



Sustainability of a Regional Quality Assurance Program Two Years After Outside Funding Ceased: Niger

Do successful hospital quality assurance programs developed by QAP with USAID funding sustain their success after outside funding ceases and QAP bows out? A QAP follow-up study¹ addressed this question for the Niger QAP/BASICS Joint QA Project in Niger's Tahoua Region (1993–98). That project implemented several key components of a QA program: health worker training in QA methods, improved supervision of providers on compliance with quality standards, coordination meetings with staff, operations research, and functioning QA teams in facilities and districts. Ending as planned in December 1998 when USAID funding ceased, the Joint Project and its accomplishments were well documented.² The follow-up study conducted in 2001-2 assessed whether the QA activities and improvements were sustained for two years, or faded away.

Methods

The study assessed two types of performance: key component implementation and quality of care. Both types of performance were estimated in the Tahou Region during the Joint Project, in the Tahou Region in 1999-2000 two years after the Joint Project, and during 1999–2000 in a comparison region, Maradi, which did not have a QA program but was doing some QA activities.

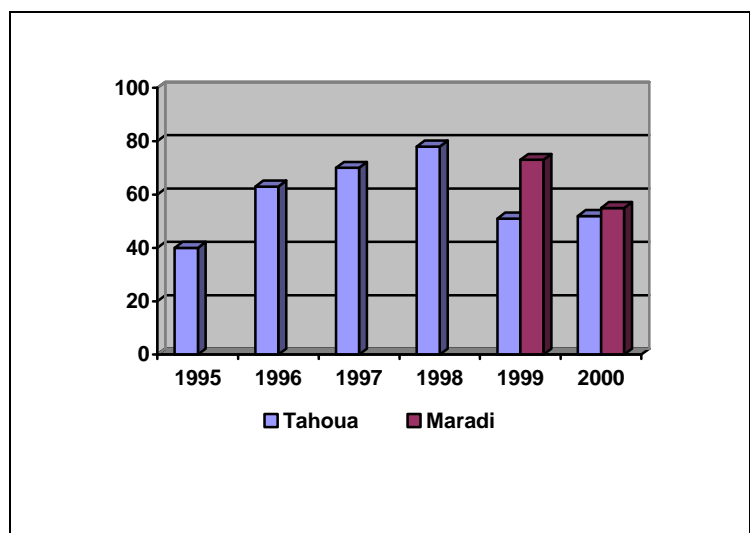
Key component performance: Component performance was obtained in Tahou for 1993 through 2000 from document review (project records, district and facility budgets, others) and health staff interviews. Interviews were held with 96 health personnel at several levels of the Ministry and included most of the health staff who had been involved in the Joint Project. A special self-evaluation questionnaire of QA Teams in Tahoua was completed by most members of the teams. Similar data, except from QA Teams, were obtained for 1999–2000 from Maradi, the comparison region.

Quality of care: The quality of care actually provided to young children in Tahoua had been measured in 1998, and the protocol and forms used from that study were repeated in Tahoua in 2001 and applied for the first time in Maradi in 2001. Provider performance was observed in 88 cases from 16 health centers in Tahoua and 38 cases in eight health centers in Maradi. Exit interviews were held with the mothers and caretakers in all but two of these cases.

Results

Performance of components dropped off after its closure. Supervision, quarterly staff meetings, and QA team activities in Tahoua all decreased in frequency in 1999 and 2000. Figure 1 shows the decrease in supervisory visits, which is typical of the component decreases. Observed compliance with

Figure 1: Percentage of planned supervisory visits completed



IMCI standards also dropped, decreasing in Tahoua in five of the six indicators measured. This decrease was significant in three of the indicators. However there were no significant differences in compliance between Tahoua and Maradi in 2001 (see Table 1).

The findings indicate that although essential QA activities continued in 1999 and 2000 after Joint Project closure in 1998, their frequency decreased. This was true for supervision, staff coordination meetings, and quality improvement teams. The quality of care provided to the observed children at Tahoua health centers in 2001 declined for five of six performance items, including significant declines for three.

Table 1: Percentage of observed cases performed to IMCI standard

Standard	Tahoua 1998	Tahoua 2001	Maradi 2001
Child correctly examined	38	30	32
Child checked for 2 danger signs	64	26 *	12
Nutritional status checked	47	5 **	27
Child correctly treated	76	79	71
Mother counseled on treatment	63	11 **	13
Mother counseled on when to bring child back	48	33	49

Significant differences between Tahoua 1998 and Tahoua 2001 are denoted by asterisks at the .01 level (*) and the .001 level (**) in the Tahoua 2001 column. There were no significant differences at the .05 level between Tahoua 2001 and Maradi 2001.

The findings indicate that although essential QA activities continued in 1999 and 2000 after Project closure in 1998, their frequency decreased. This was true for supervision, staff coordination meetings, and quality improvement teams. The quality of care provided to the observed children at Tahoua health centers in 2001 declined for five of six performance items, declining significantly for three.

Many factors were identified as possible causes for the decline in QA activities and health worker performance. Major disruptions in Tahoua and Niger included disease outbreaks, floods, a military coup that disrupted foreign aid, and political changes at the national level that caused massive reassignment of health personnel. Although Niger had identified other funds to continue the QA activities after 1998 when the USAID funds would end, the budgetary problems brought on by the cessation of foreign aid greatly curtailed funds available to support the Tahoua Project. The QA staff in Tahou had been trained in QA methods and in IMCI, but nearly all were reassigned to other regions shortly after Joint Project closure, and the incoming replacements had little or no exposure to QA or IMCI.

¹ The complete study is reported in: Djibrina S, Edson WN, Boucar M, Diogou A, Hama IM. 2005. The Niger QAP/BASICS Joint Project: An Evaluation of QA Activities Two Years Later. *Operations Research Results*. Bethesda, Maryland: Published for USAID by the Quality Assurance Project (QAP), University Research Co., LLC, Bethesda, MD. QAP publications are available at www.qaproject.org.

² Legros S, Tawfic Y, Crespín X, Djingarey M, Goodrich E, Abdallah H. 2000. The Niger QAP/BASICS Project: Final Evaluation. *Evaluation Report 1(1)*. Published for USAID by the Quality Assurance Project (QAP): Bethesda, Maryland.