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SDC Health Network

Summary Report: E-discussion on Quality of Care

In the framework of the SDC backstopping mandate 2014-2017

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Disclaimer

The views and ideas expressed herein are those of the author(s) and do not necessarily imply or reflect the opinion of the Institute.

Abbreviations

CBO	Community based organisations
CHW	Community health workers
CME	Continuous medical education
Coof	(Swiss) Cooperation office
EFQM	European Foundation for Quality Management
FDG	Focus group discussion
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit; German International Cooperation
HMIS	Health management information system
IOM	American Institute of Medicine
ISO	International Organization for Standardization, It provides a norm for quality management with its 9000 series
LMIC	Low and middle income countries
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization
PASS	Projet d'appui au système de santé
PBF	Performance based Financing
PDCA	Plan-Do-Check-Act; Deming cycle or quality wheel
QM	Quality Management
QoC	Quality of Care
RBF	Results based financing
RIAS	Roter Interaction Analysis System; interactive training program for health worker training on communication
SCO	Swiss Cooperation Office
SDC	Swiss Agency for Development and Cooperation
SMART	Specific, Measurable, Attainable, Relevant, Timely; a characteristic of objectives and their indicators
SSA	Sub Saharan Africa
SWAp	Sector wide approach
Swiss TPH	Swiss Tropical and Public Health Institute
TBA	Traditional birth attendant
TQM	Total quality management
WHO	World Health Organization

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Executive Summary

The quality of health services is conceived and perceived differently by professionals, service users and public stakeholders so that service providers as well as health systems need to take into account the different perspectives when configuring their services. Quality is best understood using quality frameworks (for example the WHO Quality framework) considering the different stakeholders and their expectations. There are international and national standards to help start quality initiatives (e.g. ISO, EFQM, others). Government health development plans as well as health facilities should use these frameworks to organise their services.

Quality is not optional but a necessity for the provision of health care. It concerns everybody from leadership to the lowest ranks in a health facility and needs to be in the heads of everyone to strive for continuous quality improvement. Improving quality means first of all to engage in a change process related to amongst others improved patient satisfaction, minimise complications, increase life expectancy and reduce costs. However, each and every service, unit or team has to translate this into their own reality to engage in the necessary change processes.

The e-discussion held between 2 and 13 February 2015 introduced quality as a multidimensional concept based on stakeholder concepts and perceptions and user requirements. It discussed the process dimension of quality and the way it is applied in governments, health systems, facilities and communities. Measuring health care quality is difficult due to its different perceptions. However, quality frameworks like the WHO framework provide approximations with can be measured through appropriate scientific and operational research methodology.

The management approach to quality considers quality leadership, staff/health worker motivation, resources/financing and successful partnerships as key factors to engage in processes to improve quality. Staff motivation is a key requirement. Although frequently suggested, monetary incentives are only one way of boosting and maintaining motivation, which may be provided. Responsibility, recognition and leadership roles can be very powerful instruments.

The e-discussion also looked into the role of financial instruments such as performance based financing (PBF) and current experience with its application in various SDC partner countries in terms of increasing utilisation of services and improving quality.

Community participation plays an important role in most primary health care systems. Communities are important in governing primary health care structures, providing extensions to the health system through community health work and health promotion activities. As final beneficiaries of health services they are as well making judgements about the quality of services provided. The role of community health committees and community health workers has been also discussed.

Overall the e-discussion was well attended and well followed by participants. Content and preparation through thematic papers was well appreciated and the majority of participants perceived this type of moderated exchange as a well suited method discussing topics of common interests. However, expectations on the moderation style of the e-discussion seem to have been different and varied amongst participants from stronger guidance with a specific outcome (teaching style with pre- and post-testing) to rather an exchange of experience with technical input, which was actually the anticipated format.

The present report is a compilation of the input papers and discussion summaries and includes a library of documents and web-links suggested by both, moderators and participants. It also includes an analysis of the end of discussion evaluation and a list of suggested topics for future events of this type. Please note that all documents and contributions to the discussions are stored in the SDC DGroup archive.

1 Introduction and Background

The purpose of this e-Discussion is to provide for mutual learning between members of the SDC Health Network, who are staff from the Cooperation Offices and the headquarters in Berne as well as invited participants from SDC partners and implementing NGOs. The topic of the present e-discussion as well as its content has been developed based on a little opinion poll conducted by the SDC health network[1].

The present e-Discussion on "Quality of Health Services" was facilitated by a group of thematic experts from the Swiss Tropical and Public Health Institute (Swiss TPH) in Basel[2] coordinated by Manfred Zahorka and Christina Biaggi.

Contributions from a number of Cooperation Offices have helped to develop the agenda and to identify facilitators for the e-discussion[3]. The main objectives were to

- Establish a basic common understanding of Quality of Care
- Gain a solid overview of different approaches to improving Quality of Care
- Share experience and identified technical resources
- Connect people (across countries and institutions)
- Discuss relevant guidance documents and concepts
- Assess the needs for further support and advice.

The present e-discussion started with a short introductory questionnaire to stimulate participation and provide a sense of direction for the upcoming discussion[4]. The actual discussion was held using the SDC DGroup platform during the period from 2 to 13 February 2015.

The e-discussion was conceptualised as a dialogue involving SDC field offices and NGO partners moderated by experts from Swiss TPH on specific topics related to Quality of Care and identified from a list of topics suggested by SDC offices. Discussions were held in English language during the normal working time of participants.

The current report summarizes the material provided by Swiss TPH (thematic papers, summaries of discussion days), the links to resource information provided by the moderators and participants, and an analysis of the evaluation questionnaire with recommendations for similar future events.

The actual discussion material is grouped into two sections: the first section (chapters 2.1 to 2.3) is dedicated to **quality definitions and quality measurement,** the second section addresses **approaches to quality improvement** (chapters 2.4 to 2.7).

Quality care and patient safety are a longstanding concern of health managers, policy makers, patients and civil society. **Defining quality** is not a clear cut issue as the understanding and expectations of quality vary amongst stakeholders and service users. Also quality is not an absolute value; technical developments, new knowledge, user expectations and legal requirements continuously drive quality development in the health sector. Therefore, the understanding of quality as well as approaches to its measurement can best be done through quality frameworks.

Typically **quality improvement** in the health sector requires a set of interventions used in parallel and showing positive effects on quality of care. Over the past decades, an array of interventions has been tested and implemented to improve the situation. Typical measures are capacity building, technical upgrades and improvement of working conditions, initiatives to motivate health workers for delivering high quality health services, the application of clinical practice guidelines and others. Additionally, Continuous Quality Improvement offers instruments to improve the service delivery processes itself.

[1] Themes for an e-discussion in annex 1

[2] Who is who of experts in annex 2

[3] See e-discussion agenda in annex 3

[4] See questionnaire in annex 4

2 E-discussion by topics

2.1 Introduction to Quality

2.1.1 Introduction:

Quality is a multidimensional concept. Quality of services is perceived differently by professionals, service users and public stakeholders so that service providers as well as health systems need to take into account the different perspectives when configuring their services.

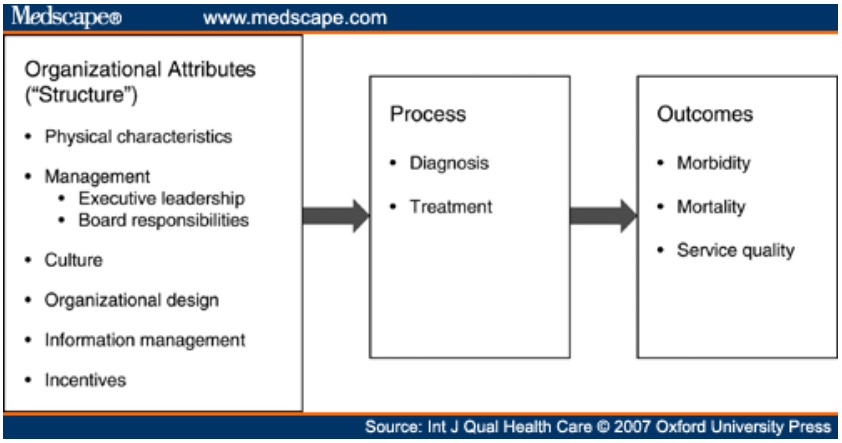
Quality is best understood using quality frameworks (for example the WHO Quality Framework) considering the different stakeholders and their expectations. Government health development plans as well as health facilities should use these frameworks to organise their services.

How are governments, health facilities and health related projects addressing quality in health services in your respective countries? What is your experience?

2.1.2 Thematic Paper:

Monday 02.02.15	**INTRODUCING QUALITY OF CARE** **What are the key determinants of Quality of Care (QoC)?**

The quality discussion has evolved from the idea of eliminating sub-standard products at the end of a production chain in the 1950s, to the control of the production process itself during the 70s/80s and further to the management of quality based on client and stakeholder expectations at all levels of the production and service delivery process starting in the 1990s. Discussions about quality services in the health sector were initiated by Donabedian et al in the late 1960s[1]. His simple **Structure – Process – Outcome framework** to understand factors or categories related to quality of health services is still used as an analytic framework today. In his model structure refers to "input" factors such as the physical infrastructure, staff capacity, organizational design, information, leadership and other factors, which are needed to provide health services. The process refers to the actual production of the service, e.g. admission, diagnosis,



treatment, care, discharge. Outcomes are not only related to morbidity and mortality criteria but also to perceptions of service quality by the service user – the patient.

What is quality in health care?

Quality is no absolute term, which can be clearly defined. In fact quality in health care has different meanings for patients, health care providers, managers or policy makers. This has led to a variety of definitions of quality in the past. However, the definition suggested by the American Institute of Medicine (IOM) in 2001 has gained wide acceptance:

Quality in health is: **"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"**[2]

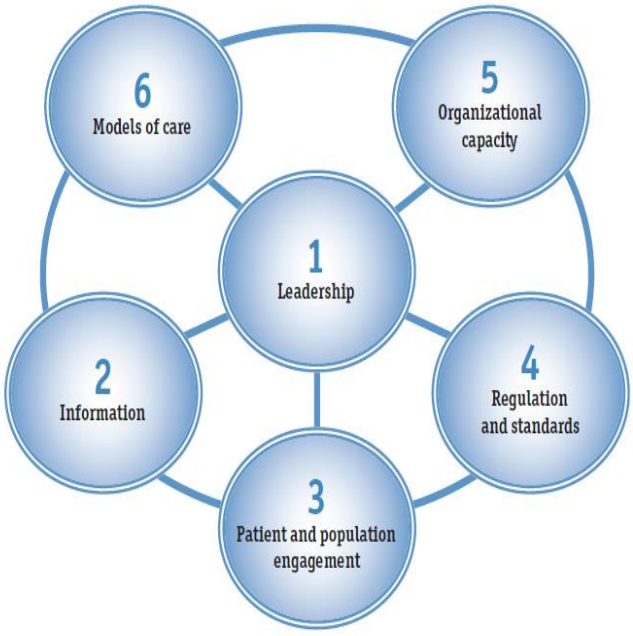
The definition focuses very strongly on patients and populations and their preferences and relates to state of the art professional knowledge, taking structural elements of quality for granted. The variety of meanings of quality and the various stakeholder expectations makes it essential for health care providers to analyse and consider these different perspectives in order to satisfy clients and to continuously adapt/improve services[3], which in turn requires a managerial approach to quality. In fact, today systems to manage quality in health facilities are mandatory in many countries in Western Europe and North America.

