Quality Collaborative - Strategy and Plan

1. Introduction and Background

'Community Case Management' (CCM) or 'community Integrated Management of Childhood Illnesses' (c-IMCI) as it is referred to in Rwanda, is strategy to deliver life-saving curative interventions for common childhood illnesses in the community, particularly in cases where there is limited access to facility-based services.[i]

The **goal** of the Supply Chains 4 Community Case Management (SC4CCM) Project is to improve product availability at the lowest level of the supply chain, thereby contributing to improved child health in communities. In Rwanda, SC4CCM's **main country level objective** is to ensure that CHWs have useable and quality medicines available when needed for appropriate treatment of childhood illness. As such, the Project aims to find affordable, simple supply chain (SC) solutions that address the challenges faced by community health workers (CHWs). SC4CCM will test supply chain innovations and generate best practices that can be put into broader practice for SC operations at community level. These efforts will complement the work of the government, SC technical assistance and ICCM implementing partners by sharing what is learned and serving as a catalyst to help them to take promising solutions to scale.[ii]

In order to achieve its goal and objectives, SC4CCM/Rwanda will work with the Government of Rwanda (GoR) and other stakeholders to develop and test a number of implementation approaches, including:

1. The use of performance-based incentives to motivate Community Health Workers (CHWs) to perform SC tasks (in 3 districts)
2. The use of the "Quality Improvement Collaborative" approach (or "Quality Collaborative" – QC, in short) which will focus (in 3 districts) on:
   A. Enabling performance-to-standard of selected SC tasks;
   B. Training and supporting local quality improvement (QI) teams to identify problems in SC management and develop and test locally appropriate solutions and best practices that can be spread to other locations; and
   C. Building the capacity of existing supervisors, pharmacy staff, and cell coordinators, to:
      - Use QI tools and techniques to make changes that close performance gaps in the topic area of the QC (resupply)
      - Participate in QI teamwork
      - Provide support to CHWs to in order to engage them in the demonstration and roll-out quality improvement changes in the topic area of the QC
      - Participate in the spread (scale-up) of best practices in SC management tested and shown to be successful in during the life of the QC.

This strategy and plan provides an overview of the Quality Collaborative approach as designed for SC4CCM/Rwanda.

2. Rationale and Technical Approach

2.1. Overall need

Findings from the SC4CCM baseline assessment, validate by stakeholders at all levels, indicate the need for improvement of SC management in five main areas:

1. **Product availability at the community level**
   A. A key finding from SC4CCM baseline assessment indicates that just less than 50% of the 208 CHWs who manage the 5 health products (medicines)[iii] needed to treat common childhood illnesses[iv] had all the products in stock on the day of visit (DOV).[v]
   B. Stock-outs ranged from 1-2 months.
   C. Stock imbalances such as overstocking and/or under-stocking of various products were found to be common.

2. **Product availability at resupply points**
   A. Only 36% of the 85 health centers which reported managing the 5 key products have them all in stock on the DOV.

3. **Knowledge and Capacity of CHWs and staff at re-supply points**
   A. Supply chain data not visible at all levels of the system; logistics data aggregated at cell level and not used to inform resupply decisions
   B. No shared operating procedures (SOPs) standard formula for calculating resupply quantities for CHWs exists.

4. **Storage conditions at CHWs**
   A. 6% of CHWs were observed as having insufficient storage and organization of existing medicines and supplies.
   B. 11% of CHWs cited lack of adequate storage space as their main challenge to managing health products.

