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TECHNICAL REPORT

A Thoughtful Conversation on National Improvement Strategies and Infrastructure for Improving Health Care in Kenya

JUNE 2013

This technical report was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID). The work described was conducted under the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is made possible by the generous support of the American people through USAID and its Office of Health Systems.

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For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

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ACRONYMS

ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
BMI	Body mass index
CDC	Centers for Disease Control and Prevention
CHAK	Christian Health Association of Kenya
COHSASA	Council for Health Service Accreditation of Southern Africa
DFID	Department for International Development
DHIS	District Health Information System
DOH	Department of Health (South Africa)
EU	European Union
FBO	Faith based organization
GIZ	German Society for International Cooperation
HCI	USAID Health Care Improvement Project
HMIS	Health Management Information System
HR	Human Resources
IHI	Institute for Healthcare Improvement
IHPMR	The Institute of Health Policy Management & Research
IMCI	Integrated Management of Childhood Illness
IQMS	Integrated Quality Management System
JCI	Joint Commission International
JICA	Japan International Cooperation Agency
KEBS	Kenya Bureau of Standards
KENAS	Kenya Accreditation Service
KQMH	Kenya Quality Model for Health
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPH	Ministry of Public Health
MSI	Management Sciences International
NASCOP	National AIDS and STI Control Program
NHIF	National Hospital Insurance Fund (Kenya)
PDSA	Plan-Do-Study-Act
PEPFAR	The President’s Emergency Plan For AIDS Relief
PSI	Population Services International
QA	Quality Assurance
QI	Quality Improvement
TQM	Total Quality Management
TWG	Technical Working Group
UNICEF	The United Nations Children's Fund
URC	University Research Co., LLC
USAID	US Agency for International Department
WHO	World Health Organization

EXECUTIVE SUMMARY

Kenya is in a period of transition. The new constitution of 2010, which has mandated the current devolvement of service delivery to the county level, has led to a new health sector *Vision 2030* and a proposed *Kenya Quality Model for Health* (KQMH), to develop and implement a robust and operational policy for quality in health care that can positively impact health outcomes for all Kenyans. With this backdrop, the Ministry of Public Health and the Ministry of Medical Services, in collaboration with the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, convened a "Thoughtful Conversation on National Improvement Strategies and Infrastructure for Improving Health Care" from February 19th to 21st, 2013. This three-day quality improvement policy seminar brought together key Kenyan stakeholders and health care quality leaders from other countries to share experiences and ideas on successful models for leading and supporting improvement of health care at all levels of the health system.

The meeting was conducted in two parts: The first day and a half offered an overview of what quality improvement initiatives have achieved to date in Kenya. The second and third days were designed as a thoughtful conversation around developing a national strategy for improving the quality of Kenyan health services. The second half of the meeting was designed around four questions:

- How did the improvement effort(s) you have experienced start? Who championed it? How was commitment sustained? How were improvement priorities set? What infrastructure was created to support improvement? How did it work?
- What improvement approaches were used? How and why did you choose them? How did they work? How did you resolve the balance between minimal standards and best practices? How did you review progress? How did you communicate and coordinate? If you were to undergo this experience(s) again, what was important that you would want to see repeated?
- What is the role of accreditation? What are the next steps and directions for accreditation in Kenya?
- What would you advise the health Ministries relative to a national improvement strategy?

The meeting concluded with a conversation on the way forward for the Government of Kenya, donors, and implementing partners.

Participants discussed improvement experiences from Kenya, Sweden, South Africa, Germany, Thailand, and Malaysia. During the conversation, participants were able to come to agreement on a number of important points. Through the sharing of experience, participants recognized that in the health care improvement work done so far in Kenya, while different improvement methods were used, the underlying principles in each approach were similar, typically including standards and the plan-do-study-act cycle. Consensus was achieved that Kenya needs a national strategy for quality improvement in health care and that the strategy does not need to stick to one model and instead should embrace a multiplicity of approaches to improve care. This will allow implementers to be innovative and creative and to experiment and provides them the chance to see what the different approaches can give them. An important consideration in using multiple approaches is to continually assess which methods are improving care and to judge by results. Even if one method is dominant, it does not mean the Ministry has to use it alone. The field of improvement is dynamic and the methods continue to evolve, thus the MOH and implementers need to keep evolving.

In the KQMH, the MOH has priority objectives that identify the main quality gaps of concern, but priorities for quality improvement still need to be determined. It was agreed that the MOH should set priority areas of focus because to try to improve everything at once would overburden the system. This is a dynamic process that should be revisited annually. The job of the MOH must be to utilize the whole system to

accomplish these aims. Focusing on the priority areas, the MOH should empower providers to make the changes that need to be made and foster shared learning.

Quality assurance and standards are both national functions that should be coordinated by the government; all partners contributing in these areas should work through the national government. Regulation is also important to guide policy and quality improvement, and there are opportunities to build on pending legislation. The MOH needs to define tools that can operationalize the KQMH and provide direction to all stakeholders.

There is a need for clear indicators for each of the health sector's operations in the five-year strategy. As far as creating one national monitoring and evaluation framework for health care quality, the current indicators for the health management information system may not adequately address the quality improvement work Kenya wants to see develop throughout the health sector. The national Technical Working Group for quality has discussed having quality indicators that can track priority target areas so that the same core indicators can be given to all projects and everyone can use the same indicators. Further thinking is needed to determine whether they should be quality indicators or other indicators that would also serve as a metric for quality issues.

A related point discussed was the need for tools to uniformly assess quality. Quality improvement cannot be done without incorporating assessment. In the KQMH there is a checklist that could be used across all organizations, regardless of the specific quality improvement approach.

The topic of accreditation was also discussed at length since Kenya's Vision 2030 encourages the government to have an accreditation framework that not only involves the private sector but also the public sector. The existing Kenya Accreditation Service (KENAS) currently focuses primarily on laboratories but also certifies certifiers and inspection bodies in all sectors. They look at competencies and limit themselves to a conformity assessment body focused on inspection, certification, and calibration. The KQMH standards could be approved to be standards for accreditation. There is a checklist for every level of care, and the checklists are defined by what is supposed to be at all levels. Participants acknowledged that there is a need for Kenya to define what accreditation for health facilities will mean. While participants agreed that it may be best for an independent accreditation body to be created and tasked with accrediting health facilities, they also acknowledged that accreditation on its own does not ensure quality. Participants did note the possible synergies between health facility accreditation and quality improvement. For example, for a facility to be accredited, perhaps it could be required to undertake specific actions to improving key parameters of quality.

Charting a solid way forward for Kenya will involve developing a broad framework that outlines the vision for the health sector, keeping in mind the new constitution and new legislation that address issues such as subcontracting and regulatory bodies. Discussions at the seminar generated agreement on using evidence-based methods, developing indicators for key areas, the importance of client involvement in the process, and the central coordination role of the MOH.

There are many windows of opportunity in this transition period, and Kenya can leverage these opportunities to institutionalize a culture of quality and aspects of improvement in things that will be set. The MOH should look for ways to strengthen partnerships with existing structures and look for new partners, as new bodies are being set up and allies to champion the agenda. While local and external feedback can be useful, Kenya must ultimately adapt and create its own model. The MOH is part of a global community of improvers with whom they can share and learn from as they move forward to improve the quality of health care in Kenya.

1 INTRODUCTION

Kenya is in a period of great change and transition. From the new constitution of 2010, which has mandated the current devolvement of service delivery to the county level, to the health sector Vision 2030 and the Kenya Quality Model for Health, there are more opportunities now than ever before to develop and implement a robust and operational policy for quality in health care that can positively impact health outcomes for all Kenyans. It is with this in mind that the Ministry of Public Health (MOPH) and the Ministry of Medical Services MOMS), in collaboration with the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, convened a "Thoughtful Conversation on National Improvement Strategies and Infrastructure for Improving Health Care" from February 19th to February 21st, 2013. This three-day quality improvement policy seminar brought together leading stakeholders to share experiences and ideas from different countries on successful models for leading and providing support for improving health care at the national level, including to develop policies and plans for improvement, to exchange ideas on appropriate infrastructures that enable Ministries of Health to lead and support health care improvement, and to stimulate a thoughtful conversation around this topic area that would be helpful to participants in their work in the respective countries.

Names and Affiliations of Participants

Name	Affiliation
Dr. Lucy Musyoka	MOMS
Dr. Charles Kandie	MOMS
Mr. Samuel Milgo	KENAS
Ms. Doris Mueni	KENAS
Dr. Bedan Gichanga	USAID/Kenya
Dr. Peter Amiri	USAID East Africa
Dr. M. Rashad Massoud	URC/USAID ASSIST
Ms. Dorcas Amolo	URC/USAID ASSIST
Dr. Donna Jacobs	URC/USAID ASSIST
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Dr. Prisca Muange	URC/USAID ASSIST
Dr. Joyce Hightower	WHO
Dr. Humphrey Karamagi	WHO
Dr. Bruce Agins	HEALTHQUAL International
Mr. John Wanyungu	HIVQUAL
Mr. Samuel Mwenda	CHAK
Ms. Annette Awiegand	CHAK
Dr. Joachim Szecsenyi	AQUA Institute
Dr. Patricia Odero	GIZ
Dr. Irmgard Marx	GIZ
Dr. Rolf Korte	GIZ
Ms. Lynette Kisaka	Commission for University Education
Dr. Naftali Agata	JICA
Ms. Nicole Spieker	PharmAccess
Ms. Millicent Olulo	PharmAccess
Mr. Sven-Olaf Karlsson	Jonkoping County Council
Ms. Margaret Kola	KEBS
Ms. Elizabeth Oywer	Nursing Council of Kenya
Dr. Mwanza Joachim	MOPH

1.1 Meeting Design

The meeting was overseen by Dr. Lucy Musyoka, Deputy Director of Medical Services and Head, Department of Standards and Regulatory Services, MOMS. Dr. M. Rashad Massoud, Senior Vice President of University Research Co., LLC's (URC's) Quality & Performance Institute and Director of the USAID ASSIST Project, facilitated the meeting.

The meeting was conducted in two parts: The first day and a half offered an overview of what quality improvement initiatives have achieved to date in Kenya. The second and third days were designed by Dr. Massoud as a thoughtful conversation around developing a national strategy for improving the quality of Kenyan health services. He had designed and facilitated three similar health improvement meetings with the Ministry of Public Health in Kabul, Afghanistan; the Jordan Health Care Accreditation Council in Amman; and the Ugandan Ministry of Health (Hiltebeitel et al. 2010; Dick 2011; Koegler 2011). This meeting was designed so that different countries could learn from each other: not to advise each other what to do, but rather offer examples and

share learning of what has and has not worked in various settings. This arrangement allowed for the host country to make its own informed decisions based on an understanding of its unique environment and knowledge of similar efforts.

For all participants to be able to fully engage in informed conversation around the discussion questions, several recommended readings had been distributed to participants in advance. These readings provided insight into national quality improvement efforts of various countries, including both successes and failures. These and other relevant readings are in the Bibliography.

2 QUALITY IMPROVEMENT IN KENYA

The Government of Kenya first developed a policy for quality in health care – the Kenya Quality Model (KQM) in 2001. It comprised a checklist, standards, and an electronic assessment tool and was piloted in 2003. However, with the development of the Kenya Essential Package of Health (KEPH), the KQM needed to be updated. During 2007–2009, a participatory consultative process among health stakeholders was organized and resulted in the development of the Kenya Quality Model for Health (KQMH).

