THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

COMMUNITY QUALITY IMPROVEMENT FRAMEWORK (CQIF)

Health Quality Assurance Division

First Edition

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Foreword

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) is committed to ensure that high-quality health and social welfare services are provided to all citizens countrywide through implementation of evidence-based interventions. The Health Sector Strategic Plan Number Four (HSSP IV): July 2015 – June 2020 pledged to increases efficiency through more integration and capitalizing synergies, improve quality of services through better performance, enhance partnerships and prioritize where to gain more value for money.

The main objective of HSSP IV is to reach all households with essential health and social welfare services, meeting as much as possible expectations of the population and objective quality standards applying evidence-based, efficient channels of service delivery. All five specific objectives of HSSP IV (Attain objectively measurable quality improvement of primary health care services; Improve equity of access to services by focusing on geographic areas with higher disease burden and vulnerable groups; Achieve active community partnership through intensified population interactions for better health and social wellbeing; Applying modern management methods and innovative partnerships; Improve social determinants of health through inclusion of health protection and promotion) are calling for concerted actions focusing on community quality services.

Development of this framework is a major step towards responding to quality of care challenges in a comprehensive and systematic manner and geared to the five specific objectives of HSSP IV. This document provides decision-makers at different levels with a systematic process that will allow them to design and implement effective interventions that promote use of quality improvement approaches.
Conceived as a capacity-building tool in community health and social welfare quality of care, this framework focuses attention on four levels that include the client, the care teams, the organizations and the environment. The client has the role of understanding his/her rights, demanding for quality services, caring for others and providing feedback on the quality of service received. The care teams are obliged to provide quality services, but also continuously improve quality. The organizations oversee the work of care teams while the environment entails provision of policy guidelines and resources to support interventions. The reason for this approach is to ensure that the importance of each level in planning and institutionalizing QA/QI approaches is underscored.

The framework for improving quality of community health and social welfare services is developed to provide guidance and influence the thinking, planning and delivery of services in different community settings. It provides a strategic approach to improving quality at the frontline (Wards, Village/Mtaa), subnational (Local Government Authorities, Regions) and National levels.

The aim of the framework is to foster a culture of quality that continuously seeks to provide community health and social welfare services in the context of all dimensions of quality. For frontline teams and improvement initiatives, the framework will serve as a reminder of the key areas that consistently require focus to ensure successful and sustainable improvements in the quality of care. It provides guidance that can be used to develop quality improvement work plans at various levels focusing on community interventions. All work to improve the quality of care through applying this framework recognizes the significant constraints that health and social welfare services continue to face.

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Acknowledgements

The first Community Quality Improvement Framework (CQIF) is a product of intensive work by the MoHCDGEC through the Health Quality Assurance Division through a consultative process with key stakeholders.

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Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AIHA	American International Health Alliance
ART	Anti-Retroviral Therapy
ASSIST	Applying Science to Strengthen and Improve Systems
CBHS	Community Based HIV and AIDS Services
CBOs	Community Based Organizations
CHQIF	Community Health Quality Improvement Framework
CDC	United States Centers for Disease Control and Prevention
CHW	Community Health Worker
CHMT	Council Health Management Team
CSOs	Civil Society Organisations
FBOs	Faith Based Organisations
FP	Family Planning
GBV	Gender Based Violence
HEI	HIV Exposed Infants
HCWs	Health Care Workers
HSSP	Health Sector Strategic Plan
HTS	HIV Testing Services
IP	Implementing Partner
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MVC	Most Vulnerable Children
NACP	National AIDS Control Program
NACS	Nutrition Assessment Counselling and Services
NHSWQISP	National Health and Social Welfare Quality Improvement Strategic Plan
NPA-VAWC	National Plan of Action to End Violence Against Women and Children
PDSA	Plan, Do, Study, Act
PMTCT	Prevention of Mother to Child Transmission of HIV
PO-RALG	President's Office - Regional Administration and Local Government
QA	Quality Assurance
QI	Quality Improvement
QIT	Quality Improvement Team
RHMT	Regional Health Management Team
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
SWAs	Social Welfare Assistants
TQIF	Tanzania Quality Improvement Framework
UNAIDS	United Nation for AIDS
USAID	United States Agency for International Development
VAC	Violence against Children
VMAC	Village AIDS Multisectoral Committee
WCPC	Women and Children Protection Committee
WIT	Work Improvement Team

Glossary of Terms

Mtaa	Equivalent of a village but located in urban or semi-urban area

Chapter 1: Background, Assumptions and Basic QI Concepts

1.1 Background and Assumptions

For many decades the medical profession has accumulated enough evidence and experience in enhancing healthcare through application of improvement and implementation sciences. Despite this, many healthcare settings, especially in the developing world, have not embraced Quality Improvement (QI) approaches during designing and implementation of different interventions. Integration of QI methods in designing and implementation of healthcare interventions in the developing countries, including Tanzania, is slow and largely uncoordinated as it is mostly introduced through vertical projects such as HIV and AIDS, TB, Malaria and Reproductive Health.

The first edition of the Tanzania Quality Improvement Framework (TQIF) was developed in 2004 and this was the first attempt to escalate the quality of health care agenda to an actionable arrangement. The framework aimed at elevating culture of quality improvement among service providers and stakeholders. The framework outlined what needed to be done to improve and institutionalize quality of health care in the country. The second edition produced in 2011 (TQIF 2011-2016); responded to policy changes and incorporated several QI initiatives and approaches that had been introduced.

A Situation Analysis of Quality Improvement in Health Care (2012) that was conducted through support of USAID/Health Care Improvement Project identified a weak community QI component. It was therefore recommended that a QI monitoring tool for Community Based Health Care and Home-Based Care need to be developed[1].

The first National Health and Social Welfare Quality Improvement Strategic Plan (NHSWQISP 2013-2018)[2] that was produced to operationalize the TQIF 2011-2016 was instrumental in the use of QI methods for health programing in Tanzania. Several hospitals established Quality Improvement Teams (QITs) and Work Improvement Teams (WITs); however, challenges were still eminent on rendering the teams active and the above site QITs were nonexistent or nonfunctional in many regions, according to Site Improvement Management System (SIMS) assessment reports. A rapid scan conducted by the National AIDS Control Program (NACP) in collaboration with American International Health Alliance (AIHA) in 2018, which assessed the extent of integration of quality improvement into Community Based HIV and AIDS Services (CBHS) found that two thirds of the studied councils (n=17) had no functional CBHS QI teams and 60% of the service providers reported to have been supervised for the past 6 months.

Experience drawn from USAID ASSIST project as they rolled out QI in community based interventions, suggest two main paths that community-level improvement can take; improvement through community-level providers; and/or engaging the wider community to support health care providers to promote community health. For the first approach, engage local leaders and stakeholders to set up teams of service providers to look at their processes and content of services; Service providers for

orphans and vulnerable children, for example, would form a team or add improvement activities to an existing committee to review their processes for identifying vulnerable children and families, assessing needs, referring to service providers, and follow up. In all cases, a simple training to the improvement teams on setting aims, using an indicator, analyzing their current situation and processes, developing changes, and using the PDSA is important. Since literacy levels can be low to non-existent, this is often activity-based training. Work with local government officials and leaders to help teams create or strengthen data systems and, most importantly, mentor them on how to review and use data on a frequent basis to determine whether what they are doing is working[3].

