

# How can we achieve Universal Health Coverage with quality? A quality improvement model for community health from Kenya

## Key Messages:

- The push for Universal Health Coverage needs to be accompanied by a focus on health service quality
- Initiatives that focus on quality within health systems tend to emphasise the facility level and are rarely applied to community health services
- Community health volunteers are a vital cadre but little attention has been paid to strengthening the quality of the services that they provide
- Communities must be engaged in the design, delivery, and ongoing assessment of health services to ensure they meet local health needs
- USAID SQALE has developed a robust model for embedding quality into community health services
- Community Health Units, supported by their counties are now successfully using robust local data to solve common health problems in their communities

The international commitment to the Sustainable Development Goals and Universal Health Coverage is accompanied by an understanding that every person should have access to high-quality health services without risking financial hardship. Kenya has embraced Universal Health Coverage as defined in the President's 'big four agenda'. To achieve these targets, the national government needs to ensure that basic standards of care are in place and providers are motivated to improve their practice. Supply-side improvements must be accompanied by active patient involvement and community demand for quality.

The main agenda of the President's drive toward Universal Health Coverage is to increase enrolment in the National Hospital Insurance Fund (NHIF) across the entire Kenyan population.

Several counties have proposed using community health volunteers to mobilise communities to enrol in NHIF. Enrolment provides an opportunity to map communities, identify health inequities and formalise the community health cadre. However, if data and service quality are not assured, and the current challenges of community health programs are not addressed, UHC may not succeed.

International level guidance documents on quality improvement in the health system often assume that health facilities are the first point of care for service users. Yet for many, community level services are crucial to better health, particularly in low and middle income countries. The USAID SQALE program has taken quality improvement (QI) to the community level in Kitui, Migori and Nairobi Counties in Kenya. Our model, based on the work

of the international research consortium REACHOUT, applies a simple, low-cost, sustainable way of embedding quality into community health services, strategy and policy. The program provides a tested and replicable model of quality improvement that can be scaled up within Kenya and beyond. We are already providing technical assistance to USAID-funded implementing partners in Kenya to scale up this approach.

## Challenges in Kenya's Community Health Strategy

The main purpose of Kenya's Community Health Strategy is to increase uptake of essential health services at primary care facilities through sensitisation, education and referral. The programme is staffed by salaried community health extension workers (CHEWs) based in primary care



Photo by: Kalwa/Kavuti WIT

facilities, who supervise community health volunteers (CHVs), chosen by the communities in which they live. The CHVs are allocated to specific households that they serve by carrying out home visits. They provide a monthly report of their activities using standard data registers to their supervisors. While the Community Health Strategy is a national level approach, devolution means that day-to-day decisions about the scope, management, organisation and financing of this work are made at the county level.

Evidence has shown that CHVs play an important interface role between the community and health system and the concerns and priorities of the two can sometimes be at odds. Little is known about the quality of the services they deliver. The supervision that they receive is not always supportive and may be more concerned with fault-finding. While CHVs have the potential to be the eyes and ears of the health system, and a mechanism for reporting new and emerging health challenges, feedback and data use are not a routine part of their role. The data that they collect and report is often of poor quality (1). Some CHVs have not finished primary school education and yet are expected to grapple with multiple reporting tools, which are written in technical English (their second or third language) and are not designed with the user in mind.

## USAID SQALE quality improvement model

The USAID SQALE program supports the national drive for better coordination in the delivery of Kenya's Community Health Strategy and builds the capacity of stakeholders at the national, county and community level to prioritize, plan and budget for community health using an equity approach. We are focused on maternal, newborn and child health, although the model can be adapted to other areas of health or health system performance.

### A whole system approach

The USAID SQALE model takes a whole system approach, acknowledging that change at community level can only come about with support and alignment elsewhere in the health system. At the

## SQALE KEY PRINCIPLES

1. Alignment with existing Ministry of Health standards, models and tools
2. Data collection for data use
3. Focused, small set of quality indicators
4. Simple, jargon-free training materials
5. Clearly defined roles and responsibilities for quality improvement at all levels
6. Recognition of good practice and celebration of success
7. Incorporation of community voices

beginning of the program we mapped pre-existing quality improvement structures and augmented existing structures or created new ones where gaps were identified. Kenya had already developed the Kenya Quality Model for Health (KQMH) which includes standards and guidelines for all levels of the health system, however at community level these standards have not yet been widely disseminated.

