



Ministry of Health

# KENYA QUALITY MODEL FOR COMMUNITY HEALTH FACILITATOR'S MANUAL

LEVEL 1



2022 EDITION



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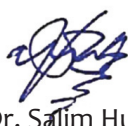


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## ABBREVIATIONS

ANC	Ante-natal Care
CHC	Community Health Committee
CHS	Community Health Strategy
CHV	Community Health Volunteer
CHA	Community Health Assistant
CHIS	Community Health Information System
CQI	Continuous Quality Improvement
CHDU	Community Health Development Unit
CHU	Community Health Unit
DHIS-2	Kenya Health Information System and software
DQA	Data Quality Assessment
DSQAR	Department of Standards, Quality Assurance and Regulations
GoK	Government of Kenya
HH	Household
KHIS	Kenya Health Information System
KEPH	Kenya Essential Package for Health
KDHS	Kenya Demographic Health Survey
KQMCH	Kenya Quality Model for Community Health
KQMH	Kenya Quality Model for Health
LSTM	Liverpool School of Tropical Medicine
LVCT	LVCT Health, Kenyan NGO
MOH	Ministry of Health
MUAC	Middle Upper Arm Circumference
NGO	Non-Governmental Organisation
NHIF	National Hospital Insurance Fund
MCH	Mother Child Health
MNCH	Maternal Newborn and Child Health
PDSA	Plan-Do-Study-Act
PNC	Post-natal Care
QA	Quality Assurance
QI	Quality Improvement
QIT	Quality Improvement Team
SDG	Sustainable Development Goal

SOP	Standard Operating Procedure
SQALE	Sustaining Quality Approaches for Locally Embedded Community Health Services
TBA	Traditional Birth Attendant
ToR	Terms of Reference
ToT	Training of trainers
TWG	Technical Working Group
UHC	Universal Health Coverage
URC	University Research Corporation
WHO	World Health Organisation
WIT	Work Improvement Team



## GLOSSARY

Best practice	Approaches that have been shown to produce superior results, selected by a systematic process and judged as exemplary
Client	Individuals provided with advice, care or treatment by a service provider
Community Health Volunteer	Volunteer frontline workers who provide level 1 services including disease prevention, health promotion and simple curative care; they lead and help their communities in health improvement initiatives to improve health status
Community Health Committee	Governance body for Community Health Units which consists of representatives from different groups and villages who provide leadership for managing level 1 services and activities
Community Health Assistant	Health or development workers who support CHVs and CHCs through supervision, mentoring and strengthening the interface between the community and primary health care system
Community Health Unit	A health service delivery structure within a defined geographic area covering a population of approximately 5,000 people
Consent	Voluntary agreement or approval given by a client
Continuous Improvement	A systematic, ongoing effort of making something better measured against standards or indicators
Criteria	Principle or standard by which something may be decided
Data	Facts and statistics collected together for reference or analysis, from which information can be generated
Effective	Providing services based on evidence which produce a clear benefit
Efficient	Avoiding waste
Equitable	Providing care that does not vary in quality because of a person's characteristics
Ethics	Acknowledged set of principles that are deemed morally correct and which guide professional and moral conduct
Evaluation	Assessment of the degree of success in meeting goals and expected results
Evidence	Data and information used to make decisions, derived from routine data, research, learning and evaluation.
Guidelines	Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific circumstances
Health Outcome	End-result or effect of care
Healthcare Provider	A person who provides health care e.g. a doctor, nurse, allied health professional
Health Record/ Register	Information about a client in hard or soft copy eg. clinical records, administrative records and financial records
Health system	The organisation of people, institutions, and resources that deliver health care services to meet the health needs of target populations
Indicator	Variable or aspect of service to be measured
Institutional Readiness	Community Health Unit/Health facility is established and working as per national guidelines

Learning Event	An interactive six-monthly forum with multiple stakeholders for evaluating what has worked, identifying good practice, stimulating ideas and innovation and advocacy for quality improvement
Monitoring	Observation and recording of events over time
Performance	How well a person, team, project, programme, organisation or policy is being implemented against expected results
Person-centred	Establishing a partnership between providers and clients to ensure care respects clients' needs and preferences
Protocol	An established set of rules used for the completion of tasks or a set of tasks
QI Champion	Individuals who go above and beyond in their actions and efforts to improve quality of community health services
QI Coach	Individuals from county and sub-county level who support and mentor work improvement teams through three main roles; facilitator, trainer and quality improvement expert.
Quality	Delivering the right services, every time, for every user to the best of our knowledge to achieve health outcomes
Quality Assurance	A systematic approach to planning, defining, monitoring, improving and evaluating quality of health services on a continuous basis
Quality Improvement	A systematic process for assessing performance, identifying gaps and causes and introducing measure to improve quality and monitor its impact.
Referral	The act of a facility or provider directing a client/patient to the care of another facility, or service provider
Safety	The degree to which the potential risk and unintended results are avoided or minimized
Standard	A statement of the expected quality that specifies a desired and achievable level of performance.
Standard Operating Procedures	Set of detailed, written instructions, having the force of a directive, to achieve uniformity or standardization of the performance of a specific function
Supportive Supervision	A facilitative approach to supervision that promotes mentorship, joint problem-solving and communication between supervisors and supervisees
Target	A realistic objective towards achieving a quality standard
Timely	Reducing waits and sometimes harmful delays
Work Improvement Team	Multi-disciplinary teams comprised of CHU and Link facility staff responsible for monitoring and improving the quality and performance of community health services



# INTRODUCTION



## 0.1 Context

The KQMCH training and capacity building approach aims to improve health outcomes by embedding quality into the scale-up of community health services in Kenya. This is through a process of capacity building and community engagement that is delivered through the development and coaching of Work Improvement Teams (WITs) for Community Health Services (CHS) at sub-county and community levels. The approach is aligned with the national Kenya Quality Model for Health (KQMCH) that focuses on health facilities, uses existing MOH tools and simple materials, grounded in the reality of implementing QI capacity building within Kenyan communities.

## 0.2 Assessing Readiness for Quality Improvement

Quality Improvement works best when there is institutional readiness (i.e. the community unit is set up and working as per national guidelines). Key pre-requisites include:

- Fully-trained community health volunteers (CHVs) in the basic community health modules;
- Uninterrupted supply and use of community health data collection and reporting tools; household registration and mapping.

Once a community unit is functioning and institutionally ready; then QI can be initiated.

## 0.3 Establishing Work Improvement Team (WITs)

Establishing WITs at Community level and at sub-county level (where they do not already exist), provides structure for QI training in community health. Advised WIT membership is shown in the table below.

QI training targets the team not the individual.

Community Level WIT (advised 6-8 members)	Sub-County Level WIT (advised 6-10 members)
<ul style="list-style-type: none"><li>• Community health officer or community health assistant (Chair)</li><li>• Link facility in charge (Co-chair)</li><li>• Community health volunteer (all team leaders +2)</li><li>• Community health committee member</li><li>• Adolescent community member</li><li>• Chair of Health Facility Management Committee</li><li>• Other stakeholders</li></ul>	<ul style="list-style-type: none"><li>• Community health service coordinator (Chair)</li><li>• Quality improvement focal person</li><li>• Health Records &amp; Information Officer</li><li>• RMNCH Officer</li><li>• Nutrition Officer</li><li>• Health promotion Officer</li><li>• Community Health officer (representing community level WIT Link facility incharge)</li><li>• Other partners</li></ul>

## 0.4 About this Facilitators' Manual for QI in Community Health Services

**Manual development** - This manual has been developed to train sub-county and community WITs in QI for community health services. To ensure training is useful, simple and likely to be taken up at county level the manual has been developed with the following guiding principles:

- Aligns with Kenya Quality Model for Health standards, national policies and country priorities.
- Reflects the latest thinking in QI, sourced from published literature and QI experts.
- Built on international and local research.
- Iterative user-centred design process involving stakeholders from community, sub-county and national level.
- Supports knowledge exchange between community and sub country levels.
- Empowers community health workers to take ownership of the QI programme and become QI champions.

**Target users** - This manual is directed at managers, supervisors and coaches involved in community health, working at county and sub-county levels; and health care providers and community health volunteers working at community level.

Ideal facilitators bring a diverse background to the team and could include:

- Community health service coordinators;
- QI coordinators;
- Maternal, new-born and child health focal person;
- Community Health officers;
- Health records information officers and others as relevant.

Facilitators from national level and implementing partner organisations can also train using this manual.

## 0.5 How to use the manual

Training is delivered over 3-phases in a modular format. Each phase contains:

- A set of training modules with lesson plans;
- Facilitators' notes;
- Handouts;
- Case studies;
- A participant's handbook;
- Power point presentations.

It is highly recommended that facilitators get acquainted with the manual and the facilitators' notes, presentations and handouts before the training.

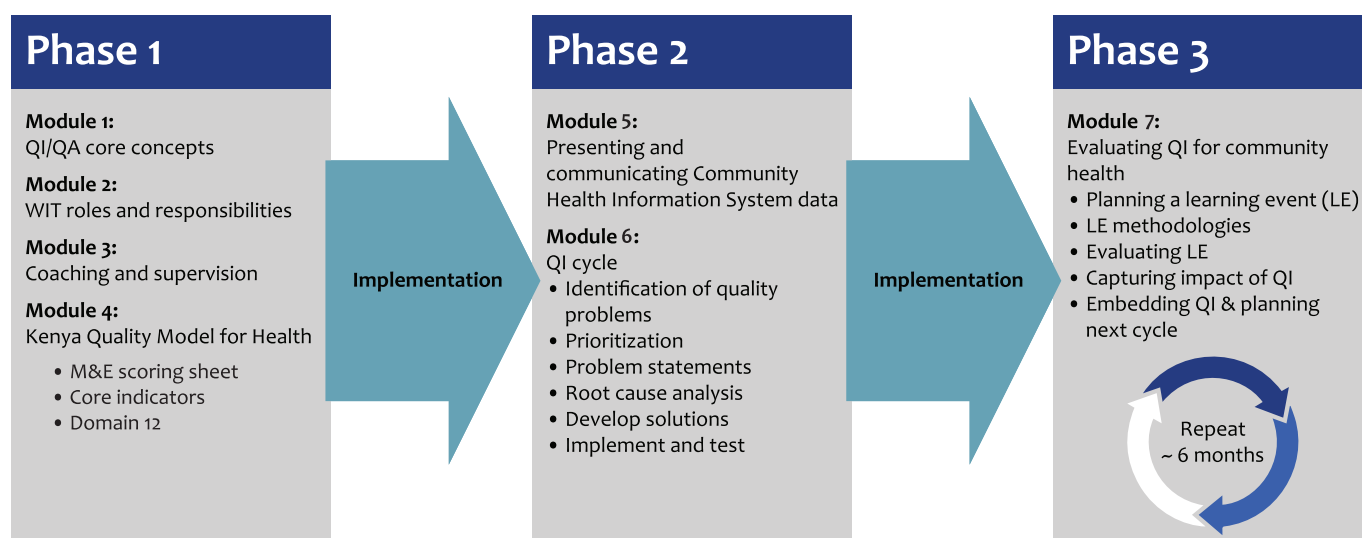


**Course Description** - The QI in community health course equips participants with the necessary knowledge and skills to effectively improve the quality of service delivery at household level and link household members to health facilities. There are specific learning outcomes for each phase of the programme and for each module.

One-off training with little to no follow-up does not work. Teams should be trained using simple, practical tools in a phased action-learning approach with regular QI coaching in between classroom sessions to sustain QI efforts. This provides the right support and an environment in which WIT members can thrive.

**Course structure** - The QI in community health course is delivered over 9 days over a period of 9 months with intervals for action learning.

	Duration	Participants
<b>Phase 1</b>	4 days training followed by an implementation period of 1-2 months.	Sub-county and community WITs. Advised class size – 30 max.
<b>Phase 2</b>	3 days training followed by an implementation period of 6 months.	Sub-county and community WITs. Advised class size – 30 max.
<b>Phase 3</b>	2-day learning event in which representatives from all teams come together to meet and learn from one another.	Stakeholders, community members and representatives from all sub-county and community WITs brought together. With careful facilitation, up to 150 participants attend.



**Phase 1** focuses on how to measure data quality and monitor community perceptions of community health services.

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

In **Phase 3**, teams from across the sub-counties are brought together to learn from each other. These learning events provide a unique space for sharing experiences and reflection, involving policy makers, managers, QI coaches and supervisors, providers and community members.

## **Sustaining a culture of quality**

QI coaches from county and sub-county level play three main roles; facilitator, trainer and QI expert. They mentor and support WITs to confidently use and apply QI tools, to advocate to higher levels of administration as well as improve community health volunteer (CHVs) performance, motivation and retention, recognising the important role that CHVs play as part of the wider health system. It is recommended that County leadership establishes regular coaches' meetings to provide 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.

## **Training methodology**

Methodologies employed across the three-phase training programme use a mix of experiential, participatory and didactic techniques which include:

- Lectures
- Role playing
- Group work and discussions
- Brainstorming
- Case scenarios
- Quizzes
- Application of learning in their work setting

Detailed facilitator notes set out in a step by step fashion how to facilitate each module using a range of methods and tools.

## **Evaluation and support**

Evaluation is built into the Kenya Quality Model for Community Health Services. During the quality improvement in community health course, evaluations are conducted during each phase using both qualitative and quantitative methods. During periods of action learning, quality improvement coaches make regular visits to support WITs in implementing and evaluating their quality improvement change plans. Regular supportive supervision is also conducted to support CHVs in their roles.

## **Certification**

The innovative nature of the programme ensures an experiential learning experience in which participants use their own data and are supported in the direct application of learning. Competency is attained through successful completion of all course activities including;

- Attending at least 90% of the class sessions.
- Implementation of the activities in their action plans and quality improvement change plans that are developed at the end of each phase of training.



# INTRODUCTION TO PHASE 1



## Preparation for QI for CHS Course: Phase 1

### Participants

At the heart of the Kenya Quality Model for Community Health Services (KQMCHS) are work improvement teams (WITs) for community health services (CHS) at both community level and sub-county level. WITs are therefore the target groups for this training programme. In advance of Phase 1, it is essential that the appropriate individuals are invited to attend as per the following recommended membership:

Once these individuals have been brought together, then the WITs for CHS can be properly established. Module 2 describes this in more detail.

For Phase 1 training there should be separate training workshops as follows:

- A training workshop for Sub-County CHS WITs
- A training workshop for Community Health Unit WITs

The ideal number for a training workshop is a maximum of 30 participants. Therefore, training workshops should include 3 WITs. Depending on the number of participants, it may be necessary to hold multiple training workshops.

Sub-County CHS WIT	Community Health Unit WIT
Sub-County MOH	Facility In-Charge
Sub-County CHS coordinator	Community Health Officer/ Assistant (CHO/CHA)
Sub-County QI Focal Person	CHVs (maximum of 3)
Sub-County Health Records Information Officer	Chair of health facility management committee
Sub-County Reproductive Health Coordinator	Community Health Committee member
Sub-County Nutrition Officer as member Link facility incharge	Community members <ul style="list-style-type: none"><li>• Maximum of 2</li><li>• One community member should hold a position of authority within the community e.g.: Chief, Assistant Chief, Village Elder etc.</li></ul>
Community Health officer or assistant (CHO/ CHA) <ul style="list-style-type: none"><li>• 1 CHO/ CHA representing each Community Health Unit participating in QI for CHS training</li></ul>	

Training workshop(s) for the Sub-County CHS WITs must take place first because the expectation is that the Sub-County CHS WITs are then responsible for training the Community Health Unit WITs. It is recommended that Sub-County CHS WITs training takes place 1 week before Community Health Unit WITs training.

### WIT pre-training preparation

Instruct Sub-County CHS WITs to bring the following to the workshops:

- Each Community Health Volunteer's (CHV's) MOH 514 Service Delivery Log Book
  - » Must include the data reported by each CHV for the previous three months
- MOH 515 summaries for the previous three months
- At least one member of each Sub-County CHS WIT should bring a laptop computer to access the Kenyan Health Information System (KHIS) during the training workshop for retrieval of community-level health data and facility-level health data.

The most appropriate person to bring their computer is the Sub-County Health Records Information Officer and subcounty community health service coordinator.

Instruct Community Health Unit WITs to bring the following to the workshops:

- MOH 515 Summaries for the previous three months
- At least one member of each Community Health Unit WIT should bring a computer to access the Kenyan Health Information System (KHIS) during the training workshop for retrieval of community-level health data and facility-level health data
  - » The most appropriate person to bring their computer is the CHA.

## Suggested workshop timetable

Day 1		
	Sub-County CHS WITs	Community Health Unit WITs
8.00am	Registration	
8.30am – 10.30am	Official Opening Welcome & Introduction & An Overview of the KQMH	Official Opening Welcome & Introduction & An Overview of the KQMH
10.30am – 11.00am	TEA BREAK	
11.00am – 1.00pm	Core Concepts of Quality Assurance (QA) and Quality Improvement (QI)	Core Concepts of Quality Assurance (QA) and Quality Improvement (QI)
1.00pm – 2.00pm	LUNCH	
2.00pm – 4.30pm	WITs	WITs

Day 2		
8.00am	Registration	
8.30am – 10.30am	Quiz 1 - Supervision for QI	Quiz 1 - KQMH Quality Standards
10.30am – 11.00am	TEA BREAK	
11.00am – 1.00pm	Coaching for QI	Overview of Kenya's Community Health Information Systems & Importance of Data Quality
1.00pm – 2.00pm	LUNCH	
2.00pm – 4.30pm	KQMH Quality Standards & Overview of Kenya's Community Health Information Systems	Importance of Data Quality



Day 3		
8.00am	Registration	
8.30am – 10.30am	KQMH standards for community Health Services	
10.30am – 11.00am	TEA BREAK	
11.00am – 1.00pm	KQMH standards for Community	
1.00pm – 2.00pm	LUNCH	
2.00pm – 4.30pm	KQMH M&E scoring sheet	

Day 4		
8.00am	Registration	
8.30am – 10.30am	KQMH core indicators	N/A
10.30am – 11.00am	TEA BREAK	
11.00am – 1.00pm	Domain 12 Results	N/A
1.00pm – 2.00pm	LUNCH	
2.00pm – 4.30pm	Summing up of workshop & Evaluation	N/A

## Quizzes

As indicated in the timetables above most days begin with a quiz. The following describes how to deliver each quiz.

1. All Quizzes can be found in the annex of this manual.
2. Instruct each participant to work on their own to write responses to each question on the paper without referring to their notes.
3. Instruct participants to pass their completed Quiz to the person sitting to the left of them such that each participant will mark the answers of a participant other than themselves.
4. Take participants through the correct answers as they appear on the answer sheet.
5. Instruct participants to allocate marks as per the marking scheme.
6. After you have taken participants through all the correct answers, instruct participants to add up the marks and write the total score.



# Core Concepts of Quality Assurance and Quality Improvement

MODULE

**1**







## 1.1 Module Overview

The purpose of this module is to give participants a basic introduction to the core concepts of quality, quality assurance and quality improvement as they relate to community health services. Participants will collaboratively develop a definition of quality in relation to community health services. Module content and exercises will emphasize the reasons as to why quality of community health services is so important. Participants will consider the different perspectives and priorities of the various stakeholders in community health and will be introduced to the different dimensions of quality and understand the importance of using a systematic approach.

## 1.2 Learning Objectives

By the end of this module participants will be able to:

1. Describe concepts of quality in relation to community health services
2. Describe the importance of quality in relation to community health services
3. Describe stakeholders in community health and their different perspectives
4. Define Quality Assurance and Quality Improvement and relate these to community health services

## 1.3 Session Plan

Day 1		
Topic	Activity	Time
Concepts in Quality in relation to community health	Presentation/ Discussion/ Group Work	30 minutes
Why is quality of community health services important?	Discussion/ Presentation/Buzz	20 minutes
Stakeholders in community health	Presentation/ Group Work/ Discussion	40 minutes
Quality Assurance and Quality Improvement	Presentation	30 minutes

**Total time 120 minutes**

<b>PowerPoint Presentations</b>	Module 1 – Core Concepts in Quality Assurance and Quality Improvement (Sub-County CHS WITs/ Community Health Unit WITs)
<b>Handouts</b>	Quality Improvement Cycle
<b>Stationery</b>	Flip Chart, Marker Pens, Projector

## 1.4 Facilitation Steps

Inform participants of the learning objectives of the session.

- Group work activities are highlighted in blue.

## Topic 1: What is quality?

Ask the participants to think about the last time they or a close relative accessed health services and to share what made it a good or bad experience.

- To start off the discussion, give an example of a health service experience.
- Accept all responses from participants and write them on a flipchart.
- Present the ‘What is quality?’ slide and relate the content to the responses given by the participants.

Inform participants that in addition to the overview of quality just provided, a useful framework is the World Health Organization (WHO) dimensions of quality.

- Where possible, relate these dimensions to the responses given by participants in the opening activity of this session.

Instruct participants to divide into their WITs and write their definition for high-quality community health services for their Sub-County/ Community Health Unit building on the results of all discussions held thus far.

- Allocate 15 minutes for this task.
- Each WIT should allocate one member to present their definition of high-quality community health services to the rest of their group.
- Encourage the rest of the group to provide feedback.
- Allocate 10 minutes to revise their definitions if necessary and for individuals to write their WIT’s definition of high-quality CHS in their handbook.

## Topic 2: Why is quality of community health services important?

Instruct participants to talk to each other in pairs about why it is important to provide high- quality community health services and to write these in their handbook.

- Allocate 5 minutes for this task.
- After participants have completed this exercise, ask each pair to give one reason and write it on the flip chart. They must not repeat something that has already been said. Keep going around the pairs until all their responses have been exhausted.
- Present the slide ‘Importance of quality of community health services’ and relate the content to the participants’ responses.

## Topic 3: Stakeholders in community health

Inform participants that there are four key groups of stakeholders to consider when it comes to community health services – **clients; service providers; supervisors; and managers.**

- Highlight the type of individuals included in each of these groups as presented on the slide ‘Who are the stakeholders in community health services?’

Using the slides ‘What are the interests of these stakeholders in community health services?’, emphasize to participants that each of these different groups of stakeholders has a different perspective and different priorities and highlight what these are.



Inform participants that they will now review the following community health case study which can be found in their participant's handbook: Two pregnant women are in different community health units. In one unit, the community health volunteer (CHV) not only advises the pregnant woman (Lakicia), to go for skilled delivery at the link facility, the CHV also follows up with Lakicia to ensure she attends at least 4 antenatal care (ANC) visits at her link facility. In the other unit, the CHV advises the pregnant woman (Neema) to give birth at her link facility. However, this CHV does not follow-up on Neema's antenatal attendance. The two expectant mothers arrive at their link facility in labour. Lakicia gives birth to a healthy baby whilst Neema's baby is born with a congenital deformity on her back (spina bifida). The clinician explains this to be because of insufficient folate levels in the mother's blood during pregnancy which she would have received during ANC visits.

- Instruct one of the participants to read out the community health case study.
- Allocate a stakeholder group to each group, e.g. Group 1 clients, group 2 service providers, group 3 supervisors, group 4 managers.
- Instruct each of the groups to discuss amongst themselves, from the perspective of the stakeholder group they've been allocated, and in relation to the case study, what would be of most concern to them regarding delivery of high-quality versus low-quality community health services.
- Group work' slide contains guide questions for this task.
- Allocate 15 minutes for this task.
- When each group has completed this task, collect answers in plenary from each of the different stakeholder groups.

Explain that when it comes to considering whether health services are high-quality or not, it is crucial to consider the perspective of all the various stakeholders involved.

#### **Topic 4: Quality Assurance and Quality Improvement**

(Skip to the definition of Quality Assurance' for Community Level WITs)

Only for Sub-County CHS WITs – Remind participants of the components of a health system. Present the Donabedian model of structure, process, outcome to participants using the slide 'The Donabedian model'.

- Inform participants that alternative models for considering the components of a health system do exist.
- Inform participants that the Donabedian model is a conceptual model that provides a framework for examining health services and evaluating quality of health care.

Highlight to participants that in order to deliver high-quality health services, we need to have the right inputs in place in order to ensure that we do the right things in the right way (processes) in order to achieve the outputs/ outcomes that we want.

Emphasize to participants that the only way to know whether you are achieving the results you want is through measurement e.g.: monthly reports to see if community health services are being delivered as they should. Emphasize that we must monitor results to know if we are improving quality.

Inform participants that often, it is the processes where we can improve things i.e. the way we work. For example, making appropriate referrals, follow-up of pregnant mothers for ANC compliance and reviewing Mother & Child Health Handbooks do not require additional resources but should result in improved health outcomes for the mother and child.

Invite the participants to relate the Donabedian model to the community health case study discussed earlier in this session. Instruct participants to think what could have been done to strengthen each of the three components of the community health system (structure, process, outcome). Collect responses in plenary and write these on flip chart paper. For example:

Structure	Process	Outcome
<ul style="list-style-type: none"> <li>• Provide pregnant women with Mother &amp; Child Health Handbooks.</li> <li>• Provide CHVs with MOH 100 Community Referral Forms.</li> <li>• Train CHVs on antenatal care (ANC) and the importance of following up pregnant mothers to ensure ANC compliance.</li> <li>• Train CHVs on how review Mother &amp; Child Health Handbooks for ANC compliance.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure CHVs prioritize household visits to pregnant women.</li> <li>• Provide supportive supervision to CHVs to communicate effectively with pregnant women regarding ANC and its importance.</li> <li>• Community dialogue days/ forums regarding ANC and its importance.</li> <li>• Review CHVs' data collection and reporting tools to ensure accurate data collection and reporting.</li> <li>• Celebrate CHVs who ensure complete follow-up of pregnant women throughout their pregnancy.</li> </ul>	<ul style="list-style-type: none"> <li>• High proportion of pregnant women completing 4 ANC appointments.</li> <li>• High proportion of pregnant women have skilled deliveries.</li> <li>• High number of healthy newborns delivered.</li> <li>• Pregnant women and community members express satisfaction with community and facility health services.</li> </ul>

### (Definition of Quality Assurance' for Community Level WITs)

Present the definition of Quality Assurance on the slide 'Quality Assurance'.

Inform participants that Quality Assurance should be a cycle made up of 5 key components that you will shortly provide definitions for – **Plan. Define. Monitor. Improve. Evaluate.**

- Instruct participants to recite the five components until they can do so by memory.

Inform participants of example activities in Quality Assurance for community health services and how they are implemented.

- Clarify to the participants that Work Improvement Team is just another name for Quality Improvement Team and this will be covered in detail in the next module.
- Instruct one participant to read out the example activities.

Present the slide 'Quality Assurance of community health services' highlighting to participants that these are the principles that should underpin quality assurance of community health services.

Inform participants that 'Improve' is one of the components of the Quality Assurance cycle, thus Quality Improvement is a component of Quality Assurance.

Remind participants that Quality improvement doesn't necessarily require lots of resources and even small or simple changes can make a big difference to the outcome.

Inform participants that Quality Improvement is about closing the gap from what is (low quality) to what should be (high quality).

Read out the following definition: "Quality Improvement (QI) of community health services is a systematic process of assessing the performance of a community health system and its services, identifying gaps in performance that lead to low-quality community health services and then identifying causes for these gaps, and then introducing measures to improve quality by filling in these gaps by addressing the causes for these gaps and then very importantly monitoring the impact to know if what you are doing is actually improving quality which as we had said earlier is demonstrated by improved outcomes."

Inform participants that Quality Improvement is a cycle composed of four key steps:

- **Step 1: Identify.**
- **Step 2: Analyse.**
- **Step 3: Develop.**
- **Step 4: Implement and test.**

Instruct the participants to recite these four steps until they can do so by memory.