A cluster randomized controlled trial to investigate the effectiveness of a CQI intervention amongst CHWs providing home-based health education among pregnant and postnatal mothers; indicated that mothers served by intervention CHWs were more likely to have received a CHW visit during pregnancy (75.7 vs 29.0%, $p < 0.0001$) and the postnatal period (72.6 vs 30.3%, $p < 0.0001$). Intervention mothers had higher maternal and child health knowledge scores (49 vs 43%, $p = 0.02$) and reported higher exclusive breastfeeding rates to 6 weeks (76.7 vs 65.1%, $p = 0.02$). HIV-positive mothers served by intervention CHWs were more likely to have disclosed their HIV status to the CHW (78.7 vs 50.0%, $p = 0.007$). It was concluded that improved training and CQI-based mentoring of CHWs can improve quantity and quality of CHW-mother interactions leading to improvements in mothers' knowledge and infant feeding practices[4].

Another experience is drawn from the Partnership for HIV Free Survival (PHFS), a multi-country initiative that supported national efforts towards elimination of new HIV infections among children and keeping their mothers alive. In Tanzania, three districts of Nzega (Tabora), Mufindi (Iringa) and Mbeya City Council (Mbeya) were involved. The initiative largely utilized QI approach to integrate PMTCT and Nutrition Assessment Counseling and Services (NACS) with a remarkable facility-community linkage through CHWs, peer mothers and community volunteers. The final report revealed that 10 improvement teams increased retention of HIV positive mother-baby pairs from 18% - 91% (Mbeya); 0% - 82% (Mufindi) and 0% - 90% (Nzega) between June 2013 and December 2015[5].

1.2 Basic Concepts of Quality Improvement

1.2.1 Definitions and the Dimensions of Quality

There is need to have a working definition of "quality" in health and social welfare systems as our starting point to be able to understand how to design interventions and measures used to improve results. There are many definitions of quality used both in relation to health care, social welfare services and health systems, and in other spheres of activity. The focus of this framework is on community health and social welfare systems and the quality of the outcomes they produce. For this reason, this working definition needs to take a whole-system perspective and reflect a concern for the outcomes achieved for both individual service users and whole communities.

The WHO definition of quality of care is “the extent to which health care services provided to individuals and patient populations improve desired health outcomes. It suggests that a health system should seek to make improvements in nine areas or dimensions of quality, which are named and described below.

Technical Performance

The degree to which the tasks carried out by health workers and facilities meet the expectations of technical quality (comply with standards). Technical performance refers to the skills, capability, and actual performance of health providers, managers, and support staff.

Effectiveness of Care

This dimension refers to the degree to which desired results (outcomes) of care are achieved through appropriate diagnosis and treatment. It requires the provision of appropriate services based on scientific knowledge to all who could benefit, refraining from providing services to those who would likely not benefit and avoiding underuse and overuse of treatment or services. Success of service delivery is measured based on the expected outcome of doing the right thing for the right person at the right time.

Efficiency of Service Delivery

Efficiency refers to the use of minimum resources to achieve desired results. This is an important dimension of quality because it affects product and service affordability and because health and social welfare care resources are usually limited. When we provide optimal rather than maximum care to the patient and community, we provide the greatest benefit within the resources available.
Poor care resulting from ineffective norms or incorrect delivery should be minimized or eliminated. In this way, quality can be improved while reducing costs. Harmful care, besides causing unnecessary risk and patient discomfort, is often expensive and time-consuming to correct. It would be misleading, however, to imply that quality improvements never require additional resources. But by analyzing efficiency, health facility and community supervisors may select the most cost-effective interventions.

Safety

Safety refers to the degree to which the risks of accidental or preventable injury, infection or other harmful side effects produced by medical care are minimized. Safety requires a system of care delivery that prevents errors, learns from the errors that do occur and is built on a culture of safety that involves health care providers and patients.

Access to Services

Access to services refers to the degree to which healthcare and social welfare services are accessible by all; not restricted by geographic, economic, social, organization or linguistic barriers.

Interpersonal Relations

Positive interpersonal interaction between client and provider can play a large role towards proper service provision and high client satisfaction. Positive interpersonal relations can be defined by a close, friendly or pleasant association between two or more people, often based on regular business interactions or social commitment that may be brief or long term. Interpersonal relations are enhanced when confidentiality, trust, respect, responsiveness, empathy, and effective communication is practiced between providers and clients. Providers are primarily responsible for initiating this type of interaction.

Continuity of Services

Continuity of services refers to uninterrupted and consistent services that are provided to the population/community. Continuity means that the client receives the complete range of health and social welfare services that he or she needs, without interruption or unnecessary repetition of assessment and identification exercises. Services must be offered on an ongoing basis. The client must have access to routine and preventive care provided by a health and social welfare worker who knows his or her medical history or social ties background. A client must also have access to timely referral for specialized services and to complete follow-up care and support.

Physical Infrastructure and Comfort

The physical infrastructure and comfort of the facility in relation to physical appearance, provision of privacy, and other aspects are important to clients.

Choice of services

The client can decide which facility to attend, time to seek health care and treatment plan.

1.2.2 The Six Principles of Quality Management

Quality management principles are a set of fundamental beliefs, norms, rules and values that are accepted as true and can be used as a basis for quality management. The Quality Management Principles are used as a foundation to guide an organization's performance improvement. The principles of Quality Management apply equally to every area, function, and person in the organization. The principles are:

- Focus on clients' needs and expectations
- Focus on communication and gaining feedback
- Focus on team and teamwork
- Focus on Measurements of Quality of Health Services
- Focus on systems and processes
- Leadership

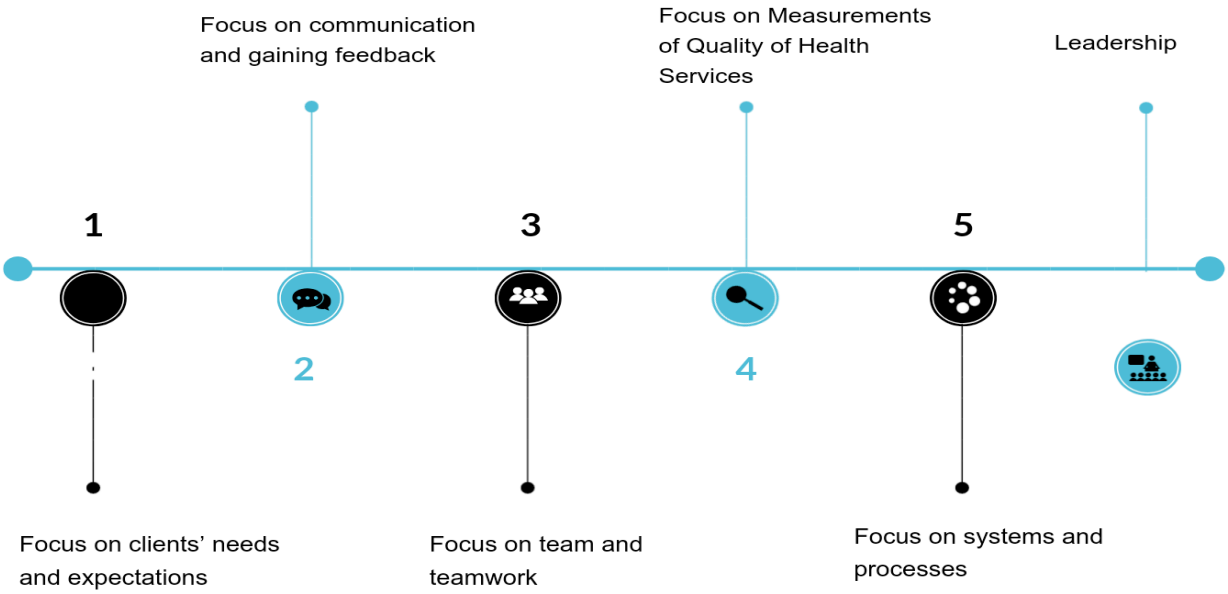

Figure 1: Principles of Quality Management.

