Quality Improvement for community health services

Learning Event Report

Hosted by Nairobi County October 2017, PanAfric Hotel, Nairobi

Executive summary

One of the key innovations of the Kenya Essential Package for Health (KEPH) is the recognition and introduction of Community Health Services. These services aim to empower Kenyan households and communities to take charge of improving their own health. Kenya is in the process of scaling-up community health programs with commitment from the national and county governments and Non-Governmental Organisations (NGOs). But there are risks that rapid scale-up will compromise the quality, equity, and sustainability of services.

The three-year USAID SQALE Program Program aims to improve maternal and child Health in Nairobi, Kitui and Migori counties by embedding quality into the scale-up of community health services. It comprises a process of capacity building, coaching and community engagement that is being delivered through Work Improvement Teams at sub-county and community levels who receive a three-phase action learning programme, interspersed with 'learning by doing' and coaching.

The Learning Event

In October 2017 representatives from community to national level participated in a two day "festival of learning" that formed the third phase of the USAID SQALE Program quality improvement training model. The overall aim of the event was to share experiences and learn from one another. The specific objectives were to:

- Evaluate and present quality improvement change plans for community health services
- Celebrate success, recognising high performing teams and innovative changes
- Share learning on the application of quality improvement approaches in community health
- Identify key enablers and challenges for Work Improvement Teams in implementing quality improvement for community health
- Plan for further embedding quality improvement into the community health system

Twenty-four Work Improvement Teams from Nairobi and Kitui counties came together for the first time to share their experiences. Nairobi County hosted the event, with over 100 participants and facilitators, which comprised of twenty-four quality improvement teams, Kitui and Migori Counties and participants from the National Ministry of Health Departments for Community Health and Health Standards, Quality Assurance and Regulation.

Innovative methods

We made the event as interactive as possible and ensured all voices, from community members to policy makers, could be heard. We used a wide-range of learning and sharing methods including plenary presentation and discussions, hand-designed poster presentations, panel discussion, peer assessment, quality improvement awards and a World Café. We purposely minimised the use of technology and PowerPoint presentations.

Community members and health volunteers took a prominent role in describing the practical reality of their work on the ground to policy makers and managers. Involving senior Ministry of Health officials, paired with community health workers in judging team documentation and poster presentations provided them with insights and in-depth understanding of the work and achievements of community-based teams. Powerful interactions between Work Improvement Teams from different sub-counties gave a sense of friendly-competition and healthy debate around how to engage communities and improve quality with existing resources. We rewarded best practice through team certificates of recognition for the best poster presentations and best-kept Work Improvement Team folders.

Local solutions to local problems

Within the context of devolution in Kenya, this learning event highlighted promising results from the 24 Work Improvement Teams from Nairobi and Kitui. For example, a community unit in Nairobi with high rates of home delivery described how they mapped all pregnant women in the community and changed the way they track, support and refer pregnant women for skilled delivery. Because of the intervention they had not reported a single home delivery in the preceding four months. A number of units from Kitui managed to improve the accuracy of their community health data from no reporting at baseline to over 60% accuracy. HDD unit reported an impressive increase in the number of Community Health Volunteers (CHVs) visiting households on a monthly basis from 60% to 80%. This was achieved by addressing allocation of CHVs to households and following up issues that had arisen in their root case analysis. While it is too early to demonstrate impact on maternal and child health outcomes, both sub-county and community level Work Improvement Teams have shown that it is possible to improve the quality of community health data and services using a simple, planned and systematic approach which incorporates community voices. Teams were able to demonstrate that quality improvement at community level is feasible and can have positive impacts.

The learning event captured discussion on the enablers and barriers to quality improvement for community health and how to improve quality using existing resources. These included leveraging existing structures to implement activities and the inclusion of community members in Community Health Unit Work Improvement Teams to improve communication about activities at community level. There were discussions on how to strengthen the linkages between the Community Health Units and primary health care facilities by including the Facility-in-Charge as a key member of the team.

Creativity and innovation at the local level was a recurring theme. Multiple innovations were described. For example, one Community Health Unit initiated a 'household visit week' to ensure CHVs allocated their time to this task and were appropriately supported. Several units paired weaker and stronger CHVs, creating a mentoring approach that improved knowledge, data quality, and performance of the weaker CHV. Referral was tracked too. Facility files were created at all sites to monitor and track community referrals. Ministry of Health 100 referral forms from CHVs are now stored in one place, giving opportunity for review and feedback. This in turn has led to an increased recognition of the key role CHVs play at the interface between communities and the health system.

Conclusion

The learning event methodology demonstrated that dialogue, rewarding best practice, and advocacy are fundamental to the success of quality improvement at community level and can be achieved with a modest resource investment.

Preliminary results of the USAID SQALE Program model for quality improvement at community level are promising and indicate that it is feasible and can have positive impacts. By using a systematic approach to collecting, analysing and using community health data, CHVs have been able to dramatically improve reporting, community engagement with the health system, and efficiency and performance by focusing on priority maternal, newborn and child health issues. These Work Improvement Teams are spearheading a quality revolution in Kenya - starting where it matters most - with the community.

Full report

The Millennium Development Goals (MDGs) on health expanded access to basic health interventions to millions of people in low- and middle-income countries. However, access alone will not be sufficient to meet the Sustainable Development Goals (SDGs). If health systems cannot provide high quality care that improves health outcomes and provides value to the communities they serve, then countries such as Kenya will not achieve the universal health coverage target set out in the health SDG. To improve future health outcomes across the world we will need to pay attention to what happens when people interact with health services at both community and facility level.

USAID SQALE Program seeks to improve maternal and child health outcomes by embedding quality into the scale-up of community health services in Kenya. This is delivered through a process of capacity building and community engagement through the development and coaching of Work Improvement Teams for Community Health Services at sub-county and community levels. The aim of the program is to strengthen leadership and coordination at national, county and community levels by embedding a culture of quality improvement practice. The quality improvement approach builds on the work of the REACHOUT Consortium and involves a five-step process: Plan, Define, Monitor, Improve, and Evaluate. This approach is aligned with the national Kenya Quality Model for Health (KQMH) Standards for level 1, uses existing Ministry of Health tools and simple, jargon-free materials, grounded in the reality of implementing quality improvement within Kenyan communities.

