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RESEARCH AND EVALUATION REPORT

What has HCI done to institutionalize improvement? A report from 17 countries

MARCH 2013

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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

AIDS	Acquired Immune Deficiency Syndrome
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
COP	Chief of Party
EONC	Essential Obstetric and Newborn Care
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCI	USAID Health Care Improvement Project
HIV	Human Immunodeficiency Virus
IQHC	Improving Quality in Health Care Unit (Afghanistan)
MCH	Maternal and Child Health
MDR-TB	Multi-drug Resistant Tuberculosis
MINSA	Ministerio de Salud (Nicaragua)
MNCH	Maternal, Neonatal, and Child Health
MOH	Ministry of Health
MOHSD	Ministry of Health and Social Development (Russia)
MOHSS	Ministry of Health and Social Services (Namibia)
MOHSW	Ministry of Health and Social Welfare (Tanzania)
MOPH	Ministry of Public Health (Afghanistan)
MOU	Memorandum of Understanding
NTCP	National Tuberculosis Control Program (Swaziland)
OVC	Orphans and Vulnerable Children
QA	Quality Assurance
QAP	Quality Assurance Project
QI	Quality Improvement
SESAL	Secretaría de Salud (Secretariat of Health), Honduras
SNAP	Swaziland National AIDS Program
TASC3	Technical Assistance and Support Contract, Three
TB	Tuberculosis
UNICEF	United National Children's Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction

The USAID Health Care Improvement Project (HCI) defines institutionalization as the establishment and maintenance of continuous improvement activities as integral and sustainable within the health system or other organization. In a March 2012 assessment, HCI put forth a framework comprised of elements which may contribute to the institutionalization of quality improvement at the national, regional/provincial, district, and service delivery levels. These elements are:

- Political will and leadership;
- Roles and responsibilities;
- Organization;
- Orientation;
- Resources;
- Monitoring and tracking of data; and
- Transfer, or the application of improvement methods to areas of service beyond those supported by HCI or other implementing partners.

The March 2012 assessment focused on the level and form of institutionalization across all levels of the health system in 15 HCI-supported countries. The purpose of this follow-up assessment was to examine the varying ways HCI has facilitated the institutionalization of improvement at the national level across 17 HCI-supported countries.

Methodology

This was a qualitative descriptive investigation across 17 countries. We included all 15 countries that participated in the March 2012 assessment: Afghanistan, Bolivia, Cote d'Ivoire, Ecuador, Guatemala, Honduras, Mali, Namibia, Nicaragua, Niger, Russia, South Africa, Swaziland, Tanzania, and Uganda. We also included Ethiopia and Kenya whose programs had developed and appeared to have made some gains in institutionalization.

Semi-structured interviews with HCI Chiefs of Party (COPs) were conducted either in person or via telephone in the period September-October 2012. Based on each country's quarterly and annual reports, the interview guides were tailored to focus on HCI's role in supporting institutionalization. The semi-structured nature of the interviews gave COPs the opportunity to reflect upon and highlight those activities they found to be most effective or meaningful. Content analysis was performed to identify activities HCI carried out to support ministries. Using the aforementioned framework as a guide, data were also analyzed to identify facilitating factors and barriers to institutionalization.

Findings

COPs reported HCI playing an important role supporting the institutionalization of improvement at the national level in five key ways. First, HCI brought together key government, non-government, and sometimes private stakeholders to address quality improvement. HCI also worked to raise awareness and knowledge of these key stakeholders, not only about quality improvement but also around technical areas, such as tuberculosis. A related activity was advocating for a place for quality improvement, often through the use of data and demonstrating results. HCI's passionate and committed staff also played an important role in advocating for quality improvement. HCI also supported ministries in integrating quality improvement into their existing systems through developing and testing standards, guidelines, and policies; working to incorporate improvement into pre-and in-service training; and providing other

resources to support facilities to integrate and sustain improvement. Finally, HCI prepared national governments to take ownership over improvement work.

COPs were also asked their views on factors that facilitated or hindered institutionalization of improvement. Key facilitating factors included strong leadership and champions within the ministry and clear roles and responsibilities, including having individual positions or units/divisions dedicated to improvement. Regular meetings and visits between national level actors and those at other levels of the health system also facilitated institutionalization. Finally, the use of data and evidence supporting the benefits of quality improvement helped garner support among national level actors to institutionalizing quality improvement.

COPs also described challenges to institutionalization. Political will and buy-in at the national level were reportedly lacking in some countries. Even when there was support for improvement, COPs expressed that financial and human resources were absent or insufficient. Additionally, poor organization and structure within the health system impair the ability to institutionalize. Finally, conflicting priorities were mentioned as hindering institutionalization of improvement methodologies.

Conclusions and Recommendations

HCI, across 17 country programs, has supported the institutionalization of quality improvement at the national level in several key ways: through bringing stakeholders together and raising awareness; using data to advocate for improvement; integrating improvement approaches into the functionality of the health system; and preparing the national government to take ownership over quality improvement. Essential to these activities was continued communication and professional relationships with key stakeholders.

While there are several limitations to this study, it provides interesting exploratory insight into how to support institutionalization of quality improvement. Future research is needed to identify and validate indicators and the human factors that contribute to institutionalization.

I. INTRODUCTION

In March 2012, the USAID Health Care Improvement Project (HCI) published the findings of an assessment on institutionalization of improvement across 15 HCI-assisted countries (Smith, Broughton & Coly 2012). In that report, institutionalization was defined as establishing and maintaining continuous improvement activities as an integral and sustainable part of a health system or organization's daily activities. This approach to institutionalization encompasses both the establishment of structures, processes, and mechanisms to address and improve the quality of care, and the maintenance or sustainability of these structures, processes, and mechanisms. We recognize improvement as institutionalized when there is a continuous process of using data to identify problems, implementing changes to address problems, and monitoring indicators after the end of HCI's assistance.

