions for program planning and improvement. Communication is also the process by which clients can provide their input and express their satisfaction or dissatisfaction with the services they receive (see example in Box 5.7).

Each phase of the institutionalization process presents different communication challenges. A simple planning process can establish an effective information and communication mechanism. Such a process includes: defining the specific goals of information gathering and communication for that phase; identifying any obstacles in meeting those goals; developing profiles for the different target groups (audiences) to be reached with the information; segmenting and prioritizing the target audiences; selecting appropriate communication messages, materials, and chan-

### Box 5.7 Promoting the National Crusade for Health Quality in Mexico

Reflecting the top priority given to improving the quality of healthcare (see Box 3.1), the National Crusade for Quality, led by the Secretariat of Health of the Mexican government, created a national communication initiative to promote quality in the health sector. The campaign has been widely publicized through the mass media and promotional materials such as posters and pamphlets. A key campaign objective is to ensure that improvements in healthcare quality are clearly perceived by the population. In addition, a statement of health client rights has been developed and is being introduced in all health facilities. The campaign has created a website and a national quality hotline to allow Mexican citizens to report concerns or problems with health service quality.

Another proposed aspect of the campaign is to develop a system of incentives to improve the performance of individual providers and healthcare organizations. The Secretariat is developing incentives on an experimental basis to determine what combinations of incentives would be effective and economically feasible for public sector institutions.

Source: Secretariat of Health, Mexico 2001

nels for each group; developing and pre-testing materials; assessing effectiveness; and using feedback to refine the communication program (Center for Substance Abuse Prevention 1997). Activities to develop information and communication functions during each phase of the institutionalization process are listed in Table 5.9.

**Awareness:** In the awareness phase, an organization interested in implementing QA may not have full support from relevant stakeholder groups. Thus, in conjunction with capacity-building activities to increase knowledge and awareness, communication's key role is to advocate for QA, explain why QA is necessary, show that QA can successfully address quality of care issues, and strengthen commitment to implement quality assurance programs. Giving key stakeholders information about quality problems that has been generated from research studies, assessments, or other sources is also useful, as is sharing results from QA efforts in other organizations.

**Experiential:** During the experiential phase, the organization usually starts to experiment with ways of generating information about both the process and results of QA



efforts, in order to advocate for an expansion of QA efforts. Organizations at this phase need to develop and test mechanisms for both documenting the results of QA efforts and for sharing this information with decision makers, communities, other teams and facilities, and other stakeholders. Indications of readiness to move on to the next phase include regular documentation by those experimenting with QA and sharing of experiences across numerous target audiences. Also, mechanisms are in place to ensure that improvements, successes, and failures made in one department or division are communicated to other units.

**Table 5.9 Possible Activities to Develop the Essential Element *Information and Communication* and Move to the Next Phase/State**

Awareness	<p>Gather all information available on QA activities occurring in the organization</p> <p>Collect information about relevant QA activities occurring in other organizations, regions, or countries</p> <p>Organize internal and external forums to advocate for a focus on quality and QA</p>
Experiential	<p>Develop guidelines and formats for QA teams to document their work</p> <p>Provide support to QA teams with documentation of their work</p> <p>Organize regular meetings or other venues for QA teams to share their results</p> <p>Develop a communication plan with key decision makers or leaders in QA to help them garner more support and consensus about expansion</p> <p>Foster a culture of open communication of successes and opportunities to learn from less successful efforts</p>
Expansion	<p>Monitor and evaluate ongoing documentation and communication processes</p> <p>Continue to organize or facilitate regular meetings or other venues for QA teams to share their results</p> <p>Continue advocacy efforts</p> <p>Support dissemination of QA experiences and lessons with other organizations both domestically and internationally</p>
Consolidation	<p>Evaluate documentation and communication activities with a view toward their sustainability within the organization</p> <p>Work with human resources and policy makers to incorporate responsibility for documentation and communication in job descriptions</p>

**Expansion:** Once expansion begins, whether it is a geographic expansion or an expansion in scope, information and communication efforts are needed to help build consensus among more stakeholders. This phase calls for perhaps the most aggressive communication effort. Previous awareness-raising interventions may have created heightened expectations from consumers, providers, and other regions or departments, and criticism of the effort may have surfaced. As the organization embraces broader implementation of QA, information and open communication will facilitate this transition. The documentation processes established for the awareness and experiential phases will serve as a foundation for this phase and provide data to demonstrate improvements in the quality of care. Benchmarking successful QA efforts, both within and outside the organization, may be helpful. Indicators of readiness to move on to the consolidation phase include mechanisms and systems for routine documentation of findings and lessons learned, regular dissemination and sharing of results, and habitually using information for continued advocacy.

