SQHN In-Country Survey Report
January 2014
EXECUTIVE SUMMARY

Background
The Society for Quality in Healthcare in Nigeria (SQHN) was incorporated in May 2006 as a not-for-profit, charitable organization which has multidisciplinary involvement and governed by a constitution, with its focus to bring about a wider understanding and acceptance of Quality in Healthcare towards improved patient outcomes and reduction in healthcare delivery costs. SQHN, since its inception, has advocated for the need of sharing best practice and successful strategies among healthcare professionals throughout Nigeria. In line with this need, in November 2011, SQHN developed an overall goal of interviewing identified multidisciplinary healthcare senior leadership and front-line professionals (known as key informant stakeholders) to gain an understanding of the perception and the state of healthcare quality in these healthcare organizations in Nigeria.

Objective
The overall goals of the key informant interviews were to:

• Interact with identified stakeholders in the healthcare industry, in order to further understand the existing regulatory and quality assurance frameworks in operation in private and public healthcare sectors.
• Develop an understanding of the contextual realities of implementing quality management systems within each stakeholder’s organization.

Methodology
Methodology employed was identification of key stakeholders in the Nigerian healthcare industry and selection of key informants to be interviewed. A questionnaire was developed and used as an interview tool with subsequent analysis of responses along common themes and variations.

Results
All the key informants from the 20 organizations had extensive quality management program backgrounds spanning work experience in clinical practice and healthcare administration.

Respondents’ opinion on issues with Quality Management
Concerning the respondents’ opinions about Quality Management, the common themes, opinions and suggestions are as follows:

Major challenges people with quality management expertise faced while managing the program in healthcare facilities included lack of uniform collaboration between healthcare organizations e.g. high patient; doctor ratios and substandard facility infrastructure. Severe resistance to change from healthcare workers was also a major hurdle necessitating massive culture and attitudinal change. Lack of awareness of quality management by healthcare professionals and financial constraints were also noted as major impediments to quality management implementation.

With respect to quality management, risk management and regulatory reporting mechanisms, one of the
private hospitals that participated in this survey is JCI- accredited, while three others are COHSASA-accredited healthcare, and one more facility is ISO 15189 standards accredited. These ISO standards require the implementation of 12 different essential quality elements (such as verifiable testing procedures and processes, protocols/policies, standard documentation, etc.) Another facility is in the process of applying for ISO 15189 standard accreditation within the next 12 months. Several hospitals track and review non-clinical outcomes, championed by in-house quality teams. A state ministry of health has also implemented a patient-centric service charter in its hospitals.

*The table below is a comparative analysis of the COHSASA, JCI and ISO 15189 standards.*

<table>
<thead>
<tr>
<th>Accreditation/Certification</th>
<th>COHSASA – The Council for Health Service Accreditation of Southern Africa</th>
<th>The Joint Commission International</th>
<th>ISO 15189 Standard</th>
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</thead>
<tbody>
<tr>
<td>Accreditation/Certification Description</td>
<td>COHSASA is a not-for-profit professional non-government organization (NGO). It has no shareholders or executive directors. It seeks to ensure that all patients have access to equitable, quality health care</td>
<td>TJC is a United States (U.S.) based non-profit organization. The majority of U.S. state governments have come to recognize TJC as a condition of licensure and receipt of Medicaid reimbursement. JCI was established in 1994 as a division of Joint Commission Resources (JCR).</td>
<td>This lab-specific certification covers essential elements for medical laboratories to demonstrate the quality and competence of their services and the consistent delivery of technically valid test results as they are known in the standard. Originated from two ISO standards: ISO 9001 and ISO 17025.</td>
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<tr>
<td>Approach</td>
<td>Collaborative approach to survey focused on improving quality of care and services. For example, healthcare staff members are often involved in training offered by COHSASA. In addition, COHSASA offers training in quality improvement methodology, monitoring and evaluation and adverse event management, monitoring and reporting systems and research capacity to measure impact System-based approach with a focus on technical, managerial, administrative, infrastructural and support systems</td>
<td>Inspection approach, looking for deficiencies</td>
<td>It involves the independent assessment of a laboratory to determine competence, impartiality and consistency. Inspection approach, looking for deficiencies focuses on the qualifications and ongoing competency of personnel involved in medical laboratory examinations, laboratory equipment, reagents and supplies, pre-analytical and analytical factors, quality assurance considerations and post-analytical factors.</td>
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<tr>
<td>Requirements for Accreditation</td>
<td>COHASA rewards improved service provision by using Pre-Accreditation certificates at Progress, Entry and Intermediate levels. There are 2 kinds of programmes: 1) Self-Evaluation Programme to clients who are well versed in quality assurance and quality improvement, with an external survey undertaken at an agreed point; 2) Facilitated Programme for healthcare facilities that are unfamiliar with standards or the accreditation process. This includes a capacity-building element, which involves training staff in quality improvement methodology, as well as the direction of introduction of quality improvement projects in the facility.</td>
<td>The basic requirements for ISO 15189 certification are: well-documented procedure analysis by the laboratories; training manual; effective detailed analysis of medical laboratory procedures in a bid to ensure that all weaknesses have been identified; detailed evaluation reports of existing quality management system and other monitoring and evaluation reports; detailed audit of management reviews. Written by medical laboratory professionals Includes QMS elements, but also assesses a laboratory’s technical competence and its ability to provide reliable and accurate test data.</td>
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<tr>
<td>Survey/Audit Frequency</td>
<td>A facility with an initial two-year accreditation and two successive three-year accreditation awards (and no focus survey) will be awarded a four-year accreditation. An interim survey after two years is mandatory to ensure that standards are being maintained.</td>
<td>One on-site survey every three (3) years. This is also supplemented by annual periodic performance review by TJC.</td>
<td>Annual on-site survey/audit certification process</td>
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## Structure of Standards

**Accreditation/Certification**

- COHSASA – The Council for Health Service Accreditation of Southern Africa

**The Joint Commission International**

Prescriptive standards, which are frequently revised

**ISO 15189 Standard**

Developed through international expert consensus on medical laboratory best practices

The certification process involves a detailed assessment of internal processes. The criteria assessed are compliant or non-compliant. The criteria are focused on laboratory processes – the overarching QMS, and the organization’s ability to sustain an integrated QMS approach across all parts of an organization with which the laboratory interacts.