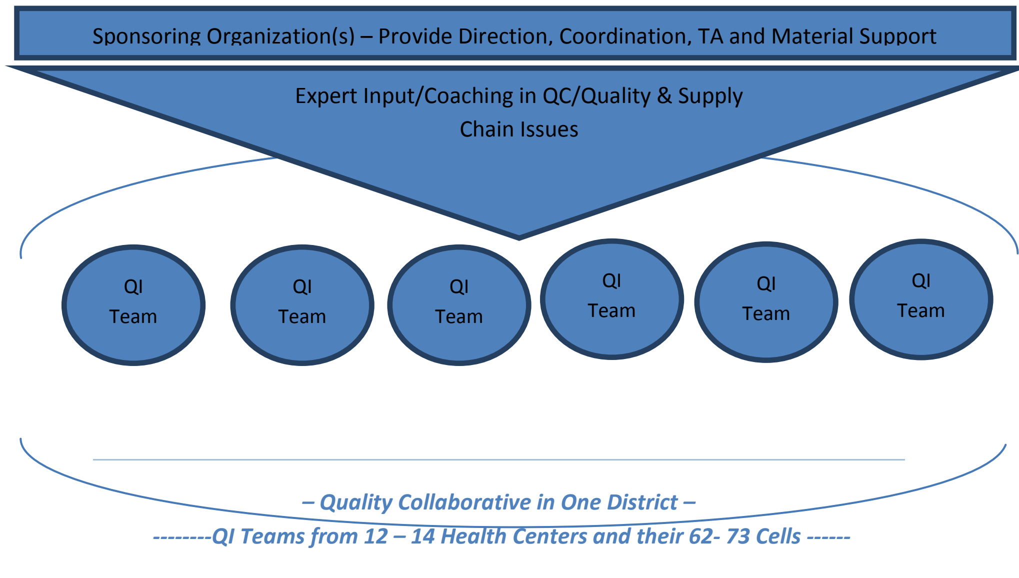
5. **Transportation between resupply points**
   A. 88% of CHWs travel by foot, 10% by bikes, 0.9% by private vehicles, 0.3% on public transportation.
   B. 27% of CHWs cited lack of transportation as the their main challenge to managing health products

6. **Motivation of CHWs to perform SC roles**
   A. Main motivators cited by CHWs included improving relationships and trust with neighbors (47%), self-fulfillment in saving children's lives and serve the community (27%).
   B. 40% of CHWs cited lack of remuneration as their main challenge to managing health products.
   C. 54% of CHWs reported being supervised monthly; 36% quarterly. Only 2% cited supervision as a motivating factor.

2.2. Definition of, and Rationale for Using, the 'Quality Collaborative' Approach

A 'Quality Improvement Collaborative' is a network of individual Quality Improvement (QI) teams that join together in a time-bound, collaborative process, using shared objectives and indicators. (*basic elements of a Quality Collaborative network.*)

Figure 1: **Quality Collaborative: A Network of QI Teams**



The **aim** of a Quality Collaborative is to close the gap between desired/expected performance and actual performance by developing, testing/ implementing and scaling-up (or 'spreading') changes quickly across many teams and/or organizations.[vi]

Members of the Quality Collaborative commit to:

1. Address a single, pre-selected topic area by making improvements at their home facility/service delivery point; and

2. Participate in shared learning with other QI teams during the life of the QC. This shared learning is accomplished through:
    A. **Learning Sessions:** Preparation for and participation in structured, 1-day "Learning Sessions" that bring together QI teams and experts in the topic area selected for improvement. The purpose(s) of the Learning Sessions are to:
        - Share – among all the QI teams in the Collaborative – data and other information on progress to date developing and testing improvements that are underway by the by QI teams at their home sites.
        - Receive feedback from peers and experts
        - Engage in new learning that can help advance the QC and QI
        - Plan forward.

The Learning Sessions usually take place on a quarterly-basis and bring together QI from the entire Collaborative.

B. **<u>QI teamwork among individual QI teams, including periodic QI team meetings</u>**: QI team meetings and teamwork take place during Action Periods between the Learning Sessions. Action Plans guide this work. Regular QI team meetings are held monthly, depending on the design of the QC and the data collection needs of the QI and QC.

C. **<u>Coaching sessions</u>** for QC/QI teams and individual team members during the Action Periods.

D. **<u>Peer-to-peer communication and sharing</u>** during Action Periods, between QI team meetings and/or Learning Sessions. This is typically done through emails, cell phones, websites and face-to-face.

The Quality Collaborative approach uses, but goes beyond, the foundation of the traditional QA and CQI (*see box at lower right)* by bringing QI teams into a larger learning system (the QC network) aimed at achieving rapid results in a key area.

