Launched in 2010, the USAID-funded Building Local Capacity for Delivery of HIV Services in Southern Africa Project (BLC) strengthens government, parastatal, and civil society entities to effectively address the challenges of the HIV and AIDS epidemic.

Throughout the Southern Africa region and with specific activities in six countries, BLC provides technical assistance in organizational development, including leadership, management, and governance in three key program areas: 1) care and support for orphans and vulnerable children; 2) HIV prevention; and 3) community-based care.

The Challenge

Botswana has a population of approximately 2 million. Morbidity and mortality for all ages are dominated by infectious diseases, with HIV and AIDS, Tuberculosis (TB), and other communicable diseases responsible for about half the deaths. Botswana’s adult HIV prevalence rate of 24.8% is the second highest in the world.

Despite significant progress, Botswana is unlikely to meet its Millennium Development Goals to reduce child mortality, improve maternal health, and combat HIV and AIDS, malaria and other diseases by 2015. The health delivery system is challenged by shortages of skilled health workers. Poor staff motivation and low productivity contribute to poor quality. These conditions are further compounded by weak leadership and management practices and poor information management systems. At the facility level, information is not consistently generated to inform decision making. Such challenges are highlighted...
in the Ministry of Health’s (MoH) Corporate Plan 2000–2005, the National Development Plan 9.1, and the National Health Policy 2011. These challenges are more pronounced in rural health facilities as a result of unfavorable working conditions.

The Building Local Capacity for Delivery of HIV Services in Southern Africa Project (BLC) shares the MoH’s vision — health care facilities and health care workers providing high quality services, supported by effective leadership and management that meets the needs of patients, staff, and the wider community. Although there are well-trained service providers at facilities around the country, continuous quality improvement is needed to strengthen the quality of services, increasing both patient and staff satisfaction. Moreover, MoH officials, district level staff, and hospital management need to share a unified approach to quality improvement.

**BLC Response**

In partnership with the Council for Health Service Accreditation in Southern Africa (COHSASA), an internationally recognized South African quality improvement organization, and the Botswana MoH, BLC is guiding multi-disciplinary teams of service providers through a process to enhance the quality of health care at 11 public hospitals and clinics, with an especial focus on six, located in semi-urban areas of western Botswana. The Quality Improvement and Leadership (QIL) program, a joint BLC/COHSASA approach, builds leadership and management skills of health personnel to strengthen quality of care and service delivery in their facilities. Through the implementation of continuous quality improvements, the QIL program leads to the accreditation of health facilities as having met international standards of care.

The QIL Program combines MSH’s Leadership Development Program with COHSASA’s Quality Improvement program. The quality improvement component assists health workers to identify gaps in health care standards and address them through periodic assessments and on-going technical assistance. Through the leadership and management component, participants—organized in multi-disciplinary teams—learn the basic practices of leading and managing to: 1) address organizational challenges and achieve results; 2) create a workgroup climate that supports staff motivation; 3) create and sustain teams that are committed to continuously improve health services; and 4) use data for decision making to ensure continuous quality improvement. This integrated approach ensures that facilities utilize knowledge gained in the leadership component to work on specific health indicators, while using data from the quality improvement assessments in management and decision making.

**To launch QIL, BLC and COHSASA trained health workers at the ministry level and in six initial facilities in leadership and management to ensure that they understood the program.** The training covered the assessment process and the scoring criteria for the service delivery elements (e.g., surgery, radiology, health and safety, community health service, and access to care). Baseline surveys measuring quality of care were conducted in six health facilities in 2010 and scores for all the service elements were recorded. There are 33 service elements measured
for a hospital and 11 service elements measured for a clinic. Management system elements include human resources management, management of information, and quality assurance. Clinical service elements include: prevention and control of infections; medical/surgical/pediatric and obstetrics; medical care; surgical care; critical care; obstetric/maternity care; pediatric care; and operating theatre and anesthesia services.

Health facility staff in all six facilities then received training on leadership and management. Health workers analyzed data from a web-based database system: COHSASA Quality Improvement System. This online system enables users to capture and analyze data, and identify gaps and their root causes. Participants developed quality improvement plans using the Challenge Model, which enabled the teams to: develop a shared vision; understand their current situation; identify root causes; define measurable results; and develop priority actions to achieve their desired results.

The teams implemented their quality improvement plans with supervision, coaching, and mentorship provided by trained coaches. BLC assisted the coaches and health teams through on-going needs-based technical assistance. The health teams were responsible for independently monitoring the implementation of the quality improvement plans by conducting self-evaluations using QIL data collection tools. Data were then used to revise the quality improvement plans. These self-evaluations were supplemented by periodic assessments conducted by COHSASA to measure changes in performance as against health care standards. Since December 2010, four validations have been conducted in each of the six facilities. The validations helped assess the health workers’ understanding of health care standards. The validation results informed the next steps: if the service element scores were 80 points or more, an external survey conducted by independent surveyors would be arranged to determine if the facility qualified for accreditation. External surveys have not yet been

Figure 1. Change in quality improvement scores for the six health facilities
conducted due to non-compliance in some service elements at the six facilities. Instead, facilities have developed new or revised quality improvement plans to address gaps in compliance. The process is cyclical until a facility qualifies for accreditation.

Results

The QIL program has resulted in: improved performance in meeting health care standards; enhanced ownership of interventions by health workers at all levels (national, district, and facility levels); and increased understanding of the concept of continuous improvement. Application of leadership and management skills has been demonstrated by: increased collaboration among teams at the health facilities; the conduct of routine self-evaluations to monitor progress and identify challenges; development/revision of quality improvement plans; and increased stakeholder participation.

In 2010, the baseline score for all six facilities was below 80 points, the benchmark for qualifying for an external survey and accreditation. Over nearly three years, all six health facilities have increased their overall facility score and various service element scores, as shown in Figure 1.

In addition to improvements in service elements and overall health facility scores, the QIL program has led to the following results:

- **Institutionalization of leading, managing, and quality improvement practices and tools in the health facilities.** For example, each facility has conducted 14 self-evaluations, an average of four assessments per year, using the QIL program for data collection, management, and analysis tools. A comparison of the self-evaluations scores with the validations scores showed little difference, indicating good understanding of quality improvement standards by health facility staff.

- **Increased team work, coordination of services, and resource utilization.** Some service elements have interdependencies, meaning that if a determinant service element is not performing well, it will have a detrimental impact on the scores of dependent service elements. QIL has helped the health facilities recognize and understand the synergies and complementary relationships among the different service elements. As a result, the teams increasingly share information and work collectively to address challenges.

Conclusion

The QIL program is a sustainable and cost-effective approach that empowers health facility and ministry of health staff to advance a quality improvement agenda. The Botswana experience shows that QIL may be implemented in health facilities facing service delivery and compliance challenges in resource-constrained environments.