Reachout
Linking Communities & Health Systems

WHAT ROLE FOR DISTRICT-LED QUALITY IMPROVEMENT APPROACHES IN PRIORITY SETTING FOR UNIVERSAL HEALTH COVERAGE: LEARNING FROM BANGLADESH, ETHIOPIA, INDONESIA, KENYA, MALAWI, MOZAMBIQUE

"UHC focused soley on expanding access and NOT simultaneously addressing quality will have limited impact on population health"
HLSP Summary Brief, June 2014

"If you have capacity built to support quality close-to-community service provision you will encourage the community to maximally access service care and ensure healthy outcomes"
Allone Ganizani, Ministry of Health Malawi

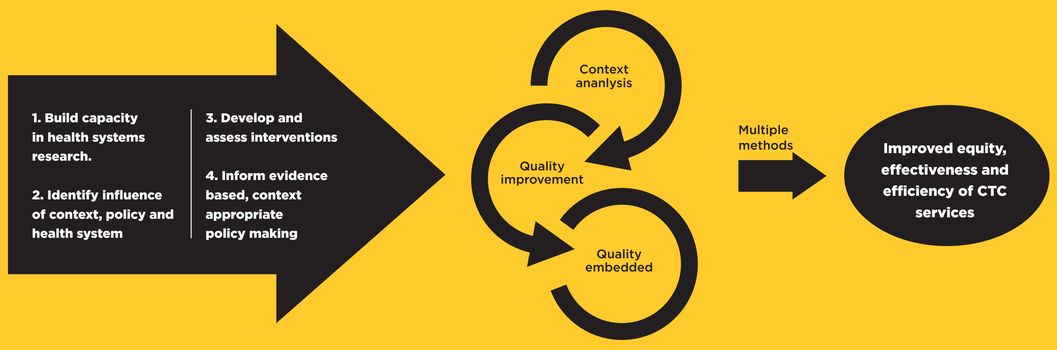
BACKGROUND

We will not achieve universal health coverage without a well-chosen, trained and supported health care workforce. In the light of existing deficiencies in this area in low- and middle-income countries policy makers are suggesting various innovations. One promising area is the expansion of cadres of close-to-community provides. These providers do play an important interface role between communities and the formal health sector and are often well placed to understand and work upon the social determinants of health. However, rapid scale up of the type that is being proposed will fail to reach its full potential if issues of quality are not afforded the prominence that they deserve. Furthermore, policy change at the international and national level that does not engage and draw upon the knowledge of local actors – such as close-to-community providers and district health managers - in the health system is less likely to succeed.

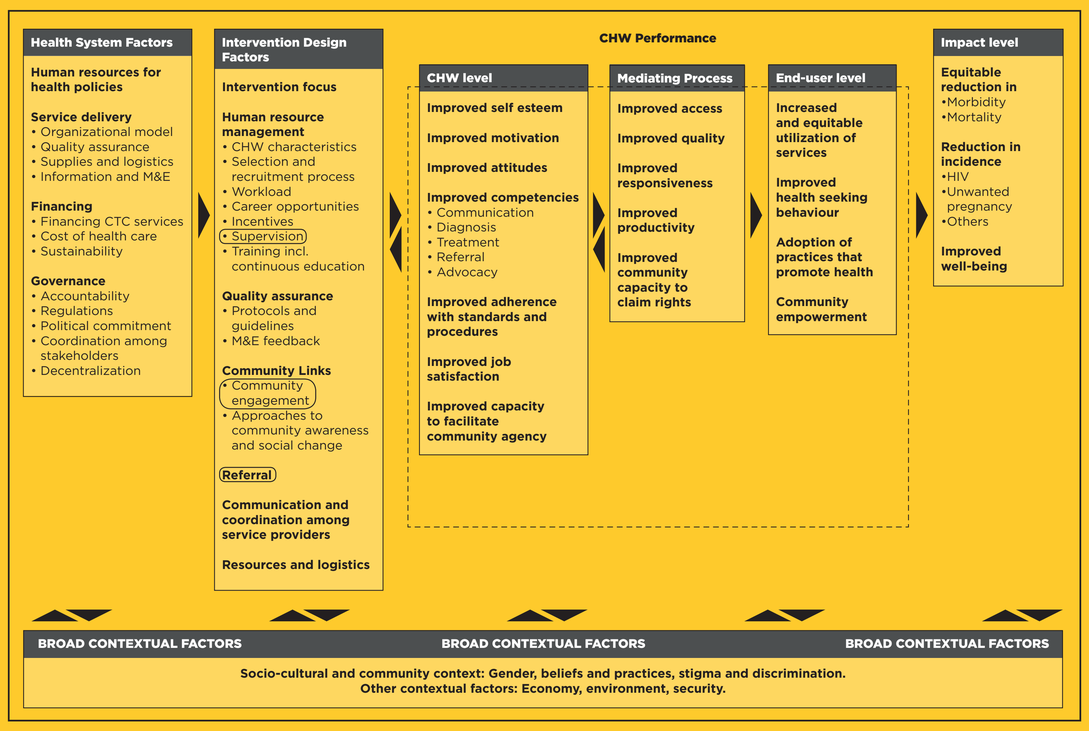
WHAT IS A CLOSE-TO-COMMUNITY PROVIDER?