The process of understanding what contributed to institutionalization began with reviewing previous quarterly and annual reports in which country programs documented the steps taken and forms of institutionalization supported by HCI. Previously, there was little guidance on what constituted institutionalization, allowing countries to highlight activities they viewed as relevant. These self-reports, combined with discussion and input from those with extensive experience working in the field, informed the development of a framework (see Appendix I) consisting of elements contributing to the institutionalization of quality improvement at the national, regional/provincial, district, and service delivery levels. These elements are:

- Political will/leadership, which includes commitment to improvement; defined policies, guidelines, strategic plans, or standards; recognition of improvement; and communications with other levels of the health system;
- Roles and responsibilities, which include assigning improvement responsibilities to individuals or a unit or department;
- Organization, such as meetings or visits with other levels of the health system;
- Orientation of new staff to improvement;
- Resources, predominantly financial, to support improvement activities;
- Monitoring and tracking of data and its use in problem identification; and
- Transfer, or the application of improvement methods to areas of service beyond those supported by HCI or other implementing partners.

Using this framework, the March 2012 report revealed notable variability in the presence of the elements listed above both across and within countries. The findings also showed that much had been achieved at the national and service delivery levels, where HCI had focused its efforts, but there was less evidence of institutionalization at the middle levels of the health system across countries.

This qualitative research study supplements the findings of the March 2012 assessment report by exploring through interviews and document review the various ways in which HCI field staff supported countries in institutionalizing improvement at the national level. The present study was carried out in September-October 2013.

Background

HCI is a six-year task order contract issued by the U.S. Agency for International Development (USAID) begun in 2007 to support countries in improving the quality and impact of health services. Guided by the vision that health care quality can be significantly improved by applying proven quality improvement methods, HCI assists national and local programs to scale up evidence-based interventions and improve outcomes in child health, maternal and newborn care, HIV/AIDS, tuberculosis, malaria, and reproductive

health. The project also seeks to help countries expand coverage of essential services; make services better meet the needs of underserved populations, especially women; improve efficiency and reduce the costs of poor quality; and improve health worker capacity, motivation, and retention.

HCI builds on the successes of the Quality Assurance Project (QAP) (1990-2007) which adapted approaches such as continuous quality improvement, improvement collaboratives, accreditation, and pay for performance to the needs of USAID-assisted countries.

II. METHODOLOGY

A. Study Design

This was a qualitative descriptive investigation into the activities and support HCI field offices provided to 17 assisted countries to facilitate the institutionalization of improvement at the national level.

B. Sampling

Table 1 lists the 17 country programs included in this assessment. All 15 countries included in the March 2012 report were included in this assessment. Data were also gathered from Ethiopia and Kenya, which were not part of the earlier report as assistance focused narrowly on standards development and piloting. However, in the year between data collection for the March 2012 report and this assessment, it was apparent that gains had been made in institutionalization of the standards, which warranted reporting.

To facilitate data collection, the scope of this investigation was limited to the national level activities.

Table 1: Country programs included in the March 2012 institutionalization assessment

Afghanistan	Guatemala	Nicaragua	Tanzania
Bolivia	Honduras	Niger	Uganda
Cote d'Ivoire	Kenya	Russia	
Ecuador	Mali	South Africa	
Ethiopia	Namibia	Swaziland	

C. Data Collection

Based on the activities reported in quarterly and annual reports, interview guides were designed to gather information from HCI Chiefs of Party (COPs) regarding HCI's activities that supported the institutionalization of improvement at the national level. Interviews were semi-structured, allowing the COPs the opportunity to reflect upon the process of supporting ministries. These interviews were conducted either in-person or via telephone. While some were audio-recorded, this was not possible for all interviews. In these situations, notes were taken by the interviewer during the interview and were further expanded after the interview. Interviews were conducted by members of the HCI headquarters Research and Evaluation and Knowledge Management teams.

D. Description of the Study Sample

The sample for this exercise covered a broad range of geographic and improvement areas, as illustrated in Table 2.

Table 2: Characteristics of sampled programs

Country	Improvement area(s)	Year HCI program began	Prior URC assistance in health care improvement?
Afghanistan	Maternal and newborn health	2009	No
Bolivia	TB	2008	Yes-QAP II and III
Cote d'Ivoire	HIV/AIDS OVC Laboratory services	2009 2009 2010	No
Ecuador	MNCH	2008	Yes-QAP I, II, and III
Ethiopia	OVC	2009	No
Guatemala	MNCH	2008	Yes-QAP I and II; Calidad en Salud I and II
Honduras	MNCH	2007	Yes-QAP II and III
Kenya	OVC	2009	No
Mali	MNCH	2010	No
Namibia	Injection safety, health care waste management	2008	Yes-Safe Injection Project under TASC3
Nicaragua	MNCH, HIV/AIDS	2007	Yes-QAP II and III
Niger	Health workforce	2008	Yes-QAP I, II, and III
Russia	MNCH HIV/AIDS TB-HIV integration	2009 2007 2007	Yes-QAP II and III
South Africa	HIV/AIDS	2007	Yes-QAP II and III
Swaziland	TB, TB-HIV integration	2007	Yes-QAP III
Tanzania	HIV/AIDS	2008	Yes-QAP II and III
Uganda	HIV/AIDS	2009	Yes-QAP I, II and III

E. Analysis

Content analysis was performed to identify HCI activities that contributed to the institutionalization of improvement within host countries. Due to the semi-structured nature of the interviews, COPs were able to provide rich information on their experiences with and perceptions of institutionalization more broadly. These data were also analyzed to provide insight into facilitating factors and barriers to institutionalization, using the framework set forth in the March 2012 report. Examples are provided for each of these activities and factors. There is not an example from each country for each activity or factor; however this should not be seen as an indication that HCI country teams did not engage in each of these activities. Rather, during the semi-structured interviews the Chiefs of Party were free to emphasize those activities and factors that they felt had the greatest impact on efforts to institutionalize improvement. Additionally, the size and scope of each country program influenced the type of activities undertaken.

III. FINDINGS

In the following sections, we present some of the key findings with illustrative examples. A more comprehensive list of examples is presented in Appendix 2.