The institutional perspective of quality[4]

The IOM suggests 7 criteria for high quality health services at the facility level:

- Safety: Following the Do-no-harm principle, injuries related to service provision need to be avoided by all means;
- Effectiveness: Services need to be based on scientific evidence and be provided to those who benefit from them;
- Patient-centeredness: Services need to respect patient preferences and needs. Clinical decisions are taken based on patient preferences;
- Timeliness: Services are to be provided in a timely manner limiting waiting time and limiting potentially harmful delays to treatment;
- Efficiency: Service providers need to avoid waste of resources (equipment, drugs, staff time, intellectual capital, etc.)
- Equity: Type and quality of services is provided irrespective of personal characteristics, such as gender, ethnicity, religion and socioeconomic status.

Figure 3: *The six domains of quality interventions*



Source: Quality of care: a process for making strategic choices in health systems. Who publication[6]

WHO[5] defines six domains of quality including

- a strong strategic and organisational leadership
- information (related to technical knowledge),

- stakeholder and patient needs as well as means of managing this information), the engagement of patients and populations (target groups),
- regulation and standards defining the scope of services provided (this includes external regulations by governments and professional bodies (guidelines) and internal regulations (protocols) of facilities,
- the capacity of the service providing institution,
- and models of care build on international evidence.

The health systems perspective of quality[6]

National health sector development strategies are ideally based on a clear understanding of the situation in terms of health needs, existing pathologies, stakeholder expectations and patient/population perspectives and how these needs match with available resources in terms of financing, human resources, facilities and others. Strategic goals are defined based on this assessments related to health and quality outcomes. Interventions are selected and planned based on evidence, available resources, cost-effectiveness criteria and others. Implementing these strategies require monitoring of the implementation and evaluation of the outcomes in order to assess whether implementation leads to the expected results.

Source: Quality of care: a process for making strategic choices in health systems. WHO publication[6]

Who is responsible for Quality?

Leadership is important for quality, be it at health systems or health facility levels. Leadership provides the targets, the sense of direction, and the necessary resources to achieve true quality. However, to make quality real it is in the heads of people where quality needs to be anchored so that the contribution of all participants in quality processes leads to quality outcomes for the best of people and populations.

2.1.3 Summary of the day:

Day 1 discussed the frameworks governments, regions and districts use to improve quality of care in health facilities provided to its clients. Quality frameworks provided by governments and integrated in health sector development strategies play an important role to organise quality improvement. The examples from Tajikistan and Tanzania show that a lot is happening in this field and service quality is high on the agenda. Government quality initiatives are generally translated through district health teams into practice. In Tanzania regional clusters provide an additional layer between government and districts engaging in quality improvement through capacity building. National quality norms are set and guidelines produced to serve as standards for health facilities. Challenges remain to bring national initiatives and the adherence to these norms and guidelines down to the primary level.

The Tajikistan experience extents quality initiatives to the primary level. This includes the improvement of management capacity, better and more rational use of existing resources and particularly the identification of areas for improvement not needing additional resources. Additionally, incentives are provided to increase staff motivation.

In both cases a new direction towards stakeholder involvement and the voice of the patient are getting increasing attention. Services are reorganised based on customer/patient preferences and community involvement/control of the quality of primary care services is implemented in some countries.

2.1.4 Literature and web links:

1. Donabedian A, Evaluating the Quality of Medical Care; The Milbank Memorial Fund Quarterly Vol 44, no 3, Pt 2 pp 166-203, 1966
2. Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington D.C.: National Academy Press. http://www.esourceresearch.org/eSourceBook/EvaluatingtheQualityofHealthCare/3DefiningQualityofCare/tabid/797/Default.aspx
3. Mosadeghrad AM, Conceptual Framework for Quality of Care; Mat Soc Med. 2012 Dec 24(4): 251-261
4. Seth W. Glickman, Kelvin A. Baggett, et al, Promoting Quality: The Health-Care Organization From a Management Perspective Int J Qual Health Care. 2007;19(6):341-348.
5. WHO website: Management of quality of Care, http://www.who.int/management/quality/en/
6. Quality of care: a process for making strategic choices in health systems. WHO publications http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf

2.2 Process-related Quality of Care

2.2.1 Introduction

Quality is a necessity for the provision of health care. It concerns everybody from leadership to the lowest ranks in a health facility and needs to be in the heads of everyone to strive for continuous quality improvement. Improving quality means amongst others improve satisfaction, minimise complications, increase life expectancy and reduce costs. There are international and national standards to help start quality initiatives (e.g. ISO, EFQM, others). However, each and every service, unit or team has to translate this into their own reality to engage in the necessary change processes.

2.2.2 Thematic Paper

Tuesday 3.02.15	**Quality as a process**

Quality is not optional. Rather, all sectors, institutions, units, teams, should operate under the perspective of 'continuous improvement': striving to improve satisfaction, minimise complications, increase life expectancy, and reduce costs. 'Quality' and 'quality improvement' embrace all those concepts and efforts to striving for improvement.

Each sector, institution, unit, team defines its own concept of quality because goals and strategies are different. So is there a common understanding of quality? There are international references ('standards') for quality in different areas (e.g. ISO); and as references, they assume a set of goals (even values) and strategies and a basic set of requirements which may not apply everywhere. This is no excuse to postpone quality; but a good reason to develop your own quality concept.

How do you define quality? One way is to identify those aspects, which are important. But important to whom? The definition of quality is a participatory exercise. Why? Because improvement is a collective action, which in the health sector includes patients and communities. Or can you improve outcomes (e.g. cure rates) without patients' collaboration (e.g. concordance on treatments options)? You need to consider all perspectives, because you need everyone (whether you like them or not) to operate sustainable improvement. Consider the perspectives of (examples of what could be important in brackets):

- Communities (affordability)
- Patients (short length of stay)
- Service providers (limited on call schedules)
- Other workforce (work recognition)
- Managers (availability of funding)
- Decision makers (reputation)
- Funders (attribution of outcomes)
- Providers (prompt payment)
- External and internal clients (speedy services)
- Other stakeholders.

Once the perspectives are taken into account, what is important needs to be spelled out, call them quality 'dimensions'. To help you to consider dimensions, frameworks can be used. There are several frameworks which can be useful,

- Inputs – Processes – Outputs – Outcomes – Impact (Donabedian)
- Access – Acceptability – Utilisation – Coverage – Effectiveness (Tanahashi)
- WHO health systems building blocks (see also chapter 2.1.2 on health systems perspective)
- Health Workforce framework (see human resources session).

How is the definition of quality elaborated? Each institutional level defines its quality concept inspired, but not limited, by the upper level. This facilitates some necessary alignment between the different tiers of the system. However, each level and institutions keeps on mind that is accountable to its own definition of quality. At national level, national health policies and strategies hopefully articulate an overreaching quality strategy which drives and monitor performance changes in the whole health sector. Regions and districts would also elaborate specific quality definitions based on their own priorities and particular preferences, depending on the health status, particular preferences and values in the region or other issues. This would be done with truly participatory approaches, based on the common recognition that sustainable improvement is a collective endeavour. The following is an example of quality dimensions, organised by perspective. You can recognise several frameworks there.

Quality improvement strategies

'Quality' is the 'label' for continuous improvement and its definition contains the organisation priorities. In this sense, there is no quality-specific strategy, but rather, any strategy which operates an improvement on the organisations is actually a quality improvement strategy.

Quality improvement, as a continuous effort to improve organisation's performance (i.e. dimensions), has to be embedded in the organisational culture. It has been widely recognised that high political commitment is essential for any quality improvement strategy to progress. Although quality does not necessarily mean more resources, without political commitment improvement strategies will be sacrificed for the sake of regular micro-management. Political commitment is also paramount to prevent barriers to quality such as high staff turnover.

What strategies do we have to improve quality? Any strategy to improve performance (see other sessions, on human resources, infrastructures, supplies and financing). Some more specific strategies (applicable depending on your definition of quality):

a) obtain high level political commitment, with appropriate incentives, visibility and engagement in official national health policies;
b) institutionalise quality, assigning resources (e.g. staff-time) to incentivise a culture of improvement, to share quality performance information, to manage quality improvement initiatives;
c) measure quality dimensions to identify what is not working (this does not necessarily mean more and new data);
d) facilitate and promote patients and communities participation (see Donabedian[5]; 7 roles of patients) with mechanisms such as 'suggestions boxes', clients surveys, provider-patient communication, social services;
    (1) DEFINERS of quality
    (2) EVALUATORS of quality
    (3) INFORMANTS of care
    (4) CO-PRODUCERS of care
    (5) TARGETS of QA
    (6) CONTROLLERS of practitioner behaviour
    (7) REFORMERS of health services

[5] Donabedian, A. The Contribution of Consumers to Promoting the Quality of Health Care. Paper presented at the Eleventh International Conference on Quality Assurance, Venice, Italy, May 28, 1994.

e) facilitate and promote providers participation in decision making;
f) create or strengthen quality monitoring forums such as 'mortality clinical sessions' in hospitals, periodic interventions coverage analyses committees.

Formal strategies include, among others:

- Licensing: governmental authority grants legal permission to an individual or organisation that complies with minimum health and safety standards;
- Accreditation: a recognised body assess and recognise that an organisation meets pre-determined standards.
- Certification: like accreditation, but applied to individuals as well, and implying some "extra" capacity or skills.

Evidence on quality

'Quality improvements' strategies, either targeting specific quality mechanisms (e.g. audit and feed-back, accreditation) or other health systems interventions (e.g. incentives to improve performance) have to be based on the best available evidence. Why? To be (reasonably) sure that what we do works and that what we do does not lead to harms (e.g. iniquities, high costs).

The best available evidence is found in systematic reviews because systematic reviews take into account ALL available evidence (including the evidence produced in countries with less research capacity.

