Paradigmatic perspective for a quality improvement training programme for health professionals in the ministry of health and social services in Namibia

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Abstract

This article focuses on the paradigmatic perspective facilitate the development of a quality improvement training programme for health professionals in the ministry of health and social services in Namibia. The study of this nature requires a paradigmatic perspective; this is a collection of logically linked concepts and propositions that provide a theoretical perspective or orientation that tends to guide the research approach to a specific. Assumptions are useful in directing research decisions during the research process.

The study adopted a constructivism and interpretivism approach, since it involved understand the current situation of quality health care/service delivery at health care facilities, and explore and describe the of the health professionals; experiences at the health care facilities. The study was based on the specific information that was accepted as true, as obtained from those lived the experiences of challenges and constraints of providing quality health care at the health care facilities.

The paradigm perspectives in this study include Meta – theoretical assumption which consisted ontological, epistemological, axiological, methodological and rhetorical assumptions. Theoretical basis of the study includes Dickoff (1968), Practice Oriented Theory; Programme development by Meyer and Van Niekerk; Kolb's Theory of experiential learning; Demining's model of quality improvement, Quality improvement policy of the Ministry of Health and Social Services (MoHSS) and Centre for Diseases control (CDC) framework for programme education.

Keywords: *Paradigmatic Perspective , Quality Improvement Training Programme , Health Professionals.*

1. Introduction

A quality improvement / management training programme is important to address the challenges that the health professionals are facing in their quest for quality health care delivery. In Namibia, most health care facilities have not been yielding good results in response to patients' health care needs. Health care dynamics are complex and inundated with several factors; among others new methods, speed of improving medical science and technology, as well as increasing demands of the clients to address emerging and re-emerging diseases. Health professionals are often criticized for unsatisfactory results due to several challenges sometimes beyond their capacity and knowledge to mitigate and manage. The difficulties experienced cannot be ignored, since there is no specific quality improvement/management training programme to prepare health professionals. Without appropriate training and empowerment, health care delivery would continue to yield unsatisfactory results. Quality improvement training refers to any activity that explicitly aims at teaching health professionals about methods that could be applied to analyse and improve quality care. A quality improvement training programme seeks to empower health professionals with knowledge, skills, and aptitudes with the aim of enhancing quality health care delivery.

This study took cognisance of QA and QI standards and processes in health care and in general health systems of both developing and developed countries in the midst of serious quality problems

owing to the inability to respond to health care needs and patient safety. For example, recent developments in Ghana, America, Britain (National Health Service), and in Namibia emphasise the need for quality improvement with the purpose of reducing errors in medical care while facilitating quality health care delivery. The Agency for Healthcare Research and Quality (AHRQ) (2002) states that research has even documented several quality problems of variations and disparities in services; such as underuse, overuse, and misuse of services. These problems might be especially hastened by increasing health care demands and knowledge obsolescence, which require learning new methods to improve quality health care services. "Multiple innovations in therapy and technology, [a] fast increase in sciences and medicines, new substances [sic] procedures, electronic devices or robotics has [sic] increased diagnostic capabilities and other range [sic] of possible interventions" Sottas, Höppner, Kickbusch, Pelikan and Probst (2013). These developments prompt the need for updating the knowledge, skills, aptitudes and training to respond to health care demands. In Namibia, a quality improvement training programme seems to be the best option to address quality health care issues; more especially when the MoHSS has planned a new direction in quality improvement and quality assurance to promote quality health care delivery. However, these endeavours are moderately or inconsistently pursued to empower health professionals at the health care facilities in Namibia. According to the National Leadership and Innovation Agency for Health (NLIAH) (2008), most health systems face challenges in providing high quality patient

care to meet health care needs. A study by the Partners for Health Reformplus (2005) concurs that " [c]linical practice does not meet national standards; there is low satisfaction of both employees and patients, as well as inefficient use of resources".

Research has even emphasised that health professionals need to be constantly involved in acquiring knowledge, skills, and aptitudes that would enable them to apply new methods to providing quality health care that meets the health needs of their patients. Although health care facilities strive to achieve quality, there seems to be inadequate quality improvement programmes that guide and prepare health professionals in their quest to provide quality health care delivery.