About the learning event

This learning event was part of the third stage of the phased quality improvement training and action learning in Nairobi and Kitui Counties.

The three-phase program aims to support the government in ensuring the right structures, systems, tools and support are in place for monitoring, assessing and improving the quality of community health services. The learning event, focused on evaluating change plans, sharing learning, celebrating success and planning for further embedding quality improvement into the community health system.

Aim and objectives

To share experiences and learn from one another to ensure high quality community health services for all Kenyans.

Programme

Representatives from national to community level participated in what was described as a "festival of learning". Twenty-four Work Improvement Teams from Nairobi and Kitui came together for the first time, to share their experience in measuring, assessing and improving the quality of community health services. These multi-disciplinary teams are spearheading the quality revolution in Kenya, starting where it matters most - with the community. In total 114 participants engaged in the learning event (see Annex 1 for the participant list).

On the first day of the event, Work Improvement Teams presented their quality improvement work, identified good practice and celebrated success. The second day focused on learning how well the structures, systems, tools and support for implementing quality improvement have been embedded into county health systems in Nairobi and Kitui (see Annex 2 for the event programme).

Three-phase QI training program

Phase 1	Implementation	Phase 1	Implementation	Phase 1
• Establishing Quality Improvement teams (WITs) • Concepts of Quality Improvement • Data quality for decision-making • Client perceptions • Monitoring performance & quality of CHS		• Presentation and analysis of data • Problem identification and root cause analysis • Quality Improvement Change plans		• Evaluation of QI change plans • Sharing and Learning • Identification of best practice • QI Awards • Action planning & embedding QI

Methodology

Work Improvement Team posters

To avoid PowerPoint fatigue, and keep participants physically and mentally active and engaged, a broad range of learning and evaluation methods were employed over the two days. Methods included:

- Presentations
- Quality improvement story boards (poster presentations)
- Plenaries
- Sharing of experiences
- Panel discussion
- Question and answer sessions
- World Café
- Brainstorming
- Action planning
- Peer voting and team certificates of recognition for the best poster and best kept Work Improvement Team folder

A quality revolution in Kenya's community health system

Dr. Lilian Otiso

"I'm very happy to see that the dream of quality improvement for Community Health Services is now a reality."

Dr. Lilian Otiso, Director Programs, LVCT Health

'It is time for a quality revolution in Global Health,' was the resounding message throughout the event. At the meeting there were rich discussions that emanated from the diverse groups of participants including community members, sub-county, county and national policy makers, researchers and quality improvement experts. Discussions focused on evaluating change plans, sharing learning about what has worked and not worked, celebrating successes and continuing to build ownership at county and sub-county levels. Poster presentations from the community Work Improvement Teams were interspersed with PowerPoint presentations from sub-county Work Improvement Teams, panel sessions as well as a World Café session consisting of focused discussions on embedding quality improvement into community health. This rich mix of activities allowed for all voices to be heard and provided the participants with a chance for deep reflection.

Dr. Lilian Otiso, co-principal investigator of the USAID SQALE Program shaped the agenda for the two days by giving an overview of the project and its milestones over the past year. This inspired a reflective mood in the audience by calling on them to think through their journeys since the beginning of the USAID SQALE Program.

National response

Dr. Salim Hussein, Head, Community Health and Development Unit, introduced his team who noted that developing standards for community health services has taken time and that the Work Improvement Teams in Nairobi and Kitui have taken this work a step further by introducing quality improvement. He emphasized the importance of providing quality services to the Kenyan people and the challenge of showing results which is why often people shy away from doing this. He described how we should learn what we have not been doing so well and how we can do better. He welcomed the fact that community members were participating in the conference and identified the Work Improvement Teams as being the driving force for sustainability so that the program does not die when external funding ends. He called upon the community members to develop a shared plan to spread the knowledge to their colleagues.


Dr. Charles Kandie

Dr. Charles Kandie, Head of the Division of Health Standards and Quality Assurance took the floor noting that he was very excited to have tools to measure quality at the community level. He described

how Kitui and Nairobi are leading the process as they have already formed structures for quality improvement and started implementing the program. He also outlined the KQMH objectives as:

- Adherence to health standards
- Improving structures, processes and outcomes
- Community participation and meeting client expectations

He stressed the role of counties in assigning budget for providing quality Community Health Services. His presentation ended with him reiterating that he was happy and looking forward to the scale-up of this program nationally.

County response

"This is one event we have come to learn together on issues of quality. I don't think I have attended any other such event in the past."

County Community Health Services focal point, Kitui County

The community health services focal persons from the three counties (Kitui, Nairobi and Migori) were then welcomed to give progress updates in Community Health in their respective counties. Dr. Carol Ngunu, focal person in Nairobi county reported that Nairobi County started setting up quality improvement systems and Work Improvement Teams from April 2016 in three sub-counties. This initiative has led to a noticeable change in data quality where data completeness has increased from 47% to 87% and data timeliness from 31% to 73% between the months of May 17 and August 17.

Dr Silu, Deputy Director of Health, described Kitui as the county on the move. *'We are happy that Kitui was considered as a pilot county,'* he stated. He described how Kitui County will continue embedding quality into the community in spite of persistent challenges such as the nurses' strike. With strong political commitment demonstrated by their Governor, Charity Ngilu, who is passionate about maternal health, Kitui hopes to build the capacity of their teams to scale this program up to other sub-counties in Kitui and beyond.

It was very exciting to hear from Migori County where the next phase of implementation will be commencing. Dr. Elizabeth Mgamb, County Medical Director, said that the county was looking forward to the start of the project mainly because they remain one of the countries with the highest burden of maternal and child mortality. Quality improvement teams have already been established at the sub-county level and they are keen to have this cascaded to the community level. Community strategy and community involvement is the way to go and community coverage in Migori is currently at 81%. She ended her presentation by saying that it was useful for the people of Migori to be clear about where are we heading to, what are we trying to achieve even before implementation begins.