Inform participants that **Step 1: Identify** is broken down into 3 smaller steps:

- a. Identify quality problems.
- b. Prioritise quality problems.
- c. Develop problem statement.

Inform participants that **Step 2: Analyse** is about understanding what is causing the problem. **Step 3: Develop** is about development of solutions to address the causes of the problem. **Step 4: Implement and test** is about implementation of these solutions and testing for change.

- Note that there may be some participants who are familiar with 'PDSA' - 'Plan. Do. Study Act' from other forums in which they have received training on quality improvement. Inform participants that **step 4** is the **Plan. Do. Study. Act** cycle.

Using the slide 'What does QI entail?', inform participants that for QI to work, it requires:

**Leadership** - to foster a culture where performance of community health systems is continually assessed and there is commitment to identifying gaps and addressing the causes.

**Client focus** - when assessing the quality of community health services, the perspective of community members is considered as discussed earlier in this session.

**Teamwork** - QI is everyone's responsibility! One person cannot identify all the gaps in quality. Furthermore, one person alone cannot address all the causes for gaps in quality. Some actions may involve levels or departments beyond their designation.

**Data-driven** - QI must be data-driven meaning that when you are identifying gaps in the quality of community health services and identifying causes for these gaps, there must be evidence that demonstrates that the gap is real and the cause is understood. Data must also be gathered to provide evidence that QI activities are effectively addressing the gap.

**System/ process focus** - what is done and how it is done is often where we have the most control

**Dissemination and shared learning** - In school we were taught that copying is bad, but in QI copying is good! We recognize that each community health unit is different and each work improvement team is different but there is a lot we can learn from one another, from how to implement a QI activity, to sharing evidence from effective QI activities.

QI is not about allocating blame to individuals. It is about assessing the way in which we work and seeing how this can be improved to bring about improved outcomes.

Highlight to participants that phase two of the QI in community health course is when they will develop their own QI plan using their own data and local knowledge and will implement and test QI activities.

Present the key messages of this session.

**Only for Sub-County CHS WITs** - Using the quote from Donabedian A. 1966(33) , emphasize to participants that the most important thing for quality assurance to work is commitment.

Close the session by inviting participants to ask any questions that they may have.

## References

Quality Improvement Made Simple (2016), The Health Foundation, UK. <http://www.health.org.uk/publication/quality-improvement-made-simple>

Kenya Quality Model for Health Quality Standards for Community Health Services (2015), Ministry of Health, Kenya. <http://guidelines.health.go.ke/#/category/23/92/meta>



# Work Improvement Teams for Community Health Services



MODULE

**2**





## 2.1 Module Overview

The purpose of this module is to create awareness among participants of Quality Improvement (QI) structures in the Kenyan health system at National, County, Sub-County, Facility and Community levels. Participants will explore the roles and responsibilities of the different Quality Improvement structures at each level, and understand how they fit in the national Quality Improvement agenda. Particular attention will be paid to the composition of Work Improvement Teams for community health services at sub-county and community level.

## 2.2 Learning Objectives

By the end of this module participants will be able to:

1. Describe the structure for Quality Improvement of community health services from national to community level
2. Describe the roles and responsibilities of Quality Improvement structures for Quality Improvement of community health services from national to community level
3. Describe how to work effectively as a Work Improvement Team
4. Describe the importance of documentation in Quality Improvement of community health services

## 2.3 Session Plan

Day 1		
Topic	Activity	Time
Structures for QI of CHS	Presentation	10 minutes
Roles and responsibilities for QI of CHS	Brainstorm/ Presentation/ Group Work	45 minutes
How to work effectively as a WIT	Case Study/ Presentation/ Game	25 minutes
Importance of documentation in QI of CHS	Presentation	10 minutes

**Total time 90 minutes**

<b>PowerPoint Presentations</b>	Module 2 – <b>Work Improvement Teams for community health services</b> (Sub-County CHS WITs/ Community Health Unit WITs)
<b>Handouts</b>	Terms of Reference – Community Health Unit/ Sub-County Team Structure, Roles and Responsibilities for CHS
<b>Stationery</b>	Flip Chart, Marker Pens, Projector

## 2.4 Facilitation Steps

Inform participants of the learning objectives of the session.

### Topic 1: Structures for QI of CHS

Present the ‘Structures for Quality Improvement of community health services’ slide.

- Highlight to participants that at each level of the health system, e.g. the National Ministry of Health, there are team(s) responsible for quality improvement of community health services.

It is now widely accepted that the health of the nation begins at the community and therefore it is key that community health services are integrated with the rest of the health system and furthermore, the way keen attention is paid to quality of facility health services, the same attention should be given to the quality of community health services.



Highlight to participants that teams should not operate in isolation and that they should regularly interact and provide feedback both upwards and downwards.

## Topic 2: Roles and responsibilities for QI of CHS

(Skip to 2<sup>nd</sup> bullet point, ‘Present the ‘National QI TWG and National CHS TWG’ slide’ for Community Level WITs)

Only for **Sub-County CHS WITs** - Ask the participants to think about what they believe should be the roles and responsibilities for each of the structures you have just outlined when it comes to quality improvement of community health services.

- Highlight that each team has multiple roles and responsibilities, not just one.
- If required, give an example e.g. “I think that the national ministry of health should be responsible for giving us standards as to what high-quality community health services are.”
- Accept all responses from participants and write them on a flipchart.

Present the ‘National QI TWG and National CHS TWG’ slide.

For **‘Leadership in Policy’ and ‘Formulate, update and disseminate standards’**, highlight to participants, particularly with Community Health Unit WITs, that the way in which community health services should be delivered comes from national government directives, who through consultation with relevant stakeholders, develop the guidance as to how we should work and the standards we should meet to enable us to say we are delivering high-quality community health services.

For **‘Advocacy for institutionalisation of QI’**, highlight to participants that quality is not a stand-alone agenda, quality is cross-cutting; whatever health service you are offering, whatever health area you are working in, you should strive to deliver high-quality performance. This is what the national government advocates for in line with an international focus on quality of health services

For **‘complete national picture’ and ‘sharing best practice’**, highlight to participants that in a household, the parents are the head of the household and should know how each of their children are performing in school, should know whether each of their children is healthy and growing as they should etc., it is the role and responsibility of the national government to know how each county is performing in regards to community health services, e.g. how much geographical area is covered by community health units, how many community health units have CHVs that are trained in all basic modules and technical modules etc. and furthermore, it is their responsibility to share innovation and best practice from a county that is doing well with other counties.

- **Only for Sub-County CHS WITs** - Wherever applicable, acknowledge and congratulate the participants on thinking of a role or responsibility in the brainstorm exercise that also appears on the slide.

Present the roles and responsibilities and membership of the County QI TWG as presented on the slide ‘County QI TWG’

Only for **Sub-County CHS WITs** – As a facilitator please note that not all Counties in Kenya have a technical working group for quality improvement of health services; in this case there may be partners through whom a QI TWG can be established and supported to meet quarterly.

For **‘Full picture of quality in the county’** and **‘Feedback on data and performance’** highlight to participants that the County QI TWG should know how the county is performing regarding community health services. Highlight to participants that of course the mandate of the county goes beyond community health services and they are also concerned with facility health services e.g.: pushing for robust tracking and referral for ANC of pregnant women and strong community-facility linkage in order to increase the proportion of pregnant women in the county completing 4 ANC visits.

For **‘Ensure equity in CHS’**, read the definition; “Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically.” And once again highlight that health equity is also concerned with health services being provided according to need, a good example of which in community health services is prioritisation of household visits to households with pregnant women and children less than 5 years of age. It is the responsibility of the County to strive towards equitable health services such that all populations receive the health services that they need regardless of where they live or social, economic, demographic status. In the context of community health services, one key activity towards equity of community health services is establishment of community health units across the entire geographical area of a County.

For **‘Plan and budget for QITs and WITs’**, highlight to participants that high-quality does not just happen, it must be planned for and this will be covered in the phase 2 of the QI for community health training. Furthermore, quality must be funded even if it is just refreshments or transport allowances to facilitate WIT meetings. In Kenya’s devolved administrative structure, it is County Health Management Teams that control the budget for health services, and it is the responsibility of the County QI TWG to advocate for funds and resources for quality improvement.

For **‘Capacity building of QITs and WITs’**, highlight to participants that it is the responsibility of the County to ensure that their health workforce are equipped with the knowledge and skills to carry out quality assurance and quality improvement. This is done through arranging training, such as the one the participants are now in, and through coaching and supervision to provide technical support and guidance to WITs.

Present the ‘Sub-County CHS Work Improvement Team (WIT)’ slide.

- Highlight to participants that Sub-County CHS WITs are a sub-set of the Sub-County Health Management Team. The Sub-County CHS WIT should report to the Sub-County Health Management Team.
- Highlight to participants that membership of Sub-County CHS WITs can be considered as dynamic and “rolling” based on the needs of the WIT at a particular point in time, e.g. if you are addressing a water, sanitation and hygiene (WASH) problem, then the WASH coordinator and Public Health Nurse would be essential individuals to be involved.

Emphasise to participants that to ensure representation and advocacy for community health units that it is essential that CHAs are also members of the sub-county CHS WIT

For **‘Quality Improvement of community health services across Sub-County’**, highlight to participants that quality improvement activities for community health services should be included in their annual work plans to ensure QI activities are allocated time and resources.

For **‘Review CHU performance’**, **‘Ensure collection and reporting of high-quality community-level health data’** and **‘Compliance with KQMH Quality Standards for CHS’**, highlight to participants that it is the responsibility of the Sub-County CHS WIT to review performance and quality of community health services in their sub-county. Primarily this is about ensuring community health services are delivered according to the national community health strategy and KQMH Quality Standards for CHS. Furthermore, beyond monthly reporting of community-level health data, Sub-County should ensure that the data generated from community level is trustworthy. This means ensuring CHVs are trained in data collection and receive continuous support supervision to ensure data is being collected and reported as it should.

For **‘oversight of CHU WITs’** and **‘build capacity of CHU WITs’**, highlight to participants that it is the Sub-County’s responsibility to provide leadership for quality improvement of community health services. This involves coaching and supportive supervision of Community Health Unit WITs to increase the likelihood of meeting the targets of quality that they have set for themselves.

For **‘encourage innovation and best practice’**, highlight to participants that the Sub-County should recognise high-performing CHUs and share lessons learnt from these, particularly in regard to activities they carry out on a regular basis that lead to high-quality community health services and good health outcomes. Present the **‘Facility Quality Improvement Team (QIT)’** slide.

Highlight to the participants that representation of facility staff in the Community Health Unit WIT is essential to strengthening community-facility linkage and that the problems affecting quality of community health services. The activities of the Community Health Unit WIT should be an agenda item and point of discussion in facility Quality Improvement Team and or Facility Work Improvement Team meetings.

Present the **‘Community Health Unit Work Improvement Team (WIT)’** slide.

Highlight to the participants that the Community Health Unit WIT should consider themselves the leaders of community health services in their community health unit(s) meaning that they identify the gaps, plan and implement the QI activities and measure the impact.

- Emphasise to the participants that the Community Health Unit WIT is responsible for guidance and capacity-building of CHVs either directly or by arranging the relevant opportunities. For example, in Phase 1, participants will be taken through how to correctly record data in the MOH 514 Service Delivery Log Book. It is the responsibility of the Community Health Unit WIT to ensure that following this workshop, all CHVs are taken through how to correctly record data in the MOH 514 Service Delivery Log Book.
- Emphasise to participants that Quality Improvement is everybody’s responsibility. Therefore, the knowledge and skills that the WIT will gain via training courses, such as this one, should not remain in the WIT, it should be disseminated and shared with all CHVs.
- Emphasise to participants that membership of a facility staff member in the Community Health Unit WIT is essential. The facility staff member should be a co-chair of the Community Health WIT along with a CHA.
- Emphasise to participants that it is vital to include a young person (15-24 years old) as part of the Community Health Unit WIT who will advocate for adolescent and young adult health.

Instruct participants to reflect and discuss the current status of leadership, supervision, support and activities for quality improvement of CHS.

- For this exercise, emphasise to participants that you do not want participants to tell you how things SHOULD be (you could read the national policy documents if that is what you wanted); what you want to know is HOW THINGS REALLY ARE.
- Inform participants that this Group Work exercise should be carried out in their WIT.
- Inform participants that they should discuss and respond to each question on the slide and note these responses down on flip chart paper.
- Inform participants that they should select a member of the WIT to present their responses to the rest of the group after the exercise has been completed.
- Allocate 15 minutes for this task.
- After 15 minutes, instruct each WIT to present to the rest of the group.

### Topic 3: How to work effectively as a WIT

Inform participants that they will now review the following community health case study which can be found in their participant's handbook:

There are two neighbouring community health units. One community health unit is called Kisimani and is linked to Kisimani Health Centre. The other community health unit is called Jata and is linked to Jata Health Centre. Both these Community Health Units have Community Health Unit WITs. In both these community health units, it has been recognised that there are a high number of unskilled home deliveries. Kisimani Community Health Unit WIT inform all CHVs at the next group supervision meeting for CHVs that this problem has been identified and it is now their goal to reduce the number of home deliveries by at least 75% in the next 6 months. Furthermore, Kisimani Community Health Unit WIT arrange for a community dialogue day in which the entire community health unit are informed that the high number of unskilled home deliveries in their community health unit is a problem and they all need to do their part to solve this problem and reduce maternal and newborn deaths.

Jata Community Health Unit WIT do not inform the other CHVs or community members that high number of unskilled home deliveries has been identified as a problem. Kisimani Community Health Unit WIT hold a WIT meeting whose main agenda is to analyse the problem to identify the causes for high number of unskilled home deliveries and to develop solutions to address the problem in order to reach their target of reduction in the number of unskilled home deliveries by at least 75% in the next 6 months. All WIT members (including the young person who is a WIT member) provide contributions to these discussions and come up with suggestions. Jata Community Health Unit WIT do not meet regularly and it is the CHA, by themselves, who assumes what the causes for the problem are and instructs the CHVs to carry out the activities they have thought of to reduce the number of unskilled home deliveries. The CHVs of Kisimani Community Health Unit began to implement the quality improvement plan developed by their Community Health Unit WIT. Through monthly group supervision meetings and monthly WIT meetings, the WIT ensures that activities are carried out as planned and ensure there is documentation of all activities carried out.

One of the key activities of their Quality Improvement plan is to sensitise and orient all the facility staff at Kisimani Health Centre of the need to communicate effectively with and provide a safe environment to young women aged 15 – 18 since it came up during WIT analysis that young women in Kisimani and neighbouring areas also are reluctant to go to primary healthcare facilities because they feel judged by facility staff since they are talked to harshly for getting pregnant at a young age. The Facility In-Charge who is a co-chair of Kisimani Community Health Unit WIT took this to heart and took the lead in creation of a safe space for young people in the facility and in a facility staff meeting informed the staff the issues young people had with how they were dealt with at the facility. Following this, the Community Health Unit WIT was provided the opportunity to sit with all staff and take them through key points about how young people would like to be communicated and dealt with.

Additionally, in their monthly WIT meetings, WIT members are reviewing facility- level health data brought by the Facility In-Charge and community-level health data in the MOH 515 Community Health Extension Worker Summary to monitor and evaluate if they are making progress towards reaching their 6-month target. Meanwhile, in Jata Community Health Unit, there are irregular group supervision and WIT meetings therefore there is no structured follow-up on whether activities to reduce number of unskilled home deliveries are taking place as they should. Also, there are no activities taking place to reduce home deliveries that involve facility staff because even though the facility in-charge was appointed co-chair and attending the first phase of QI for CHS training, they have not attended any WIT meetings since then. After 6 months, there is a 60% reduction in the number of unskilled home deliveries in Kisimani Community Health Unit whereas in Jata Community Health Unit the number of unskilled home deliveries has remained the same.

- Instruct one of the participants to read out the community health case study.
- Inform participants that the purpose of this community health case study is for them to identify the qualities of an effective WIT.
- Instruct the participants to discuss the following questions with the person sitting next to them.
  - » Which WIT would you say is effective?
  - » Why did you select this WIT as an effective WIT?
  - » Which WIT would you say is not effective?
  - » Why did you select this WIT as an ineffective WIT?
- Allocate 5 minutes for this task.
- After 5 minutes, hold a plenary discussion in which participants state their responses to the questions above.
- Accept only one response at a time from any one person.
- Note down all responses on a Flip Chart paper on display at the front of the room.
- Stop when all responses have been exhausted.
- Facilitator to summarise using slide 21 and 22



Present the ‘Qualities of an effective Work Improvement Team’ slide.

- Wherever applicable, acknowledge and congratulate the participants on thinking of a quality of an effective Work Improvement Team in the community health case study exercise that also appears on the slide.

For **‘competent members’**, highlight to participants that this means that each team member has the required skill set in order to achieve the team’s purpose of quality improvement. Inform them that this means active participation in all phases of the QI for community health training programme.

For **‘principled leadership’**, highlight that leadership is fundamental. Without leadership, even a team that has competent and committed members will fail in meeting its goals because there is no direction. The Chairs of the Sub-County CHS WIT and Community Health Unit WIT should provide this leadership.

For **‘standards of excellence’**, highlight to the participants that this means WIT members should all be aware of the KQMH Quality Standards for CHS. Furthermore, all WIT members should be aware of the specific target(s) that the WIT has set for the community health unit/sub-county.

For **‘results-driven’**, highlight to participants that an effective WIT should test for change through monitoring and evaluation and take necessary action based on the results.

For **‘unified commitment’**, highlight to participants that commitment from all team members is fundamental.

For **‘a collaborative climate’**, highlight to participants that all team members should feel confident in sharing their thoughts with the other team members and create an environment in which everybody’s opinion is respected regardless of hierarchy.

For **‘the team has to be willing to take risks’**, highlight to participants that Quality Improvement at times requires innovation and a willingness to do things differently.

For **‘recognition and external support’**, highlight that it is very important for morale of WIT members as well as CHVs to be kept high. One very important way of keeping morale high is recognizing the efforts of WIT members and CHVs, especially those who have gone above and beyond. Furthermore, Work Improvement Teams for community health systems should not exist in isolation and should provide feedback and support to each other.

Present the ‘Essential activities for an effective Work Improvement Team’ slides.

Inform participants that they will now play a quick game that highlights the importance of teamwork and collaboration.

- Divide the participants into groups of 6-7 people.
- Instruct each of these groups to sit in a circle in their own area of the workshop room.
- Instruct each group to give themselves a team name.
- Instruct each team to select one individual from their team to be the Quality Officer.
- The Quality Officer must have the following; a stopwatch, paper and pen. Once the Quality Officers have these items, instruct them to stand outside their team’s circle.
- Provide each team with a piece of fruit (for example: a mango).

- Explain to participants that the game is a competition to see which team can pass the fruit between themselves the fastest, whilst following these rules: 1) The fruit must be passed between individuals in alphabetical in order of their first names. If a mistake is made and the fruit is passed to the wrong person then the team must start again from the first person. 2) The fruit must be undamaged at the end. 3) The fruit must not be dropped. If the fruit is dropped, the team must start again from the first person.
- Inform the Quality Officers that their job is to time how long it took the group to pass the fruit between themselves, enforce the rules of the game and write down the time it takes them to complete the task on flip chart paper.
- Inform participants that in other forums, teams have gotten much faster times so now you want them to think of ideas as to how they can complete the task in a shorter amount of time and test these ideas. Repeat the game 2 more times for teams to test their new strategy and record the times on flip chart paper.
- Explain how this game highlights the qualities of an effective work improvement team. i.e. clear goals.

#### Topic 4: Importance of documentation in QI of CHS

Inform participants that documentation in Quality Improvement of community health services ranges from routine documentation (e.g. minutes of WIT meetings, minutes of group supervision meetings, minutes of community dialogue days) to documentation of innovative activities and the impact of these activities (e.g.: poster presentations, stories of change, personal success stories)

- Inform participants that they will learn more about documentation of innovative activities in Phase 2.

Present the ‘Why is documentation in Quality Improvement of community health services important?’ slide.

For **‘provides evidence of the hard work of Work Improvement Teams’**, highlight to participants that documentation can be used to promote the work and successes of the WIT to members of the community and other stakeholders.

For **‘advocacy’**, emphasise to participants that in Kenya, the national Community Health Strategy is still not financed and resourced as one would wish. In this context, documentation takes on a whole new level of importance as it can be used to prove to decision-makers at County and National level that it is worth investing in community health services.

For **‘allows for effective dissemination and shared learning’**, highlight to participants that, dissemination and shared learning is required for effective Quality Improvement. However, they can only do this if the activities and lessons in best Service Delivery, Quality Assurance and Standards Subtheme Committee meeting practice have been documented and described in enough detail.

For **‘allows for effective supportive supervision and coaching’**, highlight to participants that when they are visited by a QI Coach, the coach should document that visit in terms of their observations, recommendations and action points agreed upon with the team. This means that for future visits by a QI Coach, even if it is not the same person, they can easily refer back to the previous report and follow up on the recommendations and actions previously made.

Present the ‘Recommended minimum contents of WIT folder’ slide.

- Inform participants that the content listed on the slide will be covered later on in the QI for community health training programme.
- Emphasise that WITs should feel free to document and store anything and everything to do with delivery of and quality improvement of community health services in their WIT folder.

Present the ‘High-quality documentation is...’ slide.

For **‘true and honest’**, highlight to participants that their documentation should not paint a false picture. Remind participants that Quality Improvement is about crossing the gap between what is and what should be and state “if we are not honest with ourselves about what is, then we cannot properly plan what activities to implement to bring about change.”

For **‘detailed’**, highlight to participants that for community health units to effectively learn from one another, activities and lessons in best practice have been documented and described in enough detail.

For **‘reflective of observations, not of unfounded conclusions’**, highlight to participants that this means that documentation should only reflect what happened and/or what was said only. For example, it would be wrong to record in the minutes of a meeting ‘that delivery at facility is low because women don’t know the benefits’ if it is the conclusion of the person writing the minutes and it was not stated during the meeting.

For **‘timely’**, inform participants that activities should be documented as and when they happen as activities or statements may be remembered incompletely and/or incorrectly.

For **‘legible’**, inform participants that documentation should be written in a way that anyone accessing it can read it and make sense of it.

For **‘stored securely and easily retrieved’**, highlight to participants that documentation should be kept in a WIT folder that is stored in a safe location in the community health unit office or in the link facility/Sub- County Health Management Office.

Present the key messages of this session.

Close the session by inviting participants to ask any questions that they may have.

## References

Working in Teams, Nov 5, 2013, USAID ASSIST Project. <https://www.usaidassist.org/resources/working-teams>

Tips and Tools for Improvement Teams, May 2017, USAID ASSIST PROJECT. [https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement\\_improvement\\_teams\\_may2017\\_ada.pdf](https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_improvement_teams_may2017_ada.pdf)



# **Supervision and Coaching for Quality Improvement of Community Health Services**



MODULE

**3**







## This module is only for Sub-County CHS WITs.

### 3.1 Module Overview

The purpose of this module is for participants to be able to describe the qualities and skills of an effective supervisor, as well as to learn the different types of supervision that are useful in community health services. Furthermore, participants should be able to describe the roles and activities of a Quality Improvement Coach for Community Health Services.

### 3.2 Learning Objectives

By the end of this module participants will be able to:

1. Describe the functions of supervision
2. Describe the qualities and skills of an effective supervisor
3. Describe the different methods of supervision
4. Describe the roles of a Quality Improvement Coach for Community Health Services
5. Describe the structure and approach to coaching for Quality Improvement of community health services
6. Describe the activities that a QI Coach for CHS should engage in
7. Describe the purpose and format of QI Coaches for CHS meetings

### 3.3 Session Plan

Unit 1: Supervision for Quality Improvement of community health services		
Topic	Activity	Time
Functions of supervision	Presentation	15 minutes
Qualities and skills of an effective supervisor	Buzz in pairs then plenary discussion, Presentation	30 minutes
Methods of supervision for community health services	Presentation	35 minutes

**Total time 80 minutes**

Unit 2: Coaching for Quality Improvement of community health services		
Topic	Activity	Time
Roles of a QI Coach for CHS	Presentation	20 minutes
Structure and approach for coaching for QI of CHS	Presentation	10 minutes
Activities that a QI Coach for CHS should engage in	Presentation	30 minutes

**Total time 60 minutes**

Unit 3: Quality Improvement Coaches for community health services meetings		
Topic	Activity	Time
Purpose of QI Coaches for CHS meetings	Presentation	10 minutes
Format of QI Coaches for CHS meetings	Presentation	30 minutes

**Total time 40 minutes**

PowerPoint Presentations	Module 3 Unit 1 – <b>Supervision for QI of CHS</b>
	Module 3 Unit 2 – <b>Coaching for QI of CHS</b>
	Module 3 Unit 3 – <b>QI Coaches for CHS meetings</b>
Handouts	Module 3 Unit 1:
	Group Supervision Tool
	One-on-One Supervision Tool Home Visit Supervision Tool
	Module 3 Unit 3:
	QI Coaches for CHS Progress Report Template – Community Health Unit Level
	QI Coaches for CHS Progress Report Template – County Level
	QI Coaches for CHS Progress Report Template – Sub-County level

### 3.4 Facilitation Steps

#### 3.4.1 Unit 1: Supervision for Quality Improvement of Health Services

Inform participants of the learning objectives of the unit.

##### Topic 1: Functions of supervision

Inform participants that supervision has 3 main functions – administrative (normative), educative (formative) and supportive (restorative).

Present the ‘Administrative (normative) function’ slide. Provide participants with examples of the administrative function of supervisors.

- A Sub-County community health service Focal Person reviewing the timeliness of
- A CHA in submitting MOH 515 Community Health Extension Worker summaries.
- A CHA reviewing the number of households visited by a CHV each month.

Often when people think of supervision, it is usually the administrative function they think of. This is because it is straightforward to do. It is often a question of “ticking boxes” as to whether a particular task has been done or not and it is concerned with the “bottom line” of any job – whether deliverables and targets have been met and whether there is compliance with guidelines.

Present ‘Educative (formative) function’ slide.

Provide participants with the following examples of capacity-building:

For **‘creating a link for the supervisee between theory and practice’**, an example of this is a CHA teaching a CHV the importance of a pregnant woman attending at least 4 antenatal care (ANC) visits. To link it to practice the CHA could take a CHV through the Mother & Child Health handbook.

For **‘filling in gaps in the knowledge of the supervisee’**, an example of this is a CHA orienting a CHV how to correctly record information in their MOH 514 Service Delivery Log Book.

For **‘providing the supervisee with opportunities to strengthen their skills/gain new skills’**, an example of this is a Sub-County CHS Focal Person arranging for all the CHA in their sub-county to attend QI for CHS training.



Highlight to participants that a CHV cannot deliver high-quality community health services if they have not been provided with the knowledge and skills necessary to do so.

Present the 'Supportive (restorative) function' slide.

Provide participants with examples of the supportive function of supervisors:

- A CHA may have a CHV who struggles to visit the minimum required number of households that they should each month. They could ask the CHV to take them through their routine and from there identify opportunities for household visits and develop a strategy to achieve the minimum required number of households.
- A CHA may have CHV A who is in conflict with CHV B. The CHA can call CHV A and CHV B together, to uncover the root cause of the conflict and together come up with a resolution.

Highlight to participants that of all the functions of supervision, the supportive function is the one that is carried out the least. This is because it is not easy. It requires getting to know your supervisees on a personal basis and everyone is different thus to get the best out of each and every one of your supervisees, you have to be thoughtful and creative in the ways in which you work with them and motivate them to deliver high-quality services.

## Topic 2: Qualities and skills of an effective supervisor

Instruct the participants to buzz in pairs (discuss with the person sitting next to them) on the following question; what are the qualities and skills of an effective supervisor?