Furthermore, over the past years, there have been growing frustrations and a priority to focus on QI and QA approaches in the MoHSS with the result that little improvement would be achieved without a proper understanding of the conceptual framework at all operational levels. Unless health professionals understand the principles of quality improvement and quality assurance, health care services will remain compromised. Several complaints about mistakes and errors appear in daily print and electronic media and serve as an indication of poor results and an inability to meet patients' health needs. Moreover, this situation indicates that patients are tired of receiving sub-standard health care while the public health sector is receiving one of the largest budget allocations from Government. Other factors that may contribute to this anomaly seem to be lack of knowledge and a practical conceptual framework for QI and QA. Similarly, inaccurate methods may accelerate inappropriate use of QI tools that may result into misinterpretation and underutilisation of data. It seems there are unexplored perspectives that are needed to understand the conceptual framework and the application of quality improvement methods towards safe, effective, efficient, and timely health care services. Hence, there is a need to develop a quality improvement educational programme to facilitate quality health care delivery at the health care facilities.

The study adopted a constructivism and interpretivism approach, since it involved participants in defining the meanings of concepts related to their experiences at the health care facilities. The study was based on the specific information that was accepted as true, as obtained from those lived the experiences of challenges and constraints of providing quality health care at the health care facilities. Research emphasises that "…[t]he central tenet of interpretivism is that people are constantly involved in interpreting their ever-changing world" (Williamson, 2006). Paradigms are referred as accepted views that guide research and basis or fountain in the quest for new ideas. A paradigm is also referred to as a reflection or a window that enables researchers to align their ideas to interpret the world around them. This study leaned towards a constructivism paradigm, since it emphasised the constant interaction between and the construction of things in the real world by human beings. The study was based on a recognised scientific conceptual framework and methodological approaches that supported its findings. Paradigms " are world views or frameworks used to organise our observation and reasoning about things around us" (Babbie, 2008. "A paradigm implies a pattern, structure and framework or system of scientific and academic ideas, values and assumptions (Olsen, Lodwick and Dunlop, 1992).

In this study, QI " [r]epresents a paradigm shift away from a major concern with inspection of activities and detection of those care providers (clinics, health care teams, hospitals" (WHO, 2000). A paradigm refers to the "…collection of logical, connected concepts and proposition that provide theoretical perspectives frequently guiding the research approach towards a topic" (Ulin, Robinson, Tolley and McNeill, 2002); Amukugo, 2002; Naudé, 1995). The assumptions that were guiding this study were based on ontological, epistemological, axiological, methodological, and rhetoric assumptions. Theoretical basis of the study includes Dickoff (1968), Practice Oriented Theory; Programme development by Meyer and Van Niekerk; Kolb's Theory of experiential learning; Demining's model of quality improvement, Quality improvement policy of the Ministry of Health and Social Services

(MoHSS) and Centre for Diseases control (CDC) framework for programme education and are described as follow:

2. Aim of the study

The aim of this study was to develop a training programme for health professionals that facilitate quality health care and services delivery at the health care facilities. However to do this the paradigm perspective is required to guide the researcher.

3. Objectives of the study

The study objectives were to:

* Analyse the present situation of quality health care / service delivery at health care facilities;
* Explore and describe experiences of top manager and health professionals with regard to quality health care / service delivery at health care facilities;
* Describe a conceptual framework for the development of a training programme for health professionals to facilitate quality health care / service delivery at health care facilities;
* Develop a programme for health professionals to facilitate quality health care / service delivery at health care facilities;
* Describe guidelines for the implementation and evaluation of quality health care / service delivery by the health professionals at health care facilities; and
* Describe guidelines for evaluation of the programme to facilitate quality services delivery by health professionals at health care facilities.

