SQALE
PUTTING QUALITY AT THE HEART OF COMMUNITY HEALTH

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Bridging the Quality Gap - Strengthening Quality Improvement in Community Health Services

Symposium Report

Diana from Turkana County, Kenya. By Rosalind McCollum

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www.usaidsqale.reachoutconsortium.org

Contents

Acronyms

CHEW	Community Health Extension Worker
CHIS	County Health Information System
CHU	Community Health Unit
CHV	Community Health Volunteer
DHIS	District Health Information Systems
HIV	Human Immunodeficiency Virus
KQMH	Kenya Quality Model for Health
MES	Managed Equipment Service
NASCOP	National AIDS and STI Control Program
QIT	Quality Improvement Team
TB	Tuberculosis
TBA	Traditional Birth Attendants

About the USAID SQALE Community Health Services Program

Many women die or become disabled because they fail to access the recommended health services – both antenatal and when they give birth. It is estimated that 58% of pregnant women attend four antenatal care visits and 61% deliver in a facility. The 2014 Kenya Demographic and Health Survey estimated that under-5 child mortality is 52 per 1000 live births and only 68% of children have received complete vaccination. In some rural areas and among poorer communities in cities the situation is worse than the average.

The Kenyan government and non-governmental organisations have made a commitment to community health. This work is carried out by Community Health Extension Workers (CHEWs) who train volunteers, support HIV testing and counselling, and deliver family planning, immunization and child nutrition services, among other tasks. They supervise CHVs who are chosen by the community. CHVs are responsible for 20 households and serve on a voluntary basis, carrying out home visits and reporting on their work once a month. Although equipped to treat common ailments, their focus is primarily on health promotion and prevention, child growth monitoring and referral of women and children who need services such as antenatal care, delivery or other clinical support.

CHVs are the unsung heroes and heroines that provide a vital first link between the community and health services.

Kenya is on the brink of further scaling-up community health programs, but there are risks that rapid scale-up will compromise quality, equity, and sustainability of services.

USAID SQALE supports this effort through a process of Quality Improvement that includes capacity building and community engagement. Our aim is to strengthen leadership and coordination at national, county and community levels by embedding a culture of quality improvement practice.

This will result in:

• Leadership and communities of Quality Improvement embedded at national and county levels resulting in strengthened coordination for improved community health programs

• Increased capacity of county decision makers to prioritize and budget for community health programs in an equitable manner

• Improved community health program performance in reproductive, maternal, neonatal and child health

• Stronger community engagement and increased community participation in decision making

Welcome to the USAID SQALE symposium

On the 29 September USAID SQALE hosted a symposium in the Kenya School of Monetary Studies in Nairobi. It was an opportunity to bring together a range of stakeholders from the health sector to share learning on quality improvement. It aimed to strengthen our knowledge of how Quality Improvement methods can be applied at the community level.

Community systems are the bedrock of health systems. In cities and villages Community Health Workers - such as CHEWs and CHVs – support colleagues in facilities to deliver essential health services and identify individuals and families at risk of illness. These workers are a vital cadre that are helping us to meet our heath and development targets, yet often their efforts go unnoticed and uncelebrated.

To draw attention to the work of Community Health Volunteers (CHVs) we used the symposium as an opportunity to launch our new film, *Making the Invisible Visible*. You can view the film on the LVCT Health YouTube channel. Feel free to share the link https://www.youtube.com/watch?v=41GfUm10-Vg

We would like to thank our co-sponsor the Ministry of Health for all their assistance in conceptualising and delivering the symposium. We also feel gratitude to the plenary speakers, panellists, audience members, administrative and communications staff, and caterers who made the event such a success.

Opening plenary

The speaker is Samuel S. N. Njoroge

> *"Community health systems are the backbone of the health system in Kenya and if they are strengthened it can be a huge bonus to the nation."*

Samuel S. N. Njoroge, Community Health Services Unit, Kenya Ministry of Health

The meeting was opened by David Silu, County Director of Health, Kitui County.

The Community Health Strategy exists to empower, individuals, households and communities. Informed communities can hold policy makers to account for their right to health and they can take responsibility for their own health. Affordable, equitable, and effective health care should have the community as the core of the package. We know that communities must be included and empowered to ensure access. Through the establishment of a sustainable community health service we will remove barriers to access and support the goal of universal health coverage.

