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Round Table Meeting on the National Improvement Strategy and Infrastructure for Improving Health Care in Afghanistan

January 10, 2010 | Kabul, Afghanistan



JUNE 2010

This report was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and was authored by Simon Hildebeitel, Cathryn Green and Elizabeth Goodrich of URC. It summarizes the discussions of the Round Table Meeting convened for the Ministry of Public Health of Afghanistan by the USAID Health Care Improvement (HCI) Project. The HCI Project is made possible by the generous support of the American people through USAID.

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DISCLAIMER

The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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Abbreviations

AMTSL	Active management of the third stage of labor
ANA	Afghan National Army
ART	Antiretroviral therapy
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CHC	Comprehensive Health Center
CQI	Continuous quality improvement
DH	District hospital
EPHS	Essential Package of Hospital Services
HCI	Health Care Improvement Project
HIV	Human immunodeficiency virus
HMIS	Health management information system
HSSP	Health Systems Strengthening Project
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IMC	International Medical Corps
ISAF	International Security Assistance Force
MOD	Ministry of Defense
MoPH	Ministry of Public Health
MSH	Management Sciences for Health
NGO	Nongovernmental organization
NHS	National Health Service
PMTCT	Prevention of mother-to-child transmission of HIV
QA	Quality assurance
QAP	Quality Assurance Project
QI	Quality improvement
SBM-R	Standards-based management and recognition
UK	United Kingdom
URC	University Research Co., LLC
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

This paper summarizes the proceedings of the Round Table Meeting on the National Improvement Strategy and Infrastructure for Improving Health Care in Afghanistan, which was held January 10, 2010, in Kabul, Afghanistan. The meeting, along with a debriefing session the following day, was held to assist the Ministry of Public Health (MoPH) improve the quality of health care services in Afghanistan, and is part of the United States Agency for International Development (USAID) Health Care Improvement Project's (HCI) efforts to support the MoPH in developing a new strategy and infrastructure for health care quality improvement.

The MoPH has made great strides since it began to rebuild the Afghan public health system in 2002. It is particularly proud that it has been able to greatly expand access to services: By January 2010, 57% of the Afghan population had access to an Essential Package of Hospital Services (EPHS), and 85% had access to the Basic Package of Health Services (BPHS), which are provided by health centers and smaller facilities throughout the country. However, while services have expanded, gaps in the quality of care remain.

Recognizing these gaps, the MoPH began a series of initiatives to improve quality in 2004, initiatives that also increased the number of partners working on health care in the country. In 2009, the MoPH began a new phase in its efforts to improve the quality of care. In order to improve coordination and complementarity and help prioritize activities, it decided to establish a strategy for quality in health care that will provide a framework to focus MoPH, donor, and partner efforts to improve care for the Afghan people.

The Round Table Meeting provided an opportunity for two days of thoughtful conversation among members of the MoPH, partnering organizations, and a panel of experts. The purpose of the Round Table was to share relevant international health care improvement experiences with the MoPH so it can draw on them as it develops its national strategy and makes progress in improving the quality of health care services. Instead of the usual focus on prepared presentations, Dr. M. Rashad Massoud, HCI Director, designed the meeting as a forum for thoughtful dialogue in which both local and international expertise could be brought to bear in approaching Afghanistan's unique issues of quality. The experiences shared by the panelists represented a wide range of diverse health care systems, including those in South Africa, Malaysia, Palestine, Sweden, the United Kingdom, Rwanda, and Tanzania. Topics discussed included vision and prioritization, defining quality, leadership to create and sustain a culture of quality, empowering local staff and communities, adapting processes to the local context, using data for decision making, learning and spread, involving stakeholders, setting standards, training and resources for health workers, the challenge of partner and donor coordination, and different approaches to quality.

The meeting was a full day and was followed the next day by a debriefing where MoPH staff, the panelists, and other participants discussed the ideas of the first day in more detail. The key themes that emerged from both sessions were:

- The key components of successful national strategies have been creating a shared vision of quality, determining a set of priorities to focus improvement efforts, and allowing people the freedom to pursue improvement in those priority areas through the means and methods they prefer so long as they can demonstrate efficacy in achieving agreed aims.
- Priorities must be updated over time as progress is made and new evidence emerges.
- Quality is "top led and bottom fed," meaning that 1) quality is a local product and cannot be improved simply by giving direction from the top, and 2) quality is everyone's job, and leadership for quality cannot be delegated. Leaders must create an environment that enables and encourages frontline practitioners to make improvements.
- Peer learning is especially powerful: Leaders can facilitate peer-to-peer learning focused on common aims, which has been shown to accelerate improvement in national efforts.

- While organizing a national health system is complex and multifaceted, local providers can, if empowered, make remarkable improvements with few resources.
- Standards are important but not sufficient to improve performance and encourage people to do better. There is a science to improvement, and improvement requires change.
- It is important to use data to make evidence-based decisions for improvement and not to punish those providing services. “Define what you want to have happen, determine what is impeding that, and manage by fact.”
- Encouraging front-line staff who work in different parts of the care process to come together to problem solve generates powerful ideas for improvement that are often easy to spread across the wider system.
- The value of personal recognition, even if it’s only a public hand-shake and “thank you,” should not be undervalued. In addition, events where public recognition is given can provide a platform where successful “positive deviants” can tell their stories and describe their success. It is rare that new innovations are accepted by others in their entirety, but if we encourage local adaptation, we minimize resistance to change.
- New approaches to improving health care should be piloted and their impact demonstrated before considerable investment is made to implement changes across a wider area. Where challenges and potential solutions exist across a part of the health care system—cutting across community, health center, and hospital services—a “slice” of that system that includes these different levels should be included in the pilot phase.
- Great success has been achieved by working on specific priority disease areas involving representatives from all parts of a system in a collaborative improvement effort. Problems often occur in getting different parts of a system to work together, so involving representatives from across the system is essential. Once improvements are made in one disease area, the system can then transfer what has been learned to make improvements to other priority disease areas. This has been more successful than trying to focus on hospital-wide standards or to create “model facilities,” which has not proven to be a highly effective strategy.
- Every experience is different, and there is no one experience that can simply be imposed onto Afghanistan. The hope of the panelists and organizers was to share helpful experiences so that the Afghan MoPH would have that information available when making its own decisions about how to move forward with its strategy.

The MoPH decided that following the Round Table meeting it will establish a new unit to guide its efforts on quality. The unit’s first task will be to work with the other MoPH departments, NGOs, stakeholders, and funders to develop a new national strategy for quality. A technical working group and task force established by the MoPH will prepare a draft strategy using guidance from the MoPH’s framework for strategy development. At that point, a technical committee will work to finalize the strategy document.

The USAID HCI Project continued support to this process includes the establishment of an expert review committee that will continue to offer the MoPH the kind of dialogue around quality that was featured at the Round Table. Members of this committee include Ms. Sheila Leatherman, Ms. Cathryn Green, Dr. M. Rashad Massoud, and Mr. Sven-Olof Karlsson.

Round Table on the National Improvement Strategy and Infrastructure for Improving Health Care in Afghanistan

I. Introduction

The Round Table Meeting on the National Improvement Strategy and Infrastructure for Improving Health Care for the Ministry of Public Health of Afghanistan (MoPH) was held Sunday, January 10, 2010, at the Serena Hotel in Kabul, with a follow-up debriefing meeting Monday, January 11. The purpose of both was to assist the MoPH in its efforts to improve the quality of health care service provision. While the Ministry has undertaken several initiatives since 2004 to improve the quality of health services (described below), in 2009 it planned to undertake a major new effort to strengthen this work by creating an infrastructure, including a dedicated unit to support improvement, and to develop a strategy to help coordinate MoPH, donor, and partner activities. The United States Agency for International Development (USAID) Health Care Improvement Project (HCI), in collaboration with other partners, supported the Round Table Meeting by convening a panel of experts who could share with the MoPH relevant international experiences to help it make informed decisions in this new phase of its journey to improve the quality of health services in Afghanistan.

Dr. M. Rashad Massoud, working with MoPH and USAID counterparts, designed the Round Table to be a “meeting of the minds” on the topic of “national health care improvement strategy and infrastructure to support it.” The meeting was designed to encourage participation and conversation among local and international health professionals and avoided the use of formal presentations of experiences from other countries (see Section II). Formal presentations were appropriately limited to one presentation on the background of quality initiatives in Afghanistan (see Section III).

The objectives of the Round Table were:

- To share experiences from different countries and ideas on successful models for leading and providing support for improving health care at the national level,
- To exchange ideas on appropriate infrastructures for the MoPH to lead and support health care improvement,
- To clarify the roles of partners in supporting the MoPH in developing the infrastructure to lead and support health care improvement, and
- To address MoPH objectives and questions in this area.

The Round Table was moderated by Dr. Mohommad Ibrahim Maroof, USAID/Afghanistan Health Officer and former Chief of Party of HCI/Afghanistan; the debriefing meeting was moderated by Dr. Mirwais Rahimzai, Chief of Party HCI/Afghanistan. The Round Table panelists were:

- Mr. Sven-Olof Karlsson, former Chief Executive Officer (CEO) of Jönköping County Council in Sweden;
- Dr. James Heiby, Medical Officer, USAID Global Health Bureau;
- Dr. Brian McCarthy, Centers for Disease Control and Prevention (CDC), Public Health Technical Lead for the Department of Health and Human Services Afghanistan Health Initiative;
- Admiral Vincent Berkley, former Chief Medical Officer of the Phoenix Area Office for the Indian Health Service (IHS) and Technical Lead of the IHS in Afghanistan;
- Ms. Cathryn Green, Independent Consultant for the USAID HCI Project; and
- Dr. M. Rashad Massoud, Director, USAID HCI Project.

Biographies of the panelists are in Appendix A.

Participants in the Round Table included the following individuals (a full list is in Appendix B):

- Deputy Ministers of Health Dr. Nadera Hayat Borhani and Dr. Faizullah Kakar;
- MoPH Director Generals and key MoPH staff;
- Dr. Randolph Augustine, Ms. Susan Brock, and Dr. Mohommad Ibrahim Maroof of USAID Afghanistan; and
- Key partners supporting the Afghan health system from the Health Systems Strengthening Project (HSSP), Afghan Ministry of Defense, Management Sciences for Health (MSH), International Security Assistance Force (ISAF), International Medical Corps (IMC), Cure International Hospital, IWE, Healthnet TransculturalPsychosocialOrganization, and Aga Khan Health Services.

The panelists were asked to respond to the five sets of questions below, and then panelists and participants engaged in a discussion around the 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?
- If you were to undergo this experience(s) again, what proved not important that you would not want to see repeated? Or what would you have done differently?
- What would you advise the MoPH on national improvement strategy (priority setting and method mix) and infrastructure to support it?

The debriefing meeting subsequently provided an opportunity for further discussion of key themes from the first day and covered next steps including how to put the ideas discussed during the Round Table into practice.

Rather than providing a chronological record of the proceedings of the Round Table, this paper was written to extract parts of the meeting conversation relevant to Afghanistan’s national strategy and infrastructure for quality and synthesize them around key themes.

II. Background on the Round Table Meeting

The Round Table meeting evolved out of the desire of the Ministry of Public Health to embark on developing a quality improvement infrastructure within the Ministry’s current structure. The Ministry expressed this interest to HCI, and HCI Director Dr. M. Rashad Massoud proposed to convene the Round Table Meeting and worked with the HCI in Kabul and the Ministry in planning it.

The basic premise underlying the thinking behind the Round Table Meeting was that there is no clear answer to the question of what is the required improvement infrastructure for Afghanistan. The second premise was that the infrastructure should reflect and follow the functions that it would need to fulfill. That would be set out in the national health care improvement strategy for Afghanistan. The third premise was that there have been varying degrees of success in developing national strategies for health care improvement and infrastructures to support them in different countries. Although no one of these experiences from other countries necessarily represented the solution or model for Afghanistan to follow, much could be learned from other countries experiences. The MoPH requested that the question of the appropriate quality improvement “method mix” for Afghanistan also be addressed.