In order to make breakthrough, rapid change, to close the performance gap, the **<u>QC method applies and intensive process which includes the elements listed below</u>**.

- **Identification of a single topic area** that is related to a gap (or multiple gaps) between desired and actual performance. The topic area, which can be broad or specific, is selected by the by the sponsoring organization(s) (e.g., an NGO and MOH) with input from subject matter experts.

- **Preparation and application of an 'implementation package"**(IP)[vii] by the sponsoring organization and subject matter experts. The IP includes best practices, SOPs and other relevant information to address the topic area, as well as stipulates what sort of training /skills may be necessary as part of the change package but will take place outside the QC.

- **Establishment of common objectives and indicators**.

- **Selection of regions and sites** to participate in the QC.

- **Preparation of training materials and illustrative meeting plans.**

- **A launch meeting/workshop, followed by several, periodic "Learning Sessions"** during which teams receive expert input into in the topic area, share their respective progress and experience (back up by data) and engage in peer-to-peer learning, feedback and 'friendly competition' in terms of

Traditional quality assurance: (QA)
- Norms and standards, SOPs
- Training
- Certification/accreditation
- Materials and equipment
- Supervision
- Job aids.

Quality Improvement (QI) / Continuous Quality Improvement (CQI): all of the QA elements above, *plus:*
- Client focus
- Established QI team
- Use of regular/routine teamwork for:
  - monitoring quality /collecting and using data
  - problem identification
  - problem solving using and continual processes (e.g., Plan-Do-Study-Act)
- Coaching
- Peer support

progress to achieve the QCs objectives/indicators. Action plans elements are identified for the next action period.

- **Work by individual QI teams during "Action Periods**" (between Learning Sessions) to apply the implementation package in their home setting using the SOPs/tools from the topic area and QI process and tools in the IP. The process used by QI teams during the Action Periods is the (data driven) Plan-Do-Study -Act (PDSA) cycle. Teams identify problems and solutions to implementing the IP and closing performance gaps; as well develop and test innovations and best practices that come from the local level can be used further to refine the IP before it is scaled-up (spread) to other locations beyond the original QC members.

- **Coaching** and/or supervision support during Action Periods for QI teams and individual team members in the topic area and QI methods.

- **Communication within and between QI teams** between during Action Periods (between Learning Sessions.

See Appendix 1, Figure 1 for an overview diagram depicting how these elements and process can be designed for application by SC4CCM/Rwanda.

A Quality Collaborative typically last between 12 and 24 months. Through the process described above and in Figure 1 (Appendix 1), the IP is tested and refined using local leadership and problem solving, with the guiding input of coaches and other experts. Once the solutions in the IP have been shown to achieve results, a 'spread' (i.e., scale-up phase) phase occurs, bringing in QI teams from new locations. Frequently, successful QI teams and champions from the first round take an active part in the spread phase.

<u>Success of QCs</u>: The SC4CCM QC will embrace the following features which have proved to be essential to the success of an improvement QC,[viii] and to the performance of the QI teams:[ix]

- Well-defined improvement objectives
- Adequately supported QI teams
- An explicit implementation package
- Regular analysis of measured results to guide quality improvement
- Shared learning for accelerated improvement at a greater scale
- An explicit spread strategy, planned for from the outset
- Organizational structures to support the collaborative and improvement activities
- Information: continual and reliable information about best practice, current practice, targets/benchmarks for improvement
- Engagement: engaged leadership and staff at all stages of the improvement work and at all levels necessary to make and sustain necessary changes
- QI Infrastructure:
    - buy-in, influence, credibility, champions for QI in the topic area the QC approach
    - knowledge of the underlying systems (relevant to the topic area) needs to be represented on the quality improvement team and in the coaches

- knowledge of measurement and data management needs to be represented on the quality improvement team and in the coaches
- teamwork skills, training and coaching, mutual learning
- system and support to facilitate improvement work (e.g., time during the work day work on QI efforts; time and resources to meet for mutual learning; access to reliable data and tools)
- follow-up plan/systems to ensure sustainability of successful changes/improvements made by QI teams during the QC.