## Process Measures

**The process measures whether systems are in place to ensure that the correct things happen**

**The process measures whether required activities and actions have been carried out, required consumables, medicine, technology are available, etc.**

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## Scoring

**Aggregate scoring, with a minimal standard requirement category**

**Aggregate scoring that impacts the organization’s accreditation status. For example, only one instance of non-compliance could result in a finding that directly impacts the aggregate scoring in determination of accreditation status**

**Pass or fail scoring system**

Major difficulties facing clinicians in helping their patients understand the importance of quality management include poverty or low-income levels in some patient populations, often results in problems with accessing quality health care organizations, especially in the private health sector. Low literacy levels in some patient populations as well as cultural barriers also hamper the delivery of quality healthcare.
There appears to be issues in the Pharmaceutical sector where there is no consistent regulatory oversight or gate keeping pharmacovigilance process for medication management. All the key informants from the organizations believe that everyone working in the healthcare industry will benefit from quality management training. Majority of respondents are of the opinion that a Public-Private organizational focus was the best way to manage Quality Management programs in Nigeria.

Majority of respondents were of the view that a quality management outcome should consist of both clinical and non-clinical parameters, as well as be quantitative and non-quantitative, while the common barriers to participation in a quality management program included knowledge gaps for healthcare personnel, lack of funding for sustainability and resistance to change by healthcare workers.

**Respondents’ opinion on solutions to issues with Quality Management**

All the key informants from the 26 organizations re-iterated the critical need for training programs addressing the basic principles of quality management systems, specific discipline-related trainings (e.g. customer service, environment of safety, environmental infection control and waste management topics, clinical safety topics, etc.) Leadership training is also needed to improve resource development.

Multi-disciplinary round-table discussions are necessary. There should be representatives present from the government (only for their advisory input), professional licensing agencies, professional associations, HMOs, outpatient facilities (such as clinics, laboratories, radiotherapy centers, etc.), a few patient representatives who have experienced preventable healthcare-related illnesses (e.g. falls, infections, etc.)

The ISO 15189 was the most popular scale of quality management programs assessment with laboratory professionals and is used for laboratory accreditation. It is a measure of the technical competence and quality management of medical laboratory staff members. Other scales of measurement familiar to healthcare administrators interviewed include Six Sigma and Lean management.

JCI, ISO, EFQM (European Foundation of Quality Management), COHSASA, and AHRQ (American Healthcare Research and Quality) were the quality management programs respondents were aware of.

**Conclusions**

All respondents interviewed during this survey agree on the need for an umbrella organization to champion a formal quality management program in the Nigerian healthcare industry.

All respondents also agree that quality management expertise is required by all workers in any healthcare setting i.e. both clinical and non-clinical personnel.

The respondents interviewed in the public sector (Federal regulators and State level) also appear to be open to collaborate with an “expert quality management organization” towards achieving their existing quality management objectives. One area for such collaboration is in Continuous Medical Education (CME).
Recommendations and Action Plans

The Quality Improvement (QI) program in Nigeria should involve public-private partnerships, with extensive collaboration with technical partners, who already have an existing scalable step-wise Quality Management program and Accreditation process in place.

Healthcare facilities should be assessed under the QI program for the following indicators: healthcare infrastructure, skills set and expertise of personnel, and safety processes for both patients and healthcare workers. A stakeholder meeting should be convened by SQHN to chart a road map for the QI program in Nigeria, whilst working with identified quality champions across the healthcare industry.
INTRODUCTION (Study Background and Aims)

The Society for Quality in Healthcare in Nigeria (SQHN) is an organization that is focused on quality in healthcare delivery. SQHN is a member-based not-for-profit organization that aims to build capacity while providing a platform for Continuous Professional Development (CPD) in the healthcare industry, focused on Quality Assurance (QA), Quality Improvement (QI), patient safety, and improved patient outcomes. SQHN has been accredited by the MDCN as a CPD provider.

On November 11, 2013, the Society for Quality in Healthcare in Nigeria (SQHN) selected Independent Consulting companies to conduct interviews with key informants in multiple states in Nigeria. These key informant interviews, together with other planning efforts, will facilitate key expert discussions for developing and meeting the following SQHN’s core objectives over the next few years:

- Provide a national voice on quality improvement and risk management initiatives in healthcare
- Facilitate opportunities for communication, cooperation and exchange of ideas and experiences in healthcare quality
- Promote the principles and practice of quality improvement and risk management in healthcare
- Facilitate training and continuing education in healthcare quality
- Develop and foster alliance with related national and international bodies

The overall goals of the key informant interviews were to:

- Interact with identified stakeholders in the healthcare industry, in order to further understand the existing regulatory and quality assurance frameworks in operation in private and public healthcare sectors.
- Develop an understanding of the contextual realities of implementing quality management systems within each stakeholder’s organization.

METHODOLOGY

Approach to developing the Key Informant Interview Schedule: Starting on November 11, 2013, the Interview Consultants began collaboration with SQHN staff on a rapid turnaround schedule for the key informant interviews. After a pilot test interview with the first key informant, some of the questions were re-ordered to improve question flow and other questions were revised to improve clarity and reduce interview length.
Setting up the Key Informant Interviews: The initial approach for requesting the interviews was made via text messages and letters sent via email. The text messages were sent and letters were emailed to each potential key informant, explaining why the interview was being requested, asking the person to participate, and saying to expect the Independent Consultants to set an appointment for each in-person interview.

Conducting the Interviews: Between November 11 and December 15, 2013, a total of 26 key informant interviews were conducted, for a response rate of 74% (see Appendix A for a table showing the list of the key informant interviews completed (as of December 15, 2013) by category of healthcare sector type, e.g. HMO, self-regulated institution, etc.).

Analyzing Results and Creating a Report: For each question in the interview schedule, a document was created on which a brief description of each key informant’s views was tabulated. As interview responses were initially summarised, the document reflected the extent of commonality and variation in responses across informants.

QUALITY DEFINITION

International Definitions of Quality

There is no collectively accepted definition of “quality.” Within the global healthcare community, the definition from the US Institute of Medicine (IOM) is usually used: “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”¹ In a similar vein, Dlugacz, Restifo, and Greenwood (2004) define quality more explicitly to be “care that is measurably safe, of the highest standard, evidence-based, uniformly delivered, with the appropriate utilisation of resources and services.”

There are six generally-accepted dimensions of quality, as laid out by the IOM:

- **Safe**: avoiding injuries to patients from the care that is intended to help them; the WHO defines “patient safety” as the prevention of errors and adverse effects to patients associated with health care
- **Effective**: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit
- **Patient-centred**: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions
- **Timely**: reducing waits and sometimes harmful delays for both those who receive and those who give care
- **Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy

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²Ibid.