A. Defining Institutionalization

HCI COPs described institutionalization of quality improvement as a process in which the health sector incorporates quality improvement methodologies as a routine and sustained component of its daily work and integrate improvement into the health sector's functional structure. As Jean Nguessan, HCI COP in Cote d'Ivoire, stated:

[Institutionalization of quality improvement] is incorporating improvement into daily activities so that it becomes routine, when you apply improvement methods without knowing that you are doing it.

There was also acknowledgement that institutional investment is needed to ensure that quality improvement “will not operate as just a one-time limited vertical program”, but is “performed on a regular basis as part of the work” (Davis Rumisha, COP, HCI-Tanzania).

B. The Role of HCI in Institutionalization of Quality Improvement

COPs reported HCI playing an important role in the institutionalization of improvement at the national level. This role often involved bringing together key government, non-governmental, and, sometimes, private stakeholders to address quality improvement. In Russia, HCI COP Victor Boguslavsky felt that because HCI was external, but with professional relationships with key stakeholders across the system, HCI was able to bring members of different sectors together to facilitate discussions, agree on a shared vision, and identify areas for improvement. Similarly, in South Africa, COP Donna Jacobs reported that HCI staff facilitated dialogue and relationship building, providing partners with the opportunity to take responsibility for improvement work.

Key to institutionalizing improvement methodologies was raising awareness and knowledge of these methodologies and approaches. HCI, in all countries, has trained health workers at multiple levels of the health system in improvement methods and their application to a diverse range of health areas, including but not limited to maternal and neonatal health, HIV/AIDS, infection prevention, and tuberculosis. In Honduras, for example, HCI assisted the National Quality Assurance Department in organizing national conferences on quality assurance and improvement, held annually beginning in 2004. The conferences exposed health workers and officials to best practices in improvement. In Ethiopia, HCI country staff brought key government officials and decision-makers on visits to the field to observe firsthand how improvement approaches had been integrated at facilities and the impact this has on delivery of services. Exposing these key stakeholders to improvement work on the ground strengthened their commitment to institutionalizing quality improvement. The Ethiopian MOH has since taken ownership over the national OVC standards, with a commitment to review and update them every five years. Similarly, in Kenya, the establishment of OVC standards, supported by data provided by HCI, has made the government “more confident in overseeing the work carried out by implementing partners because the MOH now knows what these implementing partners are supposed to be doing” (Dorcas Amolo, COP, HCI-Kenya).

Raising awareness need not be limited to awareness of improvement work. In Swaziland, where HCI has focused on improving the quality of tuberculosis (TB) care, HCI facilitated a series of high-level meetings with senior Ministry officials to raise their understanding of TB as a major public health problem. HCI also provided technical assistance to the National Tuberculosis Control Program (NTCP) to organize two workshops for members of Parliament and the Senate to educate them on TB/HIV as impacting both health and the economy at the national level. In this instance, raising awareness of among senior government officials was a means of garnering political commitment.

Many HCI COPs reported using data, particularly evidence regarding the impact of adopting improvement approaches, to influence key stakeholders at the national level to integrate improvement into the health care system. In Nicaragua, advocacy for political will was done using data from Ecuador, where notable improvements in perinatal and maternal care had been achieved. The passion for improvement demonstrated by HCI staff also contributed to success in advocacy efforts, according to HCI-South Africa Chief of Party, Donna Jacobs. This passion was supported by the use of strong data illustrating the impact of integrating quality improvement into the health system.

Ivonne Gomez, HCI Chief of Party in Nicaragua, noted that HCI's strong relationships with MINSA, the Nicaraguan Ministry of Health, "helped speed up the advocacy process", creating political will for improvement and institutionalization at the national level more quickly. This sentiment was echoed by HCI Chiefs of Party across geographical areas.

Integration of improvement at the national level is particularly pertinent in countries where the health system is highly centralized. At the national level, indicators of integration of quality improvement include the development of standards of care, guidelines, and policies related to improvement; incorporation of quality improvement into pre- and in-service training of all levels of health workers; and provision of resources that support health facilities across the health system to integrate and sustain quality improvement. Most HCI COPs described providing technical assistance at the national level in developing guidelines, standards of care, and national policies and strategies for quality improvement. For example, in Ecuador, HCI worked with the Ministry of Health to update the manual of Quality Standards and Indicators for Emergency Obstetric and Newborn Care, resulting in a new manual that the Ministry of Health approved, published, and distributed nationally. This engagement led to the first-ever guidelines for the immediate treatment of preeclampsia, hemorrhage, and sepsis at peripheral health facilities and referrals to better equip provincial hospitals. In some countries, such as Namibia and Tanzania, HCI has worked with the Ministries of Health to develop training manuals on improvement.

Preparing governments to take ownership over improvement work at the national level is key to successful institutionalization. In Russia, HCI signed Memorandums of Understanding (MOU) with the Ministry of Health and Social Development and other Russian partners to clearly define roles and responsibilities. Victor Boguslavsky, HCI COP in Russia, credits these MOUs with positioning the government to make a commitment to quality improvement. In South Africa, it was made clear, first under QAP and then HCI, that efforts to improve the quality of care could not be sustained unless the Ministry took a leadership role. HCI has also advocated at the national level for government commitment to providing necessary resources for the institutionalization of quality improvement. Another example comes from Nicaragua, where HCI encouraged the Ministry of Health to commit its own funds to procure contraceptives to ensure sustained availability of essential family planning commodities in anticipation of Nicaragua's graduation from USAID's assistance. HCI has also aided governments in securing funds from other donors when domestic resources are not available. In Swaziland, HCI supported the Ministry in writing the Round 8 Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) proposal, which was awarded for \$13.7 million.