Inter-sectoral action

There is a need to ensure dignified livelihoods across the life cycle as people of different ages have different health needs. Our constitution and key policy documents emphasise a community approach is central to this. Through the different sectors at community level we deal with the social determinants of health. We provide the basics and we aim to reach those who are geographically marginalised.

Political commitment

Government policy states that five CHEWs serve one Community Health Unit (CHUs) that covers 5000 people via CHVs. The community health committee oversees this. By end of 2015 there were 4587 CHUs, 4048 CHEWs, and 90579 CHVs delivering services.

More and more health programmes are interested in using these community structures as a way of delivering services. The government provides a Master CHU listing where you can see all the health facilities and understand their functionality and quality assessment tools that deal with quality within these services. The strategy was evaluated in 2010 which demonstrated that it works and in 2014 the Kenya Demographic and Health Survey showed improved child and maternal health indicators.

Potential challenges

The Community Health Strategy may not be appropriately prioritised in some counties after devolution. The government does not have adequate resources to support staff and disseminate standards. We are reliant on donor funding which may not remain stable. Knowing how to incentivise the CHVs and ensure that they are aware that they are appreciated can be difficult. Thus, there is a high turnover of volunteers. We need to address challenges through recruitment and retention of CHEWS and CHVs. More advocacy and communication and better telling of success stories in a way that they reach more people is necessary. Work at the community, county and national levels needs to better link to global commitments. At the community level issues of income generating activities are crucial. We need to accelerate the use of digital tools and monitoring and evaluation and health information systems need to be taken seriously. There are opportunities: there is research work happening that can drive the development of the programme; public-private partnerships may be useful; devolution means we can press for change. All programmes must see the Community Health Strategy as an integral part of health systems strengthening.

Miriam Taegtmeyer, USAID SQALE

Community health workers are considered a way of delivering many vertical programmes. Sustainable Development Goal Indicator 2.3 deals with quality in health services – however we don't know whether adding on additional health-related tasks to the load of community health workers is effective or how it effects the quality of services. The REACHOUT Consortium provides a platform for research analysis between countries about what works where in improving quality in community health. We have trialled Quality Improvement through researcher-led action research cycles. With USAID SQALE we are moving away from an outsider-led, or researcher-led, process for quality improvement in community health to one led by the national, county, and sub-county levels of government.

Overcoming tensions of access vs quality?

There can be a tension between adding numbers of people reached by community health workers and investing in quality. Challenges associated with this include: 1) That all actors in the process need to know who is responsible for quality 2) We don't have measures of the community experience of quality and what brings satisfaction.

There is a need to strengthen the coordination structures for quality at community level and the capacity to prioritize and budget and simultaneously bring in the voices and experiences of the community.

Alignment with government

We want our Quality Improvement intervention to align with standards, models, and tools circulated by the Kenyan government. We want them to be simple and jargon free. During the process, we will recognise best practice and ensure that everyone knows their role.

USAID SQALE will work in eight counties where there is poor maternal and child health. We will choose locations where there is existing work on Quality Improvement and where there are functional

Quality Improvement Teams (QITs) at county level. During a trial period in two counties people will be trained, then implement improvements whilst being supported through coaching and mentoring. After this we will have developed a practical curriculum that can be rolled out. We also want to identify quality improvement champions at community and sub-county levels who can become trainers and help roll out and scale up.

> *"We need better coordination at the national and county levels to capture and communicate what is being learned about the various projects being implemented at the community level."*
>
> Dr Sheila Macharia,
> Head MNCH, USAID

Dr Sheila Macharia, Senior Health Advisor, USAID Kenya

There is nothing particularly new about community health programmes and there are many organisations around the country implementing programmes at this level. However, sometimes we don't capture the evidence of the work that we do. Community Health Workers are visiting households – for TB, for home based care, for sanitation etc. But we haven't captured the communities' perceptions of the service they provide and its impact. We need better coordination at the national and county levels to capture and communicate what is being learned about the various projects being implemented at the community level.

Questions remain

There are many questions that remain unanswered. The chalk boards outside the health care centre – tell us what the community does not have – e.g. bed nets. Who is interested in this information? Is there truly a listening place for what the CHVs are doing? How are we tracking referral and linking the CHV and the facility?

