PISAF (INTEGRATED FAMILY HEALTH PROJECT) QUALITY ASSURANCE IMPLEMENTATION PLAN

APRIL 2009
PISAF, Projet Intégré de Santé Familiale, is funded by the United States Agency for International Development (USAID), under Cooperative Agreement No. 680-A-00-06-00013-00. PISAF is managed by University Research Co., LLC (URC) in collaboration with Abt Associates.

The author’s views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development of the United States Government.
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1. INTRODUCTION

The Integrated Family Health Project (PISAF, or Projet Intégré de Santé Familiale) was launched in April 2006 with the goal of increasing the quality and accessibility of health services and improving knowledge, practices, and participation of the population in healthcare services in the departments of Zou and Collines. PISAF’s objectives are to increase the use of health services and prevention measures in a favorable policy environment.

1.1 THE PISAF PROJECT

To achieve these objectives, PISAF embraces the following key principles:

• Foster investment and ownership by the Beninese at every level of the health system.
• Assist in making decentralization operational at the health zone level.
• Stress quality assurance and the institutionalization of ongoing improvements.
• Work with the communities and health facilities to stimulate demand and the quality of care.
• Use multisectoral approaches and collaboration with other partners to strengthen capacities in local management, community mobilization, and behavior change communication.

Of these, the third presents a cross-cutting way to contribute to the sustainability of changes and results. Quality assurance (QA) is a proven way to define, measure, and improve the quality of care and support services so that people benefit from effective and efficient healthcare and receive attention based on their expectations and needs.

PISAF’s core principle holds that by implementing QA health workers and their partners at the community level will be able to 1) sustain quality care after PISAF support ends and 2) continue working to meet the needs of the population.

1.2 BACKGROUND ON WAYS TO IMPROVE QUALITY

In past years, much effort has been made in Benin and other countries to improve the quality of care as a key step in reducing morbidity and mortality. These efforts started with developing standards, training or retraining health workers in standards, supervision, and ensuring the availability of equipment and drugs. However, the results of these efforts were disappointing, for many reasons: The standards were not sufficiently communicated, only some health workers were trained, and/or the system lacked a way to communicate to others information about how to solve problems. Moreover, the health facilities’ systems and work processes were not suitable for implementing new standards.

Early disappointments led to the second, “traditional quality assurance” approach: implementing team-based QA in the sites where the standards were to be implemented. This approach is based on four principles: focus on the client, work in teams, examine systems and analyze their processes, and use data for decision-making (see Figure 1). This approach is valid for clinical care and “support services,” such as reception, janitorial services, and drug supply management. Much work is performed through processes that should be “standardized,” and the quality of work should be defined in terms of the application of standards. Experiences in Borgou and Alibori showed that this approach, when paired with the implementation of standards and required inputs, can improve the quality of healthcare and services and improve health workers’ approach to their work.

FIGURE 1
Quality Assurance

<table>
<thead>
<tr>
<th>QA is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defining quality (standards)</td>
</tr>
<tr>
<td>Measuring quality</td>
</tr>
<tr>
<td>Improving quality</td>
</tr>
</tbody>
</table>

The four principles of QA are:

- Client focus
- Teamwork
- Analysis of systems and processes
- Use of data for decision-making

Quotations from health workers in Borgou/Alibori who worked with the previous project, PROSAF:

“Before QA, I was harsh and didn’t listen to the others. The QA approach has helped me correct this, and I learned how to behave in a group.”

“I was somewhat obstinate, and QA helped me to be more flexible (it’s a better way of managing).”
2. KEY QA INTERVENTIONS IN ZOU AND COLLINES

PISAF uses the same QA approaches as the Benin Integrated Family Health Program (PROSAF: Programme de Promotion Intégrée de Santé Familiale dans le Borgou et l’Alibori, 1999-2004) and carries out activities to strengthen the health system. PISAF’s principal QA interventions are:

2.1 USE DATA FOR DECISION-MAKING
PISAF supports data collection and analysis to improve the continuous availability of reliable data on health system operations, as follows.

Management assessment: Baseline data enable an evaluation of the quality of the health system before an intervention begins. This management assessment covered all 136 facilities in Zou/Collines and involved health workers at various levels (DHD, departmental hospital, zone hospitals, health zone coordinating physicians, and health facility providers) in every stage of the process (preparing and validating the methodology; pre-testing and correcting the data collection tools; training data collectors and supervisors; and collecting, analyzing, interpreting and validating data). Through a peer evaluation strategy and learning by doing, these health workers came to see the weaknesses in their health system even before PISAF interventions were implemented.

Data findings clearly demonstrating poor performance relative to standards were presented at the departmental, national, and communal levels. The data were then used as a basis for preparing action plans for the DHD and health zones. PISAF used the findings to plan clinical and management collaboratives, and implementing them will improve poor performance found during the assessment.

Performance Monitoring Plan: PISAF uses a series of process and results indicators to assess the performance of the activities it supports. Some indicators from the management assessment are also part of PISAF’s Performance Monitoring Plan (PMP). The PMP includes process indicators whose data are used by Zou/Collines health system managers to make data-based decisions. Health zone statisticians collect PMP data quarterly under the supervision of a joint DHD/PISAF team. As part of the data collection process, health zone data managers visit health centers and provide coaching in data collection.

Scoreboard: Another important dataset that contributes to the quality of health services is the scoreboard, which presents a summary of important health system management information indicators. It includes selected indicators validated by consensus. An electronic form of this tool was installed with each Health Zone Management Team (HZMT); and is managed by statisticians who have been trained to complete it.