C. Factors Facilitating the Institutionalization of Quality Improvement

COPs were asked to identify factors that they perceived facilitated institutionalization of HCI's quality improvement work and to describe what they perceived to be needed to better facilitate the institutionalization of quality improvement in their respective countries. COPs identified several factors that could facilitate the institutionalization of quality improvement. These factors have been organized by several domains proposed in the HCI Framework for Institutionalization (Smith, Broughton & Coly 2012), including political will/leadership, roles and responsibilities, organization, and the use of data/evidence.

Several countries, including Russia, Ecuador, Uganda, Ethiopia, Tanzania, and Niger, reported leadership and having a champion within the ministry as playing key roles in facilitating the institutionalization of quality improvement at the national level. In Niger, the General Secretary for Health has been a champion for institutionalizing QI at the national level. He served as the regional medical officer in a region where HCI had implemented collaborative improvement projects, which exposed him to quality improvement methodologies and the benefits of integrating improvement approaches within the health sector. Humphrey Megere, HCI COP in Uganda, also reported the presence of champions with the health system for the institutionalization of quality improvement, particularly the Director General of Health Services who provided important leadership in this area. In Ecuador, the Division of Norms has provided leadership for improvement efforts in the country, such as the scale-up of collaborative quality improvement activities focused on emergency obstetric care.

In the context of findings from this inquiry, roles and responsibilities included the establishment of individual positions and/or units for quality improvement at the national level and the specification and allocation of roles and responsibilities by the Ministry of Health. For example, there are several quality improvement teams in Ethiopia operating at the higher levels within the health system that have facilitated the institutionalization of quality improvement. There is a leadership team composed of government officials, representatives from implementing partners, and USAID responsible for reviewing standards and preparing guidance. In addition, there is an operational team responsible for the routine management of QI at the regional level. In Niger, there is a National Quality Improvement Committee responsible for encouraging regions to integrate quality improvement into the system.

Ecuador also serves as an example of the value assigning roles and responsibilities for the institutionalization of quality improvement. The MOH of Ecuador hired two individuals at the national level to work with provincial offices on integrating quality improvement in health facilities throughout the country. The MOH also created a staff position at the national level in charge of managing a national database of reports of compliance with EONC standards. Individuals in these positions have played key roles in leading national efforts to institutionalize quality improvement, including updating the “National Maternal and Newborn Care Norms and Standard” and the “Manual of Quality Standards and Indicators for EONC.”

In Afghanistan, HCI, through the seconded HCI staff member within the MOPH, advocated for the establishment of the Improving Quality in Health Care Unit within the MOPH. In 2012, the unit became an integral part of the structure of the MOPH with funding being allocated for 16 staff for the unit. This unit will provide technical support on quality assurance and improvement across departments within the MOPH.

Organization, such as meetings and visits with different levels of the health system, has also helped facilitate the institutionalization of improvement work at the national level. For example, the Ministry of Health and Social Services (MOHSS) in Namibia has instituted quarterly supervision visits to regions, during which staff are mentored, supplies are distributed, and challenges are addressed. The Quality Assurance division of the MOHSS in Namibia has a set budget for these supervision activities. Though some countries reported holding national meetings on quality improvement, it was unclear from the data collected whether these meetings have been sustained over time or instituted as routine.

The use of data and evidence were reported by many countries as facilitating the institutionalization of quality improvement at the national level. Data and evidence were often framed by key informants as being imperative to garnering support at the national level to institutionalize QI within the health system. Research spearheaded by HCI has provided the Ministries of Health in several countries with strong evidence of the positive impact of integrating quality improvement in clinical practice. Findings from these studies have influenced national government adoption of quality improvement.

D. Challenges in Institutionalizing Quality Improvement

Despite most countries taking steps toward integrating quality improvement within the health system, including raising awareness and knowledge of improvement methodologies and approaches among providers and government health officials and assisting governments in developing QI standards and guidelines, many have faced challenges in institutionalizing quality improvement at the national level.

Financial and human resources dedicated to quality improvement were reported as being insufficient or, in some instances, absent all together. Uganda, Tanzania, Ecuador, Guatemala, and Honduras reported insufficient levels of funding allocated by the government for quality improvement. HCI-Uganda COP Humphrey Megere explained that despite its good will and buy-in, the Ministry of Health had not supplied the financial resources necessary to integrate and institutionalize quality improvement within the national health system. Some countries were able to overcome inadequate financial support from the national government by soliciting resources from different donors, including UNICEF, the World Health Organization, the World Bank, and other donor agencies, to fund improvement activities. The availability of human resources was also reported as a challenge to institutionalizing quality improvement. Some countries reported shortages of staff or the lack of capacity of existing staff as hindering institutionalization. In Cote d'Ivoire the inadequate capacity at different levels within the health system has prevented health workers and health officials from actually implementing policies and adopting standards developed at the national level.

A few countries, particularly Russia, Swaziland, Tanzania, and Mali, reported a lack of political will and leadership at the national level as a barrier to institutionalizing quality improvement. Maina Boucar, HCI Regional Director for West Africa, described Mali's MOH as not taking a leadership role, however it was stipulated that this may be due to the infancy of HCI's presence and engagement in improvement work in Mali.

Weak organization and lack of coordination at the national level was reported by two countries, Swaziland and Niger, as being a challenge to the institutionalization of quality improvement. Initially in Swaziland there was weak organization of improvement activities at the national level. Niger reported a lack of coordination and lack of agreement among different partners on the core principles of improvement. The HCI Chief of Party for Niger, Maina Boucar, described the existence of different schools of thought (i.e., definitions of and approaches to improvement) among different partners operating in Niger, which makes coordination of a national approach to institutionalizing quality improvement a challenge. In Nicaragua, HCI COP Ivonne Gomez commented that the structure within MINSA changed during HCI's work in the country. Prior to this structural change, MINSA had the authority to approve and disseminate norms regarding service delivery and quality of care. This process was changed to require MINSA to submit any officially published materials to the President's office for approval, delaying the roll-out and implementation of updated standards and guidelines.