USAID SQALE Program progress and key achievements

Linet Okoth, Senior Technical Advisor, USAID SQALE Program, presented the key achievements of the project in the past year in relation to the program objectives which are summarized below.

1: Strengthen national coordination for improved quality of community health programs

- Inclusion of quality improvement for community health in the Community Health and Development Unit annual work plan 2017-2018
- Participation of national and county representatives at the Institutionalizing Community Health Conference (ICHC), in Johannesburg March 2017
- Establishment of the national quality improvement committee for community health services
- Development and testing of KQMH facilitators' manual for quality improvement in Community Health Services

2: Increase capacity of National, County and Sub-County decision makers to prioritize and budget for community health programs using an equity approach for improved service availability

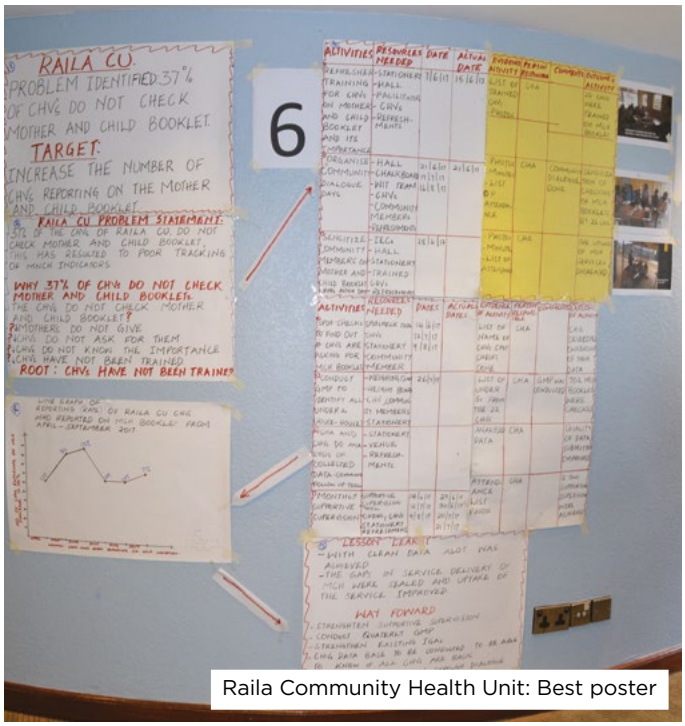
- Inclusion of community health and quality improvement for community health in national and county annual work plans
- Planning for a household survey on equity of community health services in Migori (2017/2018)

3: Improve community health program performance in maternal, newborn and child health

- Formation of 18 Community Health Units Work Improvement Teams and six sub-county Work Improvement Teams in Nairobi and Kitui
- Development of Baseline Data Quality Assessment of maternal, newborn and child health indicators in Kitui and Nairobi Counties
- Dissemination of KQMH Quality Standards for Community Health Services in Kitui and Nairobi Counties. Facilitation of training of CHVs in selected Community Health Units in Kitui and Nairobi on maternal, new born and child health
- CHVs provided with and oriented to data collection and reporting using key Ministry of Health tools (MOH 514, MOH 515, MOH 100)
- Work Improvement Teams trained on analysis of data, problem identification, root cause analysis and action plans
- Administration of the community follow up tool to track quality of services at household level.
- Development and implementation of quality improvement coaching strategy for Community Health Services
- Study underway on the functionality, sustainability and impact of Work Improvement Teams

4: Strengthen community engagement in community health services

- Formulation of inclusive Community Work Improvement Teams with representatives from the community (e.g. chiefs, village elders etc.)
- Community Health Extension Workers tasked to participate in facility and sub-county meetings to represent needs of their communities
- Facility-in-Charge included in the Community Health Unit Work Improvement Teams to improve linkages between communities and facilities.
- Dialogue days have been strengthened



Raila Community Health Unit: Best poster

The sub-county and community Work Improvement Teams

"I have learnt that quality improvement starts with me; it has to come from me."

(Kasarani Work Improvement Team member)

Three parallel streams took place in which every Work Improvement Team had the opportunity to showcase their work. The community teams gave poster presentations (see Annex 3 for a summary of themes) while sub-counties gave PowerPoint presentations. Recurrent themes focused around data accuracy and timeliness, referrals between community and link facilities, skilled birth attendance, growth monitoring, frequency of household visits and checking the mother child health booklet. The passion and energy of the presenters was evident, demonstrating commitment to improved quality of Community Health Services. This also provided a strong learning environment for other Work Improvement Teams to see what is being achieved in other communities and how others have been tackling similar issues.

The three facilitators gave a summary of the feedback from the parallel session in the form of enablers and barriers to implementing quality, training and capacity gaps, lessons learned and examples of innovations and change. Key discussion points are summarized in the tables below.

Enablers	Barriers
• Willingness to change at an individual level • Committed CHVs • Recognition of CHVs • One-on-one supportive supervision of CHVs • Leveraging on existing structures to implement activities - e.g. regular CHV meetings • Regular meetings between Community Health Extension Workers and CHVs (provides non-financial motivation and forum for refresher training) • Teamwork and learning from each other • Inclusion of community members in Community Work Improvement Teams optimises community-based activity • Using songs to communicate messages • Focusing on one problem at a time • Good root cause analysis helps Work Improvement Teams develop their own solutions and interventions • Bench marking • Linkage between community health units and primary healthcare facilities • Linkage between those providing community-level health services and sub-county health management team • Power of data that proves an intervention is working is motivating	• Poor data quality which compromises decision making • Language and need to translate tools to Kiswahili • Literacy levels of some CHVs • Coverage, denominator and reporting systems • Training CHVs only once has been shown to be ineffective as it is not internalized • A relatively small number of CHVs covering a large number of households and/or vast geographical area • Lack of support in sites not supported by LVCT Health • Sustainability when it comes to financing, e.g. provision of transport allowances • Clarity on sustainability of quality improvement efforts post SQALE • Elections in Nairobi slowed down implementation • Doctors' strike followed by nurses' strike