Focus on Clients' Needs and Expectations

Health care and social welfare services need to be comprehensive and broad enough to meet all common needs and expectations of the clients' and surrounding community. A client is a person or organization using services of a professional person or organization. In health setting there are two types of clients; External clients being individuals accessing a facility to receive services (e.g. patients in health care setting) and internal clients being individuals involved in the delivery of care (e.g. doctors, nurses and administration). In social welfare setting there are three types of clients, namely; involuntary (normally these clients are referred or linked by community member), voluntary (client who is aware of own problem/need) and none voluntary (these are clients who are aware of their own problem/need and demand for specific services) Knowing the needs of clients both felt and unfelt is important for health facility or institution or community level social welfare service points in identifying issues related to quality improvement. Felt needs are those, which a client is aware of, while unfelt needs are those that the client is unaware of. For a quality improvement Program to succeed it must carefully identify its clients and learn their needs and expectations and then find ways to meet them.

Focus on Communication and Gaining Feedback

Communication is the transfer of information from one person to another for sharing the idea or information verbally or non-verbally (via speech, writing or physical signs/gestures). Effective communication is essential for ensuring quality services and client satisfaction. Communication occurs at several levels of interaction (client/provider; health system/community; provider/

management and between providers) within the health care system. Effective communication builds a relationship of trust, understanding and empathy with the client and shows humanism, sensitivity and responsiveness. Barriers to communication such as language used, channel used to convey message and message content can affect the quality of service. It is very important to be aware of these barriers in health care service delivery as their presence can severely affect quality of service and client satisfaction.

Feedback is an important component of communication in health care setting as it opens channels for clients to express opinion on the service provided. Providing feedback is important to fostering communication with clients and working towards ensuring clients' satisfaction. After obtaining clients' feedback the health service providers need to work on them, by devising improvement plans to address the clients' suggestions.

Focus on Team and Team Work

Improving quality of the system requires people working in different parts of the system to work together in a coordinated manner and to focus on realization of the same main goal. When people work in teams, they can combine their talents, skills and efforts to accomplish results that individually they would not be able to do. Having an effective teamwork requires leadership, participation of team members in analyzing system deficiencies, agreeing on changes to be made and meeting regularly to evaluate progress. The team should also be able to lobby, sensitize, and share information with others on what they are doing and to get leadership support for incorporation of the QI plan into the overall plan of the health facility.

Focus on Measurements of Quality of Health Services

Measurement is critical to quality improvement initiatives because it provides information about how the objective for improvement is being achieved. Comparing collected data on a process of care under assessment with standard requirements reveals the gap i.e. what should be improved. Measurements provide objective information that allows the development and testing of changes, as well as monitoring progress after a change has been implemented.

In implementing QI, it is important to use data to measure components of a system that includes inputs, processes and outcomes. Data is needed to determine the baseline performance status, decision-making, planning, monitoring and evaluation. Quality improvement efforts should be focused on evidence-based practice using correct, complete and current data.

Measuring quality requires the development and application of performance measures or indicators against which to make judgement on the level of quality. Indicators are based on agreed standards and are evidence-based; they provide a quantitative basis for health service providers, organizations, and planners to achieve improvement in health services and the processes by which health services are provided. Indicators can be related to structure, process, or outcome of health services.

Focus on Systems and Processes

Quality improvement views all health services offered as a product of interactions of interdependent parts of a system made up of three components: input, process and output. Health service delivery involves several processes occurring simultaneously, each affects the quality of services offered. Inefficiencies in providing health services is directly related to systems and processes; therefore, it is essential for health service providers to understand systems and processes to be able to narrow quality gaps and improve services given to clients.

Every system is perfectly designed to achieve exactly the results that need to be achieved. A system left unchanged can only be expected to continue to achieve the same results it has been achieving. To achieve a different level of performance, it is essential to change the system in ways that enable it to achieve that different level of performance.

Each system has its own processes that are often based upon the needs of the system. Processes can cause inefficiencies due to problems during execution or transition from one step to the other. In designing and implementing QI activities a system view (inputs, processes and outputs) should be considered and a fragmented approach must be avoided.

Leadership

Leadership is a critical component for any organization seeking to drive improvements in health care quality and patient safety[6]. Leaders establish unity of purpose and direction of the organization. They should create and maintain the internal environment in which people can become fully involved in achieving the organization's improvement objectives. Effective leadership makes people understand and motivated towards the organization's goals and objectives, help with improvement evaluation and implementation in unified way and minimize mis-communication between levels of an organization[7].

Application of this principle leads to; Considering the needs of all interested parties, establishing a clear vision of the organization's future, setting challenging goals and targets, creating and sustaining shared values, fairness and ethical role models at all levels of the organization, establishing trust and eliminating fear and providing people with the required resources, training and freedom to act with responsibility and accountability.

1.2.3 Quality Improvement; Definition and the Quality Improvement Model

Defining Quality Improvement

Quality Improvement is a systematic process of assessing performance of the health system and its services, identify gaps and causes, and introducing measures to improve quality and monitoring the impact. Also, Quality improvement can be defined as the combined and unceasing efforts of everyone i.e. healthcare providers and educators, patients and their families, researchers - to make the changes that will lead to better patient outcomes, better experience of care and continued development, and supporting of staff in delivering quality care[8].

Quality Improvement Model

The Model for Improvement (API), developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement. The model of improvement is a strategy to systematically and effectively manages change having two parts that are interdependent;

Part one: Three fundamental questions;

- What are we trying to accomplish?
- How will we know that a change is an improvement? and
- What changes can we make that will result in improvement?

