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USAID'S HEALTH EVALUATION AND APPLIED RESEARCH DEVELOPMENT (HEARD) PROJECT

THE STANDARDS-BASED MANAGEMENT AND RECOGNITION (SBM-R) APPROACH IN GUINEA

Case Study Brief

BACKGROUND

The USAID Guinea's Health Service Delivery (HSD) Activity implemented the Standards-based Management and Recognition (SBM-R) approach to improve performance, accessibility, and quality of facility-based health services in three primary domains: emergency obstetric and neonatal care, family planning, and infection prevention and control. Facilities participating in the SBM-R process underwent internal and external assessments of performance standards periodically through self-assessment and accreditation review. Facilities that successfully met a minimum average score of 80% for correct implementation of the standards were accredited with a gold star. Facilities could earn a second star by meeting 86% of the standards in a subsequent assessment.

Within the final performance evaluation of the HSD Activity, a case study explored the extent to which the SBM-R approach led to health service improvements over the first 4 project

KEY PROGRAM AND POLICY RECOMMENDATIONS

- ▶ *Infrastructure and equipment upgrades:* Facility improvements, including water, sanitation, and sterilization, as well as the availability of basic equipment, are imperative for staff morale, as well as the provision of integrated quality care.
- ▶ *Consolidation of performance indicators:* A minimal set of criteria that capture the most critical aspects of quality care should replace the current list. Current SBM-R performance criteria are extensive, and many are interdependent. Further, progress indicators should be introduced to reflect incremental achievements.
- ▶ *Community engagement:* Engaging communities as partners in quality improvement is needed as it increases commitment, motivation, and accountability among facility staff.
- ▶ *Institutionalization of SBM-R committee:* The national committee that validates SBM-R at the facility level should be institutionalized to ensure that assessments are conducted at regular intervals, which is critical for the validity of the process.
- ▶ *Managerial guidance:* Skills-building, continuing education, and close follow up are needed with managers at all levels to encourage ownership and commitment to the process.
- ▶ *Ministry of Health (MoH) engagement:* The SBM-R process needs to implicate the MoH at all levels to own challenges and achievements, and ultimately guide necessary organizational culture shifts.
- ▶ *Clinical performance oversight:* When clinical performance is found to be unsatisfactory, mechanisms for immediate recourse should be in place, with transparency and consistency.
- ▶ *Sustainability efforts:* To maintain the momentum that SBM-R has created, it is necessary to advocate for other sources of external support, through the MoH, as well as multi-sectoral stakeholders.

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At the Kassapo Health Center a star earned for provision of quality health services through the SBM-R process is displayed, Boké (Credit: Marie Boré)

years, as well as the potential for replication, scale up and sustainability. This document provides a summary of case study findings and recommendations. Refer to the full case study for additional detail.

METHODS

The case study utilized the qualitative and quantitative data collected for the main evaluation at the national, facility, and community levels¹. Primary data included key informant interviews, focus group discussions, observation checklists, and provider surveys; and secondary data included document review and quantitative facility-level data. For the main evaluation, primary data included key informant interviews, focus group discussions, observation checklists, and provider surveys, while secondary data included document review and quantitative facility-level

data analysis. In six purposively-sampled SBM-R case study facilities (two hospitals, and four health centers)², additional data collection covered the following four topics: understanding the SBM-R process; achievements and outcomes; internal and external performance drivers; and ownership, replicability, and sustainability. A realist evaluation approach informed the analysis of the case study, structured around a context-mechanism-outcome framework.

FINDINGS

Context: The SBM-R approach was implemented within the context of major structural challenges facing the health system, including chronic staff shortages and turnover, inadequate infrastructure, and community mistrust in the health system stemming from the 2014-2016 Ebola epidemic.

Process: The SBM-R process takes place in two steps. First, a regular self-assessment is carried out at the facility-level by a team of providers, senior managers, COSAH representatives, and community members. Then, the facility requests external evaluation and validation by the national committee when ready. If facility performance on external review is 80% or greater, it receives one star. A second star is achieved when a facility with one star demonstrates performance for at least 86% of the standards. Of 272 HSD-supported facilities, 97 implemented the SBM-R program, of which about half (51%) had earned one or more stars.

Engagement: The 97 SBM-R facilities implemented the approach, on average, for four years. Wide variation existed in the frequency of facility assessments, ranging from once per quarter, which is the target, to once per 15 months, which is much longer in between assessments than intended. Nearly half of all SBM-R facilities (47%) achieved three or fewer assessments from 2017-2019, and were thus categorized as low engagement.

Performance Drivers:

Clinical Performance: The case study demonstrated marked improvements in scores for infection prevention and control practices, ranging from a 25 to 70 percentage point increase. Other large improvements in clinical

1 The sample of 10 hospitals and 26 health centers were purposively selected for variability in the region, SBM-R (or other indicator) performance, location, and service volume. Health centers were further selected for: benefit of infrastructural improvements and receipt of equipment, and presence of active community components.

2 The sample of six case study facilities was purposively selected to include variation within the sample in region, performance, length of time participating in SBM-R, location, and service volume.

