A health system left unchanged can only be expected to produce the same results. To achieve better results, systems need to be changed in ways that enable greater achievements.

URC quality improvement experts have been agents of change for decades, working with local partners and funders to identify priorities and develop strategies to achieve these priorities. URC improves health systems and health care quality by:

- Expanding people’s and organizations’ skills and capabilities;
- Empowering people to develop, test, and implement local solutions to challenges; and
- Tracking the results produced by these solutions and adapting as needed.

**CHALLENGES**

Improving health care delivery isn’t sustainable without local ownership and leadership. And even with proper leadership, funding, and wide support, gains from quality improvement initiatives can be halted or erased by conflicts, natural disasters, and poverty.

**WHAT IS QUALITY IMPROVEMENT?**

In health care, improvement science emphasizes changes in service delivery processes and systems in ways that enable high-impact, evidence-based interventions to achieve better results. Using this model, URC empowers health workers to introduce process changes to yield effective and efficient delivery of health care.

Our assistance includes improvements at all levels, including communities, hospitals and health centers, districts and provinces, and national programs and policy. We design context-specific strategies to bolster our quality improvement work.

URC also helps redesign regulatory strategies, such as health profession certification and licensure and facility health care accreditation.
URC – like USAID and other funders – seeks to foster self-reliance and resilience in the countries and communities with whom we work. In Paraguay, Northern Uganda, Ghana, Cambodia, and elsewhere, URC is helping communities, governments, the private sector, and other stakeholders achieve measurable improvements to health systems, health care, and more.

QUALITY IMPROVEMENT THEORY PUT INTO PRACTICE

Model for Improvement

Using quality improvement (QI) to improve healthcare, strengthen health systems, and advance the frontier of improvement science is a central focus of the global USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, led by URC. ASSIST has achieved multiple significant improvements in quality of care and leadership in dozens of countries.

For example, in April 2018 a team of pediatricians, nurses, and other health professionals at the Ciudad del Este Regional Hospital in Paraguay agreed for the first time to work together to improve the quality of care provided by the hospital. Similar work is being carried out in 13 other hospitals across the country.

The team began analyzing performance indicators defined jointly with the ASSIST Project during an ASSIST-led training on QI, the Zika virus, the virus’ consequences on newborns, newborn screening, and other topics. They identified 11 cases of babies born with microcephaly at their hospital during 2017 and 2018 and determined that none were receiving follow-up care. Motivated by the training and the data, the team contacted the families of these babies and invited them to the hospital for additional care. But the challenge was that potential patients faced hours of waiting at the hospital to be seen.

The team proposed the creation of a consulting room specifically designed for high-risk babies and assigned medical staff to facilitate follow-up care for babies with microcephaly. They identified a physical space for the consulting room which also would serve as an early stimulation room for high-risk babies, including those with other disabilities.

ENHANCING LEADERSHIP FOR IMPROVEMENT

Leaders are critical for owning and expanding QI approaches and providing the energy needed for implementation and scale-up. But how does one become such a leader?

People with little to no formal knowledge of improvement science can lead system improvements. With the right training of techniques, they will be able to improve at a much greater scale. The selection of what to improve and how to do it is equally as important as is consideration of the culture and environment in which the work is being conducted.

To help grow the pool of local leaders driving QI, ASSIST created “Effective Leadership for Quality Improvement in Health Care: A Practical Guide.” The guide is aimed at leaders of all levels – community, health facility, district, regional, and national – and is suitable for those who want to support improvement focused in all health service areas. The guide is designed to help leaders, for example:

- Entice others to join their efforts: good communication skills are needed to explain the changes being implemented and how the changes will improve care;
- Balance their individual initiative with continued collaboration with others;
- Rally a team around a strategy and draw out the best in each team member to implement the strategy; and
- Challenge team members to be better while continually these efforts.

ADDRESSING HIV PREVALENCE WITH QUALITY IMPROVEMENT TEAMS

ASSIST always has employed collaborative models to sustainably improve the performance of health systems. Often, this means guiding the creation and management of health facility QI teams, who then measure and monitor performance indicators, plan changes to improve gaps, and determine which changes were
successful. QI teams also share their successes with each other to spread and scale up improvements.

But sometimes QI teams must address challenges outside of a typical clinical environment. In places such as Northern Uganda, the risk of HIV contraction among adolescent girls and young women (AGYW) is increased by gender-based violence, cross generational sex and early marriage, transactional sex, multiple sexual partnerships, poverty, illiteracy, and drug abuse. Therefore, ASSIST created a model that establishes and supports community QI teams (QITs) to:

- Build AGYW skills to avoid risky behavior and influence safer sex practices with their partners;
- Mobilize community resources to support AGYW and their partners to stop risky behavior; and
- Link AGYW, their partners, and their communities to HIV prevention services and commodities.