You may be surprised about the amount of evidence which exists even of very complex topics (see in the Cochrane Library[6]).

• Links with national strategic health plans.

Whatever quality definition or approach is taken, it needs to be embedded in the national health strategic plans, in order to:

- ensure high level political commitment which can be unfolded to the periphery of the system;
- facilitate that 'quality' is not an 'add on' but rather an organisational culture;
- gain efficiencies between programmes, at operational (e.g. quality in one area will spread over others) and strategic level (e.g. use M&E for planning);
- draw lessons to be fed into subsequent health policy cycles.

2.2.3 Summary of the day

Initially, a document with some ideas around quality processes, including how to reach a definition of quality, perspectives and quality dimensions, strategies to improve quality, patients or clients' roles and evidence on quality.

Experiences from the field were aligned in highlighting the problems to implement a quality strategy at all levels of the health system. Most of the problems mentioned were related to the systems itself, such as lack of resources or lack of autonomy, to mention only two examples. (Lack of) community participation was also signalled by several contributors, especially in relation to the poor communication skills of health care providers. Actually, it is precisely because of these problems that

[6] The effect of financial incentives on the quality of health care provided by primary care physicians; The effect of social franchising on access to and quality of health services in low- and middle-income countries; Continuous quality improvement: effects on professional practice and healthcare outcomes; The effect of financial incentives on the quality of health care provided by primary care physicians; Managerial supervision to improve primary health care in low- and middle-income countries. http://www.cochranelibrary.com/.

quality improvement initiatives are required. But certainly, there are some contexts more prone than others, or more sensitive to changes in decision flows.

It was also rightly mentioned that evidence on what works in quality is scarce. One of the areas where experience and research seem to coincide is in the effects of clinical guidelines, where positive effects have been reported. There were several initiatives suggesting promising venues for quality, in the PASS Nogzi project (community participation and communication), the WHO's IFC approach (communities participating in decisions), the RIAS - Roter Interaction Analysis System, not to forget training initiatives such as the Quality Management trainings in Ukraine and Moldova. Very often, quality interventions are actually part or constituted by a complex set up of different approaches including clinical practice, financing, institutionalisation of quality (e.g. accreditation), like in Rwanda and Burundi.

In summary, there is no magic bullet as to the mechanisms to improve quality and good quality evidence is lacking. However, imaginative and very varied approaches have been tested and lessons should be drawn from these. Eventually, these experiences could inform a robust research agenda on quality improvement.

2.2.4 Literature and web-links

Donabedian, A. The Contribution of Consumers to Promoting the Quality of Health Care. Paper presented at the Eleventh International Conference on Quality Assurance, Venice, Italy, May 28, 1994.

Asadov DA, Aripov TY. The quality of care in post-soviet Uzbekistan: are health reforms and international efforts succeeding? Public Health. 2009 Nov;123(11):725-8. doi: 10.1016/j.puhe.2009.09.013. Epub 2009 Nov 3. www.ncbi.nlm.nih.gov/pubmed/19889431 .

2.3 Measuring Quality

2.3.1 Introduction

Engaging in quality improvement means to engage in change processes. A useful instrument is the Deming cycle or quality wheel (see also chapter 2.5.2 below) for continuous improvement, which starts with the assessment of a given quality situation, defines an object or target for the change process, implements the improvement program and finally evaluates whether the improvement process has led to the anticipated change. In order to distinguish between useful and unnecessary change we need to measure quality and particularly quality improvement. This is helped by the utilisation of quality frameworks (see above) and analysis by priority dimensions.

2.3.2 Thematic paper

Thursday 5.02.15	Approaches to measuring / assessing quality of health services

Measuring what, at which level, and how

Measuring quality is not different from measuring performance and all routinely collected data from health services can and should be used to describe and monitor quality. Some principles may help to understand how to approach data (both quantitative and qualitative) transparently and efficiently:

1. You only measure something if:
   - It is important to solve a people's problem (not your particular problem);
   - Someone is going to make a decision about it;
   - No one else has already measured it (reasonably) before (you have to look for it).

2. There is ALWAYS bias, which is an UNKNOWN deviation from 'truth'.
   - To reduce bias is very difficult and costly; but you have always to be aware of it, to acknowledge it, and interpret your findings with extraordinary caution.

3. You have to ALWAYS estimate error (based on the ability of your tools to measure accurately)
   - You do not need to reduce error (that's life); but you can report it.

4. You have to be transparent and systematic
   - If you do not use validated methods, your findings and conclusions are USELESS (you will never know how far from reality you are)
   - Report what approaches you used to measure, even if wrong

5. ALWAYS use quantitative and qualitative methods together, as appropriate

Monitoring quality of services

When monitoring quality you should focus on the dimension of quality that you want to measure and in the perspectives and/or context that you have considered. Different dimensions should be treated one by one.

For each dimension (e.g. access, satisfaction) you define a 'standard'.

- The **standard** says how things should be. For example: 'poor population have access to health services" (in your definition of quality, you thought that it was important that poor population had access).

- Then you define the **criteria**; for example: (a) vaccination dropout rates among people living in neighbourhood X are not larger than in the general population; (b) perceived waiting times for population X are less than 1 hour.
- Now (and ONLY NOW) you can think of **indicators** to measure these criteria, and then (and ONLY THEN) you can think of the measurement methods and tools that you will need. For example:

Quality Dimension	Examples of indicators	Method
Efficiency	Amount of activity per unit of resource; completeness of reporting.	Health unit questionnaire, HMIS
Safety	Use of single use injection material; waste disposal.	Health unit questionnaire, HMIS
Effectiveness	Mortality, length of stay, TB defaulting.	Health unit questionnaire, HMIS
Access	Waiting time, DPT1-3 drop-out rates, gender disaggregated data.	Health unit questionnaire, HMIS, Exit interview, FGD
Social acceptability	Client-provider interaction, provision of information.	Exit interview, FGD
Equity	Fees, ability to pay.	Exit interview, FGD

FGD: Focus Group Discussions; HMIS: Health Management Information System.

Remember! Indicators have to be SMART:

- Specific
- Measurable
- Attainable
- Relevant
- Timely

Measuring progress

You want to know at every moment (e.g. monthly, weekly, annually, depending on how likely are the indicators to actually change their values) where you are and how the quality of the services is. In order to get an idea about this, you have to compare what you measure with a benchmark. Note that conclusions about 'comparisons' can only be stated if you have used the appropriate methods and the same methods over time; otherwise, you have to be careful (e.g. changes 'might have happened', 'may be suggested'). You have several possibilities:

a) you can carry out a situation analysis at a given point in time and then compare later on measuring the same indicators in the same way; however, note that you cannot rule out at all whether changes would have occurred anyway;
b) you can compare with another health facility, area or district. Again, note that you cannot rule out whether changes would have occurred anyway;
c) you can also compare against benchmarks that you have set up as part of the quality definition process. Again, note that you cannot rule out whether changes would have occurred anyway.

Setting up benchmarks has to be done sensibly and by taking into account the situation at the start and a reasonable pace of progress. Setting up impossible benchmarks does not help in any way.

Instruments and tools for measuring QoC

There are many tools which can be used for organising all the information that you will collect while measuring quality. Here some examples:

- Brainstorming: to generate as many ideas as possible, which are not discussed or criticised and where every idea is acceptable and builds on the ideas of others; the point is to get as many ideas as possible;
- Flow charts: to relate events with causal links including decisions nodes where different courses of action can be taken;
- Fishbone diagrams: to establish causal effects without decision nodes.
- Decision matrix: where information is represented in a list of criteria each of which is assigned a score and total scores are used to prioritise. Note that the value of it is the process of building the matrix and not the 'blind' adherence to the final scores;
- Force-field analysis: where each stakeholder is represented in its role and strength magnitude as barrier, neutral, facilitator or champion towards a given goal. The representation of forces from several stakeholders provides an idea to the chances of success.
- Data management and statistical tools: MS Excel and other statistical software.
- Graphic tools: MS Excel but also many other online resources to produce infographics.
- Storytelling and storyboards are ways of organising quantitative and qualitative data in order to document continuous progress in quality and quality assurance.

Practical advices

1. Select and write the methods and tools ('protocol') BEFORE any activity is carried out.
2. Consider ALWAYS ethics (for example, if collecting information about clients' satisfaction).
3. For quantitative data: decide the sampling method and sample size
   a) You do not have the resources to measure everything, everywhere, in everyone.
   b) Therefore, you have to sample. How and what sample size?
   c) The larger the sample size, the smaller the (sampling) error. It does NOT affect representativeness. Imagine that the 'real' hospital mortality is 10%; if you sample only 2 patients (yes, very unreasonable) you can only obtain 0%, 50% or 100%; to get accuracy (less error) you need many more patients. How many? Call a statistician, that's what we all do.
   d) Now that you know how many, how will you sample? If you want representativeness ("what I found in my sample is what I would find in the whole population the sample was drawn from") you need RANDOM sampling. In any other approach you cannot rule out (very serious) bias. Call the statistician.
4. For qualitative data
   a) Do not use qualitative methods just because you are not familiar with quantitative methods; qualitative methods are much more difficult to implement and findings to interpret.
   b) Do not analyse qualitative data using quantitative methods.
   c) Involve participants in the selection of methods and tools.
   d) Do not get stuck with the first responses, go deeper with 'whys'.
   e) Interpret quantitative findings under the light of qualitative findings (and vice versa).
5. You measure quality; i.e. dimensions and perspectives
   a) Dimensions of quality. Consider an existing taxonomy or framework; examples:
      - WHO health systems building blocks
      - Tanahashi's: availability, access, utilisation, coverage, effective care.
      - Inputs – Processes – Outputs – Outcomes – Impact
      - Others…

b) Perspectives of quality
   - Clients (patients, internal clients in the system)
   - Service providers
   - Managers
   - Decision makers
   - Other stakeholders

c) Measuring and reporting changes in quality,
   - ONLY IF you can COMPARE: either between different groups or before and after.
   - Otherwise, you may “suggest”, “imagine”, “consider” that a change “might have” taken place to some extent.

6. Building conclusions and recommendations
   - Do not go beyond your findings. Your findings are interesting enough.
   - Interpret with caution, things do not always are as they seem.
   - Do not make recommendations unless:
     - you understand the problem;
     - you have the evidence to support them.

2.3.3 Summary of the day

Day 3 of the e-discussion dealt with ways of assessing quality of care as an important step towards quality improvement. Assessing QoC requires some instruments, which provide systematic analysis, procedural rigorosity and some scientific methodology; a set of values usually associated with Operations Research. These instruments should be appropriately chosen to be used at the respective level of analysis, be it the government or more the health facility level.