We place a lot of responsibility on people who are poor. Who works for free? Is there a way to incentivise CHVs who refer mothers to maternal health programmes – is this part of a county budget? USAID has prioritized sustainability of CHW programs and will now only match what counties invest in CHW programs.

Dr Anne Wamae, Head, Clinical Services gave a speech on behalf of Dr Jackson Kioko, Director of Medical Services, Kenyan Ministry of Health

Invited guests, ladies and gentlemen,

Good morning,

I am very happy to join you at the "Sustaining Quality Approaches for Locally Embedded Community Health Services" (USAID SQALE) Symposium. Let me start by taking this opportunity to acknowledge the efforts and contributions of our health care institutions, partners, and volunteers I health promotion and advocacy.

Kenya adopted the Community Health Strategy to enhance community access to health care in order to improve productivity, education and reduce poverty, hunger, child and maternal deaths.

The community health service is therefore one of the cornerstones of our country's health system as envisioned in the Kenya Vision 2030 and the Health Policy which is aimed at achieving the Universal Health Coverage.

I am indeed encouraged to note that the Community Health and Development Unit is partnering with LVCT to pilot a project named Sustaining Quality Approaches for Locally Embedded Community Health Services (USAID SQALE) in four counties, to reduce maternal and child deaths.

The project has four objectives namely to strengthen national coordination for improved quality of community health programs; increase capacity of counties to prioritize and budget for the community health program; improve community health program performance in maternal and child health and strengthen community engagement in community health services.

This project is one of our weapons deployed to enhance maternal and child health. I am glad to note that standards for the Community Health Services have already been developed by the Ministry's Division of Health Standards, Quality Assurance and Regulation in liaison with the Community Health and Development Unit.

I therefore wish to comment this effort which aims at championing the Kenya Quality Model for Health (KQMH) at the community level. We intend to fight and win this war by better connecting our troops and sharing information by strengthening leadership at all levels of the community health structures; embedding the culture of Quality Improvement at national and county levels and increasing community participation in decision making.

Our agenda is focused on improving the quality of community health services by operationalising the quality standards for level one. The Government has taken a significant step in building public private partnerships to strengthen community health services. This kind of partnership provides an avenue for learning best practices to embed the Quality Improvement in community health services and scale it up at national, county, and community levels.

Through this collaboration, the Ministry will strengthen coordination and leadership of Quality Improvement by embedding a culture of Quality Improvement through capacity-building and community engagement.

Indeed, this partnership complements the Ministry ISO 9001:2008 certification and I am urging all units and programs within the Ministry to adopt this approach.

To provide clearer articulation of community roles and competencies, our agenda today is to realise regular Data Quality Audits, dissemination of current standards, training and sensitization of national and county teams, continuous mentorship and support among the community health workforce and review and adoption of KQMH standards for community health services across the country.

Lastly, I want to reaffirm our Ministry's commitment to improve the quality of health care to Kenyans. Our healthcare financing system, comprising subsidies, elimination of user fees in primary healthcare facilities, the Free Maternity Services and the Managed Equipment Service (MES) project has helped us keep healthcare affordable, especially for the lower- and middle-income Kenya, while ensuring long term sustainability.

As a Ministry, we shall continue to work with all stakeholders to strengthen the community health interventions to reduce deaths of mothers, newborns and tackle the wider challenges of improving the health of all Kenyans.

Ladies and gentlemen, it is my pleasure to officially launch the Sustaining Quality Approaches for Locally Embedded Community Health Services project.

We must all do whatever it takes to ensure NO woman dies when giving life and that children are given a chance to survive fully by enhancing quality in community health services in Kenya.

Thank you very much. May God bless you all."

"There are well-known, evidenced interventions for Quality Improvement but the question is how you contextualise them and make them relevant for the health care worker."