The KQMH improves on KQM shortcomings and recognizes the paradigm shift in quality for health care, which includes customer-oriented services, preventive and continuous improvement, and design and self-assessment. Quality is defined in the KQMH as the totality of features and characteristics of the Kenyan healthcare system that relates to its ability to satisfy a stated or implied health need. Recognizing that quality improvement is a process, the KQMH aims to improve adherence to standards and guidelines focused on evidence-based medicine, to improve structure-process outcome by applying quality management principles and tools, and to satisfy patient/client needs in a culturally appropriate way. KQMH also has the following underlying principles: leadership, customer orientation (external and internal), a systems approach to management, process orientation, involvement of people and stakeholders, continuous quality improvement, and evidence-based decision making. While the KQMH is a more comprehensive policy than KQM, improvements are still needed, and it will be reviewed and revised in the year to come.

A number of quality improvement initiatives have been implemented in Kenya over the years and the following activities were presented during the meeting.

2.1 Recent Quality Improvement Initiatives in Kenya

5S-KAIZEN-Total Quality Management (TQM)/Japan International Cooperation Agency

The Japan International Cooperation Agency (JICA) began working in Africa in 2003 following the International Conference on African Development III to share experiences from their work in Asia and to improve the quality of services provided in various sectors, including health.

Working with JICA, a number of sites in Kenya began using the 5S-KAIZEN-TQM approach to improve quality. 5S comprises five elements: *Sort:* removing unused items from workspaces and reducing clutter; *Set:* organize everything needed in proper order for easy operation; *Shine:* maintain a high standard of cleanness; *Standardize:* maintain these as standard practice; and *Sustain:* train and maintain discipline of the personnel engaged.

KAIZEN is a form of continuous quality improvement by means of a non-stop process to uplift the standard of your work environment and services contents to the obtainable best condition and maintain it as user-friendly and convenient as possible. CQI has to be practiced by all categories of staff, including the management team. Top management is not an exception and should participate in the process. For top management of a project or institution, and for activities, including community-based health services,

it is crucial to make this process a “movement” or “campaign” within the organization as a management target.

Mathari Hospital in Nairobi was the initial pilot site for 5S-KAIZEN and reported that the processing of lab specimens and filings have become faster and patient wait time shorter. Kericho District Hospital reported on improved facility cleanliness, including complete signage and labeling. Rera Health Centre of Kenya’s Gem District shared that since beginning 5S-KAIZEN activities, more clients have been coming for services and that job satisfaction has improved because the environment is cleaner and nicer to work in. Kaluo Dispensary in Siaya District had similar improvements, adding that patient waiting time has reduced and that retrieving patient records is faster.

Integrated Quality Management System/German Society for International Cooperation

In 2011 in Kenya, the German Society for International Cooperation (GIZ) Health Sector Program funded the development of an Integrated Quality Management System (IQMS) to facilitate the operationalization of KQMH using maternal health as an entry point. The contract was awarded to a consortium comprising Evaplan GmbH consulting group in International Health at the University of Heidelberg, Germany; the AQUA Institute, Göttingen, Germany; and The Institute of Health Policy Management and Research in Nairobi. Implementation began in early 2012 and will continue for two years. The goal is to contribute to the improvement of health indicators in Kenya and to improve service delivery.

IQMS is based on the KQMH and provides a method for health facilities to assess the quality of outpatient care. IQMS is a multi-perspective, indicator-based quality management system that builds on existing indicators in the sector and in which indicators are derived from KQMH standards and new developments in the sector. The implementation methodology for IQMS is adapted from the European Practice Assessment with proven scientific methods and instruments. IQMS can be used at all levels of the health system without specific training in quality management. It provides opportunities for health facilities to benchmark themselves with other facilities, giving them a better understanding of how they are doing.

Safe Care Initiative/PharmAccess

SafeCare began in 2011 as a collaboration with PharmAccess, the Council for Health Service Accreditation of Southern Africa (COHSASA), and Joint Commission International (JCI) and is based on innovative and realistic standards for health care providers in resource-restricted settings. The standards are linked to a step-wise improvement process that is recognized by certification.

SafeCare standards and tools can be used for baseline assessment, upgrading plans, technical assistance, follow-up of assessments, certificates, and accreditation. The standards cover the areas of management, clinical support services, and technology. Improvement is done locally while evaluation is done externally, by SafeCare, and accreditation is done by JCI/COHSASA.

In Kenya, SafeCare has been providing external validation for social franchises (such as Population Services International [PSI] and Management Sciences International [MSI]), since May 2012. Additionally, SafeCare is providing technical assistance to the National Hospital Insurance Fund (NHIF) in Kenya to develop stepwise certification of health care facilities in the new outpatient scheme and has been collaborating with Kenya’s MOH to carry out national mapping on patient safety and using the SafeCare tools for the new licensing structure for health facilities.

USAID Applying Science to Strengthen and Improve Systems Project (ASSIST)/URC

The USAID ASSIST project is currently active in Kenya and builds on the work of its predecessor, the USAID Health Care Improvement Project (HCI). USAID ASSIST builds the capacity of host country implementers to apply the science of improvement to health care and other services for vulnerable populations; ensure that high-impact interventions reach every patient or client, every time; and improve

outcomes. The science underlying modern improvement draws on psychology, organizational behavior, adult learning, and statistical analysis of variation and is grounded in a systems understanding of work. Improvement requires change in the way we do work, though not every change is an improvement. The following core principles underlie the science of improvement:

- The work of delivering health care happens in processes and systems. Understanding them and changing them in ways to produce better results is at the heart of improving health care.
- Working in teams of different providers involved in delivering care is key to making changes work and fostering ownership of the changes to enhance sustainability.
- Testing changes to determine whether they yield the desired results is at the heart of improvement. Data are used to analyze processes, identify problems, determine whether the changes have resulted in improvement, and act accordingly.
- Care should meet the needs and expectations of clients, patients, and communities.
- Shared learning, where multiple teams work on common aims and exchange what worked, what did not, how it worked, and why, is an essential part of improvement, producing better results in a shorter period.

Since 2011 in kenya's Kwale district, under HCI, district health management and facility personnel have been working to increase the utilization of and improve the quality of integrated maternal health services (antenatal care, skilled delivery, and prevention of mother-to-child transmission of HIV). With particular emphasis on community participation, they have been able to increase the uptake of antenatal care services: Pregnant women completing at least four antenatal visits rose from 37% in January 2011 to 57% in August 2012. The percentage of women receiving skilled delivery rose from 33% to 46% in the same period.

Additional presentations were made about quality improvement in the German health care system by Dr. Joachim Szecsenyi and on accreditation by Dr. Rolf Korte and Dr. Particia Odero of GIZ. Dr. Massoud gave a global overview of improving health care; and Dr. Musyoka presented on accreditation in Kenya.

2.2 Keynote Speech

The first part of the meeting concluded with a keynote speech by Dr. Simon Mweki. He said that Kenya began down this road a while ago and while there are challenges, such as increased disease burden and reduced numbers of health workers, Kenya should not lose its motivation. Kenya has more partners now than before and has the power to mobilize the money and resources available in meaningful ways to save lives. Speaking on behalf of his Director, Dr. Mweki said the two health departments in Kenya – the MOPH and MOMS – have been providing leadership for a sector-wide approach to improving quality of service delivery, which includes integration of quality management; monitoring of improvement initiatives; and coordinating the development of the framework, standards, guidelines, protocols, and dissemination. The two Ministries have also taken a lead role in facilitating the development and implementation of an evidence-based improvement strategy, looking at methodologies and tools to ensure priorities are aligned. Now is the time, he said, to disseminate the KQMH so that inadequacies from the first model can be improved based on what was learned while piloting the model. Implementing quality management in resource-limited settings faces challenges, such as inadequate resources and subpar infrastructure, but these challenges should motivate Kenya to come up with new ideas, he said. The purpose of this meeting, he said, was to provoke thoughtful conversation among stakeholders from around the world to share experiences with Kenya and strengthen the resolve to continue to improve care.

Dr. Mweki also shared comments from the Permanent Secretary who said that the Ministry is ready to support this timely initiative. The contributions of the participants in their sharing of best practices are appreciated while Kenya works to figure this out. Quality of care is close to every Kenyans' heart because quality has great bearing on prognosis and determines morbidity and mortality arising from diseases. The Permanent Secretary reaffirmed the commitment of the government, recognizing the need

for an environment conducive to improvement. In order to achieve sustainable economic development, Kenya needs to transform the health sector to provide equitable care. The Ministry has identified five priorities: hospital revitalization, commodity supply management and institutional reforms, health care financing, strengthening public/private partnerships, and strengthening human resources and regulation. This will require a policy that is informed by what works in resource-constrained settings around the world.

3 DISCUSSION

The second part of the meeting was designed around four questions:

- How did the improvement effort(s) you have experienced start? Who championed it? How was commitment sustained? How were improvement priorities set? What infrastructure was created to support improvement? How did it work?
- What improvement approaches were used? How and why did you choose them? How did they work? How did you resolve the balance between minimal standards and best practices? How did you review progress? How did you communicate and coordinate? If you were to undergo this experience(s) again, what was important that you would want to see repeated?
- What is the role of accreditation? What are the next steps and directions for accreditation in Kenya?
- What would you advise the health Ministries relative to a national improvement strategy?

The meeting concluded with a conversation on the way forward for the Government of Kenya, donors, and implementing partners.

3.1 Experiences in Improvement

The first set of questions relate to speakers' experiences with improvement: How did the improvement effort(s) you have experienced start? Who championed it? How was commitment sustained? How were improvement priorities set? What infrastructure was created to support improvement? How did it work?

Dr. Samuel Milgo, CEO of Kenya Accreditation Service (KENAS), shared his experience in improving accreditation in Kenya, which started in 2004. A problem was identified with delivery of accreditation services. A peer evaluation was carried out and gaps were identified. The organization realized they needed to start the process of having a department that would later transform itself into a national accreditation body and that they needed to improve upon the structure. To address these improvements, a department was formed to start the process. They looked at issues and developed a work plan that involved first taking it for cabinet approval. This led to a cabinet memorandum, which gave the basis for the development of a national accreditation body. The Kenya Bureau of Standards (KEBS) was then tasked with the support of the government and established a department. The department developed terms of reference and a work plan. They conducted training so people knew what to do. From the work plan, they developed a 30-milestone approach and an anchoring document to create the legal statute for the organization; they also carried out benchmarking. To continuously improve, they looked at gaps along the way and carried out evaluation at every stage, saw weaknesses, and made changes. In 2010, the national accreditation body was established. They continue with efforts to improve quality and are now on milestone 30, which is to achieve international recognition.

Mr. John Wanyungu, Program Manager for HIVQUAL in Kenya, shared his experience with PrevHIVQUAL, which began in 2009 with a stakeholder meeting. At the time there was a big scale-up of cabinet but there was not a place to assess quality of care, so the meeting was designed to see which area of care should be the focus. Following this, they developed indicators to assess the quality of care in pediatric HIV, exposed infants, etc. A pilot was started in 15 areas of the country, which has since spread to be in nine of the regions of Kenya. All these areas have collected data, which has allowed

them to identify the areas of care that are weak and work on improving them. This is coupled with coaching and mentorship visits from national and regional teams. At the national level, they work with all partners in all the Kenyan regions that can support the activities. They have also held joint learning sessions in all the regions to provide people the opportunity to come together and learn from each other, sharing what they have done. Scale-up continues in line with the National AIDS and STI Control Program (NASCOP).