**Consolidation:** Communication activities in the consolidation phase should contribute to the diffusion of quality goals, objectives, and core values throughout the organization. Information should continue to feed into the decision-making and policy processes. The mechanisms and systems set up for documentation, sharing, and advocacy during the expansion phase are routine, and responsibilities for these activities are incorporated into staff job descriptions.

**Maturity:** At maturity, mechanisms for regular documentation and sharing of QA experiences are well established. Improvements made in one part of the organization are shared with other parts and stakeholders. Documentation and data are used routinely for decision making at both the policy and operational levels to identify areas for improvement as well as best practices.

## 5.8 Rewarding Quality

Recognizing and rewarding quality are two of the most effective ways to motivate health staff and managers to continue and persevere in their efforts to meet client needs in the most effective and efficient manner. The goal of institutionalizing the element of rewarding quality is to create an organizational culture where efforts to improve or assure quality are recognized, appreciated, and rewarded and where staff take pride in the quality of their work. It is important to note that in addition to tangible and intangible incentives to promote the pursuit of quality,

institutionalization of QA will require removal of disincentives that discourage and prevent behaviors not explicitly aimed at providing quality healthcare or that ignore client needs.

Box 5.8 describes one mechanism for rewarding quality applied in Malaysia. Activities to develop rewards for quality during the institutionalization process are presented in Table 5.10.

**Awareness:** The first step in developing mechanisms for rewarding quality is to develop awareness of both the need for incentives to improve quality and for removing disincentives to quality. Initially, the organization must reach consensus on what constitutes quality in its work. Are efforts focused primarily on efficient use of resources, or are improvements in clients' health and satisfaction important for the organization as well? In order to focus rewards and use reward systems as an incentive to build a culture of quality, staff must clearly understand the direction of quality efforts and about performance expectations. Another critical aspect is awareness and understanding of how the current human resource management system contributes to or hinders rewarding quality. An indication that an organization is ready to move to the next phase is the recognition by leadership of the need to develop mechanisms or processes for rewarding quality work and QA efforts among staff.

### Box 5.8 Rewarding Quality in Malaysia

Innovations to increase productivity and improve quality have been documented in Malaysia's Ministry of Health since the 1960s. However, they received no formal recognition until a 1991 government-wide decree called for the recognition of formal innovation projects and for the creation of a national innovation award. Innovations were defined as "new ideas in all aspects of work to produce quality service and improve productivity as well as to enhance client satisfaction." Several health sector innovation projects have subsequently won the award.

A 1997 evaluation of the national health sector quality improvement effort found that while the idea of innovation was widely accepted in the MOH, its practice was not uniform throughout the country: some states were much more proactive than others. The evaluation recommended that innovations be more widely publicized throughout the country to stimulate interest and help others to learn from successful improvements.

Source: Suleiman and Jegathesan 2000

**Experiential:** This phase offers opportunities to explore different ways of recognizing and rewarding quality, experiment with removing disincentives or barriers to producing high quality care, and create disincentives for poor performance. While incentives used by other organizations may provide valuable ideas, each organization will have to learn what works best and is affordable within its context.

**Table 5.10 Possible Activities to Develop the Essential Element Rewarding Quality and Move to the Next Phase/State**

Awareness	<p>Visit organizations that have reward or performance management systems in place to encourage quality-focused work</p> <p>Assess whether all staff have a job description and whether job descriptions include explicit performance expectations</p> <p>Identify any disincentives in the system that contribute to lack of attention to quality among staff</p>
Experiential	<p>Develop job descriptions for all categories of staff</p> <p>Begin experimenting with different incentives to reward quality initiatives in the organization</p> <p>Consider and test a modification of the performance evaluation system</p> <p>Organize meetings with managers at different levels of the organization to discuss incentives and disincentives for quality work</p> <p>Work closely with those developing new organizational policies to harmonize efforts and develop joint implementation strategy to reorient the organization toward quality work</p>
Expansion	<p>Work with human resources and policy makers to incorporate incentives for quality into staff performance evaluations</p> <p>Develop supervisors' capacity to give feedback and motivate staff to improve quality</p> <p>Initiate the development of mechanisms to solicit input from communities and clients for the incentive system</p> <p>Assess staff satisfaction with incentives and rewards for quality</p> <p>Analyze whether any disincentives to quality work endure in the organization and identify strategies to remove them</p>
Consolidation	<p>Assess whether all parts of the organization and all staff are included in the new incentive system</p> <p>Eliminate any remaining disincentives</p> <p>Conduct a formal evaluation of the effectiveness of incentives and rewards for quality</p>



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During this phase, an organization may experiment with various packages of incentives and disincentives or changing certain human resource management practices. The creation of incentives for communicating results might also be analyzed. Key indications of readiness to move on to the expansion phase of rewarding quality include: the presence of a clear understanding about what impedes quality work and what can motivate workers and teams towards quality and the implementation of tested incentive packages.