4. Significance of the study

The study would provide knowledge, skills, and aptitudes in QI and QA to enhance health care and service delivery. The study aims at developing a training programme to empower health professionals with knowledge, skills, and aptitudes (KSAs) about QI and QA. This study is important to empower health professionals and managers with knowledge, skills, aptitudes, and attitudes to enhance quality health care delivery and meet the aspirations of the clients. A QI training programme would assist health professionals to reflect on their actions and behaviour during care and treatment, especially when presented with practical tools and methods, such as the Plan-Do-Study-Act (PDSA) model by Deming, (1994) which is applicable to any organisation, including health care facilities. It seems overwhelming to apply the increasing demands and changes in medical technology in order to meet the expectations of clients. Moreover, there seem to be no framework or programme with the specific focus of providing capacity on quality improvement at the health care facilities in Namibia. The study findings might help health professionals to reflect on their actions and examine whether health care adheres to QI "…[p]rinciples of client focus, responsive systems, effective processes and teams" (U.S. Department of Health and Human Services, 2011). QI emphasises that "…[a]n effective QI program [sic] also requires change in an organisation's culture and infrastructure to overcome the traditional barriers and works toward a common goal of quality".

5. Paradigmatic perspectives of the research

A paradigm refers to the "collection of logical, connected concepts and proposition that provide theoretical perspectives frequently guiding the research approach towards a topic" (Ulin, Robinson, Tolley and McNeill, 2002); Amukugo, 2002; Naudé, 1995). The assumptions that were guiding this study were based on ontological, epistemological, axiological, methodological, and rhetoric assumptions. Theoretical basis of the study includes Dickoff (1968), Practice Oriented Theory; Programme development by

Meyer and Van Niekerk; Kolb's Theory of experiential learning; Demining's model of quality improvement, Quality improvement policy of the Ministry of Health and Social Services (MoHSS) and Centre for Diseases control (CDC) framework for programme education and are described as follow:

5.1. Meta-theoretical assumptions

According to Botes (1995), meta-theoretical or meta-paradigm assumptions influence the research decisions throughout and serve as a framework within which theoretical statements are made. Creswell (2013) suggests that the following four fundamental interrelated questions should be asked by an inquirer in order to understand the assumptions.

5.1.1. Ontological assumption

Mouton and Marais (1996) define ontology as the social context in which research is being conducted and the interpretation of reality as understood by the participants. Ontology is "…the study of being" (Crotty, 2003) while Guba and Lincoln (1989) state that ontology tries to answer "…the question: what is there that can be known?". Just like epistemology, it is also referred as metaphysics that focuses on the understanding the existence of living things (being) and their characteristics (Jackson, 2007).

Ontological assumptions in this study were based on true stories, actions, and experiences of health professionals while interacting with the clients in their day-to-day activities. The researcher understood that the context investigated consisted of health professionals, managers, and patients who had different ideas, experiences, thinking, and meaning about reality. To understand the behaviour and thoughts of individuals, qualitative research methods of individual and focus group interviews, as well as a checklist were used. The use of recognised methods of interviews, field notes, voice recording, verbal and non-verbal forms of communication contributed to understand the feeling, attitudes, or behaviour, which was useful to conceptualise the context of this study. Furthermore, the facial expression, and the lifting of hands and shoulders conveyed some emotional feelings (Chapter 3). The study was conducted in a natural environment that was familiar to the participants while they were constructing meaning and views about the topics studied. Participants were more relaxed and comfortable to provide rich information based on experiences and knowledge about reality in a familiar environment. Another animated motion was the use of body language and short expressive phrases, such as "um…" and "ah…" or head nodding that enriched the analysis and interpretation to understand the feelings, the environment, and inner thoughts about the problems they were facing and potential strategies to find solutions.

5.1.2. Epistemological assumption

This study was based on a constructivist approach "…the view that all knowledge and the meaningful reality is contingent upon human practices, being constructed in and out of interaction between human beings and their world and transmitted within the social context" (Crotty, 2003; Creswell, 1994; Culbertson, 1981). The study endeavored to respond to the following research questions: What approaches were existing to enhance quality health care delivery at the health care facilities? Could these approaches be enhanced by introducing a QI training programme to empower health professionals and managers with KSAs to improve quality health care delivery? To respond to these questions, the study described the phases of and guidelines for developing and implementing the programme. The information was generated through interacting with health personnel who provided reliable information based on their experiences of existing approaches to enhance quality health care delivery. The analysis resulted in five themes that formed the centre of knowledge about QI and QA approaches pursued by the health care facilities.