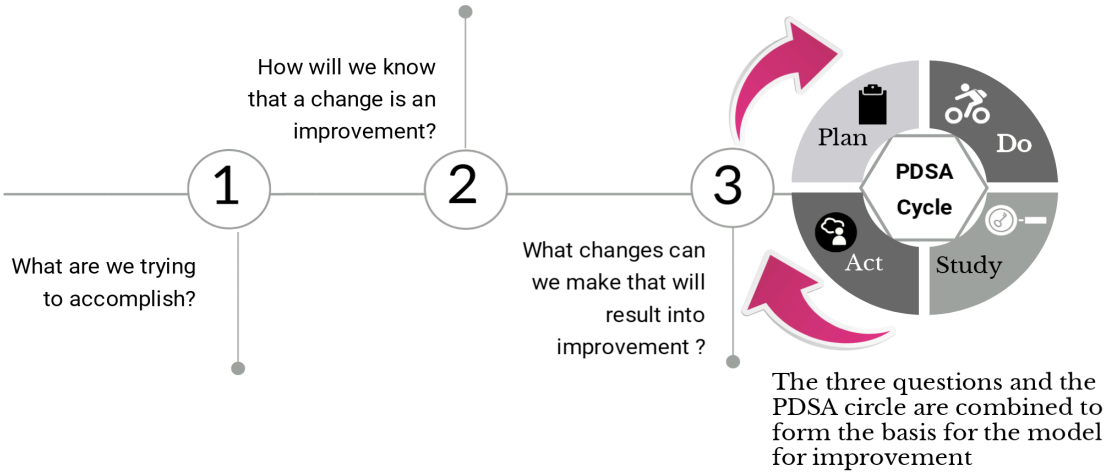

Figure 2: PDSA Model and the three questions for improvement

Adapted from Nolan Model Diagrams Associates in Progress Improvement (API)

These three questions provide the basis for making any sort of improvement through test and learning, the use of data and the design of effective changes.

Part two: Plan-Do-Study-Act (PDSA) cycle to test and implement changes in real work settings. To facilitate the development of tests and implementation of changes, the Plan, Do, Study and Act (PDSA) cycle will be applied. The cycle begins with a plan and ends with an action based on the learning gained from the Plan, Do and Study phases of the cycle.

The three questions and the PDSA cycle combined will form the basis of a model for improvement (figure 1). The model is applicable for both simple and sophisticated situations and applied efforts may differ depending on the complexity of the product or process to be improved.

The Improvement model is systematically designed to also explicitly detail out the four key steps for improvement (figure 2);

Step I: Identify: Determine what we want to improve
Step II: Analyze: Understand the problem
Step III: Develop: Hypothesize about what changes will improve the problem
Step IV: Test and implement; Test and implement the hypothesized solution to see if it yields improvement. Based on the results, decide whether to abandon, modify or implement the solution

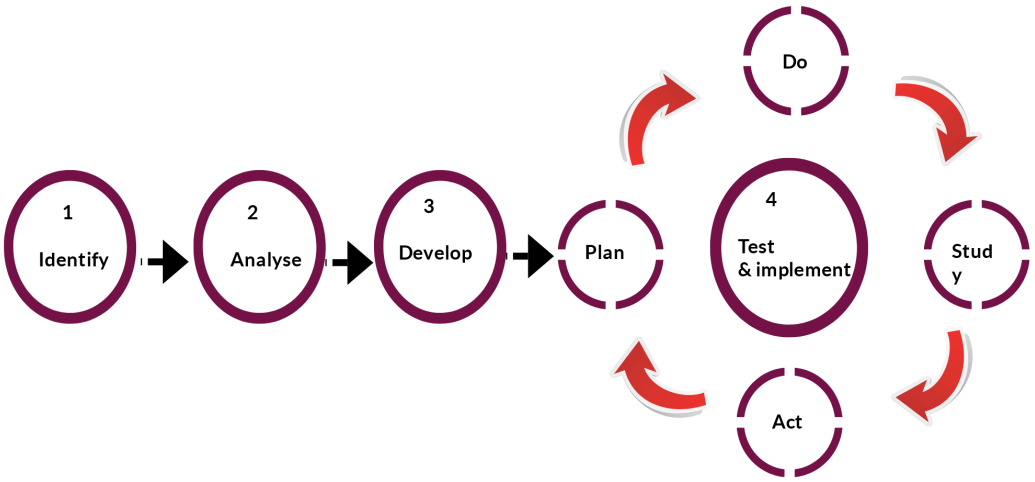

Figure 3: Steps in Quality Improvement

Adapted from: T. Nollan et. al The Quality Improvement model.

Differenciating Quality Assurance and Quality Improvement

Quality Assurance (QA) is an approach to assure that service delivery sites meet minimum standards through regulatory approaches such as accreditation which are based on the application of explicit standards of care and external quality assessment (EQA) to measure the extent of compliance to these standards, often conducted by independent individuals or organizations using standard tools.

Quality improvement (QI) is the process of collecting and using valid data to:

- Understand the current level of quality (defined by compliance with standards of care),
- Identify gaps between actual quality and expected quality for that setting
- Introduce changes in the care system (affecting inputs and processes of care), and
- Frequently measuring the effect of those changes on health outcomes and system performance.

Quality improvement integrates the traditional quality improvement way of monitoring content of care by comparing performance against evidence-based standards protocols and guidelines with QI approaches that include team-based problem solving, performance improvement monitoring, and collaborative improvement resulting into a continuous quality improvement (CQI). CQI embeds the improvement process in the routine delivery of services. CQI engages frontline health and social welfare service providers and site supervisors in an ongoing process of comparing their own performance

against standards and figuring out what they can do to meet those standards by introducing changes in care and support processes and monitoring the results in a continuous cycle of assessment and action. Implementation of and support for CQI involves forming a team at the site level to do the improvement work, training in CQI and in the use of tools, regular assessment using these tools, and ongoing coaching and mentoring support, and sharing of learning across teams.

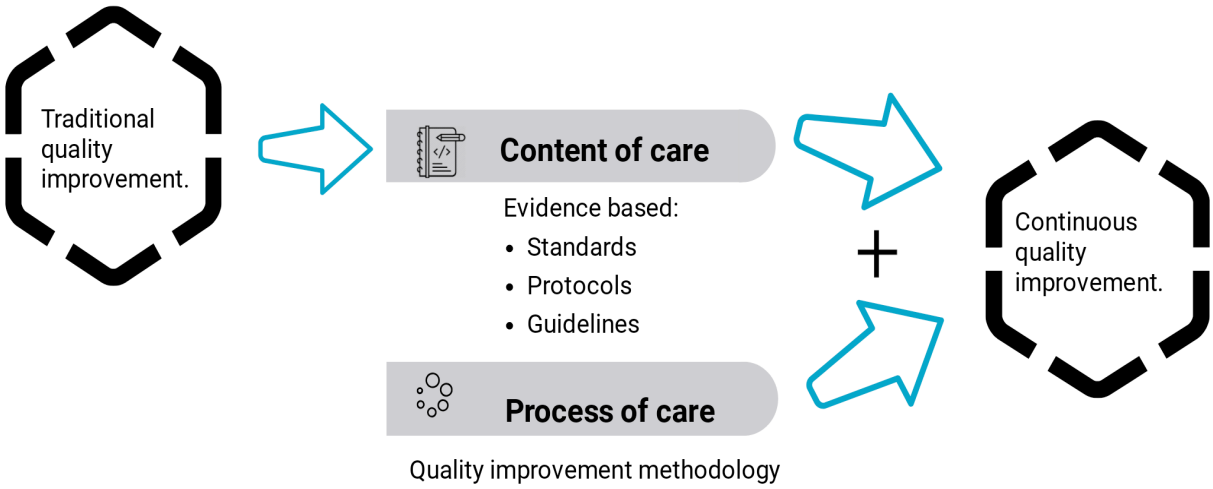

Figure 4: Continuous Quality Improvement

Adapted from Batalden and Stoltiz 1993.