The design of the Round Table Meeting involved identifying a range of experiences from different countries, identifying the appropriate representatives with in-depth knowledge of those experiences, and engaging them in a “meeting of the minds” on the topic of “national health care improvement strategy

and infrastructure to support it.” Several countries and representatives were identified and invited. It was decided upfront to convene the session in Kabul in order to maximize participation of a broad range of stakeholders, including the Ministry’s senior leadership. In spite of the security situation, there was positive response from several experts representing a range of experiences from different countries who participated in the Round Table Meeting. The design of the meeting deliberately excluded prepared presentations of these country experiences, and instead provided selected readings on these country experiences as well as on the health sector in Afghanistan before the Round Table Meeting for participants to review. The meeting itself had the unique design of a “thoughtful conversation” around five key questions related to the topic of national health care improvement strategy and infrastructure to support it. Hence the nature of this report and its conclusions are focused on the discussion that took place around the five sets of key questions.

III. Background on Quality Initiatives in Afghanistan

At the time of the Round Table Meeting, activities to improve the quality of health services were not new in Afghanistan. The history and current status of these efforts were laid out in presentations by Deputy Minister of Public Health, Dr. Nadera Hayat Burhani, and General Director of Health Service Provision, Dr. Ahmad Shah Shokohmand. These presentations demonstrated the Ministry’s commitment to improving health care services for the people of Afghanistan.

Dr. Burhani explained that when the MoPH started to reconstruct the health system in 2002, the initial years were spent on developing policy guidelines and protocols and on the expansion and improvement of quality services. Several key documents were developed that have formed the framework for health services: the National Health Policy 2005–2009 and National Health Strategy 2005–2006, the Essential Package of Hospital Services (EPHS), and the Basic Package of Health Services (BPHS). Great strides had been made to expand access to services since 2002, with 57% of the population now having access to EPHS services and 85% to BPHS services.

With increasing expectations from the Afghan population and involving more partners in quality of services, the MoPH together with its partners decided to develop a strategy to help all stakeholders in their intervention to contribute to quality health services and ensure complementarity.

– Dr. Nadera Hayat Burhani

While working to expand access, the MoPH and its partners had kept the quality of services on its agenda. In 2004, it began working with the Johns Hopkins University, with support from the World Bank, to establish a National Health Performance Assessment to monitor the quality of services countrywide. This program uses a “Balanced Scorecard” to assess the quality of services on the national and provincial levels. Following the introduction of this annual evaluation, the MoPH partnered with the MSH Rural Expansion of Afghanistan's Community-based Healthcare (REACH) project to develop the Fully Functional Service Delivery Point, a tool for improving quality that was implemented in 13 provinces where BPHS delivery was funded by USAID. Also, standards-based management was implemented in five provincial hospitals with support from TechServe. Similarly, standards-based management and recognition (SBM-R) was implemented in 280 health facilities. In all, MSH, TechServe, HSSP, USAID, and now URC/HCI had worked with the MoPH to improve the quality of health care.

As the number of partners working on the quality of services grew, the MoPH determined that it was necessary to develop a strategy for quality that would help all stakeholders contribute in a way that ensures complementary efforts, quality health services, and equity and provide a clear framework for all partners to assist the MoPH in improvement and assurance of quality.

Dr. Shokohmand summarized the history of quality in health care in the country and reiterated that while continuing to work on the important goal of increasing coverage, it was also important to move in parallel to introduce greater quality into health service delivery. He explained that the approaches to

quality taken so far by the MoPH fell into three categories. The first concentrated on standardization and attempted to integrate the fully functional service delivery point, SBM-R, and quality assurance approaches. The second focused on quality assessment and included the balanced score card and national monitoring checklist approaches. The final category included the improvement collaborative methodology used by HCI and the partnership-defined quality approach. To be effective, these different efforts must complement each other.

A. Standardization

In addition to the BPHS and EPHS, the MoPH is also developing minimum standards for private hospitals. This is seen as an essential MoPH responsibility, because the private sector constitutes the main component of the health sector in Afghanistan, particularly in tertiary and secondary services. These standards address infrastructure, equipment, staff, etc. Another more recent project in the MoPH's quality portfolio is the World Health Organization (WHO) patient safety initiative and a safe surgery checklist to be introduced in five national and district hospitals in Kabul.

To support these standardization efforts, the MoPH established a Central Quality Assurance Committee, which focused first on standards for the BPHS. It took the four-step SBM-R approach to standardization: setting standards, implementing standards, measuring progress, and rewarding achievement (see Figure 1). After field testing standards in Parwan and Kabul provinces, a final set of standards was developed around 14 practice areas for basic health centers (BHC), comprehensive health centers (CHC), and district hospitals (DH). For some top priority areas, such as family planning, the standards are the same across all three facility levels. In total, 219 BHC, 234 CHC, and 252 DH standards were developed.

The next step was to train health providers in quality assurance and conduct a baseline assessment in 258 facilities. After the difficult and time-consuming process of implementing the first internal assessment of progress, the MoPH recognized the dramatic achievements facilities had made in improving compliance with the new standards. This was the first time that formal recognition was used to motivate and reward achievement in the Afghan health sector. This recognition was expressed at the central as well as at the field/community level.

At the EPHS level, the MoPH used an SBM-R approach. After developing standards for 13 management and clinical areas, SBM-R was introduced in five provinces receiving USAID support: Helmand, Nangarhar, Laghman, Kunar, and Logar. Work is also underway to develop new clinical standards relating to nursing, laboratory, medical care, and emergencies.

B. Quality Improvement

The health care improvement collaborative is a structured improvement approach that organizes a large number of teams or sites to work together for a 12- to 24-month period to achieve significant improvements in a specific area of care (e.g., maternal health or pneumonia care for children). This approach combines the traditional quality improvement (QI) methods of teamwork, process analysis, introduction of a known best practice, measurement of quality indicators, training where required, job aids, and coaching with techniques based on social learning and the diffusion of innovations. In a collaborative, teams of health care providers work independently to test changes in how they deliver care, seeking to implement best practices and accepted standards for the area of care (see Figure 2). Teams use a common set of indicators to measure the quality of the care processes they are trying to



Figure 1 The Four Steps of Standards Based Management & Recognition (SBM-R)

improve and the desired (or proxy) health outcomes (e.g., fewer maternal deaths, shorter hospital stays for pneumonia). The collaborative organizes regular workshops where teams can share their results and learn from each other about which changes were successful and which were not. This dynamic approach fosters rapid dissemination of successful practices.

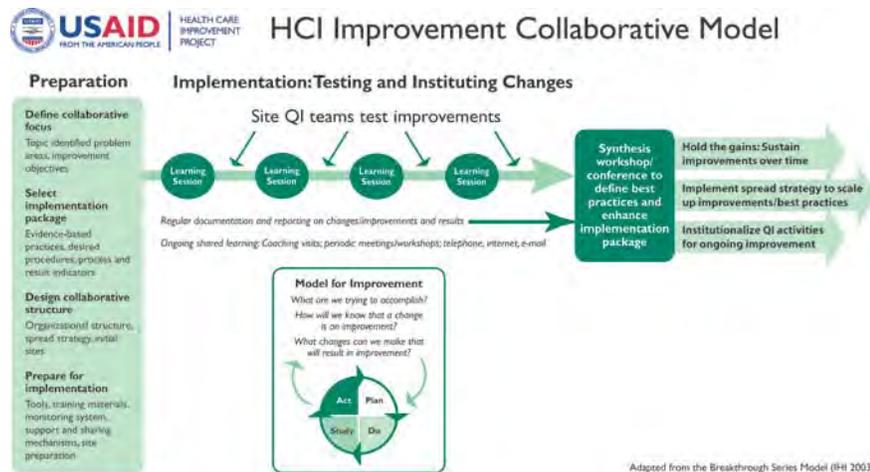


Figure 2 HCI Improvement Collaborative Model, adapted from the Breakthrough Series Model (IHI 2003)

The improvement model used in HCI-supported collaboratives is described in *The Improvement Guide* (Langley et al. 1996). Depicted in Figure 3, this model incorporates the Shewhart Cycle for Learning and Improvement, otherwise known as the Plan-Do-Study-Act (PDSA) Cycle. In this model, a change believed likely to yield improvement is proposed. However, whether it will yield an improvement or not is a hypothesis that needs to be proved or disproved. A plan is therefore developed for testing the change on a small scale over a short period. The plan is then executed, and the effect of that test is studied to determine whether the change did in fact yield the improvement expected. What action is taken next is based on the result of the test. Dr. Shokohmand described the approach as “Please think big, start small, and act now.” In this process, it is important to start with small tests to ensure that you are introducing successful changes and you have the opportunity to modify and improve upon them before going to scale. To implement without testing first can lead to failure and misuse of limited resources.

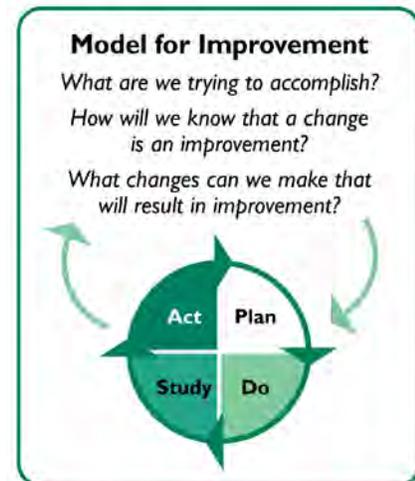


Figure 3 Model for Improvement, *The Improvement Guide* (Langley et al. 1996)

Dr. Shokohmand described the progress to date of the HCI project in Afghanistan. The project selected maternal and newborn care as its priority area for improvement. The work had begun in a demonstration collaborative in 15 facilities in Kunduz Province and 11 facilities in Balkh Province. Changes introduced in this collaborative are still being tested. Furthermore, the project was beginning work on a maternal and newborn health community collaborative in Balkh and Kunduz provinces, working with community health workers and health posts around three facilities in each province. A household survey to determine baseline data had been conducted at the time of the Round Table and results were pending. Lastly, the HCI project was working to establish a maternity hospital demonstration collaborative in Kabul, working in four public and three private hospitals in Kabul to improve maternal and newborn care.

All the people of Afghanistan have the same right to have access to quality health services in different health facilities and different provinces.

– Dr. Ahmad Shah Shokohmand

C. Opportunities for the Future

Dr. Shokohmand listed several key elements for developing an effective strategy and infrastructure for quality in Afghanistan. The first was the clarification of the MoPH stewardship role. The second was the involvement of BPHS implementers because the level of current resources precluded introducing quality in the health sector without their full involvement and support. He said that the national guidelines defining the BPHS and EPHS were very important. Another key element was donor support. Donors needed to be convinced of their role in supporting the health sector to promote quality and equity because “all the people of Afghanistan have the same right to have access to quality health services in different health facilities and different provinces.” He also reiterated that the MoPH’s top priority is maternal and child mortality.

D. Challenges

Dr. Shokohmand then discussed several key challenges to improving the quality of services. They included security; geography; staff turnover; lack of female staff; incomplete government health facility infrastructure; and a shift of responsibility from one implementer to another, which creates problems of lost capacity for sustaining existing efforts.

E. Conclusion

MoPH staff said that efforts to improve quality must be clarified by a national strategy and coordinated by a body responsible for quality within the Ministry. Dr. Shokohmand explained that one reason for the unit was to sustain quality in the health care system; another was to have a body that could encourage international donors to support all the provinces in improving the quality of health care, rather than having different strategies supported by USAID, the World Bank, and the European Commission, respectively. He further envisioned that the department would take responsibility for analyzing data on quality in the system.

A prior meeting to explore the outline for this strategy was held in September 2009 with the support of HSSP. The Round Table Meeting and on-going work of the unit recognized and would build on this initial work.

With this background, the Round Table proceeded to the discussion of key questions and the sharing of the experiences of the panelists.

IV. Lessons Learned from Other Country Experiences

Anyone attending the Round Table Meeting might ask: What can the MoPH, in a country that is rebuilding after decades of conflict and war and facing its own unique challenges, learn from the experiences of Jönköping County in Sweden, which has the best performing health system in the world? The panelists anticipated the question and responded that while each country faces unique challenges and any approach must be thoughtfully adapted to a new context, a set of underlying principles cuts across most if not all successful national efforts to improve quality and most if not all methodologies to improve quality. No one model is directly applicable to Afghanistan, but there is an underlying science of improvement, informed by years of testing and application from which we can learn. The panelists illustrated some of these principles by sharing key experiences of efforts they had participated in and observed in other countries.