Dombrowski A. Explorations in quality assessment and monitoring: the definition of quality and approaches to its assessment.
Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.\(^2\)

While the IOM defines dimensions of quality, other models describe frameworks to evaluate care. The Donabedian Model, for instance, is a framework used to evaluate quality of care. Based on this model, information about quality of care is drawn from three categories: **structure, process, and outcomes**.

- Structure is the background in which care is delivered, which includes hospital buildings, staff, financing, and equipment.
- Process refers to interactions between patients and providers during the provision of healthcare.
- Outcomes refer to the consequences of healthcare on the health position of patients and populations.\(^3\)

The Juran Trilogy summarizes three magnitudes to quality: Quality Planning, Quality Assurance, and Quality Improvement\(^4\):  

**Quality Planning** involves determining the requirements that a health care system must meet, and establishing the goals and strategy to fulfil these needs. Quality planning involves creating a framework that provides the right care to patients at the right time, every time. It is anchored mainly on key doctrine laid out by W. Edwards Deming:\(^5\)

- Systems produce results
- Data, especially variation in performance, reveals how the system functions
- The system must create, adapt to, and disseminate new knowledge
- Humans ultimately do the work; the system must be fashioned around human psychology

**Quality Assurance (QA)**, or Quality Control, is often the starting line for a country’s quality sojourn. QA is typically a regulatory framework to ensuring quality remains at or above baseline expectations. QA could include accreditation, licensing, empanelment of facilities, etc. Often these are key government or parastatal functions to ensure a certain level of quality with a broad stroke. Viewed within the Juran Trilogy, it is apparent that QA is a key component of a quality strategy, which must be tightly incorporated with planning and improvement activities.

Finally, **Quality Improvement (QI)** allows a system achieve a new level of performance beyond what QA requires. QI is a continuous process whereby organizations iteratively test and measure changes, achieve ambitious aims, and spread best practices.

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\(^{2}\text{Ibid.}\)

\(^{3}\text{Donabedian A. “Explorations in quality assessment and monitoring: the definition of quality and approaches to its assessment,” Ann Arbor, MI: Health Administration Press; 1980.}\)


\(^{5}\text{Deming W. System of profound knowledge. The New Economics. Cambridge, MA: Cambridge Center for Advanced Educational Services, Massachusetts Institute of Technology; 1994.}\)
Approaches to Quality Improvement

Within QI, there are several modalities to foster change and hasten the improvement of quality. These concepts include:

**Lean Enterprise (Toyota Production System TPS)**

Lean Enterprise is a set of concepts, principles, and tools used to create and deliver the most value from the customer’s perspective while consuming the fewest resources in transforming the organization. The Lean Thinking model focuses on:

- **Purpose**: What customer issues will the organisation solve to achieve its own purpose of thriving?
- **Process**: How will the organisation gauge each key value chain to make sure each step is value adding, capable, available, sufficient, malleable, and that all the steps are linked by flow, pull, and levelling?
- **People**: How can the organization guarantee that every process has someone responsible for continually evaluating that value stream? How can everyone interacting with that value stream be actively occupied in operating it rightly and constantly improving it?

Lean ideology defines a model of revolution that concentrates on: recognise value; comprehend value stream; eradicate waste; institute flow; facilitate pull, and chase perfection.

**The International Organization for Standardization (ISO)**

ISO is an international standard-setting body that publishes over 19,500 international standards. It concentrates on improving quality through standards, a document that provides requirements, specifications, guidelines, or characteristics that can be used consistently to ensure that materials, products, processes, and services are “fit for their purpose.” The most relevant to healthcare is ISO 9000 – Quality management.

**CURRENT STATE OF QUALITY IN NIGERIA**

**EVALUATION ON DISEASE PRIORITIES**

An ideal healthcare quality strategy for Nigeria needs to focus on interventions within disease areas that are feasible and lead to the greatest impact on the current national drivers of mortality and morbidity.

Deaths from communicable, maternal, perinatal, and nutritional conditions account for 67% of all mortality, while mortality attributed to NCDs is estimated at 27%. The rates of maternal and infant mortality have decreased, though maternal mortality rates remain high at 630 maternal deaths per 100,000 live births, thus making maternal health a key priority. Maternal haemorrhage, infection, toxaemia/eclampsia, obstructed labour, unsafe abortion, anaemia, and malaria rank (in descending order) as the largest contributors to maternal mortality. Antenatal coverage suffers from significant geographic

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6WHO NCD Country Profile, 2011.  
7WHO Health Profile, 2011.  
8NSHDP, 2010-2015.
disparity (lowest rates in northern Nigeria). Only 58% of women receive some antenatal care nationally, while 36% of women receive no antenatal care.\textsuperscript{9} Significant regional variation in infant and under-five mortality rates exist, with the highest burden zones in the northwest and the lowest burden in the southwest.\textsuperscript{10} 70% of under-five deaths can be contributed to preventable infectious disease (e.g., malaria, pneumonia, diarrhoea, and HIV/AIDS).

At the same time, NCD is on the rise in Nigeria with an expected 54 million deaths in 2010 attributed to cardiovascular disease, cancer, diabetes, chronic respiratory conditions, among other NCDs. Figures are expected to rise. Injuries also contribute to 5% of the total mortality.\textsuperscript{11} Road traffic accidents are of particular concern. The overall road traffic injury rate stands at 41 per 1,000 and a 1.6 per 1,000 mortality rate.\textsuperscript{12} Victims within Nigeria experience 29.1% disability and 13.5% are unable to return to work post-injury.\textsuperscript{13} With variable access to emergency care, coupled with generally poor quality of emergency services, expanding the capacity of healthcare to better handle A&E is of great importance.

RESPONSIBILITY OF POLICYMAKERS IN MOTIVATING QUALITY

Function of the FMOH and parastatals

Nigeria’s public health infrastructure comprises a FMOH, 37 State Ministries of Health (SMOHs), and approximately 1,300 primary health centres (PHC) serving 774 Local Government Areas (LGAs). At the policy level, the FMOH develops and implements policies and programs that should deliver quality care that is effective, efficient, and affordable. The FMOH has seven departments directly reporting to the Minister. They are: Department of Family Health (DFH); Department of Finance and Account; Department of Health Planning, Research, and Statistics (DPRS); Department of Hospital Services (DHS); Department of Human Resources; Department of Procurement, and Department of Public Health. Other government parastatals, though semi-autonomous, have a direct reporting line to the FMOH.

