Quality improvement for community health services: A strategy to improve performance and quality in Kenya

There are over 6000 maternal deaths in Kenya every year - one of the highest rates in the world. Community health programmes have been shown to reduce maternal deaths and improve child survival. Community health workers (CHWs) undertake various tasks to support this, including case management of childhood illnesses (e.g. pneumonia, malaria, and neonatal sepsis), delivery of preventive interventions such as immunization, promotion of healthy behaviour, and mobilisation of communities. In Sub-Saharan Africa, CHW programmes have been an important strategy to address the severe shortages of skilled health workers, particularly for the poorest and most vulnerable populations.

Evidence has shown that appropriately trained CHWs have the potential to address barriers to preventive and curative care, to bring care closer to communities, and provide accessible services relevant to the needs at household level. However, if community-based services are to be effective, it is important that CHWs receive appropriate support that spans training in different aspects of community health and quality improvement methods as well as receiving regular support supervision and coaching beyond the initial training when they are recruited.

Kenya has had a national community strategy since 2006 with revisions in 2011 and 2014. The country set a target following the Recife workshop in Brazil in 2014 to increase the number of community health workers from 2,100 to 44,000 by 2017. Investment in expansion of community health programmes has however been limited with varying opinions by Kenyan policy makers and county leaders on their effectiveness. Rather than additional rapid expansion, a priority for the Ministry of Health in Kenya in 2017 is to improve the functionality of existing community units which requires that CHWs are appropriately trained, have the right tools, and report through national mechanisms.

With the devolution of health services in Kenya in 2013, counties became responsible for financing community health but this has varied widely with some counties considering CHWs important for achievement of health goals and investing in them while others focus on curative services. Decisions are made in the absence of data and evidence and are based on the priorities of local politicians. It is important to demonstrate effectiveness of community health and the significance of community health in the broader health systems in order to gain local political support and more funding.

Globally, there has been interest in improving quality of health programmes with quality improvement (QI) gaining prominence. QI is a widely used management approach that engages multi-disciplinary teams from the bottom-up in developing solutions to resolve problems. QI interventions for community health, though few, have demonstrated results for maternal health. For example, in Tanzania more than 90% of women who had interacted with volunteers in a QI intervention village were going to a health facility for childbirth, compared with only around 60% of women in a non-QI intervention village.

In Kenya the updated Kenya Quality Model for Health (KQMH) was launched in 2014, QI teams have been active at facility level over the past six years with promising results. However until recently the KQMH model did not include community health services. In 2015 standards for community health services were published, however, robust mechanisms to track and support adherence to standards at community level have been lacking.

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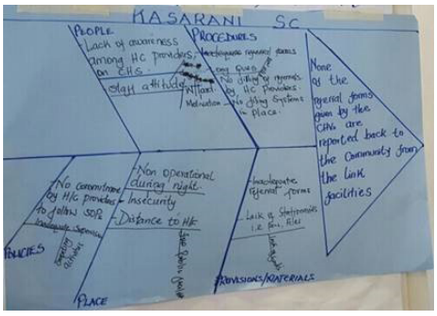
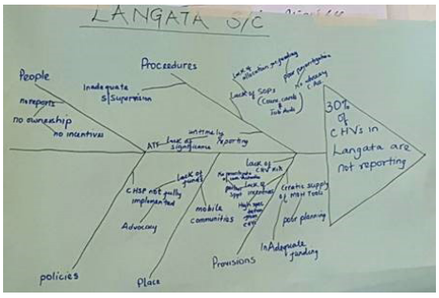
Methodology





Fishbone diagrams for Kasarani and Lang'ata sub-county WITS developed during QI phase 2 trainings

We conducted an intervention study to embed a culture of using data for QI in community health services in three Sub-Counties and nine community health units in Nairobi County in Kenya in 2015-2016. This was a follow up of an intervention study in 2014 to introduce a community health supervision intervention where Community Health Extension Workers (CHEWs) and CHW team leaders were trained on how to conduct group and individual supportive supervision.
The QI intervention entailed enhancing the capacity of health sector managers and implementers at Sub-County and community levels on how to conduct QI in community health with a key focus on improving data quality for community health services. We facilitated monthly Work Improvement Teams (WITs) to review data, identify problems and their root causes and develop and implement locally appropriate action plans to address the problems (figure 1) .

What we found

Both CHWs and their supervisors demonstrated an improved understanding of QI and appreciated its relevance for their work.

"It's what we had been doing before and that which was not being done. But now it has been improved a little than it was. And that is before we reach the level that is required for that service is needed in the village. It is that we have become enlightened about our work which has made us more responsible about our roles and what we are supposed to do. And there are no shortcuts. It's what you will follow step by step. Because it will have repercussions; you will see where you were and where you are presently. See, that is progress that you can take home when you reach that level. And once you reach that level, you see that it is a (higher) standard level. Then look at where you are headed."

(WIT participant, Nairobi)

Improved data quality

Before the intervention, data collected by CHWs was not accurate and could therefore not be used to assess the performance of community health programmes. A Sub-County respondent who conducted a Data Quality Audit (DQA) as part of the intervention suspected that CHWs were 'cooking' data:

"...from the DQA I would clearly tell that some of them don't understand the indicators; that was very apparent and I could also tell that some of them were cooking data because if you look at some data for three months, they have just been changing a two to a three; a three to a two or a one to a one."