The discussions covered two angles of QoC measures: the more strategic level needed at health systems levels (e.g. government or public health administration) and the operational level at the health facilities. QoC measures at strategic levels are frequently indicator based and are used for strategic decision making, long term follow up, resource allocation decisions, strategic planning and priority setting and others. Data sources could be Health information systems as well as national or regional studies.

Quality improvement at facility levels is driven by other mechanisms and possibly other data needs. Patient related quality problems might actually be caused by very small adverse conditions (e.g. water problems due to broken pipes, patient dissatisfaction due to staff behaviour, disadvantageous organisation of service provision and others). Most quality improvement initiatives are problem based and solutions are not necessary found only at the macro level but should be looked at from a facility standpoint. In fact considering macro level solutions might prevent a problem from being solved due to the long reaction time of administration not even lead to sustainable solutions because the underlying causes have not been identified correctly as the Mozambique example in the discussion showed. The first step here is to narrow down the problem to a level where the solution can be found locally not requiring too many resources. The dynamic of continuous quality improvement is nicely captured in the Deming cycle or Quality wheel, which defines the steps assessing, target setting and planning, testing and evaluation and finally system wide implementation (see also chapter 2.5). Quality improvement at that level needs to focus on small focalised problems and solving them one by one (local problems – local solutions) for service providers not to be overwhelmed. It is important that only measures that offer true solutions are finally implemented. QoC measurement at this level needs to be very well targeted to the problem to be solved and close to the solution anticipated. ,

Although patient satisfaction is an interesting QoC measure involving patient opinions, its value as a measure for Quality is limited. First the measure itself is not comparable across regions or even facilities and secondly client satisfaction does not necessarily mean high quality care.

2.3.4 Literature and web-links

Infographics: www.tableau.com/public

Mohammadreza Hojat, PhD; Daniel Z. Louis, MS; Kaye Maxwell; Fred W. Markham, MD; Richard C. Wender, MD; Joseph S. Gonnella, MD¸ A Brief Instrument to Measure Patients' Overall Satisfaction With Primary Care Physicians¸ (Fam Med 2011;43(6):412-7.), http://www.stfm.org/fmhub/fm2011/June/Mohammadreza412.pdf

Michelle Beattie, William Lauder, Iain Atherton and Douglas J Murphy; Instruments to measure patient experience of health care quality in hospitals: a systematic review protocol; *Systematic Reviews* 2014, **3**:4 doi:10.1186/2046-4053-3-4; www.systematicreviewsjournal.com/content/3/1/4 .

Jason W Nickerson, Orvill Adams, Amir Attaran, Janet Hatcher-Roberts and Peter Tugwell; Monitoring the ability to deliver care in low- and middle-income countries: a systematic review of health facility assessment tools Health Policy and Planning 2014;1–12

T. Tanahashi, Health service coverage and its evaluation, Bull World Health Organ. 1978; 56(2): 295–303. www.ncbi.nlm.nih.gov/pmc/articles/PMC2395571/

2.4 Motivation of health workers

2.4.1 Introduction

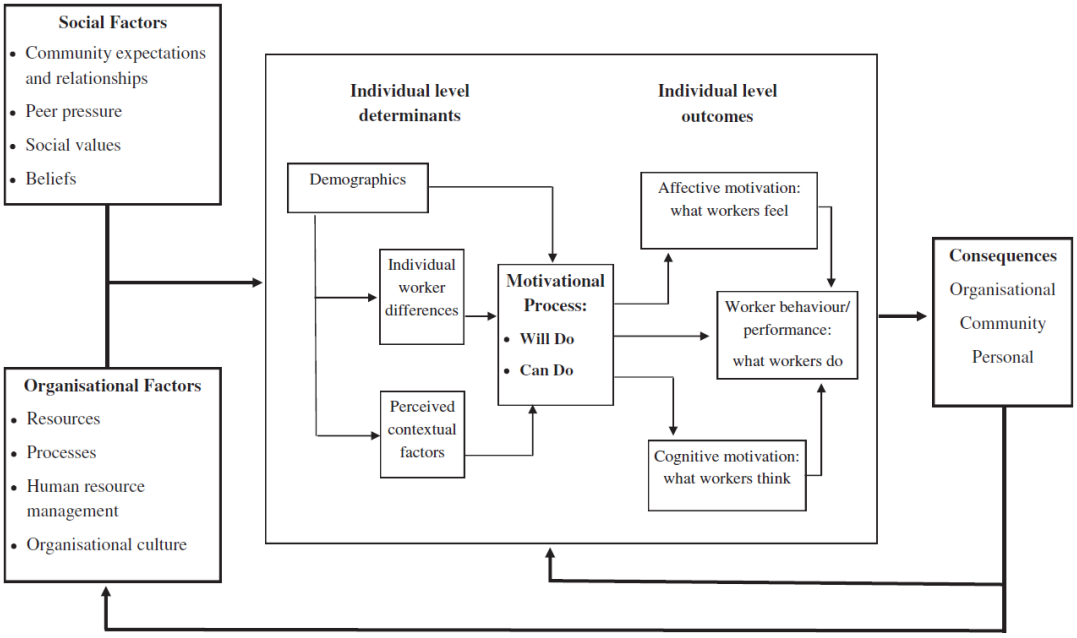
Motivated staff is important in any organisation and a key dimension in most quality frameworks. A low level of staff motivation is frequently quoted as a major stumbling block of improving quality of health services and may be closely linked to negative health outcomes. In many environments motivation is used synonymously for financial incentives. Although they do increase staff motivation, the effect is usually very short lived. Determinants of staff motivation are much more complex comprising individual, organisational and social factors.

2.4.2 Thematic Paper

Friday 6.02.15	**Motivating health workers to deliver high quality services**

Some key issues at stake: In low- and middle-income countries, the low level of health worker motivation is often been identified as a central problem in health service delivery and quality of care. From the perspective of health professionals, the factors that may negatively influence their performance include among else the lack of equipment, frequent shortages of supplies, low salaries combined with high workload, and weak human resource management (recruitment, overall staff distribution, remuneration, promotion and transfers, supervision). Typically, these problems are accentuated in rural and remote areas, especially at primary health care level. Looking at the problem of health worker motivation from the perspective of the patient, it is a major contributing factor to poor service quality, typically associated with absenteeism from work and long waiting times, informal fees, unfriendly and disrespectful attitudes, and inadequate treatment outcomes. All these aspects impede directly or indirectly on quality of care.

Figure 1. Framework of determinants of health worker motivation (Source Franco et al., 2004)



Defining motivation: Motivation, in the work context, can be defined as an individual's degree of willingness to exert and maintain an effort towards organizational goals. Motivation has been defined as *"an internal psychological process and a transactional process: worker motivation is the result of the interactions between individuals and their work environment, and the fit between these interactions and the broader societal context*" (Franco et al. 2002).

Interventions for better quality services: Quality care and patient safety are a longstanding concern of health managers, policy makers, patients and civil society. Over the past decades, an array of interventions has been tested and implemented to improve the situation so to make the workforce as effective as possible for delivering high quality health services. Tested measures include among else motivating health workers through improved infrastructural conditions, higher salaries and incentives, such as provision of staff accommodation, short promotion intervals, paid annual leave and organization of professional development courses. Evidence indicates that there is no single magic bullet. Typically it is a set of interventions used in parallel showing positive effects on motivation and quality of care.

Capacity building and continuous professional development: The development of a skilled and motivated workforce is essential to improving quality of care. This requires investments into approaches and systems for Continuing Professional Development often also summarized under the term Continuing Medical Education & Learning. Indeed, this is essential for updating skills and the development of professional capacities for all staff cadres. To be effective, Continuing Professional Development ideally is built around different tools such as quality circles, training workshops or self-studies and needs to be integrated into a broader (national) framework, which addresses issues such as licensing and accreditation.

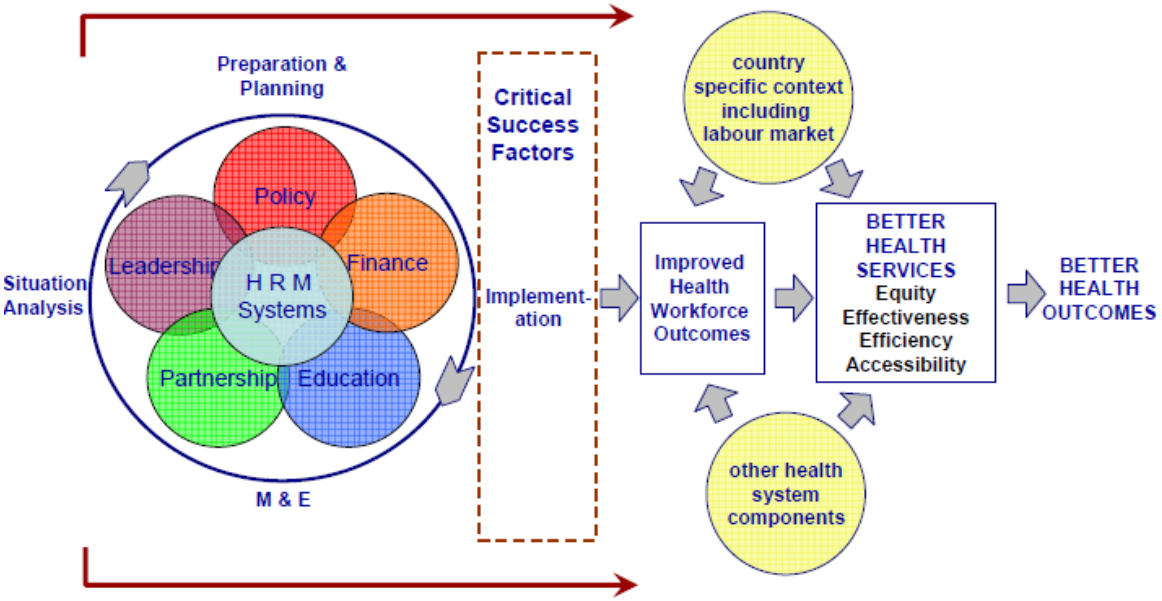
Coaching and mentoring of health workers: Traditional forms of training such as lectures, workshops or seminars is acknowledged to generally be of limited effectiveness in changing behaviours or practices unless strategies are deployed to reinforce compliance. Personalised learning strategies, such as coaching and mentoring, offer an opportunity to overcome this challenge.

Coaching is a supportive tool to facilitate learning and guiding people on the pathway towards better performance and hence to improve quality of care. Coaching is a one-to-one intervention with the aim to improve a health worker's effectiveness by focusing on technical issues and psychological considerations and/or on organisational change using tools such as goal setting, support in achieving the goals, and feedback.