One of the challenging efforts in research seems to be determining the truth and reality of phenomenon because both participants and researchers hold different views about the world and interpret reality differently. "A major problem in establishing a correct or valid paradigm of reality comprises two aspects: Firstly, while there is possibly an objective reality to be investigated, each person does so through the subjective reality of one's personal understanding, as influenced by one's immersion in a physical, social, and cultural context (Huitt, 2011). "Epistemology is the study of knowledge and justified belief" (Encyclopedia of Philosophy, 2005). It refers to "…a way of understanding and explaining how we know what we know" (Ahmed, 2008). The definition and the two types of knowledge are discussed in Chapter 3 of this study. Mouton and Marais (1996) state that the suppositions of social science research are the search for truth based on valid findings.

5.1.3. Axiological assumption

The study adhered to the ethical obligations by following the research protocol according to the guidelines of the MoHSS and the University of Namibia following the approval of the research by both organisations. Axiology is considered as "the science of value" (Hartman, 1999) and ethics that are adopted to guide research principles and respect the rights of subjects. "Ethical issues in research include codes of conduct that are concerned with protection of research from physical, mental, and/or psychological harm (Chilisa, 2005 in Ahmed, 2008). Babbie (2008) adds that "ethics is typically associated with morality and both deal with matters of right or wrong". Although the objectives of research in health care are mostly to improve the social well-being of the clients, researchers should adhere to ethical guidelines, principles of justice and beneficence so that human subjects are protected all times.

In order to adhere to research protocols and ethical standards, the following obligations and steps were considered: Respect for participants' privacy, confidentiality, rights to withdraw from a study, and anonymity. Before this study commenced, the ethical aspects of the research project had been explained to the participants.

Informed consent: Prior to each interview and focus group discussion, as well as administering a checklist, the researcher informed the participants about the purpose of the study, the methods of data collection, approval of the study by the research ethical committees of the MoHSS and the UNAM. Each participant signed a written letter of consent, which informed them about voluntary participation and their right to withdraw at any point of the study. The participants were also informed that there was no rewards or incentive for participating in the study. Babbie (2008) states that the importance of obtaining verbal or written consent from participates in a research study to remove any form of force or coercion to persuade people to participate in a study.

Protection from harm and risk: In this study, the researcher ensured that to the research study neither caused any harm or risk to participants, nor forced them to participate or provide information that would cause physical or emotional harm. No participants were exposed to physically or psychologically harmful situations during their participation. Babbie (2008) states that "harm may include emotional or psychological distress, as well as physical harm".

The right to privacy, confidentiality, and anonymity: Health care deals with sensitive information about patients' illness that are often restricted or confidential. Sometimes, access to such information may violate people's rights or cause harm that might result in emotional or physical damage. In this study, participants were informed that no information would be related to individuals' names or identity. The study ensured total anonymity through non-identification of names in the process of data collection and analysis. The researcher clarified that the information from the interviews and group discussions would only be analysed by the researcher and kept confidential. During the focus group interviews, participants were allocated number from 1 – 10, which they used to participate in the discussion that were voice recorded.

5.1.4. Methodological assumption

Research methodology "…is defined as the logic of the application of scientific methods to the investigation of phenomena"

(Mouton & Marais, 1996). Methodology is "the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of the methods to the desired outcome" (Crotty, 2003). Kiel Mann, Cataldo and Seeley (2011) state that anthropological methodology, unlike epidemiological research, focuses on social institutions (norms and rules) that govern people's lives; processes and structures to understand how people communicate and interact; sharing experiences, knowledge and meaning, and on the explanation and rationale that justify their decisions and actions.

The study had a constructivism and interpretivism orientation with a quantitative and qualitative, explorative, and descriptive approach. In this study, the research methodology served as a roadmap that explained the approaches, conceptual framework used in developing the training programme, as well as the data collection and analysis methods of the study. The methods employed in this study were based on a qualitative research approach that allowed the researcher to interact with the participants in their natural environment (health care facilities) to understand and listen to the stories with regard to their experiences of quality improvement and quality assurance approaches at the health care facilities. The researcher sought to understand the stories and events at the health care facilities based on the interpretation and description of the events. The research instruments used in this study were interviews and focus group discussions using unstructured open-ended questions to solicit the storylines and narrations of experiences in relation to quality health care delivery.