Another challenge to institutionalizing quality improvement revealed through the interview with the HCI COP for Cote d'Ivoire, Jean N'guessan, was the conflicting priorities among health workers and health officials at different levels of the health system that hinder them from integrating improvement methodologies and making it routine. As Dr. N'guessan explained, health workers and health officials are busy and may have more pressing concerns to address than quality improvement.

IV. DISCUSSION AND RECOMMENDATIONS

A. Summary

Across the 17 country programs, HCI supported the institutionalization of improvement in several key ways. First, HCI brought together key stakeholders across levels of the health system and across sectors to raise awareness of the value quality improvement approaches offered. Second, using data to demonstrate sustained improvements aided in advocating for political support, commitment, and

resources. HCI was able to draw on data from other HCI-supported countries to demonstrate impact, but also drew on data from small demonstration projects within the country, illustrating the importance of using data from the service delivery level as an effective advocacy tool.

With both of these approaches to supporting the institutionalization of improvement, continued communication and professional relationships with national level stakeholders were essential. A related factor is the passion and commitment that HCI staff have for quality improvement, which they demonstrate daily in their interactions with stakeholders and counterparts at all levels of the health system. The experience, professional relationships, and enthusiasm for quality improvement that HCI staff bring to their work and their interactions with stakeholders is essential for gaining support for the institutionalization of quality improvement.

HCI COPs identified several factors as facilitating and hindering the institutionalization of quality improvement. Factors perceived by COPs to facilitate the institutionalization of quality improvement at the national level included leadership and champions for QI at the national level, supervision activities, meetings on improvement, having a quality improvement unit at the national level, and using data to garner support for improvement among national health stakeholders. Barriers identified by COPs to institutionalizing quality improvement included insufficient financial and human resources, lack of political will and leadership at the national level, lack of coordination of quality improvement activities, and conflicting priorities among health workers and health officials.

B. Limitations

There are several limitations of this assessment that should be considered when interpreting these findings. First, this assessment provides an overview of HCI's support for institutionalization of improvement at the national level. As such, it is not able to attribute institutionalization to HCI's efforts. The decision to limit the scope to the national level was made for practical reasons, but did result in the exclusion of important HCI activities that may have aided in the institutionalization of quality improvement at other levels of the health system. Second, this investigation relied on self-reports from COPs and written HCI reports on what HCI has done to promote institutionalization in the countries included in the assessment. It did not include perspectives from health providers or government health officials or any direct measurements of the institutionalization of quality improvement to corroborate information provided by COPs and in HCI reports. Third, this investigation used the framework put forth in the March 2012 report as a guide, which has not yet been validated. Finally, this assessment was conducted while HCI-supported activities were ongoing or had only recently been completed in the 17 participating countries. An ideal study would be longitudinal, examining the work of field teams alongside valid measures of institutionalization from the start of a program through several years after assistance had been concluded.

C. Recommendations

As noted in the March 2012 report, "the true test of institutionalization and sustainability of improvement methods in health care is examination of elements of the framework at a point or points in time after the direct intervention of HCI has concluded and the project no longer has any direct involvement in the implementation of health care improvement activities at various levels". This assessment and the March 2012 assessment were initial explorations into understanding the process of institutionalizing quality improvement within a health system. The findings provide valuable information into how to proceed with future research under the follow-on to HCI, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. Further research is needed to identify and validate indicators of institutionalizing quality improvement across all levels of the health system. These indicators could be prospectively monitored to build evidence for the institutionalization of quality improvement within a national health system.

Additionally, more in-depth research on the human factors that contribute to institutionalization should be conducted, including policy makers and other stakeholders' decision-making processes. Related is developing a better understanding of the characteristics of leaders or champions of both quality improvement and its institutionalization at all levels of the health system.

V. REFERENCES

Smith S, Broughton E, Coly A. 2012. Institutionalization of Improvement in 15 HCI-supported Countries. Research and Evaluation Report. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

APPENDICES

Appendix 1: Institutionalization Framework

The USAID Health Care Improvement Project defines institutionalization as establishing and maintaining continuous improvement activities as an integral, sustainable part of a health system or organization's daily activities. This approach to institutionalization encompasses both the establishment of structures, processes, and mechanisms to address and improve the quality of care, and the maintenance or sustainability of these structures, processes, and mechanisms. The objective is to institutionalize and sustain improvement after the end of HCI assistance. We define improvement to be institutionalized when there is a continuous process of using data to identify problems, implementing changes to address problems, and monitoring indicators.

The subsequent framework describes the elements necessary for institutionalization of quality improvement at the national, regional, and facility levels. For each element, a list of questions has been provided to guide the documentation of institutionalization.

Level	Element	Description	Questions
National	Political Will/ Leadership	Commitment to include improvement as an activity; advocate for funding	<ul style="list-style-type: none"> • Has a commitment been made by the MOH (high ranking officials) to address and improve care? • Have funds been advocated for? Are funds regularly/continually advocated for?
		Policy and guidelines/ strategic plan/ standards	<ul style="list-style-type: none"> • Have health service standards, etc. been established and agreed upon by the MOH? Who was/is involved in setting standards, etc.? In which areas of service? • Is there a written improvement strategy? • Is there a mechanism through which clinical standards are reviewed and updated/ revised as necessary?
		Recognition of improvement	<ul style="list-style-type: none"> • Is explicit recognition given for achieving improvements? (May include publication of performance). If so, describe.
		Communication with regions on policies/plans/standards/ etc and performance feedback	<ul style="list-style-type: none"> • Is there a mechanism by which information on policies/plans/etc. are communicated from national to regional? What is the mechanism? • Are successes or gaps in performance communicated with regions?
	Roles and Responsibilities	Assignment of improvement responsibilities. This could include appointment of official(s) to follow up on improvement or establishment/ maintenance of an improvement unit/division/ committee	<ul style="list-style-type: none"> • Is/are there staff member(s) who are tasked with improvement responsibilities? What are his/her names? What are his/her specific responsibilities? • Is there a position at the national level dedicated to improvement? What is the position title? • Is there a division/unit at the national level dedicated to improvement? Is there a plan to establish an improvement division/unit within the MOH?