A. Vision and Prioritization

Envisioning a path for improvement and prioritizing are important in part because such concentration of effort on one specific problem at a time will more likely yield results than spreading limited resources too thinly. Furthermore, resources are limited in most cases. Dr. Berkley noted that one of the reasons IHS, where he had 20 years’ experience, began to improve quality was lack of money. He said

that the U.S. government does not spend a tremendous amount of money on Native Americans, so an IHS leader, Dr. Charles Grim, realized that the IHS had to do more with less and focus on its strengths rather than its weaknesses. IHS staff had to focus on what they could do rather than complain about what they couldn't. They selected maternal and child health as a first step, believing, "If one can improve what happens in the family, then one can improve the health care of an entire nation." Dr. Berkley concluded that that was a key belief that helped the IHS improve quality.

Dr. Massoud gave an example from Malaysia with a similar theme. In a project called in the "National Indicators Approach," Malaysian officials articulated key national priorities, asking themselves, "What are the things that matter to health care in the country?" They developed indicators against which these priorities could be monitored. Then they then worked to identify, recognize, and reward anyone who demonstrated improvement in those indicators. From this straight-forward beginning, they now have a thriving system based on a clear vision of what needs to be improved. Key to this success was not micro-managing people but rather enabling them to use any method or means they wanted to so long as they showed results. It was a very forceful way to proceed. They re-evaluated the indicators and priorities and set new ones regularly. They also provided support through various organizations, including the Ministry of Health Quality in Healthcare Section and the Institute of Public Health.

The Swedish example differed somewhat. Mr. Karlsson reported that in Jönköping County they initially focused on six priorities that they saw as key problem areas: access, prevention/self-care, cooperation/flow, clinical improvement, patient safety, and medication. In the long run, however, it was very important to see quality as pervading the entire system, not just centered in certain areas. For Afghanistan, Mr. Karlsson suggested that choosing cross-cutting indicators and priorities could be an effective way to spread improvement systemwide. However, he acknowledged that such an approach had its own problems because looking at an entire complex health system at once is very difficult. To overcome the complexity, what they had done in Sweden was to work on one question at a time, so, for example, on Monday they worked on finances, on Tuesday human resources, and so on.

Dr. Burhani asked whether Afghanistan should focus on the BPHS or EPHS level. She pointed out that in public health it is a widespread practice to focus on the local and rural level first particularly in a context such as Afghanistan. With this in mind, she wondered if it made more sense to proceed sequentially from the local level up through the hospitals and ultimately to tertiary services or to work on them all simultaneously. The

It's important that from the top to the bottom and from the bottom to the top, we have one voice and one vision so that we can bring about changes and make improvements in quality.

– Dr. Ahmed Jan Naim

panel indicated that the approach that had worked in other contexts was to work on quality issues simultaneously at all levels. Dr. Berkley said that was the approach IHS had taken: to improve basic care services while improving EPHS-type services at a basic level. In that system, providers and managers focus on basic primary care and basic hospital services and leave tertiary services to the private sector. IHS doesn't have hospitals that perform complex surgery, for example. Furthermore, he said, quality is not always cosmetic. He gave the example that in the US, many private facilities are assumed to be better because they are newer, but care is really about the people providing it, even in conditions that may not always be the best. Some of the most prestigious hospitals in the US, such as Johns Hopkins and the Cleveland Clinic, are not the best choice for routine problems: They don't do simple things routinely. They do complex things, and sometimes they forget how to do the simple. With that in mind, Dr. Berkley suggested that when comparing the public and private sectors, policy makers should be aware of what the public sector does well.

Dr. Burhani agreed and mentioned that Afghanistan has a new public-private partnership policy that hopefully can help improve tertiary as well as other care in the private sector. She agreed with the panel that it made sense to work simultaneously on the primary and hospital levels.

Dr. Massoud elaborated on this point by saying that an approach he has seen work in many countries was to work in what he called a “slice of the system,” which included facilities from all levels in a given region. “We’re interested in patient outcome, which depends on the care that a patient gets all along the continuum of care,” he said. To get better outcomes, we need to work in the community, the health posts, the health centers, the district hospitals, and so on, following the patient through the entire continuum of care. “If we can’t work with everyone at once, we take a slice of the system, including representative facilities from all levels to demonstrate that improvements can be made,” he said. This is usually appropriate anyway as we should be piloting new programs in a selection of facilities to prove that a new approach will work before implementing it widely. Once we have demonstrated improvement, we ask the people from the facilities that made those improvements to spread them to the other facilities in the system. Because a patient’s outcome depends on the care that he or she receives all along the entire continuum, we need to work across that continuum. Furthermore, because each patient often receives care from both the private and public sector, it’s very important to include the private sector in efforts to improve quality. Unless we understand how the patient uses both sectors, the chances are we won’t achieve satisfactory outcomes.

Cathy Green agreed, saying that in the United Kingdom’s National Health Service (NHS) the same approach was used. It didn’t try to focus on hospital-wide standards, but rather worked on specific disease areas involving representatives from all parts of the system in a collaborative improvement effort. She and her colleagues found that problems often occurred in getting different parts of the system to work together, so involving representatives from across the system proved highly productive. Having been successful in making improvements in one disease area, the system was then able to transfer what it had learned to make improvements to other disease areas.

In setting priorities, one suggestion from Ministry staff was to concentrate on weaker subcomponents of the public health system. The example given was monitoring and evaluation and having an effective mechanism to gather data, analyze them, and give feedback about practice that should be improved. Ms. Green responded by saying that a common problem is that when data were reported up the line, management usually either responds in a punitive manner or does not respond at all. For sustainable improvement, people should own and use their data as well as report them for purposes of supervision, support, and oversight. This ownership results in more accurate recording of data. She suggested that if the MoPH worked on a data system in isolation, people may become demoralized, but focusing on improving a clinical outcome should lead to better data collection and people energized by the process.

Ms. Green also urged the MoPH not to define problems in terms of an anticipated solution. For example, sometimes people define a problem as “we need more staff or equipment.” However, the lack of staff or equipment may not really be the problem. “In saying our problem is the need for more staff, we limit our options in finding a solution. Instead, we need to ask why more staff are needed: more staff to do what? I think one of the things we need to learn to do is reframe our problems in a way that will enable us to be more creative about the solutions,” she advised. Dr. Massoud gave an example related to this idea, saying that even poor countries have a lot of waste in the system. “It’s very logical: If you’re not doing the right thing, you are doing the wrong thing, and that wastes money.” He noted that it’s a very simple equation: It probably costs less to do the right thing than it does to do a lot of wrong things. Every system has waste no matter how poor it is.

In line with this thinking, Dr. Massoud suggested that for Afghanistan it might be best if the priorities are broad. He was considering his recent participation in a global health initiative on strengthening health systems. One of the things that came up was that mortality among women of reproductive age—not just maternal mortality related to childbirth—is one of the best indicators of the performance of an entire health system because so many factors affect that one indicator. Taking an indicator like this and making that the aim for overall improvement would provide room for a lot of specific, manageable,

small-scale improvements that would contribute to the overall aim. That would be one way to operationalize the improvement strategy.

Dr. Shokohmand added that many issues are cross-cutting. Using the example of reproductive health standards, he said that while all medical staff should know the national standards, without clean water, enough space for counseling, proper administration of infection prevention standards, health facility management, and so on, implementing the reproductive health standards properly would be impossible. Dr. Najibullah Safi, Manager of the National Malaria and Leishmaniasis Control Program, suggested that at least one cross-cutting priority could be to focus on management activities within the BPHS and EPHS systems, which would help on all levels and help the MoPH make changes at the point of service delivery.

Dr. Heiby pointed out that when considering priorities, it is important to remember that these are the initial priorities. Ultimately, everything is included in the goal to improve the quality of health care countrywide: No part of health care should be outside the strategy. Dr. Massoud followed up saying that in Malaysia, after they had laid out initial priorities, these were updated them every year or two and over time they broadened the effort throughout the health care sector. Dr. Don Berwick, a renowned U.S. health care quality expert, proposed a similar strategy in the mid-1990s in a paper called, “Eleven Worthy Aims for Clinical Leadership of Health.” Priorities should be dynamic, not fixed, Dr. Massoud concluded.

In terms of selecting more specific priorities under general aims, Dr. Heiby suggested that in terms of prioritization, it is always a good idea to pick some “low-hanging fruit” first. Early successes can demonstrate the process and its outcomes, making the future work easier. This idea echoed the experiences the other panelists. Ms. Green said the NHS started small but successes had a multiplier effect: “We had to prove that the methodology we wanted to use was successful. Consequently, we started small and got results...Once we had results, which were very powerful and were achieving performance that we’d never seen before, success began to breed success. We generated political interest; we generated local interest—frontline staff became anxious to learn and participate in similar experiences based on their colleagues’ success.” She said it was very important to engage frontline workers who can champion their own work.

Mr. Karlsson reported a similar strategy from Sweden. After first learning of the QI methodology, he became convinced that the right way to change health care was to work with small, targeted projects and many contributors. “So my strategy...was to involve lots of people and let them do a small improvement project, and if we can have a small result in each of these projects, we together would have very big results.” In terms of setting specific priorities, he suggested that it was key for the MoPH staff to take time to make those decisions so that they would own the ideas. In Sweden, it was important to set priorities on the biggest problems because it was impossible to work on everything at once, and some problems were bigger than others. But most importantly, the priorities must be decided by the leadership so that ownership of the strategy was in the right hands.

Dr. Massoud said that in Palestine, he had helped develop a strategic plan that laid out what the country wanted to accomplish and described the infrastructure it needed to accomplish the plan. They then chose priorities. The planning document proposed a set of principles, not methods. In Malaysia, the Government had national level priorities, let everyone try to make improvements, and rewarded those who accomplished progress on the priorities. Several African countries have produced good strategies for quality on specific health areas, such as HIV.

Summing up his thoughts on the importance of vision and priorities, Dr. Massoud said that if he were to re-live any of his experiences trying to improve care, he would always start with an aim. He would define what needed to be accomplished in the system and describe the health priorities that needed to be made better: “If we don’t know where we’re going, how will we get there?...Improvement starts

with an aim.” He recommended that Afghanistan take that approach: Emphasize what’s important to the health sector to set those priorities; don’t assign groups to specific things, but rather allow groups to approach the MoPH with ideas. Tell them that as long as they go about it in a scientific way, they can use whatever method they want, and the MoPH will judge them by their results.

B. Quality Is a Local Product

One of the key principles the panel expressed was that quality is a local product. A patient experiences high- or poor-quality services locally, at the point of service delivery, and this has broad implications for designing a strategy for quality. As Dr. McCarthy and other panel members pointed out, the Ministry could try to dictate that quality services will be provided, “but unless that is in the heart of health care providers at each level, whether it be the basic clinic, the CHC, the district hospital, or the tertiary hospital, quality is not going to happen.” It is essential to create a culture of quality that pervades the entire system. He recounted a famous example from the literature on quality that when a janitor at the U.S. National Aeronautics and Space Administration was asked what his job was, he responded, “My job is to help us get to the moon.”

Everyone must believe that what they do is important for the health of the nation.

– Admiral Vincent Berkley

In health care, quality requires a culture where everyone in the system, from caretakers and janitors to doctors and senior administrators, realizes that their contribution is key to the success of the whole system. That, for example, by cleaning the floors they are helping to reduce the chance of infection in surgery. Dr. Burhani and other MoPH participants later assessed this as the key message from the Round Table.

C. Leadership: Creating and Sustaining a Culture of Quality

Creating a culture of quality requires leadership, which Dr. Massoud described as a key role for the MoPH. He noted that a key component in successful efforts to improve quality was integrating leadership for improvement with the organization’s line structure. Thus, the top quality leader in the MoPH had to be the Minister, the top leader for quality in a hospital had to be the hospital director, etc., because leadership cannot be delegated. In the Palestinian QI experience, meeting agendas always included progress on improvement. The Minister would ask, “What improvements have you made?” and everyone in the meeting would report on what improvements had been made or were in progress.

Dr. Karlsson had the same experience in Sweden. He estimated that as CEO he spent 40% of his time driving quality improvement work. “Leadership cannot merely support the improvement work; it must drive it.” However, this did not mean that efforts to improve quality relied on a top-down approach. Rather, as Dr. Berkley put it, “Quality begins at the top *and* at the bottom.” So while quality was a local product and required frontline workers making improvements in the work they did, it also required the support and leadership at every level up the system, all the way to the top.

Illustrating this point, Dr. Massoud talked about an idea from the automotive industry. Toyota fosters a belief among workers that half their job is to do their work and the other half is to improve what they do. This was the mindset we needed to foster in health care, he said.