The FMOH and the federal parastatals - semi-autonomous bodiesthat report to the FMOH—play a key role in influencing many aspects of quality delivery within the healthcare arena. As a policy maker and implementer, the FMOH provides healthcare at the tertiary level through the DHS. As a regulator, parastatals - such as the Medical and Dental Council of Nigeria (MDCN), the Medical Laboratory Scientist Council of Nigeria (MLSCN), Pharmacists Council of Nigeria (PCN), and the Nurses and Midwifery Council of Nigeria (NMCN)—accredit and regulate healthcare professionals and facilities. The FMOH and associated

\textsuperscript{9} Nigerian Demographic and Health Survey, 2008.
\textsuperscript{10} Multiple Indicator Cluster Survey 4 (MICS4), 2011.
\textsuperscript{11} WHO NCD Country Profile, 2011.
parastatals also serve as a human resource provider. Across the primary, secondary and tertiary levels, the National Youth Service Corps, the Midwife Service Scheme (MSS), and the Subsidy Reinvestment and Empowerment Program (SURE-P) represent federal efforts to supply human resource capacity to facilities. The FMOH also functions as a healthcare purchaser through the NHIS. Parastatals also utilize tools such as regulation, accreditation, and customer feedback to drive quality under a regulatory framework.

While the FMOH is responsible for crafting and supporting implementation of national policies that promulgate quality of healthcare delivery, implementation is often hindered because of the restricted influence of the FMOH over states and LGAs.

### Situational analysis of national-level parameters to promote quality

Focusing on the FMOH’s direct sphere of control, one of the main parameters of quality that the FMOH directly oversees is the nation’s tertiary hospitals. Nigeria has 53 federal tertiary hospitals, which consist of teaching hospitals, federal medical centres, and national eye centres. These federal tertiary hospitals are directly supervised by the DHS, which directly reports to the Minister at FMOH. The DHS directly appoints CMDs at the tertiary hospitals and develops policies on nursing, coordinates training programs for nurses, and supervises health research. While the DHS monitors and holds tertiary hospitals accountable, the degree to which tertiary hospitals deliver patient-centred, safe, effective and efficient care is largely up to the individual hospital itself. For example, one tertiary hospital working to institutionalize a high quality laboratory management system that improves supply chain management and reduces waste. They hope to spread it to other departments in the hospital. Adopting contextually appropriate interventions to improve the quality of service delivery at individual hospitals is important, but a unified agenda that can galvanize improvement efforts across the tertiary hospitals will encourage broader support and adoption of QA and QI activities.

Also tied into tertiary hospitals is SERVICOM, a presidential initiative designed to receive and redress complaints from the public. Personnel are embedded within government agencies and tertiary hospitals and are charged with responding to customer complaints. The Consumer Protection Council (CPC) also serves a function of reviewing complaints about health-related products and services to ensure basic standards. Given the importance of client- and patient-centred care in improving quality, SERVICOM and the CPC can serve as an important resource to broaden conversations around patient safety and experience.

A second parameter that the FMOH can use to influence quality is primary care. The NPHCDA, a parastatal, develops policies for primary healthcare, conducts research, and runs the MSS and the SURE-P for maternal and child health at the primary care level. SURE-P aims to reduce maternal and newborn morbidity and mortality by increasing access to quality health delivery services. The NHIS and National Agency for the Control of AIDS (NACA) are also involved in the SURE-P project, a strong example of

.........sharing healthcare best practices
interagency collaboration. Although influenced at the national level, accountability for quality within PHCs is more diffused, shared across the federal, state, and local levels, as highlighted in more detail below.

The FMOH has shown leadership in positioning the SURE-P program as a way to achieve the objectives of Saving One Million Lives (SOML). The Saving One Million Lives Initiative is a public-private partnership which aims to save 1 million lives in Nigeria by 2015. These lives will be saved by delivery of proven, cost-effective, basic health interventions, particularly focusing on women and children. SURE-P was designed as a component of the SOML initiative but is financed at the federal level through the SURE-P committee. This additional resource allocation can boost the reach of SOML initiative, thereby ensuring its goals are realized. The MSS and SURE-P projects have also prepared human resources and infrastructural frameworks that delineate the structural components needed for SOML success. SOML is also being used as a platform to refocus leadership from a services input-based approach to an outcomes and evidence-based approach, which gives facilities clear deliverables and a larger tool to increase accountability and transparency. The degree to which the FMOH can ensure the sustainability of such initiatives, particularly around human resource provision, remains to be seen. In the case of the MSS, the requirement for states/LGAs to share a proportion of overall midwife remuneration has not been fulfilled by many states.

Beyond individual influence at the national, state, LGA levels, as well as oversight of the NHMIS, the FMOH national oversight of regulatory agencies is also an integral component of creating systems supportive of safe and effective care. FMOH parastatals—such as MDCN, NMCN, MLSCN, and PCN—influence quality by managing licensure for the respective professions at a national level. However, their capacity for enforcement is limited, so enforcement of professional standards is often left to the states and facilities that hire health professions. Closer integration of national and state level regulatory efforts is critical to the strategy’s success. Further detail on the roles and opportunities for regulatory agencies are provided below.

**Function of states in promoting quality**

The SMOHs set policy that can influence quality at the state and facility level. Whereas the FMOH manages tertiary hospitals through the DHS, the SMOH manages secondary facilities (i.e., general hospitals) through the state’s Hospital Management Board (HMB). The HMB supervises, monitors, and evaluates activities of secondary level facilities, and is also a signatory to each hospital’s Consumables Revolving Fund to run their activities. Therefore, the HMB plays a large role in funds disbursements to secondary level facilities.\(^\text{14}\)

In terms of the state-level PHC system, the PHC department of the State Ministries of Local Government and Chieftaincy Affairs (SMoLGA) provide some level of management support to PHCs (funding allocations) while the SMOH provides programmatic support.

One example of a state mobilising resources to systematically improve health care quality is Lagos State. The Lagos SMOH has made advances in attempting to improve patient care and safety with a state-wide quality strategy being implemented in its facilities. A quality team exists at the SMOH and a participatory

approach has been adopted that is inclusive of the CMDs and the hospital management teams. A decentralized hospital services board exists in Lagos, with each hospital run by a management team. The state gives awards to facilities that have met certain pre-determined standards and this has created healthy competition between the facilities in the state. In sum, coordination among state-level HMBs and SMoLGAs can influence quality efforts at both the secondary and primary care levels.