5.1.5. Rhetorical assumption

Rhetoric is referred to as the ability to communicate fluently, and to use of clear and concise language that is understandable to the audience. The Oxford Dictionary (2009) defines rhetoric "…as the art of effective or persuasive speaking or writing, especially the exploitation of figures of speech and other compositional techniques". It is also referred to as art of expression and eloquent oral and written text that persuades the reader to understand the communicated information without any doubt or questions.

Rhetoric was employed in this paper by the use of simple language, well-organised flow of thoughts, clear style, and persuasive language to communicate the information about the findings of the study. According to Woods, (2006) there are different forms of writing to convey the information to the reader, for example "…atmosphere, feelings and emotions or to re-create people's experiences, etc." The researcher developed her own style and voice to narrate the stories expressed by the health professionals and managers in the MoHSS with the aim of producing a quality piece of academic work. The researcher had to read and re-read the text more than 10 times to clarify the purpose of the study and avoid ambiguous concepts. The structure or format of this paper was organised into closely related sections with the purpose of indicating and explaining the main themes and the connection with literature that supported the findings that formed the theoretical basis of the study.

5.2. Theoretical basis of the study

The study was based on Dickoff's practice orientated theory (1968), which consists of related activities that were adopted while developing the conceptual framework (Chapter 4). The theory provided "…[u]seful ideas to direct the research planning and decisions (Mouton, 1996; Tomey, 1998; Chinn & Kramer, 1991). Theory may be referred as the best guess statements, suppositions, or structures that direct the researchers' ideas or questions to interpret phenomenon to find possible solutions. The theoretical assumption includes models and theories that already exist in scientific disciplines (Mouton & Marais, 1990). They also include all testable statements derived from existing theories and models (Mouton & Marais, 1990). Henceforth, the fundamental theories are described; namely the practice orientated theory of Dickoff (1968), the five phases of programme development by Meyer and

Van Niekerk (2008), Kolb's four-stage model cycle of learning, Deming's PDSA model of quality improvement, the quality improvement management policy of the MoHSS, and the six steps of the CDC framework for programme evaluation in public health.

5.2.1. Practice theory of Dickoff, James and Wiedenbach

The practice orientated theory of Dickoff (1968) in Mothiba (2012) consists of five components that apply to the development of the training programme components for health care facilities to. The theory consists of the agent, recipients, context, dynamics, and terminus for the programme activities. The practice orientated theory by Dickoff (1968) was used to mould the concepts into logical reasoning to develop a quality improvement training programme for health professionals at health care facilities of the MoHSS. A detailed description of the conceptual framework and themes that resulted in a training programme is provided in Chapter 4. The conceptual framework was important to produce pragmatic results, enhance interpretation of concepts, and provide tangible results that would be replicated to similar contexts at health care facilities in Namibia.

The elements discussed in Dickoff et al. (1968) practice orientated theory were adapted to describe the situation of developing a quality improvement programme for the health professionals at health care facilities). The assumptions of the theory were taken into consideration in this study and they applied as follow:

- Agent: The agent in this study referred to the researcher who facilitated the implementation of a quality improvement training programme for health professionals at health care facilities of the MoHSS. The agent is the main focal person responsible for planning, coordinating, and developing a programme (Dickoff et al. 1968).

- Recipients: The recipients in this study were health professionals who would benefit from participating in the training programme by receiving knowledge, skills, and abilities to improve quality health care delivery at the health care facilities. Dickoff et al. (1968) describe the second activity as the recipient. In this study, the recipients were health professionals from different categories (doctors, nurses, pharmacists, social workers, environmental health officers, and hospital managers) at the health care facilities in the MoHSS who had the responsibility to effectively and efficiently provide quality health care.