Mentoring is a stable arrangement within which an experienced person fosters a junior protégé using his/her superior professional and social experience, knowledge and connections to advance the overall development of the mentee. Thus, mentoring has been defined as "an intense, one-to-one relationship in which an experienced, senior person assists a less-experienced learner by providing upward mobility and career support". (Chartered Institute of Personnel and Development, 2014).

Integrated human resource strategies to improve motivation and quality: A systems approach to human resource management means using a coordinated set of strategies to improve motivation and performance such as improving skills and reducing staff absence. A health system's approach views human resources as a sub-system alongside and closely related to other sub-systems such as information, finance, drugs and equipment. Effective strategies for motivating health workers to deliver high quality services require complementary action in other sub-systems. For example, improving skills and reducing absence will only improve workforce performance if health personnel have adequate drugs and supplies. The Human Resource for Health action framework (WHO 2008, see Figure 2) provides guidance on the development and implementation of strategies to improve health services, including quality of care.

Figure 2. Human Resource for Health action framework (Source WHO, 2008)



2.4.3 Summary of the day

There were no major discussions to the topic so that a summary is not provided. For those interested in the topic there is the literature and web-links below

2.4.4 Literature and web-links

- Chartered Institute of Personnel and Development, 2014. Coaching and Mentoring. Available at http://www.cipd.co.uk/hr-resources/factsheets/coaching-mentoring.aspx
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- RSA Animate - Drive: The surprising truth about what motivates us https://www.youtube.com/watch?v=u6XAPnuFjJc
- TED talk: The puzzle of motivation: http://www.ted.com/talks/dan_pink_on_motivation

2.5 Quality Management

2.5.1 Introduction

We have heard about quality as a process in health care delivery, the principles of measurement of quality and the role of staff and its motivation for the production of quality services. This chapter deals with a way of looking at the combined effect of these factors providing a framework for managing service quality. It also discusses continuous change processes and how they are managed by the health care providers in many West-European countries and North America.

As mentioned previously, quality is a multi-dimensional concept with different quality perspectives of professionals, users and other stakeholders of health facilities. Additionally, quality perceptions are continuously changing depending on technical developments, the changing regulatory environment, the expectations of patients and their families, communities and others. Facility managers need to keep the different perspectives in view in order to continuously adapt their services. Quality Management offers a framework for managers to keep all these aspects under control and continuously change/improve their service offer accordingly.

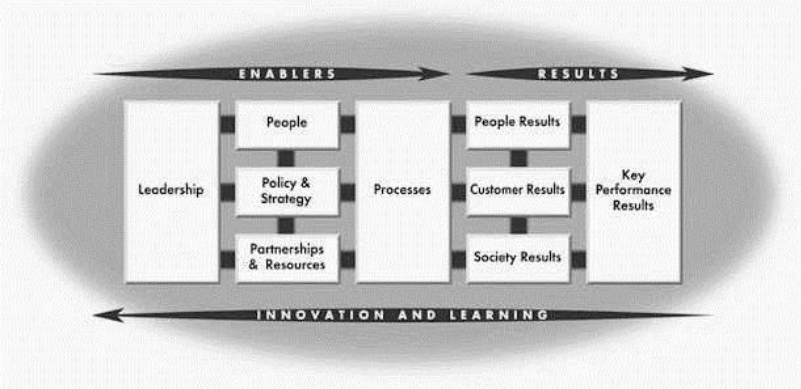
Whereas the concept seems obvious in many high income countries as well as the transition economies of Eastern Europe, this might be less obvious for low income countries with huge investment needs. However, from previous discussions, we found that patient orientation, staff motivation, and service provision according to guidelines and regulations are key elements for increasing service quality also in poor countries.

Primary Care systems work a lot at the interface between service providers and communities, Instruments, such as community health committees and village health workers are frequently used to extend services closer to community members. Capacity building of staff is on the agenda of most programs, which certainly improves staff motivation. Monetary incentives are widely discussed and performance based financing is a key topic in some African countries.

2.5.2 Thematic paper

09.02.15	**QUALITY MANAGEMENT IN HEALTH FACILITES** **From processes to outcomes**

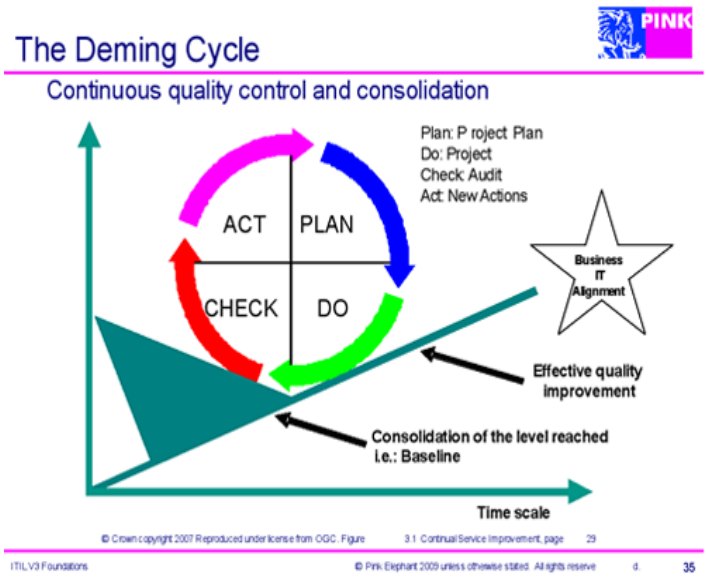
The variety of quality perspectives based on the specific views of actors, users/consumers/patients and stakeholders requires service providers to manage these expectations across all parts of an organization (quality management). The original idea of managing quality was started already in the 1940s by William Deming in the USA, who developed it further in post-war Japan`s car industry. In the 1980s the principles where picked up by Malcom Baldrige (Baldrige model of QM) as a governmental initiative to boost quality in production and service industries. In Europe 14 large enterprises including Nestle and Ciba Geigy created the European Foundation of Quality Management (EFQM) in 1988. The International Organisation for Standardisation (ISO) developed their quality norms (the 9000 family with 9001 for QM) starting in 1987, which is today one of the most frequently used quality management certification.



The key principles of QM models are based on the relationship between the service provider and its clients and stakeholders. This requires clear leadership, target orientation, the control of internal production processes and the participation of each staff member in the quality process. Based on the anticipated changes of customer expectations, the contextual changes and legal requirements require an institutional learning process and continuous quality improvement. Although not free of charge QM is rather an evolutionary model of quality improvement based on the fine tuning of internal processes. It has been developed for enterprises and public service providers rather than for entire systems[7]. However, some efforts have been made to translate this for primary health care systems amongst others by the German International Cooperation (GIZ) with its "concours qualité"[8] or for the development project environment through the instrument "Capacity works".

The above EFQM quality framework shows the key principles of QM: Leadership provides the vision and mission for the production process as well as the resources needed for the provision of services. Key enabling factors are staff, their capacity, motivation and skills; the regulatory environment and guiding principles for the production process as well as the necessary infrastructure and key partnerships (e.g. authorities, suppliers of drugs, payment schemes and others). These factors are used to produce the services/products by controlling all steps of the production process. Outcomes are not only related to the product itself (e.g. better health) but it should also contribute to staff and customer/patient satisfaction and to the community as a whole. Today QM systems are mandatory for health facilities in many countries in Western Europe and North America.

As mentioned above QM involves all parts of an organization making quality the leading institutional target (TQM – Total Quality Management). As quality perceptions change over time due to the change in expectations of clients and stakeholders, the continuous improvement of quality is a key principle requiring continuous adaptation processes within an organization. The Deming Cycle or PDCA (Plan – Do – Check – Act) Cycle illustrates this principle. Change (or improvement) is based on an initial assessment, which permits the definition of the change objective and strategy – the plan step. The implementation (Do) is followed by an evaluation (Check) of whether the change process has led to the expected results. If this is the case the piloted change is made the new standard (Act). The repeated execution of these steps leads to continuous improvement.



QM can be used in most contexts. However, health systems in many development contexts require considerable investment in infrastructure, capacity building and management skills in parallel to move service quality ahead.

But the agreement on defined quality processes, clear definition of tasks, the orientation towards and the respect of patient expectations and the adherence to regulatory frameworks can improve service provision frequently without major investments.

2.5.3 Summary of the day

Health care providers' assessment of quality gaps reveals frequently the items, lack of resources, not supportive physical environment, lack of qualified staff and professional knowledge. What is frequently left out is the interaction between these elements and the possibility to improve quality through small steps based on patient, staff and stakeholder views. Managing Quality offers instruments to engage in a continuous improvement process based on the identification of weaknesses and the design of small internal improvement projects. These projects are evaluated for their effectiveness and disseminated if successful. Leadership, staff, the regulatory environment as well as resources and external partnerships are essential elements to improve the process quality towards better service outcomes.

The Tanzania example shows how principles of QM are integrated into a governmental approach to improve service quality at the primary health care facility level. The e-TIQH instrument is used for quality assessment, identifying service quality gaps, root causes and possible solutions. These findings are disseminated and used for evidence based planning and budgeting. The resulting health plans also incorporates quality improvement activities, which are conducted by designated Quality Improvement teams and Work Improvement teams, which are in place at the facility levels.

The capacity to change lies certainly with health teams rather than individuals, who are given the authority to analyse and to change processes where required. Solutions to quality gaps need to be developed by all participants involved in the related process. An important factor in the evaluation of outcomes is certainly that not only the direct service outcome counts, but also the satisfaction of staff, the patient as well as the community in which the health facility is located.

Although a lot has been invested in capacity building for health staff, there is still a gap in combining the existing management tools (such as the health management information systems, team meetings supervision, in service training and others) towards a more integrated management system like QM. Health care facilities need to move away from simple reporting of data towards making better use of them towards continuous quality improvement.

2.5.4 Literature and web-links

- Management of Quality of Care, WHO website http://www.who.int/management/quality/en/
- Le Concours Qualité du Système de Santé du Maroc www2.gtz.de/wbf/4tDx9kw63gma/CQ_sante_maroc.pdf
- Brief: The e-TIQH approach at a glance

Brief_e-TIQH approach at a glance

2.6 Performance Based Financing

2.6.1 Introduction

Buying performance is discussed by many as a better way to fund health services than simple budget funding because it permits a more targeted approach to services and creates direct incentives to staff members. Performance based funding (PBF) has received a wide interest in development cooperation and some countries (e.g. Rwanda, Burundi) have adopted this approach as a national strategy. Usually PBF combines funding of the service itself and the resources required plus a financial incentive to staff. However, critical voices also claim that providing incentive for some medical activities facilitates the neglect of others, which are not incentivised. Others say that the controlling efforts for the approach binds highly qualified staff, which would otherwise be used for the provision of services. Today's discussion will provide some input into this discussion and provide an opportunity to share experience.

