Questions from the webinar "Quality improvement approaches for community health programmes"

April 3, 2019

1. *Implementation of QI programs requires funds. In LIMC where resources are scarce, how is it feasible to adopt and implement QI?*

   There is a lot that can be done within available resources once the training is in place and the approach is clearly understood. This does need to be funded to get it going and more and more programmes are committing to this.

   This has to be integrated into everyone's job everywhere. The danger of vertical QI is sustainability-so changing the culture, training everyone even in pre service and making a routine activity.

2. *Hi Lisa- thanks for setting the stage. I want to understand when you mention of community [other than CHW], who are the actors who should include in QoC program?*

   Community members of both genders, community health volunteers and workers, supervisors of community health workers and the in charge of the link health facility can all be part of work improvement teams.

   Would refer to Andrew's talks - consumers, policy and politicians, civil society organizations and also thinking about other sectors (education-ex. for vaccine delivery, WASH), transportation, etc.

3. *Question for Lisa: For states and regions that want to redirect efforts on quality improvement, where is the starting point?*

   Leadership and values at national level need to support district.

   Start at both community and leadership - only through multilevel engagement, education and empowerment will we see the change (push and pull), plus change at the micro (facility/provider) and policy.

4. *How do you address issues of poor data quality in your metrics describing equity? For example, while DTP3 levels may be relatively high, poor quality administrative data may mask low vaccination rates, particularly at the sub-national level. This can be evidenced by vaccine preventable disease outbreaks in areas with high coverage rates according to the HMIS.*

   Data quality audits and data verification rations can be taught as part of the QI approach. At first this makes it look as if quality improvement has led to worsening of services but this

reflects data quality having been poor.

Understanding data quality and quality of care gaps - often both and need to diagnose and manage both and sensitize that things may indeed look worse.

5. *How is the strategy for community health in Kenya linked to the national direction on quality in Kenya?*

   It is closely linked with the KQMH. The KQMCH has just been agreed and linked to the level 1 standards.

6. *This webinar has been great! I have one additional question for Lisa. What is the role of community engagement and empowerment to enhance quality systems across the world?*

   Thank you. This remains central to advocacy for quality services.

7. *What are the majors challenges facing quality of primary healthcare services in low and middle income countries?*

   Improving quality of community health workers has highlighted quality gaps at the facilities of reference and this leaves people feeling cheated.

8. *For Dr Otiso, have you considered the use of digital health to improve data quality?*

   We have but this is not in routine use or funded by MoH.

9. *Martin Muhire - from Uganda. Data quality is very broad. What elements of data quality do you look at?*

   Accuracy, timeliness and completeness – verifying two levels of collation.

10. *For improvement in service quality, i.e. measuring MUAC, how was the data collected?*

    On the routine registers.