Chapter 2: Community Quality Improvement Framework (CQIF)

2.1 Purpose of the Framework

The framework for improving quality of community health and social welfare services is developed to provide guidance and influence the thinking, planning and delivery of services in different community settings. It provides a strategic approach to improving quality at the frontline (Wards, Village/Mtaa), subnational (Local Government Authorities, Regions) and National levels.

The aim of the framework is to foster a culture of quality that continuously seeks to provide community health and social welfare services in the context of all dimensions of quality. For frontline teams and improvement initiatives the framework will serve as a reminder and sense check of the key areas that consistently require focus to ensure successful and sustainable improvements in the quality of care. The framework does not serve as an operational plan, but rather provides guidance that can be used to develop quality improvement work plans at various levels focusing on community interventions. All work to improve the quality of care through applying this framework recognizes the significant constraints that health and social welfare services continue to face. Operationalization of this framework will be guided by the same vision, mission and co-values which guided the implementation of the Tanzania Quality Improvement Framework (2011-2016).

2.2 Users of the Framework

The target audiences of the framework include health and social welfare service Senior Officials at MoHCDGEC, PO-RALG, Development Partners, Implementing Partners and other key stakeholders. The other group targeted by this framework will be: health and social welfare training institutions, health and social welfare staff at RHMT and CHMT levels, frontline service providers at primary health facilities, CSOs, CBOs, FBOs and community health and social welfare committees.

2.3 Development Methodology

In the process of developing the Community Health Quality Improvement Framework (CHQIF), firstly, a literature review was undertaken focusing on examining several frameworks, community service and QI guidelines, QI training materials, supportive supervision tool, supportive supervision manual and QI models. The framework, therefore, is well -versed by international models, national guidelines and local improvement experiences. Various models were used to prepare a conceptual framework to guide community

Vision, Mission and Core Values

Vision: To have a level of performance of health care services that are effective, equitable, sustainable, and affordable, gender sensitive and user friendly

Mission: Quality improvement shall focus all health care services through instilling among health workers a philosophy of client and community centered care, ensuring strong and transparent leadership at all levels and making quality of health care part and parcel of the culture of daily activities of all health staff, partners and the public in general.

Core Values: The values for quality improvement are to ensure that health services are provided efficiently with the following in mind:

- Care for patients / clients
- Personal integrity and respect for professional ethics
- Equitable access to health care by all with focus on community involvement and participation.

health care providers, managers and policy-makers in improving the quality of health services at community level. Building on these models and the WHO health systems approach,

a community health quality improvement framework was designed by identifying drivers that should be targeted to assess, improve and monitor care in the context community health system. Secondly analysis and discussions from the rapid scan for community QI provided the terrain where this framework is basing. The rapid scan identified the weak QI integration in the Community Based HIV Services (CBHS) but also contributed to the documentation of case studies to be used during training of community QI teams. A series of stakeholders' workshops to gain opinions were conducted involving experienced staff in the use of quality improvement approaches and those experienced in community health and social welfare interventions.

2.4 Community QI Governance Model

This model is designed to describe the relationship between major players in the execution of community health interventions, adapted from Ferlie and Shortell[9]; the community health care system is divided into four interdependent levels:

Figure 5: Community QI Governance Model

Adapted from Ferie and Shortell Model

Table 1: Key Roles for Different Levels in the QI Governance Model

Level	Description	Key Role
Client	Community member in need of preventive, curative or rehabilitative health services	The role of the client must be changed from a passive recipient of care to a more active participant in care delivery; expected to be able to demand for information and seek for quality services; provide feedback on care received and provide support to others
Care team	HCWs, CHWs, Social welfare Assistants (SWAs), Volunteers, peers, care groups and families	Delivery of care to a client or population customized to meet individual needs; ensure national care guidelines and protocols are followed to improve quality
Organization	CHMT, Implementing Partners Primary health facilities, Ward/Village/Mtaa health and social welfare committees, CSOs, CBOs, FBOs and community projects	Supports the development and work of care teams by providing infrastructure and complementary resources
Environment	Ministries, Departments, and Agencies; Development Partners and RHMT	Regulatory, Funding and Policy Framework Influence the structure and performance of organizations directly and, through them, all other levels

2.4.1 The Client

Client focus is one of the six principles of quality improvement; it is one of the six drivers of this framework for community QI and falls under the four levels of the community QI governance model being described. To avoid repetitions, this will be described among the drivers.

2.4.2 The Care Team

The care team has two main tasks: the first task is provision of basic preventive, curative and rehabilitative health and social welfare services as per Essential Package. The essential health and social welfare services include: -

- Education on prevailing health problems and methods of prevention/control
- Prevention and control of epidemic and locally endemic diseases
- Mother and Child Health/ Family Planning
- Immunization against major immunizable diseases
- Appropriate treatment of common disorders and injuries
- Promotion of household food security and adequate nutrition
- Adequate supply of water and basic sanitation
- Provision of essential supply (drugs) and basic equipment
- Provision of mental, oral and eye health care; rehabilitative services to chronic illnesses

- Psychosocial support

The second task is to improve quality continuously. Different health and social welfare interventions (e.g. identification and services for GBV/VAC/MVC, Community HIV Testing Services (HTS) etc.); and health and social welfare committees (e.g. National Plan of Action to End Violence Against Women and Children (NPA-VAWC) at community level, VMAC) at Village/Mtaa level should be supported to establish Quality Improvement Teams.

2.4.3 Community Organization and Structures

The organization (Primary health facilities, Implementing Partners, health committees, CSOs, CBOs, FBOs, community health projects) provides infrastructure and other resources to support the work and development of care and support teams. It provides an overall climate and culture for change through its various decision-making/operating systems and human resource practices.

2.4.4 Enabling Environment

Departments and Agencies under the MoHCDGEC; and PO-RALG in collaboration with Development Partners have the role of creating the enabling environment for community health interventions. The Regulatory, Funding and Policy Framework environment will influence the structure and performance of organizations directly and, through them, all other levels. The Quality Assurance Division and Health Education at the MoHCDGEC will revise policy guidelines from time to time and mobilize resources for community QI; while the Quality Assurance and Social Welfare units at PO-RALG, through RHMTs and CHMTs will oversee the implementation.

Providers (environment, organizations, care and support teams) will be committed to the broad aims of quality policy for community QI, but their main concern will be to ensure that the services meet agreed standards and meet the needs of individual service users, their families, groups and communities. Improved quality outcomes are not, however, delivered by health and social welfare service providers alone. Communities and service users are the co-producers of such outcomes. They have critical roles and responsibilities in identifying their own needs and preferences, and in managing their own health and social welfare with appropriate support from health and social welfare-service providers. While it is important to recognize these differences in roles and responsibilities, it is equally important to recognize the connections between them. That is to say:

- Decision-makers cannot hope to develop and implement new strategies for quality without properly engaging health and social welfare-service providers, communities, and service users.
- Health and social welfare-service providers need to operate within an appropriate policy environment for quality, and with a proper understanding of the needs and expectations of those they serve, to deliver the best results.
- Communities and service users need to influence both quality policy and the way in which health and social welfare services are provided to them, if they are to improve their own health and social welfare outcomes[10].