Since the data used in the management assessment, PMP and scoreboard are valid only if they are of good quality, PISAF supported training in data quality control of all statisticians in the health zones, zone hospitals, and the department hospital as well as the statisticians from the DHD. The quality of data that will be presented through the work of the collaboratives will thus likely be adequate.

2.2 STRENGTHEN GOVERNMENT AND NON-GOVERNMENTAL STAKEHOLDERS’ CLINICAL, MANAGEMENT, AND COMMUNICATIONS SKILLS
Healthcare providers and health services managers must understand standards in order to practice them. PISAF provides technical and financial support for training both in: 1) the active management of the third stage of labor (AMTSL), 2) essential newborn care, 3) the new protocol for treating simple malaria with Artemisin-based combination therapies (ACTs) and the proper use of rapid diagnostic tests, 4) prevention of mother-to-child transmission of HIV (PMTCT) and the biological surveillance of pregnant women with HIV, 5) contraceptive technology and interpersonal communication, 6) drug management, and 7) completing the new SNIGS tools. PISAF also trained FM community radio stations and theatrical and folklore companies to prepare messages on family health themes in local languages. It also trained members of COGECS (commune-level health management committees) in their responsibilities so that they can support health facilities in implementing the collaboratives.

2.3 IMPROVE CARE AND THE CARE ENVIRONMENT
The baseline assessment revealed major deficiencies in the maintenance of equipment and structures, making providers unable to provide quality care. To address this situation:

The health facilities were given basic medical-technical supplies and equipment
Based on a list of equipment necessary to provide the family health package (especially essential obstetric and newborn care [EONC] and AMTSL), a status update was performed to identify the gap between the equipment on hand and the equipment on the list. PISAF then provided the missing equipment to the health facilities.
Healthcare structures were improved
Due to the poor condition of some health facilities (a leaking roof, unstable walls, rooms that failed to comply with any of the standards for care, etc.), PISAF provided support to the DHD to renovate some health facilities. These renovations are improving working conditions for health workers and attracting clients.

2.4 REORGANIZE CARE PROVISION SYSTEMS
Implementing the integrated delivery model of family health services adopted by the Benin Ministry of Health required a reorganization of the provision of care. This involved:
• Making all components of the family health package (there were seven components before 2005) available five days a week. This necessitated teamwork and developing a system of internal referrals and counter-referrals.
• Initiating community-based activities (especially EONC and community Integrated Management of Childhood Illness) so that clients could receive seamless care from the community to the health center and hospital.
• Initiating bottom-up planning for greater community involvement in the management of health services. COGECs members took part in preparing their health center action plans.

These activities are both critical and traditional ways to improve quality. However, the quality improvement experience in PROSAF and elsewhere has demonstrated that QA is time-consuming and slow if it is isolated in healthcare sites working independently. The healthcare improvement collaborative approach has been added to the “traditional” approaches in PISAF. This approach provides a structured network of sites that work together for a limited period to make significant improvements in the processes, quality, and efficiency of care in a short period through shared learning. A collaborative aims to adapt and extend evidence-based practices in a specific topic area (e.g., AMTSL, malaria), and to prepare for scale up. Figure 2 shows how PISAF has adapted three approaches to healthcare improvement—traditional plus QA plus the collaborative approach—to address healthcare improvement holistically.

The PISAF project seeks to capitalize not only on PROSAF experiences, but on the experiences of the Quality Assurance Project on collaboratives as well, in order to implement a strategy that can be made sustainable for ongoing improvements in care.

FIGURE 2
How to improve quality

| Traditional: norms, training, equipment and materials, job aids, supervision |
| QA: teamwork, process analysis, monitoring/data, clients, coaching |
| Collaborative: common problems, change package, experience-sharing, positive competition, best practices, rapid extension |

3. PURPOSE, OBJECTIVES, AND GLOBAL VISION

3.1 PURPOSE AND OBJECTIVES
The purpose of this plan is to provide quality care to those living in the PISAF intervention zones such that QA methods will be institutionalized in the health system structures.

This plan’s general objectives:
1. Enable all health workers to apply the principles and methods of quality improvement in their health departments and facilities.
2. Enable all health facilities to offer quality care by having benefited from the lessons learned about service delivery models and about organizational changes emerging from the collaborative experiences.
3. Provide each level of the health system within the department permanent organizational structures capable of sustaining the accomplishments and continuously improving the quality of care.

3.2 GLOBAL VISION
The strategy is centered on: 1) disseminating and strengthening standards of care and other work processes and 2) implementing quality assurance. Since there are many health facilities (136 in the public sector and more than 14 in the private sector) in Zou/Collines, the improvement collaborative approach will be used to demonstrate, spread,
and ultimately scale up the best practices in applying the standards and systematically implementing the four principles of QA. Everyone who works in the public and private health sector will learn to work in teams while improving their skills, analyzing their care and management processes, using data to measure quality, meeting client needs, achieving results, and making decisions. These skills will in turn make it easier for them to incorporate all the innovations and best practices they will learn in the future, including new standards.

Experience has shown that the quality of care does not improve simply by offering training or materials to health workers. The quality assurance strategy in PISAF builds on the principle of strengthening skills, but within a comprehensive framework of monitoring, improvement, and support to make the desired changes. The collaborative approach provides such a framework. The challenge is how to train all staff members in 141 health facilities in six health zones in a short period.