Importance of Garnering Staff Buy-in and Using Results to Motivate People

Mr. Sven-Olaf Karlsson, former CEO of Jonkoping County Council, spoke of his experience garnering staff buy-in to do improvement work and using results to continually motivate them. As CEO, in 1989, there was a big focus on lowering the cost of health care, and Mr. Karlsson was happy to do so. In 1997 he attended, with three colleagues, the National Forum for Quality in Health Care, hosted by the Institute for Healthcare Improvement (IHI). By the end of the forum, he was convinced that a quality improvement approach was the right way to develop health care. By seeing the people who had done the improvement work themselves explaining it and sharing the results they had achieved, he saw the strategy clearly: If they could involve a lot of people in small improvement projects, they could get real results in Jonkoping. However, telling his colleagues back home about his experience was not enough, so the next year he took his whole leadership team to the conference. Every night they discussed what they had seen and learned that day, and at the end of the forum, they stayed an extra two days to make their own quality plan, thus beginning their journey. What Mr. Karlsson thought was so valuable was that everyone was involved from the beginning and had a feeling that they were really participating in something that mattered.

Dr. Massoud pointed out that there is nothing as powerful as results. Having people proudly share their results is one of the most powerful drivers of continuous improvement.

Mr. Karlsson went on to say that with quality improvement you get a lot of winners. The people who do the work become winners. As a CEO, he commented that you often see change that is just failure. If you work in quality improvement and have many projects, you may fail at some and win with others.

Dr. Naftali Agata of JICA shared his experience of introducing infection prevention control efforts and the challenge of sustaining the motivation for improvement work once results had been achieved. The approach was initially introduced due to challenges faced by countries with a high prevalence of highly infectious diseases, which was a concern to everyone. Among the approaches used was staff training to set up systems and processes for handling patients at both the outpatient and inpatient levels. A number of processes was internalized and accepted by staff so they started expanding them in different sections of the hospital. However, once the processes were introduced and the challenge staff had been working to address was no longer perceived to be threat, it reduced the motivation for staff to sustain and continue the improvement activities they had begun. In the beginning, fear had served as incentive.

The Role of the Champion

Ms. Elizabeth Oywer, from the Nursing Council of Kenya, had her first experience in quality improvement in 2001 when reports came from the field demonstrating to the Ministry that quality of care was very low. However, they did not know how bad it was. There were many boards and councils, but no one coordinating them. A committee was developed, and while those involved were not trained in improvement per se, they had passion for the work. They developed a curriculum for people who would be health service inspectors and covered all aspects of health, including inputs, finance, etc., and added prosecution, as even though it was known that quality was low, when people were caught doing something wrong, they got away with it because nothing was done. Then they made a checklist with a scoring system of one to five (five being very well and sustained) and standards so they could know how low was low in terms of quality. They also carried out a lot of workshops, trainings, and assessments with

teams at various levels (e.g., tertiary, midlevel). Thus, they were able to identify weaknesses, including financial management, leadership, and human resources (HR) and worked with various partners, including financial institutions, to address them. Overall, they had ambitious plans, and while not everything worked, they thought they would be able to train district boards, which did not happen. But, things continue and the story goes on.

Adding to Ms. Oywer's example, Dr. Bruce Agins of HEALTHQUAL International pointed out that this is a complex process with a lot of moving parts. There has to be someone who has ownership of the management of the work, someone who will make things happen on a daily basis. In his work, they have tried to find early adopters to buy in, start work, and get results to motivate others to join in. Also a shared common language and measurement platform is necessary. A coaching process can help people move forward when they get stuck, and opportunities for peer exchange must be created. In order to really make things happen, there needs to be a process to get information out to people even out at the farthest level and the strategies to make that happen must be thought through and planned out.

Adaptation

Dr. Mwanza Joachim of the Office of Standards and Quality Assurance in the MOPH shared his experience rolling out the World Health Organization (WHO) integrated management of childhood illness (IMCI) guidelines in Kenya in 1995 and 1997. When the guidelines were new, they were met with suspicion. CDC was working in Western Province and tried to provide the guidelines to the people and providers. Results showed that certain areas were problematic: Some had changed and some did not. An IMCI strategy was adopted based on the experience in the province. They developed a technical working group (TWG) with subgroups (clinical, etc), adapted from the WHO guidelines to make it an appropriate and country-specific plan. The subgroups created documents that required consensus, and they ended up making a broader body to work directly with the working groups and the people. Meetings are now large and include many stakeholders. Importantly, when looking at quality, what is quality today might not be quality tomorrow. As we look at issues of quality, we need to understand that many aspects of quality will be very dynamic, and certain standards will be changing from time to time.

Ms. Doris Mueni of KENAS shared her experience in medical laboratory accreditation. In 2009 a meeting was held about the state of laboratories in Africa and the need for their accreditation. WHO and partners developed the WHO AFRO stepwise to accreditation checklist to provide a process to accreditation based on ISO (International Organization for Standardization) standards. To date there are 30 African countries participating in this process, with 33 laboratories in Kenya participating. Currently, one Kenyan laboratory had applied for accreditation, a stage they were not sure they could reach before this began. This process has had challenges, she said: Accreditation does require a lot of money, but it has a lot of support. They are trying to get government buy-in in order to get accreditation to be a regulation and to have all laboratories accredited. If we start small, we can get to accreditation at the end of the day, she added.

How to Start and How to Go Forward

Dr. Charles Kandie, the acting Head of Quality Assurance and Standards of MOMS, was a Project Coordinator for a community financing for medicines project in Kenya. Commodities can be received from donors for free and a government program of distribution to facilities can be in place, but this project was trying to engage communities to purchase medicines with full cost recovery. At the time of the project, in 2001, facilities were facing acute shortages of medicines, so they wanted to see if this approach would work. They conducted a feasibility study, wrote a proposal, and received funding from the Millennium Technical Cooperation. First they mobilized the community and worked with opinion leaders and told them what they wanted to do. They ensured them that this project would be effective and would ensure that all medicines were available so patients would not need to spend money to go to hospitals far away to obtain medicines. The funding was provided, so they were allowed to implement the

project. The project built a big medical store for the district and improved stores in each dispensary. They also performed a baseline survey to know where they were and bought drugs, based on WHO expenditures, through Crown Agents, which was even cheaper than the central medical stores. Once the drugs were available at district stores, they started the distribution process and put tracking mechanisms in place. They discovered in each health center the health workers were overburdened with paperwork, so they made sure there were officers in each to take care of paperwork. They had multiple achievements, he said, including increased availability in supplies; increased use of facilities by patients, even from neighboring districts; and patients buying at facilities close to their homes. The project was not entirely replicable, however, because its location had a higher than average socio-economic status, so people were more able to purchase medicines. Nevertheless, the lessons learned were used in the public sector to improve issues around medical supplies.

Dr. Massoud responded by pointing out the importance of where you start you work: If you do pilot work in an area that is unlike the larger context, it is much harder to scale up.

Dr. Nicole Spieker, Director of Safecare of PharmAccess, noted that much of the discussion thus far had focused on the provider and ownership, but this example went beyond the provider to look at other innovations for improvement, which in this case bundled networks. If we focus only on providers, we will go only so far, so it is important to look at bundled approaches.

Dr. Joachim Szecsenyi, the Managing Director of the AQUA institute at the University of Heidelberg, responded to this example with his experience. In Germany, they have peer review groups, and at one point, they were each working for themselves with no rigorous program and little connection to each other. There were some concerns about prescribing in primary care regarding safety and long-term care. Consequently, they started with a small project examining what they knew and what they could change. They reviewed existing evidence and saw that they needed data and that there needed to be social influence. They opted to go with peer review groups because they were the cheapest. They also knew it was not wise to ask every doctor to find the best evidence for prescribing medicines. In fact, he said, it is even a problem to have doctors read through guidelines, so they made small digests of evidence reports focused on things doctors could actually change. They tested this in 50 practices, then with more; after two years, they were sure it worked. Then, in one large area a new form of contracts came up between the Social Health Insurance Fund and the professional bodies of the union of general practitioners. This was a great situation to bring this idea in and scale it up, which had always been their goal. In two years they were able to go from 200 practices to 309,000 doctors.

Dr. Massoud said the knowledge going around the room was about how to start and how to grow. Dr. Szecsenyi's story showed a deliberate, thoughtful process that started small and grew.

Dr. Agins added to Dr. Szecsenyi's point, saying that translating the evidence base into digestible summaries is key, and in his work, he has also had success using this approach. Referring to Dr. Kandie's story, Dr. Agins said deciding where to start is really critical and must be thought through. Initial planning should take into account the scale the implementers want to achieve and what things need to be tested to get there, such as rural settings versus urban, hospitals versus small facilities.

Providers Need New Skills and Motivation to Undertake Improvement Efforts

Mr. Karlsson said that providers need not only information, but also new skills in quality improvement. He asked people to think about whether the quality of care is poor because people don't want to improve or because they lack the skills, and he responded that it is a combination of the two. They are not bad, but they are living in a culture where it is enough to do the same work tomorrow as today, but, he said, improvement is to do better tomorrow than you did today, and people need new skills on how to improve. He said that he would often ask people if they had quality improvement skills training in their medical education and that most would say no. Leaders must give these new skills to employees. Health professionals need two types of skills: clinical skills and improvement skills, which include using data,

fishbone and other types of analysis, the plan-do-study-act (PDSA) cycle, etc. In Jonkoping County, when they had strong leadership for quality improvement, they began to train 10,000 employees in basic skills for improvement work. It is so important to give these new skills to people; we should not expect them to get results.

Ms. Annette Awiegand of the Christian Health Association of Kenya (CHAK) responded to Mr. Karlsson by sharing a challenge she experienced in Germany. They had educated certain nurses to be trainers of young student nurses, but when they measured the outcome, no improvement was revealed. Some people have intrinsic motivation, she added, but some do not and need extrinsic motivation. She said she knows people need incentives and asked Mr. Karlsson what he did to motivate people to change.

Mr. Karlsson said he agreed and used to say that in traditional education, people would come in and leave out the same door, forgetting everything. In his experience, they first provide basic knowledge to staff to understand what is meant by quality improvement. Parallel to that they have a learning center for learning and innovation. Now, they have about 30 very good people who have strong experience in quality improvement. When they started improvement work in their focal areas, they had teams from all departments of a hospital go to learning centers and work with some improvement theories. The teams then went back to their facilities to implement improvement, receiving support from the learning center; they measured their work, shared experiences, and so on. They held six seminars in each program, and each group was always working with its own work at home, which was the best way to learn how people learn.

Dr. Massoud added that he is extremely cautious of external motivation, it is simply temporary compliance. He said he would much rather work with a smaller group of people who are intrinsically motivated than many who need external motivation.

Leadership and Priority Setting: the South African Experience

Dr. Donna Jacobs, URC Chief of Party for the USAID ASSIST Project in South Africa, shared the experience her country has had in prioritizing quality in their health care system. In South Africa, there had been a number of quality improvement initiatives in a 15-year time span. Since 1994 a new government has been in place and along with it a new health plan and act. In the plan, a quality assurance system was to be in place, and there was to be an office of standards and compliance that would be in charge of accreditation for all facilities. When the plan was written in 1994, this was distant, but since the deadline for setting it up is nearing, the country is accelerating its efforts to reach this goal. Most quality improvement initiatives in the country have been haphazard; some have been in the MOH and they have looked at queue management, etc., without looking at quality of actual care. Donors, including GIZ, the European Union, the Department for International Development (DFID), and the President's Emergency Plan for AIDS Relief (PEPFAR) have spent millions in the country and have brought in many quality improvement and quality assurance initiatives, but they have been done in the setting up of projects and have not been coordinated. Fifteen years ago, South Africa decided to put quality (looking at both quality improvement and quality assurance) as the third priority in the 10-point National Strategic Plan. The first thing that happened was that the Minister has taken up quality as his priority, which is helping to coordinate efforts and move people in the same direction. Prior to this, there had not been a common goal or aim. Now, though, this joint vision has served to guide everyone in the same direction.