2.6.2 Thematic Paper

10.02.15	**PERFORMANCE BASED FINANCING** **Does performance based financing have an impact on quality of care?**

More than 30 sub Saharan African (SSA) countries are now in the process of introducing payment methods that reward performance or have already done so. Some donors are also supporting this direction with the World Bank for example having pledged 700 million dollars to be spent on women and children's health through Performance Based Financing (PBF) by 2015. Burundi and Rwanda are the first two countries to even implement these mechanisms nationwide. Most PBF interventions seem to target maternal and child health.

Some key issues at stake

The various forms of PBF schemes. In order to improve the performance of health systems PBF interventions provide incentives to either users of the service (Demand side) or providers of the service (Supply side) or to both. But which of these methods have succeeded? Are there successful examples of PBF?

What we know about effects of PBF in Low and Middle Income Countries (LMIC): the current knowledge base is still quite limited. Some studies have indicated increase in utilization rates and some evidence on quality improvement but few studies seem to even indicate that positive effects of incentives could even be due to a general increase in overall revenue[9] and not necessarily solely due to performance related financing. What makes a PBF intervention successful: quality and quantity of services, equity in utilization, etc.… or fail?

Main challenges for PBF interventions

How does one define quality in order to assess performance? In Rwanda and Burundi the PBF mechanism measures quality as an index of structural (equipment, drugs available, etc.) and process related (adherence to national clinical practice guidelines) measures. The scoring on the scale hence provides a 'measurement of quality' that is combined to a measure of quantity of services to eventually define the reward the facility will receive. Is this sufficient? Does one need to account for client

perception of quality? Are there other barriers causing inefficiency in the health system and are there other measures of quality? Who measures quality? There is a tendency of systems to become what they measure rather than measure who they are. Do such performance scales cause the same effect (too much focus of facility on maternal health for instance)? Should providers be involved in setting measures?

What is the level (amount) of incentive to be given? The Rwandan PBF mechanism led to larger positive effects on services of which facilities receive higher incentive rates. If a higher rate is set can it make the system unsustainable in the longer run/irreversible if expectations are raised to unrealistic levels? At the same time low rates set will make the mechanism ineffective so how do we decide on the right incentive amount? Who decides this incentive system (funder, provider or third party entity)?

What are the mechanisms employed to measure performance? In Rwanda district hospitals teams conducts unannounced visits to health centres to undertake assessments. Verifications are done based on existing documentation in the facility as well as observations. Studies in Tanzania and Rwanda though have indicated significant difference in daily practiced treatment protocols and set clinical standards for the treatments. Hence are the verification methods able to assess quality appropriately? Can flaws in the implementation mechanism cause failure in the PBF mechanism? Should the employed mechanism focus only on output or outcome parameters; or also on process parameters?

Who is given the incentive vis-a-vis whose performance is measured? The incentives in some PBF mechanisms have provided additional funds to health facilities to be used for specific purposes like salary top up or for financing drug purchase, etc. Is this a good strategy? Or should facilities be given more autonomy in using such funds? Is the regulatory authority also to be incentivized?

Is the mechanism sustainable in the longer run? In Haiti PBF initiatives determine the overall budget of the providers (10% of facility budgets paid only if performance targets were met). PBF initiative led to incentives becoming an important share of the facility budget (25% of facility revenue in Rwanda and 40% in Burundi) and in Mali for example the rewards for rural physicians employed by community-based health associations are additional top ups on top of their basic salary. The top-ups are financed through the health centres' income. Hence top ups are variable depending on the revenues. In some PBF interventions donor funds have also been used for payment of additional incentives. But with cash strapped in most health systems, can these initiatives be sustained without donors' support? If sustainable, can specific service focused incentives have negative impact on other services with lower or no incentives and thereby impacting negatively overall quality of health system? Further how are PBF integrated into other financing mechanisms?

2.6.3 Summary of the day

A large variety of PBF schemes exist, targeting supply and/or demand side. Most examples given were from Burundi and Rwanda, both countries having implemented for almost a decade a similar type of PBF. A large body of literature exists on PBF - either grey or published. Globally evidence on the effects of PBF is not conclusive on a number of dimensions apart from an increase in quantity of services (at least the ones incentivized through these schemes).

PBF rewards performance in the form of financial incentives that are used at facility and health administration levels to pay for running costs and also to reward staff individually at facility level, health administration (peripheral and central level) and communities (either through CBO or through health facilities committee). The communities are involved into quality measurements of PBF, which is supposed to make health facilities more responsive to the needs of patients. Quantitative indicators

are more frequently collected than qualitative ones but the reward finally attributed to providers takes into account both categories of indicators. What distortions and perverse effects can PBF have when one considers these salary top ups? More broadly does PBF strengthen or weakens health systems? Improvements in M&E, health information systems, and planning have been reported.

Some countries, i.e. Burundi have taken a leadership role in implementing PBF schemes in close collaboration with donors and technical partners that are involved in the M&E, steering, etc. of the PBF though their participation into national level PBF committees. While in many countries PBF relies mostly on external aid Burundi and Rwanda are examples of countries that finance a large part from their own resources. Further alike any donors' intervention is PBF always aligned to countries' national plans, and what about harmonization?

In light of high reliance on donors' funding financial sustainability of these schemes and impact of discontinuation of PBF on service delivery may be an issue depending on the specific conditions of countries.

How to define the level of incentives to be given, who to define the indicators (central/peripheral health administration), should indicators vary depending on the baseline level of performance of the providers, is the right level of management (i.e. the one that can make decision regarding allocation of resources and quality improvement) actually incentivized, etc. were also discussed.

2.6.4 Literature and web-links

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2. Kim, J., 2013. World Bank Group President Jim Yong Kim's Speech at World Health Assembly: Poverty, Health and the Human Future. Available at: http://www.worldbank.org/en/news/speech/2013/05/21/world-bank-grouppresident-jim-yong-kim-speech-at-world-health-assembly.
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13. Amanda Melina Grittner¸Results-based Financing Discussion Paper / Deutsches Institut für Entwicklungspolitik. Bonn 2013M ISSN 1860-0441; http://www.oecd.org/dac/peer-reviews/Results-based-financing.pdf

2.7 Community participation

2.7.1 Introduction

This chapter presents key issues relating to the definition of community and participation; mechanisms of bridging the gap between communities and health outlets; and accountability mechanisms. The text includes some references for more in-depth information and questions for discussion.

2.7.2 Thematic paper

12.02.15	QUALITY OF CARE AND COMMUNITY PARTICIPATION Does community participation in health service delivery impact quality of care?

Since the early 1970s, participatory approaches involving community members have been used in the public health sector to improve the quality and the accessibility of health services. These approaches have varied greatly over time but overall, the feasibility, impact and cost-efficiency of these approaches often remain unclear because of a lack of evidence on results and outcomes.

Some key issues and questions

Defining community and participation: there is lack of clarity and shared definitions for both terms. Several frameworks provide various ways to conceptualize community participation, either from the perspective of who initiates community participation (top-down vs. bottom-up approach) or from the perspective of the depth and breadth of participation (community participation defined as "levels", "ladders" or "types"). New forms of community also emerge with social media and globalization, challenging ideas of the spatial location of communities.

It is acknowledged that the less-advantaged often participate least: *"The poor often benefit less from participatory processes than do the better off."* (Mansuri 2013), which leads us to question:

- Who actually takes part in community participation?
- Do participatory approaches really benefit the most vulnerable and marginalised?
- How can we address possible tensions between the participation of the most vulnerable/marginalized groups and the requirements for effective and influential participation of community members in health delivery management (e.g. literacy skills, understanding of basic health planning, time, resources, skill sets, etc.)?

Community Health Workers (CHWs): This mechanism, which was quite popular in the 1970s, recently attracted renewed interest by development practitioners as it offers possibilities to bridge the gap in basic healthcare at the grass-roots level. But in order to realise the full potential for CHWs to strengthen health services delivery at community level, several challenges must be addressed. Although there is an array of "close-to-community" health workers (CHWs, midwives, traditional birth attendants, other informal practitioners and lay counsellors, etc.) there is no standard across countries in terms of the minimum package of training, roles and deliverables. Equally CHWs need support, supervision, coordination, M&E and clear referral mechanisms to formal health facilities. It is important

to better understand skill sets and quality-related issues, especially when lay health workers are volunteers.

This raises issues such as:

- How to assess the quality of health promotion activities performed by lay health workers?
- What are ways to measure and enhance their performance and productivity?
- What are strategies to sustain and motivate of volunteer staff?
- What are the benefits and risks of incentives and payments?
- How to institutionalize, operationalize and go to scale with CHW projects and programs?
- What are ways to integrate them to the health system?

Accountability mechanisms: quality of care can be improved by encouraging communities to realise their right to quality health services and by strengthening the accountability of health services to the communities they serve. A wide range of accountability mechanisms exist at the interface between the community and the health system (health facility committees, village committees, community groups/CBOs/NGOs, scorecards, patients' charters, etc.) with various levels of service quality control through community participation. The success of these depends on context, content and process factors, in particular membership selection mechanisms, relationship with the health system, as well as resources and support. However, very little empirical data exists on the actual impact and sustainability of these approaches.

- A number of questions surround community accountability mechanisms:
- What is the responsiveness of the health system to community accountability mechanisms?
- How are issues of legitimacy and representation addressed?
- How are they best supervised?
- How is social inclusion ensured?
- What is the cost-efficiency of such approaches?

2.7.3 Summary of the day

As well as the potential for strengthening social accountability and representation in governance, community participation can be within both the "supply" and "demand-side" of health services. The people who participate, range from volunteers to compensated and even salaried community health workers and traditional practitioners. In terms of extending the quality and range of services in rural and remote areas of resource-limited countries, community agents have a strong role to play, particularly in patient-centred treatment and care of protracted conditions such as TB and HIV, which require careful day-to-day management.

Meaningful community participation in health service and facility monitoring and management has the potential to hold providers accountable to the communities they service. Equally it enables communities to challenge their health system providers and managers as well as to shape elements of the healthcare system.

Community representation on service and facility committees tends to be quite weak in their functioning. This is related to power dynamics within the community, particularly evident in rural areas where there is a large disparity between the education and social status of providers and health service users. However, tools are being tested, such as score cards, to strengthen the role of the community in improving accountability and quality of services.