**Expansion:** During expansion, the organization moves towards aligning individual staff performance with the organizational objectives of high quality care. This might begin with a system with clear expectations for performance and work behavior, in which performance is regularly assessed, good performance is reinforced, and poor performance is explicitly discouraged. Mechanisms for rewarding quality work and QI efforts begin to become incorporated into the overall QA strategy and are introduced at various levels: individual, team, and organizational. Indications for readiness to move to the consolidation phase include increased levels of staff awareness of incentives and rewards for quality performance.

**Consolidation:** During consolidation, the human resource management system has transparent short- and long-term rewards for individual quality performance and QA efforts. The organization has also implemented rewards for effective team work as well as excellence in the performance of organizational units. When an organization is ready to be considered mature, staff believe that the system of rewards and incentives is fair and meaningful.

**Maturity:** Even when an organization reaches a mature state of QA, it still needs to have formal or systematic processes for recognizing staff and managers who perform their work in a quality manner, including incentive systems that support continuous improvement. Another indication that an organization has a mature reward element is a means for community input into mechanisms to reward quality work. In this state, quality is promoted and recognized by leaders and stakeholders, including the community.

## 5.9 Bringing the Elements into Maturity

Our description of the process of institutionalization for each essential element indicates that an organization will not necessarily have all elements in the same phase at any point in time. Because progress is not necessarily uniform across the range of elements, it is important to examine each element's progress and determine how to best direct resources and energies to develop each element. The ultimate goal is to bring all elements into maturity—or as close to that state as possible—and each element is critical in making that happen. Unless all eight elements are in place and close to maturity, sustaining QA is difficult.

Determining where each element is in its development takes careful analysis. We reviewed Zambia's institutionalization status as of August 2002 to offer an example. As Box 5.6 states, Zambia's Central Board of Health has been developing its QA program since 1993. At a recent meeting of QA link facilitators and trainers (four local coaches, five provincial level clinical specialists, and 13 national level trainers) who are supporting QA activities throughout the country, a QA Project staff member participated in analysis of the program. Table 5.11 summarizes the participants' conclusions on each essential element and the actions that will move Zambia's health system forward in its institutionalization.

The analysis of QA institutionalization in Zambia presented in Table 5.11 suggests that a focus on the elements of policy, core values, information and communication, and rewarding quality would best help to bring the overall QA effort into alignment. As the framework suggests, these elements cannot be addressed without leadership support. Therefore, an appropriate next step in Zambia would be to communicate this analysis to the senior CBOH leaders to gain their support for its recommendations. When QA practitioners regularly inform the organizational leadership of the results and benefits of QA activities, their work to institutionalize QA is more likely to succeed.

In summary of Section 5, institutionalization of QA is an ongoing process where activities related to defining, measuring, and improving the quality of care become formally and philosophically integrated into the structure and functioning of an organization or health system. Institutionalization is not a linear process of going from point A to point B but a fluid process where the essential elements of quality assurance may or may not mature sequentially. No one path exists for all organizations, but the framework of eight essential elements and the phased process of institutionalization outline the needed aspects and general roadmap to creating a lasting program to improve the quality of healthcare an organization provides.