South Africa is moving toward having national health insurance, and the country is looking at equity and access for all South Africans at every facility, whether public or private. This is something that needs to be legislated, and all facilities need to be accredited. To develop standards, they looked at and learned from the standards in other countries and used them to develop their own. There are national core standards, which have been designed to assess hospitals, and standards to assess primary health care

facilities and community health care centers are in development. South Africa is looking to have an independent body accredit these since they cannot both develop and assess the standards.

There are six quality improvement priorities (cleanliness, staff attitudes, etc.), so when facilities try to improve quality in their area, they can look to these priorities. Documentation of learning in quality improvement has been improving and the Department of Health (DOH) maintains a database of all quality improvement projects underway and their outcomes.

For accreditation, many public facilities were not keen but had no choice in the matter. Private facilities objected strongly, saying they had their own systems in place, like ISO, etc. The Ministers' leadership and ownership of the process really helped to quell this and unify the country.

There is a health professionals' council that looks at standardizing regulation for all health care providers. They have convinced the health providers' association and several medical universities to introduce quality assurance models into graduate training, and the DOH is looking at curricula for pre-service training, because once a doctor has been practicing 10 years, it is too late to tell him/her about quality assurance.

Dr. Massoud asked whether there is a link between the six priority areas, standards, and accreditation, or are they isolated from each other.

Dr. Jacobs responded that there is a link. They always looked at how the standards could be used to get to the six priority areas. And to achieve accreditation, every facility has to prove it has been doing well in the six priority areas.

Dr. Agins pointed out that what was being discussed was about accountability and the blending of accountability in a national program together with sponsoring an improvement project. He gave two examples: One was that in the US, there are program standards that lay out expectations for quality improvement activities in facilities that could be used for accreditation, and they are not complicated. The second was that in Thailand they formally integrated quality improvement into accreditation, making those two pieces one.

Dr. Massoud shared that Malaysia has made a lot of progress, starting with its "Indicators project," which set priorities for improvement and revised it every few years. They went through award and non-monetary recognition system for those who made the most progress along the indicators. They then formally turned this into an accreditation system that built on the improvement that was happening. This has been a very successful model for them. It shows that if you create the link, you can create the system to move forward.

Dr. Jacobs went on to add that quality assurance is now being integrated into every program. For instance, the new elimination of mother-to-child transmission of HIV program, a UNICEF initiative, includes a specific quality assurance component. In terms of monitoring and evaluation (M&E) of accreditation and quality assurance initiatives, as a department they started looking at quality indicators but found it did not work well because they were doing it in isolation and not involving the people who work with district health information system (DHIS) data. Additionally, they are looking to link facilities' DHIS data with theirs and their self-appraisal to see how they cross-tabulate.

Dr. Spieker asked Dr. Jacobs about capacity and financing capacity and about the decision of the South African government and how do they feel they can make it sustainable.

She responded that the government is very committed to this model and has put it in the health budget. They have also had billions of dollars coming in from donors, funding that is now being coordinated. Additionally, taxpayers will be paying for this system, and the NHIF will be seen as the vehicle for the department. So, she said, funding is available, and in her experience the money is not always the most obvious challenge: Often it is finding the will to do it and a champion to see it through. There is also a huge political impetus to make this happen, and that will push it.

Dr. Obwogo Subiri, a URC Senior Quality Improvement Advisor for USAID ASSIST Kenya, asked Dr. Jacobs what drove the Minister to take up this leadership and if there was any evidence that the six priority areas would impact the health care system.

Dr. Jacobs responded that South Africa had had four Ministers of Health in six years, and the current Minister wants to stay in his position. He is also a doctor who has practiced and thus understands the difficulties providers face. He is passionate about making a difference in people's lives. Regarding the six priority areas, every year there are patient satisfaction surveys, and they are traditionally only looked at by the quality assurance director with inconsistent follow-up. The current Minister, however, looked at these from the last 10 years and made a list of the most common complaints. Some of them were really bad (i.e., dirty toilets, staff attitudes, patient safety issues, etc.). The six priority areas reflect these findings. Through her work on HCI, Dr. Jacobs said they have been looking at these areas and have seen a definite improvement in quality of care offered to patients and, as a result, better patient satisfaction surveys have been coming in.

Dr. Patricia Odero of GIZ asked about the link between DHIS data and results of the quality improvement efforts. In Kenya, in the TWG, they have been trying to map the KQMH standards to see if they have any relation to the DHIS data. It is challenging because quality improvement often monitors process indicators while DHIS uses numerical indicators, so it has been hard to see the link. Do they have any evidence that shows a link between facilities that are consistently undertaking quality improvement and their DHIS data?

Dr. Jacobs said that yes, there is such evidence. In South Africa they have the DHIS version 1.4 now, which has a module with indicators for quality, and they are comparing programmatic indicators with quality indicators and seen improvements, she said.

Training and Personal Buy-in to Improvement

Dr. Mwaniki Kivwanga, a URC Senior Quality Improvement Advisor with the USAID ASSIST Project in Kenya, wanted to share something the TWG had been struggling with. He said they had been trying to finalize documents and figure out how they can put quality improvement in pre-service training. He wondered if people could see the link with what they have been trained to do. It is one thing to introduce them to the PDSA, and it is a very different thing for them to be able to understand what this means to them in their work. What is the best way to do this?

Dr. Irmgard Marx, of the AQUA Institute, responded that what she had seen in implementing different quality improvement initiatives is that there are frameworks, standards, measures, and guidelines, but then people do not change even when trained. The crucial element for someone to change is for them to understand why they need to change. She then provided an example of a dentist that had studied plaque removal and found that if people brushed their teeth in a certain motion they would be at very low risk for dental caries. However, parents who are taught this method to pass on to their children will not do so unless they understand why it matters. We need to focus on understanding change, she said.

Dr. Massoud said that people are not resistant to change, they are resistant to being changed. There are ways you can catalyze the process by which a person changes, which is where we should focus our energy.

Ms. Margaret Kola, of KEBS, said that the Government of Kenya has done a lot to improve quality of care. The government set up performance contracts to hold providers accountable for the quality of the services they provide. This has since cascaded down various levels. Within this, the aspect of clinical outcomes is clear, she said, but where are patient concerns looked at and addressed? There is a survey, but it is done at the national level and does not get feedback based on specific facilities. This could start with the government putting in a strategic position and providing leadership to drive quality. Then, she said, we must go to the patients and ask what they are getting and what they want. She then gave an

example of looking at complaints due to errors and the process of trying small changes to address the problem and eventually achieve improvement and reduction of errors. We can use patient feedback to guide us in improvement, she concluded.

Mr. Karlsson added that our experience as patients is the result of what value is created in meeting with doctors. This depends on how each person is doing his or her work and the decisions they make. When you want to change or improve and motivate people, you have two boxes: The first is tools, methods, techniques, models, and guidelines, which comprise the hardware. The other box is the software: the culture. It is important to have a culture that supports the tools. You can work with the tools without the culture, but then you will not sustain the work. In order to create the culture you want, you must have good leadership that stimulates employees, provides new skills to people, has a system of learning to support staff, and shares learning and experiences. We must talk more about how to have a good culture for improvement and less about our tools, he said.

Ms. Lynette Kisaka of the Commission for University Education said that until we institutionalize at a personal level, it will not work. If someone cleaned a facility, as provided in earlier examples, but it was not done again, then it was not useful. We must make improvements in such a way that I as a person feel my work is better. We have been in accreditation for a while, she said, and improvement does come. Accreditation is temporary and has to be redone. Once they do accreditation and quality assurance, she said, it follows that once things have been pointed out as not meeting standards, people will have specific points in how to improve. Her organization is shifting from external quality assurance to internal quality assurance because keeping it external has not gotten them where they are trying to go. Lastly, she said, it must be kept in mind that standards change drastically over time and people must be willing to update them and change with them.

3.2 Approaches to improvement

The second part of the discussion was around approaches: What improvement approaches were used? How and why did you choose them? How did they work? How did you resolve the balance between minimal standards and best practices? How did you review progress? How did you communicate and coordinate?

Context

Dr. Nigel Livesley, URC's East Africa Regional Director for the USAID ASSIST project, shared his experience working in an HIV clinic in South Africa before 2004. They had many malnourished patients and the clinic did have many food supplements available, but the supplements were not reaching the patients that needed them. Dr. Livesley looked at what was supposed to happen: there were seven criteria and four questions to ask in order determine malnutrition in patients. He told staff to ask the questions and made a job aid. Nothing changed. He changed the form: Again, nothing changed. It was a situation in which the technical material was perfectly clear, but the approach was wrong. A nurse on staff told Dr. Livesley that he needed to support the less experienced staff and that he was not doing that. So, he sat down with staff and, working together, discovered there were two issues holding them back: the first was that staff were not comfortable calculating patients' body mass index (BMI) and the four questions they were to ask added a lot of time for a busy clinic. Together, they looked at ways to make efficiencies. They created color coded BMI charts and eliminated inefficiencies elsewhere. Alone, Dr. Livesley did not know what those issues were; they weren't technical and they were specific to that clinic. These changes solved the problem. Reflecting on this, Dr. Livesley said there are two types of knowledge: technical and contextual. Getting material on "what" (to do) was easy, but he alone couldn't have accessed the "how." A culture that emphasized this did not exist in the clinic and the issue was not technical, it was organizational. This is common with a lot of issues in health care, he noted: We typically

address them as purely technical problems but we need to look at how to implement them and look at the organizational structure. In health care there are not a lot of resources to help us with these problems.

Dr. Massoud then elaborated to say that success is contingent upon being able to use contextual knowledge. He then asked the group how this thinking applies to improvement and the experiences with improvement science in Kenya.

Mr. Wanyungu shared the HIVQUAL experience in Kenya, whereby HIVQUAL began by looking at baselines of quality of care indicators and performance measurement to determine quality of care levels. From that, they went on to do implementation and improvement based on the data. Working with staff in the facilities, they created modalities for improvement over time and coupled them with peer learning, bringing together sites that are doing the same work and providing coaching.

Dr. Odero spoke of her experience with GIZ. GIZ supported the ministry in the development of the KQMH, based on the former model. They found a lack of focus on ambulatory care that they felt needed to be addressed. Using IQMS, they looked at how to meet needs in ambulatory care settings and others where there are standards that KQMH calls for. They looked at what has been done elsewhere and saw European practice assessments as a good example, but realized they could not do them just as is practiced in Europe – they had to contextualize them and develop Kenyan indicators, guidelines, and standards and use Kenyan experts from the beginning. Though the domains were similar and the principles were the same, they do not always link and must be contextualized.

Clarity of goals

Dr. Szecsenyi pointed out that indicators are important, and in his experience in Kenya, they are not always clear. He noted the importance of discussing what we really mean, what we want to achieve, what the goal is, and how we translate it into indicators. There is a need for a social environment to motivate people who are working in the facilities. In his work now, they work with facilitators and focus on each indicator, discussing the best way to improve each indicator in each individual facility. This enhances ownership as personnel see their own data and see how they perform compared to others and can identify where they need to set priorities for quality improvement.