Dr Prisca Muange, Senior Quality Improvement Advisor, URC

Dr Prisca Muange, Senior Quality Improvement Advisor, URC

USAID Assist, is funded by USAID, and works worldwide (in 15 African countries) to build capacity for governments on Quality Improvement in health, orphan and vulnerable children programming, and child protection. We have been working with the Kenyan Ministry of Health to develop a Quality Improvement policy. We have also worked with the National AIDS and STI Control Program (NASCOP) and at county level in 19 of the 47 counties. Work on reproductive, maternal, new born and child health is taking place in five counties in 42 facilities. Issues of sustainability have been considered and the project is trying to ensure that once we exit there is a mechanism that will sustain the process of Quality Improvement independently of USAID Assist.
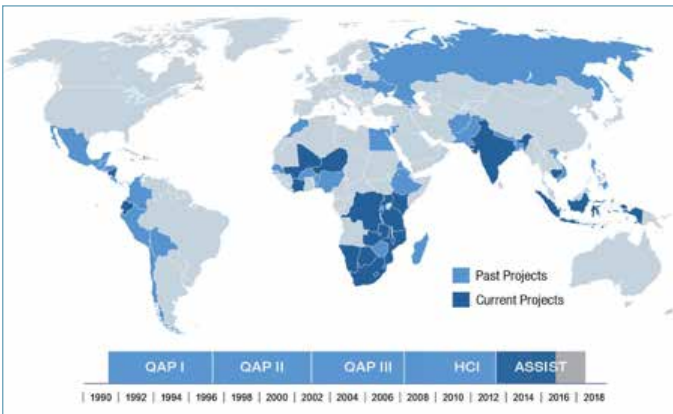

Figure 1: History of the USAID Assist Project

Figure 2: Simple Quality Improvement model

Simple, evidence based processes

There are well-known, evidenced interventions for Quality Improvement but the question is how you contextualise them and make them relevant for the health care worker. USAID Assist are interested in a focus on improvement science and not improvement jargon. We use simple problem-identification tools – this helped health care workers standardise systems within the facility. The focus is on the process of care to improve impact, developing processes with workers, which focus on patient needs.
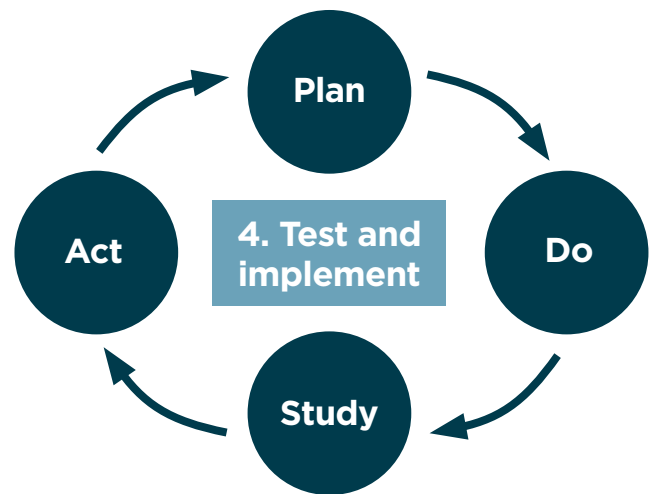
Coaching is important for Quality Improvement – it is important not to 'eat the whole elephant'. Facilities need to be walked through the process and concepts should be introduced one at a time. Peer learning and the establishment of Quality Improvement champions also supports this process.

Avoid:	
Doing what you've done before: "Let's have a training"	*Technical slow-downs:* "We will build a computer program to do this…"
Low-impact changes: "Let's put up a poster"; "Let's have an education session"; "Let's send out reminders"	**Provide:** *Next steps, not routine work plans that have no follow through mechanism*

Charles Mito, Measure Evaluation – PIMA

MEASURE Evaluation PIMA is a five-year USAID-funded project designed to support the Government of Kenya to build sustainable monitoring and evaluation capacity in evidence-based decision making to improve the effectiveness of the Kenyan Health System.

What does MEASURE Evaluation PIMA do?

We work to improve the monitoring and evaluation in national level bodies such as the Department of Reproductive Health and within County Health Management Teams. This enables them to better identify and respond to their information needs. We work to improve the availability and use of quality health information by strengthening existing systems. PIMA is currently working in ten counties: Nairobi, Machakos, Nakuru, Muranga, Kakamega, Kisumu, Siaya Kilifi, Homabay and Migori. The PIMA's support to the County Health Information System (CHIS) is focused on:

• Strengthened monitoring and evaluation capacity at national and subnational levels

• Ensuring data availability for use in decision making at community level

• Enhancing community data quality and reporting in District Health Information Systems (DHIS)

We are working in Homa Bay, Migori, Kisumu, Nairobi, and Siaya Counties. As part of this work they conducted a Rapid Assessment that: Determined the use of CHIS revised tools; enabled PIMA to ascertain sub-counties reporting rates; allowed for greater understanding of data use by communities for decision making; identified challenges encountered by the sub-counties in improving the CHIS; and identified partners involved in CHIS strengthening to enable coordination and enhance stakeholder engagement and partnerships.