**Table 5.11 Analysis of Each Essential Element in Zambia’s Quality Assurance Program**

Essential Element	Status in August 2002	
Policy	<p>Zambia’s policy environment is moving from experiential to expansion. Policies that support QA capacity building, performance measurement, and continuous improvement are embedded within general management, data management, and clinical policies and guidelines. Health/management information system indicators are used for local as well as national quality assessment and guide improvement efforts. The QA implementation plan is part of strategic and action planning at all levels (local, district,</p>	<p>province, national). To develop further, staff plan to document guidelines to formally define the roles and responsibilities related to quality for all staff, guide QA committees, and broadly explain the communication/reporting system. Developing an overall QA policy that links all types of QA efforts, including regulatory approaches such as accreditation, would also facilitate the expansion of QA activities in Zambia.</p>
Leadership	<p>Zambia is moving into the expansion phase in terms of leadership. Key leaders at all levels have the authority to expand QA activities, allowing for creative and individualized approaches to measuring and improving quality at different levels of the health system. Some districts and hospitals already have a critical mass of leaders who are</p>	<p>accountable for quality, lead QA activities, and have provided sustained support and resources for QA work, but this is not consistent across the country. To move to the next level, QA coaches are involving a wider variety of senior leaders in QA sensitization, to gain their support and assistance in leading QA efforts.</p>
Core Values	<p>“The vision of health reforms is to provide quality, cost-effective healthcare as close to the family as possible.” This statement reflects core values held by the Zambian public sector health system, placing it in the experiential phase. Staff and leaders are acutely aware of barriers that limit the achievement of this vision, but the CBOH</p>	<p>continues to include these values in performance assessment, supervision, policy development, and strategic decision making. As they solidify this phase, leaders may consider whether the vision and strategic planning imply other important values; if so, these leaders could make these additional themes explicit.</p>
Resources	<p>Resources to do QA in Zambia are in the expansion phase. Realistic budgets and other resource documents at the facility, district, and province levels identify human, financial, and material resources needed to provide quality healthcare. In many cases, QA is integrated with other activities, so a budget for introducing a new service, for example, would include resources needed for standards setting and communication, immediate post-intervention quality measurement, and longer-term monitoring. Local budgets define requirements for</p>	<p>capacity building (clinical, QA, health/management information system, etc.), staffing levels, and priorities for clinical improvements. As activities mature, the CBOH looks forward to having more of the country incorporate QA resource needs into routine budgets and anticipates having sufficient resources to fund all levels at the amounts they have budgeted. Assuring adequate resources for national and local level support for the QA program would signal an important step toward consolidation.</p>
Organizing for Quality	<p>The CBOH is in the consolidation phase vis-à-vis organizing for quality. The assessment concluded that current organizational structures do not support communication about quality or effective mentoring and monitoring of QA work by the national level. With a new service quality specialist taking over the senior technical QA role in September 2002, an opportunity exists to redefine</p>	<p>roles and responsibilities related to quality and QA at all levels. As job descriptions are being written, responsibility for quality is included. In addition, specific responsibility statements for province clinical specialists, QA committees, QA coaches, and national trainers are being revised.</p>
Capacity Building	<p>The CBOH is in the expansion phase for capacity building, moving into consolidation. Formal QA capacity building has occurred or is ongoing in every district and at each level 2 and 3 hospital, and competent coaches are available at most districts and each hospital. Many, but not all, facilities have at least one QA-trained person. Capacity building uses standard materials and qualified trainers. Training effectiveness has been routinely evaluated by national trainers, resulting in changes in technical approaches and</p>	<p>coaching training. QA coaches and national trainers have been regularly validated with competency-based assessment by senior QA practitioners. Training materials have been developed for several pre-service and post-basic school environments in technical clinical programs and nursing. Plans have been made to train additional coaches and national trainers to address attrition and reassignment, to ensure a critical mass of QA expertise.</p>

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**Table 5.11 Analysis of Each Essential Element in Zambia’s Quality Assurance Program** (Continued)

<b>Essential Element</b>	<b>Status in August 2002</b>	
Information and Communication	<p>This element had been at a consolidation level in past years. However, the mechanisms previously established for communication from the field to national level, through coaches and national trainers, were recently evaluated and found flawed. Consequently, this element is seen as currently in the experiential phase. Some districts and provinces do hold regular meetings to discuss quality issues and review quality efforts. To advance this element, information from these meetings should be regularly communicated up to the national level and routinely used</p>	<p>for QA advocacy. Another advance will be to encourage supervisors to routinely report quality information to their supervisors, so more people than just the QA coaches are communicating about quality. The most effective method of communication has been through link meetings—national-level meetings of QA national trainers, provincial clinical specialists, and selected local coaches. While budgets for these meetings are routinely provided, the funding is insufficient, so ongoing attention is needed to ensure that they are conducted routinely.</p>
Rewarding Quality	<p>Zambia is at an experiential level in terms of formal rewards for quality. Job descriptions are not yet developed for all staff, though job expectations do exist for categories of staff. The system has assumed that workers will be of high quality and has not envisioned a role for rewards or punishments based on quality performance. At the national level, leaders are discussing ways to evaluate and</p>	<p>reward quality work. At local levels, where QA efforts are sustained, people are rewarded for quality in several ways: personal recognition by supervisors, formal awards on Labour Day, recognition of “best ward” or “best nurse,” ability to use saved funds on priority needs, and personal advancement due to knowledge of quality and quality assurance.</p>

Source: Reinke 2002

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# 6 Epilogue

**T**HE QA Project has now completed ten years of work to support lower- and middle-income countries in implementing QA in national, regional, and local healthcare systems. This monograph highlights our understanding of what is needed to sustain QA in a healthcare system or organization over time.