Multiplicity of approaches

Dr. Musyoka referred to the presentations earlier in the week on the improvement work done so far in Kenya and pointed out that the underlying principles in each approach were similar. Most methodologies were similar and included standards and the PDSA cycle. Working with JICA, 5S was a starting point for improvement in Kenya. The USAID ASSIST project showed them the importance of shared learning. For the Ministry, there is consensus that there is a quality gap and no quality policy and that the aims for quality must be known. The Ministry has realized that using multiple approaches as opposed to sticking to just one approach will achieve better outcomes, though it is still necessary to have a national framework and to set priority areas to focus on.

Dr. Agins pointed out that the issues being raised now called attention to high-level policy and implementation, but the group was also talking about the “how,” looking at how we actually build the policy that fosters teamwork in clinics so people can make changes. It is recognizable when it happens this way, as Dr. Livesley’s example from the HIV clinic in South Africa highlighted, but, he asked, how do we get there? It requires a culture change, so what can the national policy do to create a system that allows this kind of culture change in Kenya?

Dr. Massoud agreed with Dr. Musyoka, that multiple approaches to improvement should be used. Doing so allows implementers to be innovative, creative, and experiment and provides them the chance to see what the different approaches can give them. There is an important factor to using multiple approaches, which is assessing which methods are working. Do we judge by results? Even if one method is dominant,

it does not mean the Ministry has to stick to it. The field of improvement is dynamic and the methods continue to evolve, thus the Ministry and implementers need to keep evolving. People must be allowed to be creative. He recommended judging by real results and looking at those that help us get to better outcomes of care, including safety, effectiveness, efficiency, patient centeredness, equity, and timeliness. It is important to be clear on what we are really doing when we say that we are improving health care.

Dr. Joyce Hightower of WHO asked Dr. Musyoka if certain methods for improvement worked better at low levels versus higher levels, or if there was disjointedness.

Dr. Musyoka said that a mix of methods is important at all levels. When she first came across 5S, she saw how important it is to start with sorting and saw that small things can make the work environment improve. 5S makes health providers comfortable. But to impact clinical outcomes, you have to use other methods. It does requires guidelines, but this can be tricky as specialized doctors have a hard time with this, and at the lower level you can easily find providers who have not been updated with the newest guidelines. The use of the PDSA cycle is applicable throughout the levels of the health care system because it i identifies problems and shows need for change. The study component is tricky, and most people don't know how to do it, so it is a big order. Overall, all methods are applicable but at lower levels, standards and guidelines are important.

Dr. Kandie agreed on the need for multiple approaches. He trained in two hospitals on 5S-Kaizen-TQM, but found that there was another ongoing initiative on laboratory improvement that stood alone. The advantage of 5S he found is it brings all players together. He trained them and told them to form quality improvement teams, making it a hospital-wide effort. So, while he agreed there should be multiplicity, it should be working within a framework, and activities should not stand alone. Quality improvement teams should work for the hospitals, and all initiatives should work through this team. Everyone must be involved in improvement and teamwork should be fostered so an attitude for change is global.

Ms. Awiegand said it is her experience that in various programs there are different methods—COPE[1], SBM-R[2], TQM, Deming's cycle, and more—and often people see these as stand alone. The challenge to be addressed, she said, is to fill in the gap and ensure that people are aware that all of these approaches are based on similar grounds. Having multiple approaches does not force people in one direct line and in fact fits better for the multiple sectors that exist in Kenya. This multiplicity of approaches needs to be in a policy so we can see that we can use methods in combination with each other.

Dr. Massoud pointed out that confusion caused by multiplicity of branded methods is a universal problem.

Dr. Rolf Korte Artz of GIZ said that KQMH is an excellent framework around which all players can orient themselves, in particular the staff who aren't knowledgeable of the many systems. He said that we all must recognize there is no one silver bullet, but we can orient around the approaches available. We must adopt the principle of using evidence-based approaches, including SMART[3] performance indicators and think about critical conditions. These should be mandatory for people to report on so they can see where they stand in the country and how they compare against other institutions providing the same services.

[1] COPE stands for Client-Oriented, Provider-Efficient and is a quality improvement approach developed by EngenderHealth.

[2] SBM-R stands for Standards-Based Management and Recognition and is a quality improvement approach developed by JHPIEGO.

[3] Specific, measurable, achievable, realistic, and time-bound.

Sustainability

Dr. Kivwanga pointed out that many improvement activities in Kenya have been donor-funded and donor-driven, with a one- to two-year lifespan, and when they end, people go back to work as it was before. In fact, people have asked him how they can sustain the work after the funding period has ended. It must be clear how the approaches for improvement align with government priorities so that when the external project is over, the activity is still aligned with the government's priorities and can be sustained. He argued that we must move from branded improvement approaches to say these are the principles underlying improvement, and they can fit into whatever work you are doing, regardless of what you call it.

Dr. Massoud agreed, saying that all of the improvement approaches used in Kenya take a scientific approach to achieving better outcomes, put a twist on it, and name it something. He advocated for taking a step back and looking at the principles to making things better. Most are time-limited, but we do not want our improvement efforts to be limited by foreign assistance, but rather to a life of their own and take their own shape. If the government were to set national priorities—for example, to reduce maternal mortality—the government sends a clear signal down the system and sets up mechanisms by which to start the work. The way to do it does not need to be stated; instead, we can judge by results. However, we do not want to create a system in which people are reinventing the wheel, so some guidance must be provided, and those involved in improvement must be followed and space for learning between those involved must be created.

Government leadership

Dr. Peter Arimi from the USAID East Africa Regional Bureau said that it is important that what the Ministry wants in the policy is well understood so partners can respond to it. He talked of a meeting on quality improvement in 2009 with the health Ministries from East and Central Africa countries. The Ministries were confused because donors were funding quality improvement approaches, but each country is divided and they all have different models for improvement. Each implementing partner comes in and says their model is the best, and it creates a lot of confusion. The Ministries told USAID they wanted a harmonized model. He used this example to highlight the need for everyone to be clear on what the Ministry wants so that responses are fitting. The models have inherent commonalities. Kenya is trying to have this answered for them so they have one model and policy.

Dr. Agins pointed out that there were two issues about sorting priorities being discussed: donor confusion over models and priority settings for improving different aspects of care and diseases. No one is saying improve maternal mortality and ignore diabetes. One issue goes back to the Ministry about priorities and the other is about models.

Dr. Massoud stated that we can have a model for QI but can have many methods within it. When looking at methods, it must be taken into consideration if the model has change as a key component and is not just inspection. When measuring against standards, does the method help to meet them or not? If all you are doing is assessing whether something is being done or not, that is only assessment not improvement.

Dr. Wanyungu said that while we can organize everyone around the KQMH, the document delves into some of aspects of quality of care. All approaches should be founded in the KQMH, and the model needs a specific statement that other approaches are allowed, but they must be anchored in the KQMH. Programs can be re-tailored to fit in and borrow from the KQMH.

Dr. Musyoka said the Ministry has priority objectives developed in the draft strategic plan and the main areas of concern are there, but for quality improvement, the priority areas still need to be determined so that when the strategy is developed, these are already known. For the framework, the KQMH can be improved upon. The Ministry needs to define tools that can operationalize the KQMH, and it needs to be revised to exhaustively cover all approaches that have been used. Additionally, she said, the KQMH can

incorporate best practices from the current approaches. As far as creating one national M&E framework, the current indicators for the health management information system (HMIS) may not adequately address the quality improvement work we want. She said that the TWG discussed having quality indicators that can track priority target areas so that the quality indicators can be given to projects and everyone will use the same indicators.

Dr. Jacobs shared that in South Africa, they have already agreed on which way they want to go and have their model. They have two principles underlying quality policy: strengthening the hand of the user and empowering communities. It is critical for users to know what they should expect as quality, and that they should not just accept any care just because it is there, that they can demand quality care. The second principle is creating an environment where quality will flourish. In South Africa, the DOH is looking at models and monitoring a quality framework. These two principles govern both how they accredit facilities in South Africa and how they look at patient satisfaction surveys and make sure everything is going in the same direction. She advised that Kenya not lose sight of the bigger picture.

Dr. Odero took a moment to point out that she was hearing there were certain principles that the group was agreeing upon that could serve as the foundation of the policy: a multiplicity of models and that those models must result in demonstrable change.

Dr. Massoud added that shared learning should be included in this.

Ms. Mueni said that while she is not familiar with the KQMH, she works in hospitals that have been accredited and can see gaps, and these are likely the same gaps that exist in the KQMH. She suggested looking at each unit in totality and examining how these gaps can help to create a better KQMH.

Coordination at the national level

Ms.Milicent Olulo of PharmAccess pointed out that improvement efforts need a lot of coordination. She said that in her work they take 90 facilities through improvement plans after assessing them, and they are all part of different projects by different implementing partners (PSI, MSI, etc.). She said that having them coordinate with each other is a challenge.

Dr. Musyoka agreed there are weaknesses in coordination. Kenya needs a national policy and strategy to provide direction. Quality assurance and standards are both national functions, and it needs to be documented that donors must come through the national level offices so the government can coordinate the partners. Otherwise, how will anyone know what outcomes are related to what? For example, partners working in HIV have to pass through NASCOP first, so NASCOP can coordinate them. Regulation is also important, she added, as there is a need to agree on the needed regulations to guide policy and quality improvement and assess if regulation is enough or if a law is needed.

Mrs. Amolo, URC's Chief of Party for the USAID ASSIST Project in Kenya, pointed out that the capacity of the national level departments must be taken into consideration so it is not difficult or overly burdensome or time-consuming for partners to work through.

Dr. Musyoka responded that there is a proposal to develop a directorate of quality assurance and standards. The Ministry has cleared a cadre for quality assurance and standards, and staff will be appointed to be quality assurance and standards officers. Staff at the national and county levels could be looking at improvement activities and know where implementing partners and what they are doing. There exists a gap in coordination between the ground and the national level, she said, and partners need to inform the national level of their approach and locations, which need to be assessed and approved by the national coordinating structure.

Dr. Massoud pointed out that we are not differentiating between two types of activities in improving health care: improving health care is about better patient outcomes; there is no point in having a clean facility, he said, if the clinical care is bad. There is no point in fixing HR issues if it is not going to feed into improving

clinical outcomes. 5S does not affect outcomes of clinical care, but it can be used to get to the point of being able to improve clinical outcomes.

Priority setting and indicator development

Mr. Karlsson shared his experience in Sweden. He said that when they spoke to frontline staff, they (staff) felt they were working hard and said they simply did not have time to work on improvement. He said that we must understand what people are doing in the front line and help them work with quality improvement and give them the best conditions for working with improvement. In his experience, they realized they could not change everything at the same time; they needed a regional level strategy to spread from. They realized they needed to set priorities, so they defined five concrete areas to start with and have since grown from these: access, cooperation and flow, clinical improvement, patient safety, and medications. All efforts were based in collaborative, and they followed them over one year to see the results. As leaders, they motivated staff and helped them to understand what they were doing. For example, they worked with providers to ask patients how many medicines they were on; some said 13 up to 29. This showed them that we must be able to talk about the why in order to get to understand the how. With transparency around data, people who worked in clinical improvement were motivated. Doctors have egos and are competitive, and they used this to motivate them.

Dr. Arimi said that for the Ministry to be able to report countrywide improvement, regardless of approaches used, there must be common quality improvement indicators agreed upon each year so that from the national perspective, quality improvement is seen as part of performance contracts. This will help everyone report on the same indicators and be able to say what they can and cannot achieve.

Dr. Musyoka agreed that there is a need for clear quality indicators for each of the Ministry's operations in the five-year strategy. Quality improvement cannot be done without incorporating assessment; in the KQMH there is a checklist, and sometimes it is better to move with what you have than not move at all, she said. They need a clear checklist for the KQMH so every organization does not have different checklists and so it can serve as an assessment tool for all quality improvement approaches. This could be made possible by working together and seeing how these approaches are linked and how they can be assessed.