Function of the LGAs in promoting quality

Working closely with SMOHs, the LGA is responsible for managing PHCs. However, unlike tertiary hospitals who directly report to the FMOH through the DHS and secondary hospitals who directly report to the state HMB, all three tiers of government—LGA, state, and federal—exert some level of influence over PHCs. Each level has some role in PHC service provision, financing, supervision, and human resources. LGAs are responsible for routine supervisory visits to PHCs; however, it appears supervision occurs irregularly and when it does happen, little information exchange happens at this time. Notwithstanding, HMOs provide more regular supervisory visits to facilities accredited by NHIS. The use of ISS appears to vary and be dependent on the support of implementing partners. In some cases, there were complaints about the comprehensiveness of the ISS checklist limiting its usefulness. Accountability for quality at the PHC level, therefore, is overlapping across multiple levels and agencies, described in more detail below. However, since LGAs are more closely linked to local community activities—specifically those related to PHCs—there are opportunities to influence quality at the VHC and WDC levels, as well as focusing attention on the need for continuous data feedback to support quality.

FUNCTION OF ROLE OF REGULATORS IN PROMOTING QUALITY

Professional regulatory agencies and associations

Professional regulatory agencies in Nigeria operate under a centralised structure with zonal and regional offices nationwide. Professions such as doctors, dentists, and pharmacists are regulated by their respective regulatory agencies, which are in turn governed by statutory acts. Most operate a similar basic core set of regulatory functions, namely:

- Registration and Licensing
- Setting of professional ethics and standards
- Best practice and patient safety promotion
- Continuous professional development
- Regulation of professional education
- Professional discipline and malpractice
- Reporting of data
- Community participation

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FMOH parastatals—such as MDCN, NMCN, MLSCN, and PCN— Influence quality by managing licensure for the respective professions at a national level. However, their capacity for enforcement is limited, so enforcement of professional standards is often left to the states and facilities that hire health professions. Professional associations— such as Nigerian Medical Association (NMA) and the Association of General and Private Medical Practitioners of Nigeria— also lobby and advocate on behalf of their professions.

FUNCTION OF PROVIDERS IN PROMOTING QUALITY

Providers from tertiary facilities to primary health facilities have a number of levers at their disposal to improve quality. These include:

Use of financial and non-financial incentives

Financial incentives include payments linked to improved quality. While this is growing in popularity, there is no evidence that shows this is a sustainable solution to improve quality.

Non-financial incentives may include reward and recognition. A secondary hospital in Lagos, for example, highlights Employee of the Month with a photograph displayed in a prominent part of the hospital. This type of recognition sets model behaviour thereby hoping to increase motivation across the workforce.

Education and training

Facilities sponsor continuous medical development for their staff. They can influence whether hospital staff attend QI trainings. One tertiary hospital in Lagos, for example, routinely sends staff to international trainings. At the PHC level, the degree to which PHC staff receive support (ranging from facility standards, clinical guidelines and protocols) seems to be largely dependent on geographic location, presence of implementing NGO partner support, and relationships with LGA HQ office.

Information Communication Technology

There has been an increase in the use of technology whether mobile technology at the PHC and LGA level e.g. in the case of MADEX for strengthening data reporting or for electronic medical record systems. For example, Lagos state has embarked on rolling out an electronic medical record (EMR) system. The Lagos State Isolo General Hospital has been deemed a “shining” example of integrating eHealth interventions into its operating principles. This has been supported by a partnership between the IT and health departments while being led by the vision of the Chief Medical Director. These types of innovative partnerships and programmatic roll-outs can be led by providers, couched in their ability to influence quality.

Reporting of adverse event and patient complaint tools

A reliably implemented adverse event reporting system across facilities at all levels of care is critical to ensuring QI in Nigeria. Although there are reports of adverse event systems being embedded in some facilities, there is no nationally endorsed list of serious adverse events (as in the United States where the National Quality Forum has such a list) that facilities can leverage as a standard by which they can measure
their performance in reducing preventable harm. Such a list integrated in a nationwide adverse event reporting system that links regulators, providers and the public where there are clear mechanisms by which adverse events can be reported, analysed and widely disseminated is critical to augmenting patient safety.

**FUNCTION OF THE PRIVATE SECTOR AND NON-GOVERNMENTAL PARTNERS IN PROMOTING QUALITY**

QI in Nigeria’s healthcare system is carried out by an immense range of actors using differing methodologies and accountable to different people and entities, many operating in parallel silos.

**Current landscape of QA and QI initiatives in Nigeria**

In many countries, QI is a loosely defined and an underdeveloped component of an overall health for improving quality; in Nigeria there are a handful of examples of QA and QI initiatives with a clear steering towards the HIV/AIDS and MCH sectors. This fact is likely reflective of the global movement across many NGOs to use QI methodologies as a vehicle for testing innovation at the frontline level.

Non-governmental partners play a significant role in introducing systematic methods for QI and QA in both private and public sector facilities and scaling up across states and LGAs. A review of available documents supplemented with interviews of select non-governmental partners revealed a broad range of QI tools, terminology and methodologies being implemented with the unifying aim to improve the quality of health care. There are commonalities across different methodologies being used, but failure to see the commonalities is creating a barrier to communication among QI partners and is impairing overall coordination. That said, recently developed Nigeria Quality framework for the HIV/AIDS sector is a concerted multi-partner attempt to achieve synergy across their respective QI activities.

In addition, one of the facilities interviewed outlined the role of its partnership with an independent organisation to deliver healthcare services to its enrollees, to increase access to quality basic health care through risk-pooling and health insurance for over 100,000 currently uninsured Nigerians.

A handful of organizations are using all parameters for their quality improvement programmes:

**Society for Quality in Healthcare in Nigeria (SQHN)**

The Society for Quality in Healthcare in Nigeria was incorporated in May 2006 as a not-for-profit, charitable organization which has multidisciplinary involvement and governed by a constitution, with its focus to bring about a wider understanding and acceptance of Quality in Healthcare towards improved patient outcomes and reduction in healthcare delivery costs. This will also be a platform to share best practice and successful strategies.

SQHN’s mission is to lead, advocate and facilitate the continuous improvement of quality and safety in healthcare in Nigeria through Education, Collaboration, Training and Accreditation. The Society’s activities include:
**Training:** SQHN is accredited by the MDCN as a CPD provider and also facilitates and assists individuals who are interested in pursuing the Certified Professional in Healthcare Quality (CPHQ) program. The CPHQ program is an international voluntary certification program in the field of healthcare quality management. It is the only certification program in healthcare quality management to achieve full accreditation by the National Commission for Certifying Agencies (NCCA) of the National Organization for Competency Assurance in Washington D.C. USA.