Additional training needs/capacity gaps

1. Work Improvement Team capacity in identification and tracking of indicators, especially on accuracy of data
2. How quality improvement for community health fits into the entire KQMH structure should come out more clearly in training curriculum
3. Mentorship/proposal writing for Community Health Units on income generating activities
4. Financial management for Community Health Units
5. CHV training on reporting maternal deaths

Examples of innovation and sustaining change

- Division of roles within the Work Improvement Teams
- Community record book to put the names of CHVs who have performed exceptionally well
- Households visit week – plans are made to ensure the unit put aside a week where all CHVs must visit their households
- Effective referral tracking by going back to the community to ensure that the person referred reached the facility
- Income generating activities adopted by one Community Health Unit
- 2,000 KSh stipend to each CHV (Kitui), 1,000 KSh is saved to go to income generating activities
- Pairing of CHVS - weaker and stronger ones
- Establishing community desks
- Collaboration of private and public health facilities
- Dropbox for referrals
- Tracking book for monitoring performance of CHVs every month (City Carton)
- Division of Community Health Unit (and consequently CHVs) into zones that are represented in the Work Improvement Team so that when a CHV in a particular zone is found to be underperforming, this can be addressed by the Work Improvement Team member from that zone speaking with said CHV (City Carton)

Examples of innovation and sustaining change (Continued)

- Files in primary healthcare facilities to keep track of MOH 100 Community Referral Forms (Embakasi West Sub-County)
- Task Facility-in-Charges to sensitize their staff/ new staff on the importance of referrals from CHVs and completing and storing MOH 100 Community Referral Forms (Embakasi West Sub-County)
- Keeping a register of all pregnant women in the Community Health Unit to monitor their progress throughout pregnancy, delivery and postnatal period (Maili Saba)
- National and county-level participants discussed that during this period of the nurses' strike, CHVs should be sensitized to referring community members to private healthcare facilities where free maternal healthcare services are available.

Key messages and lessons learned

- Frequent capacity building efforts improves performance of CHVs
- Regular supervision enables achievement of QI plans
- Supportive supervision meetings are a good way to regularly reinforce key messages in addressing quality problems
- Data is a key component of QI – helps in tracking changes and performance
- QI has diffused to non-SQALE units due to involvement of Sub-County officials
- Teams are at very early stages of QI implementation and therefore achievements are process-based
- CHVs should be chosen by the community
- Planning that involves participation of all WIT members creates ownership
- Teamwork is essential
- When you have data that you trust it is very useful for decision-making/planning
- The Quality Improvement approach allows you to identify gaps in capacity
- The Quality Improvement approach allows you to identify solutions within your realm of control through root cause analysis following problem identification
- Quality Improvement builds motivation

Quality awards

"CHVs recognition and regular motivation works miracles."

HDD Community Unit representative

Bangladesh Community Health Unit best poster winner

To encourage learning and give recognition to the high performing teams, peer scoring of presentations (poster and PowerPoint) was conducted within each parallel session whereby individuals were required to score each Work Improvement Team presentation against set criteria (refer to Annex 4). This allowed peers to give recognition to high performing teams and served to strengthen individual learning in relation to both content and presentation of the Work Improvement Team's progress and achievements.

A second set of awards was for the best Work Improvement Team folder in relation to defined criteria (refer to Annex 5). Three judging panels made up of national and county level Ministry of Health staff as well as Community Health Extension Workers and Community Health Assistants reviewed Work Improvement Team folders. The purpose of this award was to acknowledge the importance of good documentation and record keeping and to give national and county Ministry of Health staff insights into the depth and breadth of Work Improvement Team activities.

Quality improvement award winners

QI Poster Presentation	Winning Unit	Runner-up Unit
Track 1	Bangladesh	Museve
Track 2	Masyungwa	Ribakia
Track 3	Raila	Kavutei/Kawala
WIT Folder		
Track 1	Museve	HDD
Track 2	Kinakoni	Masyungwa
Track 3	Kavutei Kawala	City Carton

Supporting innovation, sustaining change, and embedding quality

Dr. Vicki Doyle, USAID SQALE program Quality Improvement Adviser

Dr Vicki Doyle, in her key-note presentation on Supporting Innovation, Sustaining Change and Embedding Quality, challenged the participants by saying that high quality care is neither an aspiration for a distant future nor solely for rich countries but is central for reaching global health goals and a basic obligation of every health system to its users. Kenya is at the forefront of leading the 'Quality Revolution'. She acknowledged that globally there is a deep gap within health care systems between "what we know" and "what we do." Drawing on Massoud et al. (2012) she suggested that we should ask ourselves daily, 'Have we actually delivered the right services every time for every user to the best of our knowledge?' as that is quality and the rest is jargon. She stressed how stakeholders need to be willing to change the status quo and have the courage to do things differently. A key question is, how can we change the conversation about improving health systems from just, 'Where will we get more resources?' to include, 'What ideas can we harness to improve the system?' She concluded, if we really want to sustain change we need to have the right structures in place, understand how our work relates to other areas of the health system, have the right quality measurement tools and management support.

Panel discussion

A panel discussion allowed participants from different perspectives and levels of the health system to be asked questions and to present their ideas on an equal platform. Panelists included representatives from national, county, sub-county and community levels. We addressed issues like how quality improvement fitted into already existing government structures, what the panelists had done to introduce and improve quality at their different levels, funding to provide quality community health services, and future priorities once the current change plans have been implemented.

Form the panel we can see that there is a willingness to apply quality improvement at all levels of the health system especially at community level where this has not been done until now. There was a recognition that quality improvement can, and should, be scaled up within different settings and this can be done with minimal resources. Additional resources can be raised from partners on the ground as well as the county government. Some felt that community health should be a key item in budgets and that it should be considered core business when it comes to meeting maternal, newborn and child health targets.

One panelist felt that there are gaps that remain, especially in terms of data tools particularly Ministry of Health tools. There is need for enhanced community participation. How do we involve the community in selection and recruitment of CHVs? How do we involve them when we change policies, guidelines, tools and training packages? Are we getting their views or are we sitting here as the experts and determining it for them?