PISAF is addressing this challenge by using an innovative strategy of implementing six collaboratives simultaneously on different topic areas, with a plan to assemble the practices tested in one collaborative and scale them up in the health facilities that did not participate in that collaborative. The next section explains this strategy and how it will achieve 100% coverage of the health facilities for QA and the content of the “change packages” that will result from the collaboratives.

4. IMPLEMENTING THE COLLABORATIVE APPROACH IN ZOU/COLLINES

4.1 THE COLLABORATIVE AND ITS PHASES

A collaborative is a shared learning system that brings together several site-based quality improvement teams (QITs) that work together to generate major improvements in the processes, quality, and efficiency of care with the intention of spreading these improvements to other sites. The collaborative structure provides common mechanisms for monitoring results and sharing experiences that generate significant results and best practices within a short time, with a deliberate strategy for scaling up the best practices. A collaborative is distinguished from other QA approaches by the essential features listed in Figure 3. These essential features are described in greater detail in Annex 1.

PI SAF will support a collaborative in each of the following topic areas:

1. Essential maternal and neonatal care
2. Malaria treatment
3. Family planning
4. PMTCT
5. Human resources management (HRM)
6. Strengthening the operations of community-based health insurances and the quality of care offered to members

A collaborative develops over several phases, starting with a preparatory phase. That phase is followed by one or more phases that implement the change package developed in the preparatory phase. The number of implementation phases depends on the number of sites targeted for spread of improvements. Three implementation phases are planned for Zou/Collines: a demonstration phase, a spread phase, and a scale-up phase.

**FIGURE 3**

**Essential features of an improvement collaborative**

- Shared improvement objectives or aims
- Adequately supported QITs testing changes
- A change package
- Regular analysis of measured results to guide quality improvement
- Shared learning for accelerated improvement at greater scale
- A spread strategy
- Organizational structures

The content of the various phases will differ since each phase has a different purpose. Although documented improvement in care is a shared objective, the preparatory phase will clarify the standards, articulatethe standards will be implemented, and organize the health facilities for participation. The demonstration phase will develop and test a set of practices that enable the consistent use of standards. Together, these practices will comprise an extended or enhanced change package that will be introduced to other facilities in the spread phase. Finally, the scale-up phase seeks to institutionalize these best practices in protocols, procedure manuals, etc. This phase will also bring the best possible change package to any remaining health facilities. More detail on each phase follows.
**Preparatory phase:** This phase sets the foundation for properly carrying out the improvement collaborative’s activities. It includes technical, logistical, and management planning. Depending on the complexity of the collaborative topic and whether clear, up-to-date standards and baseline data exist, this phase takes one to nine months. If the collaborative is not well prepared during this phase, delays will ensue in the implementation phases.

The preparatory phase will result in:

- An initial, evidence-based change package validated by experts;
- An organizational structure with well-defined roles and responsibilities for its various components;
- Indicators for monitoring results and a monitoring system (data collection forms, monitoring manual, etc.);
- A strategy for spread;
- Capacity building for the skills needed to implement the change package (including the standards on which the package is based) and quality improvement;
- A plan for establishing QITs, including tools for team functionality; and
- A system for coaching and trained coaches.

**Demonstration phase:** This phase is the first phase of implementing and testing the change package. Generally, this phase works with a limited number of sites to facilitate testing the change package and discovering ways to improve it. QITs work to implement the change package, monitor the results, and share the lessons learned.

At the end of this phase, the collaborative will have an improved change package, based on the QITs’ experiences and lessons. This package will have been shared with other teams so that they can test them and establish the most robust and effective, the “best practices.” With this package and the tested training, monitoring, and coaching strategies, it is possible to advance to the spread phase.

**Spread phase:** This phase further refines and streamlines the change package. This phase also builds capacity to support the QITs, incorporates coaching into supervision, and incorporates indicators in routine monitoring. In addition, this spread phase demonstrates the scalability of the results achieved thus far; determining whether the results can be expected to scale up to a larger segment of the healthcare system. At the conclusion of this phase, a change package will be ready for implementation at the national (or departmental) level. This package is a streamlined version of its precursor packages, with monitoring indicators and a tested strategy for building clinical and quality assurance skills.

**Scale-up phase:** This phase achieves the overall goal of a collaborative: scaling up the implementation of standards and best practices emerging from a process of testing and refinement; in other words, all 141 health facilities (health centers, zone hospitals, and departmental hospital) will be positioned to deliver the best possible care in the six topic areas and prepared to implement future standards efficiently.

### 4.2 ACHIEVING 100% COVERAGE

All the health facilities (including the zone hospitals, departmental hospital, and legally registered private medical practices) will participate in one collaborative, either in the demonstration or spread phase. With this strategy, all health facilities will be mentored closely in their quality.

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**FIGURE 4**

The collaborative phases

- Definition collaborative focus
- Select implementation package
- Design collaborative structure
- Prepare for implementation

**Preparation**

- Define collaboration focus
- Select implementation package
- Design collaborative structure
- Prepare for implementation

**Demonstration Phase**

- QI teams validation of change phase testing improvements
- Conference on best practices

**Spread Phase**

- QI teams validation of change phase testing improvements
- Conference on best practices

**Scale-up Phase**

- Synthesis workshop/conference to define best practices and enhance implementation on package
- QIT teams validation of change phase testing improvements
- QIT = quality improvement teams

- Hold the gains: Sustain improvements over time
- Institutionalize QI activities for ongoing improvement
- Implement spread strategy to scale up improvements/best practices

Other sites

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**Model for Improvement**

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

Art  Plan  Study  Do
improvement implementation through training and coaching and will be motivated by working with a network of other sites at learning sessions, etc. Table 1 shows the initial coverage the proposed strategy will achieve. Each health facility will participate in a collaborative during one phase. Hospitals will participate in all clinical collaboratives, and the HRM collaborative will focus on health system levels having responsibilities in human resources management (health zone, hospital, and departmental health directorate).