- After 5 minutes, hold a plenary discussion in which participants share, their responses to this question.
- Accept only one response at a time from any one person.
- Note down all responses on a Flip Chart paper on display at the front of the room.
- Go around the room until all responses have been exhausted.

Present the 'Qualities and skills of an effective supervisor' slide.

- Wherever applicable, acknowledge and congratulate the participants on mentioning a quality or skill in the plenary discussion that also appears on the slide.
- Inform participants that they will learn what a Coach is in the next unit of this session.
- Remind participants that they already know what is meant by being supportive; it means not forgetting the supportive function of supervision.

Present the 'Qualities and skills of an effective supervisor – good communication skills' slide.

- Emphasise to participants that active listening means fully concentrating on what is being said to you rather than just passively hearing the message. Active listening involves giving your full attention to the supervisee which means:
- avoiding interrupting at all costs.
- paraphrasing (which means summarizing and repeating back what has been said to you in order to show that you have been listening and to ensure you have understood correctly what was being said to you).

- being seen to be listening.
- building trust and rapport with phrases such as “Tell me what I can do to help.”
- demonstrating concern through phrases such as “I am eager to help you.”
- maintaining eye contact.
- nodding of your head.
- paying attention to posture (e.g. leaning slightly forward or sideways whilst sitting).
- avoiding distraction meaning refraining from fidgeting, looking at phone or watch.

Present the ‘Qualities and skills of an effective supervisor – challenging supervisees in an effective way’ slide.

Provide examples of closed-ended questions:

- A closed-ended question that has a yes or no answer – “Did you visit all the households allocated to you this month?”
- A closed-ended question to establish agreement – “So, you are telling me that there are some mothers who are reluctant to allow CHVs to review their Mother & Child Health Handbooks?”
- A closed-ended question to check something before going any further – “Before we continue, has everyone understood that a referral for postnatal care (PNC) given to a woman who had an unskilled delivery at home includes immunisation of the newborn?”

Provide examples of open-ended questions:

- An open-ended question to understand the thinking of your supervisee – “When you say that pregnant women in this community health unit don’t want to go for ANC clinic too early, what do you mean?”
- An open-ended question to discover any assumptions your supervisee may be making – “You have said that your client is refusing to listen to your advice about exclusive breast-feeding until 6 months of age – what might be her reason for doing that?”
- An open-ended question to get your supervisee to think about the implications of what they think, say and do – “If you say that to your colleague, how do you think he/she might react?”
- An open-ended question to get your supervisee to consider other points of view or perspectives – “As a male CHV, why do you think female CHV feel the need to discuss family planning in private with their clients?”

Instruct the participants to buzz in pairs (discuss with the person sitting next to them) on the following question:

- What is the difference between the following two questions: “Do you know how to use a mid-upper arm circumference (MUAC) tape?” Vs. “Please explain to me how you use a mid-upper arm circumference (MUAC) tape.”
- After 5 minutes, hold a plenary discussion in which participants share with the rest of the group, their responses to this question.

- The key points that participants should pick up is that with the first question “Do you know how to use a MUAC tape?”, the only responses are “yes” or “no”. The problem with a “yes” response in this example is that the supervisee may just be being dishonest or the supervisee may think they know but in reality, their knowledge is incomplete and/or their technique is incorrect meaning that the supervisor will miss an opportunity to build the capacity of their supervisee. However, by asking the supervisee to “Please explain to me how you use a MUAC tape” then the supervisee will have to talk through the technical process of measuring MUAC step by step and it will be straightforward for the supervisor to identify gaps.

Present the ‘Qualities and skills of an effective supervisor – provides constructive feedback’ slide.

Read out what constructive feedback should be as appears on the next slide ‘Qualities and skills of an effective supervisor – provides constructive feedback’.

For **‘be specific’**, highlight to participants that supervisors should not give general comments to their supervisees, they should always be specific. Provide participants with the following examples for constructive feedback that is specific:

- Do not say “Your performance is below what I expect”, instead say “You did not submit your MOH 514 Service Delivery Log Book on the agreed deadline and furthermore the data recorded in your MOH 514 Service Delivery Log Book is incomplete.
- Do not say “Good job.”, instead say “The way you provided that pregnant woman with a referral form for antenatal care and ensured she went to the health centre was very good”

For **‘include both negative and positive observations’** with the note that negative feedback should be sandwiched between positive feedback. Provide participants with the following example:

- “It is highly commendable that you visit all the households allocated to you each and every month. However, there are discrepancies in the data that you have collected in your MOH 514 Service Delivery Log Book. As you pick up things very quickly I know that I can work with you to improve the quality of the data you report.”

For **‘be focused on behaviour/actions rather than on the person’**, highlight to participants that supervisors should never attack the personality or character of their supervisee. Provide participants with the following example for constructive feedback that is focused on behaviour/actions rather than on the person:

- “Do not say “you are lazy.”, instead say “It is very important to ensure that you follow up with every individual for whom you have made a referral to the link facility.”

For **‘takes into account the needs of the supervisee’**, highlight to participants that when a supervisor is providing a suggestion for improvement to the supervisee, they must consider what will work best for the supervisee in order for them to be able to make the necessary change.

- For example, consider CHV A and CHV B. Both CHVs are failing to visit the minimum number of households that they should each month. For CHV A this is because she is a single mother with a young child and she now has to commit more time to childcare. For CHV B this is because he is a young man who is the breadwinner for his family and his working hours clash with the times most of his clients would be at home. As can be seen in this example, though the failure to meet a specific deliverable is the same, the reasons for this in each of their cases is very different therefore as a supervisor you cannot give them the same advice.

For **‘be timely’**, highlight to participants that feedback should be given as soon as possible after the event.

- For example, there is little point in a supervisor telling a supervisee in October that submission of their monthly report for February and March was late.

For **‘be confidential’**, highlight to participants that constructive feedback intended for a particular individual should be given to that individual privately where no-one else can hear or observe the interaction.

For **‘not involve assumptions or guesses as to why your supervisee behaves the way they do’**, provide participants with the following example:

- “Imagine you have a CHV who has volunteered and served for several years, ever since the community health unit was established. They have never failed to submit their monthly reports and they always strive to visit as many of the households allocated to them as possible each month. However, for the past two months you have noticed that they have failed to attend the group supervision meetings and have not submitted their monthly report. After chasing them you manage to get their report for the past month but they have only visited very few households. As a supervisor you should not assume that this is because they are no longer committed. In reality it is because they have suffered a bereavement. As a supervisor, through supportive supervision, you should be able to find this out from them, offer them condolences and make a realistic plan for the future together.”

For **‘be well-understood’**, highlight to participants that they should always ensure that the feedback they have been given has been completely understood by the supervisee including the suggestions for improvement and personal targets.

- A simple way of doing this is asking the supervisee to repeat back to you what they have understood from your discussion.

Present the ‘Qualities and skills of an effective supervisor – understands the group dynamics of his/her team’ slide.

Highlight to participants that in any team, there will always be a mixture of personalities and characters. Supervisors should take advantage of the strengths of the team members but should also build capacity in areas of weakness and identify creative ways in which individuals in the team can work together.

### Topic 3: Methods of supervision

Inform participants there are three main methods of supervision that are useful in community health services.

- Group supervision
- One-on-one supervision
- Home visit supervision

Present the ‘Methods of supervision – group supervision for community health services’ slide.

- Highlight to participants that group supervision meetings should not exceed more than 15 people because with groups larger than this, it is very difficult for supervision to be effective since individual needs and concerns cannot be addressed.

Inform participants that typical agenda items of a group supervision meeting include:

- Discussion of matters arising from the previous group supervision meeting.
- Assessment to see if key actions agreed upon in previous group supervision meeting have been achieved.
- Provision of updates from higher levels of the health system.
- Open the floor for any and all supervisees to share their experiences and challenges in delivering community health services.
- Highlight to participants that through brainstorming as a group and plenary discussion, advice to overcome challenges and suggestions for improvement should be given wherever possible.
- Highlight to participants that this also allows the supervisor to identify any supervisees who may benefit from one-on-one supervision.
- Emphasise to participants that data review should be a standing agenda item in all group supervision meetings.
- Emphasise to participants that group supervision meetings are only administrative, and the supportive function of supervision is neglected. Remind participants that is vital to identify the challenges affecting the delivery of high-quality community health services and to work with supervisees to develop solutions to overcome these. Inform participants that taking an interest in supervisees this way is also a form of non-financial motivation.
- Emphasise to participants that group supervision meetings provide the perfect opportunity to continuously build the capacity of CHVs. Highlight to participants that utilizing the potential of group supervision meetings for capacity-building is much more effective and less resource-intensive than having supervisees attend one-off trainings where more often than not, not all CHVs are invited to attend and CHVs forget what they have been taught after some time because the learning has not been reinforced. Highlight to participants that in a group supervision, the capacity of CHVs on a particular topic should be built.
- Highlight to participants that often, as part of the administrative function of supervision, there are specific checklists to be completed dependent on the context. For example, for the national Community Health Strategy, there exists a 'Support Supervision Checklist for Community Health Units' from the Ministry of Health that should be completed by Sub-County CHS Focal Persons (see references)

Supervisors must take the time to plan for group supervision meetings in advance.

Inform participants as to what a data review during group supervision meetings should include. Read these out as they appear on the relevant slide.

- Quote a famous saying in health systems worldwide; “If it is not documented, it did not happen”. Highlight to participants that data review is required to review the performance of community health services.

- Highlight to participants that in the spirit of generating high-quality community-level health data, that is trusted for decision-making, high-quality data reporting should be everybody's priority. Group supervision meetings allow CHAs an opportunity to provide feedback to CHVs as to whether data is being correctly recorded in MOH 514 Service Delivery Log Books. If not, then the capacity of CHVs to record data correctly can be built during group supervision meetings. Data Quality Assessment (DQA) results should also be given to all CHAs and all CHVs in order that they can contribute their thoughts as to the reasons for any discrepancies in the values reported by the different levels of the community health information system.

Highlight to participants that it is crucial to discuss adverse and unexpected events such as maternal deaths and newborn deaths and when they occur, in order to identify the reasons why such an event occurred and what can be done differently to prevent such incidents in the future.

Present the 'Methods of supervision-Group supervision for community health services advantages' slide.

Present the 'Methods of supervision – one-on-one supervision for community health services' slide.

- Highlight to participants that in some contexts, one CHA supervises multiple community health units, meaning the recommendation of meeting each CHV they supervise for one-on-one supervision at least once a year is not feasible. In such contexts, the CHA must adapt. For example, the CHA may plan to meet each CHV they supervise for one-on-one supervision at least once every 18 months.

Present the 'Methods of supervision –home visit supervision for community health services' slide.

- Highlight to participants that the supervisor for home visit supervision is often the
- CHA but it can also be any facility staff member or Sub-County Health Managers such as the Sub-County CHS Focal Person.
- Emphasise to participants that home visit supervision is the one and only way for supervisors to be confident that CHVs are communicating effectively with their clients, passing on correct health information, carrying out practical tasks such as measuring and recording data accurately.

Provide the participants with the following supervision tools for their use in the field.

- Group Supervision Tool
- Home Visit Observation Checklist
- One-on-One Supervision Tool

Read through the key messages of this unit.

Close the session by inviting participants to ask any questions that they may have.

## References

Monitoring and Evaluation Plan for Community Health Services (2014-2018) - Annex 8 Support Supervision Checklist (2014), Ministry of Health, Kenya [http://guidelines.health.go.ke:8000/media/CHS-ME\\_Plan\\_FINAL\\_201409022.pdf](http://guidelines.health.go.ke:8000/media/CHS-ME_Plan_FINAL_201409022.pdf)



### 3.4.2 Unit 2: Coaching for QI of CHS

Inform participants of the learning outcomes of the session.

#### Topic 1: Roles of a QI Coach for CHS

Inform participants that a QI Coach for CHS is an individual who uses their position, knowledge and experience to offer moral support, technical advice and capacity building to individuals and teams working in community health services in order to bring about quality improvement of community health services with a specific target of helping them to achieve/surpass the KQMH Quality Standards for community health services.

Emphasise to participants that all coaches are supervisors but not all supervisors are coaches.

Instruct the participants to recite the roles of a QI coach, facilitator, trainer and QI Expert, until they can do so by memory.

Present the 'Facilitator' slide.

Highlight to participants that being a facilitator means actively observing the team's work and providing constructive feedback. Emphasise that this can only be achieved via regular contact with the team.

Describe the facilitator role for each step of the QI cycle:

- **Step 1 Identify:** A QI Coach should ensure that a WIT has identified a list of problems using multiple sources of relevant data (e.g. MOH 514s, MOH 515, Minutes of Dialogue Days etc.); a QI Coach should ensure that a WIT has appropriately prioritised a problem to tackle using a systematic method such as voting or a prioritisation matrix and that individuals have not been manipulated or pushed towards a certain problem but instead each individual has voiced their opinion; a QI Coach should then ensure that a problem statement has been developed that is simple, precise, clear and quantifiable.
- **Step 2 Analyse:** A QI Coach should ensure that a WIT has undertaken root cause analysis in a systematic way and have arrived at problem causes that are based on evidence not assumptions and that if tackled are likely to have a meaningful impact.
- **Step 3 Develop:** A QI Coach should ensure that a WIT has arrived at QI Change Plan consisting of solutions for their problem that are feasible at their level.
- **Step 4 Implement and Test:** Through regular contact with a WIT, a QI Coach should ensure that a WIT is collecting, correctly analysing and using the data that is relevant to measuring whether they are achieving the target set in their QI Change Plan to inform decision-making, i.e. whether to continue with the activities in the QI Change Plan, go back to the drawing board or move on to another problem because they have achieved success in tackling the problem.

Present the 'Trainer' slide.

- Emphasise to the participants that being a trainer means sharing their knowledge and expertise. Being a trainer means that you build the capacity of an individual or team. To do this, lessons should be delivered at the appropriate level for your audience (i.e. use a language and terms that those involved in community health services can understand) and bring teaching to life using examples.

Trainers should ensure that knowledge has been retained and applied – this requires regular contact with individuals and teams. Give examples of how this can be assessed i.e. observing community health volunteers during home visits.

Present the ‘Quality Improvement (QI) Expert’ slide.

- Read the following quote attributed to Albert Einstein: “If you can’t explain it simply, you don’t understand it well enough”. Emphasise to participants that being a QI expert means that you can get individuals and teams at community level to understand the core concepts of quality improvement using the simplest language and in the simplest way possible while making regular contact, ensuring that they understand which concept/method/tool they should apply each step of the way.

Having established the three main roles of a QI Coach for CHS present the ‘Why coach?’ slide.

For **‘encourages mutual loyalty,’** highlight to participants that supervision is a one-off that usually only happens once or a few times a year; however, coaching requires regular contact meaning that a relationship is built.

For **‘increases retention and motivation of CHVs,’** highlight to participants that this relationship shows CHVs (who in most contexts are not remunerated) that the higher levels of the healthcare system actually care about them and the work they do and the communities they serve, thus acting as a form of non-financial motivation.

For **‘improves organisational performance,’** highlight to participants that the transfer of knowledge and technical expertise means that they are more likely to meet the KQMH Quality Standards for community health services as they will be supported and advised on how to work in targeted ways.

For **‘creates a greater sense of involvement in the higher levels of the health system,’** highlight to participants that regular contact from a QI coach will highlight to those involved in community health services that they truly are an integral part of the larger health system.

For **‘catalyst for an innovative work environment,’** highlight to participants that regular contact with those involved in community health services means that QI coaches themselves are able to hear what the concerns and priorities are instead of making assumptions. Relate to steps 1 to 3 in the QI cycle.

For **‘to enable WITs and their leaders to sustain quality improvements in community health services,’** highlight to participants that a QI coach ensures that a particular Community Health Unit doesn’t just meet KQMH Quality Standards for CHS for one month only but rather, the regular contact means that through advice and moral support, standards are being met from month to month and indeed new goals for standards which have not yet been met can also be set.

For **‘to enable WITs and their leaders to confidently use and apply Quality Improvement tools and approaches,’** highlight to participants that a QI coach, with their knowledge and experience in the core concepts of Quality Assurance and Quality Improvement, should build the capacity of individuals and teams at community-level to apply these concepts to solve their problems and maintain improvement.

Present the ‘Most important qualities of a QI Coach for CHS’ slide. Highlight to the participants that these qualities bring together three crucial elements:

QI coaches must have relevant knowledge or experience to build the capacity of an individual or team to achieve specific goals.

It is not possible to insert knowledge, experience and technical skills into an individual or team. This is a process that takes time, patience and a coaching strategy which is supportive and respectful.

Being a QI Coach requires genuine passion and commitment to make the regular contact and visits and to be patient with individuals and teams as they progress.

## **Topic 2: Structure and approach for Coaching for Quality Improvement of community health services**

Inform participants that all WITs for Quality Improvement of community health services should be visited at least once a quarter by a QI Coach for CHS.

- Emphasise to participants that a QI Coach for CHS does not always have to attend a WIT meeting. Depending on their objectives, a QI Coach for CHS can visit any activity pertaining to community health services including, but not limited to, group supervision meetings, community dialogue days or action days.

Inform participants that County QI Coaches for CHS can support both Sub-County CHS WITs and Community Health Unit WITs and Sub-County QI Coaches for CHS support Community Health Unit WITs.

Inform participants that the suggested QI Coaches for CHS are the QI Focal Person, CHS Focal Person and Health Records Information Officer. Additionally, any County or Sub-County Health Management Team members most relevant to the current Quality Improvement agenda should be involved, e.g.: if a Sub-County CHS WIT is tackling an issue pertaining to malnutrition, the County and Sub-County Nutritionist should be involved as QI Coaches for CHS.

## **Topic 3: Activities that a QI Coach for CHS should engage in**

Instruct different participants to read out the activities that a QI Coach should engage in as listed out in the slides ‘As a QI Coaches for CHS, these are the activities you should engage in.’ After each activity read out, emphasise the following points.

For ‘Attend and guide WIT meetings,’ emphasise to the participants that it is crucial they are familiar with the action plan/QI Change Plan of a WIT beforehand and discuss reasons why this is important. Also emphasise to the participants the importance of accurate and detailed documentation as discussed previously.

For ‘Monitoring and Evaluation of WIT progress using the following tools,’ emphasise to the participants that Quality Improvement is a journey. A journey in which one hopes to see a Community Health Unit and their WIT grow in terms of the national standards met and surpassed, in terms of improvement of health status and trends, in terms of organisation and frequency of meetings and feedback between different levels of the healthcare system, in terms of contribution from a diverse group of individuals, and in terms of capacity to carry out QI. The KQMH Quality Standards for Community Health Services and documentation of previous coaching visits can be used to track progress.

For **‘Identify success stories and lessons in best practice,’** emphasise to participants that it is crucial for QI Coaches for CHS to recognise stories and lessons that arise from Quality Improvement in community health services and document these for knowledge sharing.

For **‘Identify QI champions,’** inform participants that you will provide them with more detail regarding this later in this unit.

For **‘Provide feedback and advocacy for community health services to Sub-County Health Management Teams and County Health Management Teams,’** emphasise to participants that the community health strategy in Kenya is underfunded. By improving the quality of community health services, and thereby improving health outcomes, a strong case can be made for increased government funding for the community health strategy.

For **‘Prepare WITs for making presentations and sharing their experience at Learning Events,’** remind participants that Learning Events are forums in which WITs from different sites come together to present their achievements in QI. WITs should be supported by QI Coaches in telling their stories.

For **‘Attend meetings of QI Coaches for CHS meetings,’** inform participants that you will expand on this in the next presentation.

Highlight to participants that QI Champions are individuals and WITs who fully commit to improving quality in all aspects. Emphasise that QI Champions are identified in the following ways.

- Promoting a culture of Quality Assurance/ Quality Improvement.
- Sharing of knowledge and experience, for example via documentation of success stories and lessons in best practice.
- Demonstration of motivation and effort above and beyond the norm.
- Tireless work in meeting the needs of their community.

Emphasise to participants that it is important to identify QI champions for the specific reason that champions at any level (CHV, CHA, Sub-County or County level) can serve as trainers in QI for community health services. For CHVs this can also act as a non-financial form of motivation.

Instruct one of the participants to read through the key messages of this unit.

Close the session by inviting participants to ask any questions that they may have.

### **3.4.3 Unit 3 – QI Coaches for CHS meetings**

Inform participants of the learning objectives of the session.

#### **Topic 1: Purpose of QI Coaches for CHS meetings**

Present the ‘What is a QI Coaches for CHS meeting?’ slide.

- Inform participants that a QI Coaches for CHS meeting is a forum in which QI Coaches (i.e. Sub-County and County Health Management Team members, as well as CHAs and Facility In-Charges) from different sites are brought together to share specific lessons and best practices. Furthermore, QI coaches can benefit from the technical advice and experience from others to help them overcome challenges. Finally, it also provides a useful forum in which specific capacity-building of QI Coaches for CHS can be carried out.

Inform participants that QI Coaches for CHS meetings should be hosted by the County Health Management Team and that it is recommended that QI Coaches for CHS meetings be held at least once every quarter. Emphasise meetings need not last longer than one day unless the needs of the County Health Management Team necessitate a longer meeting.

Present the 'Role of a QI Coach for CHS in a QI Coaches for CHS meeting' slide.

Emphasise to participants that for a QI Coach for CHS meeting to be effective, these meetings should be truly interactive and participatory forums in which each QI Coach for CHS should: presents progress reports; share stories of change that have been brought about as a result of QI for CHS; share lessons in best practice; and support other QI Coaches for CHS in problem-solving.

## **Topic 2: Format of QI Coaches for CHS meetings**

Present the 'Typical agenda items of a QI Coach for CHS meeting' slide.

- Inform participants that they will be taught data quality assessment and use of community follow-up tool later on.

Inform participants of the following regarding needs-based capacity building.

- The final session in a QI Coach for CHS meeting should consist of a capacity-building session which meets the needs of QI Coaches for CHS. Provide examples of capacity building activities.

Display the relevant example template slides when describing the progress report.

- Emphasise to participants that these templates are just examples to display the minimum of what should be presented at QI Coaches for CHS meetings. QI Coaches are very welcome to develop their own templates and not feel bound to those shared in this unit.

Present the 'Presentation and analysis of Community Health Information System data' slide.

- Emphasize to participants that the purpose of the presentation of Community Health Information System (CHIS) data is to create demand for data driven decisions and promote regular review of community-level health data for identification of problems. (Step 1 QI Cycle)
- Inform participants that should they wish they are also very welcome to present facility- level health data.

Inform participants that an overview of Community Health Information Systems and an in- depth study of data quality will be covered later in later on in Phase 1 and that visual display of data shall be covered in the Phase 2 of the QI for community health course.

Read through the key messages of this unit.

Close the session by inviting participants to ask any questions that they may have.

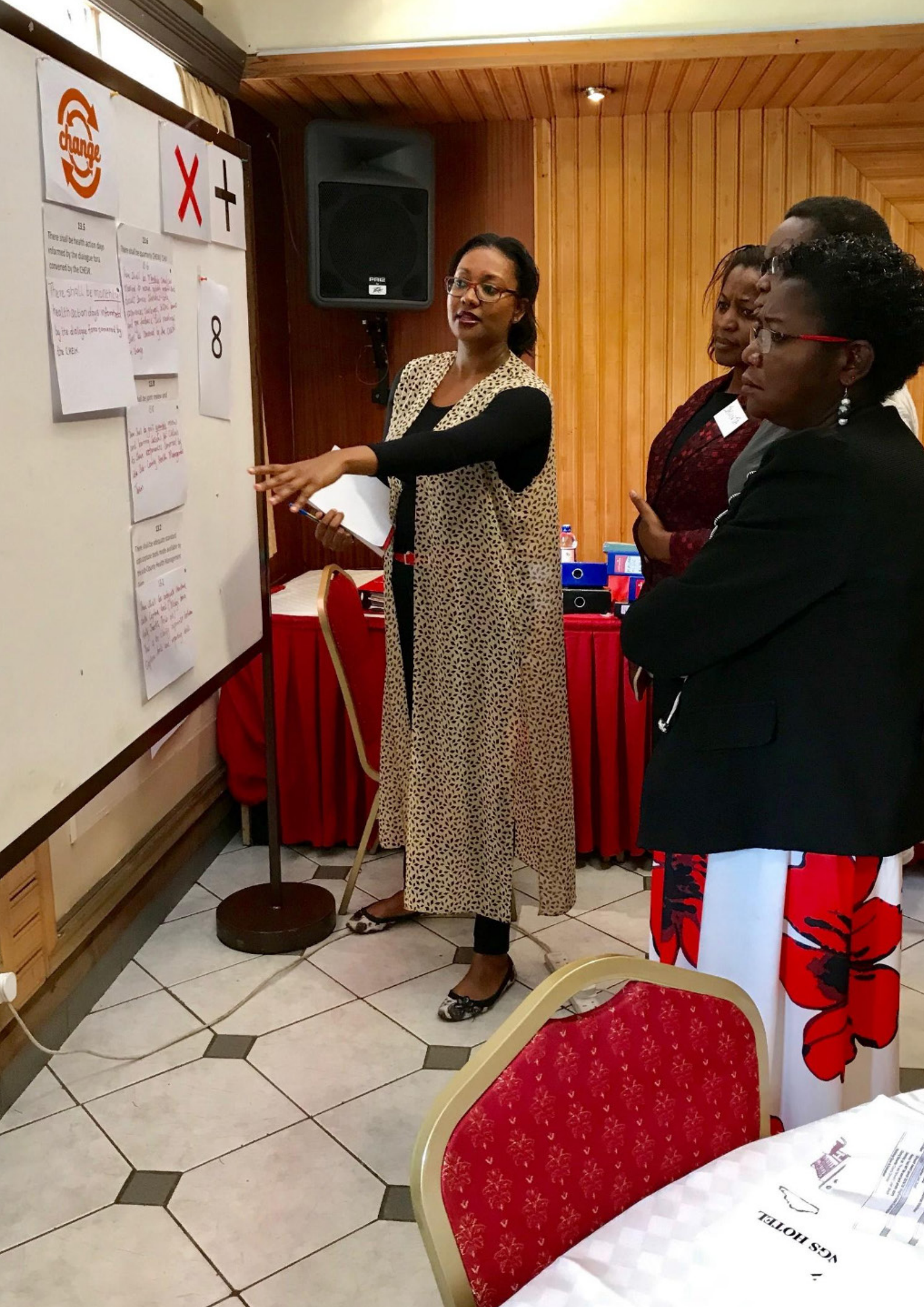


# Kenya Quality Model for Health (KQMH) Quality Standards for Community Health Services

MODULE

**4**





12.5  
There shall be health action days  
informed by the dialogue forum  
covered by the CHSR.

12.6  
There shall be health action days  
informed by the dialogue forum  
covered by the CHSR.

12.7  
There shall be health action days  
informed by the dialogue forum  
covered by the CHSR.

12.8  
There shall be health action days  
informed by the dialogue forum  
covered by the CHSR.

NGS HOTEL

## 4.1 Module Overview

The purpose of this module is to give participants a basic overview of Kenya's healthcare system to appreciate how community health services fit into the larger healthcare system. Participants will then be introduced to the Kenya Quality Model for Health (KQMH) Quality Standards for community health services to gain an understanding of how standards can be used to measure performance and quality of community health services.

## 4.2 Learning Objectives

By the end of this module participants will be able to:

1. Describe the levels of Kenya's healthcare system
2. Describe the Kenya Quality Model for Health (KQMH)
3. Describe the Kenya Quality Model for Health (KQMH) Quality Standards for community health services.