Level	Element	Description	Questions
		in Ministry	
	Organization	Meetings and visits to province/district	<ul style="list-style-type: none"> • Are there meetings with regional staff about improving health service delivery? How often?
	Orientation	Improvement induction by non-HCI staff	<ul style="list-style-type: none"> • Is new MOH staff (and relevant national-level partners) oriented to improvement?
	Resources	Financial support included in budget (meetings, transport, etc.)	<ul style="list-style-type: none"> • Do activities directly targeted at improving care receive funding?
	Data	Monitoring and tracking data, identification of problems	<ul style="list-style-type: none"> • Are improvement indicators being tracked at the national level? Which indicators? What is done with the data?
	Transfer	Application of improvement activities to other clinical areas	<ul style="list-style-type: none"> • Have improvement methods been used in areas of clinical practice distinctly different from the area of clinical practice that HCI focused on? Which areas?
Regional	Political Will/ Leadership	Commitment to include improvement as an activity; advocate for funding	<ul style="list-style-type: none"> • Has a commitment been made by the regional health office (high ranking officials) to address and improve care? • Have funds been advocated for? Are funds regularly/continually advocated for?
		Policy and guidelines/ strategic plan/standards	<ul style="list-style-type: none"> • Is there a written improvement strategy?
		Recognition of improvement	<ul style="list-style-type: none"> • Are there explicit incentives for achieving improvements? (May include publication of performance). If so, describe
		Communication with facilities on policies/plans/standards/ etc. and performance feedback	<ul style="list-style-type: none"> • Is there a mechanism by which information on policies/plans/etc are communicated from regional to facility? What is the mechanism? • Are successes or gaps in performance communicated with facilities? • Are successes or gaps in performance communicated with the national level?
	Roles and Responsibilities	Assignment of improvement responsibilities: This could include appointment of official(s) to follow up on improvement or establishment/ maintenance of an improvement unit/division/ committee in Ministry	<ul style="list-style-type: none"> • Is/are there staff member(s) who are tasked with improvement responsibilities? What is his/her name? What are his/her specific responsibilities? • Is there a position within the regional health office dedicated to improvement? What is the position title? • Is there a regional division/unit dedicated to improvement? Is there a plan to establish an improvement division/unit within the regional health office?
	Organization	Regular meetings and visits to facilities	<ul style="list-style-type: none"> • Are there meetings with facility staff about improving care? How often?

Level	Element	Description	Questions
	Orientation	Induction of new staff into improvement by non-HCI staff	<ul style="list-style-type: none"> Are new regional staff (and relevant regional-level partners) oriented to improvement?
	Resources	Financial support included in budget (meetings, transport, etc.)	<ul style="list-style-type: none"> Do activities directly targeted at improving care receive funding?
	Data	Monitoring and tracking data, identification of problems	<ul style="list-style-type: none"> Are improvement indicators being tracked at the regional level? Which indicators? What is done with the data?
	Transfer	Application of improvement activities to other clinical areas	<ul style="list-style-type: none"> Have improvement methods been used in areas of clinical practice distinctly different from the area of clinical practice that HCI focused on? Which areas?
Facility	Political Will/ Leadership	Recognition of improvement	<ul style="list-style-type: none"> Are there explicit incentives for achieving improvements? (May include publication of performance). If so, describe
	Roles and Responsibilities	Assignment of improvement responsibilities	<ul style="list-style-type: none"> Is/are there staff member(s) who are tasked with improvement responsibilities? What is his/her name? What are his/her specific responsibilities? Is there a position within the facility dedicated to improvement? What is the position title? Is there a facility-level division/unit dedicated to improvement? Is there a plan to establish an improvement division/unit within the facility?
		Indicator monitoring and promoting changes	<ul style="list-style-type: none"> Is/are there staff member(s) who are tasked with monitoring data, recognizing problems and promoting changes? What is his/her name? Is there a position within the facility dedicated to monitoring indicators and promoting changes? What is the position title?
	Orientation	Induction of new staff into improvement	<ul style="list-style-type: none"> Is new facility staff (and relevant facility-level partners) oriented to improvement?
	Data	Monitoring and tracking data, identification of problems	<ul style="list-style-type: none"> Are improvement indicators being tracked at the facility level? Which indicators? What is done with the data?
		Documentation of activities/changes to address problems identified	<ul style="list-style-type: none"> Is there a written record of the changes that facilities implemented to bring about improvement in care?
	Transfer	Application of improvement activities to other clinical areas	<ul style="list-style-type: none"> Have improvement methods been used in areas of clinical practice distinctly different from the area of clinical practice that HCI focused on? Which areas?

Appendix 2: Activities, Facilitating Factors, and Barriers to Institutionalization of Improvement in 17 HCI-assisted Countries

Activity/Factor	Illustrative Examples
Activities Undertaken by HCI Convening stakeholders	Afghanistan: At the request of USAID-Afghanistan, HCI has been involved in working with the MoPH and other implementing partners to harmonize the different quality improvement approaches employed by several implementing partners. This has involved extracting the best practices from each of the different approaches and preparing an implementation plan.
	Ethiopia: HCI facilitated an Africa regional meeting in Addis Ababa on quality improvement, which attracted attention from the Ethiopian government.
	Guatemala: HCI facilitated the establishment of a Quality Committee at the central level of the Ministry of Health. The committee was comprised of the Minister, Vice Minister of Administration, Technical Vice Minister, and the Fiscal Administration Manager.
	Honduras: The National Plan for the Accelerated Reduction of Maternal and Newborn Mortality was designed in 2004/05. In 2008, HCI's role was to promote the policy and ensure its legal standing. This was done through convening regular meetings with key stakeholders, such as the Department of Integrated Family Health, Department of Hospitals, the Vice Ministry of Population Risk, and the Vice Ministry of Health Networks.
	Namibia: HCI convened meetings with faculty from various medical, nursing, and midwifery institutions as well as other partners to advocate for the inclusion of quality improvement in pre-service training. During these meetings, key stakeholders agreed upon which components could be integrated into the curriculum.
	Russia: HCI, as an organization external to the health system, was able to bring members of different sectors together to facilitate discussions, agree on a shared vision, and identify areas for improvement.
	South Africa: HCI acted as a facilitator to create dialogue and build relationships. Meetings convened by HCI provided an opportunity for partners to take over responsibility for improvement work.
Raising awareness among stakeholders	Ethiopia: HCI staff brought key government officials to facilities to see how improvement approaches were integrated into practices and the impact this had on service delivery. This increased appreciation for improvement led to the Ethiopian MOH taking ownership over national OVC standards.
	Honduras: HCI assisted the National Quality Assurance Department in organizing national conferences on quality assurance and improvement, held annually beginning in 2004. The conferences exposed health workers and officials to best practices in improvement.
	Kenya: The establishment of OVC standards, supported by data provided by HCI, has made the government "more confident in overseeing the work carried out by implementing partners because the MOH now knows what these implementing partners are supposed to be doing" (Dorcas Amolo, COP, HCI-Kenya).
	South Africa: HCI staff are active members of national level working and other strategic groups focused on clinical areas, as well national level groups working on quality assurance and strategic planning. These memberships have allowed