3. Proposed Approach for SC4CCM/Rwanda

3.A. Quality Collaborative Participation, Topic, Goal, Objectives and Indicators

The purpose of a Quality Improvement Collaborative is to close the gap between desired and actual performance by developing, testing and scaling-up successful changes quickly across many teams. It is a short term initiative (12 months) that identifies and tests innovations to address gaps in system performance to generate best practices. The QIC is a network of individual Quality Improvement (QI) teams that all focus on a single topic area and have shared objectives and indicators. Quality Improvement teams in Rwanda will consist of:

- Director of the Health Centre
- CHW Supervisors from HC level
- Pharmacy Store Managers from HC Levels
- Data Manager at health centre
- Cell Coordinators

HC staff and Cell Coordinators will:

- sensitize the CHWs to the QI/QC objectives
- supervise and coach CHWs on their performance of their resupply SOPs/tasks,
- engage the CHWs in identify problems, make changes in their practice, and test changes in order to better apply the resupply SOPs and/or refine the SOPs where necessary,
- ensure data use and documentation of the QIT actions at the cell and HC levels.

District based coaches will support the work of QIT teams. District staff who will participate in the QC will consist of:

- District Hospital Monitoring and Evaluation Officer
- Monitoring and Evaluation Officer from Mayor's Office
- District Pharmacist
- District Data Manager
- District CHW Supervisor

The broad **topic area** for the SC4CCM Quality Collaborative will be**:**

- Supply chain management for the 7 key products necessary for community-Integrated Management of Childhood Illnesses' (c-IMCI).

The **goal** (i.e., ‘improvement aim’) of the Quality Collaborative, will be:[x]

- To improve re-supply procedures and practices in order to help ensure that CHWs have useable and quality medicines available when needed for appropriate treatment of childhood illness.

Successful implementation of the Quality Improvement Collaborative approach is expected to bring about the following outcomes:

1. Resupply procedures for the 7 key products (5 CCM products, RDTs, gloves) are applied according to standards at:
    a. All resupply points (health center)
    b. All service delivery points (CHWs and cell coordinators)
2. Goods are routinely transported between resupply points and CHWs
3. All CHWs and Cell Coordinators have all 7 key products in stock.

The common QC indicators that will be assessed quarterly are presented in the table below. The indicators are derived from the Project Theory of Change (TOC). The TOC provides a way in which data can be organized to guide strategic decisions about where in the supply chain to test interventions that are likely to result in significant improvements in product availability, and helps to identify the kinds of interventions that are needed. The TOC also serves as a monitoring and evaluation framework to guide data collection, analysis and interpretation as well as to develop hypotheses and causal pathways for change within the community health supply chain

TOC Box #	Outcome: **Quality Improvement Collaborative**	**Proposed Indicators**	**Baseline Results**	**Midline Targets**	**Data Source and Frequency**
37a.	Coaching and supervision guide exists	• Existence of CHW coaching and supervision guide (y/n)	• No	• Yes	• Country Implementation Plan
46.	Procedures for forming and maintaining QITs exist and are documented	• Existence of procedures for forming and maintaining QITs (y/n)	• No	• Yes	• Country Implementation Plan
38.	Members of the QC are trained in forming & conducting a QIT	• Number and % of *staff* at intervention sites trained in their roles and responsibilities on the QIT: ◦ HC pharmacy managers ◦ data managers ◦ CHW supervisors ◦ cell coordinators ◦ coaches	• Zero • Zero • Zero • Zero • Zero	• 95-100% • 95-100% • 95-100% • 95-100% • 95-100%	• Program records • Monitoring • Midline
38a.	QITs are formed with cell coordinators and HC staff	• Number of QI teams formed in the quality collaborative (of total HCs in the intervention area) ◦ Number and % QITs who have selected and documented one or more SC improvement indicators ◦ Number and % of QITs with a documented 12-month target for each improvement indicator [*Qualitative*] Are member roles and tasks operational as defined on the QIT? If not, why not?	• Zero • Zero • Zero	• 36 of 44 • 95-100% • 95-100%	• Program records • QIT Documentation Journal or Synthesis forms • Monitoring (LS) • Midline
25.	QIT members attend and participate in		• Zero	• 85-90%	• Attendanc