## 4.3 Session Plan

Day 1		
Topic	Activity	Time
Kenya's healthcare system	Lecture	15 minutes
Kenya Quality Model for Health (KQMH)	Lecture	30 minutes
Kenya Quality Model for Health (KQMH) Quality Standards for community health services	Lecture, Community Health Case Study Group Work	75 minutes

**Total time 120 minutes**

<b>PowerPoint Presentations</b>	Module 4 – <b>Kenya Quality Model for Health (KQMH) Quality Standards for community health services</b> (Sub-County CHS WITs/ Community Health Unit WITs)
<b>Handouts</b>	Ideally, each participant or at the very least, each WIT, should be provided with a hard copy of the Kenya Quality Model for Health Quality Standards for Community Health Services
<b>Stationery</b>	Flip Chart, Marker Pens, Projector

## 4.4 Facilitation Steps

Inform participants the learning Objectives of the session.



## Topic 1: Kenya's healthcare system

Inform participants that according to Kenya's national health policy, Kenya's healthcare system has a hierarchical structure that begins with community health services and then graduates with complicated cases being referred to higher levels of healthcare.

Inform participants that at present, Kenya's health system is structured into the following six levels.

- Level 1 – Community
- Level 2 – Dispensaries
- Level 3 – Health centres
- Level 4 – Primary referral facilities
- Level 5 – Secondary referral facilities
- Level 6 – Tertiary referral facilities

Display organisation of healthcare service delivery in Kenya figure and inform participants of the following.

- Level 1 refers to community health services. Community health services are organised around community health units. Community health services are delivered according to the national community health strategy. This strategy entails CHVs and CHAs providing health promotion, health prevention and simple curative health services at household level. Therefore, the key purpose of community health services is to create demand for essential primary healthcare services, e.g. antenatal care. CHVs also refer individuals to higher levels of the healthcare system for more advanced care when necessary.
- Primary healthcare services are offered by dispensaries (level 2) and health centres (level 3). Primary healthcare services include:
  - » Basic outpatient diagnostic, medical, surgical and rehabilitative services
  - » Disease prevention and health promotion services
  - » Normal maternal delivery services
  - » Ambulatory services
  - » Inpatient services for emergency clients awaiting referral and clients for observation
  - » Management of clients referred from community health units
  - » Referral to facilities at higher levels of the healthcare system
- County referral health services are offered by primary (level 4) and secondary (level 5) hospitals. County referral health services include:
  - » Comprehensive in-patient diagnostic, medical, surgical and rehabilitative care, including reproductive health services
  - » Specialised outpatient services
  - » Management of referrals from lower levels of the healthcare system
  - » Management of cemeteries, funeral parlours and crematoria

- National referral health services are offered by tertiary (level 6) referral hospitals, national reference laboratories and research and training institutes. National referral health services include:
  - » In-patient high-level specialist medical care and surgical care
  - » Blood transfusion services
  - » Reference laboratory support
  - » Research

## Topic 2: Kenya Quality Model for Health (KQMH)

Inform participants that the human right to health is meaningless without good quality healthcare. Providing health services that do not meet a minimum level of quality is ineffective, wasteful and unethical.

Provide participants with an example of poor-quality healthcare.

A pregnant woman visits a health facility to deliver. She arrives at the facility and finds no health worker. She stays waiting for one and a half hours. Finally a nurse arrives. She was rude and demanded to know why she was starting antenatal care late in the pregnancy. She is asked if a CHV ever visited her. She claimed she has never been visited by a CHV

- Inform participants that the whole world, including Kenya, has woken up to the realisation that providing health services that do not meet a minimum level of quality is pointless. This is why Kenya's drive to achieve Universal Health Coverage (UHC) specifically recognises the importance of quality.

Inform participants that the full definition of Universal Health Coverage from the World Health Organization is as follows: "Universal Health Coverage means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services that they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."

Inform participants that the importance of quality means that health managers and health service providers should be motivated to continuously improve quality at all levels of the healthcare system and that there is increasing demand from the community for health services that meet a minimum level of quality.

Inform participants that in order to achieve delivery of high-quality health services in Kenya, the Kenya Quality Model for Health (KQMH) was developed.

Present the 'What is the Kenya Quality Model for Health (KQMH)?' slide.

- Refer to the Kenya Quality Model for Health as KQMH if this is easier.

Present the 'How does the Kenya Quality Model for Health (KQMH) work?' slide.

- Highlight to participants that healthcare standards form the basis of the KQMH
- Inform participants that they will gain further clarity on the KQMH when they are taken through the KQMH Quality Standards for community health services later on in this session

Inform participants that a standard is an explicit statement of expected quality.

- Highlight to participants that standards provide specific guidance as to how we should perform and that if standards are achieved, then this will lead to the highest possible quality in the system.
- Highlight to participants that in healthcare, standards are developed to be used by health service providers everywhere, to ensure that no matter where a client is receiving health services, they are receiving health services that meet the World Health Organization (WHO) dimensions of quality covered in Module 1. That is, services that are safe, timely, effective, efficient, person-centred, equitable and integrated.
- Inform participants that in healthcare, standards should not be kept a secret among health service providers, clients should be made aware of healthcare standards to know what to expect from the healthcare system. For example, community members should be aware of what to expect from CHVs when CHVs visit their households and they should also be aware of what to expect at health facilities when referred.

Inform participants of the qualities of a good standard. (Refer to the slide)

- **Clear:** the standard should be understood by everyone in the same way leaving no room for confusion.
- **Valid:** the standard is based on evidence and experience. Remind participants that the KQMH focuses on adherence to evidence-based healthcare standards.
- **Realistic:** when health service providers can meet this standard using existing resources. Inform participants that this is often the most difficult part about defining and implementing standards.
- **Reliable:** a reliable standard is one that it does not matter where it is applied and achieved, the result will always be improved quality.
- **Measurable:** a good standard is one that is measurable. This means that health service providers have a straightforward means of knowing if they have achieved that standard or not.

Inform participants that the KQMH Quality Standards for CHS is a book that provides standards for delivery of community health services. (Refer to the slide)

- Highlight to participants that these standards are organised into 12 different domains that cover various aspects of community health services.
- Ideally, each participant or at the very least, each WIT, should be provided with a hard copy of the Kenya Quality Model for Health Quality Standards for Community Health Services.

Inform participants that the objectives of the KQMH Quality Standards for CHS are as follows .(refer to slide)

- To ensure delivery of community health services that meet at least a minimum level of quality.
- To ensure that community health services are responsive and sensitive to client needs and expectations.
- To ensure that health managers and community health service providers apply principles of Quality Assurance and Quality Improvement to identify problems and work systematically to address these in order to achieve and sustain at least a minimum level of quality.



Inform participants that the KQMH Quality Standards for CHS has a scoring system to know if a minimum level of quality is being met as follows:

### Scoring for the Domain 1-11

Score	Notes
0	No documented/observable effort of compliance. (This is denoted NO in the scoring sheet)
1	Standard is not fully met, there is need for improvement. (State areas for improvement under remarks). This is denoted PARTIAL in the scoring sheet
3	Fully compliant. This is denoted YES in the scoring sheet

### Scoring for Domain 12

Score	Notes
0	More than 75% off target (0 - 24%)
1	75 to 50% off target (24% - 49%)
2	49 to 25% off target (50% - 74%)
3	24 to 1% off target (75% - 99%)
4	Met target (100%)

### Topic 3: Kenya Quality Model for Health (KQMH) Quality Standards for community health services

Inform participants that now that they have a detailed understanding of the background and intended use of the KQMH Quality Standards for CHS, it is time to use an example for WIT members to see how they can use the KQMH Quality Standards for CHS in their day-to-day working life.

Instruct one of the participants to read out Domain 5 – Community Health Information System, Monitoring and Evaluation, Standard 5.4 Sub-county health records officer shall upload all monthly report summaries into Kenya Health Information System (KHIS) as per national guidelines

Highlight to participants how this standard has the components of a good standard as covered earlier in this session.

- **This standard is clear:** all community health service providers are aware of which data submitted by community health service providers on a monthly basis. These are commonly the MOH 514 Service Delivery Log Books; the MOH 515; and the MOH 516 Community Health Unit Chalkboard.
- **This standard is valid:** it is widely proven and accepted in healthcare systems across the world that decision-making should be informed by high-quality data.
- **This standard is realistic:** remind participants that being realistic is often the most difficult part of a standard and almost always assumptions are made. In this case, the assumptions are that the necessary data collection and reporting tools are available for use by all those who should use them and that these individuals have all been trained. If indeed these assumptions are true then this standard is realistic.

- **This standard is reliable:** in Kenya the data collection and reporting tools for community health services were developed by the National Ministry of Health meaning that they should be used everywhere and inform planning and monitoring everywhere.
- **This standard is measurable:** emphasise to participants that all the KQMH Quality Standards for CHS are measurable using the scoring system discussed earlier and that each domain has its own specific scoring system.

Instruct participants to read out the scoring system for Domain 5 – Standard 5.4 in its entirety on page 38 of the KQMH Quality Standards for CHS:

	Score	0	1	3
<b>5</b>	<b>DOMAIN 5: COMMUNITY HEALTH INFORMATION SYSTEM, MONITORING &amp; EVALUATION</b>			
5.4	Sub-county health records officer shall upload all monthly report summaries into Kenya Health Information System (KHIS) as per national guidelines	No	Partial	Yes

Highlight to participants to score themselves for this standard. This should be straightforward. For example, recording how many subcounty record officer have uploaded their report to health information system.

Emphasise to the participants that they should use the specific KQMH for CHS scoring system for each standard.

Remind participants that one of the key objectives of the KQMH Quality Standards for CHS is to ensure that health managers and community health service providers apply principles of Quality Assurance and Quality Improvement.

- Highlight to the participants that for many of the KQMH Standards for CHS, to score 3, key principles of Quality Assurance and Quality Improvement must be in place and being applied continuously. For example, one of the key principles of Quality Assurance is using data to assess if standards of quality are being met and for Quality Improvement to work it should be data-driven in terms of problem identification, problem analysis, development of solutions and measuring for change following implementation.
- Another key principle of Quality Assurance is a multi-disciplinary team approach to problem solving and Quality Improvement and one of the underlying components required for Quality Improvement to work is team work. This is why a score of 5 is given when data is being reported and used for decision-making and when there is feedback to all those involved in delivery of community health services, including community members.

Inform participants that it is important to adapt the KQMH Quality Standards for CHS to their context, especially where services of a minimum level of quality must be offered

Instruct one of the participants to read out Domain 5 – **Community Health Information System, Monitoring and Evaluation**, Standard 5.8 All CHVs shall record the services they have provided during household visits.

Instruct participants to read out the scoring system for Domain 5 – Standard 5.8 in its entirety. This can be found on page 25 of the KQMH Quality Standards for CHS:

	Score	0	1	3
<b>5</b>	<b>DOMAIN 5: COMMUNITY HEALTH INFORMATION SYSTEM, MONITORING &amp; EVALUATION</b>			
5.4	All CHVs shall record the services they have provided during household visits	No	Partial	Yes

After participants have read out all of the above, emphasise that standard 5.8 is a good standard in that it is clear, valid, reliable and measurable; however, in many community Units volunteers may not all have MOH 514,

- Inform participants that WITs must provide direction as to how to work around standards that are for the time being unrealistic, while still delivering community health services that meet a minimum level of quality. For example, Nairobi County was faced with the challenge of standard 5.8 being unrealistic. So, they issued a directive that there shall be quarterly (not monthly) visits to every household by the community health volunteer. Note that this directive also came with the guidance that households with pregnant women and/or children aged 5 years and under should be prioritised such that they receive a household visit every month and this is recorded during each visit
- Instruct one of the participants to read out DOMAIN 4: COMMUNITY HEALTH INFRASTRUCTURE AND EQUIPMENT – Standard 4.3 Community Health Unit (CHU) shall have access to ICT equipment

Instruct participants to read out the scoring system for Domain 4 – Standard 4.3 in its entirety. This can be found on page 24 of the KQMH Quality Standards for CHS:

	Score	0	1	3
<b>4</b>	<b>DOMAIN 4: COMMUNITY HEALTH INFRASTRUCTURE AND EQUIPMENT</b>			
4.3	Community Health Unit (CHU) shall have access to ICT equipment	No	Partial	Yes

After the participant has read out all of the above, display the slide ‘Minimum standard vs. Aspire standard’ and explain to participants that while all the standards in the KQMH Quality Standards for CHS are useful, not all are essential to deliver community health services that are safe, timely, effective, efficient, person-centred, equitable and integrated.

For example, a computer is not essential though it would definitely be useful in terms of allowing CHAs and CHVs direct access to the Kenya Health Information System (KHIS) to review community- level and facility-level health data. A computer for each CHU however is currently beyond the current level of resources allocated to the community health Services.

It is therefore important for WITs to realise which KQMH Quality Standards for CHS are minimum standards that are essential for the delivery of high-quality community level health services and focus on achieving the minimum level of quality.

**Instruct one of the participants to read out the following case study:**

Ziwani Community Health Unit is located in Viwandani Sub-County. Ziwani community health unit is linked to Ziwani Health Centre. In this community health unit, there are 25 CHVs who are supervised by one CHA. Ziwani community health unit was formed 5 years ago without any household mapping or household registration. In this community health unit, only 15 CHVs submit their MOH 514 Service Delivery Log Book to the CHA by the 28<sup>th</sup> of each month. The CHA always has to follow the other 10 CHVs for their MOH 514 Service Delivery Log Books. Because of this, the CHA submits their MOH 515 Community Health Extension Worker Summary to Ziwani Health Centre on the 7<sup>th</sup> of each month. Group supervision meetings of CHVs and Community Health Committee (CHC) meetings are conducted every month but only the group supervision meetings of CHVs are documented with minutes. The community health unit conducts dialogue days, but only when there is an emergency in the community. All referrals made by CHVs that are received at Ziwani Health Centre are filled with comments by the clinician and stamped. The clinician then returns one copy to the client for the CHV to see when they conduct a follow-up household visit and they keep one copy to store in a community referral form file kept in the health centre.

- Instruct one of the participants to read the example of a minimum standard (Domain 8 - Standard 8.1: All CHVs shall refer all cases that require procedures outside of their approved scope of work to the nearest link health facility..) and the example of an aspire standard (Domain 7 – Standard: 7.1 The County department of Health shall provide transport for Community Health services.)
- Instruct the participants to divide into groups of 4 and Instruct each group to carry out the follow tasks.
- Identify the KQMH Quality Standards for CHS relevant to this community health case study.
- For each KQMH Quality Standard for CHS that you identify, score Ziwani community health unit based on the description provided.
- Instruct participants to use the score sheet in their Participant’s Handbook
- Allocate 15 minutes for this task.
- Give the participants the clue that there are 7 answers which is why there are 7 rows in the score sheet table.
- Call on representatives from each to write one of their answers on Flip Chart paper at the front of the room. For example, on the flip chart paper they should write: Domain 1 / Standard 1.9/ Score 1. Continue doing this until all groups have had a chance to write at least one of their answers on the flip chart paper and until all answers have been exhausted. Inform participants that the correct answers are as follows:

Domain	Standard	Score
Domain 1: Leadership and Governance	1.6 There shall be a trained community health workforce and a governance structure as per the CHS national guidelines	1
Domain 2: Community Health Workforce Management	2.7 There shall be adequate Community health workforce as per Kenya Community Health Policy	1

Domain 8: Referral System	8.4 Each Community Health unit shall have a functional means of communication for referral	1
Domain 5: community health information system, monitoring and evaluation	5.7 All households in the CHU shall be mapped and registered	1
Domain 5: community health information system, monitoring and evaluation	5.4 Sub-county health records officer shall upload all monthly report summaries into Kenya Health Information System (KHIS) as per national guidelines	1
Domain 5: community health information system, monitoring and evaluation	5.8 All CHVs shall record the services they have provided during household visits	1
Domain 11: Service Delivery	11.1.1 All women, their families and the general community are sensitised and provided with health education on Reproductive, Maternal and New-born Health at household level.	1

Instruct one of the participants to read through the key messages of this session.

### Core indicators

- Ask one participant to read indicator under standard 2.3
- Distribute core indicators and group the participants into four groups
- Ask them to write all indicators that are under CHVs, CHAs, Facility and county leadership & National leadership
- Ask them to present in plenary

### Domain 12

- Ask one participant to read one the key performance indicator
- Distribute the performance indicators and ask the team to score
- Ask them to present in plenary
- Close the session by inviting participants to ask any questions that they may have.

### References

Kenya Health Policy 2014 – 2030 (2014), Ministry of Health, Kenya. <http://publications.universalhealth2030.org/ref/d6e32af10e5c515876d34f801774aa9a>

Kenya Quality Model for Health Quality Standards for Community Health Services (2015), Ministry of Health, Kenya. <http://guidelines.health.go.ke/#/category/23/92/metaA>

A Taxonomy of health system standards, USAID ASSIST. [https://www.usaidassist.org/sites/assist/files/taxonomy\\_of\\_health\\_system\\_standards.pdf](https://www.usaidassist.org/sites/assist/files/taxonomy_of_health_system_standards.pdf)





# Action planning, Summing up and Evaluation of Phase 1



No more than 6-8 weeks should pass between Phase 1 and Phase 2 of the QI for Community Health training programme. Phase 2 for the WITs to begin meeting regularly, to begin addressing and improving data quality and to collect data. Phase 2 is where the WITs are supported through a Quality Improvement Cycle using their own data.

In order to ensure that the WITs begin to put into practice what they have been taught in the Phase 1 and bring the necessary data to Phase 2, time must be dedicated at the end of the Phase 1 for action planning as indicated in the programme.

### **Action planning- Sub-County CHS WITs**

The following are the key activities that each Sub-County CHS WIT should plan for and complete in the time between Phase 1 and Phase 2.

Feedback to Sub-County Health Management Team. This feedback should include:

- Informing Sub-County Health Management Team that a Sub-County CHS WIT has been established and describing its purpose.
- Provision of the key messages learned during Phase 1 regarding Quality Improvement of community health services.

Facilitate Phase 1 training workshop(s) for Community Health Unit WITs.

Conduct the first monthly Sub-County CHS WIT meeting.

### **QI coaching visits.**

- Sub-County QI Coaches for CHS should plan to start their quarterly QI coaching visits.
- Ideal occasions for first QI coaching visits for CHS would be:
- The first CHV group supervision meeting following the Phase 1 training workshops for Community Health Unit WITs with reviewing community health data.

### **Action planning- Community Health Unit WITs**

The following are the key activities that each Community Health Unit WIT should plan for and complete in the time between Phase 1 and Phase 2.

Feedback to Community Health Unit. This feedback should include.

- Informing Community Health Unit that a Community Health Unit WIT has been established and describing its purpose.
- Provision of the key messages learned during Phase 1 regarding Quality Improvement of community health services.

Conduct first monthly Community Health Unit WIT meeting.

### **CHV group supervision meeting.**

- CHVs should be informed that data quality will now be a standing agenda item in all CHV group supervision meetings.
- CHVs should be oriented to the collection and reporting of high-quality data in MOH 514 Service Delivery Log Books by being taken through the same MOH 514 Service Delivery Log Book data collection simulation exercise as in the Phase 1 Training Workshop.

Can be obtained by administering training online evaluation.

### **Phase 1 Evaluation**

Before the official closing Phase 1, it is important to evaluate participants' experience. Feedback can be used to improve the delivery of the workshops and it shows participants they truly are working in a collaborative environment.

Feedback from participants can be obtained by administering training online evaluation:

- What went well.
- What did not go well.
- Suggestions for improvement.



# INTRODUCTION TO PHASE 2



## Preparation for QI for CHS Course: Phase 2

### Participants

For Phase 2 training there should be separate training workshops as follows:

- A training workshop for Sub-County CHS WITs
- A training workshop for Community Health Unit WITs

The ideal number for a training workshop is a maximum of 30 participants. Therefore, training workshops should include 3 WITs. Depending on the number of participants, it may be necessary to hold multiple training workshops.

Training workshop(s) for the Sub-County CHS WITs must take place first because the expectation is that the Sub-County CHS WITs are then responsible for training the Community Health Unit WITs. It is recommended that Sub-County CHS WITs training takes place 1 week before Community Health Unit WITs training.

### WIT pre-training preparation

**Instruct Sub-County CHS WITs to bring the following to the workshops:**

A computer to access the Kenyan Health Information System (DHIS2).

- The most appropriate person to bring their computer is the Sub-County Health Records Information Officer.

**Instruct Community Health Unit WITs to bring the following to the workshops:**

Filed MoH 515.

A computer to access the Kenyan Health Information System (DHIS2).

- The most appropriate person to bring their computer is the CHA.

### Suggested workshop timetable

Day 1	
	Sub-County CHS WITs & Community Health Unit WITs
8.00am	Registration
8.30am – 10.30am	Official Opening, Welcome & Introduction & WIT presentations
10.30am – 11.00am	TEA BREAK
11.00am – 1.00pm	Understanding and presenting community health information system data
1.00pm – 2.00pm	LUNCH
2.00pm – 4.30pm	Understanding and presenting community health information system data Identification of quality problems



Day 2	
8.00am	Registration
8.30am – 10.30am	Recap Day 1 Prioritisation of quality problems
10.30am – 11.00am	TEA BREAK
11.00am – 1.00pm	Development of problem statements Analyse
1.00pm – 2.00pm	LUNCH
2.00pm – 4.30pm	Root cause analysis Development of solutions

Day 3	
8.00am	Registration
8.30am – 10.30am	Recap Day 2 Implementing solutions and testing for change
10.30am – 11.00am	TEA BREAK
11.00am – 1.00pm	Summing up of workshop Official Closing Evaluation
1.00pm – 2.00pm	LUNCH

## Recaps

As indicated in the timetables above, Days 2 and 3 of the QI for CHS Phase 2 Training Workshop should begin with a recap of the previous day. Recaps should briefly describe the key QI concepts and QI tools used the previous day.



# Understanding and Presenting Community Health Information System Data



MODULE

5



## 5.1 Module Overview

The purpose of this module is for participants to appreciate that data to be used for decision-making, it must be processed to generate information that is meaningful. This module will take participants through the different ways in which community health information system (CHIS) data can be presented.

## 5.2 Learning Objectives

By the end of this module participants will be able to:

1. Define the term data management
2. Describe the two main types of data
3. Describe the data management cycle and how data should be processed to generate information that is used for decision-making
4. Describe the different ways in which community health information system (CHIS) data can be presented visually
5. Identify different stakeholders and their information needs

## 5.3 Session Plan

Topic	Activity	Time
Data and data management	Presentation	10 minutes
Types of data	Presentation	5 minutes
Presentation of community health information system data	Presentation and group work	90 minutes
Different stakeholders and their information needs	Presentation and group work	30 minutes

**Total time 135 minutes**

<b>PowerPoint Presentations</b>	Module 5 – <b>Understanding and presenting community health information system data</b> (Sub-County CHS WITs/ Community Health Unit WITs)
<b>Stationary</b>	Flip Chart, Marker Pens, Pencils, Erasers, Rulers

## 5.4 Facilitation Steps

Inform participants of the learning objectives of the session.

## Topic 1: Data and data management

Inform participants that Phase 2 of the QI for Community Health Course will be all about WITs using their own data to go through the Quality Improvement cycle. Therefore, it is essential that all participants understand what is meant by the term data.

Inform participants of the definition of data: “data are measurements or values that are collected using specific instruments.”

- In the context of community health services, an example of a measurement is the number of children 0-59 months participating in growth monitoring. This is an information need/indicator – the first stage of the data management cycle.
- Continuing with this example, the specific instrument that is used to collect this data is the MOH 514 Service Delivery Log Book. This is a data source – the second stage of the data management cycle.

Emphasise to participants that data must be processed to be meaningful.

Instruct one of the participants to read out the table content on the slides titled ‘Example’. After the participant has read out the table content, highlight the following points to participants.

- For data analysis, inform participants that the work is not over when they have a MOH 515 Summary that says for example, there are 50 children aged 0-59 months participating in growth monitoring. A WIT should ask themselves what this data means. This is data analysis. For example, does 50 children represent good performance when compared to the total population of children aged 0-59 months? What has the trend been for children aged 0-59 months participating in growth monitoring in recent months? How does this community-level health data compare with the relevant facility-level data?
- Inform participants that the term “trend” means whether the values reported for an indicator are increasing or decreasing over time. An increasing trend could be positive or negative depending on the question being asked.
- For use of information for decision-making, highlight to participants that data analysis can lead to information to support decision-making. In this case the decision of whether or not the number of children aged 0-59 months participating in growth monitoring is a quality problem that needs to be addressed.

Emphasise to participants that “Information is processed data.”

## Topic 2: Types of data

Inform participants that broadly speaking there are two types of data: quantitative and qualitative data.

Inform participants that quantitative data refers to measurements that are counted using numbers, e.g. number of pregnant women referred for ANC; and that qualitative data refers to data that cannot be expressed using numbers. In the context of community health services, these data may be about how clients perceive the quality of services or these data may be reasons for someone’s behaviour e.g. reasons given by a pregnant woman for not taking up a referral for ANC.



- Highlight to participants that quantitative and qualitative data are equally important. For example, it is important to assess performance of CHVs by quantifying the number of referrals and comparing this to other sources of quantitative data such as facility registers that will show if there is appropriate uptake of primary healthcare services. It is also important to know why CHVs are not making referrals to local primary health facilities and/or why community members are not taking up referrals by CHVs at primary healthcare facilities.

Remind participants that the QI for Community Health training programme focuses on three Ministry of Health data collection and reporting tools for community health services (MOH 514, MOH 515, MOH 100) and the MOH 516.

Read out the contents of the table on the slide ‘Key data sources for community health services.’

- Inform participants that a majority of these data collection and reporting tools collect quantitative data. Two tools collect qualitative data. The MOH 100 Community Referral Form and the Community.

Emphasise to participants that it is important not just to process quantitative data but also to know objectively (and not based on assumptions), the reasons behind the trends at community level, and the only way to know these reasons is to collect qualitative data to explain the trends.

### Topic 3: Presentation of community health information system data

Inform participants that you will be providing them with an overview of four different ways of presenting community-level health data, namely: tables, bar charts, pie charts and run charts.

Inform participants that the first visual display method you will show them is tables. Display the slide ‘Tables-example.’

For **Sub-County CHS WITs** Inform participants that this is a table displaying Data Quality Assessment (DQA) of community-level health data results.

- Remind participants of the interpretation of data verification ratios

Instruct participants to work in pairs to answer the question ‘What does the table tell you?’

- Instruct the pairs to write their responses down.
- Give the participants 10 minutes for this task.
- After 10 minutes instruct participants to present their responses.

Display the slide ‘Bar Charts- example.’

- Inform participants that this is a Bar Chart displaying the exact same Data Quality Assessment (DQA) of community-level health data results as the slide ‘Tables- example.’
- Highlight to participants that bar charts should have the bars labelled.
- Highlight to participants that the bar chart should also have a line cutting across it (i.e. the green line in this example) to clearly show the audience what the target is (i.e. 100% in the case of DQA results).

Instruct participants to work in pairs to answer the question “What does the Bar Chart tell you?”

- Instruct the pairs to write their responses down.
- Give the participants 10 minutes for this task.
- After 10 minutes instruct participants to present their responses.
- Note that as the bar chart is displaying the same data as the table the responses should be the same.

## Answers for the Data Quality Verifications for Table and Bar Chart

For **Sub-County CHS WITs** the key points are as follows:

- At CHA level, there is over-reporting of 4 out of 7 indicators.
- At CHA level, there is under-reporting of 2 out of 7 indicators.
- At CHA level, there is a perfect match for 1 out of 7 indicators.
- At Sub-County HRIO level, there is over-reporting for 1 out of 7 indicators.
- At Sub-County HRIO level, there is under-reporting of 1 out of 7 indicators.
- At Sub-County HRIO level, there is a perfect match for 4 out of 7 indicators.
- At Sub-County HRIO level, there is a perfect match of 1 out of 7 indicators. In summary, there are numerous occurrences of inconsistency in the value reported by one level of the community health information system and the next, particularly at CHA level.