	<p>HCI staff to raise awareness around quality improvement among other programs, departments and units within the Ministry.</p> <p>Swaziland: HCI facilitated meetings with senior Ministry officials to raise awareness of TB and TB/HIV as impacting both health and the economy at the national level. This type of awareness-raising was a means to garner political commitment.</p> <p>Tanzania: HCI has focused on creating awareness among leaders, implementing partners, and others on the benefits of and need for improvement.</p>
Advocating for improvement	<p>Afghanistan: Beginning in 2010, HCI started advocating for a unit within the MoPH dedicated to quality improvement, the Improving Quality in Health Care (IQHC) Unit. Through continued advocacy over a two-year period, the Unit is now officially in the MoPH's organogram and has expanded from three staff to 16.</p> <p>Ethiopia: Using data from six months of HCI's work on NACS, HCI was able to demonstrate the value of improvement methodologies beyond audit, which had been the only improvement method previously used by the MOH.</p> <p>Nicaragua: HCI presented data from Ecuador demonstrating notable improvements in perinatal and maternal health to advocate for greater political support for quality improvement. After working in several demonstration sites, there were sufficient data from within Nicaragua to use as an advocacy tool.</p> <p>South Africa: HCI staff in South Africa, many of whom had previous experience working at facilities as matrons, demonstrated such passion when talking about quality improvement, which aided in advocacy efforts. This passion was supported by strong data demonstrating the impact of integrating quality improvement into the health system.</p>
Assisting in integration of improvement into structure and function of health system	<p>Afghanistan: HCI facilitated the drafting and signing of the national improvement strategy. Going beyond this, HCI recognized the importance of having quality integrated into the reproductive health strategies and worked with the MoPH to incorporate quality into other documents. This has included integrating Helping Babies Breathe into the Learning Resource Package for nurses and midwives across Afghanistan.</p> <p>Bolivia: HCI provided the National TB Program with several tools and guidelines and implemented these in several demonstration sites. HCI has provided a full model, CD-ROM, laboratory structures, processes of care, and some technical assistance to the National TB Program, with support from the Ministry of Health. The National TB Program is now responsible for scaling up to the remaining facilities.</p> <p>Ecuador: HCI worked with the Ministry of Health on updating the manual of Quality Standards and Indicators for Emergency Obstetric and Newborn Care, which has since been approved, published, and distributed nationally. The Ministry of Health is now responsible for updating and distributing all materials.</p> <p>Namibia: HCI provided technical assistance for the development and review of the National Waste Management Policy, the National Infection Prevention and Control guidelines, the Consolidated Waste Management Guidelines, and the national training manual for medical injection safety. The training manual has been integrated into the health worker training curriculum, including for doctors and nurses.</p> <p>Nicaragua: HCI was involved in the design and evaluation of national protocols</p>

	<p>on essential obstetric and neonatal care, including the use of the partograph.</p> <p>South Africa: HCI supported the development of protocols and guidelines at the national level for community-based integrated management of childhood illnesses and antenatal care. HCI also participated in the technical working group responsible for revising the National Core Standards for Health Establishments. HCI also assisted with developing the National Clinical Audit Guidelines.</p> <p>Swaziland: HCI assisted the NTCP and SNAP to develop guidelines for integrating TB/HIV services, TB infection control, and management of drug resistant TB. Guideline development involved inviting stakeholders to participate in establishing priority issues and reviewing global evidence which could be tailored to the Swaziland context. HCI also assisted the NTCP in updating the National Tuberculosis Five Year Strategy (2006-2011) and aided the MOHSW in drafting and reviewing a strategic plan for national quality assurance and improvement integration. HCI also assisted the NTCP to establish an MDR-TB program.</p> <p>Tanzania: HCI supported the Ministry to develop HIV/AIDS Quality Improvement Guidelines and a Quality Improvement Training Manual to standardize practices and harmonize procedures. HCI also supported the Ministry in the National Quality Improvement Framework and the Sector Strategic Quality Improvement Plan to facilitate implementation of improvement activities. HCI also provided assistance in organizing a National Forum for all stakeholders to share and learn about quality improvement activities.</p>
Preparing governments to take ownership	<p>Ethiopia: in preparation for the MOH to take ownership over OVC activities, HCI, in conjunction with Save the Children and USAID, provided training on the national OVC standards in February 2010. The MOH has since taken responsibility for reviewing and updating these standards every five years and has installed OVC coordinators within the offices of HIV and Women, Children, and Youth.</p> <p>Guatemala: HCI COP Rodrigo Bustamante noted that the successes gained in institutionalizing improvement at the national level were, in part, because HCI was aware from the start that “we can teach them [the Ministry] new things, but we can’t implement them.” In his view, HCI in Guatemala did not have to prepare the government to take ownership because the government had the role of implementer from the start.</p> <p>Honduras: HCI engaged with SESAL from the beginning in developing national level policies. In the words of HCI Chief of Party, Norma Aly, “we made it so they [SESAL] couldn’t make any excuses, they could say ‘mañana’...we didn’t want them to say that it was HCI’s job, so we involved them completely from the beginning so that the Secretary was involved with the content of the policies.”</p> <p>Kenya: Through capacitating Ministry officials on the OVC standards and providing data from economic analyses of OVC programs, the government became more confident in overseeing the work carried out by implementing partners because the government now knows what these implementing partners are supposed to be doing.</p> <p>Namibia: In FY12, HCI worked with the MOHSS to develop a transition plan to transfer all support for injection safety, including waste management and an</p>