Close-to-community providers include community health workers, volunteers and in contexts of rapid urbanisation informal and private sector close-to- community providers are growing in importance. Because they live and work within their communities, visiting people in their homes and workplaces every day, they can have a vital role in informing realistic health services in different contexts, developing approaches to universal health coverage and taking forward improvements that may deliver results for different communities through interventions in a range of contexts.

METHODOLOGY



EXAMPLES OF CHALLENGES IDENTIFIED



COUNTRY	FOCUS AREA
Bangladesh	Supervision Referral
Ethiopia	Supervision Referral Pregnant women forum + health development army leaders meeting
Kenya	Supervision Community dialogue days
Indonesia	Supervision Community engagement Health promotion
Malawi	Supervision Performance (best practice)
Mozambique	Supervision (Referral)

"I had my last supervision in June last year and so far not yet had any other visit, that demotivates me because it seems that I was forgotten."
APE, female, 23 years old, Mozambique

FINDINGS:

Leadership rests at the district level. Equity, effectiveness and efficiency are all dimensions of quality, however, there is often no plan on how to capture these. Standards for performance vary widely and indicators of quality may not be captured by routine data.

Improvements in programming depend on local problem identification and the capacity to prioritise problems, problem analysis and local solutions. This capacity has been built through the research process. Doing something small and feasible in steps that empowers a shift in values requires leadership and a culture of improvement.

Improvements can be challenged by issues like:

- Expectations of per diems and other incentives (Ethiopia, Mozambique)
- Competing priorities and workload of close-to-community providers and their supervisors (Mozambique, Ethiopia, Bangladesh, Kenya)
- Changeover of key stakeholders at district and/or national level (Malawi, Indonesia)
- Difficulty in sustaining changes in supervision (Ethiopia, Indonesia)
- Political upheaval (Bangladesh)

The key elements to ensure sustainability are community ownership and accountability; institutionalization of data collection, analysis and use by providers, supervisors and programme staff; capacity strengthening of key individuals; buy-in from county and national stakeholders, including civil society, and the inclusion of quality and equity indicators in policy.

RECOMMENDATIONS:

To address issues of embedding quality improvement approaches we need to move from a researcher-led project to a country led approach.

ABOUT US:

The REACHOUT Consortium is an international research project which aims to understand and develop the role of close-to-community providers of health care in preventing, diagnosing, and treating major illnesses and health conditions in six countries in Africa and Asia. Their work at sub- national and district level has enabled health care actors to identify challenges in the health system related to close-to-community programmes and to design and implement quality improvement cycles which have shed light on the challenges being faced at that level. REACHOUT is funded by the European Union Seventh Framework Programme ([FP7/2007-2013] [FP7/2007- 2011]) under grant agreement number 306090

READ MORE:

Thematic series on close-to-community providers in the journal Human Resources for Health
www.human-resources-health.com/series/CTC

Join the Thematic Working Group on Supporting and Strengthening the Role of Community Health Workers in Health Systems Development by contacting Faye Moody (faye.moody@lstmed.ac.uk)
Read more www.healthsystemsglobal.org/twg-group/5/Supporting-and-Strengthening-the-Role-of-Community-Health-Workers-in-Health-System-Development/

Authors: Lilian Otiso, Kate Hawkins, Daniel Gemechu Datiko, Mohsin Sidhat, RukhsanaAhmed, Sabina Rashid, Ireen Namakhoma, Korrie de Koning, Olivia Tulloch, Sally Theobald and Miriam Taegtmeyer

CONTACT US:

www.reachoutconsortium.org
Twitter @reachout_tweet
contact email lotiso@lvcthealth.org

European Commission