3: EQUIP's Quality Improvement Approach

Introduction: Why quality improvement?

Insufficient implementation of essential health care interventions hampers improvements in maternal and newborn health as well as many other health areas. Quality improvement has the potential to overcome low implementation levels by assisting quality improvement teams in finding local solutions to problems related to provision of quality care and to the underutilization of health services by community members. Different approaches in quality improvement are used around the globe.

Methods: What was done?

EQUIP's quality improvement approach was based on the Collaborative Model for Improvement which has been promoted by the Institute for Healthcare Improvement (Figure 1)[1]. The model is a short-term, rapid learning approach to make improvements in specific topics. Teams were guided to work using three questions:

- What are we trying to accomplish?
- What changes can we make that will result in an improvement?
- How will we know that the change is an improvement?

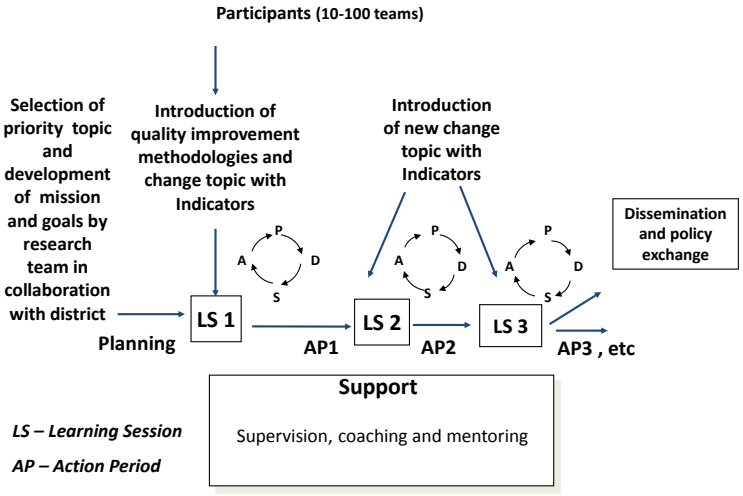

Figure 1. The collaborative approach to quality improvement

Teams were mentored to use Plan-Do-Study-Act (PDSA) cycles to identify problems, define a strategy that could produce change ("a change idea"), and test the strategy using locally generated data to determine if the change idea resulted in an improvement. Run-charts using the local data were used to monitor progress (Figure 2).

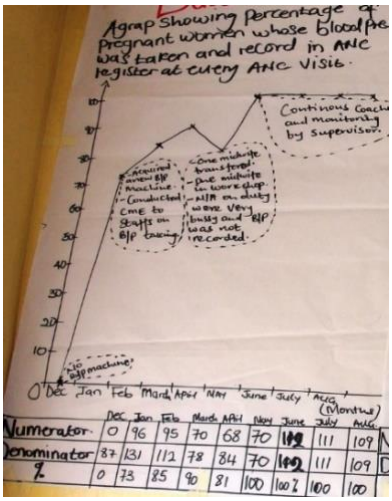

Figure 2. A run chart

Maternal and newborn health topics for improvement were introduced during "learning sessions" held every three months where teams from multiple sites were encouraged to brainstorm obstacles related to each topic and to develop plausible change ideas to address these problems. The learning sessions also provided an opportunity to refresh knowledge of essential maternal and newborn health interventions, to share experiences, and to learn from each other. The learning sessions were followed by an "action period" where quality improvement teams of health providers or community participants implemented their change ideas and monitored progress. During this action period, quality improvement mentors provided coaching and mentoring to the teams.

Conclusion

The learning sessions and the regular mentoring and coaching visits were highly appreciated. The largest limitation was the volume of resources (human and financial) needed to assist the quality improvement teams. A dedicated and qualified team of mentors and sufficient financial support to facilitate their work were needed.

[1] http://www.ihi.org/Pages/default.aspx; see also Institute for Healthcare Improvement (2003). The Breakthrough Series. IHI's Collaborative Model for Achieving Breakthrough Improvement. Innovation Series 2003. Cambridge.

Coaching and Mentoring Through Existing Government Structures

Background: Why structured QI support?

Teams working on quality improvement need regular support to maintain their efforts and to continuously improve performance. Supervision, mentoring, and coaching is critical but often difficult to operationalize in low resource settings.

Methods: How did we address support?

The EQUIP project employed two people in both countries to work on designing the overall approach, implementation, and research. Two additional people were involved in conducting the learning sessions and in the coaching and mentoring of the quality improvement teams. EQUIP included several members of the district health teams for the learning sessions and the mentorship of the health facility and community teams (Figure 3*)*.

In Uganda, two health facility mentors and two district community mentors were trained on quality improvement, and coaching and mentoring. In addition, four health facility sub-district mentors and 30 community mentors were trained to support the health facility and community teams in the sub-district.

In Tanzania, one health facility and one community mentor were trained, together with two more members of the district team engaged in implementation. The community district mentor was part of the community development office and established a structure for community work where extension workers were included in the EQUIP implementation process. Ten community extension workers were carrying out regular visits to community teams.

Results

During the 30-month implementation period, a total of seven learning sessions were held in Uganda and Tanzania for both the health facility and community quality improvement teams. Mentorship took place eight-to-ten times per year, achieving more than 75% of the planned supervision of teams.

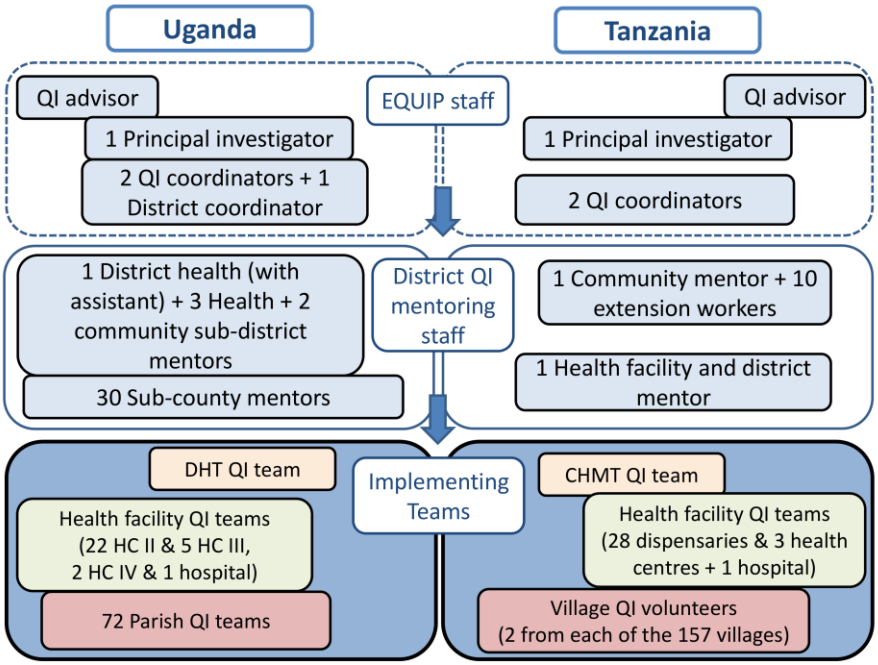

Figure 3: Support structure in Uganda and Tanzania. (**QI** Quality Improvement, **HC** Health centre, **DHT** District Health Team, **CHMT** Council Health Management team)

Conclusion

It was feasible to align mentoring and coaching to the district's supervision structures, but the EQUIP project funded transport and communication allowances for the learning sessions and supervision visits to the health facility and community improvement teams. EQUIP was able to build district health team capacity for quality improvement through its own funding, but it additional resources will be needed for sustainability.

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