We heard that the level of education of CHVs is sometimes a challenge when it comes to reporting quality data as this requires reasonable writing skills.

A Community Health Assistant said that for us to achieve quality in community health services, we need to look at our structures, systems, tools and embedding quality improvement into our work. Many of the gains that had been made from 2006, when the Community Health Strategy was developed were reversed when the devolved government came into place. Some felt that the community health management system was weak and this was a barrier to progress. For example, community chalkboards in the facilities, even in Nairobi, are outside being rained on because the support being given to community health service providers is very poor. As a result, many of these providers are not motivated. The lack of Community Health Assistants was also raised, in some counties there are none.

A national level panelist stressed that we need to think of very strategic ways of moving forward, for example how can we ensure that community health is written into national planning such as the proposal to the Global Fund to fight AIDS, TB and Malaria. Our advocacy must be very targeted to particular audiences. We also need to define the role of advocacy to technical people as well the political class like the Members of the County Assemblies, County Executive Committees, and at the highest levels like the Director of Medical Services and Permanent Secretary to ensure that they recognize the importance of community health and give it the passion that it deserves.

The need to convene more meetings to share experiences was also raised so that learning goes beyond the few counties that are working on the USAID SQALE Program and the issue is made a national one.

World Café

World Cafe Two

"As someone who was trained in quality improvement at facility-level, I did not see how this could be done with community health services but it became clear that it can."

Sub-county Nursing Officer, Mwingi North

The World Café was used as a tool for knowledge sharing and to create an interactive environment. Stations were set up at large tables, each with a facilitator and note taker who has a priority topic. Mixed groups of participants from the various counties and levels rotated around the stations, spending half an hour at each to discuss their ideas and learning in relation to the themes. This method helped encourage everyone's contribution, enabled us to look for patterns and insights and allowed participants to share discoveries. It is hoped that the learning from this exercise will enable participants to:

- Advocate and budget for quality improvement for community health at county level
- Strengthen the program of quality improvement coaching to Work Improvement Teams, building on weaknesses and consolidating skills and knowledge
- Brainstorm key activities to be incorporated into Work Improvement Teams' annual quality improvement action plans
- Inform the updating of the National KQMH quality improvement facilitators manual
- Feed into recommendations for updated KQMH Community Health Services Level 1 Standards

There were seven World Café stations that explored the following topics:

- Work Improvement Team roles and responsibilities
- Quality improvement capacity building for Community Health Services
- Community perceptions of Community Health Services (Community Follow-up Tool)
- Data Quality Analysis
- Using data to analyse performance
- Implementing quality improvement change plans and teamwork
- Costing quality improvement activities/interventions

Key findings from each World Café station

Work Improvement Teams are multi-disciplinary teams formed at sub-county and community level responsible for monitoring, assessing and improving the quality and performance of community health services at their respective level within the health system

Key findings

- Team membership varies from seven to 15 members
- Community Work Improvement Teams are typically made up of: Community Health Extension Worker (CHEW) / Community Health Assistant (CHA), Facility-in-Charge, facility chairman, community health volunteers, the Chief, community health committee representatives, village administrator and village elders
- Sub-county Work Improvement Teams are typically made up of: community health focal person, Health Records and Information Officer, reproductive health focal person, nutritionist, health promotion officer, family planning coordinator, pharmacist, Community Health Extension Worker/Community Health Assistant
- Need to co-opt other members into the team when specific issues arise e.g. cholera outbreak
- Community Work Improvement Team members should be selected for their local knowledge, power and influence

Key findings (Continued)

- Need greater clarity on the role of the Facility-in-Charge in community Work Improvement Teams
- Full engagement of Facility-in-Charges has been problematic due to strike action
- Division of work between Work Improvement Team members is perceived to be fair
- Work Improvement Team members report high motivation and satisfaction with greater ability to solve problems locally
- CHV Work Improvement Team members reported an elevation in their status
- Some facilities reported reduction in workload and reduced morbidity
- There has been better collaboration between Community Health Extension Workers and Facility-in-Charges (in most cases)
- Recurrent costs post-USAID SQALE program funding include transport and lunch for Work Improvement Team meetings, regular supportive supervision, quality improvement coaching, backpacks, identification cards, health commodities
- Recurrent costs for sub-county Work Improvement Teams post-USAID SQALE program funding include supervision travel costs, printing tools and regular supportive supervision

Quality improvement capacity building for Work Improvement Teams consists of a three-phased training programme interspersed with periods of implementation

Key findings

- Attendance at all phases problematic due to patient load, staffing levels, selection criteria applied, and annual leave
- Positive aspects of the training included participatory learning approach, focused and responsive facilitation, and the teaching methodologies employed
- Negative aspects of the training included fast pace of training and insufficient time allocated to content
- All teams reported application of quality improvement skills, and in some cases outside of maternal, newborn and child health, for example during the cholera outbreak
- Work Improvement Team progress is variable - some Work Improvement Teams are working on new problems and change plans
- Suggested changes:
- Increase training duration
- Phase One should be less conceptual and more practical
- Facilitators should always use simple language and Swahili

Key findings (Continued)

- Introduce exchange program between CHVs to encourage benchmarking and learning
- Increase training allowances
- Will not achieve good coverage and data quality until more CHVs are recruited
- For greater impact and community empowerment we need to include village administration and religious leaders in the Work Improvement Teams

Community perceptions of Community Health Services are being monitored through the introduction of the community follow-up tool. A trained member of the community visits a sample of households to assess the quality of service provided by the CHV on their last household visit

Key findings

- All teams have administered the tool since Phase One quality improvement training
- Some Work Improvement Teams have used the results to work on specific quality problems e.g. checking mother child booklet during household visits
- Results have been shared with other CHVs but less so with the sub-county level
- Identification and training of community members to administer the tool and selection of households worked well when criteria were correctly applied
- When selection and training was inadequate, CHVs had less trust in the data collected
- Summarization of data was time consuming/ challenging when 50+ households were visited
- Suggested changes to the tool:
  - Adapt to include other indicators beyond maternal, newborn and child health
  - Translate tool into local dialect
  - Rephrase referral question to avoid confidentiality issues
- Official mother and child health booklets are not available in many sub-counties (substituting for exercise books which do not capture all relevant information)
- Will require budget to ensure regular administration of the tool from sub-county/county level

