Introduction

The use of quality improvement (QI) teams to improve HIV care service in Africa is well documented (Franco, 2011). However, the association between the level of team functionality and performance of health units is not known.

Objective

- To determine factors that affect functionality of improvement teams;
- To determine if there is an association between team functionality and linkage of HIV positive mothers into HIV care at 16 HIV clinics in Central and Western Uganda.

Methods

The USAID Health Care Improvement Project (HC III), the predecessor to the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, supported 16 HIV clinic QI teams in Central and Western Uganda to improve linkage of HIV positive mothers into HIV care through on-site coaching and peer to peer learning sessions. A cross-sectional assessment was conducted after a 21-month period to determine their functionality and performance. Functionality was assessed using a composite indicator (team composition, team activeness, use of right data tools and coaching) and teams were classified as functional or non-functional using a cut off of 70% which has previously been used (Baker, 2000).

Table 1. QI Team Functionality

<table>
<thead>
<tr>
<th>SITE OF QI TEAM</th>
<th>NUMBER OF FACTORIES</th>
<th>FORMATIVE (Wt 20%)</th>
<th>ACTIVATION (Wt 35%)</th>
<th>TASK (Wt 25%)</th>
<th>COACHING (Wt 15%)</th>
<th>ENDURAL FUNCTIONALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>6</td>
<td>75.3</td>
<td>51.3</td>
<td>77.6</td>
<td>81.7</td>
<td>71.5</td>
</tr>
<tr>
<td>HC III</td>
<td>6</td>
<td>71.2</td>
<td>69.7</td>
<td>88.6</td>
<td>85.6</td>
<td>79.8</td>
</tr>
<tr>
<td>Overall</td>
<td>12</td>
<td>72.9</td>
<td>54.3</td>
<td>86.6</td>
<td>85.6</td>
<td>79.8</td>
</tr>
</tbody>
</table>

Figure 1. Number of QI team meetings held and number deemed successful

Figure 2. Functionality performance rating of teams based on a 70% cut off

Figure 3. Linkage of HIV positive mothers into HIV chronic care at 16 health units

Figure 4. Linkage of HIV positive mothers into HIV chronic care by functional and non-functional QI teams

Results

Overall QI team functionality was 74.8%. Team activeness (frequency of meetings and ability to identify gaps and test changes to bridge the gaps) was the most challenging component of team functionality at 54%, while use of right data tools (availability, use and update) was the best performing component of functionality at 87% (Table 1).

After formation, QI teams are very active and the majority of their meetings are successful (gaps/solutions are identified). However, as time goes on, the frequency and success rate of meetings wanes. The major reason behind this is fatigue and lack of quorum for the meetings.

Using a cut off of 70% above which teams would be classified as functional, otherwise non-functional, 63% of the facilities in which the assessments were conducted were classified as functional. All six HC III teams assessed were functional. In HCW and hospital teams, the percentage of functional teams was equal to the non-functional teams (50%) (Figure 4).

Quality improvement teams significantly improved the linkage of HIV positive mothers from an average of 25% before team formation to 70% after 12 months of their existence (p<0.001) (Figure 3). The performance of QI teams in linking of HIV positive mothers into HIV care was positively associated with team functionality, with functional teams performing better than the non-functional teams, (R2 0.84 vs 0.50 respectively) (Figure 4).

Conclusion

QI teams significantly improved the linkage of HIV positive mothers into HIV chronic care at 16 HIV clinics with the functional teams performing better than the non-functional teams. QI team activeness is the biggest hindrance to QI team functionality. There is need to address factors that lead to poor team activeness if QI teams are to be made functional and thus post better performance.

Acknowledgements

The work was supported by the American people through the United States Agency for International Development (USAID) and its Applying Science to Strengthen and Improve Systems (ASSIST) Project. ASSIST is managed by University Research Co., LLC (URC) under the terms of Cooperative Agreement Number AID-OAA-A-00-0201. Prior to ASSIST, this work was supported by USAID’s Health Care Improvement Project (HC III) under the terms of Contract Number GHN-I-03-07-00003-00. For more information on the USAID ASSIST Project, please visit www.usaidassist.org or contact assist-info@urc-chs.com.

References