However, Mr. Karlsson pointed out, this was not easy and required a real cultural change in health care. Most people, health care providers included, are not accustomed to thinking about quality routinely. Furthermore, people do not necessarily do what we want them to do, especially physicians. He saw in Sweden that physicians didn’t follow guidelines. In fact, no hospital in Sweden was above 65% compliance with official guidelines. When it came to improving quality, people had to change their own minds.

Dr. Berkley gave a practical suggestion on how leaders could create and spread a culture of quality. He suggested starting by asking the frontline staff, “Do you know what you do for patient care?” Taking the example of the cleaning staff, do they know how cleaning the kitchen helps patient care? If they don’t,

then it's the role of leaders to let them know, to show them why they are valued. "Every member of the health care organization is valuable. It's important for you as leaders to convince them of that," he charged, "and if they do, they too will understand the importance of quality."

D. Empowering Local Staff and Communities

Dr. Kakar expressed the concern that Afghanistan's the health system is extremely complex, involving many different programs, institutions, and systems. Ms. Green responded, "Often, we try to manage this complexity through a command and control approach. Actually, that will not serve us particularly well, especially in trying to improve quality. We need to move to a more bottom-up system that empowers and energizes frontline staff and equips them such that they can make continuous improvements. It's about building continuous improvement into everyone's job description; it's not just telling them to do it, it's equipping them and enabling them to be able to make improvements."

She reported that it in her experience it was leadership's responsibility to create a framework that encourages frontline staff. Giving a reproductive health example from Northern Ghana, she talked about trying to improve access to skilled delivery. "When we started working with our frontline teams, we had no idea how to improve access. What we did know was that we could equip them to start problem solving. They worked with their communities, found out what was preventing mothers from accessing care, and then started making changes....After nine months, midwives could present data over time, understand the importance of showing both process and outcome measures relating to their improvement work, and demonstrate through the data which changes had been effective. This was extraordinarily powerful and showed that frontline staff had been equipped and could now take their learning and apply it to any disease area, management challenge, or aspect of their personal lives....They knew how to use data and were effective champions for this work. Based on their experiences, they could then speak to their colleagues about how to spread changes and energize the system."

Every person in a health system is a decision maker in his or her own right and will do what they want no matter what we say, Dr. Massoud added. He offered an analogy to illustrate this point. He described throwing a stone versus throwing a bird. One can aim both a stone and a bird, but while the stone will go in the direction one throws it, once released, a bird will go where it wants. In health care, the care provider will make the decision according to his or her own wishes, not that of the central MoPH. However, thinking back to the analogy of a bird, putting some seeds where one wants it to go improves the chances that the bird will go there. Dr. Massoud suggested keeping this in mind when trying to guide a health system in a particular direction.

Dr. Heiby offered a cautionary tale about what can happen when local staff do not feel sufficiently empowered and supported. A Zambia program was initially successful, making some improvements in services using the sound methodology of continuous quality improvement (CQI). However, when the external support ended and the program was evaluated a year later, only 26 of 127 facilities were still conducting CQI activities, and of those that were active, only one in five had records of their activities. Of those recording their work, most had undertaken only one activity and then stopped. Dr. Heiby felt that this failure to sustain effort was a result of a lack of support from the central level and a lack of connection among the teams. "Even an effective methodology takes planning and active support," he said. In this case, the central Ministry did not maintain that active support, so the teams quickly lost interest. Additionally, because each team worked in isolation, without central or donor support, they were left completely alone to tackle the challenges facing their facility. USAID learned from this lesson that a more effective approach to improving quality was to have teams work together. Not only does this allow them to learn from each other, but it motivates people to do the difficult work of improvement. That was why the methodology was changed to facilitate more collaboration among teams.

Indeed, the importance of collaboration between teams was highlighted by Dr. Berkley as a key lesson he had learned at IHS. He said that the most important thing he would do differently if he could go back in time would be to have the independent teams work more collaboratively together early on. As it was, some best practices discovered early on weren't shared immediately. Without collaboration among teams, good ideas had to go "up, over, and down [the system hierarchy] rather than just across." He suggested that establishing these connections early would build a solid infrastructure for improvement in Afghanistan.

The panelists also discussed allowing practitioners and local teams to be creative in solving problems. Dr. Kakar said that an important question to ask then is, "What does creativity require?" He recommended giving some independence to clinics and hospitals so that they could be creative rather than waiting for Kabul to give them instructions. At the same time, he acknowledged that such an effort would not be easy in the Afghanistan context: "Our system is such that we have not yet decentralized things so that staff could be creative." He said that while it is known that decentralization is very important in public health and for creativity, political reasons called for a centralized system in Afghanistan: to avoid a situation where the country would become divided and fragmented. Nonetheless, he agreed that more independence should be given to hospitals.

Dr. Massoud responded by recommending thinking about empowerment at two levels: What happens at the individual health professional level versus the institution level? At the individual level, if more people have ownership over their work and feel empowered to do their best, they will create solutions. As a rule, people go into the health care professions because they want to do good. They want to help patients. Young professionals, when they first enter the workforce, are excited and motivated to do good, but over time they become demoralized, less active, inhibited, etc. Over that time, they have been told, "You can't do that, you can't do this. Here is the rule you must follow. Here's the standard you must adhere to." Over time, the energy and enthusiasm may die away, and they become disengaged implementers of a work process that is not producing good results. If our focus is to instruct people on a standard process and ensure that they follow it, that's what we'll get. How do we change that? If the system tells people: "We simply want better results," a lot of people will be motivated, will make improvements, and won't give up over time. Those are the champions we'll want to cultivate.

On an institutional level, Dr. Massoud pointed out that in most countries where the Ministry of Public Health provides services, the facility is essentially a cost center. They have a budget allocated from the central level that covers supplies, even staff, and so on. As a result, the facility provides services based on the supplies it gets, and it has no say in the matter: a situation ripe for inefficiency. To increase efficiency, Dr. Massoud suggested that Afghanistan could do at the institutional level what he had promoted at the individual level. The hospital could be a place that is rewarded based on its work and have control over its destiny, processes, supplies, hiring processes, etc. Many countries have started to transform facility units from cost centers to functional units. The NHS was centrally run, and over time people realized they had to decentralize it to encourage innovation and efficiency.

Dr. Heiby commented that "empowerment" is a pretty word, but the challenge is how to achieve it in a practical sense: How do you operationalize it? In his experience, rapid, large-scale improvement required large numbers of health workers at the local level empowered to make changes. But how was that done in practical sense? He pointed to Zambia as offering at least a partial example of lack of empowerment. Teams in Zambia did not continue to change and improve because they were not empowered: They were afraid. He acknowledged that large bureaucracies, including that where he works, don't encourage independence. Many countries have big public sector bureaucracies that do not empower health providers.

However, USAID continues to look for practical ways to address this problem. Dr. Heiby described the improvement collaborative as a methodology that has provided such a practical approach. To demonstrate its effectiveness, he referred to research published in 2009 of 27 collaboratives in 12

countries that worked on compliance with evidence-based guidelines and had at least 12 months of data (Franco et al. 2009). For the 52 indicator charts with baseline compliance levels below 25%, the mean endline compliance was 80% for maternal, newborn, and child health; 65% for HIV and TB; and 69% for other health areas. He said that not only did these efforts end up with good outcomes, but health workers felt empowered to make the changes that made these levels of performance possible.

Returning to the issue of the Ministry’s role in empowering health workers, Dr. Heiby said that one of the elements important to the collaborative methodology, which was developed by the Institute for Healthcare Improvement (IHI), is sponsorship. Part of the design is that the collaborative is a distinct activity that has an official sponsor, for example, the highest ranking official in that topic area (e.g., the national TB director or national director of health services). In order to empower the participants and make it clear that they are free to make changes, the official publicly and explicitly gives them a mandate to test changes and make improvements. In the projects he has observed, Dr. Heiby said it would be hard to make an objective measurement of how important that sponsorship was, but he thinks it was very important. Health care workers needed to hear that they were not going to get in trouble for trying to improve care.

In addition to knowing that they are not attracting trouble by trying to improve care, health care workers should be recognized and rewarded when they are successful in doing so. Dr. Shokohmand said that a lot of success had been achieved in Herat Province, largely due, in his opinion, to regular monitoring, supervision, and feedback. In his experience, supervision and mentoring helped to encourage people; he believed that people now expect supervision. Another lesson was that recognizing people’s hard work motivates them. “At least we should shake their hands. I have gone to many different remote areas just to shake hands and offer encouragement.” The panelists agreed and commended Dr. Shokohmand for his leadership and for taking time to meet with and encourage frontline workers. Dr. Massoud reiterated that people put a lot of work into improvement and to the extent that we can recognize that, we’ll be in better shape.

Dr. Sayed Habib Arwal asked how service quality can best be improved at the community level in Afghanistan. He cited examples of the Community Active Participation Methodology—which included community health workers, community health committees, family health action groups, and community health supervisors—and community empowerment as strategies to strengthen the system. The panel

responded that the fundamentals of improvement, which can sound complex in the abstract, can be understood in concrete terms at the community level. Dr. McCarthy reported that he had used a simple graphical tool, a community monitoring board, to show community surveillance volunteers how to record the outcome of every pregnancy for both the mother and child (see Figure 4). The chart helped the community understand what interventions were necessary to save the baby’s life, following the adage, “Every pregnancy counts, so account for every pregnancy.” In the end, the community members understood from using the board that, for example, a pin in one square meant a death due to transportation problems in reaching the facility, and a pin in another square meant a death due to another cause.

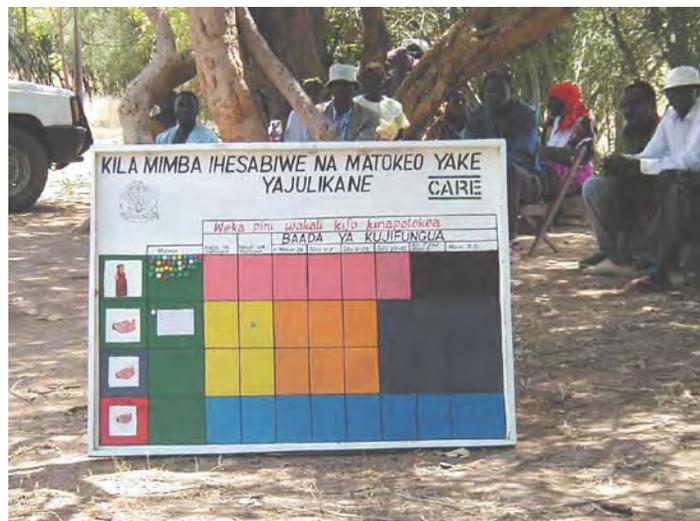


Figure 4 Community Monitoring Board stating “every pregnancy must be counted and the outcome recorded” in a community in Tanzania

Photo by the Centers for Disease Control and Prevention

Most importantly, the community could take these data, use their understanding of the local environment, and work to prevent further deaths.

To put these ideas in concrete terms, Dr. Heiby explained how improvement work operating in a conducive culture looked at the local level. The work was really done by ordinary providers in hundreds of clinics, and this would also be true in Afghanistan no matter what model of quality improvement it chooses. He gave an example from his experiences in Niger, where the leading cause of maternal mortality was postpartum hemorrhage. Thus, 29 maternity hospitals took on the challenge of reducing their postpartum hemorrhage rates,

The challenge for you will be to develop a national program that will empower hundreds of facilities around Afghanistan to improve the care they offer and to share the attendant learning with others.

– Dr. James Heiby

asking “How can we improve the care we give to mothers?” With no external funds, they worked on facility deliveries in maternity hospitals that might have 4–10 beds. He said that although “Quality improvement can sound very complex—and I agree that organizing a national program is complex—at the local level it’s very logical and reasonably simple and, I think, within reach of ordinary providers.” What can providers in a small rural clinic in Niger or Afghanistan do to improve care? In Niger, they devised a few change ideas they believed would help. They knew that postpartum hemorrhage could be treated by a low-cost intervention known as active management of the third stage of labor (AMTSL). AMTSL involves the administration of Oxytocin within a minute of birth, uterine massage, and controlled cord traction. At baseline, not a single woman received all three steps, so the providers examined the obstacles to providing this care. “Some of the problems they discovered would never have been discovered by some outside expert, because only the local people understood these issues.” For example, one problem was the location of the Oxytocin. There was a good supply, but it was kept refrigerated, as it needed to be, in the pharmacy, which was sometimes locked. However, the midwife didn’t have a key, and even if she did, she couldn’t leave a woman she was attending alone if she was the only provider on duty. Consequently, the providers put an ice chest in the delivery room and stocked it with pre-filled syringes of Oxytocin. That way, the Oxytocin would be within reach when the midwife needed it. Another problem was that although there was a national guideline for AMTSL, the national partogram form did not include a place to record that it had been administered. The creative solution that teams developed was to use a rubber stamp to add such a place to the partogram. This allowed for accurate record keeping and meaningful review of records (and feedback was given to providers on their attentiveness to record keeping, as revealed through the review).