TOC Box #	Outcome: **Quality Improvement Collaborative**	**Proposed Indicators**	**Baseline Results**	**Midline Targets**	**Data Source and Frequency**

	QIT meetings for data review, problem-solving, and receiving recognition	• Number and % *staff* in attendance at QIT scheduled meeting, out of total in QIT:
		  ◦ cell coordinators
		  ◦ CHW Supervisors
		  ◦ data managers
		  ◦ pharmacy managers
		• Number and % QITs with at least one QIT Documentation Journal entry that includes action items from the last scheduled QIT meeting
		[*Qualitative*] Do teams receive recognition when earned, according to the recognition strategy (part of procedures for QITs)?
		[*Qualitative*] What data-based areas for improvement were identified by QITs this quarter?
		[*Qualitative*] Were solutions acted on by QITs this quarter? If not, why not?
			• Zero
			• Zero
			• Zero
			• Zero
				• 85-90%
				• 85-90%
				• 85-90%
				• 95-100%
					e lists from QIT meetings
					• QIT Document ation Journal or Synthesis forms
					• Program records (*core team*)
					• Monitoring
					• Midline

26.	Supervision checklist and data collection tools available and used to monitor and provide feedback on CHW performance	• Number and % cell coordinators who can show data collection tools:
		  ◦ Supervision checklist
		  ◦ Tally Sheet
		  ◦ Bar Graph template
		  ◦ Job aid
			• Zero
			• Zero
				• 85-90%
				• 85-90%
					• Monitoring
					• Midline

39.	QITs and coaches have data for QIT performance monitoring	• Number and % of QITs with a synthesis report for last quarter • A representative of the QC maintains an inventory of changes/solutions to test at each site (y/n) [*Qualitative*] What obstacles prevent making data (in the form of synthesis reports) available? [*Qualitative*] Is data produced and used by the QITs good quality for performance monitoring?	• Zero • Zero	• 100% • yes	• QIT Synthesis Form (LS) • Monitoring • Midline
25a.	Coaching of QIT in SC & QI processes is performed regularly	• Number and % of QITs with performance data prepared by data manager before last monthly meeting • Number and % of QITs documenting use of problem-solving approaches (as defined by QC trainings) at the last monthly meeting	• Zero • Zero • Zero	• 100% • 100% • 1 learning session/q	• QC level Synthesis • Monitoring • Midline

TOC Box #	Outcome: **Quality Improvement Collaborative**	**Proposed Indicators**	**Baseline Results**	**Midline Targets**	**Data Source and Frequency**
		• Number and % of QIT leaders who report receiving SC performance feedback from coaches at district level in the past quarter		uarter • 90%	
14.	Resupply issues are incorporated into routine supervision	• Resupply issues are incorporated into routine supervision tool (y/n) [*Qualitative*] Are issues related to improvement indicator(s) proactively addressed using the supervision checklist? If not, why not?	• No	• Yes	• Monitoring • Midline
24.	QITs meet as QCs for regular learning sessions to share data , receive input & engage in peer to peer learning	• Number of quarterly QC learning sessions held where QIT data are reviewed, by quarter	• Zero	• 1 learning session/q uarter	• Monitoring
24a.	QITs take action to improve performance	• Number and % of QITs showing performance improvements after adopting changes/solutions, based on chosen indicators & targets [*Qualitative*] If actions not taken to improve QIT performance, why not? • [*Long term*] Number and % of quality improvements in QI/QC improvement areas maintained 6 months post-collaborative • [*Long term*] Number and % of intermediate outcome indicators maintained at satisfactory level 6 months post-collaborative	• Zero	• 50%	• QIT Document ation Journal or Synthesis forms (LS) • Monitoring • Midline • Endline
24b.	QCs produce one combined, refined change package based on findings for spread	• Refined change package resulting from QC work exists (y/n) • Change package endorsed by MOH (y/n) • [*Long term*] Number of new districts (outside original intervention area) joining the QC in spread phase • [*Long term*]Number of new QITs formed (outside original intervention area) in spread phase • [*Long term*] % new QITs that adopt tested solutions in spread phase	• Zero • Zero	• Yes • Yes	• QIT documenta tion • Monitoring • Midline • Endline
11	Cell coordinators attend monthly meeting and collect goods to transport	• (9) Number and % cell coordinators who need products, who collect them for their cell from the pharmacy after health center meetings [*Qualitative*] If cell coordinators are not collecting goods at monthly	• NA	• 85-90%	• Incentives database, Monitoring

