

283: IMPROVING QUALITY THROUGH MICROPROJECTS: CAN DEVELOPING COUNTRIES DO BETTER?

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Objective:

To assess the performance of multiple quality improvement teams in Africa.

Methods:

University Research Co., LLC (URC) is implementing the USAID-funded Quality Assurance Project (QAP). In Africa, QAP helped districts improve quality of care through multiple facility-based projects. Teams in many health centers are trained in a 6-step problem-solving (PS) method, select a topic for improvement of their choice and receive facilitative visits from the district health management team. This study of the overall performance of this model was undertaken to help policy-makers make informed decisions for the development of an improvement strategy that has an impact on population health status. More specifically, we measured performance against 3 criteria: efficacy of the model in improving quality of care; cost of its implementation; and sustainability over time.

The key steps of this study were:

- i) Formal evaluations of the micro projects model in Niger, Zambia, Malawi, Rwanda and Morocco;
- ii) Analysis of results according to the criteria described above;
- iii) Recommendations to improve the performance of this model.

The tools we used were :

- i) review of teams' achievements;
- ii) competency testing of problem-solving teams;
- iii) interviews with team members and district coaches;
- iv) cost-analysis.

The analysis was performed over a period of three years, and level of efforts varied between country.

Results:

- Efficacy of the teams: on average, 80% of teams do not select clinical care topics, but rather coverage and utilization issues. The impact of their work on case-management of patients according to standards is not addressed. Teams face many problems with QA tools, especially data collection, analysis and use. The proportion of teams who achieve results varies greatly (40% in Zambia, 75% in Niger, 89% in Morocco). The main determinants of performance are internal team climate, team size, external support from coaches, interest of the leadership in the teams' project and individuals' motivation for quality.
- Cost of the model: Main recurrent costs are labor costs, which amount to 104 US\$/cycle in Niger and 81 US\$ in Morocco.
- Sustainability of the model: in Niger, 2 years after the end of QAP technical assistance, the annual number of improvement cycles decreased from 30 in 1998 to 21 in 1999 and 17 in 2000 on a total of 63 teams initially trained. In Zambia, 65% of teams completed a cycle.

Conclusion:

When designing a quality improvement strategy, healthcare leaders and managers should know the strengths and limitations of the multiple micro projects model. Consistent findings among African countries were found. The model yielded mixed results and has not demonstrated impact on the quality of care that patients receive. Intangible results such as the enthusiasm to work in teams lead to enhanced communication among staff, but has little consequences on the health status of their clients if compliance with evidence-based guidelines is not the focus of improvement. The model has low recurrent costs, but is logistically heavy to implement and sustain in resource-constrained environments.

To be effective, this model needs considerable refinements, such as

- i) building the conditions for success before implementation (commitment of leaders, staff time allocation and logistics resources);
- ii) selecting a priority clinical care topic to be addressed by a limited and more manageable number of teams;
- iii) building team skills in data collection and analysis;
- iv) developing mechanisms to replicate best practices among all facilities;
- v) continuous internal evaluation of this model in order to refine it.