Still another problem the facility teams saw was failures to provide skilled birth attendance. “They recognized the need to have a skilled birth attendant available and volunteered to organize an on-call schedule so there was always a skilled attendant available.” This kind of local innovation and motivation is far more effective than a top-down approach. Dr. Heiby noted that if a national order were given that all births be attended by a skilled birth attendant and that staff organize an on-call schedule, the edict would usually meet enormous resistance. This local initiative was better than a national order because the providers themselves believed the changes would save lives.

In conclusion, Dr. Heiby showed the results that the Niger teams achieved, significantly reducing postpartum hemorrhage incidence (see Figure 5). He said that results like these were effective in sustaining commitment and motivating teams: “Seeing results like this was very motivating for these workers. It made other clinics want to do the same, so the change was extended to additional maternities. Even the cleaning staff noticed that there was less blood for them to clean up.”

However, Dr. Heiby pointed out, one thing revealed in research into the diffusion of innovations was that some people are more open to new ideas than others, so this process of empowering and motivating frontline workers won’t necessarily be easy.

Some people will be more eager than others. That’s just unavoidable. However, he said, the Ministry could be confident that future initiatives would be easier with success and that by having early successes, their progress would not be just linear, but exponential. He said he repeatedly saw that when a health clinic director or district director found out about the improvement work, he or she asked to join. To be part of this improvement process and to be successful was attractive to just about everyone.

Summing up the ideas presented on this topic, Dr. Kakar said that the

“creativity of those involved in health is instrumental in improving the quality of health services....It’s very important that we give ownership to people who are in the periphery—in the hospitals and the clinics—so they will be more creative to improve the quality of health services. And, if I could add something, we need to emphasize results rather than methods. When it comes to methods, let them adapt and let them be creative.”

E. Adapting to the Local Context

The importance of adapting the process to the local context was stressed by the panelists. As Dr. McCarthy said, “You will find...that this panel has a considerable amount of expertise, but we are not the experts in Afghanistan. What we have is a process, and we hope to convey that process to you. When you implement that process, you are in fact the experts. So our expertise is in experience, and what we’re recommending is not for you to adopt what we say, but for you to use your wisdom—which only you have—to adapt what we say.”

Dr. Massoud agreed, stating, “It is not to adopt, it is to adapt.

These ideas worked very well in other contexts, other countries. Behind them are key principles that may be of use to Afghanistan—maybe not. It is for you to choose what is useful and for you to rethink—reinvent it for the context of Afghanistan.” Having been part of and followed many different efforts, he said, he understood that each was different.

All the panelists had experience with adaptation. Ms. Green, for example, began working in the NHS and was convinced that what they had done both had tremendous impact in the UK and was transferable to other systems. She left the NHS and has since worked on improvement in South Africa, Ghana, Malawi, and Afghanistan, which were all unique systems with different challenges.

Also discussed was the fact that it will not be not enough to adapt ideas to the Afghan context; they need to be further adapted to the unique characteristics of each region in Afghanistan. Dr. Shokohmand agreed, pointing out that different provinces face different kinds of problems with security, weather, roads, etc. Accordingly, the same approach cannot be implemented in secure and insecure provinces. For example, Herat Province has had a lot of success, but Kandahar Province could not simply use the same approaches. Indeed, beyond adaptation to the characteristics of each region, some ideas may even need adaptation at the facility level to address their unique characteristics.

ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR AND POST-PARTUM HEMORRHAGE RATES IN TARGETED FACILITIES, NIGER, JANUARY 2006–DECEMBER 2008

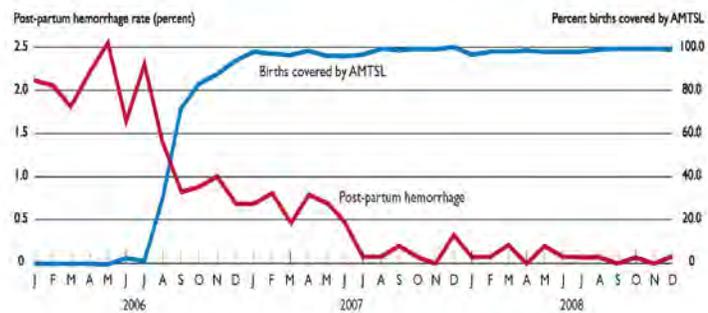


Figure 5 Active Management of the Third Stage of Labor and Postpartum Hemorrhage Rates in Targeted Facilities, Niger, January 2006– December 2008

It’s very important that we give ownership to people who are in the periphery—in the hospitals and the clinics—so they will be more creative to improve the quality of health services....We need to emphasize results rather than methods. When it comes to methods, let them adapt and let them be creative.

– Dr. Faizullah Kakar

F. Using Data for Decision Making

Using data to make decisions means several things. Firstly, data should be used by the same people who collect it. This not only helps to ensure that the data becomes more accurate as it is reported upwards through the system, but it also means facility-based workers can study their data to learn about gaps in their system and understand whether the changes they are making to that system improve health outcomes or not.

Dr. McCarthy said that one of the first things CDC asks when it offers technical assistance is to what extent the data are used at the point of collection. Data that are actually used locally tend to be very good, while data that pass from the facility to the district, regional, and national levels without being used along the line tend to be less accurate. “You have to increase the capacity of the local level to translate the data into information for action for change.” In the end, “Without data, you’re just another person with an opinion. The quality of the data increases depending on how much it is used at the point of collection.”

Dr. Massoud agreed that local use of data is essential to reflect current performance and performance over time. To illustrate the use of data at the local level, he recalled a story from Dr. Don Berwick’s experience in the early 1990s looking at work supported by the Aga Khan Foundation in Pakistan. In a facility with no good records, no HMIS, a young doctor who had learned improvement was describing the improvements he had made and reported the facility had reduced deaths by half. How did he know? Every week, he counted the new small graves in the local graveyard. It was an imperfect system, but it helped him to know he was reducing deaths and making meaningful improvements to care in that facility. Using data at the local level is essential to improving quality.

In terms of managing data, Dr. Shokohmand said that the health management information system (HMIS) unit is a strong one at the Ministry level; he asked for discussion on the proper relationship between the HMIS system and an effort to improve quality throughout the system. His thought was that the HMIS should be a cross-checking mechanism—a mirror—that allows the Ministry to measure achievement. Dr. Heiby pointed out that most HMIS data report on inputs and outcomes, but to improve quality, it was necessary to look at processes, such as compliance with evidence-based guidelines. However, he thought that there probably isn’t a single system in the world that reports routinely on compliance because doing so on a large scale is too complicated. On the other hand, QI interventions routinely collected compliance data for their own purposes, so data on processes could be connected with data on outcomes. He suggested that while an HMIS could identify issues and problems, more targeted QI activities should be used to look at the process failures behind those poor outcomes.

Dr. McCarthy gave the example of the number of C-sections performed in Afghanistan, which did not meet WHO-recommended rates of 15% of all deliveries. He said increasing C-section provision was a good goal because then-current data showed that far too few women experiencing complications during labor were receiving the right care. However, if C-sections were not performed correctly—if the goal of increasing C-sections was not connected to the goal of improving their quality as measured by a positive outcome for the baby and mother—you risk having “a life-saving procedure become life-threatening if it is not implemented well.” It is essential not just to focus on the process of providing more C-sections, but also on the outcome: ensuring that performing C-sections resulted in the survival and health of the women and newborns.

Several MoPH staff raised the issue that data need to be monitored continuously, not sporadically. Dr. Sadia suggested that data monitoring should be a continuous process that collects data that allow people to assess quality. She suggested that ad hoc teams should be authorized to monitor the data, identify gaps in quality, and work to solve identified problems. Dr. Massoud agreed, saying that his experience demonstrated the importance of reviewing data regularly to be able to see whether and why performance was improving. If data weren’t collected continuously and were collected only from spot

checks, those collecting the data could only really see if performance is higher or lower. To understand causal factors behind changes in results, data must be monitored continuously.

In devising measurements, some MoPH staff had questions about the relationship between quantity and quality. Dr. Heiby saw the distinction as one that drew on the early quality work done by the late Dr. Avedis Donabedian, a pioneer in the evaluation of quality of health care. Almost always in evaluations of health care, the system was divided into three distinct areas: inputs, processes, and outcomes. In Dr. Heiby's opinion, most assessments of the quantity involved measurement of inputs (buildings, drugs, staff, vehicles, etc.). In quality improvement, however, it was necessary to collect data on processes and outcomes. In his experience, which he believed would be borne out by Afghanistan's experiences, quality improvement actually costs very little in terms of inputs: It is mostly an intellectual investment that requires relatively small levels of resources.

Dr. Massoud described the relationship between quantity and quality as a simple one. If we have a certain number of patients we want to provide services to, then that's the quantity. However, the problem in health care, independent of the wealth of system, is that we don't always provide the right care to every patient every time it's needed, so quality is about bridging that gap. Putting patients on treatment is a quantitative measure, but it's not enough: We must also ensure that they adhere to treatment and do well on treatment. Having patients do well on treatment is a quality measure, indicating the quality of services.

To give an example, Dr. Massoud pointed to pneumonia. Afghanistan's BPHS has certain standards for children with pneumonia, including that they should be seen and a standard that determines whether they should receive antibiotics. Whether they are seen and receive antibiotics is a quantitative measure. The quality measure is, of those seen and receiving treatment, how many had no complications? It is not enough to provide the service: The health outcome is what matters and requires a look at indicators such as mortality, morbidity, complications, and referrals. He cited a case where community case management was used to improve patient outcomes: Antibiotics were provided at the community level even if a child was referred to a health center, because an initial early dose could reduce mortality significantly. The goal should be to develop indicators that show not just coverage (quantity) but success in treating patients (quality).

Dr. McCarthy summed up his experience in over 40 countries, 10 extensively: "The biggest challenge is translating data into information for action to bring about change....Define what you want to have happen, and then determine what it is that is impeding that, and manage by fact. Use the data for decision making in an evidence-based approach."

G. Learning and Spread

While emphasizing the importance of data for decision making, the panelists agreed that it was essential to use data to make improvements and not to punish people. Ms. Green said that she could not "emphasize enough how important measurement was, but not measurement to judge or penalize, but measurement to inform whether we were doing a good job or our performance had deteriorated. It was measurement to help us be curious and to learn." Dr. McCarthy described this as holstering the blame gun: "When data were used to blame or scapegoat individuals, it was extremely counterproductive," he said.

To describe a positive use of data, Mr. Karlsson gave the example of Skania, a large Swedish manufacturer, as an example of how to approach mistakes. At this company, whenever a problem surfaced, it was described in writing on a board everyone could see. Everyone then had two days to work together to solve the problem. The key lesson was that measurement had to be transparent and the results widely shared so that everyone who was part of the system was aware of where the problems were. This allowed more people to be part of a solution and made it more likely for that solution to be shared with others.

Dr. Heiby pointed out that this is a cultural change. “We are suggesting that in looking candidly at health care—looking at it as it is—you are not looking for problems or failures but for opportunities to improve. And that is a change in culture...It sounds like it’s just words, but I think this really means something.” It’s the difference between focusing on ways to improve instead of focusing on failures, fault, and blame.

A key strategy Mr. Karlsson used in Sweden to spread improvements was to find good examples of work that had been done and have the people who did it explain how to colleagues in other parts of the health system. He found that many people, especially nurses, were very motivated to help colleagues make improvements. The reason he favored this approach was that people were much more likely to listen to their peers than to their managers. Engaging these “champions” motivated others to make improvements and be more receptive to change. This approach acknowledged that for adults, the best way to learn was through peer-to-peer engagement and exchanging experiences. Dr. Massoud suggested that facilitating peer-to-peer learning around common aims would improve chances of making progress and represented a key role that the MoPH could play, rendering it a vital part of the strategy.