Figure 5 and Table 1 show the planned geographic coverage over three years. Each collaborative will begin its demonstration phase in all health zones simultaneously, progressively covering more health facilities operating in the zone. For example, the EONC/AMTSL collaborative

**TABLE 1**

<table>
<thead>
<tr>
<th>ZOU/ COLLINES</th>
<th>Phase</th>
<th>DH</th>
<th>ZH</th>
<th>HC</th>
<th>HZ</th>
<th>Arrond</th>
<th>DHD</th>
<th>TOTAL phase</th>
<th>TOTAL collaborative</th>
<th>TOTAL scale-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>EONC/AMTSL</td>
<td>Demonstration Spread</td>
<td>1</td>
<td>4</td>
<td>12</td>
<td>24</td>
<td>-</td>
<td>-</td>
<td>17</td>
<td>24</td>
<td>41</td>
</tr>
<tr>
<td>Malaria</td>
<td>Demonstration Spread</td>
<td>1</td>
<td>4</td>
<td>12</td>
<td>24</td>
<td>-</td>
<td>-</td>
<td>17</td>
<td>24</td>
<td>41</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Demonstration Spread</td>
<td>-</td>
<td>-</td>
<td>12</td>
<td>18</td>
<td>-</td>
<td>-</td>
<td>12</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Demonstration Spread</td>
<td>1</td>
<td>4</td>
<td>12</td>
<td>22</td>
<td>-</td>
<td>-</td>
<td>17</td>
<td>22</td>
<td>39</td>
</tr>
<tr>
<td>HRM</td>
<td>Demonstration Spread</td>
<td>1</td>
<td>4</td>
<td>-</td>
<td>6</td>
<td>-</td>
<td>1</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>TOTAL Health Facilities</td>
<td></td>
<td>1</td>
<td>4</td>
<td>136</td>
<td>6</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**TABLE 2**

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td>EONC/AMTSL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMTCT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-based health insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human resources management</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Light color = demonstration phase | Dark color = spread phase | Striped color = scale-up phase | Dark color with stripes = scale-up spread phase |

**FIGURE 5**

Geographic sequencing of clinical collaboratives
(maternal and neonatal care) will begin its demonstration phase with 17 sites: the departmental hospital, the four zone hospitals, and two health centers in each health zone.

**5. PERMANENT AND AD HOC STRUCTURES**

Sustaining QA achievements depends on institutionalizing QA principles. As described below, institutionalization occurs when the approaches to managing quality of care as well as the activities, mechanisms, and values that are inherent to these QA approaches become an integral part of the health system.

PISAF will establish and make operational quality management structures with the goal of building capacity of all clinical and management staff to put QA principles into practice and maintain improvements in quality over time. The “permanent” management structures (institutionalized) will be incorporated into the existing health service management structures, while “ad hoc” structures will exist only as long as necessary to solve certain quality issues or scale up certain practices.

**5.1 PERMANENT STRUCTURES FOR QUALITY MANAGEMENT**

Each level of the health system has its role to play in managing quality, and each person within the system has his rights and duties related to managing quality. With this in mind, committees or councils will be created that will be in charge of managing QA efforts in health centers, hospitals, health zones, and departments. A national QA committee already created by ministerial order will oversee these committees/councils.

**5.2 AD HOC STRUCTURES LINKED TO THE COLLABORATIVES**

In their efforts to achieve and scale up improved quality of care, collaboratives also have management structures, but they dissolve once the collaborative achieves its objectives. These structures include: quality improvement teams (QITs) at the point of service delivery, coaches who support these teams, an expert group that ensures the validity of technical standards and practices to be implemented within the collaborative, and a core collaborative management group in charge of managing collaborative activities.

Table 3 presents the permanent and ad hoc structures for the different levels of the health system.

Annex 2 provides more details on the roles/responsibilities and the composition of the different permanent and ad hoc structures.

**6. KNOWLEDGE MANAGEMENT**

Knowledge management is a system to harvest; analyze, process and synthesize; and share knowledge. In the quality assurance context, such a system will have the following purposes:

- Facilitate/encourage improvements in the quality of care provided to the population,

---

**TABLE 3**

Quality Management Structures

<table>
<thead>
<tr>
<th>Health system level</th>
<th>Permanent structure</th>
<th>Ad hoc structure</th>
<th>Ad hoc structure linked to the collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Village QA committee</td>
<td>QIT member</td>
<td>EONC/AMTLSL Malaria FP HIV/AIDS HRM Community-based health-insurance</td>
</tr>
<tr>
<td>Health center</td>
<td>Health center QA committee (QAC/HC)</td>
<td>QIT</td>
<td>✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>(commune and</td>
<td></td>
<td></td>
<td>ZH)</td>
</tr>
<tr>
<td>arrondissement)</td>
<td></td>
<td></td>
<td>Zone hospital QA committee (QAC/ZH)</td>
</tr>
<tr>
<td>Health zone</td>
<td>Health zone QA committee (QAC/HZ)</td>
<td>QIT</td>
<td>✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Departmental</td>
<td>DH QA committee QAC/DH)</td>
<td>QIT</td>
<td>✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>hospital (DH)</td>
<td></td>
<td></td>
<td>Departmental Health Departmental QA committee (QAC/DHD)</td>
</tr>
<tr>
<td>Directorate (DHD)</td>
<td></td>
<td></td>
<td>Collaborative management core</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>National Quality Assurance Coordinating Committee (NQACC)</td>
<td>Expert Group</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td></td>
<td>Permanent Secretariat (PS)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Improve the efficiency and effectiveness of efforts of QITs and the collaborative overall, and
• Assist the Ministry of Health in scaling up the number of facilities providing quality care.