TOC Box #	Outcome: **Quality Improvement Collaborative**	**Proposed Indicators**	**Baseline Results**	**Midline Targets**	**Data Source and Frequency**
	between resupply point and CHWs	meetings for their cell, why not?			• Midline
	(indirect)				
11a	CHWs are able and willing to travel to HC to pick up products	• Number and % CHWs who report no obstacles to traveling to HC to pick up products [*Qualitative*] Reasons transport is an obstacle for CHWs, cell coordinators	• 72% (n=321)	• NA	• Monitoring • Midline

9.	Persons responsible for resupply perform their roles in the CCM product supply chain as expected	• Number and % Pharmacy managers from HC who submit SC reports to District that are:
		  ◦ Accurate (based on community level data)
		  ◦ Complete
		  ◦ On time
		[*Qualitative*] Cell coordinators: Are stockouts at resupply HC causing stockouts for CHWs?
			• NA
			• NA
			• 47% of n=181 who had stockouts at BL reported it was bc of SO at resupply
				• 75%	• Monitoring
					• Midline

3.B. Implementation Package (Change Package)

The implementation package (or change package) is comprised of a set of changes that need to be introduced and acted upon in order to improve quality and/or performance to standards. IPs can be comprised of elements such as: clinical guidelines and/or standards of care; organization of care; skill building in the QC topic area (resupply) and in QI methods.

The IP for the SC4CCM Resupply Collaborative will be complied by the sponsoring organization JSI in collaboration with the MOH. The IP will be comprised of:

- The Resupply SOPs, any associated forms/tools, and any best practice information in the topic area of resupply relevant to closing the performance gaps in resupply.
- Skill building in resupply (for team members and/or relevant health care staff that have not yet received the resupply training
- Skill building in QI process for QI teams
- Skill building in QI process and coaching for those selected to be coaches (e.g., supervisors, pharmacy staff)

OVERVIEW CHART OF QC CORE IMPLEMENTATION PACKAGE Documents, Tools, Forms				
DOCUMENT/ FORM/ TOOL	**PURPOSE & COMMENTS**	**USED BY &/OR COMPLETED BY WHOM**	**FREQUENCY**	**SHARE WITH / HOW**
1. Stock cards	Stock Cards are records kept with products within a storage location that show the amount of product on hand and the movement of product into and out of the storage area. They are a tool for: ▪ CHWs ▪ Checked by the Cell Coordinators during supervision visits ▪ Used by Cell Coordinators to refill orders ▪ Used by HC Pharmacy Managers at the Health Centre Store to manage their stock.	▪ CHW complete and give to the Cell Coordinator to report stock levels at the end of every month ▪ Cell coordinator or HC Supervisor check during meetings with CHWs in their homes	On each occasion that medicines are received or dispensed	Cell Coordinators and CHW supervisors during supervision visits
2. **Cell Resupply Worksheet** (Fiche de Requisition Communnautaire)	Used by Cell Coordinator to capture data from binomes on stock on hand and consumption. Tool for: ▪ Cell Coordinators for calculating how much they need for each drug for their next order (refill orders) ▪ Used by HC Pharmacists to refill orders	▪ Completed by Cell Coordinator at Cell Monthly Meeting(	Monthly	CHW Supervisors for supervision as necessary
3. **Cell Calculator Form** (Fiche de Calcul)	Tool supplied to Health Centre Pharmacists and Cell Coordinators that helps them calculate the quantity of drugs to order based on the reported consumption and stock on hand by the CHW. Tool for: ▪ Cell Coordinators for ordering more medicines (refill orders) ▪ Used by HC Pharmacists to refill orders	This tool is not completed but used by Cell Coordinator to calculate re-supply quantities and the pharmacy manager to validate the amount required	Monthly	
4. How Do I Re-supply the Community Health	Tool for Cell Coordinators that outlines the tasks and forms	Cell Coordinators (and/or	Monthly	Information is given