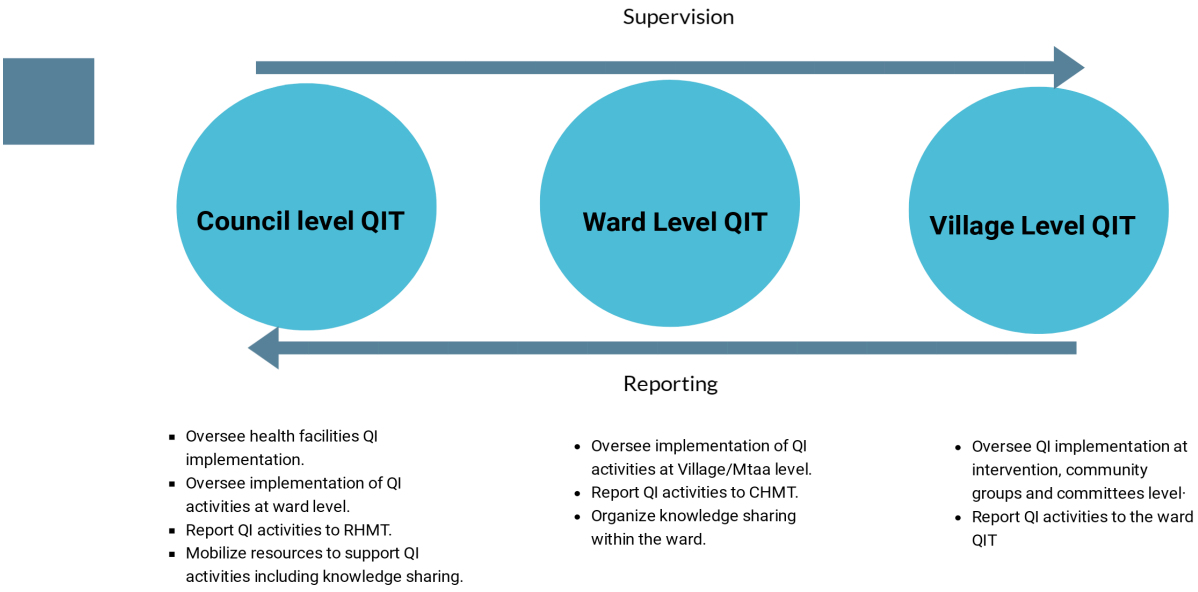

Figure 6: Roles of Quality Improvement Teams at different levels

2.5 Drivers of the Community Quality Improvement Framework

The design of this framework was modified from the International Planned Parenthood Federation (IPPF) Quality of Care Framework[22]. Governance of community QI will be designed to reflect the significance of all important stakeholders summarized in the community QI governance model.

This framework has five Drivers of quality of care and support within the community part of the health system. Although it focuses on the care and support provided at community level, it accounts for role of health facilities and service users in identifying their needs and preferences and in managing their own health and social welfare.

The five drivers of community QI framework are:

1. Leadership and Governance for community QI
2. Client needs, expectations and involvement
3. Coordination and integration
4. Application of QI methods
5. Data and measurement

The drivers for community quality of care have been amplified to 31 key elements and 38 standards as follows (monitoring tool is shown in annex 1).

T**able 2: Key Elements and Standards for the Community QI Drivers**

S/N	Driver	Number of Key elements	Number of standards
1	Leadership and Governance for community QI	9	12
2	Client needs, expectations and involvement	9	9
3	Coordination and integration	3	5
4	Application of QI methods	7	7
5	Data and measurement	3	5
	Total	**31**	**38**

2.5.1 Leadership and Governance for Community QI

This section on community QI leadership and governance summarizes the necessary **structures**, **processes** and **standards** that will ensure that safe, client centered, and effective services are delivered at community level. Leadership fosters a culture of continual learning and improvement. The leadership team will ensure that providers are supported to deliver quality community health services. Governance guides the establishment of learning systems so that experiences within community is shared and used for continuous improvement. Good governance will support strong relationships between facility-based health workers, community health workers, volunteers and leaders within any community.

Table 3: Community QI Leadership and Governance, Key Elements and Standards

Key Elements	Standards
Shared vision	A shared **vision** focused on quality is constantly communicated to everyone at all levels
Values, beliefs and norms that promote QI	Values, beliefs and norms that support QI are agreed and shared at all levels
Objectives and expected outcomes for community QI	Prioritized aims, objectives and expected outcomes for community QI are set and shared
Resources for sustaining quality improvement	Resources for supporting community QI activities including learning and recognition of QI champions are mobilized
Efficient community health and social welfare	Community level health management information

service delivery approach	system operational Information to measure, monitor and oversee quality and safety of care is used intelligently
Effective supportive supervision	Clear executive leadership and accountability for quality and safety is in place Inclusion of functionality of community QITs during quarterly supportive supervisions
Policies, standard operating procedures and guidelines	QI policies, protocols and guidelines are presented in simple and clear language; translated in swahili and are widely disseminated and available
QI knowledge and skills	Members of ward and Village/Mtaa QITs have the knowledge and skills to achieve their roles in driving Quality care.
Documentation and sharing of change packages	Community QITs are supported to share best practices and spread them

2.5.2 Client Needs, Expectations and Involvement

Needs and preferences of the client should be the defining factors in community health system. Service delivery points must be client focused and should have well-functioning monitoring and evaluation systems, in which both client and community are empowered to take an active part in achieving and ensuring the highest quality of care and continuous quality improvement. This means that there should be a mechanism to receive client feedback at the service delivery point and within the community, and to respond to it in a timely and appropriate manner. The Star Rating System for health facilities seeks to assess the extent to which the facility-based services have a client focus. Domain B, Service area number seven of the Star Rating Tool (SRT) examines the use of Client Service Charter and Client Satisfaction to measure the extent of Client Focus at facility level. Health care providers are now trained to consider clients, their families and community as “partners” and incorporate their values and wishes into care processes. In our settings, most of the clients leave decision making to a trusted provide, however, clients still need to exchange information with providers and the organizations that provide the supporting infrastructure for the care teams. Clients will be able to communicate and negotiate with providers only when they are well informed. Community education programs must be implemented and continuously improved.

Community engagement ensures that services are responsive to community needs, which in turn foster quality assurance and improvement, responsive planning and programming, create demand and

empowerment and promote rights. Engaging clients (patients, families and community) during planning and implementation of health interventions ensures that care is appropriate to their needs and is respectful of their preferences. Engagement builds a culture of listening to and learning from the care experiences of clients.