Although there have been concerted efforts over the last 30 years to bring village health workers and traditional midwives closer to primary care services, approaches have changed from initial capacity building to deliver curative and maternal services to their communities (e.g. TBA's skills strengthened to improve maternal and neonatal survival; CHWs dispensing medicines etc.) to more recent concentration on the "software" side of health promotion, disease prevention, awareness-raising and mobilization. Indeed community health promoters have proven to play a key role in supporting the health status of populations in difficult to reach settings such as in rural Tajikistan and Cambodia, where improvements in skilled delivery and reductions in maternal and neonatal mortality have been observed.

Socio-cultural context is very important in terms of volunteerism and reducing reliance on traditional care providers, particularly TBAs, yet it is not always well studied, understood or incorporated into programme design.

To sustain community actors and action to improve health service quality and demand for services, it is important to ensure that CHWs are adequately supported financially as well as with supervision and training. In some settings such as Rwanda, funds from Community Performance Based Financing are used by CHW cooperatives to fund income generating activities, the benefits of which form incentives.

Given the persistent gap between Community participation in policy and practice, there is a strong need for trans-disciplinary research and feedback to inform approaches and strengthen the evidence base in a broad range of community settings.

2.7.4 Literature and web-links

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- Molyneux S, et al. (2012). Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. Health Policy Plan. 27 (7): 541-54.
- http://frontlinehealthworkers.org/
- http://1millionhealthworkers.org/
- **Upcoming event:** Swiss TPH Spring Symposium, 23 April 2015, in Basel, Switzerland. Community Participation in Public Health: What's the Added Value in Research and Implementation? www.swisstph.ch/news-events/symposia/spring-2015.html
- WHO guidelines on community-based rehabilitation: http://www.who.int/disabilities/cbr/guidelines/en/

- A short (3.5 minute) video on the process developing of community health action plans to promote health: http://vimeo.com/album/2635119/video/82300215
- Kate Molesworth; Community Action for Health Conflict; Symposium: “Community Action for Health”: Nepal MMS Bulletin #99 January 2006 http://www.medicusmundi.ch/de/bulletin/mms-bulletin/community-action-for-health-gemeinsam-fur-gesundheit/symposium-vom-9-november-2005-reader/community-action-for-health-in-conflict
- Biren Bangdel; Lessons from the Rural Health Development Project in Nepal; MMS Bulletin #86 October 2002 http://www.medicusmundi.ch/de/bulletin/mms-bulletin/gesundheitsforderung/geschichten-aus-der-welt/lessons-from-the-rural-health-development-project-in-nepal

3 Evaluation and Recommendations

The e-discussion was followed by a short online questionnaire with 8 questions and opportunities for comments using flexiform. We received 17 replies to the questionnaire. We generally used five-item Likert scales of the type fully agree – partially agree – not sure – partially disagree – fully disagree to record the responses.

All participants agreed to the usefulness of the information provided (11 fully agree; 6 partially agree). The participants said that the sessions provided a good overview, one was particularly interested in community approaches and one mentioned that quality is crucial for the provision of services.

Referring to the quantity of information provided, the majority (11) stated that it was just right, 3 participants said that it was too much and another 2 were not sure. The thematic papers provided were widely appreciated and some participants would appreciate if there was a summary of the discussions with links to the topics discussed. Quite a few participants said that the working schedule did not permit them to regularly follow the discussions and therefore they could not fully appreciate the information provided. These statements appeared under several comments to different questions throughout the evaluation. We generally observed that there was more participation on Tuesday's and Thursdays, than on Mondays and Fridays. However, we cannot exclude that this is rather related to the topics than to the timing.

In terms of an increase familiarity with the topic following the discussion, 12 participants felt more comfortable discussing the issues during their daily work (fully agree 4, partially agree 9), whereas 3 were not decided. Comments were that the session should be better planned and prepared by the participants to have more time for the topic. An additional remark was also that some suggestions made during the discussion did not provide an indication for their applicability in the field.

We also asked whether participants felt that this type of guided discussions were a good way to improve knowledge on a particular topic, which was confirmed by a large group (fully agree 4, partially agree 12). However, participants said that the presented themes changed too fast and sometimes discussions were overlapping because comments arrived on a previous day topic, when the discussions on the new topic of the day had already started.

When asked about the optimal set-up of the e-discussion in terms of numbers of events and duration, the opinions varied greatly. The majority stated that they wanted less sessions per week either for the two weeks or even more. Some suggested that the e-discussion should be concentrated only for one week. In our opinion one should think about leaving a space between each discussion day to allow for the inclusion of the experience of late responders. This might ease the conflict between heavy workload and interest in the discussion.

We also asked participants of how future e-discussions could be improved to increase participation or make it generally more useful for participants. Participants felt that topics should be extended for longer periods of time to allow for more participation for people who need more time (and probably for in-depth discussions – remark of the author). Also, more time should be provided for participants' preparation for the individual topic and the discussion should be opened for project field staff.

There was also a feeling that the moderation style was not consistent, sometimes the moderator was more a participant and on other occasions the person gave stronger directions. One comment suggested that instead of just contributing their experience, people should be more challenged in their opinions and approaches to initiate change. A suggestion for future improvement was to have a pre-post-test scenario included (we provided only a self-test/teaser, which was not evaluated and we cannot said how it was used by people). Also a stronger focus on the communication of best practices was suggested as well as a future involvement of WHO experts.

When asked about their future participation in such e-discussions, the majority responded in the affirmative and a smaller group would restrict it to their topic of interest. Asked about topics for future discussion participants mentioned:

- health financing, mandatory health insurance in low income countries; universal coverage, private sector engagement; priority setting and budget allocation
- SRH and rights, neo and postnatal care,
- how to deal with institutional change, improvement of health admin,
- how to influence policy for health reform; donor coordination
- health determinants in low and middle income countries;
- human resources for health;
- lessons learnt from SWAP,
- community health committees and other instruments for community driven management of health services;
- decentralisation, management at decentralised levels, supervision, HMIS, M&E;

This list is not ranked and topics are grouped by the authors and not necessarily by the participants.

From the moderators' point of view the e-discussion was generally well attended and well followed by participants. Expectations on the moderation style of the e-discussion seem to have been different and varied amongst participants from stronger guidance with a specific outcome (teaching style with pre- and post-testing) to rather an exchange of experience with technical input, which was actually the anticipated format. The development of the agenda was mainly based on the specific interest of SDC offices as describe in the assessment done in October 2014 with the objective to provide a thematic overview and link it with field experience. An alternative could certainly be to identify one topic and engage in in-depth discussions, which could have a stronger knowledge transfer aspect.

An interesting aspect might be the future inclusion of project field staff, which may increase opportunities to better share lessons learnt or to discuss specific topics more in depth, or from a more practical angle.

4 Annexes

1. E-learning themes identified by Swiss Collaboration Offices
2. Who we are: List of Swiss TPH and SDC moderators
3. SDC e Discussion – Quality of Care Programme
4. Summary table for e-discussion evaluation results
5. Quiz for introductory message, 28.01.2015
6. List of participants in the e-discussion

Annex 1: E-learning themes identified by Swiss Collaboration Offices

Themes for an *E-Discussion*
Virtual Seminar due to take place in January or February 2015

Results of the consultation => 13 responses

Issue	Your Key Questions	What you can bring + Additional comments
1. Improvement of the quality of health services and of the continuum of care (from health promotion to palliative care).	➢ Instruments for quality (guidelines, Standard Operating Procedures & others) ➢ How to make the referral system function properly? Motivation, RBF & Incentives ➢ What can we reasonably expect from result based funding? ➢ RBF, PBF again, three countries and three applications. We would be interested I discussing the correlation (or lack of) between RBF and quality of services. + What can we reasonable expect from result based funding? ➢ And finally, again on RBF, Rwanda is targeting the convergence of the international Accreditation criteria with the PBF criteria (for hospital for instance). ➢ Effective non-financial incentives for motivating providers for better performance? ➢ What approaches can be used for staff motivation in resource strained environments? Financing for Quality ➢ How to ensure quality of health services when state health financing is inadequate? ➢ How to balance quality of services and costs of service provision? ➢ Community Health Insurance (Costing of health services, coverage, voice of members). We have three	<u>COOF Bosnia and Herzegovina</u> ➢ Experiences in introducing new approaches in community-based mental health care provision (continuous education, peer-support, monitoring) and pilot experiences with community nursing (re. continuum of care) ➢ Experiences in development of local implementation plans for introducing new services (community nursing) at the level of PHC facility <u>COOF Tanzania</u> ➢ We are taking on board a tool developed by Novartis Foundation called E-TIHQ on assessing quality of services in health facilities (currently done in one region Morogoro but to be scaled up in two others). The central ministry is working on using this tool broadly. ➢ Experience on health promotion at the village level and HP plans to be included in districts health plans ➢ Referral system: how to get a clear division of labor and responsibility between primary and secondary HF? How to promote service agreements between the government and public/FBOs run HF? ➢ RBF: how to focus on incentives for health facilities v.s. Health workers, in a HSS approach? How to focus on HSS v.s. Theme or disease specific incentives? <u>COOF Albania</u> ➢ Building a Continuous Medical Education system in Albania and challenges

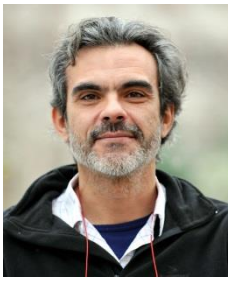
	countries with three different applications of the same principles. ➢ Ensuring sustainability of the continuous education for service providers? ➢ How can CME influence the quality of health? ➢ Universal health coverage? ➢ How to address Cost benefit / Cost effectiveness in health projects? ➢ What health insurance can be set in resource poor countries? And how to make it sustainable? Service Delivery ➢ How to push health promotion from theory to practice? ➢ Under what circumstances de-concentration of competences from central to district level can help improve provision of services at the lower level? ➢ How to formulate dialogue with service providers to ensure quality? ➢ How to address quality in extremely remote areas? ➢ How to train community focal points/health agents for quality? ➢ Quality of services VS patients/clients satisfaction, Quality of services VS high health staff turnover	<u>COOF Mozambique</u> ➢ Mozambique's experience (successes and challenges) in health promotion; ➢ Community health councils (activists) approaches and outcomes in rural settings <u>COOF Kirgizstan</u> ➢ Experience with civil society organization monitoring quality of services and demanding their improvement in collaboration with service providers at grass root level <u>COOF Tajikistan</u> ➢ Monitoring of service performance, continuous medical education (Swiss TPH), clinical audit by Aga Khan Health Services. ➢ It would be too early to speak about the experience of the newly launched RBF at PHC level by the WB <u>COOF Horn of Africa</u> ➢ Determinants of quality gaps in nomadic communities of the Somali ecosystem, hopefully first findings of baseline studies (STPH + other) on the community based and/or household health agents approach

Ausserholligen, 27.10.2014 MJQ

Annex 2: Who we are: List of Swiss TPH and SDC moderators

his of SDC/Swiss TPH experts

eDiscussion Quality of Care: Who we are



Xavier Bosch, Swiss TPH (MD, MSc, PhD, Specialist Public Health), group leader at Swiss TPH. 10 years living and working in Sub-Saharan Africa and 20 years' experience in health care management and evidence. Practical and academic experience in quality of care, as medical officer, district officer and project manager, including teaching and training of health care providers, managers and officials. Special emphasis on evidence of interventions to improve quality (e.g. Cochrane review on supervision).