Another key role for the MoPH in facilitating learning, as described by the panelists, was in sharing and disseminating lessons learned. To illustrate this point, Dr. Heiby described the experience of an HCI program in Ecuador that exemplified a pattern he saw in several countries. In efforts to increase compliance with AMTSL standards, a first group of hospitals took almost two years to achieve 80% compliance. When this practice was spread to additional hospitals, they took much less time in achieving that percentage, and a subsequent group was even faster (see Figure 6). Staff at the later hospitals had learned from the first group. However, they didn’t simply copy what other hospitals had done, they adapted it to their own particular circumstances. Learning from peers who had already worked on these issues in similar circumstances, they were able to make improvements at a much faster rate. This pattern had been observed in other services and in other countries.

In terms of adaptation, members of the MoPH commented that there is diversity in Afghanistan that required a lot of adaptation as approaches and improvements were spread throughout the country. Dr. Heiby responded that the MoPH staff knew better than the panelists how areas of Afghanistan differed in terms of security, infrastructure, perhaps culture, capacity for methodologies to improve quality, etc. He suggested that the areas where it was easiest to work might be where improvements should be piloted, because the piloting phase takes longer than spread phases. More disadvantaged areas would then benefit from the experiences and learning of others.

This spreading of learning could happen even at the earliest phases of an improvement effort, Dr. Massoud pointed out. He cited the successes in Herat, saying that it was very important that if there were good performers in the system, we should identify them and be inquisitive to understand what it

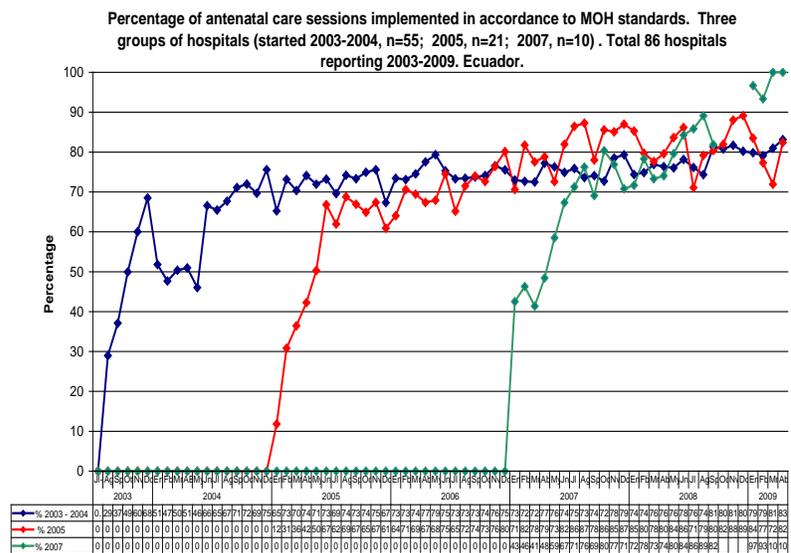


Figure 6 Percentage of Antenatal Care Sessions Implemented in Accordance to MOH Standards, Ecuador

was that made them more successful. The Ministry should take these high performers—or “positive deviants” as they are sometimes been called—and open channels for others to learn from them. We have used this approach, Dr. Massoud said, “when setting up a collaborative, we asked who was doing well and invited them to participate in an “all teach, all learn” environment where they could share their successes.” However, he said, the key thing about any high-performing system was that we never ask others to adopt in its entirety what others have done to improve health outcomes. We ask them to understand what was done and then adapt it to their settings if found to likely improve health outcomes. Asking people to adapt successes to their settings is a very powerful method for improvement.

Dr. McCarthy noted that while looking at other people’s successes and then adapting them to another context was an important concept, another was learning from mistakes. He said that about half the projects he had been involved in failed. What he learned from this was, “You’re stupid if you don’t learn from your mistakes; you’re smart if you do; but you’re wise if you learn from someone else’s mistake.” In his experience, most of the failures came in the inability to translate data into information to bring about action and change at the local level, which was an ongoing challenge. Dr. Heiby admitted that one of the areas we have continued to have problems in was documenting how improvements were made at the local level—documenting exactly what QI teams did. This meant that valuable learning about what changes led to improvements and what changes did not lead to improvements was lost, reducing the likelihood of effective spread to new facilities and regions.

Dr. Kakar summed up these ideas saying, “If you improve the quality of health care in one area, it serves as an example and is also infectious....The MoPH could play a very important role in coordinating that and sharing information.” Dr. Massoud added that in his experience, the infrastructure needed for quality at the provincial and even district level needed to be taken into account as well. You needed an infrastructure that could work at all levels to deal with any issues. In national strategies, often, there was too much emphasis on the national infrastructure. While that national unit was necessary, he urged the Ministry to recognize that a national unit could not spread improvements to the whole country. To do that, an infrastructure must be set up at the provincial health authority level and even perhaps the district level that would be able and ready to work on improvements.

H. Involving Stakeholders

Ministry staff asked about how and whether particular approaches to improving quality would be applicable to different aspects of the health care system, from service delivery to supply management to management. The basic answer from the panel was yes. Dr. Heiby said that the HCI Project was extending QI approaches to human resources management issues, addressing issues of job descriptions, career development, and so on. He added that the methods were particularly effective in improving supply chain management, as they brought together different stakeholders in an effort to make a system function better. For supply-chain management, there were national level organizations, logistics operations, local-level supply managers, and so on, who could be organized into a collaborative effort to address problems. Dr. Safi commented that this was an important example, because while quality is a local product, management, supply systems and processes must still be improved in order to improve quality at the point of service delivery.

Dr. McCarthy gave another important illustration of why it was important to involve multiple stakeholders. As far back as the 1978 WHO Alma-Ata Conference on Primary Health Care, the WHO recognized that what other sectors did impacted on health at the individual, community, organized health system, and inter-sectoral system levels. The lesson was that solutions to health problems that involved only the health sector tended to be expensive, medical solutions. For example, in the U.S. over the last few decades, progress on infant mortality has been achieved through better management of low-birth-weight neonates rather than tackling the prevention of low birth weight that would require far more involvement of other sectors. Without targeting improvements in other sectors of society, only costly medical solutions remained, which didn’t achieve as much and cost far more.

MoPH participants agreed that there were important stakeholders outside the health system. Dr. Safi commented that health care provision relied on such sectors as transportation and education. Dr. Mohammad Basir Farid recommended involving the Ministries of Education and Women's Affairs as stakeholders in the development of the strategy for improvement in healthcare. Dr. Shokohmand acknowledged that many issues were cross-cutting and if improvements were to be made, it would require the support of a diverse group of stakeholders. Using the example of reproductive health standards, he said that while all medical staff should know the national standards, without clean water, space for counseling, proper administration of infection prevention standards, health facility management, and so on, implementing the standards properly would be impossible.

Including the community as a stakeholder was a persistent theme of the Round Table discussions. Ms. Green pointed out that it was important to ensure that patients' priorities were heard and responded to in our efforts to improve services. In the NHS, patients had joined QI teams so that their experiences and suggestions for improvements could be reflected in action plans. Dr. Pir Mohammad Paya, MSH Hospital Management Advisor, agreed that there was not enough patient satisfaction focus in Afghanistan and that communities' ideas must be reflected in improvements. As it was, the Afghan system was top-heavy. Dr. Kakar summed this up, saying, "When you go to a community, you diagnose their problem with their help and in their language.... That is important in motivating the community so that they can do something about their own problems.... This is one of the big principles of primary health care." His suggestion was to cooperate with the community so that the health workers could be more creative: The MoPH role would be to expedite and coordinate this effort.

I. Setting Standards

Much of the discussion focused on standards since setting same had been a key MoPH role since 2002. Dr. Kakar explained that because the health system was started more or less from scratch in 2002, most of the effort to date had been to create laws, regulations, and standards necessary for the new system. When it came to quality, the panelists agreed that standards were generally not enough. This was an important issue for the MoPH staff, who had considerable experience in creating standards and using standards-based approaches to improve quality.

Ms. Green stated that sometimes improving the performance of the current system or achieving defined standards did not go far enough toward meeting service users' needs. Standards could sometimes put an artificial cap on progress in redesigning the system. An example from South Africa to illustrate this. She had worked in a district where the gap between the number of people needing to be started on antiretroviral therapy (ART) and those being initiated was huge. The system was achieving incremental improvements over time and meeting prescribed standards, but it was falling well short of addressing the population's need. When the system providers analyzed these data and saw the size of the gap, they decided that the incremental approach was unacceptable: They should aim to satisfy demand even though they did not know how to do so. This triggered a complete redesign of the system of care. In the then-current system, patients had to go every four weeks to an accredited hospital to receive antiretroviral drugs (ARVs). As many lived too far from hospitals to benefit from this high-quality service, they failed to access treatment and died. Staff decided to redesign the system making use of all available resources. After the redesign, trained nurses provided care at the local level. Each patient made only one visit to the hospital to be initiated on treatment, after which drugs were made available at a local clinic. While some could argue this change reduced the quality of care for the few, it significantly improved it and made care available to many.

The example made the point that in terms of standards, sometimes a system is incapable of meeting the needs of service users. Looking at the data *and* the need is essential to determining the approach to take. If the current system can meet the need, then incremental improvements and the introduction of minimum standards is appropriate. However, if the current system cannot meet the needs, a fundamental redesign is necessary before standards are put in place.

Dr. Massoud gave an example from Rwanda to illustrate the point that setting standards alone did not necessarily lead to improvements. In 2002, the Quality Assurance Project (QAP), the predecessor to HCI, was working in Rwanda in a collaborative to improve the prevention of mother-to-child transmission of HIV (PMTCT). Before QAP became involved, the Rwanda MoPH had developed national guidelines for ART/PMTCT. One of these standards stated that every woman who presented for antenatal care should be tested for HIV as should her husband.

The collaborative involved 40 facility teams that were all testing changes to try to improve compliance with this and other standards. At a “learning session,” where team representatives meet to share experiences, all teams presented the changes they were testing and their results. Most showed approximately 20% compliance to the standard on spouse HIV testing, but one team had achieved 80%. Like the others, this team had started at 20%. Its success began when a nurse discussed the problem with a patient. The patient said that she asked her husband to be tested but he refused. When the nurse asked what she and the facility staff could do to help, the patient responded that if the doctor wrote a note inviting the husband he might come. The doctor did so, and a few days later the husband came in for testing. After successfully testing and then implementing this method, the team achieved the 80% compliance rate.

In addition to celebrating the facility’s success, the learning session enabled the other 39 collaborative teams to learn from this example. The teams discussed *why* the change had worked and the underlying concepts that made it work. One such concept was that the Rwandan culture holds that it is disrespectful to decline an invitation from a man of equal or higher status. Once the teams understood that that concept supported compliance with the spouse HIV testing standard, they could design other changes to achieve similar successes. For example, one doctor tried calling the husbands, which worked just as well. In improvement work, if you understand why a change is successful, you can design something that will help you accomplish your aim efficiently.

Having achieved 80% success, the original team sought to understand what was preventing the remaining 20% of spouses from being tested. It learned that many of them had jobs preventing them from visiting the clinic during its opening hours. In response, the clinic decided to open briefly on a Saturday, thus raising compliance to more than 90%.

In summary, having standards is important so that staff know what they should do, but it is not enough. People do what they can, but not necessarily such that every patient gets all the care they need. We need to understand the reasons for gaps between expected and actual performance and implement changes to close them. When leadership taps into staff’s creativity and facilitates opportunities for staff to learn from peers, improvements can occur in health outcomes. Not every test will succeed, but sometimes all that’s needed is one successful test that everyone can learn from.

Dr. Berkley pointed out another major issue: Standards and guidelines continually change. Thinking back on his own career as a nephrologist, he said that standards had changed significantly since he began practicing. At that time, medical professionals were often taught to memorize information and learn by rote. Accordingly, when people talked about standards and guidelines in health care, it reinforced the idea that it was easy to make changes by telling people what to do. When we sought to improve quality, it was very easy to think in the same way and simply ask what to do. Instead, we found that we needed to think about our goals and how to achieve them because standards and guidelines change.

Dr. Massoud noted that standards were often higher for the private sector but were usually related to inputs, such as the number of staff, certain equipment, and so on. He and others had seen that some better equipped facilities did not necessarily produce better outcomes than those with less, because the relationship between inputs and outcomes was not a direct one. Beyond certain essential inputs, the key was in implementation: getting all the pieces to work together to produce a good result. The care provided had to be evidence-based and organized such that it enabled the evidence to be properly

implemented. In better performing facilities, workers knew their roles and worked together to produce good results. Some of the best results occurred in poorly equipped facilities where processes were particularly well organized.