Data Quality Analysis has been introduced to sub-county Work Improvement Teams to allow a comparison between what is reported through primary data collection tools with what is recorded within the government health information system (DHIS2). This gives a measure of the quality of community health services data which should be used for planning and management decision making

Key findings

- All sub-county Work Improvement Teams have conducted at least 1 Data Quality Analysis
- Sub-county Health Records and Information Officers and Community Health Service focal persons perform the data verification process which depends on CHVs providing the MoH 514 service log book and Community Health Extension Workers collating MoH 514s into MoH 515 summary
- Data Quality Analysis results have:
- Informed content of support supervision
- Identified where CHVs are incorrectly completing MoH 514
- Identified weak CHVs for one-one supervision/ pairing with strong peers
- Helped Community Health Extension Workers verify and investigate unexpected results
- Increased awareness on the different dimensions of data quality
- Increased motivation of CHVs to collect and report high quality data
- CHVs value feedback on data quality which makes them feel supported and together
- Data Quality Analysis means that CHVs cannot "cook" data so easily
- In Mwingi North, Data Quality Analysis enabled the sub-county to advocate for current versions of government tools (MoH 514/5) so as to be aligned with the government reporting system
- Communicating/sharing Data Quality Analysis results to CHVs is delegated to Community Health Extension Workers
- All Work Improvement Teams reported that Data Quality Analysis is part of the culture of Community Health Services and can be integrated into supportive supervision meetings without external support
- In the future Data Quality Analysis for Community Health Services should use software

Using data to analyze Community Health Service performance is a fundamental skill that all Work Improvement Teams perform at monthly meetings so that they can analyze trends and changes in data over time and ascertain whether their quality improvement efforts are having an impact

Key findings

- Community Health Units monitor their performance through supportive supervision, monthly Work Improvement Team meetings, monthly CHV reports, using chalkboard and at facility level
- Sub-county monitors the performance during data entry and analysis and county level by giving feedback
- Key challenges include shortage of referral books and other Ministry of Health tools (Nairobi only), CHV competence, data accuracy and inconsistent reporting from CHVs, mobility (CHVs and community), mapping issues, motivation and lack of refresher training
- Challenges in monthly reporting of MOH 515 into government health information system (DHIS2) include network issues, mismatch between indicators on MOH 515 and DHIS2, transcription errors, data not always entered
- Work Improvement Teams are not accessing DHIS for Community Health Services data
- Community Health Assistants/Community Health Extension Workers who reported connectivity problems and that some functions are not accessible
- Lack of trust continues to exist in DHIS data although confidence is increasing, with greater trust in primary data (MOH 514)
- Work Improvement Teams reported that use of Community Health Service data has led to greater community empowerment, improvement of referrals, reducing home deliveries, better data accuracy from CHVs
- Work Improvement Teams' future support needs from the county include provision of tools, greater use of information technologies, mobile reporting, continuous sensitization for CHVs and quarterly remapping

Implementing quality improvement change plans and sustaining change is a key aim for Work Improvement Teams. On completion of Phase Two training all Work Improvement Teams had identified a quality problem using existing data, had brainstormed potential solutions to the root causes and developed a quality improvement change plan

Key findings

- Some Work Improvement Teams have struggled to complete all planned activities
- Work Improvement Teams that have completed all activities took longer than planned
- CHVs prioritized activities based on availability of stipends Ministry of Health staff prioritized according to health risk
- Work Improvement Teams monitor their progress through coaching, review of quality improvement change plans and monitoring key indicators
- Key challenges were cited as competing priorities, resources, health worker strike,cholera outbreak (Nairobi), famine (Kitui), insecurity during election time, and CHV attrition (Nairobi)
- Changes because of quality improvement included an increase in complete referrals, improved support between facility staff and CHVs, improved reporting by CHVs, improved data quality, and CHVs more competent using Ministry of Health tools
- Unanticipated changes included improved uptake of immunization and skilled delivery, increased workload due to new role, increased awareness of Community Health Services among Ministry of Health staff at sub-county level, improved involvement of local leaders, rapid improvement in data quality, diffusion of quality improvement efforts to non-USAID SQALE Program units, more confident CHVs, tension between Work Improvement Teams and CHVs over differences in stipends
- Work Improvement Teams were unsure how to monitor how well they work as a team and were generally not familiar with the quality improvement maturity tool

Costs for quality improvement activities and interventions (training, coaching, Work Improvement Team meetings, community dialogue days) are currently resourced by USAID SQALE Program although county and sub-county plans for 2017-18 have included quality improvement for Community Health Services into their annual work plans with the aim of embedding quality improvement costs and activities

Key findings

- The USAID SQALE Program has covered the major costs associated with quality improvement interventions including venue hire, transport, catering, airtime, data bundles and stationery
- Costs have been negotiated on a case-by case basis unless linked to existing activities (e.g. supervision)
- Other partners (Afya Jijini, APHIA plus, World Vision, Concern Wordwide, and the International Red Cross) and some local businesses and politicians have also been supportive
- Some activities did not happen due to cost constraints (e.g. venue for dialogue days, continuing education for CHVs, snacks for community days)
- Committing staff time has been a challenge for sub-county level
- Need to integrate quality improvement into the community health program, coordinating with partners and lobbying county and national for budget allocation which is a slow process

The way forward

The learning event was a very successful innovative approach that we intend to repeat at regular intervals. This means Community Health Units will be reporting on their change plans on a regular basis and this will hopefully stimulate further action. Future learning will be county rather than the USAID SQALE Program-led and will focus on sharing between county community Work Improvement Teams to save transport and travel costs and ensure longer term sustainability. We look forward to reporting on how these evolve in future. National and county representatives reiterated their commitment to improving the quality of Community Health Services.