Kate Molesworth, Swiss TPH (Cert. Ed., MSc., PhD), Senior Public Health Specialist has 25 years' experience of research and technical assistance in the fields of health, gender, social inclusion and development relating to livelihoods and mobility. She has developed and rolled out a package of community development interventions to strengthen systems to support community development projects in Tanzania. She is an experienced lead evaluator of community development projects and advisor for community participation with experience in CIS countries and South East Asia.

Cyril Nogier, Swiss TPH (MSc, MiM), senior project leader and health economist, long term experience in Africa and short term mission in Africa, central Europe and Asia. Currently director of the SDC health district project in Chad and providing technical support on health financing issues in SDC regional health system strengthening project in the Great lakes. Regular teaching assignments (Msc, MBA level) in health financing and health economics.

Alex Schulze, SDC (MSc, MAS, PhD) is advisor for health systems strengthening and financing at the Global Programme Health, Swiss Agency for Development and Cooperation. His main foci are access to primary healthcare, social health protection (in particular through community-based health financing) as well as quality of health services. Country experiences include Tanzania, Mali and the Philippines.

Siddharth Srivastava, Swiss TPH (MSc. Operational Research) is a Health Financing Specialist with a focus on design, implementation and research on health insurance systems primarily in developing countries. He is supporting the health financing (community health funds) component of the SDC funded Health Promotion and System Strengthening (HPSS) project in Tanzania.

Manfred Störmer, Swiss TPH (M.A. Public Policy and Management), is a senior health financing expert with more than 20 years of professional experience. He has provided his expertise as consultant and team leader in the field of development and analysis of health care financing concepts such as health insurance, performance-based funding, and user fees in Africa, Asia, and Eastern Europe. He is currently head of the Health Economics and Financing Group and deputy head of the "Systems Support Unit" of the Swiss Centre for International Health

Kaspar Wyss, Swiss TPH (PD, PhD, MPH, M.Sc.) senior Public Health specialist in charge of a team of 18 professionals focusing on health systems development primarily in low- and middle income countries. Management of SDC funded health sector support projects in Albania and Tajikistan. Longstanding experience with quality of care assessment and improvements, with a specific focus on the role and importance of human resources for health. Extensive teaching and training experience for the University of Basel and others in the area of health systems strengthening; Supervision of several PhD and MSc students.

Manfred Zahorka, Swiss TPH (MD, MPH, EOQ Auditor), senior Public Health specialist with a focus on Reproductive Health, long-term project management experience in African countries, consultancies and backstopping missions in African and Eastern European countries, longstanding collaboration with SDC both at HQ and at field level, support to Quality Assurance and Quality Management processes in Ukrainian, Romanian and Moldovan health care institutions at a systemic and institutional level.

Annex 3: SDC e Discussion – Quality of Care Programme:

Phases	Timing	Theme	Issues to be addressed	Moderator/ Expert
Preparatory Phase	28.01.2015	Preparing for e-Discussion - QoC	• Organisational issues (login etc.) • Introduction of programme and expert team Thematic papers for each discussion day will be sent a day prior to the discussion as preparatory readings	Manfred Zahorka
Discussion Phase	02.02. 2015	Introducing Quality of Care (QoC)	• Concepts and definitions • Quality Frameworks • Contextualization of Quality	Manfred Zahorka
	03.02.2015	Quality process	• (Local) Definition of quality: perspectives and dimensions • Quality improvement strategies • Evidence on quality • Links with national strategic health plans.	Xavier Bosch
	05.02.2015	Approaches to measuring/ assessing quality of health services	• Measuring what at which level and how • Monitoring quality of services, • Situation analysis • Instruments in QoC; Standards, Guidelines, Quality Checklist / Score Cards, Accreditation	Xavier Bosch
	06.02.2015	"Motivating health workers to deliver high quality services"	Intro to Motivational theories Instruments: • Capacity building and CE • Incentives and approaches for better quality services, • Inspection/Supportive Supervision	Kaspar Wyss
	09.02.2015	"Managing quality in health care facilities	Models and Instruments in Quality Management for Health • Processes models • Total Quality Management? • Continuous improvement • PDCA – Continuous Quality Improvement • Benchmarking and peer learning	Manfred Zahorka
	10.02.2015	"Financing quality of health services"	• Instruments for health care financing and quality • Performance based payment PBF • community health insurance funds • Incentives and approaches for better quality services,	Manfred Stoermer
	12.02.15	Community participation and good governance	• Service quality control through community participation • Incentives for demand creation • The Role of health committees and community health workers	Kate Molesworth

Phases	Timing	Theme	Issues to be addressed	Moderator/ Expert
	13.02.2015	Evaluation	• Capitalisation of lessons learnt • Participant feedback (short questionnaire)	Manfred Zahorka

Annex 4: Summary table for e-discussion evaluation results

Question	**Summary of Answers**
The information provided during the two week e-discussion was useful for the setting I am working in.	• fully agree 11, • partially agree 6
Comments	• good overview, • community approaches very interesting, • quality is crucial
The quantity of information provided during the discussions was	• just right 11 • too much 3 • not sure 2
comments	• thematic papers much appreciated, • a summary of the discussions with links to topics would be appreciated, • working schedule too busy to fully appreciate, • Two 2 weeks are too dense for the information provided • sometimes suggestions provided in the e-discussion was given without indication of applicability
After participating in this e-discussion I feel more comfortable to discuss Quality of Care approaches in my daily work.	• fully agree 4 , • partially agree 9 , • not sure 3
comments	• plans for a session on community participation; • need for summary; • need to plan for participation, • some issues need more time for preparation, • appreciateion of notes and materials.
Guided discussion rounds, like the one I participated in, are a good way to learn/improve my knowledge on a given topic.	fully agree 4,partially agree 12: I am not sure 1
comments	themes change too fast, challenge is the daily work load , poeple need to be challenged more to review their approaches; second week better guided, discussions happened simultaneously, difficult ot understand the guiding
What is in your view the optimal number of discussion sessions for e-discussion of this type?	less sessions per week for two weeks 7; less sessions for more weeks 5; 4 sessions per week, more weeks 1; 4 sessions one week: 4;
comments	not enough time to respond to topics, participation could be better if less sessons per week, one week could be better so people would not loose the point.
Would you like to participate again in an e-discussion on a different topic?	yes 14, depends on the topic 3

What topic would you like to suggest for the next/any future e-discussion?	health financing, universal coverage, private sector engagement; priority setting and budget allocation, SRH and rights, neo and postnatal care, how to deal with institutional change, how to influence policy for health reform; health determinants in low and middle income countries; human resources for health, improvement of helath admin,-management at decentralised levels, donor coordination; supervision, HIS, M&E; lessons learnt from SWAP, mandatory health insurance in low income countries, community, health committees and other instruments for community driven management of healht services; decentralisation
How could the next e-discussion be improved/what could be done differently?	topics for longer periods to allow for participation of people who are slower, different quality of moderation and input (clarify moderation style: exchange vs. Teaching?); some days too busy; enlarge participants to project field staff; more time for preparation, quiz at the beginning and the end, inputs on best practices, participation of experts from WHO

Annex 5: Quiz for introductory message, 28.01.2015

Instructions for programming questionnaire in flexiform:

- Give always two attempts for each question
- In **Pass Result/Fail Results** please add the following sentence: Please note that all the issues addressed by the questions in this quiz will be taken up and discussed during the two-week e-Discussion on Quality of Care coming up soon!
- If technically possible, there is no need for them to see their score as it is not a test but just a teaser for the two-week programme.

Question 1

Please decide if the following statement is true or false.

Even in places where health systems are well developed and resourced, there is clear evidence that quality remains a serious concern, with expected outcomes not predictably achieved and with wide variations in standards of health-care delivery within and between health-care systems.

True/False

Question 2

At which level rests the lead responsibility to keep the performance of the health care system under review and develop strategies for improving quality outcomes? Please select the correct answer.

At the global level
At national & regional level
At the community level
At the level of health service providers

Question 3

Quality improvement is about change. From the list below, please select all the key stakeholders to be involved in the decision-making process.

Political leaders
Regulatory bodies
Community leaders
Service users
Service provider organisations
Persons in charge of quality improvements at the Ministry of Health

Question 4

Please decide if the following statement is true or false.

Equity is a critical dimension of quality.

True/False

Question 5

Please decide if the following statement is true or false.

Service quality at the health facility level is the exclusive responsibility of leadership.

True/**False**

Question 6

At what levels of service provision should quality be managed?

Leadership
Staff satisfaction
Community relationship of service providers
Clinical procedures
Infrastructure
Clinical outcomes

Question 7

Please decide if the following statement is true or false.

Most of the time quality improvement needs considerable investment to fund the radical changes implied.

True/**False**

Question 8

If we increase the salary of a health worker his/her motivation proportionally increases and thus we automatically improve quality of care.

True/**False**

Annex 6: List of participants in the e-discussion

No	Name	Country
1	Jacqueline Matoro	SCO Tanzania
2	Maja Zaric	SCO Bosnia Herzogovina
3	Mousamma Djamalova	SCO Tajikistan
4	Merita Stavileci	SCO Kosovo
5	Cecilia Capello	Enfants du Monde
6	Elvira Muratealieva	SCO Kyrgyzstan
7	Eric van Willert	Swiss TPH Tajikistan
8	Tommaso Tabet	SCO Kigali
9	Seleus Sibomana	SCO Burundi
10	Erika Placella	SDC HQ
11	Aurelie Righetti	SCO Tanzania
12	Barbara Profeta	SCO Horn of Africa
13	Carlo Santarelli	Enfants du monde
14	Helder Ntimane	SCO Mozambique
15	Theoneste Twahirwa	SCO Kigali
16	Mujinga Ngonga	SCO Mozambique
17	Mathias Leicht-Miranda	SCO Moldova

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