The issue of standards also came up in the context of performance-based contracting. Dr. Ashraf Mashkoo, MoPH Head of Health Information Systems, explained the MoPH had specific indicators against which the performance of contracted NGOs and the private sector was assessed. Dr. Heiby suggested that while incentives around achieving performance indicators were very important in contracting, it was also necessary for the implementers to have the ability to improve. He suggested that one of the important roles of the Ministry was to help provider NGOs improve.

J. Training and Resources for Health Workers

As in most countries, maintaining human resources is an ongoing challenge in Afghanistan. Dr. Kakar referred to keeping “brains” in the MoPH, saying that low salaries contributed to brain drain from the MoPH to NGOs and elsewhere: “Keeping the committed Afghans who are doing the work in the Ministry is the biggest challenge we have.” Dr. Safi said that low compensation was not the only reason qualified, educated health professionals left the public system: It also occurred when a qualified individual felt ineffective in the public sector and faced resistance to change in the system. Another problem was that the MoPH could not always give talented people responsibilities that matched their potential, so they ended up doing a job below their qualifications. He added that even when they had received support from donors and acceptable compensation, brain drain continued. Dr. Ibne Amin, Director of the Supervision and Evaluation Department, responded that although brain drain occurred, it could be reversed: Many people were willing to help; what was needed was a strategy to bring them into the system and retain them.

Dr. Heiby noted that QI and human resources management are closely related in at least two ways. QI is a stimulating and rewarding challenge that increases job satisfaction. Also, QI approaches are directly applicable to human resources management. The MoPH could use QI methods in developing job descriptions and career development plans and in managing human resources.

With these ideas in mind, the panelists and participants discussed ways in which it would be important for the MoPH to build capacity for quality among its staff. Mr. Karlsson explained that in Sweden while medical staff had professional skills related to their disciplines, they usually didn’t have QI skills. For this they needed training and support. He suggested that the skills they lacked included basic principles of improvement as well as some practical information about improvement tools and basic statistics. Dr. Massoud suggested that developing the skills of frontline staff should be a key role of the Ministry. He didn’t think that this required extensive expertise but rather fundamental skills in making something better: understanding one’s work in terms of processes and systems, testing changes, and allowing evidence to inform what’s working and what’s not.

Dr. Mashkoo suggested that the key role of the quality unit should be to build capacity for quality at different levels of the system, especially at the frontline level, that can be drawn upon by all systems and programs. He said that if quality becomes its own vertical program, it won’t work. Dr. Ibrahim Maroof, Health Advisor, USAID, agreed, saying that quality must be well integrated and be everyone’s aim.

In terms of specifics, Dr. Pashtoon called the participants’ attention to the successes of the midwifery pre-service education program that demonstrated good results according to baseline, internal, and external assessments. This training included a unit on quality assurance tools. She recommended that the semi-governmental accreditation board that was a part of this effort could be scaled up nationally to cover more than just USAID-supported schools while additional materials on quality improvement could be added to the curriculum and corresponding standards could be added to the accreditation for the schools. She then asked if this system could be used for quality in support of the new department. Dr. Shinwari indicated that close links to the medical schools would be essential and that the strategy should

consider pre-service education in medical schools as a vehicle for raising awareness and skill in applying QI techniques. Dr. Paya suggested that including midwifery, nursing, and surgeon's associations would be a good idea, as they could help disseminate knowledge via their learning centers throughout the country. Dr. Karlsson agreed that it was very important to teach people how to make improvements and that the learning resources must be decentralized to the provinces.

Nonetheless, Ms. Green stressed that training alone was probably not enough. People learning the methodology and techniques also needed some practical experience in applying the tools and making improvements. She added that initially it would be important to use some resources to support training and offer facilitated learning and improvement opportunities, but that over time coaching support could be reduced as frontline workers became more skilled and confident in continuing the work on their own.

K. The Challenge of Partner and Donor Coordination

Another challenge for the MoPH is coordinating the complex network of donor and implementation partners working in the country. Several attendees noted that the Ministry was the only body that had the authority to perform this essential task. MoPH staff felt it was very important that the three major donors: USAID, the World Bank, and the European Commission, supported the MoPH strategy for improving quality. As Dr. Safi pointed out, if they didn't, Afghanistan could end up with different approaches being implemented in different parts of the country. Dr. Kakar agreed, pointing out the difficulties that arose by, for example, in having different drug procurement systems for these donors. In his opinion, it was not an issue of one system being better than another, it was that the lack of standardization made things more difficult. Beyond approaches, the three donors also had different ways of measuring and assessing programs, further complicating the possibility of a unified approach. Dr. Ahmad Jan Naim, General Director Policy and Planning, agreed with Dr. Safi, saying that in the future the MoPH needed to plan the contribution of each stakeholder. It was the stakeholders role to support the Ministry in delivering the activities the MoPH had defined.

Dr. Shokohmand returned to this issue later, pointing out that a representative from the Ministry of Defense (MOD) was in attendance at the meeting, and that perhaps as many as a million people—police, military, and their families—received care through the MOD system. Dr. Amadi agreed, suggesting that close coordination between the MOD and MoPH was crucial. Furthermore, while the Ministry was finalizing minimum standards for public facilities, it was important to remember that most public sector staff worked concurrently part-time in the private sector. Since the goal was to create a national strategy for quality that was comprehensive and applicable throughout the country, the strategy needed to take these realities into account and be acceptable to all major donors if it was to be effective. It would then be up to the MoPH to ensure that all partners knew their responsibilities in implementing the strategy. As Mrs. Pashtoon Asfar, Head of the Midwifery Association and Advisor to HSSP, pointed out, this kind of clarity and support was necessary if the MoPH was to implement a national strategy to improve quality.

Dr. Naim said the original work to improve the quality of healthcare in Afghanistan was initiated by the donors and not the MoPH. This had created a problem of ownership. In order to shift ownership and ensure the work was sustainable and institutionalized, he suggested that donors work with the Ministry to ensure their efforts were sustained and coordinated within the Ministry. "If we really want change, we need to start within the Ministry."

Dr. McCarthy pointed out that a core principle of development and improvement is to empower host-country nationals to do the work themselves rather than relying on consultants to do it and that enabling local people to do the work is much more powerful. In Afghanistan, the goal needed to be to build a system that will be completely sustainable and independent. The mission to improve service quality in Afghanistan was a long-term one. Mr. Karlsson added that it takes a long time to change a

system. While it was possible to achieve many small successes in Sweden that motivated the members of the system to improve over a short period, to really change the whole system in a sustainable way took time. “When you change a system, you must be sure it is sustainable. It takes a long, long time. And when you start you don’t know exactly what you want to do. You learn all the time.” Dr. Heiby agreed, saying that all health workers will have to contribute, and not just for six months, a year, or even ten years: A permanent commitment requires everyone in health care to always be looking for ways to improve. He added that while that was an attractive philosophy, it had a practical implication: that the work of improving quality must be made attractive as well. One way this is done is through recognition. Another is that organizations must allow people to do improvement work.

L. Different Approaches to Quality

Another challenge the MoPH faces is that each partner trying to help improve the quality of health services seems to have a unique method for doing so. Indeed, the field of quality in health care has produced a vast “alphabet soup” of quality approaches (see article on pseudoinnovation in the recommended readings). MoPH staff expressed concern that the panel’s recommendation would be that current methods should be phased out for newer methods or, even worse, that current methods should be abandoned because they were somehow wrong. Dr. Paya felt that one reason why some methods were abandoned for newer ones was the absence of a central coordinating unit that could ensure continuity, sustaining successful efforts while phasing in new ideas. Based on the panelists’ comments, he agreed that the point was not to institutionalize a certain methodology or set of methodologies, but to create capacity to evaluate approaches and adopt new ideas. “As quality is a journey, we should not be satisfied; there is room always for improvement.”

Responding to these concerns, Dr. Massoud said that over the course of 20 years he had used just about every method he knows of, and that most methods provided good results. In the end, they were all similar to each other, except for those that didn’t facilitate change but rather gave people instructions. He said that he believed that if you simply gave people instructions, chances were those instructions would not be carried out. If you gave people the opportunity, underlying concepts, and motivation to change, chances were you would be successful.

To illustrate this, he described a quality assurance (QA) unit that used a scorecard to measure performance. If a facility received a score of some pre-determined percentage or above, it passed; if not, it failed. He called this the “finding the bad apples approach” and said it generally did not yield improvement. What worked were methods that centered on a theme derived from industrial improvement, where workers understood work as processes and systems: different people doing different activities that gave a result. The result was a function of the sequence of work that was done, so to get a different result, the workers needed to change what they did. He quoted the adage, “The definition of insanity is doing the same thing over and over and expecting a different result.” Unless they changed what they did, they wouldn’t get a different result.

There is a science to improvement. The more we understand the science the less we emphasize the tools. The less we understand the science the more we hang on to tools because that’s all we have. But when you have a rigorous understanding of the science, the tools become secondary. Because when you understand the science you develop the tools, and you adapt the tools continuously.

– M. Rashad Massoud

Dr. Massoud continued that tools were far less important than a broad understanding of the science of improvement. Furthermore, the many terms and names for various methods cause confusion, so he avoided the word “quality” and used “improvement.” Ultimately, it didn’t matter what you called it as long as you were doing it right. Instead of focusing on choosing methods, he suggested that MoPH staff become well grounded in the scientific basis of how to make anything better, including health care. We have a variety of methods and tools at our disposal, understanding their scientific basis will allow us to

know which one applies where. The main thing is to get the scientific basis right. If we emphasize application of tools, methods, and approaches, we could miss the point. He suggested that the MoPH could allow different methods and tools to flourish and judge them by the success they provide. If one gave better results, that was the more appropriate tool to use. Flexibility in approaches was good, and being able to judge correctly was also very important.

Ms. Green agreed and suggested that in embarking on this new phase in the MoPH's improvement journey it was important to be less prescriptive about methodology. She suggested that the MoPH should not concentrate on defining what methodologies should be used, but rather produce a clear set of priorities with associated indicators that could be tracked continuously to assess progress. Within such a framework one should be open to different approaches for improvement. Dr. Heiby added that ultimately you wanted to be confident that changes were effective as proven by objective information and this had practical implications for doing more measurement and relying on objective data as a way to improve. This reinforced the idea that it was not a matter of picking the right or popular methodology, but one that worked on the basis of evidence. Dr. Massoud emphasized this by saying that people should be able to use different methods and the only judge of the method would be whether it achieved good results. His approach was, "Here's how we're doing it today. If you show me a better result, I'm going to switch to your method, because I want to learn." He recommended that the MoPH use the same approach, being open to new ideas.

Ultimately, the methods were less important than the capacity of the staff implementing them. Dr. Kakar said that partners could bring any method that they wanted, but without committed Afghans to champion and implement it, nothing would be done. Dr. Mohommad Basir Farid, HSSP Quality Assurance Manager, summed up these ideas by saying that in terms of methodology, the strategy should be like a glass and the methods should be like water. When one puts water into a glass, it takes the shape of the glass. In other words, Afghanistan's strategy should be flexible enough to accommodate different methods within an overall framework.

V. The Ministry-Level Unit for Quality

The Round Table's immediate goal was to advise the MoPH on developing a strategy for quality and help the MoPH determine an effective and appropriate role for the new MoPH unit through the sharing of experiences from other countries. Dr. Massoud initiated this discussion by saying that when thinking about infrastructure for improvement, the key question should be, "How can we develop an infrastructure around the function that we need it to fulfill?" He suggested that rather than designing the unit before the strategy was finalized, the MoPH should start with some clarity around the function of the unit and ask, "What is it that this body needs to accomplish?" The structure must reflect the priorities set by the leadership and support the health system in accomplishing them. He suggested that the unit could provide methodological support. It could also be instrumental in bringing about the cultural changes needed to support improvement, where "a worker in a clinic, instead of saying 'I clean the clinic,' said 'I help improve patient care, and I help patients feel better.'" Dr. Massoud suggested that the unit should also help empower people to make changes, helping them collect and analyze the data needed to see whether the changes were yielding improvement.

Dr. Shokohmand suggested that the unit's main responsibility would be to coordinate technical departments and facilities, using the data available to the MoPH to make informed decisions. He added that the goal should not be to transfer responsibilities from other departments to the new unit: the technical units had a responsibility to think about quality. The quality unit would coordinate and give support to other departments. Dr. Kakar suggested another main task: implementing the quality strategy.