Dr. Massoud agreed, saying that if you do not track what you are doing, you will not know if you are making improvement. And some methods that are presented as improvement, do not actually lead to improvement.

Dr. Musyoka said they should propose clinical audit tools to operationalize the agreed upon framework. WHO clinical audit tools could be used. While some are not applicable, once the priority intervention areas are agreed upon, national clinical audit tools will be needed.

Dr. Kivwanga said that improvement must be within the MOH structures and that district health managers should empower people to know what they are doing. Partners' work is to align with the Ministry and create an organizational culture to do improvement.

Dr. Sammy Milgo, CEO of KENAS, said that we are looking to the MOH and MOPH to prioritize areas for improvement. He agreed that it should be included in performance contracts and this needs to cascade down to health facilities.

Dr. Szecsenyi said Kenya needs to have a set of national indicators, a framework for the policy and have many improvement activities. But, he said, it is not wise to only look at outcomes, we must also look at processes and structures. But should be cautious of overloading the system with data collection. While this is wise, he said, it is not easy. Indicators need to be evidence-based and likely to influence outcomes.

Dr. Massoud said that Kenya should focus on key areas, but also look at outcomes and proxy outcomes that will indicate if they are heading toward their outcome goals. It is up to the ministry to determine if they want to develop specific quality indicators or just use existing indicators. Is there are difference? What will

show the ministry that they are achieving what they are trying to achieve? The ministry should think about what matters for health care in Kenya.

Mrs. Amolo pointed out that assessment is part of improvement but ending there is not improvement. It must be taken further and used to implement change in order to achieve improvement.

3.3 The role and need for accreditation

The next part of the conversation was about accreditation with a discussion on next steps and priorities for improvement.

Dr. Massoud started off the conversation by saying it is important to figure out where accreditation fits in and to create consistency between accreditation and the improvement process.

KENAS

Dr. Samuel Milgo from KENAS provided the group with background on the organization. KENAS became operational, by law, in 2009 as part of state cooperation act 46. It is an independent accreditation committee that makes decisions and has a staff and budget as provided by treasury. It is certified in ISO 11 standards. Accreditation has two facets and needs national level support. KENAS is moving through their work plan with 30 indicators, the 30th being to attain international recognition. Their mandate will give accreditation to labs working closely with the ministry and support partners. KENAS was created, in part, because accreditation is expensive and having it close can reduce costs. KENAS works with WHO which helps them share resources. The expectation is that there will be commitment from the national level down to facility level, even within budgeting systems. KENAS does not have all the expertise that is needed for every assessment, so they rely on using specialized experts as needed. To achieve international recognition, KENAS is benchmarking itself against other accreditation bodies around the world. Other countries have made sure they have one accreditation body that is not profit driven. KENAS also wants to have a critical mass of customers so they can break even and not depend on government.

Dr. Agata asked if the main focus of KENAS was just on laboratories, or if KENAS was involved in accreditation of other health institutions.

Dr. Milgo responded that accreditation work is used in many contexts. In the case of KENAS, he said, they are looking at laboratories in all things: looking at certifiers, looking at inspection bodies in all fields and all sectors. In terms of personnel, they are looking at competencies and limiting themselves to a conformity assessment body focused on inspection, certification, and calibration.

Dr. Amiri asked the group for those who had experience in accreditation to share their experiences. In Kenya, he said, there are levels of hospitals and there is a clear standard of what each level should be. But, he asked, is there is a system that assesses whether what is mentioned is applicable? That may be different than what KENAS does.

Dr. Musyoka said that the KQMH's predecessor, the KQM had an electronic assessment tool which was used by NHIF and was called accreditation by NHIF. These KQMH standards can be approved to be standards for accreditation. There is a checklist for every level of care and the checklists are defined by what is supposed to be at all levels. Although, she said, there was an issue of rolling out their dissemination. There is a need to define what accreditation for health facilities means. Since the mandate of KENAS does not incorporate health facilities, she wondered, could it be expanded to be an accrediting body for health facilities? Most stakeholders in the study conducted in 2009 felt that an independent body for accreditation was needed. If this responsibility is put on KENAS they might not be able to manage. Kenya could replicate the South African model and build a council so it could be independent from the government.

Dr. Massoud asked if the law in Kenya specified if health facilities have to be separate from the current functions of KENAS?

Dr. Musyoka responded that the government is currently reviewing the laws in line with the constitution of 2010. They have proposed the need for accreditation for health facilities, and proposed it to be done by a council. The next step is to agree on how we want to structure that system.

Dr. Massoud asked if this should be open for conversation, whether it is needed or not.

Dr. Korte Artz said that he has read the KENAS legal framework which states that KENAS is the body for accreditation in Kenya and anything else is just certification. Many people think KENAS is only dealing with medical laboratories but, he asked, is there ultimately interest on the part of KENAS to go into medical services, and if so, will KENAS accredit the thousands of service providers themselves or will they put accredited compliance agencies under them that will do accreditation on behalf of KENAS? As currently proposed in the health bill, the health professional council will do accreditation, so will there be two bodies. If so, will the health council be accredited by KENAS? The definitions need to be clearly spelled out, he concluded.

Ms. Awiegand pointed out that KENAS is very involved in ISO. In Germany, she said, they could choose whatever system they wanted, so many facilities chose ISO but it didn't cover the needs of a hospital, they found while it is good for organizational aspects, it does not address patient issues. They developed another system for certifying hospitals in which they added measures for patient aspects.

Dr. Odero brought up the issue of licensing and who should do it. She asked who should certify facilities, and after a hospital is certified to meet standards, who accredits it? From there, she said, it can be seen which existing institutions meet those functions, then we can determine if there is a gap, how it can be bridged. There is a need to license, a need to certify, and a need to accredit.

Dr. Jacobs said that in South Africa, they have accredited laboratories by SAMAS, health professionals are licensed by the professional council, and they created a body known as the office of standards and compliance to accredit health facilities. All of these fall under DOH so the Minister has control of these bodies. It was important, she said, to separate accreditation of facilities and laboratories because they are not the same. ISO does not work for all the differences in the facilities. To address the question that was raised about the need for Kenya to embark upon legislation in order to accredit health facilities, in South Africa, they are working on their health act and passed an amendment to establish the office of standards and compliance. Passing the amendment was much faster than creating a new law altogether. With creation of an office of national standards and compliance she said they have been able to set up provincial offices of standards and compliance so they can monitor compliance within all provincial facilities will be covered by this structure. Lastly, in South Africa they chose to separate the accreditation of facilities in the office of standards and compliance so they are totally independent and outside the DOH. Quality improvement falls under the DOH. Accreditation takes place every two years and in the meantime, the DOH is active in ensuring quality improvement is occurring during that time.

Dr. Massoud pointed out that the act of improvement is separate from accreditation and the two are needed but not related.

Integration of improvement and accreditation

Dr. Agins said there are opportunities to explore integration of these separate activities within the framework of the different processes. There is a separate improvement component that is linked to an accreditation component and they are separate, but the processes can come together, he argued. In the US, they are looking at improvement in the process of professional certification. It is hard to do it all at once when starting anew, but there are ways to bring the processes together so improvement becomes a key domain for both facility accreditation and professional competencies.

Dr. Massoud suggested that Kenya look at creating synergies between the two once things are up and running a bit more. For example, for a facility to be accredited, perhaps it could be required that they are engaged in improving key parameters. This will build the understanding that your job is not just to do it

routinely, , your job is to improve on it and you must be able to demonstrate that you know how to improve your skills.

Dr. Szecsenyi said in his experience it has been historically bad to distinguish between all these pieces – accreditation, certification, standards, and improvement. In Germany, to overcome this, they run a certification system for primary care facilities and in this system the achievement on quality indicators is showing that improvement is a pre-condition to get re-certified. The advantage is that by having a system based on quality indicators, you can easily set a rate of improvement by which a facility should achieve in order to fulfill the needs for re-accreditation. Kenya should not keep accreditation or certification completely different from improvement, he advised.

Need for an independent accreditation body

Dr. Musyoka asked Dr. Milgo if KENAS feels it can take responsibility of accreditation of health facilities or if the ministry should go to the option of the proposed health professional council body?

Dr. Milgo replied that the scope of KENAS as stated in their legal notice makes it clear that is serves as a conformity assessment body and KENAS is the sole accreditation body for these other bodies. Medical institutions are not their niche. Kenyatta hospital has ISO certification, but there are laboratories in the hospital and for those to demonstrate competence, they have to be accredited. As this is a conformity issue, it falls on KENAS. The NHIF is doing a form of certification, but is not going into accrediting health facilities.

Standards, he said, are very generic as necessary but if you want to suit a specific business you have to adapt them to match what it is doing. When checking for conformity, they are not just looking at the standard but must also meet what the customer wants and what the law wants. They have also noticed regulation has to be brought in as you can read a standard but within it there can be regulations. For example, something may meet the standards, but not other regulatory requirements. Policy must bring in regulation. Terms need to be well-defined within the context they are used, he said. We can borrow and adapt what will work for us.

Annette said that in Germany, the government is giving out indicators with goals that have to be reached and are compulsory. If a hospital does not follow these, you cannot operate. They are measured and feedback is provided. ISO and other methods are a more competitive system as they started being used by hospitals that were trying to draw in patients. Now though, if a hospital does not have its certification, it is harder to gain patients. In Kenya, she said, we need think about what will be mandatory, what will be self-driven, and what will be market driven.

Dr. Milgo said that it is not by default that in the health sector there are some things you have to do – you are dealing with life. Therefore, one must have licensing in order to meet key things to be able to operate. The integrity certifications at ISO level are having an issue, if applying them, you must be able to see whether things that are set are being followed. When we had certification in Kenya, there was little being followed and everybody could see there were things that were supposed to be done but no one was doing them. Where there is regulation, business must fulfill those regulations.

Dr. Arimi asked if the focus will be on the mandatory piece? Or should part be mandatory and relax policy that allows for competition; which will happen eventually because the private side that provides 52% of services in the country is interested in that. The public sector does not worry about competing for patients and what is made mandatory applies to them. The policy must provide for both.

Dr. Korte suggested it be looked at pragmatically. Government facilities do not compete much, but this will change with universal health coverage and insurance. Creating a level playing field would allow patients to be free to choose where they go and helps foster competition. There should be a transition period that starts with pioneers who volunteer to go ahead with accreditation so the system can be built. A culture of continuous quality improvement must be developed first and then a system for accreditation or

certification should be designed in such a way so improvement is measured from step to step more than just looking at standard compliance.

Dr. Jacobs said that public facilities in South Africa provide 80% of care, however, financing for private facilities is 80% of total health spending. They decided to write a policy that applies to both public and private facilities so the country could take ownership. They have managed to have a gradual process of certification and accreditation. When the policy was written, it provided 15 years to get it right, but now it is urgent to get this finalized because it is linked to health financing. Kenya should be thinking of efficiencies that can be built in from the beginning.

Dr. Musyoka pointed out that everything needs to be linked with Kenya's Vision 2030 which is pushing the government to have an accreditation framework that not only involves the private sector but also the public sector. If they go by the definition of accreditation of KENAS, she said, which is a body that is assessing conformity, then they need to think seriously about whether this is what is needed, or if inspection, licensing, and gazettement by inspectorate agencies is enough. What needs to be agreed upon is that KENAS is not ready to take up that responsibility. Stakeholders want an independent body. Since KENAS' definition does not fall into what is wanted, she said, can we propose to form that body, can we put it inside the health bill so that when it goes to parliament, it is in there. In part six of the draft law, where we have issue of inspectorate body, we need another clause where we talk about accreditation. When this goes to parliament, consensus needs to have been built with KENAS so they are in agreement with the proposal.