**Workshops and seminars:** The Society organises quarterly workshops and seminars spanning different subject areas in Quality Management. Recent seminars covered topics including biosafety and infection control, patient safety, medical waste management and quality management in laboratories.

**Conferences:** SQHN holds an annual conference for its members and the general public. A recent conference focused on Safety, Standards and Customer Service with renowned national and international speakers in attendance.

**Pharmaccess/SafeCare**

Pharmaccess/SafeCare has developed “SafeCare Standards” that are International Society for Quality in Health Care accredited and focused on implementation in resource-limited settings. Using a stepwise approach, a clear improvement trajectory coupled with reinforcing incentives aims to effect large-scale change by use of QI methods. The standards currently focus on 13 dimensions of service delivery, including: management and leadership; human resource management; patient rights and access; risk management; primary healthcare services; laboratory service, medication management, and support services. The SafeCare system of stepwise recognition of improvements allows for the introduction of practical performance-based financing incentives. Healthcare facilities can be rewarded on the basis of adherence to pre-defined improvement steps and such incentives will improve their business model. In addition, the SafeCare system, if applied at scale, allows for benchmarking and data-driven resource allocation which would enable a more efficient use of available resources. Donors, investors and governing bodies are able to use the data collected in the upgrading and quality improvement process about the status quo in individual facilities or across groups of facilities to make strategic and cost-effective decisions about how funds are allocated and if they are allocated efficiently and effectively. SafeCare sets the standards for meeting basic safety demands and this will likely impact child and mother mortality rates which are particularly high among low-income groups. SafeCare is currently engaged with the FMOH to roll-out the SafeCare standards and methods to PHCs in six states. This effort demonstrates the momentum around adoption of accepted quality standards at the PHC level. This work will be integrated into the broader strategic interventions.

**Hygeia Community Healthcare (HCHC)**

HCHC is implemented on behalf of Health Insurance Fund (HIF) by PharmAccess and in Nigeria they have contracted Hygeia Nigeria Limited as the local implementing partner. The benefit package provides coverage for the most common medical problems found among the target groups and consists of primary
care, limited secondary care and medication, including HIV/AIDS treatment. The scheme currently has over a 100,000 enrollees.

The insurance is currently available for five groups:

- The first target group consists of approximately 40,000 people, market women and their families in Lagos. The women are organized in market associations. They trade a wide variety of products.
- The second target group consists of approximately 27,500 people, workers of small business that are part of Computer and Allied Products Dealers Association of Nigeria (CAPDAN) an umbrella organization for small- and medium sized enterprises (SMEs) and their families in Lagos.
- The third, fourth and fifth target groups consists of approximately 165,000 people, farmers and their families in rural farming community of Kwara Central, Kwara North and Kwara South in Kwara State.

HCHC has contracted 21 healthcare providers to deliver healthcare to the enrollees. The provider network is involved in a continuous quality improvement program. Through the quality improvement program, HCHC and PharmAccess support the providers to continuously improve the quality of care. The QI program includes upgrades in the form of improved infrastructure, procurement of vehicles, equipment and consumables and training of personnel. Having been integrated into the Safecare program, the quality of the care can be easily monitored and evaluated.

**Applying Science to Strengthen and Improve Systems Project (ASSIST)**

**Aim**

ASSIST, funded by USAID and implemented by University Research Co. (URC), has been working on a national orphans and vulnerable children (OVC) programme with PEPFAR/Nigeria and the Federal Ministry of Women Affairs and Social Development (FMWASD) designed to improve the well-being of vulnerable children and caregivers through a sustainable, comprehensive, and coordinated response.

Key objectives of the program include strengthening institutional, organizational and technical capacities of government and civil society with a focus on health, education, economic growth, and other social services. URC is also working on building capacity of partners and government in the design, collection, analysis, dissemination and learning from data.

**Approach**

A key aspect of their program is to collaborate with partners, including Management Sciences for Health (MSH) and governmental bodies, to design appropriate and useful community-level data and support for rapid small tests of change that enable them to assess their progress towards specific OVC indicators outlined in the recent FMWASD national OVC standards policy document. In addition, they conduct
supportive supervisory visits to states/LGAs and sub-grantees to observe, monitor, provide guidance, and quality feedback on the use of OVC data and indicators.

ASSIST is a global QI project working to improve clinical processes and outcomes across a number of care settings and programmatic areas. As the USAID flagship initiative on improvement science, ASSIST brings with it expertise in improvement science and implementation, including how to spread and scale-up QI initiatives. Although focused on OVC care currently, the rigor of ASSIST’s methods can serve as an exemplar for additional QI initiatives within Nigeria.

**Nigerian Alliance for Health Systems Strengthening (NAHSS)**

The Nigerian Alliance for Health Systems Strengthening (NAHSS) was recently developed to build capacity in sustainable clinical quality through partnership with NASCAP, NACA and several partners, such as FHI360, MSH, and Institute for Human Virology Nigeria(IHVN). NAHSS is partnering with HealthQual International, IHV Nigeria, Solina Health and GHLI, Ltd. to develop NigeriaQual, a technical QI program to equip both tertiary, secondary and primary sites, and state and local government to make data driven decisions to improve patient care. The focus is on initially supporting PEPFAR-funded partners through QI capability training programs in clinical care and logistics, finance and supply chain management with the intent to expand beyond the HIV/AIDS sector. The NigeriaQual framework represents an effort to align and coordinate the existing QI efforts in HIV in the country.

**Partnership for Transforming Health Systems Phase II (PATHS2)**

PATHS2, a DFID-funded initiative managed by Abt Associates, is a six-year programme designed to improve the capacity of five states—Enugu, Kaduna, Kano, Jigawa, and Lagos—and local health systems to finance, manage and deliver sustainable and replicable pro-poor health services for common health problems in Nigeria. The programme is designed to strengthen the existing system of care with a focus on the development of stewardship at the federal level and support to the states to put social accountability mechanisms for health services and complaint systems into place. Additionally, PATHS2 focuses on mobilizing and strengthening existing systems of community structures, such as WDCs and VHCs, as a means to mobilize the demand side of quality services.
RESULTS

The interview schedule included fifteen total questions, with the first 2 questions focused on verifying the key informant’s contact information and the key informant’s brief description of his/her background with or knowledge of quality management programs.

The common themes, opinions and suggestions from the respondents are outlined below:

**Individual background and knowledge of quality management programs:**

All the key informants from the 20 organizations had extensive quality management program backgrounds spanning clinical practice and healthcare administration.