As the Round Table was coming to a close, Dr. Heiby offered four possible key functions of the unit in its role of supporting hundreds of teams doing QI work. While the scope of work would be large, it could be managed by a few experts at the central level who would work to:

- 1) Make sure that activities were based on evidence, providing a kind of quality control of QI. A common feature of QI methods was that they are based on evidence. It was not just that someone thought this was the right way to improve quality so people should just do it. Ideas should be rigorously tested before being scaled up to a national level.
- 2) Recognize the improvement work being done. Hundreds of health workers were already working hard, and we were giving them additional work. Increasingly, we were asking them not just do their jobs but improve the way they did their jobs. They deserved recognition for these efforts and would be motivated by it. This is usually a weak area in most health systems.
- 3) Learn from the work being done. Every successful *and* unsuccessful QI effort produced some learning. When activities were collecting evidence, that was the basis of knowledge, and it was important to capture it. This was a key role for the central level so that the knowledge gained through all the work was captured and diffused throughout the system. This does not happen without some effort.
- 4) Spread improvements. Once we learned something from an improvement effort, that knowledge could be applied elsewhere. Spreading that knowledge was very efficient in terms of time and effort. Those ideas that had already been tested and proven to be effective were very likely to work, with appropriate adaptations, in other areas. The central level was in the best position to ensure that gains were spread throughout the country.

Dr. Massoud concluded that the key was creating an infrastructure that would enhance the capability of whole system to become better by providing methodological support, sharing experiences, facilitating the improvement work, and empowering people. During the debriefing, Dr. Paya suggested that in Afghanistan, the focus should be on people performance, process performance, ownership, customer satisfaction, recognition and rewards, a supportive culture, and a wide range of involvement by different Ministries.

Envisioning the final strategy document, Dr. Heiby said he hoped “that it will be possible to hand that paper to any health worker in this country and he or she could read it and understand your vision of quality—of improving the health services—and that they would understand how the QI unit is available to help them and to help make this happen.”

VI. Conclusion of the Meeting

As one of the key next steps following the Round Table, the MoPH decided to proceed with its plan to equip the new quality unit within the Ministry and appoint two or three people to the office. The inauguration ceremony for the MoPH Improving Quality in Health Care Unit was held on March 17, 2010, and was attended by MoPH staff, including Dr. Suraya Dalil, Acting Minister of Public Health, and representatives from USAID, the European Commission, the World Bank, WHO, and partners organizations and NGOs (see Figure 7). This new unit will take the lead in developing the strategy. Dr. Borhani stated that the strategy would be drafted applying standard MoPH processes and using the framework developed by the planning department, which covered



Figure 7 Inauguration of the MoPH Improving Quality in Health Care Unit, March 17, 2010

objectives, human resources, financial resources, sustainability, and monitoring and evaluation procedures. Within that framework, the MoPH planned to set up a working group and task force to assess all relevant documents and build upon the ideas shared at the Round Table. From there, a technical committee would be formed to develop the strategy, assigning responsibilities and tasks to specific people and departments. The USAID HCI Project continues support to this process includes the establishment of an expert review committee that will continue to offer the MoPH the kind of dialogue around quality that was featured at the Round Table.

VII. The Changing Field of Improvement

A final Round Table message was that the field of quality in health care is growing and changes over time. Over the last few decades and increasingly in the past 10 to 20 years, a great deal of learning has been generated on how to use scientifically based approaches to improve the quality of health services at all levels of the health care system in a wide variety of countries. Dr. Heiby noted, “The field of QI itself is changing, and you can be absolutely sure that in the next 10 or 20 years that there will be more developments in QI that will be very useful to Afghanistan.” Dr. Berkley agreed, saying that in the IHS, “We have had to learn and relearn quality over the past 20 years.” For countries that were just beginning their journey to improve quality of health services, countries like Afghanistan that had begun that journey and were ready to take the next step, and even countries that were well on their way in that journey, it was vitally important that we all endeavored to learn from each other’s experiences.

Quality is a journey that never ends.

– Sven-Olof Karlsson

Below is a selected bibliography of key readings relevant to developing national strategies or approaches to improving quality of health services. Some were referenced during the Round Table or debriefing. Others were distributed at the meeting or were selected for this report.

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Appendix A: Biographies of the Round Table Panelists

VINCENT BERKLEY, DO, MBA

Dr. Berkley is the Chief Medical Officer of the Phoenix Area Office for the Indian Health Service (IHS). He was promoted to Rear Admiral in the U.S. Public Health Service Commissioned Corps in 2006. As Chief Medical Officer for the Phoenix Area, Dr. Berkley provides leadership and direction to all clinical programs and has been the catalyst in improving communications among the Clinical Directors for nine service units. He continually seeks ways to improve services through partnerships and collaboration. He is a nephrologist with the Indian Health Service and heads a U.S. Public Health Service task force tasked with restoring the system.

CATHRYN GREEN, BSC, MBA

Ms. Cathryn Green worked as a senior civil servant in the United Kingdom Department of Health, working to improve health care at a regional and national level. In 2005, she moved from the United Kingdom to Cape Town to join the Institute for Healthcare Improvement's Developing Countries team. After working for three years as an Improvement Advisor to projects in Gauteng, North West Province, and Eastern Cape, she became an independent consultant. She is now a member of IHI's faculty and works closely with MaiKhanda in Malawi and Project Fives Alive! in Ghana. In addition to her work in Africa, she is supporting USAID Health Care Improvement Project collaboratives in Afghanistan that aim to reduce maternal and neonatal deaths. She continues to explore her other professional interests, including culture, the psychology of change, and leadership.

JAMES R. HEIBY, MD, MPH

Dr. Heiby received his MD from the Johns Hopkins University and his MPH from Harvard University. He completed clinical training in internal medicine at the New York Hospital-Cornell Medical Center. After working in the Bureau of Epidemiology at the Centers for Disease Control and Prevention, he joined the United States Agency for International Development in 1978; since then he has worked in nearly 40 countries. His current position is Medical Officer in the Office of Health, Infectious Diseases and Nutrition in the Global Health Bureau.

In 1984, he developed the first in a series of projects to address the quality of care in lower- and middle-income countries. He currently serves as Project Officer for the Health Care Improvement Project (HCI), which is the fifth five-year project in this series.

In 1994, Dr. Heiby received the USAID Science and Technology for Development Award, recognizing the importance of health care quality.

SVEN-OLOF KARLSSON, MA

Mr. Karlsson has a long experience of high-quality workmanship on a managerial level and is now a senior fellow of IHI, advising on the concepts concerning management development.

At the Jönköping County Council, Sweden, starting in 1972, he held the post of Chief Finance Officer and Chief Executive Officer for 19 years. From 1996–1997, he was the Chairman of the National Investigation on Drugs and Medication Cost and in 1993–1994, the National Investigator and Project Director to the Swedish Government to develop the system of tax equalization.

In 2000–2007, he served as Chairman of Carelink, a national organization dedicated to homogeneous and integrated Information Technology infrastructure in health care. In 2005–2008 he was a member of the Swedish Council on Technology Assessment in Health Care. Mr. Karlsson has also worked as a consultant in Armenia, advising the Armenian government on strategies for quality.

M. RASHAD MASSOUD, MD, MPH, FACP

Dr. Massoud, a physician internist and an internationally recognized leader in improving health care, is Senior Vice President for the Quality and Performance Institute at University Research Co., LLC, (URC) in Chevy Chase, MD, USA, and Director of the USAID Health Care Improvement Project (HCIP). He centrally procured global contract active in 25 countries at the time of the Round Table. He served as Senior Vice President of IHI, overseeing its Strategic Partnerships, the key customers working with IHI on innovation, transformation, and large-scale spread. In his previous capacities, he worked at URC where he led several improvement efforts worldwide, including helping develop the World Health Organization's (WHO's) strategy for design and scale-up of antiretroviral therapy to meet the 3 x 5 Target and large-scale improvement in the Russian Federation. He also founded and for several years led the Palestinian health care quality improvement effort. He was a founding member and chaired the multi-country Quality Management Program for Health Care Organizations in the Middle East and North Africa (QMP-MENA). He worked as a Medical Officer with the United Nations Relief and Works Agency. He has also consulted for and collaborated with several NGOs, KPMG, UNICEF, the World Bank, USAID, and WHO.

BRIAN McCARTHY, MSC, MD

Dr. McCarthy works in the Centers for Disease Control and Prevention (CDC) Division of Reproductive Health and is the CDC Public Health Technical Lead for the Department of Health and Human Services Afghanistan Health Initiative. He is the principal investigator of CDC's WHO Collaborating Center for Reproductive Health in Afghanistan.

Appendix B: Participants in the Round Table

Ministry of Public Health

Dr. Sayed Ali Shah Alawi, Head Child and Adolescent Health Department
Dr. Ibne Amin, Director Supervision and Evaluation Department
Dr. Sayed Habib Arwal, Director, Community Based Health Care Department
Dr. Sadia Fayaq Ayubi, Director Reproductive Health Department
Dr. Nadera Hayat Borhani, Deputy Minister of Health, Health Services Provision
Dr. Sayed Habib, Director Control of Communicable Disease Department
Dr. Hamayoon, Training Coordinator, Afghan Public Health Institute
Dr. Amina Hashimi, Director Curative and Diagnostic Services
Dr. Faizullah Kakar, Deputy Minister of Health, Policy and Planning
Dr. Mohammad Tawfiq Mashal, Director Preventative and Primary Health Care Department
Dr. Ashraf Mashkoor, Head of Health Information Systems
Dr. Ahmad Jan Naim, General Director Policy and Planning
Dr. Bashir Noormal, Director General Afghan Public Health Institute
Dr. Pokhla, Kandahar Province Public Health Director
Dr. Hashem Rahimi, Director Global Fund HIV/AIDS Round 7
Dr. Rashed, Herat Province Public Health Director
Dr. Sayed Shafi Saadat, Coordinator Private Sector Department
Dr. Najibullah Safi, Manager, National Malaria and Leishmaniasis Control Program
Dr. Ahmad Shah Salehi, Director Health Economics and Financing Department
Dr. Ahmad Shah Shokohmand, General Director Health Services Provision

Ministry of Defense

Dr. Shirsha Amadi, Deputy of the Afghan National Army Office of the Surgeon General

Health Services Support Project

Mrs. Pashtoon Azfar, Head of Midwifery Association and Advisor to HSSP
Dr. Nasrat Ansari, Technical Director
Dr. Mohammad Basir Farid, Quality Assurance Manager
Dr. Hamid Shinwari, NGO Capacity Building Manager

USAID

Dr. Randolph Augustine, USAID
Ms. Susan Brock, Health Advisor, USAID
Dr. James Heiby, Health Officer, USAID
Dr. Mohommad Ibrahim Maroof, Health Advisor, USAID

ISAF

Dr. Joseph Anderson, Command Surgeon, NATO Tracking Mission-Afghanistan/Combined Security Transition Command-Afghanistan

Lt. Col Robert Engells, ISAF, Combined Security Transition Command-Afghanistan

Capt. Joe Hodge, ISAF, Combined Joint Medical Branch

URC/HCI

Dr. Fahim Ahmady, Provincial Improvement Coordinator, Kunduz

Ms. Cathryn Green, Consultant

Mr. Simon Hildebeitel, Program Officer

Dr. Kamran Hekmati, Provincial Improvement Coordinator, Balkh

Dr. Abdul Naser Ikram, Research/Monitoring and Evaluation Advisor

Dr. Karima Joyan, Maternal Newborn and Child Health Advisor

Mr. Sven-Olof Karlsson, Consultant

Dr. M. Rashad Massoud, Director, USAID Health Care Improvement Project

Dr. Mirwais Rahimzai, Chief of Party, Afghanistan

Dr. Najibullah Saidi, Provincial Improvement Coordinator-Kabul

Dr. Farid Ahmad Sohail, Senior Technical Advisor

Other

Dr. Andwele Bryan, Department of Health Officer, Aga Khan Health Services

Mr. Gary Davis, Monitor, Military Professional Resources, Inc

Dr. Farhat, Program Manager, Ebnesina

Dr. Jill John Kall

Dr. Yusof Khan, Deputy Medical Director, Cure International Hospital

Mr. Daniel Koehler, Senior Medical Mentor Consultant, Military Professional Resources, Inc

Dr. Majeed, Head of Mission, Healthnet Transcultural Psychosocial Organization

Dr. Pir Mohammad Paya, Hospital Management Advisor, Management Sciences for Health

Mr. Alleu Qreenwan, Chief of Party, IWE

Dr. Samiullah, Military Professional Resources, Inc

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