- Context: The context is the health care facilities that are providing health care and services to the patients and clients in the MoHSS. The specific context in this programme was the referral, intermediate, and district hospitals operating under the MoHSS. The third aspect of the practice orientated theory described by Dickoff et al. (1968), as indicated in Mothiba (2012) is the context. The programme was designed for the health care facilities; specifically, for referral, intermediate and district hospitals under the MoHSS.

- Dynamic: The dynamics in this study were the challenges that the health professionals were experiencing in terms of obstructions or interferences with the provision of health care services.

- In order to improve quality health care delivery, there was a need to improve the skills, competencies, and attitudes of those health care workers who were providing health care and services to support the successful implementation of the programme. Dynamics were based on the storylines shared by the health professionals as forming the source of energy. If outstanding factors as the source of energy are not managed well, it might hinder the successful implementation of quality health care delivery at the health care facilities. The dynamics or challenges experiences by the health care workers includes; lack of implementation of policies and guidelines; inadequate management of the resources to facilitate QA and QI; inadequate interpersonal relationship; adequate research and information, lack of monitoring and evaluation includes indicators and lastly was a lack of appli-

cation of QA standards, as well as qi process and methods to facilitate quality health care delivery.

- Procedure: Procedures are referred as processes that are employed to address certain problems or guide the actions to implement a policy or programme. In this study, the procedure was the training programme that was implemented at the health care facilities to empower health professionals with knowledge, skills, and abilities to facilitate quality health care delivery. The procedure (programme) explains the development, implementation, evaluation techniques, programme content, learning objectives, and learning outcomes in order facilitate QA and QI in health facilities.
- Terminus: In this study, the word terminus referred to the endpoint of the training programme, which completed the activities in the cycle of developing the conceptual framework of the training programme, as described by Dickoff et al.'s (1968) practice theory in Mothiba, (2012) that the terminus is the last or final activity of the process.

This activity described how health professionals demonstrated the abilities to apply QA and QI concepts and methods during execution of their duties that resulted in improved quality health care delivery. In conclusion the anticipated end product include: competencies of health professionals in QA and QI; QI and QA empowerment lead to professional and personal growth and autonomy in the execution of quality improvement standards for care and service delivery

5.2.2. Kolb's experiential learning theory

Kolb's theory of experiential learning guided the procedure and the technique during the implementation of training programme were into four-stage cycle that includes:

- Concrete experience: The health professionals can use imagination to solve problems; pragmatists are more practical and take time to listen to others; experts in collecting information; suitable at examining concrete situations and different opinions. 'Diverging' because adults perform better in situations that require ideas-generation and thinking. Interested to work in teams, listen tentatively, are open-minded, and accept criticism. However, educator should guide on the fact that adult learners may get bored easily, especially when they are not involved.
- Reflective observation: The health professionals can understand a wide range of information and organise it in logical format. They are less focused on people but interested in ideas and abstract concepts and more attracted to logically sound theories than approaches based on practical value. In formal learning situations, adults in assimilating (watching and thinking) style prefer readings, lectures, exploring analytical models, and having time to think things through.
- Abstract conceptualisation: The health professionals can solve problems and will use their learning to find solutions to practical issues. They prefer technical tasks, less concerned with people and interpersonal aspects but best at finding practical uses for ideas and theories and can solve problems and make decisions by finding solutions to questions and problems. Adults with a converging learning style are more attracted to technical tasks and problems than social or interpersonal issues. They like to experiment with new ideas, to simulate and work with practical applications.
- Active experimentation: The health professionals can use 'hands-on' experience and relies on intuition rather than logic. As an accommodating learning style, adults use other people's analysis and prefer to take a practical, experiential approach. Attracted to new challenges and experiences and carrying out plans. Commonly act on 'gut' instinct rather than logical analysis. Tend to rely on others for information than carry out their own analysis and prefer to work in teams to complete tasks. They set targets and actively work in the field trying different ways to achieve objectives.