Table 1: Star-earning facilities by region

Region	SBM-R facilities	No. with at least 1 star	% with at least 1 star	No. with at least 2 stars	% with at least 2 stars
Boke	14	2	14%	0	0%
Conakry	10	5	50%	2	20%
Faranah	15	12	80%	3	20%
Kankan	17	6	35%	1	6%
Kindia	15	9	60%	1	7%
Labé	16	8	50%	2	13%
Mamou	10	7	70%	1	10%
Total	97	49	51%	10	10%

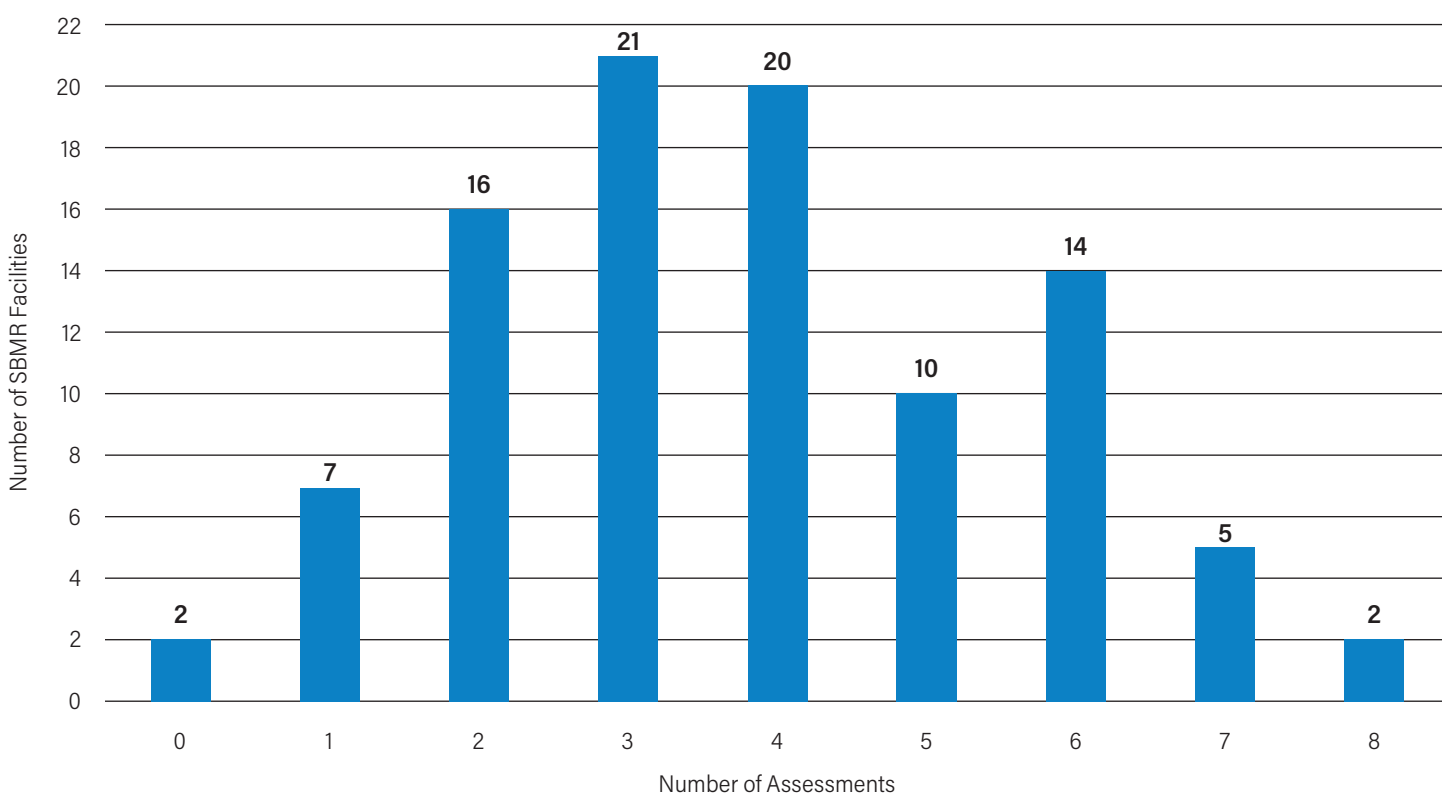
practice were attributed to obstetric interventions, though more improvements are needed for respectful care and complex newborn health interventions. Further, family planning performance standards generally improved across the case study facilities, while challenges remain in providing evidence-based information on specific family planning methods.

Managerial Performance: Managerial performance indicators were quite variable. Managerial issues included poor client-provider communication; low availability of

information, education, communication materials; lack of job descriptions for staff; and long wait times for clients. Management of infection prevention and control through regular monitoring and oversight of cleanliness was an issue in several of the case study facilities as well.

Equipment, Supplies, and Infrastructure: Many of the case study facilities struggled in the initial years to obtain supplies, such as scales, blood pressure gauges, and examination tables. Facilities' capacity to perform sterilization and waste management was particularly

Figure 1: SBMR assessments facilities completed (October 2017-September 2019)



problematic, due to a lack of disinfectants, antiseptics, and personal protective equipment. Though space was a major infrastructure issue in early years, most facilities overcame these limitations within two years of their engagement in the SBM-R. Management played a critical role in mitigating these issues.

Conclusions: The two key factors for performance improvement are: 1) HSD-provided inputs, such as training, equipment, and managerial guidance; and 2) facility-level receptivity to SBM-R. Training and equipment alone are insufficient to drive quality improvement. Leadership by facility managers and supervisors, coupled with the engagement and commitment of district and regional actors within the MoH, is essential. Long-term maintenance of facilities and equipment must be managed locally, through participation of government officials, community leaders, and community members. Despite positive perceptions of the SBM-R process, many facilities did not engage, either due to the perception of the additional work it entails, or a sense of fatalism that improvements cannot be achieved given the facility's current condition. While the SBM-R process is appreciated by staff and communities in many locations, higher-level leadership is needed to drive participation in quality improvement processes more broadly.



Evaluation fieldworkers with the Labé regional health director and JHPIEGO regional focal point, from left to right: the JHPIEGO focal point in Labé, Dr Barry Néné Djiba, Dr Houdy Bah (Régional Health Director), Dr Ciré Diallo, and Dr Bah