OVERVIEW CHART OF QC CORE IMPLEMENTATION PACKAGE

Documents, Tools, Forms

DOCUMENT/ FORM/ TOOL	PURPOSE & COMMENTS	USED BY &/OR COMPLETED BY WHOM	FREQUENCY	SHARE WITH / HOW
Worker: A Guide for Cell Coordinators	associated with the **basic standards** for resupply of products for CHWs.	other CHW supervisors)		to the HC Pharmacist
6. **Ensuring Product Availability of the CCM Program: Coaching and Supervising Community Health Workers**	Tool for Cell Coordinators (and/or other CHW supervisors). All QC and QIT members need as a reference. Provides **guidelines** to Cell Coordinators (and/or other CHW supervisors) on what to do during a Supportive Supervision to ensure that resupply procedures are being carried out according to standards. The guidelines focus particularly on resupply and initial issues around storage of drugs (also called medicines, commodities, products). Includes: 1. A supervision checklist, and 2. A coaching tool (modified flowchart format) to support moving through the supervision checklist and a supervisory visit. The coaching tool identifies problems in filling out stock cards and/or storage, and helps the CHW supervisor and Cell Coordinator know where to correct mistakes, providing information for coaching the CHW on how to improve performance in areas where mistakes have been made. All information collected with the supervision checklist needs to be shared with the QIT to be fed into problem identification, change selection, and progress toward reaching indicators.	Cell Coordinators (and/or other CHW supervisors) complete during routine supervision visits to CHWs	Completed at each visit to a CHW	Share findings with the HC CHW Supervisor monthly

In addition to the implementation package mentioned above the project will also supply tools that will assist the Quality Improvement teams to identify the gaps and document the changes. These include:

ADDITIONAL TOOLS TO SUPPORT OF QC PROCESS Documents, Tools, Forms				
DOCUMENT/ FORM/ TOOL	**PURPOSE & COMMENTS**	**USED BY &/OR COMPLETED BY WHOM**	**FREQUENCY**	**SHARE WITH / HOW**
1. Action Plan	▪ Used at the beginning of every quarter by the QIT teams to document supply gaps, objectives indicators targets and timelines	QIT		Coaches at coaching visits
2. QIT Monthly Synthesis Form	▪ Monthly meetings among the HC staff and Cell Coordinators The format for the monthly meeting report is found on page	QIT	Monthly	Project on a monthly basis 2 weeks after each meeting/email
3. QIT Quarterly Journal	▪ Used to documents significant changes by the QIT group before the learning session.	QIT	Quarterly	Project on a quarterly basis 2 weeks before learning session/email
4. Coaching Evaluation form	▪ Used by the district coaches to access performance of QIT teams as they visit QIT Teams every month	District Coaches and SC4CCM staff	Monthly	Project
5. Coaching Evaluation and Desk Monitoring Template	▪ Combines key indicators from coaching visits and desk monitoring of QIT Monthly Synthesis Forms	Project	Monthly	HQ and consultants

3.C. Process, Events, Timeline

See Appendix 1, Figure 2 for an overview diagram depicting the Rwanda SC4CCM QC Process, Events and Timeline. Appendix 1 Figure 2 has the specific calendar for each district. The attached spreadsheet

Detailed plan for QC Implementation has the specific dates for all activities related t the Implementation.

3.D. Structure and Roles for the QC

A. **Steering Committee**:
   - ***Role:*** Leadership, strategic direction, high-level technical guidance, overall QC management
   - ***Membership:*** Sponsoring organizations-- JSI and MOH(Community Health Desk)
   - ***Responsibilities:*** Provide implementation support to QITs, monitor intervention, document experiences and successes
   - ***Proposed Opportunities to meet routinely***: CHD Partners meetings including but not limited to Logistics Working Group.