5.2.3. Knowles' Andragogical Learning Theory

Besides Kolb's stage four theory of experiential learning, Lieb (1991) and Goodland (2005) confirm that adult prefer learning in situations that consider and incorporate the following elements:

- Practical and problem-centred: Health professionals were recognised to be involved in practical situations that required problem solving skills. Hence, they would join the learning environment with a wide range of experience that assisted them to learn more effectively. This programme provided opportunities to actively involve participants in group discussions and presentations to enhance KSAs by establishing linkages between the content and previous experience. It further assisted them to apply new ideas to situations at work based on experiences to solve problems that were identified as hindering quality health care. In this programme, the learning process was fun, since it contributed to positive outcomes. Learners assumed an active role in deciding on problems that needed to be solved in real situations while the educator simply facilitated the learning. The learning became practical because participants were involved in designing their own learning content to establish connections between prior learning and experiences of quality health care delivery, which not only encouraged a sense of ownership; it also stimulated interests in designing projects with the aim of solving problems, creativity, and working independently or in groups to share experiences related to their work. They were allowed to take ownership of and responsibility for their learning through presentations and assuming leadership roles in teams. As discussed in Chapters 3 and 4, among the competencies that needed to be reinforced in this approach were strategic planning and problem solving.
- Promote positive self-esteem: Adults learn confidently when they perceive encouragement to learn during low risk activities and in smaller groups. They learn more effectively when they notice that the programme contributes to building their capacity and progresses self-development. They, however, need to be assisted with developing confidence and becoming effective through practical learning and a well-established predictable and unsurprising programme. Adult dislike surprises in their learning. They want to understand the goals and outcomes of their learning.
- Integrate new ideas with existing knowledge: Adult are interested in learning in situations where they can relate the learning to what they already know, since they have accumulated rich experiences that they bring to any learning experience. They are interested when the assumptions and agenda of training is communicated to them and the topics and the time of training is adjusted to suit their needs. They want to enter a learning programme that provides broad skills, knowledge, and an opportunity to take part in understanding the topics and learning content more effectively. This programme attracted adult learners on the grounds of its flexibility to change with the view of addressing their needs from time to time. The programme was also welcomed by adult learners because it had intrinsic follow-up ideas and supported continuity mechanisms.
- Show respect for the individual learner: Adults prefer to be respected and are interested to learn when they feel accepted and equally accommodated. They are very conscious of the use of language and interpretation of actions. So, the choice of words and expressions matter when adult learners are trained. They are more motivated when they perceive that the learning component would not only improve their mental capacity but their physical needs too; for example, including elements of relaxation, leisure (comfort), snacks, and coffee during breaks. A programme should offer quality, well-organised, and standardised modules to utilise learners' efforts and time effectively and efficiently. They are interested in learning when their potential and contributions are

valued, acknowledged, and feedback about their work is timely provided.

- Capitalise on their experience: Adult have accumulated a wealth of experience; an educator should maximise prior learning as a source for improving and enriching the learning experience. For learners to be interested, alternative activities and a choice of methods need to be adjusted to suit their level of experience. They would be more inspired when the activities are based on their previous experiences and knowledge. Besides, the learning would be more successful when it considers participants' needs during and even after the sessions.

- Allow choice and self-direction: Adults learn better when they are self-directed and interested in learning activities that impact their lives positively. They are more interested in training programmes that focus on their needs and support the desired behaviour. They want to be included in the goals and agenda of the programme, hence they would be happy to provide valuable input to pertinent topics.

6. Conclusion

These guidelines have been developed to assist quality manager(s) and facilitator(s) with the implementation of the quality improvement training programme for health professionals at the health care facilities (MoHSS). The guidelines enhance consistency in steps and methods to be followed during the implementation of the programme. The guidelines were derived from the conceptual framework that was developed during the exploratory and situation analysis of quality health care delivery at the health care facilities. Two prominent theories were adapted in developing these guidelines: Firstly, Deming's PDSA model of quality improvement and secondly, Kolb's experiential learning theory; These theories were used to understand the teaching and learning styles, as discussed in Chapter 1. The formulation of the guidelines also borrowed the CDC (2001) steps and UNFPA phases of developing the guidelines for successful implementation of the training programme at the health care facilities in the MoHSS. The facilitator(s) and implementers of the training programme are advised to first understand the background and the development process of the training programme for successful implementation. This chapter presents the guidelines for implementing the quality improvement training programme for health professionals at health care facilities (MoHSS).

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