For **Community Health Unit WITs** the key points are as follows:

- 92% of CHVs asked if there are children aged under 5 years in the house.
- 52% of CHVs checked the Mother & Child Health Handbook for each child in the house under 5 years to check that they are attending growth monitoring clinics.
- 64% of CHVs used a MUAC tape to measure the arm of all children in the house aged 6 months – 5 years.
- 60% of CHVs wrote a referral form for children aged 6 months – 5 years whose MUAC measurement indicated acute malnutrition.

Ask participants the following question: Which of the visual display methods (table versus bar chart) was easier to analyse?

Display the slide ‘Pie Charts- example.’

For **Sub-County CHS WITs**, Inform participants that this is a pie chart displaying the scores of 23 different Community Health Units (CHUs) in Amana Sub-County.

- Highlight to participants that pie charts should have the ‘slices’ labelled.
- Remind participants of the scoring system of the KQMH Quality Standards for CHS and highlight to participants that the ‘slices’ of the pie chart are different colours as each colour corresponds to a particular category, in this case there are three criteria for scoring a standard ‘Yes’ ‘No’ and ‘Partial’

For **Community Health Unit WITs**, Inform participants that this is a pie chart displaying the number of households in Kisimani Community Health Unit visited by CHVs in January 2022.

- Highlight to participants that pie charts should have the ‘slices’ labelled.
- Highlight to participants that the ‘slices’ of the pie chart are different colours as each colour corresponds to a particular category, in this case there are two categories. Households visited by a CHV and households not visited by a CHV.

Instruct participants to work in pairs to answer the question “What does the Pie Chart tell you?”

- Instruct the pairs to write their responses down.
- Give the participants 10 minutes for this task.
- After 10 minutes instruct participants to present their response

For **Sub-County CHS WITs** the key points are as follows:

- There are a total of 1000 Households in Kisimani community health unit in Amana Subcounty
- 791 out of 1000 households in Kisimani community health unit, i.e. the majority of households have been mapped and registered, having a score of 3= Yes
- 94 out of 1000 households Kisimani community health unit have been mapped but not registered have a score of 1 = partial.
- 115 out of 1000 households Kisimani community health unit have not been mapped or registered have a score 0= No

For **Community Health Unit WITs** the key points are as follows:

- There are a total of 1,000 households in Kisimani Community Health Unit (208+792).
- Only 208 households out of 1,000 households (i.e. a minority of households) in Kisimani Community Health Unit were visited by a CHV in January 2022 .

Display the slide ‘Run Charts’.

- Inform participants that this is a run chart displaying the number of children 0-59 months participating in growth monitoring each month in Kisimani CHU.
- Inform participants that run charts can also be called line charts.
- Highlight to participants that run charts should be labelled by writing the actual number/percentage for each data point.

Instruct participants to work in pairs to answer the question “What does the Run Chart tell you?”

- Instruct the pairs to write their responses down.
- Give the participants 10 minutes for this task.
- After 10 minutes instruct participants to present their responses

The key points are as follows:

- This is a run chart showing the number of children 0-59 months participating in growth monitoring over a period of time (June 2021 – May 2022).
- The highest recorded number of children 0-59 months participating in growth monitoring was 58 in June 2021 and after this the general trend was a downwards trend/reducing trend to as low as 4 in December 2021 (the numbers rose only in the months of August and September 2021 to 22 and 23 respectively).
- There is no data recorded for this indicator beyond December 2021.

For **Sub-County CHS WITs** Display the slide ‘Run Charts- example 2’

- Inform participants that the run chart displayed on this slide is an example to show the usefulness of a run chart.
- Emphasise to participants that run charts illustrate a trend of a particular indicator(s) over a period and by assessing a trend, they can identify points in time where there were drops or rises in the indicator measurements, especially unexpected ones. Participants may then relate trends to events in the health system context. For example, the first several weeks covered by this run chart, 0% of patients’ nutritional status is being assessed because healthcare workers are still being trained and have not yet been instructed to do so.
- Highlight to the participants that even though the external stakeholder visit raised the percentage of patients whose nutritional status is being assessed using MUAC to 100%, this was a non-sustained change as the percentage significantly dropped right after the event. However, assigning a member of staff specifically to measure MUAC and training expert clients to measure MUAC are examples of sustained changes because these interventions led to a rise in the percentage of patients whose nutritional status is being assessed using MUAC that was sustained over time. Quality Improvement is about sustainability.

Display the slide ‘Which visual display method should we use?’

Inform participants that this slide provides guidance on when to use a particular visual display method.

**Tables** are used to display a whole data set for a selected group of indicators for a particular point in time, e.g. the values for the MNCH indicators for a month. Tables are usually found in reports and they are used for audiences such as Sub-County, County or National managers of community health services.

**Bar Charts** are used as a visual display for a selected group of indicators for a particular point in time. For example, values for the MNCH indicators of interest a month. Advantages of bar charts is that they are more visually appealing than tables and they allow a more immediate comparison of values reported for different indicators by comparing the height of the bars. Bar charts are usually displayed on the walls of healthcare facilities where the audience is usually facility- or community-level.

**Pie Charts** are used to display data regarding performance by showing the proportions of individuals/units achieving a certain score for a particular standard. An advantage of pie charts is that they allow immediate visual assessment of where the majority of Community Health Units lie. As pie charts are mostly used to display data regarding performance, their audience is healthcare managers and administrators i.e. sub-county, County or National-level.

**Run Charts** are used to display trends over time for a specific indicator(s), e.g.: number of children 0-59 months participating in growth monitoring from January- December 2022 . The advantage of run charts is that they allow immediate visual assessment of whether indicators are generally rising or reducing and whether there are any sudden drops or rises. Run charts can be used with any audience from community to national-level.

Inform participants that the slide titled ‘Rules for visual displays’ is a reference for essential features that any visual display they create must have so that the audience can easily make sense of the data being displayed.

- For any visual display method, a title is required, and this should include location.
- For bar charts and run charts, it is crucial that the axes are labelled so that it is clear to the audience for which indicator(s) data is being displayed and for what point in time/ period.
- Remind participants once again that for bar charts, pie charts and run charts they should write the actual numbers/percentages represented in order that the audience can see specific values without having to look elsewhere.
- Highlight to participants that when calculating percentages, they should round up or down to the nearest whole number. This is so that percentages are displayed as whole numbers which makes them easier to understand.
- Ensure that for bar charts and run charts that the scale is consistent i.e. that it goes up in standardized increments that are marked on the axis, e.g. 5, 10, 15, 20, 25 etc., not 5, 10, 20, 35, 40, 80 etc.
- Indicate data source in order that audience are clear where the data being displayed has been obtained from. This is particularly useful for two reasons
- If the audience should wish to, they can review the original data source to verify that the data displayed is the same as that reported in the original data source.
- If the audience would like to create a similar visual display for another site(s), then they know which data source to obtain data from.
- Use colour wisely to ensure that audience can easily distinguish between different colours and text is legible.
- Highlight to participants that for pie charts it is essential to provide a colour key in order that the audience know what each colour corresponds to.

## Topic 4: Stakeholders and their information needs

Remind participants of the four key groups of stakeholders to consider; clients, service providers, supervisors, and managers.

Instruct participants in their WIT to work through the questions as presented on the slide ‘Group Work: Communicating your data to different CHS stakeholders’.

- Participants should brainstorm and write down their responses on flip chart paper.
- Each WIT should choose a rapporteur who will present their responses to the rest of the group when the task is completed. Give participants 15 minutes for this task.

Following presentations from each WIT, inform participants of the following:

- Clients refer to community members in their households being visited by CHVs/ CHAs . Clients are most concerned with receiving information about the health status of their community and what community health services and primary healthcare services they are receiving. Are their pregnant women still having unskilled deliveries? Are there still outbreaks of diarrhoea? If so, how many cases?
  - » For example, a Community Health Unit WIT could prepare a run chart displaying the number of pregnant women having unskilled deliveries each month and the number of referrals for skilled delivery made by CHVs and the number of referrals for postnatal care made by CHVs each month. This could all be presented on the same run chart.
- Service Providers refer to CHVs, CHAs and primary healthcare facility staff. Service providers are most concerned with receiving information about whether the community health services and primary healthcare services being provided are meeting the needs of the community.
  - » For example, a Community Health Unit WIT could prepare a run chart displaying the number of CHVs measuring MUAC during household visits each month and another run chart displaying both the number of referrals for moderate acute malnutrition made by CHVs and the number of referrals for severe acute malnutrition made by CHVs each month and another run chart displaying the number of cases of acute malnutrition treated/referred for treatment at the link healthcare facility each month.
- Supervisors refer to CHAs (who supervise CHVs) and Sub-County Health Management Team members (who supervise CHAs and primary healthcare facility staff). Supervisors are most concerned with receiving information about whether community health services are being delivered with directives set by higher authorities.
  - » For example, a Sub-County CHS WIT could prepare a run chart displaying the proportion of households in their sub-county that are visited by CHVs each month or prepare a bar chart for a particular month displaying the proportion of CHVs in each CHU who submitted their reports for that month.
- Managers refer to County Health Management Team members and National Ministry of Health staff. Managers are most concerned with receiving information about coverage, functionality and compliance with national policies and guidelines.
  - » For example, a Sub-County CHS WIT could prepare pie charts displaying the scores of their CHUs for KQMH Quality Standards for CHS.



Inform participants of the following structures for communicating with the above stakeholders.

- For Clients, community dialogue days and Community Health Committee meetings are the most common structures for communication.
- For Service Providers, Facility QIT and WIT meetings and Facility Health Management Team meetings are the most common structures for communication.
- For Supervisors, Sub-County Health Management Team meetings and Sub-County Stakeholder Forum meetings are the most common structures for communication.
- For Managers, at county level, County Health Management Teams, County QI technical working group (TWG) meetings, other County-level TWG meetings (e.g. County reproductive, maternal, newborn, child and adolescent health (RMNCAH ) TWG meetings) are the most common structures for communication. At national level, meetings of the national Division of Community Health services (DCHS) (e.g. Operational Research TWG, M&E TWG, Capacity TWG) and national QI Committee meetings are the most common structures for communication.

Discuss the run charts and bar charts in the PowerPoint presentation:

- What do the data visuals tell you?

Instruct participants to work in their WIT to carry out the exercises presented on the slide 'Practical session'.

- Participants should produce the visual displays on flip chart paper using marker pens, a ruler etc.
- Each WIT will produce multiple visual displays however the WIT should choose a rapporteur to present one of the visual displays/one set of the visual displays that go together, to the rest of the group when the task is completed; which visual display/set of visual displays that go together to present to the rest of the group is their choice.
- Allow participants to provide feedback and ask questions to WITs after each presentation.

Read through the key messages of this session.

Close the session by inviting participants to ask any questions that they may have.

## References

QA Monograph: A Modern Paradigm for Improving Healthcare Quality, Nov 5, 2013, USAID ASSIST. <https://www.usaidassist.org/resources/modern-paradigm-improving-healthcare-quality-o>



# Quality Improvement Cycle



MODULE

6





## 6.1 Module Overview

The purpose of this module is to take participants through the Quality Improvement Cycle highlighting that it is composed of four key steps.

The sessions covered in this module primarily consist of group work with the output of each group work session leading on to the next. Of utmost importance is that the sessions covered in this module are driven by the Work Improvement Teams' own community-level and facility-level health data.

## 6.2 Learning Objectives

By the end of this module participants will be able to:

1. Identify different data sources for problem identification
2. Identify quality problems using their own data
3. Define and describe the importance of problem prioritisation
4. Describe different problem prioritisation methods
5. Complete a prioritisation matrix
6. Define and describe the importance of a problem statement
7. Describe the features of a good problem statement
8. Develop a problem statement for their selected problem
9. Apply Quality Improvement (QI) tools to identify root causes of quality problems
10. Define and describe the importance of developing solutions to improve quality
11. Develop solutions that address the root causes of quality problems
12. Develop a Quality Improvement (QI) Change Plan
13. Describe the role of monitoring and evaluation to test for change

## 6.3 Session Plan

Unit 1: Identification of Quality Problems		
Topic	Activity	Time
Data sources for problem identification	Brainstorm in plenary/ Presentation	20 minutes
Quality Problems in your Sub-County/ Community Health Unit	Group Work	40 minutes

**Total time 60 minutes**

Unit 2: Prioritisation of problems		
Topic	Activity	Time
Definition and importance of problem prioritisation	Plenary discussion/ Presentation	15 minutes
Problem prioritisation methods	Presentation	15 minutes
Problem prioritisation for your Sub-County/ Community Health Unit	Group work	60 minutes

**Total time 90 minutes**

### Unit 3: Development of problem statements

Topic	Activity	Time
Definition and importance of a problem statement	Presentation/Plenary discussion	15 minutes
Features of a good problem statement	Presentation/Plenary activity	15 minutes
Developing a problem statement for your selected problem	Group work	30 minutes

**Total time 60 minutes**

### Unit 4: Root Cause Analysis

Topic	Activity	Time
Definition and importance of root cause analysis	Presentation	10 minutes
Quality Improvement (QI) Tools for root cause analysis	Presentation	5 minutes
Root cause analysis of your selected problem	Presentation/Group work	45 minutes

**Total time 60 minutes**

### Unit 5: Development of solutions

Topic	Activity	Time
Definition and importance of development of solutions	Presentation	15 minutes
Development of solutions to address selected problem	Presentation/Group work	45 minutes

**Total time 60 minutes**

### Unit 6: Implementing solutions and Testing for change

Topic	Activity	Time
Development of Quality Improvement (QI) change plan	Presentation/ Group Work	30 minutes
Quality Improvement (QI) change plan for your selected problem	Group work	30 minutes

**Total time 60 minutes**

### PowerPoint Presentations

Module 6 Unit 1 – **Identification of quality problems**  
Module 6 Unit 2 – **Prioritisation of problems**  
Module 6 Unit 3 – **Development of problem statements**  
Module 6 Unit 4 – **Root Cause Analysis**  
Module 6 Unit 5 – **Development of solutions**  
Module 6 Unit 6 – **Implementing solutions and Testing for change**

## Handouts/ Stationary

Module 6 Unit 1: Flip chart Paper, Marker Pens

Module 6 Unit 2: Prioritisation matrix; Flip chart Paper, Marker Pens

Module 6 Unit 3: Problem statement cards for 'Match the problem statements' plenary activity; Flip chart Paper, Marker Pens

Module 6 Unit 4: Flip chart Paper, Marker Pens

Module 6 Unit 5: Flip chart Paper, Marker Pens

Module 6 Unit 6: QI change plan template; Flip chart Paper, Marker Pens

## 6.4 Facilitation Steps

### 6.4.1 Unit 1: Identification of Quality Problems

Inform participants of the learning objectives of the session.

Inform participants that they are about to embark on a journey together known as the Quality Improvement Cycle that it is composed of four key steps:

Inform participants that Step 1: Identify is actually broken down into 3 smaller steps:

- a. Identify quality problems.
- b. Prioritise quality problems.
- c. Develop a problem statement.

Inform participants that Step 2: Analysis is about Root Cause Analysis to understand what is causing the problem.

Inform participants that Step 3: Develop is about development of solutions to address the causes of the problem.

Inform participants that Step 4: Implement and test is about implementation of these solutions and testing for change.

Emphasise to participants that the sessions they are about to go through regarding the Quality Improvement cycle will involve the use of their own real-life data and WIT group work will inform the activities that the WIT and CHVs will carry out on the ground following the session.

### Topic 1: Data sources for problem identification

For **Sub-County CHS WITs** Instruct participants to brainstorm in plenary how they currently go about identifying problems regarding community health services in their Sub-County.

- Highlight to participants that they should not present potential sources of information; they should present real sources of information being used at present.
- Make note of the responses from the plenary brainstorm on a flip chart paper.

For **Community Health Unit WITs** Instruct participants to brainstorm in plenary how they currently go about identifying problems regarding community health services in their Community Health Unit.

- Highlight to participants that you do not want to hear potential sources of information; you want to hear real sources of information being used at present.
- Make note of the responses from the plenary brainstorm on a flip chart paper visible to all participants.



Read out the different possible data sources for problem identification that could potentially indicate a problem affecting the health of communities/a problem in the delivery of community health services.

Inform participants this section will focus on use of community-level health data and facility-level health data for problem identification.

- Emphasise to participants that the MOH 515 Summary is the most common source of community-level health data for problem identification.
- Highlight to participants that the data source for facility-level health data varies according to the indicator(s) of interest.

For **Sub-County CHS WITs** emphasise to participants that in order to ensure they are referring to the correct data source for the facility-level health data that corresponds to the community-level health data of interest, they should consult the Sub-County HRIO.

For **Community Health Unit WITs** emphasise to participants that in order to ensure they are referring to the correct data source for the facility-level health data that corresponds to the community-level health data of interest, they should consult the link health Facility In-Charge.

- Inform participants that to use community-level health data and facility-level health data for problem identification, it must first be visualized and analysed as taught and practiced in Module 7.

Display the slide 'Example of community-level health data'

For **Sub-County CHS WITs** inform participants that this is a run chart displaying the number of referrals for immunisation made by CHVs in Kimaria Sub-County in 2022.

For **Community Health Unit WITs** inform participants that this is a run chart displaying the number of referrals for immunisation made by CHVs in Ayada Community Health Unit in 2022.

Display the slide 'Example of facility-level health data'

For **Sub-County CHS WITs** inform participants that this is a run chart displaying the percentage of fully immunized children under 1 year in Kimaria Sub-County in 2022.

For **Community Health Unit WITs** Inform participants that this is a run chart displaying the percentage of fully immunised children under 1 year at the link health facility for Ayada Community Health Unit, Ayada Health Centre, in 2022.

Instruct participants to discuss the following in plenary: From these visual displays of data, identify the quality problems.

- Write the responses from the plenary discussion on a flip chart paper visible to all participants.

Inform participants that the quality problems revealed by the run charts is that the percentage of fully immunized children under 1 year decreased from January to July 2022 and whereas this should have corresponded with an increase in the number of referrals for immunisation made by CHVs, the number of referrals for immunisation made by CHVs actually decreased from January to July 2022.

- Congratulate participants if they identified these quality problems during the plenary discussion.

## Topic 2: Quality Problems in your Sub-County/Community Health Unit

For **Sub-County CHS WITs** instruct participants to work in their Sub-County CHS WITs to use community-level health data and facility-level health data to identify three key quality problems in their Sub-Counties that involve community health services.

For **Community Health Unit WITs** instruct participants to work in their Community Health Unit WITs to use community-level health data and facility-level health data to identify three key quality problems regarding community health services in their Community Health Units.

- Highlight to participants that for each quality problem identified they should indicate the data source and provide their reason.
- Each WIT should write the above on flip chart paper and select a rapporteur who will present the 3 key quality problems identified to the rest of the group.
- Give the participants 30 minutes for this task.

### 6.4.2 Unit 2: Prioritisation of Quality Problems

Inform participants of the learning objectives of the session.

## Topic 1: Definition and importance of problem prioritisation

Ask the participants the following question in plenary: ‘Referring to the three quality problems your WIT identified in the previous session, are you able to tackle them all at the same time?’

- Write the responses down on flip chart paper that is visible to all participants.

Inform participants that problem prioritisation is the process of determining which quality problem should be tackled at the current point in time.

Highlight to participants that a key principle of Quality Improvement (QI) is that only one quality problem should be tackled at a time; it is therefore necessary to identify the quality problem of highest priority to tackle first.

- Experience shows that tackling several quality problems at once results in diluting efforts and resources.

## Topic 2: Problem prioritisation methods

Inform participants that there are two common methods that they can use for problem prioritisation; voting or prioritisation matrix.

Inform participants that voting is when team members simply raise their hand or write down which quality problem they feel should be prioritised above the others at the current point in time. The quality problem with the highest number of votes is the problem that the WIT will address first.

- A key advantage of voting for problem prioritisation is that it is simple.
- A key disadvantage is the reason(s) behind people’s votes are not clear and may not be objective. This means that people may have voted a certain way based on personal feelings and opinions and it also means that in the WIT, not all members are considering the same factors when deciding which quality problem to vote for.

Inform participants a prioritisation matrix provides a more objective way to prioritise.

- Use of a prioritisation matrix ensures that a WIT selects an appropriate problem to tackle. In this context the word appropriate is used to mean a problem that the WIT can feasibly do something about.

Inform participants that a prioritisation matrix makes each WIT member take 3 factors into consideration when deciding which quality problem should be prioritised: urgency of the problem; cost of resolving the problem; and feasibility. Describe each of these factors to the participants by reading out the contents of the slide 'Prioritisation matrix criteria'

- For cost of resolving problem and feasibility, emphasise to WITs that they must think of the resources they know they have available to them to address the problem, not those they wish they had.
- Explain to participants that what is meant by urgency is for them to consider what problem, if tackled first, would have the greatest benefit on the overall health of the sub-county/community health unit and/or delivery of community health services. For example, two problems identified could be 'low number of households visited by CHVs' and 'discrepancy between data reported in MOH 515 Summary and that reported in DHIS2'. Discuss with participants how the data quality problem fits the urgency factor.

Display the prioritisation matrix table.

Inform participants that the key advantage of using a prioritisation matrix for problem prioritisation is that it makes WIT members think deeply about key factors that influence the impact of quality improvement activities.

Inform participants that the key disadvantage of using a prioritisation matrix is that it can be more difficult and time consuming to use with a large group of people

Read out the instructions on the slides 'How to use a prioritisation matrix.'

- Emphasise that the exercise must first be carried out individually without consulting others and that each WIT member must have confidence in their opinions.
- Emphasise that as an individual, you should not write any duplicate scores. For example, if for the first problem you gave it a 3 when it comes to urgency, you cannot also give the second problem a 3 when it comes to urgency.
- Ensure there is correct understanding across all participants of the scoring system for each criterion.

Read out the example of a completed prioritisation matrix.

- Highlight to participants that this example pertains to a team made up of 3 people and in order to make it very clear to the participants how a WIT should complete a prioritisation matrix, the example has been colour-coded as follows:
  - » Blue = Team member 1
  - » Orange = Team member 2
  - » Pink = Team member 3

- Read it such that the participants can appreciate how they should work individually and how this contributes to the final completed prioritisation matrix for the WIT.
- Point out that there is no duplication of scores.

Inform participants to sum of the scores across the row for each problem to provide each problem with a final score. The problem with the highest score is the problem of highest priority. In this example that is low number of pregnant women complete 4 ANC visits.

### **Topic 3: Problem prioritisation for your Sub-County/Community Health Unit**

Instruct participants to work in their WITs to complete a prioritisation matrix for the 3 quality problems identified in the previous session.

- Provide individual WIT members with the prioritisation matrix handout for their individual use.
- Instruct the participants to select a rapporteur who will present the prioritisation matrix and state which problem has been selected as the highest priority.
- Advise participants to record their prioritisation matrix in their Participant's Handbook.
- Give the participants 30 minutes for this task.
- When each WIT presents their completed prioritisation matrix to the rest of the group, there is no need for the rapporteur to read out each individual score from each individual person but instead they can give the overall score.
- Allow participants to provide feedback and ask questions after each presentation.

## **6.4.3 Unit 3: Development of problem statements**

Inform participants of the learning objectives of the session.

### **Topic 1: Definition and importance of a problem statement**

Read out the definition and importance of a problem statement, highlighting that a problem statement is not complete if it does not indicate the consequences if the selected problem is not addressed.

### **Topic 2: Features of a good problem statement**

Read out the features of a good problem statement.

Highlight to participants that a WIT should be very clear on the data source(s) for their problem and confident that the numbers/percentages cited are accurate.

- Use of numbers and/or percentages allows stakeholders in community health services to appreciate the extent of the problem.

Emphasise to participants that writing a good problem statement will play a fundamental part in whether or not your planned interventions will overcome the quality problem identified.

Present the slide ‘Example of a good problem statement’.

- Highlight to participants that this is a good problem statement because it is simple, precise, accurate and clear. Furthermore, the problem has been quantified and we know the site affected by this problem and the time period being referred to. Lastly, the problem statement informs us what the consequences of not addressing the problem are.
- Emphasise to participants that a good problem statement is made up of two parts. The first sentence describes the problem. The second sentence indicates the importance of the problem by indicating the consequences if the selected problem is not addressed.

Ask the participants the following question in plenary: ‘How would you turn these bad problem statements into good problem statements?’

### **Low number of pregnant women complete 4 ANC visits.**

For Sub-County CHS WITs, Low number of referrals for acute malnutrition from community level.

For **Community Health Unit WITs**, Low number of referrals for immunisation defaulters.

- Write the responses from the plenary discussion on a flip chart paper visible to all participants.
- The main points that should be raised are as follows: quantifying the problem, indicating the location, specifying the time period being referred to and indicating the consequences of the problem if not addressed.

Inform participants that they will now participate in a plenary activity called ‘Match the problem statements’ to reinforce learning regarding the features of a good problem statement.

- Shuffle the stack of problem statement cards.
- Distribute the problem statement cards amongst the group randomly, giving only one problem statement card per person.
- Those who do not get a problem statement card can help the others.
- Inform the participants that each problem statement card has a problem statement written on it that has either been written well or badly. The purpose of this activity is to match your problem statement with the corresponding good or bad problem statement.
- Instruct participants that to do this they must walk around the room and find the participant with the corresponding good or bad problem statement.
- For example, the problem statement card that has the problem statement ‘Unskilled delivery’ written on it should be matched with the problem statement card that has the problem statement ‘Skilled delivery has dropped by 20% over the last 3 months in Hazina Community Health Unit. This could lead to an increased number of maternal and newborn deaths.’
- When all participants have matched their problem statements, go around the room instructing each pair to explain to the rest of the group which is the bad and which is the good problem statement.

### Topic 3: Develop a problem statement for your selected problem

Instruct participants to work in their WITs to write a good problem statement for the quality problem they prioritised as their selected problem in the previous session.

- Instruct the participants to write their problem statement on flip chart paper and select a rapporteur who will present the problem statement to the rest of the group.
- Give the participants 15 minutes for this task.
- Allow participants to provide feedback and ask questions to each WIT after each presentation.
- Provide feedback to each WIT to ensure that the final problem statement has all the features of a good problem statement.

#### 6.4.4 Unit 4: Root cause analysis

Inform participants of the learning objectives of the session.

##### Topic 1: Definition and importance of root cause analysis

Read out the definition and importance of root cause analysis.

##### Topic 2: Quality Improvement (QI) Tools for root cause analysis

For Sub-County CHS WITs inform participants that there are two common QI tools that Sub-County CHS WITs can use to carry out root cause analysis of quality problems affecting community health services. These are:

- Flowcharts
- For Sub-County CHS WITs - Fishbone diagrams
- For Community Health Unit WITs - 5 Whys

Inform participants that the best description of a flowchart is that it is a road map of a process including any decision points and optional routes along the way.

- Highlight to participants that flowcharts use a set of standard symbols.
- Highlight to participants that it is important to have all stakeholders in the process involved in describing and flowcharting the process.

Emphasise to participants that flowcharts allow a WIT to identify where things are not happening as they should. It is therefore key to develop flowcharts that represent the reality of how a process is currently being carried out as opposed to the ideal way in the process should be carried out.

Read out the meaning of the symbols used in flowcharts.

Read out the contents of the slide 'How to create a flowchart.'