(Sub-County Health Records Officer)

Feedback provided to CHWs on community health performance following the DQA improved the quality of the data collected and reported by CHWs:

"The numbers are impressive; the numbers of Community Health Workers reporting.... There are some indicators which they were not reporting but nowadays I see figures for deliveries especially skilled and I'm still observing."

(Sub-County Health Records Officer)

The capacity of CHWs improved as did the quality of their work

The QI change plans developed and implemented by the WITs identified specific capacity gaps among CHWs that resulted in improved quality of service delivery by CHWs:

"We also sensitized on the tools; the MOH 514, the summary that I do, the 515, and also the mother and child booklet. Yes they have also been sensitized by the nutritionist on the use of MUAC which they have also been given MUAC tapes to move around with at the household level. They can now monitor growth for the children in their household level."

(CHEW)

Other areas that many WITS identified as gaps and prioritized for improvement included improving referrals to health facilities by providing referral tools and following up on them. They followed up specific services which were underutilized in the link health facilities such as improved participation by under-fives in growth monitoring:

"...we have been doing the nutritional; what we had picked in our community units is the growth monitoring...we have moved by 3% up...we wanted to pick one item and move with it and we have also scaled up on growth monitoring. Last week we had gone to the Early Childhood Education Centers (ECDs) to do the growth monitoring of the children. We had involved the teachers and the parents for those children."

(Facility-in-Charge)

Unlike many interventions where the CHWs or facility members expected funding from NGOs to implement the change plan, the WITs focused on interventions that they could solve on their own including setting up referral desks and capacity building with CHWs during review meetings among others. The project only provided support for referral tools which the County was not able to print in time for the intervention.

Improved community-facility engagement

To ensure engagement of beneficiaries, community members were engaged as members of the WITs to aid in developing and implementing solutions for improved service uptake by community members. WITs appreciated the need to engage community members in monitoring of their QI efforts, getting feedback on their QI activities, and observing changes as a result of the QI plans. Supervisors also conducted checks and observation in the community to follow up on the effects of the QI changes:

"And then from doing spots at the village you find the community are also understanding like the importance of the mother and child booklet, the importance of taking the child to the facility, the importance of good nutrition for their children, the importance of attending the clinic, the pregnant mothers and also delivering in the facility."

(CHEW)

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Lessons learned

The key facilitators of QI among CHWs:

1. **Supportive supervision of CHWs by their supervisors.** In sites where CHEWS and Sub-County supervisors offered regular supportive supervision sessions with CHWs as part of QI, there was a reported change in the quality of data collected by CHWs, an increase in the number of households covered by CHWs, and improved timeliness in reporting.

2. **Training and continued mentorship and coaching on QI.** A one-off training was not enough to sustain learning. A phased approach with incremental learning proved effective. The participation of QI coaches during WIT meetings helped to reinforce the learning and correct implementation of QI approaches to improve quality of services.

3. **Availability of tools and commodities.** Lack of commodities such as basic medicine, family planning commodities and HIV and malaria testing kits, by CHWs was reported to hinder delivery of good quality services and was a cause of frustration among community members. Lack of reporting tools directly affected the quality of reports interfering with the ability of CHWs and facilities to assess performance and improve services.

4. **Team approach to implementation.** WITs had to be formed from among the CHWs, the CHEW, the Facility-in-Charge, and community members to strengthen referrals and community-facility linkage that were found to be a gap at the beginning of the intervention. Having a Facility-in-Charge as part of the community WIT was a motivator for CHWs who reported that it has improved the relationship between CHWs and the facility and served as a motivator for CHWs. The diversity of the team allowed different team members to take up responsibilities aligned to their strengths.

Recommendations for policy and practice

The study demonstrates that a QI approach at community level is both acceptable and feasible and can be implemented within the existing community health programmes. QI is not a new approach in Kenyan health system, however QI at community-level is novel. The project demonstrates that it enhances community linkage with the facility - a priority of community health programmes which has not always been successfully implemented.

QI approaches improve the quality of services delivered and reported by existing CHWs and their overall performance by improving their efficiency and effectiveness and contributes to overall achievement of County and Country primary health care goals.

Supervision and QI may not only improve performance of CHWs but also raise awareness of their role, legitimize their role in the community, and improve CHW motivation and retention.

1. Policy makers should ensure that QI is a priority in CHW policies, trainings, and funding priorities. This would enable the existing community health structures function optimally and achieve desired impact before having to invest in the more difficult process of increasing the number of CHWS.

2. By supporting implementation of QI for community health, health managers at County or district and facility level would benefit from improved results and motivated CHWs and community members who utilize services and are actively engaged. Managers should facilitate the process by providing the necessary tools, commodities, and ensuring supervision and feedback to and from CHWs and community members takes place consistently.

3. Alongside increased funding for community health services, donors need to prioritize QI in programme design to increase the efficiency, effectiveness, and impact of community health programmes.

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