Figure 6 shows the three major knowledge management functions in the context of collaboratives and other efforts to improve quality. PISAF will develop processes for harvesting, synthesizing, and sharing knowledge and learning. Since quality improvement is fundamentally a learning system, it fits well into the knowledge management scheme. Knowledge management and the process that ensures mutual learning within a collaborative can also benefit other sites in other locations.

Knowledge management is necessarily based on good documentation of changes implemented, an analysis of the results achieved resulting from these changes, and a synthesis of experiences across various quality improvement teams.

7. ASPECTS OF QA TO BE INSTITUTIONALIZED

The purpose of quality assurance is not only to improve quality of care in the short term, but also to establish capacity and the desire to do so continuously. Institutionalization requires a clear vision of the improvement priorities, changes in the way people work, and mastery of quality improvement tools and approaches. PISAF aims to promote this “culture of quality” to ensure that QA becomes a permanent feature in the health system operations. Figure 7 presents the essential elements to achieve this goal.

Institutionalization includes three categories of elements: an internal enabling environment, organization for quality (structure), and support functions. These categories account for much of the activities already described. A summary of these elements follows, as well as how PISAF aims to strengthen them.

FIGURE 6
Functions of Knowledge Management

<table>
<thead>
<tr>
<th>Harvesting learning</th>
<th>Analyzing and synthesizing learning</th>
<th>Sharing learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI teams</td>
<td>Operational knowledge to improve the quality of care</td>
<td></td>
</tr>
<tr>
<td>Coaches</td>
<td>• Successful and unsuccessful changes tested</td>
<td></td>
</tr>
<tr>
<td>Learning sessions</td>
<td>• Results achieved</td>
<td></td>
</tr>
<tr>
<td>Scoreboard</td>
<td>• Enhance implementation package Excel database</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Norms for data presentation</td>
<td></td>
</tr>
</tbody>
</table>

To: QI teams
Other facilities
MOH and partners

Through:
Meetings
Learning sessions
Reports
etc.
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 (i.e., 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.

PISAF’s collaborative strategy includes strengthening these three elements. Each collaborative includes: 1) clinical capacity building, 2) training in quality assurance and improvement methods, and 3) training and support of coaches. With regard to information and communication, the following mechanisms are in place: the baseline assessment, the Performance Monitoring Plan, the health zone scoreboard, and collaborative learning sessions. The third function, rewarding and recognition, is achieved through efforts to eliminate barriers to good work, rewarding work that is well done, and opportunities to share results. Other capacity-building strategies for quality are: improving the organization of services (e.g., creating a triage system), redistributing tasks among staff, and setting up teams to solve problems through new collaboratives.

Organizing for quality: Institutionalization requires a clear delineation of roles, responsibilities, and accountability for implementation of QA activities. We consider organization for implementing QA as the essential element structure: management of QA activities by combining QA responsibility within the health system’s existing structures and duties. We consider organization for implementing QA as the essential element, structure. This entails the management of QA activities through building QA responsibility into the health system’s existing structures and duties.

This document describes the collaborative management structures and how they are harmonized and combined with the existing structures of zone management teams and the DHD. PISAF also supports the national level and its involvement in activities carried out in the departments. In addition to its participation in events such as learning and synthesis sessions in Zou/Collines, PISAF will seek opportunities to strengthen the capacities of the QA core group at the national level.

Enabling internal environment: Finally, QA requires 1) policies that support, guide and strengthen QA; 2) leadership that establishes priorities, fosters learning, and cares about its employees; 3) core values of the organization that stress respect, quality, and continuous improvement; and 4) adequate resources for QA implementation.

PISAF has worked to strengthen teamwork at the Zou/Collines DHD as a precondition for providing better support for QA activities within the department. PISAF plans a close partnership with the central level for QA activities in the zones. The project will continue to advocate for including a line item in zone, departmental, and national budgets for quality assurance activities.

Each category of element is important in its own right, but it is the combination of these essential elements that facilitates and guarantees institutionalization of QA. At the same time, it is clear that the health system is operating in a broader environment, which influences its ability to implement QA. The external environmental factors create both constraints and opportunities for ensuring quality and the institutionalization of QA.
ANNEX 1: ESSENTIAL FEATURES OF A SUCCESSFUL IMPROVEMENT COLLABORATIVE

Based on experience implementing collaboratives since 1998, HCI has identified seven essential features for the successful implementation of improvement collaboratives in developing and middle-income countries. These features are key to a collaborative’s success in achieving significant improvements rapidly and at scale.

ESSENTIAL FEATURES OF A SUCCESSFUL IMPROVEMENT COLLABORATIVE

1. Shared improvement objectives or aims
2. Adequately supported QI teams testing changes
3. Implementation package
4. Regular analysis of measured results to guide quality improvement
5. Shared learning for accelerated improvement at greater scale
6. Spread strategy
7. Organizational structures

Shared Improvement Objectives or Aims
Improvement objectives or aims 1) are statements of the desired outcomes that a collaborative seeks to achieve through the application of improvement principles in a specific content area, 2) define a collaborative’s overarching objectives and guide its planning and implementation, and 3) generally identify the evidence-based practices to be implemented, the processes to be improved, and the targeted results (or outcomes).