Ms. Kola pointed out that there is licensing with minimum standards. For accreditation, she wondered, if there are going to be other standards for accreditation and if multiplicity for various certifications would be allowed.

Dr. Milgo cautioned that they must guard against duplicity and in the upcoming changes there will be many mergers and there is already a problem of confusion caused by duplication. If we say every citizen has a right to quality health care, he said, it does not matter if it is in a public or private hospital. You have to see what you can do and how long you need to do it, such as the South African government gave itself 15 years to roll out changes. KENAS is very particular about remaining within its scope of work in order to be recognized internationally.

Ms. Kisaka said that they have recently repealed old acts at universities and they were formerly only accrediting private universities. She said she thinks accrediting bodies are needed and recommended they be linked to others outside the country to add validity to the work.

Dr. Milgo said that even now KENAS is an entity that is established by law, but where will resources for third party entities come from?

Dr. Musyoka said that NHIF was doing accreditation because there was a gap since there was no independent body to assess facilities. For private insurance there is an assessment checklist but for public there was not because no one was concerned as funding came from taxpayers. The goal is to make national referral hospitals autonomous, increase medical tourism and need to make sure there is criteria they are meeting, which is accreditation. She argued that Kenya needs a phased approach like the five-star approach.

Dr. Korte said Kenya needs an accreditation agency that is truly independent. The health professionals' council cannot have a board chair that is appointed by the government and be accredited by KENAS. So the ministry needs to think about who can best provide these independent services? KENAS can, while it is government, they could accredit performance agencies that check for performance against criteria that are set by the government. KENAS can certify agents that adhere to principles under the framework of KQMH. Core indicators can be introduced and may change over time. Additionally, certification could be done not in pure conformity but in such a way that shows conformity and improvement at the same time. With the KENAS system could have a multiplicity of systems – safe care, IQMS, whoever wants to be part

of the game could be applying to receive accreditation from KENAS. There needs to be impartial judgment of whatever is certified. If a separate accreditation body is needed within the system, then it must be absolutely independent. In Germany, the task of certification is delegated by a joint council to private organizations that do it on their behalf.

Ms. Awiegand reminded everyone to remember that private agencies are making money by accrediting and could be motivated to give certifications so they get paid.

Ms. Mueni said that the government needs to make minimum requirements for both the public and private sectors. An independent body needs to be formed, she thought, and that this body does the certification and is checked by a group such as KENAS to validate the work.

Dr. Massoud pointed out that there is a difference between certification and licensure on the one hand and accreditation on the other. To be licensed as a doctor means the person fulfills certain requirements, same as certification of a facility.

Peter said that in their government system there are criteria, but currently they are not being met.

Dr. Massoud said that minimum standards are needed to qualify someone to even see patients, but that accreditation may or may not happen after being certified.

Dr. Korte pointed out that there are different definitions in the current draft document.

Dr. Musyoka said that the continuum of quality improvement is present and that assessment levels (gazzetting, licensing, and inspection) and have already been taken care of. Additionally, the inspection bodies are clear and inspectorate bodies will be made when the law is passed. These will be accredited by KENAS. Looking at the bodies that are already certified to practice, what can be done to make sure they competitively give the best to patients, achieve medical tourism, achieve positive outcomes. This is where something like a five-star approach and a framework are needed. How do we ensure that once accreditation is achieved, how does quality improvement sustain outcomes?

Dr. Massoud pointed out that quality improvement sustains outcomes while accreditation does not.

Dr. Odero said they are vesting licensing into regulatory bodies, which they want to have under the health inspectorate. There is certification that has minimum requirements, and then there is the mark of quality. If a regulatory body comes to inspect a clinic, how do they certify the services provided are of quality? Who will address that and provide standards that show that even though a provider may be licensed or a clinic certified, that the services provided are quality.

Dr. Milgo said that we should get rid of the perception that we cannot change. KENAS is being asked if these laws are in tandem with the constitution, and it is our business now as institutions are devolved to county governments that they remain relevant. They need keep in mind that it is not duplicity to always be looking to see if they could do their work better.

Dr. Musyoka asked if it is possible for the Ministry to put a clause about how they want accreditation to be. Dr. Milgo said that a bill had just been just approved by the KENAS board; it is being critiqued by others who will determine if it is doable. If we do it alone, he said, we are preparing ourselves for doom.

Dr. Musyoka asked if there are any clauses that touch on health services.

Dr. Milgo replied that if NHIF is doing conformity, then it is our customer.

Dr. Korte pointed out that NHIF is only doing accreditation now because no one else was. Its core business is financing health services, and in this they will have to write contracts with providers for services they buy. Elements of quality could come in here, and contracts could be based on whether or not a provider has been certified by someone else. They may want to maintain someone in their body to continue review to ensure providers are giving best services to clients.

He added that he liked the idea of moving forward with a graded accreditation system (such as the five-star) so facilities do not have to be kicked out altogether if they do not meet the standard. This does need recognition of an international body. As it is currently, the draft bill is lacking linkage points with the health sector, which needs to be put in, and needs more emphasis on participation of clients and health services.

Dr. Odero asked if the licensing body and certification/accreditation body would be same and what the function of the MOH would be in relation to these bodies.

Dr. Musyoka said that in the proposed health bill, there is a separation of the work of the ministry and that of the regulatory bodies. They will be independent inspectorate bodies they are reviewing their act to align themselves. The health professional council will look at providers, and the inspectorate bodies will be looking at facilities. The MOH now only has policy at national level and technical assistance to counties. The national referral hospital will be autonomous and needs a system to accredit it. New inspectorate bodies will be accredited by KENAS and will be developing standards.

Building improvement into accreditation

Dr. Massoud said body should determine whether a facility can operate and another whether a practitioner can be allowed to or not because the expertise required to decide whether a doctor can perform or not is quite different. When looking at the standards by which a facility is rated, the first thing to look at are inputs (staffing, medicines). Then they look at the process by which medical errors are managed (Is there a team that deals with errors when they happen?). And then they have to show they are doing improvement, which can be done by simply showing there is an improvement activity. None of this is related to the hospitals' death rate. This requires totally different skills to review. Accreditation is important, but it truly is just assessment. If you want to improve care or safety these require a different set of expertise.

Dr. Korte said Kenya can use indicators to follow performance, but if they deviate from performance, they could do structured dialogues, as done in Germany as opposed to closing the facility right away. This helps to learn about the root cause of deviation. These dialogues can be built into a mandatory reporting system on a continuous basis. This could easily be done in Kenya whereby there is regular reporting on the conditions the ministry wants to improve.

Ms. Awiegand said that in this case, you have to write report every two years to share what you have done and everyone can read it.

Dr. Massoud pointed out that writing the report and doing something about it are two very different things.

Ms. Awiegand said in Germany, you are measured by percent attained and if you are below 90%, you have a structured dialogue and discuss what you are going to do about it. This is compulsory from the government and in some cases, facilities can even lose departments.

Dr. Agins said that accreditation systems may require a structure or process that focuses on improving things. This can lead to a separate activity related to recognition. If you meet those criteria and demonstrate results in several areas, then the facility can receive formal recognition.

Dr. Massoud shared the experience of Malaysia where they linked accreditation and improvement together very well. They built their accreditation system around the national health priorities. The accreditation was very mild on measurement and was instead more focused around improvement. It is a different way of doing it, but it has been very effective.

Ms. Kisaka said they have had to build in quality in the university accreditation. At the input level, KENAS can tell you who is allowed to operate.

Dr. Massoud said that Kenya should have an accreditation system that requires quality improvement to be built in to it. Next, the improvement function needs to be operable. The ministry needs a body within

itself and someone responsible that convenes key players and sets priorities to ensure things are improving on an ongoing basis. One provides external assessment while the other is internal improvement. This creates a whole system that makes the ministry a learning organization. When improvement is put within accreditation, the improvement mechanism needs to be built.

Dr. Amiri pointed out that facility funding comes from the government and politicians have interest in having their facility ranked high so they can receive more government money. If an independent body says that a facility does not meet the specified level, it is self-serving to give criteria as it depends on attracting government money. There needs to be an actual body to say this is the level you can operate on based on what we see.

Dr. Musyoka agreed that there needs to be an independent body that is legalized in the draft law. The ministry needs to hear from the inspectorate body if they are ready for another body that does accreditation as they will need to get something from the government also. If KENAS can have agencies as Dr. Korte suggested, it can work but it needs to be legitimized.

Dr. Hightower asked if currently, up to the inspectorate level, the ministry could mandate that they inspect with indicators of quality.

Dr. Musyoka said they only have the minimum standards but they are moving them up to accreditation. There already exist clear functions of inspectorate bodies with quality inside, but the issue of accreditation is coming to be superior to assessment. However, the quality piece that is run through the ministry is not truly functional yet.

Dr. Massoud said that it needs to be spelled out and stated that if we are to improve care for the nation, if inspection is needed, if accreditation is needed, and if an engine that drives improvement (within the MOH) is needed, and if so, how will it function and what it will do.

Dr. Hightower said that there may be specific elements of quality improvement included in plans now, but if it cannot be adjusted or added now, how will needs be added in the future?

Dr. Musyoka said that the essence of having a policy is that it should address these things. It will address the needs of the health sector. We have already agreed that we need to have quality improvement activities and that we will have priority intervention areas, she said, and we will have common indicators. We have agreement that accreditation needs to be a political decision and that it needs to be an independent body outside the ministry since KENAS is not best suited for it.

Dr. Milgo agreed saying that both sides need mutually beneficial relationships and that the government cannot do everything.

Dr. Korte stated that this was charting a good way forward. No one central body would be able to do all these things. We should come up with broad recommendations, he said, and pinpoint the way forward and continue building as it moves forward. For example, he noted, we have agreed upon using evidence-based methods, developing indicators for key areas, and build as we go along from there.

Dr. Agata said that the framework must look forward to where Kenya wants the health sector to be and that vision should be driving what is developed. Keeping this in mind, he said, we can keep in context the new constitution and new legislations that are being created so we can feed into them. If we clarify the principles that will guide this, these principles will influence these issues about subcontracting, regulatory bodies, etc. If we do, we will have established a framework that will guide the process. We need guidance on what kind of systems need to be in place, both in the ministry and outside. We have different understanding of some of the terms and need clear definitions of the terms.

4 RECOMMENDATIONS AND WAY FORWARD

For the final piece of the conversation, participants were asked to provide advice to the MOH based on their own experiences. This advice was in three pieces: what practices in your improvement activity were worth repeating, what the MOH should not do, and what is your advice for the MOH going forward. The meeting was concluded by Dr. Musyoka who provided her thoughts on next steps and the way forward.