Instruct participants to consider the example in which only 63% of children under 1 year were fully immunised between July – December 2021. This is a problem because inadequate immunisation of children under 1 year leads to outbreaks of infectious diseases associated with poor child development and increased childhood morbidity and mortality.



Present the 'Flowchart (reality)' slide.

- Remind participants that flowcharts should represent the reality of the process, not the ideal.
- Inform participants that assessing the flowchart reveals multiple quality issues causing or related to their selected problem. These are:
  - » CHVs asking mothers is not a reliable way to identify immunisation defaulters.
  - » Verbal referrals for immunisation defaulters can easily be dismissed/forgotten and cannot be tracked.
  - » CHVs are not recording their household visits in their MOH 514 Service Delivery Log Books making it impossible to assess CHV performance.

Present the 'Flowchart (ideal)' slide.

- Advise participants that to develop solutions to address the quality issues revealed by the flowchart of the reality of the process, it can be useful for a WIT to draw a flowchart of how the process should ideally happen.
- In this example, the flowchart of the ideal process reveals multiple solutions to the quality issues identified above. These are:
  - » CHVs reviewing Mother & Child Health Handbooks thus enabling objective identification of immunisation defaulters.
  - » CHVs writing referrals for immunisation defaulters using MOH 100 Community Referral Forms thus enabling tracking of community referrals and evidence of uptake of immunisation services.
  - » CHVs recording their household visits in their MOH 514 Service Delivery Log Books thus enabling assessment of CHV performance in relation to identification and referral of immunisation defaulters.

Instruct participants to work in their WITs to develop a flowchart(s) in relation to their problem statement.

- Instruct participants to draw their flowchart(s) on flip chart paper and select a rapporteur who will present the flowchart(s) to the rest of the group
- Instruct participants to identify any quality issues that may be causing to their selected problem
- Instruct participants to identify any solutions to these quality issues
- Give the participants 30 minutes for this task.
- The rapporteur should clearly state any quality issues they have identified that may be causing their selected problem and any solutions they have identified for these quality issues.
- Allow participants to provide feedback and ask questions after each presentation.

For **Sub-County CHS WITs**, Inform participants that a fishbone diagram is a graphic tool that helps identify, sort and display possible causes of a problem.

- Emphasise to participants that the key advantage of using a fishbone diagram for root cause analysis is that it makes WIT members think about all the possible causes for a particular problem.

Highlight to participants that a fishbone diagram makes WIT members think in a comprehensive and systematic way because it provides five different categories of causes to consider. Inform participants that these five different categories of causes are often referred to as “The 5 Ps”:

- **People:** Think of possible causes of the problem related to community members, clients, CHVs, healthcare workers and healthcare managers.
- **Procedures:** Think of possible causes of their problem related to processes/systems, i.e. the way work is done. Emphasise to participants that developing a flowchart can be useful to generate causes to feed into the procedure’s component of a fishbone diagram.
- **Policies:** Think of possible causes of their problem related to existing health service standards/guidelines. Highlight to participants that common causes that would fall in this category is lack of existence of guidance from the higher levels of the healthcare system in the form of standards/guidelines or existence of guidance from the higher levels of the healthcare system in the form of standards/guidelines that the WIT does not agree with or thinks could be improved.
- **Place:** Think of possible causes of their problem related to the environment. This refers to physical factors such as terrain, distance between households, condition of infrastructure such as roads etc. This also refers to other environmental factors such as security.
- **Provisions:** Think of possible causes of their problem related to availability of the materials and equipment necessary for high-quality services. For example, unavailability of MUAC tapes may be a significant cause for the problem of lack of identification of acute malnutrition by CHVs.

Present the ‘How to complete a fishbone diagram’ slide.

Present an example of how a fishbone diagrams can be used for root cause analysis.

- Instruct participants to consider the example of Kimaria Sub-County in which there has been a 10% decrease in children 0-59 months participating in growth monitoring between July – December 2021. This is a problem because inadequate participation in growth monitoring may lead to undetected cases of malnutrition which in turn leads to poor child development and increased childhood morbidity and mortality.

Display the photograph of a fishbone diagram used for root cause analysis of this problem.

- Read out all the causes and sub-causes of the fish diagram one spine at a time, one category at a time.

For **Community Health Unit WITs** Inform participants that 5 Whys is a QI tool designed to identify the root causes of a problem by repeating the question “Why?” in that each answer forms the basis of the next question.

- Emphasise to participants that the key advantage of using 5 Whys is that it makes WIT members think “deep” about the underlying causes for a quality problem.

Present the ‘How to do 5 Whys’ slides.

Present the ‘5 Whys Example 1’ slide.

- Read out the problem followed by all its causes one path a time.
- Emphasise to participants that when it comes to 5 Whys, there is no specified number of paths of causes that should be developed nor is there a specified point at which one cause should branch into two or more paths when the question “Why?” is asked. This all depends on the quality problem selected and the WIT’s analysis.

- Inform participants that this WIT could have gone deeper still with this root cause analysis by identifying the causes behind why ‘Many women start ANC clinic late.’

Display the slide ‘5 Whys Example 2’ slide.

- Read out the problem followed by all its causes one path a time.
- Inform participants that whereas this WIT has done a good job of picking up relevant and important causes for its selected quality problem, they could have gone deeper still to determine the causes for inadequate information on ANC visits in the community and lack of company and support for adolescent girls seeking ANC.

### Topic 3: Root cause analysis of your selected problem

For **Sub-County CHS WITs** instruct participants to work in their WITs to conduct a root cause analysis of their problem statement using a fishbone diagram.

For **Community Health Unit WITs** instruct participants to work in their WITs to conduct a root cause analysis of their problem statement using 5 Whys.

- Instruct participants to draw their diagram on flip chart paper and select a rapporteur who will present the fishbone diagram to the rest of the group.
- Give the participants 30 minutes for this task.
- Allow participants to provide feedback and ask questions after each presentation.
- Provide feedback to each WIT to ensure that they revise their diagram as necessary such that it is comprehensive and sufficiently “deep” in that for each cause provided, the question why has been asked at least once, if not twice, to arrive at sub-causes for all causes.

## 6.4.5 Unit 5: Development of solutions

Inform participants that the focus of this session is development of solutions to address the root causes of their selected quality problem that they arrived at, at the end of the previous session.

- Inform participants that solutions that address the root causes of quality problems are also known as change ideas.
- Inform participants of the learning objectives of the session.

### Topic 1: Definition and importance of development of solutions

Inform participants that a change idea is an activity that if implemented effectively, addresses a particular cause(s) for a selected quality problem and results in improved quality of health services.

- For example, if one of the causes contributing to low number of pregnant women completing 4 ANC visits is found to be that CHVs do not review mother and child health handbooks to assess ANC compliance because they have not been trained on how to do so, a change idea for this would be to build the knowledge of CHVs regarding ANC and build their capacity to review mother & child health handbooks through targeted training from the CHA/CHO on these topics during group supervision meetings.

Inform participants that development of change ideas is important because without root cause analysis, effective corrective action is impossible; without corrective action, root cause analysis is a waste of time.

## **Topic 2: Development of solutions to address selected problem**

Inform participants that they will now work in their WITs to develop solutions to address the root causes of their selected quality problem from the previous session.

- Instruct participants to work in their WITs to assess their diagrams and circle root causes that if successfully addressed would likely result in improvement. Emphasise to participants that they should circle only causes that it is within their means to address.
- Instruct WITs to develop change ideas to address the causes they have circled.
- Advise the WITs that they should be creative but realistic in terms of the change ideas they arrive at. It is crucial that change ideas can be carried out within the known resources available to the WIT.
- Advise WITs also that they should generate a variety of change ideas. i.e. one-off activities, short-term and long-term changes, simple and complex.
- Advise WITs that for any activity to do with capacity-building of CHVs can never be a one-off. This is a long-term activity for two main reasons. CHV workforce turnover is frequent with high rates of attrition and new recruitment and it is unreasonable to expect CHVs to retain large amounts of technical information over long periods of time. Furthermore, CHVs should not be burdened with capacity building all at once; for example, if you want to build the capacity of CHVs in ANC, you should not try to teach them all of ANC at once. Give examples of long-term capacity building.
- Each WIT should select a rapporteur who will present the solutions to their selected problem to the rest of the group.
- Give the participants 30 minutes for this group work.
- Allow participants to provide feedback and ask questions after each presentation.
- Advise WITs that in Quality Improvement, there is nothing wrong with copying/ adapting change ideas that are relevant from other WITs.
- Provide feedback to the WITs on their solutions emphasizing that solutions should be derived from the root cause analysis and feasible.

Emphasise to participants that when developing change ideas, they should consider the following:

- Does this change idea address one of the root causes of our selected problem?
- Does this change idea have the potential to improve quality in the long term?
- What does it cost to implement this change idea?
- How much time will it take to implement this change idea?
- Are the necessary resources available to implement this change idea?
- Is this change idea acceptable to the community?
- Is there support from managers at higher levels of the health system to implement this change idea?

### 6.4.6 Unit 6: Implementing solutions and testing for change

Highlight to participants that they have gone through Steps 1, 2 and 3 in this workshop; however, the fourth step of the Quality Improvement cycle cannot be carried out in a workshop. This is the step that is done on the ground through hard work and commitment. This is the step that makes all the difference.

Inform participants that the focus of this session is for each WIT to develop a Quality Improvement (QI) change plan that they will implement.

- Highlight to participants that a key part of any QI Change Plan is monitoring and evaluation to test for change.

Inform participants of the learning objectives of the session.

#### Topic 1: Developing a Quality Improvement (QI) change plan

Inform participants that to effectively implement the change ideas they developed in the previous session; they must develop a clear plan that includes all the activities they have thought of to improve quality. This plan is known as a Quality Improvement (QI) Change Plan.

Inform participants that the first step of developing a QI Change Plan is setting a target to be achieved in relation to the problem statement.

Highlight to participants that the target should be S.M.A.R.T (specific, measurable, achievable, realistic and time-bound).

Inform participants that commonly, QI change plans are implemented over a period of 6 months to allow sufficient time for evidence of impact of the Quality Improvement (QI) activities.

Provide participants with the following example:

- Problem: Only 63% of children under 1 year were fully immunised between July – December 2021.
- Target: ‘To increase the percentage of fully immunised children aged under 1 year in Kimaria Sub-County from 63% to 90% by 30th June 2022.’

Inform participants that the second step in developing a QI Change Plan is planning for the implementation of key activities from the WIT’s suggested change ideas.

Advise participants that they should use a QI Change Plan template for this to ensure that they plan in a systematic way.

Highlight to participants that responsibility for activities should be shared across WIT members.

- Highlight to participants that to increase ownership and ensure that the right technical input/content is achieved, and to achieve the optimum level of visibility, for each activity, the activity should be led by a relevant WIT member.

Present the ‘QI change plan template’

Present the slide titled ‘Remember.’

- Inform participants that you are about to show them an example of a QI Change Plan but first of all you want to remind them of the associated root cause analysis session.



Present the slides 'QI change plan- Example'

- Highlight to participants how each activity is derived directly from root cause analysis as follows.

For Sub-County CHS WITs	
Activity	Cause
Organise community dialogue days to raise awareness of importance of growth monitoring	Mothers don't understand importance of growth monitoring
Training of all CHVs in Kimaria Sub-County on how to review Mother & Child Health Handbooks for participation in growth monitoring	CHVs do not check Mother & Child Health Handbook because of lack of knowledge on how to do so
Training of all CHVs in Kimaria Sub-County on appropriate growth monitoring referral	CHVs do not make referrals because of lack of knowledge on how to do so
Provide all CHVs in Kimaria Sub-County with MOH 100 Community Referral Form books	CHVs do not make referrals because they have no referral forms
All primary healthcare facility Quality Improvement Teams to address poor patient flow resulting in long waiting times for clients	Community members having lack of trust in primary healthcare facilities due to long waiting time caused by poor patient flow
For Community Health Unit WITs	
Activities pertaining to mapping and tracking of all pregnant women with identification and referral of ANC defaulters	Many women start ANC clinic late meaning that they do not get the health information that they should in time
Community dialogue days to educate pregnant women and women of reproductive age and their partners on the importance of attending at least 4 ANC visits during pregnancy and other key issues surrounding pregnancy, labour and the postpartum period	Women have inadequate knowledge on pregnancy, labour and the postpartum period and many women start ANC clinic late meaning that they do not get the health information that they should in time
Training of all CHVs in Matopeni Community Health Unit on how to review Mother & Child Health Handbooks for ANC compliance and how to use the Mother & Child Health Handbook as a valuable source of information to use with pregnant women during household visits to educate them on individual birth plan, danger signs during pregnancy etc.	CHVs do not review the Mother & Child Health Handbook with pregnant women because CHVs have inadequate knowledge on Mother & Child Health Handbook
Formation of support group for pregnant women (especially women pregnant for the first time)	Many women start ANC clinic late meaning that they do not get the health information that they should in time.

Highlight to participants that for each activity the WIT states the following:

- **When the activity will be carried out:** Whenever possible, actual dates should be written to create commitment.
- **Persons responsible:** Highlight to participants that for persons responsible for activity they should state an actual name(s) of an individual(s) not just designation(s). This is to create ownership.
- **Resources required:** Explain to participants that in the context of community health services in resource-limited settings, resources most commonly refers to simple considerations such as venue and the people required for an activity to be carried out effectively.
- **The evidence required to show that the activity has been implemented:** Emphasise the reasons behind why documentation of QI is vital.

Inform participants that the third and final step in developing a QI Change Plan is planning for testing for change.

- Inform and emphasise to participants that testing for change is achieved by monitoring and evaluation (M&E).
- Inform participants that Monitoring of a QI change plan means reviewing evidence that activities have been carried out correctly. For example, photographs and minutes for a community dialogue day.
- Inform participants that Evaluation of a QI change plan means assessing whether the activities carried out have had an impact on improving the situation described in the problem statement.
- Example for Sub-County CHS WITs To evaluate the impact of the activities they have implemented, Kimaria Sub-County CHS WIT would have to return to the same data source they used to develop the problem statement and calculate what percentage of children aged under 1 year are fully immunised between January- June 2021.
- Example for Community Health Unit WITs To evaluate the impact of the activities they have implemented, Baba Dogo Community Health Unit WIT would have to return to the same data source they used to develop the problem statement and calculate what percentage of children aged under 1 year are fully immunised between January-June 2021.

Inform participants that evaluation should be displayed visually as covered in Module 7.

- Advise participants that ideal spaces to display such data are walls in the Sub- County Health Management office, walls in the link health facility and walls in the community health unit office (if applicable) or any other appropriate space at community level.
- Advise participants that these visual displays of data should also be presented in stakeholder forums such as community dialogue days, Facility Quality Improvement Team and Work Improvement Team meetings, Sub-County Health Management Team meetings, Sub-County and County Quality Improvement (QI) Technical Working Group (TWG) meetings etc.

Advise participants that should they find there is an improvement, but they have not yet met their target, then they should continue with the activities in their QI Change Plan and potentially add new activities.

Advise participants that should they find there is an improvement, and they have met their target, they can move back to the first step of the Quality Improvement Cycle which is to identify another quality problem to address.

Emphasise to participants that it will be crucial that they incorporate the activities that led them to achievement of their target into their routine work plan to ensure that the positive changes are sustained and they should set themselves an even higher target of performance for that indicator even as they work on another quality problem.

Advise participants that should they find that there is no improvement, as a WIT they may need to revisit their root cause analysis because it could be that the causes for the problem they identified were not actually the main contributors to the problem which is why the activities they have done have not resulted in any improvement. After they revise their root cause analysis, they can then revise their QI change plan. They can then implement their revised QI change plan and monitor and evaluate it to see if now they are making an improvement.

Advise participants that monitoring and evaluation should be integrated into routine activities such as WIT meetings and CHV group supportive supervision meetings.

Emphasise to participants that monitoring and evaluation of QI should not be overwhelming; it should be kept focused to a few key indicators of priority at a given point in time and these will change over time as WITs meet their QI targets and address new quality problems.

## **Topic 2: Quality Improvement (QI) change plan for your selected problem**

Instruct each WIT that they must now develop a QI change plan to solve their selected problem.

- Provide each WIT multiple copies of the blank QI change plan template handouts.
- Advise participants to refer to the QI change plan checklist.
- Instruct each WIT to write their QI change plans in both the QI change plan template and on flip chart paper to present their QI change plan to the rest of the group. Each WIT should select a rapporteur who will present their QI change plan to the rest of the group.
- Advise participants that they can write their own copy of their WIT's QI change plan in their Participant's Handbook.
- Give participants 30 minutes for this group work.
- Allow participants to provide feedback and ask questions to each WIT after each presentation.
- Provide feedback to the WITs on their QI change plans to ensure that each WIT has a QI change plan with a reasonable target; comprehensive list of activities and monitoring and evaluation included. Furthermore, each WIT's QI change plan should stick to the principles outlined in the QI change plan checklist.

Close the session by inviting participants to ask any questions that they may have.



# Summing up and Evaluation of Phase 2



## **Summing up and Evaluation of Quality Improvement (QI) for community health services (CHS) Phase 2 Training Workshop**

WITs should be given a maximum of 6 months to implement their Quality Improvement (QI) change plans before the QI for CHS Phase 3 Learning Event takes place. This is because it takes times for the impact of QI interventions to be seen through routine monitoring and evaluation. In order to ensure that the WITs put into practice what they have been taught in the Phase 2 Training Workshop, implement QI activities effectively and test for change via monitoring and evaluation with visual displays of community-level and facility-level health data, supervision and coaching from QI Coaches for CHS is essential. It is necessary to dedicate time at the end of the Phase 2 Training Workshop to emphasise the importance of supervision and coaching to ensure the success of the QI change plans that have been developed. QI Coaches for CHS should develop coaching schedules to accompany the QI change plans.

### **Supervision and coaching for Quality Improvement of community health services- sub-County level**

The following are the key activities that each County QI Coach for CHS should plan to supervise and coach:

- QI for CHS Phase 2 Training Workshop(s) for Community Health Unit WITs
- Sub-County CHS WIT meetings
- Supervision of CHAs by Sub-County CHS Focal Persons
- QI Coaches for CHS meetings (as taught in QI for CHS Phase 1 Training Workshop)
- Specific QI activities planned for by Sub-County CHS WITs to meet QI target(s)

### **Supervision and coaching for Quality Improvement of community health services- community level**

The following are the key activities that each Sub-County QI Coach for CHS should plan to supervise and coach:

- Community Health Unit WIT meetings
- Supervision of CHVs by CHAs
- Specific QI activities planned for by Community Health Unit WITs to meet QI target(s)

In addition to the above, it is also necessary to emphasise to the WITs that in addition to implementation of the specific QI activities that they have planned for in their QI change plan designed to meet their QI target(s), it is also important to remember to carry out core QI activities.

### **Core Quality Improvement activities for Sub-County CHS WITs**

Feedback to Sub-County Health Management Team

- Inform the Sub-County Health Management Team of the quality problem being addressed by the Sub-County CHS WIT including description of their QI target(s) and QI change plan.
- Provision of the key lessons learned during Phase 2 Training Workshop including description of their journey through the QI cycle and the QI tools used.

QI for CHS Phase 2 Training Workshop(s) Community Health Unit WITs

- Sub-County QI Coaches for CHS should be the facilitators of the QI for CHS Phase 2 Training Workshop(s) for Community Health Unit WITs.



## Monthly Sub-County CHS WIT meetings

- All WIT meetings should be documented with minutes that have action points.
- WITs should produce and update visual displays of community-level and facility-level health data.

## Data Quality Assessments (DQAs) of community-level health data every quarter

Activities in QI change plan are implemented and WIT monitors and evaluates whether implemented activities have brought about desired change:

- If Yes, WIT begins a new QI cycle
- If No:
  - » Revise root cause analysis
  - » Revise QI change plan
  - » Implement revised QI change plan
  - » Monitor and Evaluate revised QI change plan

## Core Quality Improvement activities for Community Health Unit WITs

### Feedback to Community Health Unit

- Inform the Community Health Unit of the quality problem being addressed by the Community Health Unit WIT including description of their QI target(s) and QI change plan. All CHVs should be able to describe the QI change plan for their community health unit and their role in implementation of QI activities.
- Provision of the key lessons learned during Phase 2 Training Workshop including description of their journey through the QI cycle and the QI tools used.

## Monthly Community Health Unit WIT meetings

- All WIT meetings should be documented with minutes that have action points.
- WITs should produce and update visual displays of community-level and facility-level health data.

## CHV group supervision meetings

- Group supervision of CHVs should be used as an opportunity by CHAs and link facility staff for capacity-building of the CHVs as relevant to the QI target(s) at a particular point in time.
- Data quality is a standing agenda item in all CHV group supervision meetings with continuous orientation on collection and reporting of high-quality data in MOH 514 Service Delivery Log Book.

Administration of Community Follow-Up Tool and summarisation of Community Follow-Up Tool data every six months.

Activities in QI change plan are implemented and WIT monitors and evaluates whether implemented activities have brought about desired change.

## Evaluation of Quality Improvement (QI) for Community Health Services (CHS) Phase 2 Training Workshop

Before the official closing of the QI for CHS Phase 2 Training Workshop, it is important to evaluate participants' experience of the workshop. Feedback from participants allows you to do an even better job when organising and facilitating the next QI for CHS Training Workshop and it shows participants they truly are working in a collaborative environment.

Feedback from participants should fall into three categories:

- What went well
- What did not go well
- Suggestions for improvement

### References

QA Monograph: A Modern Paradigm for Improving Healthcare Quality, Nov 5, 2013, USAID ASSIST. <https://www.usaidassist.org/resources/modern-paradigm-improving-healthcare-quality-o>

Tips and Tools for Learning Improvement, July 2017, USAID ASSIST. <https://www.usaidassist.org/resources/tips-and-tools-improvement-series>



# INTRODUCTION TO PHASE 3



## Participants

The Phase 3 Learning Event is a follow-on to the Phase 2 trainings and provides the opportunity for WITs from sub-county and community level to meet with other WITs in the county or beyond and share their experiences and learning. Learning Events are hosted by the County Health Management Team or National Level.

In advance of attending a Phase 3 Learning Event, sub County and Community WITs prepare poster presentations of their QI change plans to present at the Learning Event. They bring their WIT files to provide documentary evidence of their QI efforts and they may also be required to bring a QI photo story as an alternative way of describing the impact of their QI change plans.

Module 7 is targeted at QI coaches to guide them in how to prepare WITs for Learning Events. This module is designed to be used by QI coaches during coaching visits to WITs.

### Example timetable for a 2-day Learning Event

Day 1	
8.00am	Registration
8.30am – 10.30am	Session Chair: Welcome & Introduction: Programme & learning objectives Opening Remarks: National/County MoH Presentation: Achievement in QI for CHS County Updates: Progress in Community Health Introduction to poster presentations: Facilitator
10.30am – 11.00am	TEA BREAK
11.00am – 1.00pm	WIT presentations and peer voting (parallel sessions x 3)
1.00pm – 2.00pm	LUNCH
2.00pm – 4.30pm	Session Chair: 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 Summing up of Day 1: Lessons Learned and innovations

Day 2	
8.00am	Registration
8.30am – 10.30am	<p>Session Chair:</p> <p>Presentation: Embedding &amp; Sustaining QI for CHS</p> <p>Panel Discussion: Embedding &amp; Sustaining QI for CHS; National to Community level perspectives</p>
10.30am – 11.00am	TEA BREAK
11.00am – 1.00pm	<p>Introduction to World Café: Facilitator</p> <p>World Café: Each group to participate in 3 work stations</p>
1.00pm – 2.00pm	LUNCH
2.00pm – 4.30pm	<p>Session Chair:</p> <p>Presentation &amp; Plenary Discussion: Planning for embedding QI into Community Health Systems</p> <p>Summing up: The way forward: County &amp; National response</p> <p>Workshop Close &amp; Evaluation</p>





# Evaluating Quality Improvement for Community Health through Learning Events



MODULE

7



## 7.1 Module Overview

A learning event is an interactive forum for evaluation and advocacy that is based on sharing and recognising best practice in QI for community health. During phases 1 and 2, work improvement teams are trained in how to systematically monitor, assess and improve quality of community health services and they implement, test and evaluate at least 1 QI change plan using their own data. In Phase 3 representatives from each WIT will attend a learning event and will need to be told what to expect. This module covers that content and it is designed to be used by QI coaches during coaching visits to WITs.

## 7.2 Learning Objectives

By the end of the session participants will be able to:

1. List who will be at a learning event
2. Describe the objectives of a learning event
3. Prepare a poster presentation for a learning event as a team
4. Prepare a photo story
5. Review a WIT folder for quality

### Topic 1: Who should participate?

Explain that diversity is celebrated and a wide range of stakeholders should be invited to participate including:

- Policy makers (national/county levels)
- Partners
- managers (county and sub-county level)
- QI coaches and supervisors (CHAs)
- Health care providers (link facilities)
- Community health volunteers
- Community members

### Topic 2: What is a Learning Event?

Explain that a really important part of quality improvement is learning from other teams to stimulate creativity and innovation. Therefore, Learning Events are designed to be very interactive. Refer to the handout in the annex, Planning for a Learning Event.

The objective of a learning event is to provide a forum for:

- Learning and exchange of ideas
- Innovation
- Capacity development
- Recognition of best practice
- Evaluation of what worked/did not work
- Advocacy
- Identification of QI champions

### Topic 3: Preparing for the Poster Presentations

Explain the purpose of a poster presentation; to allow WITs to present their own work and see the results and impact of other WIT QI projects. WITs can learn from each other in terms of innovations, what worked well and what did not work well. WIT members can also challenge teams on their selected interventions and on the analysis of their data. This should help WIT members to critique each other's work, support each other and be open to a range of different solutions.

Using the PowerPoint slides gives an overview of how to develop a prize-winning poster. Include examples of good and poor posters and highlight the importance of a clear key message.

Discuss with the WIT members about the focus and key message of the poster they are planning. Remind them that a key message should:

- Cover an important problem or issue
- Be clear and easy to understand
- Illustrates what has been learned
- Be a single issue
- Describe something that has been done and learned

Pass out copies of the handout with clear marking criteria against which to present the results of their QI projects. Posters are normally hand assembled and designed using manila papers, marker pens and photos. Explain that a member of the WIT will be given 6-7 minutes to present the highlights and key message from their poster, take 2 minutes of questions and then 1 minute is given to peers and independent assessors to score the poster presentation before moving on to the next poster presentation.

### Topic 4: Photo Stories (only include if photo stories will be part of the learning event)

Describe to participants that an alternative way to capturing result of WIT efforts is through photo stories. Explain to WIT member that they will develop a photo story.

Pin up 4 example poster stories some good and some less good. Ask WITS to review the stories and judge them against the criteria. Criteria for photo stories are included in the table.

Photo	Text
<ul style="list-style-type: none"><li>• Attention grabbing photo</li><li>• High definition image</li><li>• Good photo composition</li><li>• Good lighting and colour</li><li>• Informed consent obtained</li><li>• Strong link between photo and text</li><li>• The photo should tell a story</li></ul>	<ul style="list-style-type: none"><li>• Attention grabbing title</li><li>• Clear and simple text</li><li>• Description of context</li><li>• Contains a quote from a beneficiary</li><li>• Highlight change because of WIT activity</li><li>• Human interest story</li><li>• Within 350 word limit</li></ul>



Give a presentation on how to take a good photo using the accompanying powerpoint presentation Using participant phones ask them to take some photos and take them through editing features like brightness, etc.

This method requires advance preparation so that WITs have time to take photos (with informed consent) and to develop the story around the photo. WITs may require support in writing up their stories. There are also printing costs relating to this method so that photos and text can be printed A3 size and displayed for judging and learning during the forum.