We collaborated with the National Quality Improvement Committee and the Community Health Strategy Inter-Agency Coordination Committee, to develop and test a facilitator's manual for training in quality improvement of community health services. At the county and sub-county level, selected health management team members took on the role of quality improvement coaches for community health services, providing ongoing support to newly established Work Improvement Teams at sub-county and community level. Because of their active involvement, quality improvement for community health services has been incorporated into County Annual Work Plans - an indication of sustainability.

The composition of the Work Improvement Teams was carefully thought through in conjunction with Ministry of Health staff from national to sub-county level to ensure functional

avenues for upward and downward feedback, which is often lacking in community health systems. CHEWs were included in both the Sub-County and Community Work Improvement Teams to enable direct feedback between the two levels. Staff from primary care link facilities were included in Community Work Improvement Teams such that primary care facilities better integrate with community health and appreciate CHV roles in; referral of clients to link facilities, conducting home visits for those requiring follow up and as a mechanism of gaining feedback from the community on quality of services at link facilities. Work Improvement Teams have clearly defined roles and responsibilities and monitor the quality and performance of community health services using standard Ministry of Health tools as well as monitoring community perceptions and satisfaction with community health services through regular household interviews using the innovative SQALE community follow-up tool.

## QI capacity building and coaching

The USAID SQALE model is implemented in three phases. Between each phase, Work Improvement Teams implement their learning supported by QI coaches from their counties and sub-counties.

**Phase 1** focuses on how to measure data quality and monitor community perceptions of community health services. In the two months between phases 1 and 2, Work Improvement Teams focus on improving data quality and working with community members, they measure communities experience and satisfaction with health services using the community follow-up tool.

**Phase 2** the same teams are supported in problem identification and root cause analysis so that they can develop a quality improvement change plan using their own data and local knowledge. Over a four-six-month implementation period, the teams implement and test their QI change plans.

**Phase 3** the same teams from across the sub-counties are brought together to learn from each other. These learning events provide an unique space for

### Phase 1

- Establishing Work Improvement Teams
- Concepts of Quality Improvement
- Data quality for decision making
- Client perceptions
- Monitoring performance and quality of Community Health Services

IMPLEMENTATION

### Phase 2

- Presentation and analysis of data
- Problem identification and root cause analysis
- Quality Improvement change plans

IMPLEMENTATION

### Phase 3

- Evaluation of Quality Improvement change plans
- Sharing and learning
- Identification of best practice
- Quality Improvement Awards
- Action planning and embedding Quality Improvement



presenting progress in implementation of QI change plans, sharing experiences and reflection. Participants include policy makers, managers, QI coaches and supervisors, providers and community members. This provides an interactive forum for evaluating what has worked, identifying good practice and stimulating ideas and innovation. Learning events take place on a six-monthly basis so that teams do not lose momentum.

## Coaching and QI champions

Quality improvement coaches from county and sub-county level play three main roles; facilitator, trainer and quality improvement expert. They mentor Work Improvement Teams to confidently use and apply QI tools, to advocate to higher levels of administration as well as improve CHV performance, motivation and retention, recognising the important role that CHVs play as part of the wider health system. The USAID SQALE program supports regular coaches' meetings, providing continuous capacity building to QI coaches on themes around the measurement and analysis of data, advocacy and teamwork for quality improvement. QI Coaches are also responsible for

identifying QI champions - individuals who go above and beyond in their actions and efforts to improve quality of community health services. Recognising the power of peer-to-peer support, QI champions join the facilitation team for QI roll-out to other counties.

*"Achieving quality does not require the implementation of very complex strategies as is commonly thought..... and does not necessarily require huge amounts of resources to implement. During the QI training in Migori, I was able to share my experiences from Kitui, exchange ideas with other key players in community health, build networks and get a deeper understanding of quality improvement in a different context. This opportunity broadened and sharpened my knowledge and skills on quality improvement, public speaking and presentation skills. It also gave me a chance to compare the structures in the different counties...."*

Leonard Sharia Mbiu, QI champion, Kitui County

## Case Study: Increasing skilled delivery at birth

In Maili Saba Community Health Unit, the Work Improvement Team identified that 15% of newly delivered mothers in their community (Nov 2016 – May 2017) delivered at home without support from a skilled birth attendant. The team conducted a root cause analysis and developed a change plan to address this serious problem. Solutions included; redistribution of households among CHVs to increase coverage, targeted community dialogue, mapping and follow up of all pregnant women to ensure attendance at antenatal care clinics and development of individual birth plans. Close monitoring of these activities has prevented further unskilled home deliveries taking place in their community. They have sustained this change by ensuring that these activities have embedded into CHVs' routine work practice through supportive supervision and regular Work Improvement Team meetings.