Table 4: Client Needs, Expectations and Involvement; Key elements and Standards

Key Elements	Standards
Accessible community health services	Available community services are known to community members, accessible and affordable
Access to comprehensive information	Information, Education and Communication resources exist that facilitate clients' education to make informed and free decisions
Safe environment for both providers and clients	Systems in place for supporting and protecting providers
Privacy and confidentiality	Exchange of information between clients and service providers occurs in an environment that secures privacy Confidentiality of record keeping safeguarded
Respectful care	Caring for people with dignity, respect and kindness set as a norm for all providers
Building confidence of client and families to make right decisions for their own health	Programs that develop knowledge, skills and Confidence are designed and implemented
Clients, families and community's participation	Clients, families and communities are enabled to participate in service design and delivery of care
Community support and buy-in	System in place for incorporating client suggestions to improve service delivery
Community participation	Health facility organizes regular meetings with the community to discuss QI activities on a regular basis

2.5.3 Coordination and Integration

Health and social welfare community-based services should be coordinated around the needs and demands of people. This requires integration of health and social welfare service providers within and across health community care settings, development of referral systems and networks among levels of care, and the creation of linkages between health and other sectors. It encompasses intersectoral action at the community level in order to address the social determinants of health and optimize use of scarce resources through partnerships with the private sector. Coordination does not necessarily require the merging of the different structures, services or workflows, but rather focuses on improving the delivery of care through alignment and harmonizing of the processes and information among the different services. Better service coordination can be achieved through joint processes for planning, tools development, capacity development, supportive supervision and performance/data review.

Table 5: Coordination and Integration, Key elements and Standards

Key elements	Standards
Partnership in planning, implementation, monitoring and evaluation	Established partnership between different health interventions Joint processes for planning, implementation and performance monitoring strengthened
Integration of community health services	Clients offered integrated package of services in addition to the index services
Reliable referral and follow-up	A well-functioning network of service providers ensures that referral mechanisms are in place A feedback loop to track referrals is vital to ensure quality Effective **linkages** between services established and well monitored

2.5.4 Application of QI Methods

Quality Improvement has emerged from the theories of W. Edwards Deming and experience from the fields of psychology, social science, engineering and statistics. Most improvement methodologies have their origins in the application of Deming's theories including PDSA. Regardless of which approach is applied, to the process of improvement will not be affected as long as a proven and accepted method (which utilizes PDSA) is used. Many methods focus on simple principles such as the importance of standardization or ensuring that all QI activities must benefit the clients. Improving the quality of care, and sustaining it, requires all programs to have a theory of change that is based on the application of improvement science.

Table 6: Application of QI Methods, Key Elements and Standards

Key elements	Standards
QI competencies	Improvement of knowledge and skills that transforms culture of quality care and support among community actors developed and maintained
Improvement that focuses on processes and systems	Processes and systems for community health delivery are reviewed and improved on a continuous basis.
Model for Improvement and PDSA cycle	Community actors are practically oriented on use of improvement model and the PDSA cycle
Team and team work	Well-coordinated and effective QITs at all levels are in place
Institutionalized QI	Quality activities are incorporated into the structure of an institution, department, or community unit. Supported by a culture of quality improvement as reflected in the entity's values, vision, mission, and policies.
Use of an agreed set of quality	Community actors guided to apply QI method from the

improvement Approaches	list of agreed set of national QI approaches
Sharing and scaling best practices	Platforms for sharing best practices amongst improvement teams are supported

2.5.5 Measurement for Community QI

Information and measurement are central to improving the quality of care. Collection and Analysis of data relating to a service provides information that can be used to drive improvement and support assurance on the quality of care provided. It supports the identification of areas where underperformance highlights the need for an improvement response. Building measurement into all improvement initiatives is essential so that we know when improvements have occurred and when they haven't. However, we need to minimize the measurement burden by collecting data only on what really matters. Sharing and displaying information in a manner that influences behavior is critical to achieving success in improving quality. This requires services to have the capability to measure and analyze information as well as having access to information technology to enhance capability.

Table 7: Measurement, Key Elements and Standards

Key elements	Standards
Build **competencies** for measurement	Community actors with competencies to collect, analyze and interpret improvement information using simple methods
Measuring **only what matters**	Basic qualitative and quantitative indicators defined using simple terms, developed, displayed and shared
Establishing a **culture for data use**	Key community resource teams orientated on importance of data collection, analysis, storage and utilization Data and report presented and discussed at village/mtaa/ward health Committees and utilized for decision making. Established mentoring and coaching of community actors in data demand and use

2.6 Composition and Functions of QITs at Community Level

2.6.1 Village/Mtaa Level QIT

Establish Quality Improvement Teams (QITs) at Village/Mtaa level by drawing some members from the Village/Mtaa Health Committees, the above-mentioned WITs and community support groups, then add CHWs and Social Welfare Assistant (SWA) who work at a Dispensary. The QIT at Village/Mtaa level will be formed by a minimum of 15 and a maximum of 20 members.

Table 8: Composition of Village/Mtaa Level Quality Improvement Team

SN	Designation	Description	Role
1	Village/Mtaa Executive Officer	Also, member of the Village/Mtaa Health Committee	Chairperson
2	Community Health Workers	If no trained CHW; select community health/social welfare volunteers	Secretary
3	In-charge of a primary health care facility/Facility QI FP	Also, member of the Village/Mtaa Health Committee	Technical Expert
4	Village/Mtaa Health Officer	Also, member of the Village/Mtaa Health Committee	Member
5	SWAs from dispensary or community	If no trained SWA; any member of WCPC or PSWs	Member
6	Village/Mtaa chairperson	Also, member of the Village/Mtaa Health Committee; Representative of elected community leadership	Member
7	Representatives from Community support groups	Community groups may include PLHIV support groups, mother support groups, AGYW groups etc.	Members
8	Representatives from different health committees (VMAC, WCPC etc.)	One representative from each committee	Members
9	Representative from CSOs, CBOs and FBOs	One representative from each	Members
10	Representative from extension workers	A teacher from a Primary School (a teacher responsible for health/Counselling and guidance also a member of Village/Mtaa Health Committee	Member

2.6.2 Ward Level QIT

Establish a QIT at ward level by bringing together representatives from the Ward Health Committee and CHWs from all Village/Mtaa where they will be playing roles of secretaries of Village/Mtaa level QITs. The Social Welfare Assistant (SWA) at ward level will take the roles of secretaries while the Ward Executive Officer (WEO) plays a role of chairperson.

Table 9: Composition of Ward Level Quality Improvement Team

SN	Designation	Description	Role
1	Ward Executive Officer	Also, member of the ward health committee	Chairperson
2	SWA at Ward level/Health Center	If not available select Ward Education Coordinator or Community Development Officer	Secretary
3	In-charge of a primary health care facility	Also, member of the Ward Health Committee	Technical Expert
4	Community Development Officer	Also, member of the Ward Health Committee	Member
5	Ward Education Coordinator	Also, member of the Ward Health Committee	Member
6	Community Health Workers	All Community Health Workers from all Village/Mtaa in the ward; represent the Village/Mtaa QITs	Member
7	Representative of religious leaders	Representing both Moslems and Christians	Member
8	Representatives from CSOs (FBO, CBO)	Same members of the Ward Health Committee	Members
9	Ward Health Officer		Member

The community QIT at Village/Mtaa level will not take over the functions of Village/Mtaa Health Committee or any other committee; rather, will add imputs to the care team to perform their second task of improving quality. Integration of QI in the health committee's work will yield better outcomes and a satisfied client.