The selected QIT members included church leaders, parents/caregivers, elders, local/cultural leaders, community health workers, and others. They were asked to volunteer in community activities and were oriented on their roles. Members explored reasons for the increased HIV risk in the community, with perspectives from AGYW and the other community members, revealing that social-economic factors influence risky behaviors. For example, among the out-of-school AGYW, limited economic potential exposes them to HIV risk when they engage in transactional sex to provide for basic needs.

The QITs planned and implemented activities aimed at improving service delivery among the AGYW beneficiaries. The teams mobilized AGYW and their sexual partners for health camps to increase use of health services. In some communities, male gender champions were identified to create positive attitude and change among parents/caregivers towards supporting AGYW.

Gloria, a peer leader surveyed as part of the work, said the QI team helped parents to get actively involved in supporting AGYW to stay HIV negative. “When the community team came together, decisions were made about stopping overnight discos, mobilizing men to get tested, and ensuring that the parents allowed AGYW to participate in group activities.”

### CREATING INCENTIVES FOR BETTER HEALTH OUTCOMES IN GHANA

Systems for Health – funded by USAID and implemented by URC – is supporting the Ghana Health Service’s (GHS) efforts to improve the demand for and the quality of primary health care services at the community level across five of the country’s 10 regional health directorates.

To achieve this goal, Systems for Health is helping GHS leaders improve their skills in collaborative planning, continuous use of data, coaching and mentoring, and the implementation of follow-up actions in concert with financial incentives.

One project strategy to achieve better health care has been performance-based grants for meeting certain outcomes, known as using fixed amount awards. GHS regional health directorates earn these awards by designing and implementing QI projects that improve one or two key health outcomes in districts within each region.

In 2018, each directorate reviewed data to identify maternal and child health outcomes that were not meeting targets. They then pinpointed specific districts and facilities contributing the most to the region’s morbidity and mortality among women and children, assessed the root causes of the issues, and designed interventions to address the causes.

Many leadership-led QI projects implemented directly by the GHS in select districts achieved significant results, according to statistics reported in May 2019 compared with 2017 baselines. For example:

- In the six districts in the Volta Region, neonatal mortality declined from 9.65 deaths per 1,000 live births to 4.41 per 1,000.
In two districts in the Western Region, the stillbirth rate decreased from 23.35 per 1,000 births to 13.34 per 1,000.

And in 10 hospitals in Northern Region, the maternal mortality ratio per 100,000 live births dropped from 159 to 122.7.

**FINDING CAMBODIAN SOLUTIONS FOR CAMBODIAN CHALLENGES**

Many Cambodian doctors, nurses, midwives, and other health care providers work at health facilities with little to no access to the internet, books, or journals. Historically, they rarely have received refresher training or opportunities to ask questions, discuss cases, or receive feedback. Also, many providers are hesitant to adopt new clinical procedures – such as long-acting and permanent methods of contraception – due to a lack of knowledge, skills, or perceived capacity.

URC, through two decades of partnership and collaboration with USAID and the Royal Government of Cambodia, has contributed to improving the self-reliance of the health system in Cambodia, resulting in better quality care for all Cambodians. This has been a wide-ranging and multi-faceted collaboration with clinical capacity building, coaching, relationship building, financing reform, and other systems-level changes.

For example, under the USAID Better Health Services (BHS) Project, which ran from 2009 to 2013, URC took a holistic approach to strengthen clinical and management skills and build a culture of team problem-solving. Key principles included:

- On-site, hands-on, team-based learning strategies;
- Structured coaching approaches based on competency-based learning objectives; and
- Immediate and consistent follow-up where the competencies and clinical practices are reviewed.

URC continued to advance and scale up these models through the Quality Health Services (QHS) Project and the Social Health Protection (SHP) Project, both of which ran from 2014 until 2019.

The QHS Project scaled up the training to all 600 health centers in the nine target provinces, achieving rapid improvements in quality indicators. For example, while health center staff competency in the training modules was initially 30 percent, it increased to 72 percent by the ninth follow-up coaching visit. Notably, the number of woman-newborn pairs in QHS-supported districts who received at least three post-natal care visits increased from 16,676 women and 15,147 newborns in 2014 to 47,241 women and 53,642 newborns in 2019.

The Cambodian government has adopted these models as national strategies and included them in provincial and operational district budgets, which underscores their appropriateness in the Cambodian context.