### **Topic 5: WIT folder preparation**

A learning event may include presentation of WIT folders which will be judged for accuracy, completeness, timely and good filing. Highlight that time taken to prepare the folder will be time well spent. Participants will need their WIT folders for this session. Ask them to work as a team to check the contents of the folder against the folder criteria refer to handout in the annex. Ask one participant in each group (perhaps the WIT chairperson) to read out the criteria and the others to state what is present and whether they feel it is adequate.

### **References/ additional Reading**

Learning Event Report, October 2017. <http://usaidsqale.reachoutconsortium.org/media/1039/learning-event-report-final.pdf>



# ANNEXES







## Module 1

### Quality Improvement Cycle

STAGE	ACTIVITIES
PLAN	<ul style="list-style-type: none"><li>• Establish Work Improvement Team (WIT) for Quality Improvement (QI) of community health services</li><li>• Agree on roles and responsibilities of WIT</li><li>• Agree on definition of high-quality community health services</li></ul>
DEFINE	Get to know Kenya Quality Model for Health (KQMH) Quality Standards for community health services
MONITOR	<ul style="list-style-type: none"><li>• Agree on relevant community-level health data indicators and facility-level health data indicators to monitor for a particular QI cycle</li><li>• Ensure collection and reporting of high-quality data for analysis and use in decision-making</li><li>• Review documentation of community health services activities</li></ul>
IMPROVE	<ul style="list-style-type: none"><li>• Step 1<ul style="list-style-type: none"><li>» Identify quality problems</li><li>» Prioritise quality problems</li><li>» Develop problem statement</li></ul></li><li>• Step 2: Root cause analysis to understand what is causing the problem</li><li>• Step 3: Develop solutions to address the causes of the problem</li><li>• Step 4: Develop QI change plan to implement solutions and test for change</li></ul>
EVALUATE	<ul style="list-style-type: none"><li>• Assess whether QI target(s) has been met<ul style="list-style-type: none"><li>» If yes, identify new quality problem to address and embed and sustain activities that led to achievement of QI target(s)</li><li>» If no, revise root cause analysis, revise QI change plan, implement revised QI change plan, monitor and evaluate revised QI change plan</li></ul></li></ul>

## Module 2

### Terms of Reference: Community Introduction

The Kenya Health Quality Improvement Policy (2015-2030) commits National and County governments to lead quality improvement by example and ensure quality is visible on every management and political agenda. The Ministry of Health has reviewed the Kenya Quality Model for Health and developed the Kenya Quality Standards for Community Health Services in 2015; the first time that standards have been developed for community health services in Kenya. Leadership is essential for Quality Improvement (QI) activities to succeed at all tiers of the health system, including community health units. County and sub-county leaders play a key role by creating a culture of QI in these devolved settings. This QI culture will foster a common understanding that data collected and analysed in the community unit will be used to improve the health of the communities they serve. At sub-county level, the team that will provide leadership and oversight on QI will be referred to as the sub-county Community Health Services (CHS) Work Improvement Team. This Terms of Reference sets out their roles and responsibilities.

### Purpose

The primary role of the community health unit CHS WIT will be to provide leadership for QI of CHS in their communities. CHU CHS WITS will report to the Sub-County WIT.

### Roles and Responsibilities

- Provide leadership for QI at community level
- Identify and mobilise key stakeholders to participate in QI activities
- Identify, analyse, develop and implement solutions for problems related to CHS
- Ensure accurate recording and reporting of CHS data
- Complete and analyse monthly CHS statistics
- Give feedback to the community, service users and link facility staff
- Factor quality improvement for CHS into the unit's quarterly work plans

### Team Composition

Each community health unit CHS WIT will be composed of 7-10 members, chaired by the CHAs. One team member will perform the functions of the Secretary to the sub-county CHS WIT.

MEMBERSHIP	NAMES	Signature
1. CHA (Chair)		
2. Link facility in-charge/facility QI team member (Chair)		
3. CHV		
4. CHV		
5. CHC member		
6. CHC member		
7. Chair of health facility management committee		
8. Adolescent (peer leader)		
9. Other		
10. Other		

## Procedure

1. The CHA/Link Facility in-charge will be the Chair of the CHU CHS WIT
2. One other team member will perform the functions of the Secretary to WIT
3. The team will initially meet monthly with an agreed agenda
4. Minutes of meetings shall be kept for all meetings
5. The secretary will be responsible for arranging meetings

CHAIR Community Health Unit, CHS WIT:

Name:

Signed County Director of Health:

Name:

Date:



## Terms of Reference: sub-county Introduction

The Kenya Health Quality Improvement Policy (2015-2030) commits National and County governments to lead quality improvement by example and ensure quality is visible on every management and political agenda. The Ministry of Health has reviewed the Kenya Quality Model for Health (KQMH) and developed the KQMH Quality Standards for Community Health Services in 2015.

This is the first time that quality standards have been developed for community health services in Kenya. Leadership is essential for Quality Improvement (QI) activities to succeed at all tiers of the health system, including community health units. County and Sub-County leaders play a key role by creating a culture of QI in these devolved settings.

This QI culture will foster a common understanding that data collected and analysed in the community health unit will be used to improve the health of the communities they serve. At sub-county level, the team that will provide leadership and oversight on QI will be referred to as the Sub-County Community Health Services (CHS) Work Improvement Team (WIT). At community level, the team that will provide leadership for delivery of high-quality community health services that is responsive to community-level health data is the Community Health Unit (CHU) Community Health Services (CHS) Work Improvement Team (WIT). This Terms of Reference sets out the roles and responsibilities of the Sub-County CHS WIT.

### Purpose

The primary role of the Sub-County CHS WIT will be to provide leadership for QI of CHS in their respective sub-counties. Sub-county CHS WITs will report to the Sub-County Health Management Team and the County Health Management Team and County QI Technical Working Group (TWG).

### Roles and Responsibilities

- Provide leadership and support consistent goals for quality of CHS at sub-county level
- Identify problems affecting quality of community health services and implement QI approaches including use of the QI Cycle (i.e. identification, analysis, development of solutions and implementation and testing of solutions)
- Ensure reporting of high-quality community-level health data
- Analysis and use of community-level health data in decision-making
- Monitoring and support community health units to meet KQMH Quality Standards for CHS
- Provide regular coaching and supportive supervision to CHU WITs and CHUs
- Encourage innovation and highlight success stories
- Identify priorities for CHS, manage QI budget and advocate for resources
- Identify and mobilize key stakeholders to participate in QI for CHS activities
- Ensure that QI for CHS is factored into Sub-County Work Plans and CHU Work Plans

## Team Composition

Each Sub-County CHS WIT should be composed of 7-10 members, chaired by the Sub-County CHS Focal Person and Sub-County QI Focal Person.

MEMBERSHIP	NAMES	Signature
1. CHA (Chair) 2. Link facility in-charge/facility QI team member (Chair) 3. CHV 4. CHV 5. CHC member 6. CHC member 7. Chair of health facility management committee 8. Adolescent (peer leader) 9. Other 10. Other		

## Procedure

1. The CHA/Link Facility in-charge will be the Chair of the CHU CHS WIT
2. One other team member will perform the functions of the Secretary to WIT
3. The team will initially meet monthly with an agreed agenda
4. Minutes of meetings shall be kept for all meetings
5. The secretary will be responsible for arranging meetings

CHAIR Community Health Unit, CHS WIT:

Name:

Signed County Director of Health:

Name:

Date:



## Topic 2: Quality Improvement

### Team structure, roles & responsibilities for CHS

Level	Roles & Responsibilities	Membership
National Level QI Committee for CHS	<ul style="list-style-type: none"><li>• Policy leadership, vision, strategy and oversight for embedding quality into CHS in Kenya.</li><li>• Formulate and update national standards and guidelines for CHS.</li><li>• Approve a KQMH curriculum and training package for level 1 personnel.</li><li>• Advocate for and institutionalize QA systems and QI methodology for CHS.</li><li>• Recognise and share best practice for QI of CHS.</li></ul>	<ul style="list-style-type: none"><li>• MoH (Community Health, Standards, MNCH, Child health, nutrition).</li><li>• County representation</li><li>• NGOs and partners</li></ul>
County QI Team	<ul style="list-style-type: none"><li>• Support consistent goals for quality of CHS at county and sub-county levels.</li><li>• Promote and enhance the skills of Staff and CHVs in quality improvement of CHS</li><li>• Provide coaching and supportive supervision to sub-county QI teams.</li><li>• Encourage innovation and highlight success stories.</li><li>• Maintain an equitable and appropriate distribution of human resources and logistics for CHS.</li><li>• Ensure that QI of CHS is factored into county and sub-county health plans</li><li>• Identify priorities for CHS and advocate for resources.</li></ul>	<ul style="list-style-type: none"><li>• Existing membership</li><li>• CHS focal person</li><li>• Sub-county QI representatives</li></ul>

Sub-county CHS WIT (Work Improvement Team)	<ul style="list-style-type: none"> <li>• Provide leadership and support consistent goals for quality of CHS at sub county level.</li> <li>• Review quality and performance data and provide quarterly progress reports to the sub county HMT/QIT.</li> <li>• Ensure accurate recording and reporting of CHS data.</li> <li>• Monitor and support community health units to meet CHS standards.</li> <li>• Provide regular coaching and supportive supervision to CHU WITs.</li> </ul>	<ul style="list-style-type: none"> <li>• CHS focal person (chair)</li> <li>• QI focal person</li> <li>• Records &amp; Information Officer</li> <li>• RMNCH Officer</li> <li>• Nutrition Officer</li> <li>• Health promotion Officer</li> <li>• CHAs (representing CHU WITs)</li> <li>• Other partners (up to 10 people)</li> </ul>
	<ul style="list-style-type: none"> <li>• Identify, analyse, develop and implement solutions for problems related to CHS.</li> <li>• Encourage innovation and highlight success stories.</li> <li>• Identify priorities for CHS, manage QI budget and advocate for resources.</li> <li>• Ensure that QI is factored into sub- county health plans and community health unit quarterly work plans</li> </ul>	
Community Health Unit CHS WIT (Work Improvement Team)	<ul style="list-style-type: none"> <li>• Provide leadership for QI at community level.</li> <li>• Identify and mobilise key stakeholders to participate in QI activities.</li> <li>• Identify, analyse, develop and implement solutions for problems related to CHS.</li> <li>• Ensure accurate recording and reporting of CHS data.</li> <li>• Complete and analyse monthly CHS statistics.</li> <li>• Give feedback to the community, service users and link facility staff.</li> <li>• Factor QI for CHS into CHU quarterly work plans</li> </ul>	<ul style="list-style-type: none"> <li>• CHA (chair)</li> <li>• CHVs (x2)</li> <li>• Link facility in-charge/ facility</li> <li>• QI team member (chair)</li> <li>• CHC member (x2)</li> <li>• Chair of Health Facility Management Committee</li> <li>• Adolescent (peer leader)</li> <li>• Other stakeholders (7-10 persons)</li> </ul>

## Module 3 Unit 1

### Group Supervision Tool

Who and When: Tool to be completed by supervisors during group supervision meetings.

NB: The tool should be accompanied with a signed attendance sheet.

#### Prior Preparation:

- Share meeting agenda with supervisees in advance.
- Prior feedback about the supervisees' work from observations made by the supervisor and/or from reports given by others
- Have a summary of the routine data for presentation.
- Group supervision should be carried out after a dialogue day in the event that the two occur in the same month

<b>Link Health Facility Name:</b>	<b>Date:</b>
<b>Community Unit Name:</b>	<b>Time meeting started:</b>
<b>County:</b> <b>Sub-County:</b>	<b>Time meeting finished:</b>
<b>Supervisor's Name:</b> <b>Role:</b>	

### Questions and Meeting Documentation

NB: Action points should be clearly defined in terms of what the action is, who is responsible for the activity, and when it is supposed to be done.

#### Supportive function questions:

- What went well?
- What challenges did you face? Have other encountered similar issues?
- What can be done to overcome the issues?

**Supportive Function (Preferably for one-on-one but may also come up in a group supervision session)**

Key issues discussed with the supervisees

Action Points with time frames:

Supervisor –

Supervisees -

## Administrative function questions

- Present a summary of routine data collected in the current month. Discuss data findings with the supervisees
- Discuss monthly reporting i.e. data quality, frequency of reporting
- Discuss referrals i.e. documentation and challenges
- Discuss home visits conducted in the week e.g. percentage of visits conducted by CHWs, matters arising from observations by supervisors, general action points
- Discuss dialogue days i.e. planning for the next one if not conducted yet e.g. how to mobilize and agenda. If one has been done, discuss problems identified at dialogue day, activity plans and their status
- Discuss other activities conducted in the month and matters arising e.g. action point, status. This can include action days, outreaches, and training.
- Provide feedback of the programme from others e.g. health facility staff, community, CHC meetings, SCHMT

### Administrative Function

Key issues discussed with the supervisees

Action Points with time frames:

Supervisor –

Supervisees -

## Educative function questions

- What are the gaps in competencies and how will these be addressed?

### Educative Function

Which topic(s) did you capacity build the supervisees on?

Action Points with time frames:

Supervisor –

Supervisees -

Group supervision: Attach signed attendance sheet	Date:
Supervisor's Signature:	Date:



## Home Visit Observation Checklist

Who and When: Tool to be completed by supervisor while supervising a CHV during an observed home visit. The tool is considered complete once the supervisor has given the CHV feedback and both parties sign the document signaling that a meeting has taken place.

### Prior Preparation:

- Supervisor should have knowledge of the catchment area assigned/ no. of households assigned to CHV(s) so as to ensure observations are spread out and not done for the same households
- Prior appointment with CHV(s) to allow for meeting preparation
- Prior permission should be sought from the household members

<b>Link Health Facility Name:</b>	<b>Date:</b>
<b>Community Unit Name:</b>	<b>Time observation started:</b>
<b>County:</b> <b>Sub-County:</b> <b>Household Observed:</b>	<b>Time observation finished:</b>
<b>Supervisor's Name:</b> <b>CHV's Name:</b>	

## Guidelines

- Have the CHV introduce you to the household members and thank them for having you
- Explain the purpose of your visit: To identify supervisory support areas which will ensure CHVs provide services that are satisfactory to the community
- Explain the need to take notes for follow-up and assure household of confidentiality
- Allow the CHV to conduct the visit as if you are not there

## A: Meeting Documentation

### Scoring System

0 = Not done

1 = Attempted with little success

2 = Achieved fairly

3 = Achieved successfully

N/A = Not applicable

Aspects of service being observed	Score	Comments
Rapport with household members		
Outline visit purpose and seeks consent		
Assurance of confidentiality		
Follows up on issues raised by household at previous visit e.g. uptake of referrals		
Uses MOH 514 Service Delivery Logbook as checklist and covers all stated areas		
Asks about each individual household member separately		
Gives household members time to talk and ask questions and listens to them		
Invites household members to define problems and guides them on possible solutions		
Identifies mothers who have delivered outside of healthcare facility (home deliveries) and require referral for postnatal care services (PNC) and refers appropriately		
Provides advice on <5 years children e.g. breastfeeding and immunisation		
Identifies antenatal care (ANC), immunisation and growth monitoring clinic defaulters by confirming at Mother and Child Booklet/ Clinic care and refers appropriately		
Provides advice on family planning and refers appropriately		
Identified sick household members and refers e.g. those with fever, diarrhea, cough, injuries		
Assesses and advises on prevention of Malaria		
Assess and advises on hygiene and sanitation at home		
Advises on proper nutrition		
Identifies those on TB and ART treatment and follows up on their adherence to care through assessment of clinic cards, pill count, etc.		
Provides Home Based Care knowledge to care givers of the ill		
Uses job aids to support information dissemination		
Asks for additional questions and concerns		
Hands out referrals form to household members		
Provides health Information, Education and Communication (IEC) materials		
Double checks the MOH 514 Service Delivery Logbook for completeness		
Thanks household members and agrees on next visit		

## B: Discussion of task that has just been observed

- Assess CHV's MOH 514 service delivery log book (and MOH 100 Community Referral Form if applicable) for quality of data recorded (accuracy, precision, completeness, integrity)
- Discuss observed task as per the observed aspects

### Action Points

CHV –

Supervisor –

CHWs Signature	Date:
Supervisor's Signature:	Date:

## One-on-One Supervision Tool

Who and When: Tool to be completed by supervisor during one-on-one supervision meetings. The tool is considered complete once the supervisor has given the supervisee feedback and both parties sign the document signalling that a meeting has taken place.

NB: If CHV supervision, the tool should be accompanied with a home visit observation checklist if completed after a home visit; and the tool should be accompanied with a signed attendance sheet if completed during a group supervision meeting.

### Prior Preparation:

- Share meeting agenda with the supervisee in advance.
- Prior feedback about the CHV's work from observations made by the CHA and/or from reports given by others.

Link Health Facility Name:	Date:
Community Unit Name:	Time observation started:
County: Sub-County: Household Observed:	Time observation finished:
Supervisor's Name: Role:	
Supervisee's Name:	

## Questions and Meeting Documentation

NB: Action points should be clear defined in terms of what the action is, who is responsible for the activity, and when it is supposed to be done.

### Supportive Function Questions:

- What has gone well for you?
- What challenges have you faced? Have others encountered similar issues?
- What can be done to overcome the issues?

#### Supportive Function

Key issues discussed with the supervisee

Has supervisee attended group supportive supervision sessions?

Action Points with time frames:

Supervisor –

Supervisees -

## Administrative function questions

- Give feedback of routine data collected in the month. Discuss data findings with the supervisee
- Discuss monthly reporting i.e. data quality, frequency of reporting
- Discuss referrals i.e. documentation and challenges
- Discuss home visits conducted in the week e.g. percentage of conducted by CHVs, matters arising from observations by supervisors, general action points
- Discuss dialogue days i.e. planning for the next one if not conducted yet e.g. how to mobilize and agenda. If one has been done, discuss problems identified at dialogue day, activity plans and their status
- Discuss other activities conducted in the month and matters arising. These can include action days, outreaches, and training for example.
- Provide feedback of the program from others e.g. health facility staff, community, CHC meetings, SCHMT

### Administrative Function

Key issues discussed with the supervisee

Action Points with time frames:

Supervisor –

Supervisees -



## Educative function questions

- What are the gaps in competencies and how will these be addressed?

### Educative Function

Which topic(s) did you capacity build the supervisee on?

Action Points with time frames:

Supervisor –

Supervisees -

## General Work Assessment (To be done quarterly or annually)

### Abilities, Knowledge and Skills

The degree to which the supervisee exhibits the knowledge and skills required to fulfill job duties.

### Attitude

Does the supervisee display a positive and cooperative attitude about his/her job role, assigned work, and the community unit? Is he/she open-minded and accepting of constructive feedback by peers?

### Communication Skills

Does the supervisee communicate clearly and effectively within his/her role? Does the supervisee express himself/herself clearly both orally and in writing?

### Cooperation

Does the supervisee work well with peers and supervisors? Does the supervisee willingly contribute to the success of the team or community health unit? Does the supervisee exhibit consideration for others; a willingness to help; and maintain a rapport with co-workers?

### Reliability

Does the supervisee properly follow instructions, directives, and procedures? Does the supervisee accept accountability for his/her work?

### Attendance and Punctuality

Review the supervisee's attendance and punctuality

### Problem Solving

The ability of the supervisee to solve problems quickly and efficiently

## Action Plan from General Work Assessment

**Assessor and supervisee to agree and document key action points.**

Supervisor –

Supervisee –

<b>Supervisor's Signature:</b>	<b>Date:</b>
<b>Supervisee's Signature:</b>	<b>Date:</b>

## Module 3 Unit 3

### QI Coaches for CHS Progress Report template - Community Health Unit level

	Date	Date	Date
WIT meetings			
Group supervision meetings with all CHVs			
Community dialogue days			
	Topic:	Topic:	Topic:
Action days			
	Activity:	Activity:	Activity:
Administration of Community Follow-Up Tool			
QI Coaching visits received from County level			
	Activity:	Activity:	Activity:
QI Coaching visits received from Sub-County level			
	Activity:	Activity:	Activity:

QI Coaches for CHS visit	
Main findings	
Recommendations	
Actions agreed upon	

## QI Coaches for CHS Progress Report template - County level

QI Coaches for CHS visit	
Date	
Site	
Activity	
(i.e. WIT meeting, group supervision meeting etc.)	
Main findings	
Recommendations	
Actions agreed upon	

## QI Coaches for CHS Progress Report template - Sub-County level

	Date	Date	Date
WIT meetings			
Group supervision meetings with all CHAs			
Data Quality Assessment (DQA)			
QI Coaching visits received from County level			
	Activity:	Activity:	Activity:
QI Coaching visits made to community level			
	Activity:	Activity:	Activity:

QI Coaches for CHS visit	
Main findings	
Recommendations	
Actions agreed upon	



## Module 6 Unit 2

### Prioritisation Matrix

	<b>Urgency of problem</b> 3 = Very urgent 2 = Urgent 1 = Not urgent	<b>Cost of resolving problem</b> 3 = Low cost 2 = Medium cost 1 = High cost	<b>Feasibility</b> 3 = Most feasible 2 = Quite feasible 1 = Least feasible	<b>TOTAL SCORE</b>
<b>Problem 1</b>				
<b>Problem 2</b>				
<b>Problem 3</b>				

## Module 6 Unit 3

### Problem Statement Cards (Sub-County)

#### **There are too many unskilled deliveries.**

In Elewisa Sub-County, between October – December 2017, only 54% of deliveries were skilled deliveries in a health facility. This increases the risk of maternal and newborn deaths.

#### **There is inadequate measurement of MUAC by CHVs.**

In Elewisa Sub-County, in March 2018, only 23% of CHVs measured mid-upper arm circumference (MUAC) during their household visits. This means that detection of acute malnutrition in households by CHVs is unlikely meaning that cases of acute malnutrition progress to moderate or severe acute malnutrition instead of being detected early and prevented from advancing through referral for management at facility level.

#### **Not all children are fully immunised.**

In Elewisa Sub-County, between January – December 2017, only 68% of children 0-11 months were fully immunised. This increases the risk of acquisition and transmission of infectious diseases that result in child morbidity and even child mortality.

#### **Most pregnant women do not complete 4 ANC visits before delivery.**

In Elewisa Sub-County, between October – December 2017, only 35% of pregnant women completed 4 antenatal care (ANC) visits before delivery. Limited contact with healthcare providers during pregnancy reduces the likelihood of detection of pregnancy-related complications and awareness amongst pregnant women of danger signs during pregnancy thus increasing the risk of maternal and newborn deaths.

#### **CHAs do not submit their monthly reports in a timely manner.**

In Elewisa Sub-County, between October – December 2017, only 50% of MOH 515 Summaries were uploaded to the Kenya Health Information System (DHIS2) by the 15th of every month by the Sub-County Health Records Information Officer. This results in unavailability of up-to-date community-level health data to inform decision-making during Sub-County Health Management Team meetings.

#### **CHVs do not visit households every month.**

In Elewisa Sub-County, between October – December 2017, only 22% of total households were visited by a CHV each month. This means that majority of households do not have regular contact with a CHV meaning they do not receive essential community health services such as identification and referral of defaulters from essential facility health services such as ANC and immunisation which contributes to maternal and child mortality.

#### **CHVs are not fully trained.**

In Elewisa Sub-County, as of January 2018, only 37% of CHVs are trained in all basic modules and technical modules of the national curriculum for CHVs. This means that CHVs are not able to deliver comprehensive community health services and may even convey incorrect health messages to community members. This decreases the likelihood of effective health promotion, decreases the likelihood of disease prevention and decreases the likelihood that that CHVs will have an impact on uptake of essential health services.

### **The quality of community-level health data is low.**

In Elewisa Sub-County, a Data Quality Assessment (DQA) of community-level health data reported between October – December 2017 found that for seven indicators assessed, 92% of the data verification ratios calculated for data reported in MOH 515 Summary versus that reported in MOH 514 Service Delivery Logbooks lay outside the target range of 90-110%. 67% of the data verification ratios calculated for data reported in the Kenya Health Information System (DHIS2) versus data reported in MOH 515 Summary lay outside the target range of 90-110%. These high levels of discrepancy in reporting of community-level health data reduce trust in community-level health data meaning that it is not used by Sub-County Health Managers or higher levels of the health system for decision-making.

### **CHVs are not making referrals.**

In Elewisa Sub-County, in January 2018, 60% of Community Health Units received a score of 1 (very poor) for KQMH Quality Standard for community health services 8.1- Cases requiring further management shall be referred to higher levels of care according to the referral guidelines.

Referral of defaulters from essential health services is a core function of CHVs as per Kenya's Community Health Strategy. Failure to identify and refer defaulters means that CHVs do not have impact on uptake of essential health services thus contributing to preventable maternal and child morbidity and mortality.

### **There is inadequate supervision of CHVs.**

In Elewisa Sub-County, in January 2018, 50% of Community Health Units received a score of 1 (very poor) for KQMH Quality Standard for community health services 13.6- There shall be monthly CHA/CHV meetings to receive activity reports and discuss service statistics data, experiences, challenges, lessons learnt and give feedback. Such meetings shall be convened by the CHA in charge.

Lack of supervision of CHVs means that challenges in service delivery affecting the quality of community health services are not addressed. This decreases the likelihood of effective health promotion, decreases the likelihood of disease prevention and decreases the likelihood that that CHVs will have an impact on uptake of essential health services. Furthermore, it means that community health services are not integrated into the rest of the health system and community-level health data is not used for decision-making.

## Problem Statement Cards (Community Health Unit)

### **There are too many unskilled deliveries.**

In Hazina Community Health Unit, between October – December 2021 only 54% of deliveries were skilled deliveries in a health facility. This increases the risk of maternal and newborn deaths.

### **There is inadequate measurement of MUAC by CHVs.**

In Hazina Community Health Unit, in March 2018, only 23% of CHVs measured mid-upper arm circumference (MUAC) during their household visits. This means that detection of acute malnutrition in households by CHVs is unlikely meaning that cases of acute malnutrition progress to moderate or severe acute malnutrition instead of being detected early and prevented from advancing through referral for management at facility level.

### **Not all children are fully immunised.**

In Hazina Community Health Unit, between January – December 2017, only 68% of children 0-11 months were fully immunised. This increases the risk of acquisition and transmission of infectious diseases that result in child morbidity and even child mortality.

### **Most pregnant women do not complete 4 ANC visits before delivery.**

In Hazina Community Health Unit, between October – December 2021, only 35% of pregnant women completed 4 antenatal care (ANC) visits before delivery. Limited contact with healthcare providers during pregnancy reduces the likelihood of detection of pregnancy-related complications and awareness amongst pregnant women of danger signs during pregnancy thus increasing the risk of maternal and newborn deaths.

### **Community members do not always understand the advice given to them by CHVs.**

In Hazina Community Health Unit, in January 2022, only 57% of household members who had been visited by a CHV in the last month, responded YES when asked if they understood the advice given to them by the CHV. If the advice given by CHVs is not understood by all their clients, this decreases the likelihood of effective health pro-motion, decreases the likelihood of disease prevention and decreases the likelihood that that CHVs will have an impact on uptake of essential health services.

### **CHVs do not visit households every month.**

In Hazina Community Health Unit, between October – December 2021, only 22% of total households were visited by a CHV each month. This means that majority of households do not have regular contact with a CHV meaning they do not receive essential community health services such as identification and referral of defaulters from essential facility health services such as ANC and immunisation which contributes to maternal and child mortality.