4.1 Key Advice

Practices worth repeating

- Setting really clear expectations so people operate with same assumptions
- Not just talking to people on front line and working back to policy
- Working through partnership that we started looking at quality improvement methods we want and through this take it forward so that we include sharing in policy, which also helps scale up.
- Sharing and bringing in experts from different places to see how to work together and see current situation, involve end users, and have clearly defined terms.
- Having a strong system for data use and analysis; using of technology and being realistic with that across the country.
- Linking quality improvement efforts within the broader national system.
- Implementing quality improvement within existing government structures to build capacity and continue on when programs are no longer there: Implementation on the ground should be done under one global structure.
- Paying attention to the situation and circumstances of the local context, to this end, the KQMH is already a good improvement step.
- Starting with quality management provides opportunities for self improvement.
- Building highly dynamic processes, both internal and external processes.
- Bringing together experiences, share learning, be cognizant of sustainability.
- Ensuring the process is participative and sharing ideas.
- Building strong capture of improvement to be able to empower the people doing the work; saying how we will empower staff to do it.
- Developing a national framework and indicators that everyone can speak to but doesn't have rigid control and instead the framework provides flexibility on the ground. Drop the names of models and instead build the capacity of people to do the work with a focus on the principles.
- Focusing on evidence-based learning and not letting the KQMH act as a limit to desires.
- Embracing partnership between public and private providers; having structures in place that support quality improvement, quality management structures, and county-level peer learning.
- Having a clear legal mandate is helpful. The accreditation body is independent and based on international best practices.
- Consider a multi-faceted approach and different perspectives, including the voice of the patient and linkages to national frameworks and working within those that exist.

- The MOH is setting priorities for the nation – things that matter – and this is a dynamic process; it should be revisited annually with a focus on one to two key things so as to not overwhelm the system. We must make it the job of the MOH to unleash the power of whole system – deploy the whole system to accomplish these aims. Focusing on those key things, the Minister, etc., would have to ensure the empowerment of staff to make the changes, experimentation must be allowed, and the system must be vibrant, emphasizing people's values and feeding into that value system that moved people to go into health care in the first place. The system must be measured so we know if we are moving in the right direction. A support system must be created; people must be able to change things and authorized to make these changes themselves. Critical to improvement, it must be a learning system, and improvement must be put on the agenda.

Don't Dos

- Don't fail to develop a strong platform for data analysis on key measures before beginning the work: a strong mechanism must be in place to receive information.
- Don't run the risk of putting too little emphasis on what has been done: place major emphasis on that and what experiences are – consider lots of different experiences.
- Don't allow any lack of clarity; for example, define your terms and intent, such as sector-wide health goals, quality goals, interventions, and plans. Foster an environment that allows improvement, emphasizes learning, and assesses outcomes.
- Don't over-bureaucratize the system: some approaches have been over-loaded. Instead KQMH is a unifying entity.
- Don't fail to include representation from stakeholders and the people who will be using the policy.
- Don't dwell on understanding names but focus on the underlying principles.
- Don't have standardized training where one person is picked to travel, etc.: working directly in the facilities moves faster. Accreditation is a desirable goal, but incentivize institutionalization.
- Don't create a situation in which you have separated public and private, and don't create situations of multi-accreditation.
- Don't forget to link good solutions to problems – 1. People know what to do 2. People don't know what to do and how – clear up where they need to be solved – some are local some are central. Place much more emphasis on culture (outcomes focus, paying attention to the "So what: why am I doing this?" and how to solve problems, functions of leadership, reactive function of leadership and listening to people's problems, more respect for front-line workers – including patients – experts in delivery are frontline workers and set up data systems that reflect the needs of the context level.
- Don't fall in love with your approach: improving care is the key. Don't harm the team to improve care.
- Don't forget to set clear standards/indicators. Try to link with other ongoing projects within facilities, so we don't have tug of war. This should be a government-driven process, not donor driven.
- Don't separate improvement from management: everyone is responsible for improvement at his or her level. A quality department would be a type of technical assistance provider, but still every person has to be held accountable for improvement, starting with the Minister all the way down. Don't delegate improvement to an external body; it has to be aligned with the administration of the system and everyone's responsibility and part of what they do every day.

Advice

- There is a great opportunity here to build on a lot of successful activities in many parts of the health sector, and they can be drawn upon to make a strong national program going forward.
- Because there are so many terms being used with different meanings, always ask people what they mean and how would a new process work.
- Do more investigating to determine if what is wanted is a body to accredit or to certify and to determine where the KQMH fits in this.
- Keep the consumer voice in this work.
- Ensure that when the system is set up, it is realistic and builds on existing structures and what is already in place.
- Periodically review the KQMH to meet concerns, such as accommodating different approaches and making sure the KQMH is not stifling: quality improvement should be continuous and innovative.
- Keep up on KQMH, and keep in mind that faith-based organizations (FBOs) are important and in a different situation than private hospitals, as they are not just serving those who can pay.
- Keep the policy sweet and simple.
- Develop skills, from leadership to managers and facility level staff and implementers of quality improvement activities. Think of how to share best practices to facilitate sharing.
- Include patient satisfaction information to inform priority setting.
- Provide strong leadership.
- Accreditation needs to be independent of the MOH and, if possible, it should be connected to KENAS, as we don't want too many bodies doing the same work. If the KQMH is a national standard, then the internal consumer needs to be there to make decisions. Additionally, if the KQMH is a national standard, will KEBS have a role?
- Embrace a multiplicity of approaches.
- Address culture and tools. Changing people's thinking is difficult and takes time and needs sustainability. It takes hard work to change the culture and to work with leaders and let people participate in improvement. Spread core values of improvement; they will help make the right decisions. Do not forget the importance of building a culture for improvement, it must be natural for people to work in it every day – everyone has two jobs: one to the job and two to constantly improve their work.
- Carry out stock taking; find out who is doing what (related to accreditation), establish the situation on the ground, and clarify what we want to be similar and what should be different. To operationalize quality indicators and we need political will and commitment.
- For accreditation, there needs to be an independent body to look at issues of accreditation, and this should be checked by another body to ensure its competence.
- Document and share widely results.
- There are many windows of opportunity in this transition period; leverage this to institutionalize a culture of quality and aspects of improvement in things that will be set. The MOH should look for ways to strengthen partnership with existing structures and look for new partners as new bodies are being set up and allies to champion the agenda.

- Don’t be too shy to ask for local and external feedback: people are willing to help and want to share their personal experience. Try not to implement any one model – Kenya must adapt and create its own model. Kenya should consider itself part of the global community of improvers; many people are trying to figure this out too, and we can all learn from one another.

4.2 Conclusions

Dr. Musyoka thanked everyone for their advice and outlined the following next steps to take in order to provide a roadmap to a national quality improvement policy and strategy development, including a framework to accreditation.

Regarding the policy, she said, Kenya needs a client-oriented policy. To do this, she said they will build consensus with stakeholders and top leadership and integrate the draft health plan and draft regulations to support their enforcement. Quality improvement will be a responsibility of the government health system both at the national and county levels, she said. They will need to interrogate the law of the proposed professional council and the linkages and their advice to what the Minister is doing so they can be brought on board. The MOH will also need to interrogate the proposed inspectorate bodies and KENAS and look at the draft accreditation bill to make sure these issues aren’t left out. They will need to check the law of KEBS and the proposed independent accreditation body. The preferred way to go about it, which will need political will, she said, is to have a public-private partnership so both sides have a say. Additionally, the MOH will need to look at the draft law and draft regulations to reinforce what they have brought out in the draft law and make sure the policy for quality improvement is incorporated. This is an opportunity to take advantage and make sure these issues are highlighted, she added.

The strategic direction will be an investment plan for the health sector strategic plan. The health sector strategic plan has defined strategic intervention areas which will be looked at to see if the defined priority areas focus on quality improvement and, if not, is it possible to bring out the issue of quality improvement and zero in on proposing some recommendations that can be used for monitoring quality improvement for the next five years. Next the KQMH will be reviewed and updated in order to make it a national quality improvement model and one that will be legitimized through regulation for all providers to use. KQMH quality standards need to be looked at and examined through KEBS, a process that has already begun, to see if they can be national standards. A multi-methods approach to quality improvement will be adopted and aligned to KQMH. There will be an M&E framework with one agreed-upon checklist that everyone will use. Additionally, she said, strengthening the department of health that will coordinate quality improvement interventions will be proposed. The health sector coordinating structure will be used to enforce compliance with donors, implementing partners, institutions, and private sector and make sure that the partners in quality improvement are all regulated under one framework. The quality improvement standards will be coordinated under KEBS. Timelines must be set and clear progress indicators must be developed and used, and communication with clients needs to be maintained. Principles that are agreed upon by all stakeholders must be defined and commitment of leadership and involvement of stakeholders is needed, and shared learning must be embraced. The MOH must adopt a process orientation and system approach, and everything must be patient-centered. Teams must be empowered to problem solve. The MOH must support a change in the organizational culture to quality improvement and give the mandate to the department of health to achieve quality improvement, she said. The MOH will embrace quality assessment methods (peer review, checklist, audits) and a recognition system. The MOH will institute quality improvement in performance contracting and will make submission of progress reports mandatory by all. Frontier certifications should be piloted and the health sector coordinating structure needs to be utilized.

In terms of accreditation, she said they need to have legislation and include a bill to ensure accreditation of health facilities. These issues can be put in bills that are already drafted. An independent body needs to be proposed, she said, and this could be an agency under KENAS. The independent body should have a board composed of diverse stakeholders, including professional bodies and private sector.

For the way forward, there is a need to continue strengthening the TWG, of which WHO is the lead for quality management, with GIZ and USAID support. Through the health sector coordinating structure they will be able to enforce the proposals. Strengthening of the department is needed: even looking at manpower, they may not have enough to support this. There needs to be alignment of donors. Linkages need to be created with the team drafting the strategic plan so these issues can be reflected in it. She added that M&E is a very important component, for which the advantages and disadvantages of having quality indicators have been discussed and need to be thought about. Lastly, clear definitions must be agreed upon so it will be very clear about what is meant.

5 BIBLIOGRAPHY AND KEY READINGS FOR DEVELOPING NATIONAL HEALTH IMPROVEMENT

Baker GR, MacIntosh-Murray A, Porcellato C, Dionne L, Stelmacovich K, and Born K. 2008. "Jönköping County Council." *High Performing Health Care Systems: Delivering Quality by Design.* Toronto: Longwoods Publishing: 121–44.

Dick S. 2011. Improving health care at the national level: Insights from the Amman, Jordan International Policy Seminar. *Technical Report.* Published by the USAID Health Care Improvement Project. Chevy Chase, MD: University Research Co., LLC (URC).

Gnecco G, Lucero S, Bassi A, Loncomilla R, and Brown LD. 1999. Making a commitment to quality: Development of a national quality assurance program in Chile 1991–1998. *Country Report*. Chevy Chase, MD: Published for USAID by the Quality Assurance Project.

Hiltebeitel S, Green C, and Goodrich E. 2010. Round Table Meeting on the national improvement strategy and infrastructure for improving health care in Afghanistan. *Proceedings*. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

Koegler E. 2011. Insights from a National Health Care Quality Improvement Strategy Meeting. *Technical Report*. Published by the USAID Health Care Improvement Project. Chevy Chase, MD: University Research Co., LLC (URC).

Massoud, M.R., et al, 2012. Charting the way forward to better quality health care: how do we get there and what are the next steps? Recommendations from the Salzburg Global Seminar on making health care better in low- and middle-income economies. *International Journal for Quality in Health Care.* 10.1093/intqhc/mzs062.

Massoud, M.R., et al, 2012. Improving the delivery of safe and effective healthcare in low and middle income countries. *BMJ* 2012;344:e981.

Suleiman AB, Hamid MA, Hussein R, Ming DL, and Marikar MAK. 2001. Quality Assurance in Malaysia. In Al-Assaf AF, ed., *Health Care Quality: An International Perspective.* New Delhi: WHO/Regional Office for South-East Asia.

Walshe K. 2009. Pseudoinnovation: The development and spread of health care quality improvement methodologies. *International Journal for Quality in Health Care* 21(3):153–59.

World Health Organization. 2006. *Quality of Care: A Process for Making Strategic Choices in Health Systems.* ISBN 92 4 156324 9. Geneva: WHO Press.

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