**Respondents’ Opinions about Quality Management**

**Common challenges people with quality management expertise face in managing the program in healthcare facilities**

There is no uniform cross-collaboration between healthcare organisations (i.e. inadequate number of qualified healthcare personnel for patient care (e.g. high patient: doctor ratios). Substandard facility infrastructure, especially since the advent of managed care and increase in out-of-pocket expenses was also a widely reported challenge in Nigeria.

Severe resistance from staff as the institution of quality management involves massive culture/attitude change and it was unanimously agreed that changing the mindset of Management staff requires that their work attitudes be changed. A respondent remarked that “Healthcare workers here have to realize that they need to show empathy to all patients at all times”

Another important challenge with Quality Management is financial constraint. A private hospital owner lamented that “Quality Improvement costs money”. The limited finance available to quality practitioners is worsened by the fact that Nigerian Financial Institutions are less likely to offer low-interest loans to healthcare facilities and other healthcare agencies.

Basic infrastructural issues (e.g. irregular electricity and lack of clean water supply and medical consumables, healthcare environmental degradation and sanitation issues, etc.) plague a lot of healthcare organizations and therefore remains a big challenge in Nigeria. There is also a need for Information Technology (IT) support, particularly when electronic medical record charting systems are also used. In each organisation, there must be cross-interactions between all the areas within the organization (e.g. between patient registration, outpatient clinic, lab, billing, etc.)

Lack of the awareness or knowledge (among healthcare personnel) about the need for quality improvement in healthcare settings is rampant, while building a system based on reproducible processes, policies and outcomes is very challenging.
Organization’s quality management, risk management and regulatory reporting mechanisms

One of the private hospitals that participated in this survey is a COHSASA-accredited healthcare facility with an initial accreditation for 2 years, and subsequent re-accreditation every 3 years, while another facility is ISO 15189 standards accredited. These ISO standards require the implementation of 12 different essential quality elements (such as verifiable testing procedures and processes, protocols/policies, standard documentation, etc.)

Another facility is in the process of applying for ISO 15189 standard accreditation within the next 12 months. Furthermore, in May 18 2011, one of the healthcare facilities became the 1st Hospitals in Sub-Saharan Africa to earn accreditation from Joint Commission International (JCI). The re-accreditation process for this facility is expected to be completed in 2014.

Several hospitals track and review non-clinical outcomes, which include: patient satisfaction survey results, waiting times and employee satisfaction survey results. They also track and review clinical outcomes, which include: adverse drug reactions, morbidity and mortality rates. Hospital-acquired infection and other acquired condition outcomes are also routinely monitored. Most hospital Quality Management initiatives are driven by hospital committees (such as Quality Committee, Clinical Governance Committee, Medical Executive Committee, etc.) that review patients’ clinical outcomes and other non-clinical outcomes

A state level organization also implements a “Service Charter” which focuses on the customer experience aspects of quality management.

Major difficulties facing clinicians in helping their patients understand the importance of quality management. Clinicians with the greatest need of trainings to promote quality management:

Poverty or low-income levels in some patient populations, often results in problems with accessing quality health care organizations, especially in the private health sector. A low literacy level in some patient populations is also a contributing factor in this cadre of patients. Cultural barriers exist in particular groups of patients which prevents them from holding their healthcare personnel accountable for delivering quality healthcare services.

Knowledge limitations exist regarding how to identify patients needing education about the importance of healthcare quality management, agencies/services that are available, and how to connect them, while existing agencies and systems are fragmented with approaches and patient outcome measures a not being unified.

Reimbursement (from health insurance options) for healthcare services to patients is often a tug of war. “The health insurance industry must have some legislative backbone and support” is an opinion voiced by the Medical Director of a private hospital.

There appears to be issues in the Pharmaceutical sector where there is no consistent regulatory oversight or gatekeeping Pharmacovigilance process for:

• Filling prescription medications for the right medication, patient, route and dose
• Checking or verifying the clinical competency of the prescribing clinicians for prescription medications, especially high-risk medications (e.g. narcotics, “last line” antibiotics, etc.)

There are a few Pharmacies who have instituted their own “gatekeeping” process by incorporating best practices in medication administration. The safety processes often take a longer time to complete, but some patients are not always patient with waiting for the due process to be completed.

Other healthcare professionals (apart from people with quality management expertise and clinicians) who should be targeted in training programs to improve quality management in your healthcare facility:

All the key informants from the organisations stated that quality management training programs should be offered to everyone (i.e. from the gatekeeper, doorman to the CEO-level). The key informants repeatedly stated that these training programs should include non-clinical components, such as customer services, conflict resolution, negotiation, etc.

Description of the agency or organization that should manage quality management

Majority of respondents are of the opinion that such an organization should be an independent, non-government agency or organization. The organisation should have input/guidance from the following bodies: multi-disciplinary healthcare providers (e.g. medical doctors, lab scientists, nurses, pharmacists and other allied health professionals, etc.), federal/state/local government, professional licensing bodies, regulatory bodies, professional associations, quality-trained patient representatives.

Public-private partnership collaboration was deemed as most appropriate. In the words of a respondent “This collaboration should cover both the public and private hospitals. I say collaboration because we need to learn how to collaborate with one another in Nigeria, and not focus too much on the competition between healthcare organizations, especially hospitals, clinics, laboratory, pharmacies, etc.” Another consenting opinion was “A public-private partnership is much needed. This has been proven to work in other developing countries in Africa. Most people don’t understand quality and what it really entails.” A CMD of a public hospital is of the opinion that the organization should not be one body but a mixture of independent bodies to rank institutions in conjunction with regulatory bodies.

Most important outcome a quality management program can achieve:

Majority of respondents were of the view that a quality management outcome should consist of both clinical and non-clinical parameters, as well as be quantitative and non-quantitative. Suggested clinical outcomes include reduced infection rates, decreased medication errors, decreased length of stay and decreased emergency response times, while non-clinical outcomes included waiting times, patient satisfaction, employee satisfaction or engagement, post-visit patient follow-up (which typically involves contacting the patient within a specified timeframe after hospital discharge from inpatient stay).
Common barriers to participation in a quality management program

Knowledge gaps exist (for healthcare personnel), in terms of what quality management programs are, while there are ongoing training needs once quality management systems are initiated. There is also a common call for legislative backing for quality in healthcare. “There needs to be a uniform legislative process for ensuring healthcare quality in all healthcare organizations. For now, any organization that is interested in quality improvement work is most likely involved in this work for due diligence” remarks a respondent.

There is an overwhelming need for consistent funding for quality improvement strategies to ensure sustainability over time. Change management amongst healthcare workers is also key for sustainability. People are often resistant to change for reasons including: fear of consequences e.g. punishment and reluctance to release information due to confidentiality issues.