Annexes

Annex 1: List of Participants

1	Benson Maina
2	Erickson Kitothya
3	Hellen K. Obanyi
4	Daniel Kavoo
5	Eunice Njabu
6	Esther Sankale
7	Neville Ngira
8	Jane Njjeru Kimani
9	Beatrice Lusinde
10	Judy Wairiuko
11	Fredrick Onyango
12	Flomena Mwaura
13	Lucy Kamau
14	Dr Salim Ali
15	Lavenda Kwamboka
16	Musyoka Mwema
17	Dorothy Ndege
18	Susan Kwamboka
19	Jackline Gichana
20	Mary Njonde
21	Lilian Tito
22	Faith Kiruthi
23	Rosalyne Ndwiga
24	Lydia Atieno
25	Alice Kimani
26	Carol Ngunu
27	Pauline Wambui
28	Susan Omondi
29	Josephine Karami
30	Hiillary Chebon
31	Philomena Kavilo
32	Vincent Sunda
33	Jacinta Wambua
34	Emilio Nyabende
35	Nick Ouma
36	Sheila Muhanga
37	Erastus Mwangi
38	Patriciah Kamau
39	Pamela Anyango
40	Salome Njeri
41	Veronicah Kanini
42	Miriam Mugure
43	Leah Gichia
44	Raphael Kofeli
45	Charles Kandie
46	Esther Kiambati
47	Mary Kanganira
48	Lyddia Kwamboka
49	Esther Kanoga
50	Fremond Ndiema
51	Dr Thomas Ogaro
52	Rachel Njeri
53	David Silu
54	Hillary K. William
55	Fredrick Kinyenze
56	Beatrice Ngomo
57	Peter Kasyula Mwikya
58	Jeremiah Kasuingi
59	Reginah Ngina James
60	Peter M. Mutio
61	Samwel Mutunga
62	Francisca W. Mumo
63	Miriam Mativo
64	Penina Mwambu
65	Lilian Kisilu
66	Joseph Mutua
67	Sibjastis Mutua
68	Jacob Mutinda
69	Colleta M.John
70	Susan K. Mutia
71	Julius Agunda
72	Cosmus Kinyumu
73	Valerie Naske Kyulo
74	Joseph M. Kimwele
75	Lena C. Nyaga
76	Kisorio Nancy
77	Paul N. Ikuli
78	Samuel Abuya
79	Thomas Nzuki
80	William K. Muthui
81	Muema Mutunga
82	Samuel H. Guyo
83	Esther K. Ngei
84	Patrick Mutuku
85	Peter Mutua
86	John Ndambuki
87	Makau L. Mwanzwii
88	Tom Odhong
89	Dr Elizabeth Mgamb
90	Ruth Mutheu
91	Malcolm Okinyi
92	David Musyoka
93	Christine Sammy
94	Patrick Ngatia
95	Leonard S. Mbiu
96	Martin Njogu
97	Timothy Malusi
98	Domitilla Ogaro
99	Benson Maina

Annex 2: Learning Event Program

Achievements and lessons learned for quality improvement in community health

10th and 11th October, 2017, Panafric Hotel, Nairobi

Overall Aim

To share experiences and learn from one another to ensure high quality community health services

Learning Outcomes

1. Evaluate and present QI change plans
2. Celebrate success, recognising high performing teams and innovative changes
3. Share learning and application of QI approaches in community health
4. Identify key enablers and challenges in implementing quality improvement
5. Plan for further embedding QI into the community health system

Day 1	
8.00am	Registration
8.30 – 10.30am	**Session Chair:** Judy Macharia, Community Strategy Coordinator, Nairobi County **Welcome & Introduction**: Programme & learning objectives, Dr Lilian Otiso, LVCT Health **Opening Remarks:** Dr Salim Hussein, CHDU, MoH **Presentation:** Achievement in QI for CHS, Linet Okoth, LVCT Health **County Updates:** Progress in Community Health in Kitui, Nairobi & Migori **Introduction to poster presentations:** Dr Regeru Regeru, LVCT Health
10.30-11.00am	BREAK
11.00–1.00pm	**WIT presentations** and peer voting (parallel sessions x 3)
1.00-2.00pm	LUNCH
2.00-4.00pm	**Session Chair:** Dr Vicki Doyle, LSTM WIT poster walkabout (all WITs) & review of WIT folders (national/county teams) **Feedback & plenary discussion**: Lessons Learned **QI Awards:** Best WIT Presentation & Best WIT Folder (Daniel Kavoo & DSQAR) **Summing up of Day 1**: Lessons Learned and innovations, Dr Charles Kandie, DSQAR

Day 2	
8.00am	Registration
8.30 – 10.30am	**Session Chair:** Michael Kimani, LVCT Health **Key Note:** Embedding & Sustaining QI for CHS**,** Dr Vicki Doyle, LSTM **Panel Discussion:** Embedding & Sustaining QI for CHS; National to Community level perspectives, Dr Lilian Otiso, panel chair
10.30-11.00am	BREAK
11.00–1.00pm	**Introduction to World Café:** Dr Vicki Doyle, LSTM **World Café:** Each group to participate in 4 work stations
1.00-2.00pm	LUNCH
2.00-4.00pm	**Session Chair:** Nelly Muturi, LVCT Health **Presentation & Plenary Discussion:** Planning for embedding QI into Community Health Systems, Linet Okoth, LVCT Health **Summing up:** The way forward • County response: Nairobi, Kitui & Migori • National Response: Mr Kavoo, CHDU, MoH Workshop Close & Evaluation