Well-constructed improvement objectives support a collaborative’s effective planning and implementation. They define the scope of the collaborative work and the breadth of the health care area the collaborative addresses (e.g., a “broad” area might be pediatric hospital care, involving many systems; a “narrow” one might be the improvement of emergency triage for treatment of ill children or the use of bednets at the community level). An improvement objective should define a targeted outcome in a priority health area where a significant, documented gap exists between actual and best practice and/ or actual and desired outcomes. Improvement objectives may target high impact, evidence-based interventions known to positively affect health outcomes (e.g., AMTSL for prevention of postpartum hemorrhage), improved access to care, or improved efficiency and organization of care.

Adequately Supported Quality Improvement Teams Who Are Testing Changes
QI teams, working at the service delivery level, are the pillar of all collaborative work. Without them, there would be no collaborative, because it is they who plan, test, and study the quality improvement in their own processes and contribute their learning to the collaborative effort. Quality improvement can be defined as the process of intentionally making care/services better in some way (e.g., effectiveness, efficiency, etc.), with the ultimate goal of improving the outcomes for health care clients. Team members work together to understand their clients, analyze their processes, test and implement changes and redesigns to improve performance, and monitor results.

In a collaborative, a network of teams is created to share results, innovations, and challenges and to learn from one another. To ensure that QI teams can function optimally, the collaborative needs to ensure their knowledge and skills in both technical content related to the improvement objectives and quality improvement methods, as well as assure access to supplies and equipment needed to achieve the improvement objectives.

Experience in developing countries has shown that site teams need ongoing support to carry out their QI tasks. This assistance is provided through “coaching,” a process whereby someone with additional knowledge and skills in quality improvement and/or the technical content of the collaborative provides support and encouragement to teams in order to improve team performance. A coach helps a team carry out its work effectively and move towards self-sufficiency over time in using QI tools. Coaching provides a structure to enhance team functioning; coaches provide on-the-job training in content and QI, verify monitoring data, provide support to the monitoring process, and help teams see other opportunities to improve how they do things.

Implementation Package
The implementation package defines the critical changes to current practice that all QI teams in a collaborative will implement. The initial implementation package lays out a set of practices and desired procedures built on the best existing evidence that both local and international stakeholders and experts agree, if implemented systematically, will lead

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to the desired outcomes articulated in the collaborative’s improvement objectives. The content of the implementation package will depend on what already exists in the setting and the current level of problems with quality. The implementation package might include changes to the technical content or changes in the way services are organized and delivered, as described in the following table.

In all cases, the implementation package should be based on evidence of what works. This evidence can come from the international literature or from well-documented local experiences. In some collaboratives that address broad topic areas, the content of the implementation package may be divided into smaller units and be implemented sequentially. Collaboratives may also be built around improvement objectives for which a solid body of evidence does not yet exist, in which case the role of the collaborative is to build the evidence, in effect working to design new systems or models of care.

Over the collaborative’s life, this initial implementation package will be improved and enhanced through the work of the QI teams that create evidence for improved standards, models of care, and/or best practices for carrying out the standards that can be rapidly spread to other sites in their organization. A collaborative’s capacity to achieve rapid results and rapid scale-up of best practices is based on its capacity to synthesize and spread the lessons from the work of the QI teams. In many cases, the learning generated by the QI teams focuses on resolving operational issues around implementing a set of standards.

Depending on the initial situation and the type of implementation package, it may take a collaborative more than one phase to achieve the learning needed for full scale-up. Some collaboratives have introduced a complex implementation package in stages; others have expanded the number of teams or sites involved while implementing the initial implementation package (see section 3.6, “Spread Strategy,” below); and still others have simultaneously expanded the content and number of sites. The first phase may be considered a demonstration collaborative, which includes the development of improvement objectives and the implementation package and the selection of indicators. These steps are followed by the implementation, testing, and refinement of the implementation package. In this phase, an initial set of teams works together to test improvements, and through these efforts team members devise the first set of “improvements” on the implementation package. This “tested and refined” package may then be rolled out through a subsequent phase when additional sites are added, and continued refinements may be made to the implementation package.

Ultimately, the tested implementation package will have the following elements:

• An updated set of standards or consensus on “proper practice,” with a sense of the “essential standards” that focus on the most important tasks needed to achieve health care improvement objectives;
• A “service delivery model” or “model of care” that would more effectively ensure that standards are implemented and patients receive what they need; and
• A series of organizational changes that facilitate the implementation of standards and the service delivery model.

### Regular Analysis of Measured Results to Guide Quality Improvement

A collaborative bases both its original implementation package and any refinements on evidence, just as any quality improvement

<table>
<thead>
<tr>
<th>Current situation</th>
<th>Implementation package may be one or more of the following</th>
</tr>
</thead>
<tbody>
<tr>
<td>No standards(^1) or consensus on “proper practice”</td>
<td>A new or updated set of “essential standards” that focuses on the most important tasks needed to achieve improvement objectives</td>
</tr>
<tr>
<td>Standards exist but are out-of-date</td>
<td></td>
</tr>
<tr>
<td>Standards exist and are up-to-date but are unrealistic or too complicated for providers to follow</td>
<td></td>
</tr>
<tr>
<td>Standards exist but are not well implemented</td>
<td>A “service delivery model” or “model of care” that would more effectively ensure that standards are implemented and patients receive what they need</td>
</tr>
<tr>
<td>Standards and a model of care exist, but neither is well implemented</td>
<td>A series of organizational changes that can facilitate their implementation</td>
</tr>
</tbody>
</table>

\(^2\) For example, a collaborative addressing the broad area of essential obstetric and newborn care (EONC) may decide to start with AMTSL and immediate newborn care and then move on to surveillance of the newborn, birth preparedness, neonatal and obstetrical complications, etc. in a phased way. Such was the approach of the EONC Collaborative QAP initiated in Niger.