Leadership, both at the facility and the political levels, is perhaps the most critical element in improving and sustaining the quality of care and moving forward in institutionalization. In addition, clear policies that link QA to the organization's overall mission and that define the QA roles and responsibilities of coaches, trainers, quality committees, and supervisors must be in place. While our field experience shows that it is possible to implement QA activities with good results, without overall policies that support QA, such activities are rarely, if ever, sustained. Leadership, policies, and core values that support QA help sustain health worker motivation to persist in delivering quality care despite the difficulties they face daily in resource-constrained environments.

Building QA capacity at the facility, district, regional, and national levels for large-scale implementation is another big challenge, and one that demands further insights in how to undertake it with the least investment of resources. We know that organizations that are serious about quality assurance must allocate sufficient resources to develop a cadre of QA experts who can train, coach, and mentor others. Frequent turnover of health personnel calls for diverse strategies for developing and maintaining QA skills after initial waves of QA training. Alternatives to traditional training merit wider application: self-learning, peer mentoring, and job aids, as well as mechanisms to reach would-be healthcare providers during basic education and during service through professional organizations.

While the eight essential elements and the phases for institutionalization are the central issue of this monograph, it's important to keep the principles of QA in mind while institutionalizing QA. For instance, the principle of focusing on the client, as noted in Section 2, keeps healthcare workers performing at their best and clients satisfied with the services they are receiving. Such performance feeds into a focus on results that will resonate with health authorities, who are responsible for improving outcomes for priority health problems and efficiency, and for reducing costs. Providing objective evidence of improvement demon-

strates to health decision makers, on an ongoing basis, that investments in QA produce results. The development of quality indicators and monitoring systems that capture and communicate such results is essential to this end.

The QA Project enters its second decade with a clear understanding of the elements of QA institutionalization and a need to learn how to most efficiently support their development and scale-up. While a few countries have moved rapidly to expand QA to entire districts or provinces, many countries become mired in the expansion phase, struggling with the challenges of scaling up successful pilot or demonstration experiences. We need to learn more about how QA activities in a small number of sites can be efficiently expanded to cover all or most of a healthcare organization's operations.

No single approach to scaling up fits all countries and contexts, and we need to increase our understanding of the range of expansion strategies and the different conditions under which various strategies would work. Focusing QA activities on priority health problems is one model that can be effective in rapidly expanding QA efforts. The selection of what to improve determines much of the initial enthusiasm and leadership buy-in to the improvement effort. It is critical to select important health priorities; doing so will make the effort worthwhile and generate support for more improvement. This has the double benefit of achieving measurable results to persuade decision makers that QA activities are worthwhile and providing positive reinforcement to the health providers who undertook the QA activity. Replicating successful interventions or expanding work to other clinical areas then serves as the vehicle to spread QA concepts and methods to a larger area or to apply them to other problems.

Another promising approach for building up and sustaining QA efforts is creating demand for improved quality of care from forces external to the healthcare organization. This external demand for quality may come from clients and communities (such as the users' committees or community health boards) or through the healthcare financing system, as in the approach of tying payment or reimbursement to meeting minimum quality standards. Attention to addressing client needs and expectations can help lay the groundwork for greater community involvement in and support for QA efforts.

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Finally, the growing emphasis on health sector reform throughout the world provides “fertile soil” for institutionalizing QA. Many countries are currently undergoing major changes related to health reform, such as decentralization, integration of private sector in primary care, modernization, and health insurance diversification. For QA to be part of a national agenda and progress beyond the awareness and experiential phases, it needs to be linked to the agenda of health system reforms and not work in isolation.

QA is a dynamic field, with new ideas and tools continually being developed. The institutionalization framework

was designed to help healthcare decision makers identify concrete actions to further the institutionalization of QA in their organization or health system. It has been used in Latin America and Africa to assist Ministries of Health to plan and focus efforts and resources to strengthen QA programs. Responding to requests from country programs, we are now developing self-assessment and monitoring instruments, based on the framework, to help healthcare organizations to analyze their QA institutionalization progress more systematically over time.

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