Annex 3: Summary of community Work Improvement Team poster presentations

WIT	Problem Statement	Target	Results
Kwa Muli	50% of CHVs do not report accurately in MoH 514	Increase percentage of CHVs reporting accurate data in MOH 514 to 100% by Oct 2017	Number of CHVs reporting accurate data increased to 6 in August from 4 in June
Masyungwa	88% of CHVs in Masyungwa record inaccurate data in MoH 514	Increase percentage of CHVs recording accurate data in MoH 514 to 75% by 30th Oct 2017	5 CHVs were correctly recording data in MoH 514 by Sept from 1CHV in June.
Ribakia	50% of CHVs in RHCU do not fill the MoH 514 indicator 0-59 months participating in growth monitoring correctly.	Increase the percentage of CHVs filling MOH 514 indicator on 0-59 months participating in growth monitoring correctly from 50%-80% by September 2107	85% CHV s were recording data for the indicator of child 0-59 months participating in growth monitoring correctly.
Bangladesh	46% of CHVs do not check if client went for referrals. This has made it difficult to get feedback on services received by the client at the referral health facility	Decrease the numbers of CHVs who do not check client referrals by 10% by September 2017	By September, there were 77% CHVs reporting the referrals as opposed to 92% in June
Museve	75% of Museve CHVs submit incomplete MoH 514 reports.		8 CHVs submitted complete MoH 514 data in the month of August, from 2 CHVs in March.
Kalwa Kavuti	100% CHVs record inaccurate data in MoH 514	Increase the number of CHVs recording accurate data in MoH 514 to 62.5%	8 CHVS recorded accurate data in the month of September from 3 in the month of July
Katumbu	60% of CHVs reported incorrect data in MoH 514	Reduce the CHVs reporting inaccurate data in MoH 514 to 10% by Oct 2017	Number of CHVs recording accurate date rose to 8 in Sept from 6 in July
Matopeni	0% referral forms	To increase the number of complete referral forms from 0-40% between June and September 2017	Number of complete referral forms rose to 22 in the month of September from 6 in June and 0 in May
Kaliku	38% of the CHVs give inaccurate Data in MOH 514. This leads to in correct decision making and poor planning	Reduce the % of CHVs recording inaccurate data in MOH 514 to 10%	By Sept, only one CHV was reporting inaccurate data from 3 in June
Kanzau	44% of Kanzau CHVs submit their monthly MOH 514 reports late which affects quality data in MOH 515	Increase the percentage of CHVs submitting MOH 514 by 28th of every month to 89% by October 2017	9 CHVs submitting their monthly MOH 514 reports by 28th in the month of August as compared to 5 in March
Maili Saba	In Maili Saba CHU 15% of pregnant mothers deliver at home leading to risk of maternal and neonatal deaths	To increase number of skilled deliveries in Maili Saba CHU from 85% to 95% by 30th September 2017	In the month of September, there were no unskilled births compared to the 4 in January
City Carton	In city carton unit 31% of CHVs present their report after 28th of every month which leads to low reporting rate and untimely data compilation	to reduce the number of CHVs not reporting by 28th of every month from 31st to 25th	
Gakombe	100% CHVs record inaccurate data in MOH 514	Increase number of CHVs filling MOH 514 accurately to 50% by 30th October 201	60% now record data in the MoH 514 accurately
Raila	37% of CHVs do not check mother and Child booklet	Increase the number of CHVs Reporting on the mother and child booklet	By September, 77% of CHVs checked the mother and child booklet as compared to 63% in April
HDD Unit	40% of CHVs do not visit their households every given month	To increase the number of CHVS visiting their households by 80% by end of Sept	80% of CHVs were visiting their households by September
Southlands	85% of children 0-59 months are not participating in growth monitoring	Increase the number of children participating in growth monitoring by 15% (20-35%) between April and September 2017	

Annex 4: Criteria for best Work Improvement Team presentation

Each individual to score each poster/power point using the matrix.

For each Work Improvement Team presentation mark each of the criteria from 1 to 5 and then total your score for each Work Improvement Team poster/power point presentation. The Work Improvement Team with the overall highest score will receive formal recognition for their excellent work.

Scale

1: very poor

5: excellent

For each presentation mark for

Room Number: 1 / 2 / 3	WIT team number							
Criteria	**WIT 1**	**WIT 2**	**WIT 3**	**WIT 4**	**WIT 5**	**WIT 6**	**WIT 7**	**WIT 8**
Clearly defined problem statement								
Quality of root cause analysis								
Clear and practical quality improvement change plan								
Display of data showing tracking of indicators								
Visual impact of poster or PowerPoint								
Engagement with audience (passion and energy)								
Evidence of thinking about next steps and sustainability								
TOTAL								

Once you have totaled the scores – then you can nominate the winning Work Improvement Team based on your scores.

Winning Team _____ Work Improvement Team Number ____

Annex 5: Criteria for best Work Improvement Team file

To be assessed by county/National level representatives. Please tick for each criterion if item is present in the Folder and insert a X if item is not present

Room Number: 1 / 2 / 3	WIT team number							
Criteria	**WIT 1**	**WIT 2**	**WIT 3**	**WIT 4**	**WIT 5**	**WIT 6**	**WIT 7**	**WIT 8**
Minutes of Work Improvement Team meetings								
Minutes of group supervision meetings								
Minutes of dialogue days								
Signed ToR for Work Improvement Team								
Quality improvement Action Plan/change plan								
File is ordered and tidy								
Evidence of Community Health Service programme monitoring								
Data Quality Analysis data available (sub-county)								
Community follow-up summary data available (Community Health Unit)								
Quality improvement coaching visit report								
Quality improvement maturity index completed								
KQMH Quality standards for Community Health Service scoring sheets								
TOTAL number of ticks								

Please total the number of ticks for each Work Improvement Team – then you can nominate the winning Work Improvement Team based on your scores.

Winning Team _____ Work Improvement Team Number _____

Acknowledgements

The USAID SQALE Community Health Services Program is made possible by the generous support of the American people through the United States Agency for International Development (USAID) and is implemented under cooperative agreement number AID-OAA-A-16-00018. The program is managed by prime recipient, Liverpool School of Tropical Medicine.

This meeting was organized and facilitated by Anthony Mwaniki, Meghan Bruce-Kumar, Regeru Regeru, Lilian Otiso, Linet Okoth, Nelly Muturi, Maryline Mireku, Michael Kimani and Vicki Doyle. Many thanks to Faith Munyau, Victor Mwandije, Jane Muturi, Martin Agava, Veronica Mwania, Redempta Ngina and Dorah Bloch for taking notes at the meeting.

The report was written by Vicki Doyle, Miriam Taegtmeyer, Lynda Keeru and Kate Hawkins.