		infection prevention program, from HCI to the MOHSS.
		Nicaragua: USAID began encouraging MINSA to procure contraception using their own funds. HCI assisted MINSA in preparing for this transition.
		Russia: HCI established memorandums of understanding with the MOHSD and other Russian partners to clearly define roles and responsibilities.
		South Africa: From the start of QAP and HCI's work in South Africa, it was made clear that efforts to improve the quality of care could not be sustained if the Ministry did not take a leadership role.
		Tanzania: HCI played a central role in developing and standardizing tools, but the government has been responsible for primary health care and allocating funds for quality improvement within their annual plans.
Facilitating Factors	Leadership	Afghanistan: There is awareness of the importance of delivering high quality services at the national level, including among the President and within Parliament. The previous and current Deputy Minister of Public Health are champions for quality improvement.
		Ethiopia: There are several improvement teams working in Ethiopia, including a leadership team comprised of government, implementing partners, and USAID and an operational team responsible for routine management of quality improvement at the regional level. There is also a national level OVC taskforce managed by the Ministry of Women's Affairs, to which HCI is a member.
		Guatemala: At the start of work in Guatemala, under the Calidad de Salud project, quality improvement gained the support of the Minister of Health. However, it became apparent that technical staff needed to also buy into quality improvement; one of the director generals within the Ministry was supportive of quality improvement. When he was promoted to Vice Minister, he spread quality improvement throughout the Ministry and it then gained more widespread support.
		Namibia: The Division of Quality Assurance has taken the lead in injection safety. Additionally, a National Injection Safety Group was established and took responsibility for development and dissemination of policy guidelines. There were also champions within the Ministry who supported quality improvement.
		Niger: The General Secretary for Health has been a champion for institutionalizing improvement at the national level.
		Russia: Leadership within MNCH has evolved to facilitate the institutionalization of improvement. At the start of URC's improvement work in Russia, the chief neonatologist in the Ministry did not appreciate the need for cooperation with partners such as the Federal Research Institute for Health Care Organization. But following years of engagement, the chief neonatologist came to find it useful to merge the content with improvement.
		South Africa: HCI staff have a strong professional relationship with the Deputy Minister of Health who has seen the impact of quality improvement work and is a champion within the Ministry.
		Tanzania: The MOHSW is very committed to institutionalizing quality improvement as evidenced by the Quality Improvement Unit which is responsible for policy, strategic planning, and coordination and national organization of improvement activities.
		Uganda: There are champions of quality improvement within the health system, including the Director General of Health Services, which has aided in

		establishing commitment for quality improvement.
	Established roles and responsibilities	Ethiopia: Several quality improvement teams operate at higher levels of the health system which are poised to support institutionalization of improvement.
		Namibia: Ministry level staff were hired specifically to focus on quality improvement and has established a directorate within the Ministry for quality improvement.
	Organization	Namibia: The MOHSS institutionalized quarterly supervision visits to regions, during which staff are mentored, supplies are distributed, and challenges are addressed. The Quality Assurance division of the MOHSS has budgeted for these visits.
		Russia: Within MNCH, the Ministry is still very rigid, with a top-down approach, however they have left room for facilities to develop solutions to meet proscribed standards.
	Use of data	Honduras: Indicators from the National Plan for the Accelerated Reduction of Maternal and Newborn Mortality are measured quarterly. Hospitals are obligated to report these data to the central level.
		Nicaragua: HCI also supported MINSA in the design of a national indicator to monitor whether facility staff were regularly using the partograph to make timely decisions. This indicator is now required to be reported on.
		Russia: HCI assisted the government in better defining priorities by analyzing and using data.
		Swaziland: The NTCP has institutionalized a data verification exercise in which all health facilities receive data verification visits in accordance with standard reporting requirements outlined in the M&E Performance Framework and the TB M&E Plan. Using data for improvement has been most successful in the areas of TB/HIV.
Barriers	Resource limitations (financial and human)	Cote d'Ivoire: Insufficient capacity at different levels of the health system has prevented health workers and health officials from implementing policies and adopting standards developed at the national level.
		Tanzania: The government has not been able to allocate sufficient funding for improvement or its institutionalization.
		Uganda: Despite its good will and buy-in, the MOH has not supplied the necessary financial resources to integrate and institutionalize quality improvement within the health system.
	Lack of political will	Mali: Lack of leaders and champions for quality improvement has hindered the MOH's engagement in improvement.
		Russia: In Leningrad oblast, political change within the oblast has hindered institutionalization of improvement. However, partners were appreciative of the clinical chart audit approach introduced by HCI so there is the possibility that may continue after the termination of HCI's work.
	Weak organization	Niger: The different schools of thought on improvement across partners operating in Niger has made coordinating a national approach to institutionalizing quality improvement a challenge.
		Swaziland: At the start of HCI's work in Swaziland quality improvement activities at the national level were poorly organized and coordinated, which impaired the institutionalization process.
	Conflicting or	Cote d'Ivoire: Conflicting priorities among health workers and health officials at

	competing priorities	different levels of the system has hindered integration and routinization of improvement methodologies.
		South Africa: There has been a limited place for quality improvement within the clinical programs. HCI has worked toward bridging the gap between the Quality Assurance Directorate and the clinical programs at the national level, but there has been little integration at an organizational level.

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