### **CHVs do not check Mother & Child Health Handbook during household visits.**

In Hazina Community Health Unit, in January 2022, only 28% of household members with at least one child in the house under 1 year, who had been visited by a CHV in the last month, responded YES when asked if the CHV checked the Mother & Child Health Handbook for each child in the house under 1 year to check that their immunisations are up to date. Failure of CHVs to review Mother & Child Health Handbooks to assess immunisation status means that immunisation defaulters are not identified and referred for immunisation thus increasing the risk of acquisition and transmission of infectious diseases that result in child morbidity and even child mortality.

### **CHVs do not check Mother & Child Health Handbook during household visits.**

In Hazina Community Health Unit, in January 2022, only 19% of household members with at least one pregnant woman in the house, who had been visited by a CHV in the last month, responded YES when asked if the CHV checked the Mother & Child Health Handbook of all pregnant women for evidence of ANC appointments. Failure of CHVs to review Mother & Child Health Handbooks to assess whether pregnant women are on track to complete at least 4 ANC visits before delivery means that ANC defaulters are not identified and referred for ANC thus increasing the risk of limited contact with healthcare providers during pregnancy which reduces the likelihood of detection of pregnancy-related complications and awareness amongst pregnant women of danger signs during pregnancy thus increasing the risk of maternal and newborn deaths.

### **There is inadequate supervision of CHVs.**

In January 2022, Hazina Community Health Unit received a score of (very poor) for KQMH Quality Standard for community health services 5.9 - There shall be monthly CHA/CHV review meetings to receive activity reports and discuss service statistics data, experiences, challenges, lessons learnt and give feedback. Such meetings shall be convened by the CHA in charge. Lack of supervision of CHVs means that challenges in service delivery affecting the quality of community health services are not addressed. This decreases the likelihood of effective health promotion, decreases the likelihood of disease prevention and decreases the likelihood that CHVs will have an impact on uptake of essential health services. Furthermore, it means that community health services are not integrated into the rest of the health system and community-level health data is not used for decision-making.

### **CHVs are not making referrals.**

In January 20, Hazina Community Health Unit received a score of 1 (very poor) for KQMH Quality Standard for community health services 8.1- Cases requiring further management shall be referred to higher levels of care according to the referral guidelines.

Referral of defaulters from essential health services is a core function of CHVs as per Kenya's Community Health Strategy. Failure to identify and refer defaulters means that CHVs do not have impact on uptake of essential health services thus contributing to preventable maternal and child morbidity and mortality.

Module 6 Unit 6

QI Change Plan Template

Name of Sub-County/Community Health Unit:				
Problem:				
Target:				
Activities (towards the solution)	By when? (date)	Persons responsible (named individuals)	Resources required	Evidence activity is being implemented (monitoring mechanism)



## **Module 7Topic 1: How to Plan a Learning Event**

### **Context**

A learning event requires time, effort, and resources. If there is no commitment to properly plan the event, learning will have less impact. Learning events should be as interactive as possible to ensure all voices from community members to policy makers are heard. To make it more inclusive and interactive, we recommend minimal use of PowerPoint presentations. By using a diverse and varied range of methods, community members and health volunteers can take a prominent role in describing the practical reality of their work on the ground to policy makers and managers. Therefore, learning events are less formulaic than traditional training workshops and should be tailored to county priorities and any additional capacity building needs of the sub-county and community work improvement teams. As the maturity of WITs deepens and their competencies and skills develop, so the scope and ambition of learning events may change over time.

### **Hosting a Learning Event?**

Leadership from County Health Management Teams and National Level are required alongside a pool of experienced facilitators (QI coaches) to plan, deliver and evaluate the event. Decisions on the focus/scope, objectives, expected outputs and methodology will determine the key elements of the programme. It is important that WITs receive early and clear communication regarding what preparations they need to make to present their work effectively and maximise their learning experience. It is also important that County allocates appropriate resources for the teams to be able to present their work and travel to the venue. Due to cost considerations, we recommend that three WIT members represent the WIT and that for each Learning Event WIT members rotate in turn.

### **How often should they happen?**

Learning events should take place on a six-monthly basis so that WITs do not lose momentum and continue to share experiences and learn from one another. Ideally counties could host one annual learning event and National Level could also host an annual learning event. These events should be programmed alongside other annual meetings to minimise additional costs.

### **Who should participate?**

Diversity is celebrated, and a wide range of stakeholders should be invited to participate including:

- Policy makers (national/county levels)
- Partners
- Managers (county and sub-county level)
- QI coaches and supervisors (CHAs and CHAs)
- Health care providers (link facilities)
- Community health volunteers
- Community members

Participants represent different cadres and levels in the health system, breaking traditional hierarchies. Learning events provide an advocacy window which allows community voices to be heard. WITs can also advocate for resources using their own analysed data as evidence of quality and performance of community health services.

## Methodologies employed for learning events

People learn in different ways. Some are more visual learners; some like to hear things and yet others will remember better if they have moved around or touched things. Enabling learning for all by appealing to the different ways people learn will increase the effectiveness of learning events. Keeping language and messaging simple is also vital. We recommend using a wide range of methods which provide multiple avenues for engaging participants including:

- Poster presentations and poster walkabouts
- World Café around topical/priority themes
- Panel discussions
- Photo stories
- QI innovation and impact awards

We also recommend introducing an element of friendly competition. For example, WITs are judged against clear criteria by peers and independent assessors for their poster presentations, photo stories and WIT folders. Recognising good practice and awarding certificates and modest prizes can motivate teams to perform better. Teams and individual also learn through assessing one another's work; this can result in healthy debate around how to engage communities and improve quality within existing resources.

### Poster Presentations and Poster Walk About

Poster presentations should be a core component of all learning events. The purpose of a poster presentation and walkabout is to allow WITs to present their own work and see the results and impact of other WIT QI projects. WITs can learn from each other in terms of innovations, what worked well and what did not work well. WIT members can also challenge teams on their selected interventions and on the analysis of their data. This should help WIT members to critique each other's work, support each other and be open to a range of different solutions. Posters are normally hand assembled and designed using manila papers, marker pens and photos. Therefore, as an organiser and facilitator you will need to ensure that there is sufficient wall space in the venue to display posters, that you can fix poster to the wall and that they are spaced well apart as it can become quite noisy.

### World Café

This method is used in large meetings for knowledge sharing to create a very interactive environment in which to:

- Explore questions
- Encourage everyone's contribution
- Connect different perspectives
- Look for patterns and insights
- Share discoveries

This requires significant preparation in advance of the event, in deciding the themes to be discussed and in coming up with question guides to be used by the facilitator and note taker for each work station. On each work station the facilitator leads a semi-structured group discussion around a specific theme and probes. Participants are divided into groups of around 12 people and each group get to move around 3-4 stands spending around 30 minutes on each stand. The facilitator builds on the knowledge/ experience of the previous group to answer all the questions. Excellent facilitation skills and note taking skills are required.

## **Panel Discussions**

This method provides an alternative space to power point for debating topical/priority themes. Through careful selection of panelists this allows debate between different cadres and levels. This does not require a high degree of preparation although a good chair and clear questions are required.

## **Photo Stories**

An alternative way to capturing result of WIT efforts is through photo stories. QI coaches ask WITS to develop a human-interest story to capture impact through relating a photo to text. This provides an alternative method for WITs to capture impact stories from their own communities. This method requires advance preparation so that WITs have time to take photos (with informed consent) and to develop the story around the photo. WITs may require support in writing up their stories. There are also printing costs relating to this method so that photos and text can be printed A3 size and displayed for judging and learning during the forum. A benefit of this approach is that contextual factors can be clearly highlighted through good photography.

## **QI innovations and Impact Awards**

QI projects are presented during the learning events and provide WITs with insights into how other teams are innovating and how their efforts at community level are impacting on link facility indicators. For the QI innovations award WITs are asked to submit a full proposal related to a specific problem area. After independent judging, small cash awards are granted to the winning applicants to implement their proposed intervention. QI impact awards have a theme related to a specific priority area. Sub counties and their community units compete against each other to make the biggest impact in relation to a key theme – e.g. four ANC visits. Impact is measured both at community level – e.g. increase in number of households visited, increase in number of referrals and at link facility level – e.g. percentage of pregnant women attending at least 4 ANC visits. These method works well in large groups and keeps people alert, giving participants a chance to exchange ideas, remain energised, provide insights and recount experiences on different themes.

## **Evaluating a Learning Event**

Learning events require excellent planning to be effective and excellent documentation to ensure learning is fully captured. If expertise does not exist within the county, then it may be advisable to bring in external technical assistance. As well as capturing learning from facilitated sessions it is also important to obtain feedback from participants. For large events we recommend using an evaluation questionnaire with ratings and one or 2 open questions at the end of the questionnaire.

## **Embedding and sustaining QI**

The very process of hosting regular learning events helps embed QI. Learning events can also help raise the profile of QI in community health services at county level and provides unique opportunities for interaction with senior policy makers and partners.

LSTM and LVCT Health are intending to publish a manual on how to design, deliver and evaluate Learning Events. Look out for this in 2020.

## Module 7 Topic 3: Scoring Sheet for Best Poster Presentation

Best Presentation: Scoring Sheet      Name of your WIT: .....

Each individual to score each poster using the matrix. Do not score for your own WIT.

For each WIT presentation mark each of the criteria from 1 to 5 and then total your score for each WIT presentation. The WIT with the overall highest score will receive formal recognition for their excellent work.

Scale: 1: very poor, 2: poor, 3: average, 4: good and 5: very good

Criteria	WIT 1	WIT 2	WIT 3	WIT 4	WIT 5	WIT 6	WIT 7	WIT 8	WIT 9	WIT 10	WIT 11	WIT 12
Clearly defined problem statement & target(s) set												
Rationale and Quality of root cause analysis												
Clear and practical QI change plan												
Display of data showing tracking of indicators												
Visual impact of poster												
Engagement with audience (passion and energy)												
Evidence of thinking about next steps and sustainability												
<b>TOTAL</b>												

## Module 7 Topic 4: Example Photo Story 1

### HDD Community Health Unit: The unthinkable again



**T**oo soon to forget. That early morning was punctuated, covered and engulfed with a sorrowful voice that seemed uncared for. It was Monday, the 22nd of May 2018. In HDD Community Health Unit, Dandora Phase 1 Ward of Kasarani Sub-County. The unthinkable had happened. Wangeci, a teenage, and a mother of three, had an encounter that she narrated with tears flooding her sorrowful cheeks. She had been woken up during the night by a disturbing cry. She peeped through her window and noticed her neighbours standing outside in a circular way, whispering in low tones. She rushed to the scene.

A tiny, trembling, lightly-dressed baby laid helplessly at the area's dumpsite, next to the Korogocho river. This shocked the community to the core. Wangeci did what only those with a Mother Theresa heart could do. She took the baby, rushed to her house, washed and then put her in warm clothes, and rushed to the nearby Administration Police (AP) camp and the area's Chief's camp, en route to the link facility, Dandora One Health Centre.

If Wangeci is not a heroine, show me where the ancient ones have been preserved. Upon arrival at the health centre, it was clear that the umbilical cord had not healed and the age of the baby was estimated as 3 days old. She weighed 2.9 kilograms and was in a stable condition. BCG and OPV vaccinations were administered and antibiotic medication was given as well. She weighed 3.0kg at 6 weeks, 3.1kg at 10 weeks and 3.59kg at 14 weeks.

Community Health Volunteers (providers of level one health services) have been carrying out weekly household visits to Wangeci and this child, giving express CWC services and advising Mary on nutrition. We were able to discourage bottle feeding and introduction of other foods. We have also networked with other organisations outside our Sub-County for the provision of nutritional management – St. Catherine's in South B. We gladly report that to date, the child is fully immunized as per the Kenya Expanded Program on Immunisation (KEPI) schedule as per those that should be received by 14 weeks of age. We are still working on the myths and misconceptions of our African traditions. Wangeci has since given birth to her fourth child.

“If it did not happen in the community, it never happened anywhere!” – Professor Miriam.



## Example Photo Story 2

### Kalwa/Kavuti CU



The above photo shows a community health worker Lenah Mwova giving health talk on immunisation services to household member Carol Ndanavi (HH number 7 as per MOH 513) during her home visit on 2nd August 2018. Carol's child is 9mths old and has never received immunisation services since birth.

The CHV was accompanied with a CHA, Samwel Abuya for assessment and monitoring in order to ensure data is entered correctly in MOH 514, a referral form is written followed-up and filed in a community file and the mother is well educated and empowered in timely and informed decision making in all aspects of health and sanitation. This has improved the monitoring performance and quality in community health services and hence universal health coverage with strengthened engagements. Through SQALE approaches we have witnessed increased immunisation coverage and a positive change in the other six (6) SQALE indicators.

This is through an effort of embedded quality activities which includes community dialogue and action days, monthly review meetings and home visits. During a previous CHV MCH clinic health talk I heard a beneficiary/client saying and I quote "through a referral form which I was given by my CHV helped me to take my child to be immunized against measles" "this indicates clearly how far we have gone with the referral system in our communities.

Also through aspects of data quality (accuracy, completeness, integrity, timeliness and reliability) we have increased the number of CHV referring and follow-up referrals from 62% to 100% as it was indicated in our problem statement and I quote " 62% of CHVs In Kalwa /Kavuti Cu do not follow-up referrals they make to check whether the clients received the services referred for hence late reporting and defaulter increase in ANC and PNC clinics.



### Example Photo Story 3

#### Meet Christopher Syengo a Community Health Volunteer Who is Changing Life in Masyungwa Community Health Unit, Mwingi North Sub County in Kitui County



Christopher Syengo Ngare was born 48 years ago in kitovoto village, a healthy and focused person. He drastically lost his eyesight at the age of 31 years. This affected his casual career in hotel industry at the coast town of Mombasa. He lost his job which he depended most for his ailing mother and family. It was not easy for him. Hopeless for life he relocated to his rural home. It took time for him to accept his situation. Through harmonious family support he attended a special course on Braille reading and mobility skills at machakos school for the blind.

Being a resourceful person in the community he was selected and appointed as a community health volunteer. He underwent modules

of training in community health strategy. He makes 100 % household visits through the help of his wife. Being knowledgeable on MOH 513, MOH 514 and MOH 100 he instructs the wife to fill in data and visualize the environment for health and sanitation. He gives health education, demonstrations and refers community members to the link facility. He is dedicated to his work and gives reliable and timely report to the Community health extension worker.

Through him pit latrine coverage in kitovoto village is 100% hence declared open defecation free village, 100% pregnant mothers delivering at health facility, all children are getting fully immunized and attending child welfare clinic. His contribution is enormous and he never gets late for meetings. His punctuality is marvelous. Because of his humor he is admired by his colleagues and community members.

He says “recognizing disability challenged people in community work enlightens parents with disabled children to educate and empower them to become independent and resourceful to the community since disability is not inability since one has to accept and move on to change life positively”.

## Example Photo Story 4

### Maili Saba CU



**M**aureen has a baby who is 4 months old. The birth weight of her baby was 3.2 kilograms. The Maili Saba Young Mothers' Breastfeeding Club was started when her baby was just 1 month old, weighing 3.8 kilograms. At this tender age, Maureen had started feeding the baby with refined pawpaw and salty water once per day; Maureen was following the advice of her mother-in-law because she was not convinced the baby was getting enough nutrition. After 3 months of training on the importance and benefits of exclusive breastfeeding for 6 months followed by inclusion of complementary foods thereafter, Maureen followed this health advice and her baby is now 8.1 kilograms and healthy and sleeping calmly, as opposed to her earlier experience with the baby.

## Module 7 Topic 5: Scoring Sheet for Best WIT File

All items should be accurate, complete, up to date and filed appropriately.

Please tick for each criteria if item is present in the Folder and insert a X if item is not present.

Criteria	WIT 1	WIT 2	WIT 3	WIT 4	WIT 5	WIT 6	WIT 7	WIT 8	WIT 9	WIT 10	WIT 11	WIT 12
Minutes of WIT meetings												
Minutes of group supervision meetings												
Minutes of dialogue days												
Signed ToR for WIT												
QI Action plan / change plan												
File is ordered and tidy												
Evidence of CHS programme monitoring												
DQA data available (sub-county)												
Community follow-up summary data available (CHU)												
QI coaching visit report												
QI maturity Index												
<b>TOTAL number of ticks</b>												

## Module 7 Topic 6: Criteria for Best Photo Story

Best Photo Story: Scoring Sheet ..... Judges Name: .....

Each individual to score each poster using the matrix.

For each Photo Story mark each of the criteria from 1-10 where 1 represents not present and 10 represent perfection.

Criteria	WIT 1	WIT 2	WIT 3	WIT 4	WIT 5	WIT 6	WIT 7	WIT 8	WIT 9	WIT 10	WIT 11	WIT 12
Attention grabbing photo												
High definition image												
Good photo composition												
Good lighting and color												
Strong link between photo and text												
Attention grabbing title												
Clear and simple text												
Description of context												
Contains a quote from a beneficiary												
Highlight change as a result of WIT activity												
Human interest story												
Within 350 word limit												



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## Quizzes (Sub-County)

### Quiz 1

1. What are the 7 Dimensions of Quality according to the World Health Organization (WHO) and Health System Global's Quality in Universal Health and Healthcare TWG? (7 marks)
2. Who are the 4 main groups of stakeholders in community health services? (4 marks)
3. Describe the Donabedian model and its main components. (6 marks)
4. What are the 5 stages of the Quality Assurance cycle? (5 marks)
5. What are the 4 steps of the Quality Improvement cycle? (7 marks)
6. What is the membership of a Sub-County CHS Work Improvement Team (WIT)? (8 marks)
7. What is the membership of a Community Health Unit Work Improvement Team (WIT)? (8 marks)
8. What are the qualities of an effective Work Improvement Team? (9 marks)

**Total: /54**



## Quiz 1 (Answers)

1. What are the 7 Dimensions of Quality according to the World Health Organization (WHO) and Health System Global's Quality in Universal Health and Healthcare TWG? (7 marks)

**Safe (1 mark) - Avoiding harm (doing the right things).**

**Timely (1 mark) - Reducing waiting times and avoiding delays (doing things at the right time).**

**Effective (1 mark) - Providing services that have been proven to work.**

**Efficient (1 mark) - Avoiding waste (effective use of resources).**

**Person centred (1 mark) - Respecting the needs of clients and their communities.**

**Equitable (1 mark) - Providing services fairly based on people's needs.**

**Integrated (1 mark) - Providing care that is coordinated across levels and providers and makes available the full range of health services throughout the life course.**

2. Who are the 4 main groups of stakeholders in community health services? (4 marks)

**Clients (1 mark) - This refers to community members in their households being visited by Community Health Volunteers (CHVs)/Community Health Extension Workers (CHAs).**

**Service Providers (1 mark) - This refers to CHVs, CHAs and primary healthcare facility staff.**

**Supervisors (1 mark) - This refers to CHAs (who supervise CHVs) and Sub-County Health Management Team members (who supervise CHAs and primary healthcare facility staff).**

**Managers (1 mark) - This refers to County Health Management Team members and National Ministry of Health staff.**

3. Describe the Donabedian model and its main components. (6 marks)

**The Donabedian model is a conceptual model that provides a framework for examining health services and evaluating quality of health care. The main components of the Donabedian model are:**

- **Structure (1 mark),**
- **Process (1 mark), and**
- **Outcome (1 mark).**

**These components are broken down as follows:**

- **Structure = Resources (inputs) (1 mark)**
- **Process = Activities (processes) (1 mark)**
- **Outcome = Results (outputs/outcomes) (1 mark)**

**The components of Resources (inputs); Activities (processes); and Results (outputs/outcomes) are as follows:**

- **Resources (inputs) = People, Infrastructure, Materials/drugs, Information and Technology.**
- **Activities (processes) = What is done and How it is done.**
- **Results (outputs/outcomes) = Health services delivered, Change in health behaviour, Change in health status and Client satisfaction.**
- **In order to deliver high-quality health services, we need to have the right inputs in place in order to ensure that we do the right things in the right way (processes) in order to achieve the outputs/outcomes that we want.**

4. What are the 5 stages of the Quality Assurance cycle? (5 marks)

**Plan (1 mark)**

**Define (1 mark)**

**Monitor (1 mark)**

**Improve (1 mark)**

**Evaluate (1 mark)**

5. What are the 4 steps of the Quality Improvement cycle? (7 marks)

**Step 1: Identify. (1 mark)**

**Step 1: Identify is broken down into 3 smaller steps:**

- **Identify quality problems. (1 mark)**
- **Prioritise quality problems. (1 mark)**
- **Develop problem statement. (1 mark)**

**Step 2: Analyse. (1 mark) - Step 2: Analyse is about root cause analysis to understand what is causing the problem.**

**Step 3: Develop. (1 mark) - Step 3: Develop is about development of solutions to address the causes of the problem.**

**Step 4: Implement and test. (1 mark) - Step 4: Implement and test is about implementation of these solutions and testing for change.**

6. What is the membership of a Sub-County CHS Work Improvement Team (WIT)? (8 marks)

**Community Health Strategy (Co-Chair) (1 mark)**

**Quality Improvement (Co-Chair) (1 mark)**

**MOH (1 mark)**

**Health Records Information Officer (1 mark)**

**Reproductive Health Coordinator (1 mark)**

**Public Health Nurse (1 mark)**

**Nutrition Officer (1 mark)**

**CHAs (representing Community Health Unit WITs) (1 mark)**

7. What is the membership of a Community Health Unit Work Improvement Team (WIT)? (8 marks)

**Facility In-Charge (Co-Chair) (1 mark)**

**CHA (Co-Chair) (1 mark)**

**Any other CHAs (1 mark)**

**CHVs (maximum of 3) (1 mark)**

**Chair of health facility management committee (1 mark)**

**Community Health Committee member (1 mark)**

**Community members (maximum of 2)**

- One of these should be for example: Chief, Assistant Chief, Village elder etc. (1 mark)
- One of these should be a young person aged 15-24 years. (1 mark)

8. What are the qualities of an effective Work Improvement Team? (9 marks)

Competent members (1 mark)

Team has clear goals that have been communicated to all and understood by all (1 mark)

Principled leadership (1 mark)

Standards of excellence (1 mark)

Results-driven (1 mark)

Unified commitment (1 mark)

A collaborative climate in which there is mutual trust and respect (1 mark)

The team has to be willing to take risks (1 mark)

Recognition and external support (1 mark)

Total: /54

## Quiz 2

1. What are the 3 main functions of supervision? (3 marks)
2. What are the qualities and skills of an effective supervisor? (6 marks)
3. What are 3 useful methods of supervision in community health services? (3 marks)
4. What are the 3 main roles of a Quality Improvement (QI) Coach for community health services (CHS)? (3 marks)
5. Why is coaching for Quality Improvement of community health services important? (7 marks)
6. How often should visits from QI Coaches for CHS happen? (2 marks)
7. What activities should a QI Coach for CHS engage in? (7 marks)
8. What is a QI Coaches for CHS meeting? (2 marks)
9. What are the typical agenda items for a QI Coaches for CHS meeting? (3 marks)
10. What are the six levels of Kenya's healthcare system? (6 marks)
11. What is the Kenya Quality Model for Health (KQMH)? (1 mark)
12. What are the objectives of the KQMH Quality Standards for CHS? (3 marks)
13. Describe the structure of a health information system (7 marks)
14. What are the data collection and reporting tools for community health services? (8 marks)

**Total: /61**

## Quiz 2 Answers

1. What are the 3 main functions of supervision? (3 marks)

**Administrative (normative) (1 mark)**

**Educative (formative) (1 mark)**

**Supportive (restorative) (1 mark)**

2. What are the qualities and skills of an effective supervisor? (6 marks)

**An effective supervisor is a Coach (1 mark)**

**Supportive (1 mark)**

**Good communication skills (1 mark)**

**Challenges supervisee in an effective way (1 mark)**

**Provides constructive feedback (1 mark)**

**Understands the group dynamics of his/her team (1 mark)**

3. What are 3 useful methods of supervision in community health services? (3 marks)

**Group supervision (1 mark)**

**One-on-one supervision (1 mark)**

**Home visit supervision (1 mark)**

4. What are the 3 main roles of a Quality Improvement (QI) Coach for community health services (CHS)? (3 marks)

**Facilitator (1 mark)**

**Trainer (1 mark)**

**Quality Improvement (QI) Expert (1 mark)**

5. Why is coaching for Quality Improvement of community health services important? (7 marks)

**Encourages mutual loyalty between the coach and the coachee (1 mark)**

**Increases retention and motivation of CHVs (1 mark)**

**Improves organisational performance (1 mark)**

**Creates a greater sense of involvement in the higher levels of the health system (1 mark)**

**Catalyst for an innovative work environment (1 mark)**

**To enable WITs and their leaders to sustain quality improvements in community health services (1 mark)**

**To enable WITs and their leaders to confidently use and apply Quality Improvement tools and approaches (1 mark)**

6. How often should visits from QI Coaches for CHS happen? (2 marks)

**Each WIT/Community Health Unit should be visited by a QI Coach for CHS at least once every quarter (1 mark); A QI Coach for CHS should make at least one coaching visit every quarter (1 mark).**

7. What activities should a QI Coach for CHS engage in? (7 marks)

**Attend and guide WIT meetings (1 mark)**

**Monitoring and evaluation of WIT progress using the following tools (1 mark)**

- **KQMH Quality Standards for CHS (1 mark)**
- **Documentation of previous coaching visits by QI Coaches for CHS (1 mark)**

**Identify success stories and lessons in best practice (1 mark)**

**Identify QI champions (1 mark)**

**Provide feedback and advocacy for community health services to Sub-County Health Management Teams and County Health Management Teams (1 mark)**

8. What is a QI Coaches for CHS meeting? (2 marks)

**A QI Coaches for CHS meeting provides a forum to evaluate progress across multiple sites and share lessons in best practice (1 mark). These meetings provide a convenient way for technical assistance to be provided to multiple WITs according to particular themes (1 mark).**

9. What are the typical agenda items for a QI Coaches for CHS meeting? (3 marks)

**QI Coaches for CHS Progress Reports (1 mark)**

**Presentation and analysis of community health information system data (1 mark)**

**Needs-based capacity building (1 mark)**

10. What are the six levels of Kenya's healthcare system? (6 marks)

**Level 1 – Community (1 mark)**

**Level 2 – Dispensaries (1 mark)**

**Level 3 – Health centres (1 mark)**

**Level 4 – Primary referral facilities (1 mark)**

**Level 5 – Secondary referral facilities (1 mark)**

**Level 6 – Tertiary referral facilities (1 mark)**

11. What is the Kenya Quality Model for Health (KQMH)? (1 mark)

**The KQMH Quality Standards for CHS is a book that provides standards for delivery of community health services (1 mark).**

12. What are the objectives of the KQMH Quality Standards for CHS? (3 marks)

**To ensure delivery of community health services that meet at least a minimum level of quality. (1 mark)**

**To ensure that community health services are responsive and sensitive to client needs and expectations. (1 mark)**

**To ensure that health managers and community health service providers apply principles of Quality Assurance and Quality Improvement. (1 mark)**



13. Describe the structure of a health information system (7 marks)

**Information needs/indicators (1 mark)**

**Data source (1 mark)**

**Data collection (1 mark)**

**Data collation (1 mark)**

**Data analysis (1 mark)**

**Data reporting (1 mark)**

**Use of information for decision-making (1 mark)**

14. What are the data collection and reporting tools for community health services? (8 marks)

**MOH 513 Household Register (1 mark)**

**MOH 513 Summary (1 mark)**

**MOH 514 Service Delivery Log Book (1 mark)**

**MOH 515 Community Health Extension Workers Summary (1 mark)**

**MOH 516 Community Health Unit Chalkboard (1 mark)**

**MOH 100 Community Referral Form (1 mark)**

**Community Treatment and Tracking Register (1 mark)**

**Support Supervisory Checklist (1 mark)**

**Total: /61**



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Division of Community  
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