The head of a Federal regulatory body also opines that Inter-professional wrangling and rivalry is a major detriment to quality management programs in Nigeria, which can be solved by exposing professionals to overseas health systems where healthcare professionals work in synergy and harmony.

Solutions to reduce identified barriers

All the key informants from the 26 organizations re-iterated the critical need for training programs addressing the basic principles of quality management systems, specific discipline-related trainings (e.g. customer service, environment of safety, environmental infection control and waste management topics, clinical safety topics, etc.) Leadership training is also needed to improve resource development (e.g. grant writing for more funding opportunities). Instituting Quality Improvement programs in any healthcare organization starts with unwavering leadership commitment to quality. Each leader will need to live by example by promoting a culture of quality within the organization.

Many respondents felt that an overall technical assistance, training and/or professional education support from a “Quality Expert” organization (such as SQHN) in Nigeria was also needed, while there is a constant need to continue to provide advocacy and/or public awareness campaign about the need for healthcare quality improvement strategies in every healthcare facility, agency or organization in Nigeria.

There is a need to eliminate difficulties in allocating scarce or limited resources, for example, balancing the need to spread resources to a large number of patients in a resource-limited setting versus giving the resources in a more focused way to a specific population or geographical area in a healthcare setting. Eliminating difficulties with determining and prioritizing quality measures (e.g. determining best practices, determining where to start, current organizational/administrative structures among agencies as well as their resistance to change, and a lack of community knowledge on healthcare quality improvement) was also noted as being key.
Key stakeholders that should be at the table when planning an intervention to promote quality management

Multi-disciplinary round-table discussions are necessary. There should be representatives present from the government (only for their advisory input), professional licensing agencies, professional associations, HMOs, outpatient facilities (such as clinics, laboratories, radiotherapy centers, etc.), a few patient representatives who have experienced preventable healthcare-related illnesses (e.g. falls, infections, etc.)

Knowledge of any scales or measures effective for assessing quality management programs

The laboratory science professional association is keen on ISO 15189, written by medical laboratory professionals. In order to become an accredited laboratory, there is a lot of focus on patient safety and reporting accurate test results. This ISO standard emphasizes the total service of a medical laboratory (i.e. consultation, turn-around time for tests, test costs, etc.). It is a measure of the technical competence and quality management of medical laboratory staff members. The Quality System Essentials include: organization, personnel, equipment, purchasing and inventory, process control, documents, records, information management, investigation of abnormal events, assessment, process improvement, service and satisfaction, facilities and safety.

Other scales of measurement familiar to healthcare administrators interviewed include Six Sigma and Lean management.

Other services most helpful in promoting effective quality management in any healthcare setting, outside of formal quality management programs

Services proffered by respondents include:

1. Informal quality assurance visits
2. Constant interaction with stakeholders e.g. enrollees, providers in the HMO industry.
3. Continuous professional development programs
4. Vision and mission of organization
5. ICT for knowledge deployment
6. Leadership of the institution has to support quality

Knowledge of any (other) quality management programs

JCI, ISO, EFQM (European Foundation of Quality Management), COHSASA, and AHRQ (American Healthcare Research and Quality) were the quality management programs respondents were aware of.
Other topics or questions not asked by interviewer, that respondents think are important for discussion

An HMO executive believes there is a need to determine whose view of quality is key: patients or doctors? While suggesting that a more composite approach was best for adoption. Another HMO executive feels the quality bar shouldn’t be set too high in Nigeria, as most international quality programs like JCI are not appropriate for Nigerian organizations because of their complexities. The head of a Federal regulatory organization is of the opinion that the Standards Organization of Nigeria (SON) be carried along by SQHN on its quality management initiatives as it is the apex body for quality in Nigeria.

CONCLUSIONS

1) All respondents interviewed during this survey agree on the need for an umbrella organization to champion a formal quality management program in the Nigerian healthcare industry.

2) All respondents also believe that such an organization should have a collaborative approach between the public and private sectors.

3) The most important constraints for organizations instituting quality management programs in Nigeria are resistance to change by healthcare workers as well as lack of required funding.

4) Change management initiatives; quality awareness; as well as availability of technical support and training in quality management are essential to overcome the identified constraints to participation in quality management in Nigeria.

5) All respondents agree that quality management expertise is required by all workers in any healthcare setting i.e. both clinical and non-clinical personnel.

6) Majority of the respondents are also of the view that the important outcomes of any quality improvement program should include both clinical and non-clinical parameters.

7) The respondents interviewed in the public sector (Federal regulators and State level) also appear to be open to collaborate with an “expert quality management organization” towards achieving their existing quality management objectives. One area for such collaboration is in Continuous Medical Education (CME).
RECOMMENDATIONS AND ACTION PLANS

1) The Quality Improvement (QI) program in Nigeria should involve public-private partnerships, with extensive collaboration with technical partners, who already have an existing scalable step-wise Quality Management program and Accreditation process in place.

2) There is need to carry along the Standards Organization of Nigeria (SON) on the QI program being the apex regulatory body for quality in the country.

3) Healthcare facilities should be assessed under the QI program for the following indicators:
   - Healthcare infrastructure (this should include the overall building structure, availability of water and electricity, availability of medical consumables, etc.)
   - Skills set, clinical/non-clinical competence and expertise of healthcare personnel – there should be at least minimum standard that is set, in collaboration with each healthcare professionals’ credentials and licensure certification/verification agency.
   - Processes ensuring safety of both patients and healthcare workers, and also with standardized remediation procedures (that are known to all healthcare workers), if the safety processes are not adhered to.

4) A stakeholder meeting should be convened by SQHN to chart a road map for the QI program in Nigeria, which should include all the parties identified as being key by the respondents of this survey.

5) Identified quality champions should be utilized by SQHN in pursuing the QI program. These champions should be selected based on their high levels of quality management expertise/experience as well as demonstrable passion for the initiative. Champions should cut across healthcare sectors e.g. public and private hospitals, regulators, professional associations and HMOs.

6) More time should be allocated for engagement of respondents in the public sector in future studies by SQHN. This will improve the response rate among this cohort, as they are less flexible at granting interviews at short notice.

CHALLENGES ENCOUNTERED DURING SURVEY

The major challenge encountered whilst conducting the Key Informant Interviews was the unavailability of some respondents due to the notice period of 1 to 3 weeks given to them. The public sector respondents were particularly less flexible to granting interviews within such timelines and needed up to 3 months in some instances to grant interview appointments.