Photo by: Kasarani Sub-County CH WIT

*"Before the introduction of QI in community health services, this whole burden lay on my shoulders. I would assess the issues of the entire community individually and come up with solutions that I personally thought were logical. It goes without saying that this was very inaccurate as the whole community cannot be represented by one person. The formation of Work Improvement Teams really excites me and has relieved me a lot, not just because of burnout reduction but because the bringing together of many hands and heads has helped our community achieve our health targets."*

Emillio Nyabende, Community Health Extension Worker, Maili Saba, Community Health Unit

## Key lessons learned during implementation of the USAID SQALE model

1. Quality improvement works best when there is **institutional readiness** (the community unit is functioning as per national guidelines and there is senior management, commitment and support for quality improvement)
2. One-off training does not work; teams should be trained using simple, practical tools in a **phased action-learning approach**
3. **Leadership, QI coaching and supportive supervision** are required at all levels to embed and sustain quality improvement efforts
4. Work Improvement Teams cannot measure and improve quality without **high quality, trustworthy data** that they can confidently use for decision-making
5. **Learning events** provide protected time for reflection, recognition of good practice, **innovation, advocacy and shared learning** between and across cadres and levels in the health system
6. No county is the same; a one-size-fits-all approach does not work and quality improvement models must be **flexible and adaptable** to priorities and local norms
7. A **whole system approach** is required to embed quality into community health services which requires change at community, service delivery, management and policy levels
8. **Measuring community perceptions and satisfaction** with health services are a fundamental element of ensuring that services meet local needs

## Conclusion

The USAID SQALE model is based on wider learning and has been tested, adapted and refined in partnership with local and national government and partners. Communities in Kenya have shown that it is possible to improve quality of community level health data and improve the performance and quality of community health services using a simple, planned and systematic approach that incorporates community voices. While it is too early to attribute changes in maternal, newborn

and child health outcomes to the USAID SQALE model, we have already seen multiple examples of improvement and innovation in Kenyan communities where we work. Now that proof of concept has been established we will support actions to embed the model beyond three counties as an integral and sustainable part of community health services, led by county health managers and national policy makers.

## Recommendations for Policy and Practice

At the **community level**, ensure community members and CHVs are actively engaged in QI efforts and that Community Work Improvement Teams routinely measure household perceptions and satisfaction with community health services so that services can better respond to local needs and are of good quality.

At **facility level** ensure facility staff are active members of Community Work Improvement Teams so that primary care facilities better integrate with community health services and appreciate the interface role that CHVs play between the community and health system.

At **sub-county level** ensure that data quality and reporting is of a consistently high standard at sub county and CHU levels to support decision making and provide regular supportive supervision to Community Work Improvement Teams.

At **county level** mobilise local partners and ensure that quality improvement for community health is incorporated into County Annual Work Plans and budgeted. This should include establishing functional community health units, QI coaching and supportive supervision, QI capacity building and regular learning events. Ensure efforts to monitor Universal Health Coverage incorporate community health and include a quality and equity lens.

At **national level** spearhead the scale-up of quality improvement for community health services through supporting a whole systems approach that recognises the interface role CHVs play between the community and health system. National level should consider:

- Revise and disseminate the national KQMH standards for community health services and using evidence and experience from counties and communities.
- Finalise the KQMH QI facilitators manual to support QI capacity building in community health
- Revise community health reporting tools for greater simplicity based on CHV feedback

## Suggested reference

Lilian Otiso, Miriam Taegtmeier, Vicki Doyle, Regeru Njoroge, Linet Okoth, Meghan Bruce Kumar, Kate Hawkins (2018), How can we achieve Universal Health Coverage with quality? A Quality Improvement model for community health, Policy Brief, USAID SQALE program

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