The methodology for this was that a self-administered questionnaire was developed in consultation with the CHU with contributions from the county community health services coordinators. The tool sent to the sub-county community services focal persons who shared with the relevant CHEWs for completion based on their knowledge of community unit(s). It was then completed by the CHEWs and community focal persons for their respective community units, analysis was conducted with the support of PIMA. The sub-counties assessed were those currently getting CHIS support which are also PIMA intervention sites.
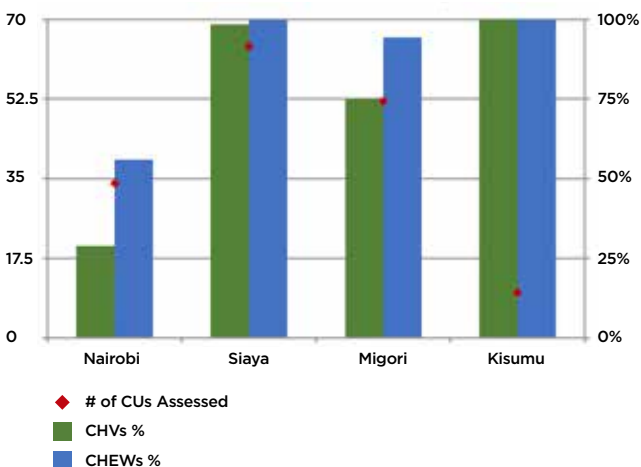
Findings

County	No of CUs	MOH 513	MOH 514	MOH 515	MOH 516	MOH 100	Treatment register	Indicator matrix	Supervision checklist
Nairobi	34	4	5	5	0	6	9	1	3
Siaya	64	12	42	5	5	2	0	1	2
Migori	52	7	41	7	8	4	5	6	5
Kisumu	10	6	8	9	7	5	1	0	5
Total	160	29	96	26	20	17	15	8	15
%		18%	60%	16%	13%	11%	9%	5%	9%

Table 1: Availability of old tools

County	No of CUs	MOH 513	MOH 514	MOH 515	MOH 516	MOH 100	Treatment register	Indicator matrix	Supervision checklist
Nairobi	34	2	2	4	2	2	2	0	0
Siaya	64	16	19	45	8	46	47	5	9
Migori	52	6	12	12	4	1	0	0	6
Kisumu	10	2	2	1	0	1	1	0	1
Total	160	26	35	62	14	50	50	5	16
%		16%	22%	39%	9%	31%	31%	3%	10%

Table 2: Availability of new tools

Timely Reporting

- ◆ # of CUs Assessed
- ■ CHVs %
- ■ CHEWs %

Report Completedness

- ◆ # of CUs Assessed
- ■ Complete %
- ■ Partial %
- ■ Incomplete %

Data Analysis and Use

Legend:
- # of CUs Assessed
- Data Analysis #
- Data #
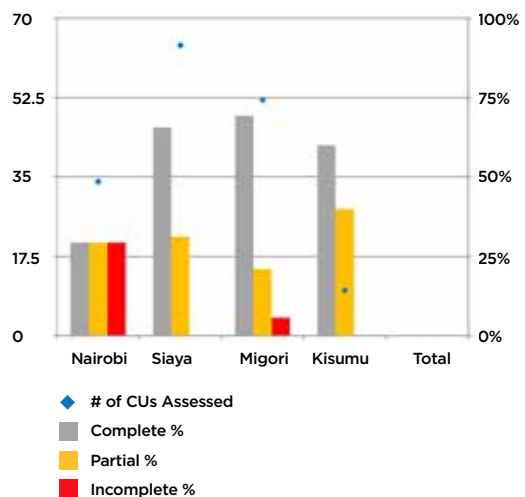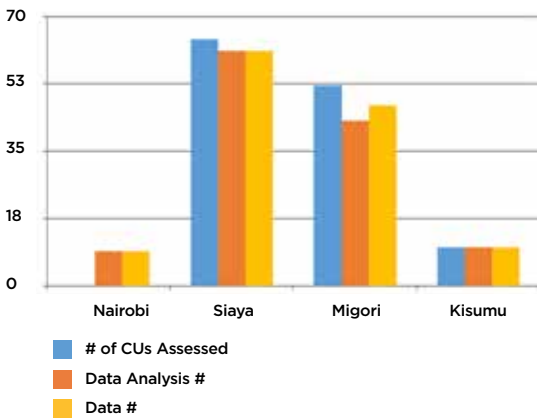
Data Use Forums and the Sub-Counties