\(^3\) “Standards” here refers to “an explicit statement of expected quality” (Ashton 2001). Other terms, such as norms, are often used, but we consider them synonymous with standards.
team bases its continued implementation of changes on evidence that these result in improvement. Thus, monitoring is an essential feature of a collaborative. Monitoring involves:

• Developing a limited set of key indicators that will reflect progress toward improvement objectives that individual teams and the collaborative as a whole use to judge their progress;

• Developing systems for collecting and compiling data on indicators and on changes or improved practices implemented at the individual team level and for the collaborative as a whole; and

• Setting up mechanisms for validation, analysis, and interpretation of those data, both at the quality improvement team level and aggregated at the collaborative level.

Where possible, indicators should include measures of process (e.g., compliance with standards related to quality of care, QI team functioning), outcome/impact (e.g., effects on case fatality rates), and, if appropriate, input (e.g., availability of key supplies or equipment). Teams need to document the improvements implemented and regularly (often monthly) measure their indicators to determine how their improvements are contributing to achieving the improvement objective(s). In addition to the common set of indicators that all teams are measuring, individual teams may also use additional measures to test how well a specific change they are implementing is achieving its desired results.

Teams will share their changes and results with other teams during learning sessions or other opportunities for sharing information (such as Web sites, etc.). Generally, data on common and individual team indicators are collected and compiled by teams themselves (self-monitoring). Thus, it is crucial to ensure that systems to check the validity of these data are in place since the results of the collaborative will be used to identify best practices and an improved implementation package that can be spread to other sites. Wherever possible, data should come from existing sources and not a separate data collection system.

Shared Learning for Accelerated Improvement at Greater Scale

Another essential collaborative feature is structured opportunities for sharing experiences, results, and promising practices across teams. This feature distinguishes collaboratives from other QI methods and is critical for rapidly achieving results, because teams learn from each other. These shared learning opportunities are often organized as “learning sessions,” but may also involve communication of results by coaches who visit multiple teams, use of a Web site where data and experiences are posted, telephone calls, smaller meetings, and other mechanisms. Learning sessions generally bring representatives from all QI teams together (or all sites in a region if the learning sessions are decentralized) on a regular basis to engage in three main activities:

• Share changes and results (both good and bad),

• Identify innovations and promising practices, and

• Strengthen their skills in the content areas and in QI (as needed).

Learning sessions are attended by selected team members and technical and quality improvement experts. Team members attending the learning session bring knowledge and materials from these meetings back to the other team members at the home organization/facility and develop action plans to start making changes. Generally, any phase of a collaborative may involve three to six learning sessions followed by a synthesis workshop/conference where best practices and final modifications to the implementation package are identified.

The powerful effect of spreading learning from one group of practitioners to another underscores the critical importance of knowledge management during a collaborative to obtain, analyze, select, organize, and make available to large numbers of facilities and practitioners, clinical and organizational knowledge related to improving processes of care, as well as practical experiences in implementation.

Spread Strategy

Because a collaborative is by definition a mechanism for developing service delivery models, organizational changes, and best practices to implement a set of standards and then share this knowledge beyond individual sites, a spread strategy is a crucial collaborative feature. The spread strategy should first define the ultimate target group that should eventually be implementing the content of the improved implementation package and then determine the steps for reaching them.

One way to spread the learning and improvements to new sites is through a spread collaborative. A spread collaborative uses the collaborative structure of a network of sites, a common (enhanced) implementation package and indicators, and learning sessions and other mechanisms for shared learning to spread proven improvements to a significantly larger number of facilities and/or practitioners. Spread collaboratives rely on QI-experienced staff and “quality champions” from the demonstration collaborative to provide support based on their own experiences and who can motivate new facilities as living proof that
improvement can happen. The spread phase can be a series of waves that increasingly scale up activities and include new regions until the whole intended area (e.g., whole country) is covered.

We have found that a spread collaborative often achieves expansion at a much more accelerated pace than the original collaborative by leveraging the wealth of knowledge—not only clinical, but also important operational and organizational knowledge—on how to improve processes of care, most of which had been tested and developed during the preceding initial collaborative.

Depending on the spread objectives and resources available in a particular situation, other spread strategies are possible and may be more appropriate. Dissemination of improvements in the form of guidelines or policy decrees, cascade training, extension agents, campaigns, and endorsement by prestigious institutions or individuals have been used, alone and in combination, to spread improvements. These approaches focus on one or several factors necessary to achieve spread: Dissemination focuses on raising awareness among practitioners about the benefits of best practices; training and supervision focus on developing technical competency; campaigns focus on building commitment and political will; policy development and endorsement focus on increasing the perceived legitimacy of the improved intervention and alignment with accepted institutional values.

The ultimate desired coverage for improvements developed in a collaborative and the strategy for reaching this level of coverage affects both initial site selection and the organizational structure needed to support spread. Roles and responsibilities during a spread phase may be quite different than those in a demonstration collaborative to ensure adequate support to an initial collaborative.