2.6.3 Functions of improvement teams at community level

1. Identify and analyze health and social welfare quality gaps (areas for improvement)
2. Prioritize and set improvement aims/objectives
3. Develop and test small changes that have impact in the improvement process
4. Identify/ solicit resources to address the identified gaps
5. Document and perform simple analysis in monitoring improvement over time
6. Share best practices with other community improvement teams during leaning platform

ANNEXES

Annex 01: Performance Audit Tool for Community Quality Improvement

This audit tool is for council, Ward, Village/Mtaa authorities, Implementing Partners and other stakeholders to use when assessing community QI performance initiatives.

Region: …….. Council: …….

Ward: …….. Village/Mtaa: ……

Date:

Part A: Administration and Management

Item/Description/Particular	Comment
1.1: Audit team from:	
1.2 Audit team Names: Title: Mobile number: Email:	
1.3: Name of Ward or Village/Mtaa Executive Officer Mobile number:	
1.4: Name of SWA/CHW involved: Mobile Number	
1.5: Number of other CQIT members participated (Attach participants list – Use template in the annex)	

Part B: Community Quality Improvement Systems

Question and Verification methods	RESPONSES (Circle Y=yes; P=Partial; N=No)	Score **Yes** = 2 points, **Partial** = 1 point, **No** = 0	Comment
2.1: Is there a Quality Improvement Team (QIT)? *Ask WEO/VEO/MEO and verify* the list in the QI file	Y. QIT established with all members as stipulated in the SOP for establishment of functional QI teams P. Team established but not meeting the standard N. No QIT		
2.2: Are the members of QIT received training or orientation on their roles and responsibilities? *Ask WEO/VEO/MEO. And verify documentation (Training report)*	Y. All members trained/oriented P. Few members trained /oriented N. None has been trained/oriented		
2.3: Do the QI team members have assigned roles and responsibilities *Ask WEO/VEO/MEO and verify documentation in the QI file*	Y. All members have assigned roles and responsibilities P. Few members have assigned roles and responsibilities N. None has		
2.4 Are the members understand their roles and responsibilities? *Randomly select three members and ask if they understand their roles and responsibilities*	Y: All three have the understanding P: One or two have the understanding N: None has the understanding		
2.5: Does the team has assigned member responsible	Y. There is assigned member responsible for handling QI data		

for handling QI data *Ask WEO/VEO/MEO and verify in the file*	N. No one assigned		
2.6: Is there a compliance file for keeping QI documents such as meeting minutes, workplans and reports. *Check for the availability of QI file*	Y. There is a file N. No file		
2.7: Does the QI file well organized as indicated in the SOP for establishing functional QI teams? *Check arrangement of the file*	Y. Well-arranged file as per the SOP N. Not well arranged		
2.9: Does the team has a six-month QI team meetings calendar *Check for the calendar in the QI file*	Y. Meeting calendar available N. Meeting calendar not in place		
2.8: Does the QIT meet on a regular basis (Monthly)? *Check for the minutes of previous three months meetings*	Y. Team meets with minutes for the previous three meetings available N. No meetings and no evidence		
2.8: Does the QI team has a guide for writing QI meeting minutes and minutes are written according to the guide? *Check for the availability of the SOP and verify its use in the previous meeting*	Y. Team has the guide and the previous meeting minutes are written according to the guide P. Guide in place but not followed N. No guide		
2.10: Does the team has SOP for conducting effective QI meetings *Check for the availability of the SOP*	Y. Team has the SOP N. The SOP no in place		
2.11: Does the QI team has workplan for the agreed format? *Check for the work plan in the file and confirm if the workplan*	Y. Work plan in place and for the agreed format P. Work plan in place but not in the agreed format		

is in the agreed format – SOP for establishment of effective QI team	N. No workplan		
2.12: Is the QI team active (Completed at least one Plan Do Study Act (PDSA) improvement circle in the previous quarter)? *Check for the completeness of PDSA cycle in the workplan*	Y. Active team with at least one complete PDSA cycle N. Team not active		
2.13: Does the QI team receive QI supportive supervision, mentoring or coaching from higher level authorities? *Ask and check for the last quarter supportive supervision, mentoring or coaching report*	Y. Team received supportive supervision, mentoring or coaching in the previous quarter N. Not supported		
2.14: Are the QI activities incorporated into ward or village/mtaa plans? Check if at least one QI activity is in the ward or village/mtaa plans	Y. QI activity incorporated N. QI activity not incorporated		
2.15: Does the team has a Platform for sharing best practices and the team had a sharing event in the past six months? *Check for the established platform and documentation – available report of the event in the past six months*	Y. Platform in place and team had a sharing meeting with report in the past six months P. Platform in place but no sharing in the past six months N. No platform established		

Part C: Performance Monitoring

(Audit at least one most recent improvement objective per team)

Improvement Objective:

Indicator name:

3. Understanding of Objective and Indicator	NO RESPONSES (Y=yes; P=partial; N=no)	comment	
3.1: Does the QI team have SMART objectives for the improvement area? *Check if the team has at least one objective and if the objective is SMART*	Y. Improvement objective in place and its SMART P. Improvement objective in place but not SMART N. No improvement objective		
3.2: Does the QI team have an indicator for the established objective to monitor improvement over time? *Check for the indicator*	Y. Indicator in place N. No indicator		
3.3: Do the QI team members understand numerator and denominator definitions *Ask at least three QI team members for the understanding of numerator and denominator*	Y. All three understand the definitions P. One or two have the understanding N. None has the understanding of the definitions		
3.4: Do the QI team members understand sources of data for numerator and denominator for this indicator *Ask at least three QI team members for the understanding of source of data*	Y. All three understand source of data for the numerator and denominator P. One or two have the understanding N. None has the understanding		
3.5: The QI team has up-to - date data for the indicator *Check for the up-to-date*	Y. Up-to-date data available for the previous three readings N. No up-to-date data for the		

(availability of data for previous three readings)	previous three readings		
3.6: The QI team has developed changes to be introduced and clearly described how, where, who and when. *Check for the quality of changes introduced in the workplan*	Y. Changes introduced clearly indicating how, where, who is responsible and when will it be introduced P. Changes introduced but not clear N. No changes introduced		
3.7: Are the introduced changes relevant? *Check for relevance if changes address the identified gap.*	Y: Relevant N: Not relevant		
3.8: Are the changes introduced realistic with available resources within reach. *Check if introduced changes are doable?*	Y. Changes introduced are realistic N. Not realistic. No resources to make it happen.		
3.9: Does the QI team study process performance and take action with reference to a PDSA cycle *Check for the analyzed data in the graph and study if the team take action in response to the indicator performance*	Y. The team study performance and take action N. Team does not study and take action.		

Action plan

Audit team should support the audited teams in developing remedial actions for the identified gaps. Remedial actions should be written in a form of an action plan. The action plan should clearly indicate what need to be done, responsible person and when it should happen. Keep a copy of action plan in the teams' counter-book for receiving supervision, mentoring and coaching feedback. See below action plan template.

Template for writing action plan

S/N	Identified gap	Action/activity	Responsible person	Timeframe

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