Legend:
- # of CUs Assessed
- Dialogue Days
- Stakeholder Forums
- Facility Meetings
- Chief Barazas
- Monthly Meetings
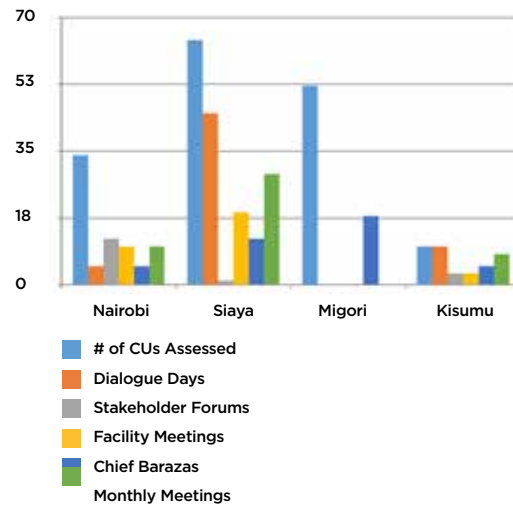
Challenges

We identified challenges which included: late reporting by CHVs due to lack of motivation such as late stipend and allowances; lack of reporting tools especially the MOH 514 and stationery, pens, note books and flip charts; some CHVs have many households to cover so reports are shared for only the households reached which may not be representative of the CHU population; and a lack of capacity among the CHVs in completion of tools and understanding of indicators.

There we problems in terms of poorly-harmonized reporting tools and some of the CHUs are still using old tools while other use both revised and old hence which led to low reporting on MOH 515 and MOH 516. The manual retrieval of data to aggregate the indicators from the community daily from the registers is tedious. There is a high dropout rate among CHVs and a lack of forums for Community Health Strategy discussions.

Moving forward

To respond to these challenges PIMA conducted a sensitisation to the revised CHIS tools and offered support to stakeholder forums. We supported the harmonisation of community data in the DHIS and collaborated with partners to disseminate revised tools ad correct the chalk boards. We collaborated with partners to conduct data quality reviews and

provided training on verbal autopsy and other issues. Other actions taken included:

- Dissemination during stakeholder fora in respective counties

- Orientation on CHIS revised tools in five target counties

- Development of sub-county specific Performance Improvement Plans

- Data review meetings in Siaya and Nairobi counties

- DHIS2/Master Community Unit List harmonization for Migori and Siaya counties

- CHIS Standard Operating Procedures disseminated during the orientation on CHIS revised tools

- County specific fora in Q2 for five target counties

- Regional stakeholder forum in Q3 in collaboration with APHIA plus where the District Health Management Team (DHIME) and Community Health Services Unit discussed issues affecting community reporting

- Support conducting county and sub-county data quality reviews

> *"If something is not happening in the community it is not happening."*
>
> Dr Miriam Taegtmeyer, USAID SQALE

Dr Florence Achungo, Westlands Sub-County MoH

Westlands County faced a challenge. Whilst there was increased demand for health care services in the community, there was reduced demand for health care services offered at primary level facilities (for example, in reproductive health, child welfare, TB, HIV, basic diagnostics and pharmacy services). Lower demand was due to clients' poor satisfaction with the services that we offered. To address this challenge Westlands employed the QIP Health Excel program.

What is QIP Health Excel?

QIP Health Excel is a tool that enabled decision makers to:

Define – construct key improvement indicators (client satisfaction, service utilization, and quality).