Depending on the spread objectives and resources available in a particular situation, other spread strategies are possible and may be more appropriate. Dissemination of improvements in the form of guidelines or policy decrees, cascade training, extension agents, campaigns, and endorsement by prestigious institutions or individuals have been used, alone and in combination, to spread improvements. These approaches focus on one or several factors necessary to achieve spread: Dissemination focuses on raising awareness among practitioners about the benefits of best practices; training and supervision focus on developing technical competency; campaigns focus on building commitment and political will; policy development and endorsement focus on increasing the perceived legitimacy of the improved intervention and alignment with accepted institutional values.

**Organizational Structures**

Organizational structures provide the framework for managing the collaborative. Several key roles are critical to the collaborative; they can be distributed to different actors within a variety of structures:

**Leadership/strategic direction:** This role ensures that the collaborative continues to work toward its improvement objectives, provides moral and political support and resources that enable and motivate participating teams and stakeholders to stay engaged and active, and facilitates the leap from changes in the way work is carried out to changes in policy that will enable improvements to be sustained and spread.

**Content and QI expertise:** Built on an evidence-based “implementation package,” collaboratives depend on strong quality improvement teams. “Content expertise” (knowledge within a discipline, such as in maternal health, HIV/AIDS, etc.) is critical in a collaborative’s preparation for developing the implementation package and the indicators for monitoring improvement, but also during implementation, providing technical support to teams and content at learning sessions.

**QI teams:** These critical actors implement improvements and create new knowledge on improved practices and an improved implementation package. The other roles described above are primarily in support of what the QI teams do on the ground. QI teams must generate and implement changes in how they carry out their daily work and then measure the effects to determine whether these changes really improve the quality of their services and thus achieve the collaborative’s improvement objectives.

Although a collaborative itself is not a permanent entity, sustainability of results achieved during the collaborative will depend on ongoing political, physical, and technical support for the “implementation package” and institutionalization of QI methods. Thus, conceptualization of an organizational structure should include the institutionalization and sustainability of key collaborative features, such as quality improvement teams, coaching of teams, monitoring of results, and opportunities for shared learning. This is best achieved by grafting the collaborative roles onto existing structures at national and decentralized levels when possible. Often, these organizational structures include a small managerial group, an “expert” group, and a “director” or “coordinator” in the Ministry of Health, along with focal persons within management structures at decentralized levels.

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4 “Institutionalization of improvements” means that they have become an integral and sustained part of the health care system’s regular operations. For an in-depth discussion on QI institutionalization, see Franco et al. 2002.
## ANNEX 2: RESPONSIBILITIES OF THE ORGANIZING AND COORDINATING STRUCTURES FOR THE COLLABORATIVES

<table>
<thead>
<tr>
<th>Level</th>
<th>Structures</th>
<th>Principal Roles</th>
<th>Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>National Coordinating Committee</td>
<td>Orientation, sustainability, support, advocacy, monitoring, resource mobilization</td>
<td>Members of the Ministry of Health Cabinet, central directors and project and program coordinators from the Ministry</td>
</tr>
<tr>
<td></td>
<td>Permanent Secretariat</td>
<td>Daily activity management</td>
<td>MOH QA Technical Advisor, Director of Hospitals, Director of Family Health</td>
</tr>
<tr>
<td></td>
<td>Committee of experts</td>
<td>Adapt change packages or care models, Validate monitoring indicators, Technical support</td>
<td>This is an ad hoc committee consisting of experts in the area of each collaborative's theme. These experts are authorities at the national and/or departmental level</td>
</tr>
<tr>
<td>Department</td>
<td>Departmental Collaborative Coordinating Committee</td>
<td>Facilitate experience-sharing, Mobilize resources, Monitor/evaluate the collaboratives, Decide on spread of effective changes, Coach and supervise the QITs</td>
<td>DHD and department heads involved in the different collaboratives as well as their counterparts at projects that support implementation of the collaboratives, the D/CHD and the head health zone physicians are also members.</td>
</tr>
<tr>
<td></td>
<td>Hospital Quality Council</td>
<td>Support, monitoring/evaluation, coaching, organizing learning sessions, Rewarding the QITs, Coordinating interventions, Monitoring the implementation of action plans for the hospital sites</td>
<td>Director/CHD, Head of the Economic and Administrative Unit, Supervisor General, Managers of medical and paramedical units</td>
</tr>
<tr>
<td></td>
<td>Site Team</td>
<td>Implement the action plans, document changes, prepare and participate in the LSs</td>
<td>All staff members at the implementation site</td>
</tr>
<tr>
<td>Health Zone</td>
<td>Health Zone Collaborative Coordinating Committee</td>
<td>Facilitate experience-sharing among teams, mobilize resources, coordinate QIT preparations for the LSs, ensure that the QITs are coached, Oversee the monitoring/evaluation of QIT activities</td>
<td>The head health zone physician, all head commune physicians, the director of the ZH, the ARM, ZH statistician, Manager of nursing care, manager of obstetric care, Chair of the Health Committee</td>
</tr>
<tr>
<td></td>
<td>Hospital Quality Council</td>
<td>Support, monitoring/evaluation, coaching, organizing the LSs, rewarding the QITs, coordinating interventions and monitoring implementation of the APs at the hospital sites</td>
<td>Director /HZ, C/Economic and Administrative Unit, C/SAF Head nurse, managers of the medical units (surgery, pediatrics and medicine) and the paramedical units (laboratory and radiology)</td>
</tr>
<tr>
<td></td>
<td>Site Team</td>
<td>Implement the action plans, document changes, prepare the learning sessions and participate in them</td>
<td>All site personnel Chair of the COGECs Manager of community-based health insurance members (for sites that have one)</td>
</tr>
</tbody>
</table>
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