Measure quality – through timeliness, safety, efficiency, effectiveness, equity and patient centeredness. The key drivers of quality in Westlands were safety and timeliness. The project measured service availability, the time of first contact and turnaround time (because often when people get to a facility there is no health care worker).

Analyze – collect evidence of the baseline situation as a basis for improvement targets.

Improve – by identifying gaps in the indicators, defining a process to seal the gaps, and determine structures needed to execute the process.

Control – Through continuous monitoring of key outputs and outcomes and data sharing.

The focus was on system strengthening; governance structures (Facility Health Management Committee) and management structures (Sub-County Health Management Team, Facility Health Management Team); evidence provision; and motivation. Key to the success of the intervention were Government and partner support and the recognition and reward of good performance.

Dr Charles Kandie, Head, Health Standards Quality Assurance Division Kenyan Ministry of Health

Dr Kandie provided an overview of the KQMH Standards for Level 1. KQMH is a set of standards on quality – improving structures and processes to this end. It has been spearheaded by the Community Health Services Unit and launched in March 2015.

In a resource-limited setting you need to be targeted – so prevention is the best form of attack. The KQMH aims to support an optimal community health service; achieve and maintain an acceptable standard of quality of care; ensure that services at community are commensurate with universal best practice and are responsive and sensitive to the client needs/expectations; and Introduce quality management to health managers and service providers at community level.

What is the KQMH?

The KQMH is a conceptual framework for an integrated approach to improved quality of healthcare. It provides a framework for holistically and systematically addressing a range of organizational quality issues with the main aim of delivering positive health impacts.

KQMH outlines standards for each domain of quality. QITs and units can use these standards to measure and evaluate their improvement. Each standard is scored on a scale of 1 to 5. It prompts users to go beyond the standard, to excel.

A total of 54 indicators have been identified, defined, frequency of collection determined to aid in establishing the baseline performance of CHUs. Sources of the data for the indicators is indicated and point of use. The information generated will assist various level of service delivery in decision making.

It will help ensure adherence to standards, regular assessments and audits and institutionalise a culture of quality management at the community, encouraging frontline workers to come up with ideas on how to make positive change.

Evidence-based medicine

Develop/revise and disseminate clinical and public health standards and guidelines that are based on evidence.

Total Quality Management

- Input > Process > Outcome:
  Use the Master Checklist
- Application of Quality Management principles

Patient partnership

- Patients/clients are co-producers of
  health outcomes
- Promote community involvement
  and participation

Panel Discussion: Community Health Services in Kenya and how they can be strengthened to meet Universal Health Coverage and the Sustainable Development Goals

Panellists: Penina Ocholla, GLUK; Lynn Kanyuuru, JHPIEGO; Mr Daniel Kavoo, MoH; David Silu, Kitui County

The day ended with a lively panel discussion in a talk show style which was moderated by Dr Miriam Taegtmeyer. Some of the key issues that were brought the fore in terms of engaging with community health systems included:

• The need to go to the community a just listen, to "shut up your mouth" and unlearn the bad habits that medical school taught you in terms of elitism

• Investment in community health which is culturally specific, as has happened in Cuba, provides a model that can be adapted

• Health care does not belong to healthcare professionals

• It is not always about the need for more money, there are many other things that we can ask for

• Devolution provides an opportunity to work together to come up with new solutions and to promote community health services. However, counties do not necessarily prioritise community health systems

• Elections tend to prompt an investment in more tangible things like hardware and it is more difficult to demonstrate the impact of illness averted. We need to continue to work on this

• If you succeed on maternal, newborn, child health and nutrition you will have better community health and this needs to be factored into indicators

• In some counties, Traditional Birth Attendants (TBAs) still deliver – whether we like it or not.

How many women actually go for all ante-natal appointments and post-natal care is important as many women are dying silently in the village. Women prefer TBAs because they rub their backs and talk to them nicely. At the health care centers, there are long queues, no drugs, corruption, and long waiting times. We need to also work on our interpersonal skills

• We need to stop running parallel community and health systems and help them to cross-refer

• Looking to the future we need to also tackle non-communicable disease, for example could CHVs do blood pressure testing and talk about diabetes?

• We need to think about our language. Do the communities understand the English that we are presenting in today? No they don't!

• We need to prepare communities and sensitise them for programmes. They need to be organised. People can be enthusiastic and enjoy interacting with data.