B. QI team(s)
   - ***Role:*** Change agents at local level
   - ***Responsibilities/tasks:***
     - Collect any local baseline data needed for QC/QI during first action period
     - Apply implementation package at home sites
     - Identify performance/quality problems and test changes/solutions related to IP
     - Develop action plans to address problems/changes
     - Attend routine QI meetings; engage in QI tasks as assigned between meeting
     - Sensitize CHWs and transfer relevant knowledge and skills for resupply and QI at this level
     - Document changes tested and gather/share relevant data
     - Participate in shared learning communications and events (e.g., Learning Sessions; communication between learning sessions)
     - Along with team members, suggest refinements in IP
     - If selected, participate as a champion in spread phase
   - ***Membership:***
     - Cell Coordinators
     - Data Manager
     - CHW supervisors at Health HC level
     - Pharmacy store manager at HC level
   - ***Existing/Proposed Opportunities to meet routinely:***
     - Monthly QIT meeting which will be supported by the project for the duration of the roll out. See Appendix 4 for Health Centre Agreements
 - ***Support to be provided to this group:***
     - training in resupply before beginning of QC
     - training in QI at launch of QC
     - implementation package
     - Transport to facilitate cell coordinators to attend the QIT sessions (Rw 6,000)

- coaching support between Learning Sessions
- support to attend Learning Sessions

C. Coaches

- ***Role***: Support learning and action of individual QI teams and team members during the QC, particularly between learning sessions
- ***Responsibilities/tasks:*** Make routine visits to QI team members to provide coaching in resupply procedures and QI processes
- ***Membership:***
    - District Level CHW supervisors
    - Data Manager at the District Hospital
    - Data manager at the District Level
    - District Level Pharmacist
- ***Existing/Proposed Opportunities to meet routinely:***
- ***Support to be provided to this group:*** See Appendix 5 for Agreement with District Coaches
    - IP; training in coaching
    - training in QI;
    - time /authorization provided to incorporate QC coaching tasks into job responsibilities
    - transportation support

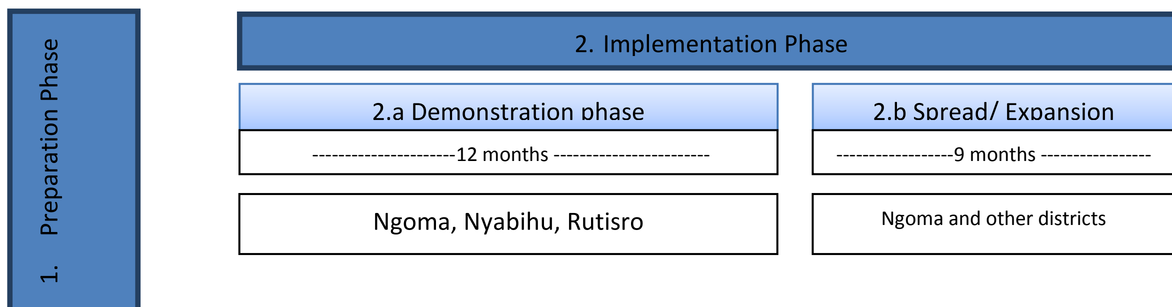
3. E. Site Selection

Strategy for Success of the QC: One underlying strategy for site selection in QCs, and the timing of when to bring various sites into the QC, is to consider two factors:

- The benefits of having a strong start to the QC; and
- Planning for the spread (scale-up) phase from the outset.

This implies developing criteria and grouping sites to enable selection of stronger sites in the first round (demonstration phase), and planning for a later entry into the QC for sites that are less well prepared, weaker in terms of performance, and/or face other challenges such as remote locations, competing priorities, and understaffing. This later entry would be during the spread phase.

Figure 3: Proposed Phases of inclusion of various districts, with timeline



When the spread phase occurs, the implementation package has been tested and refined through the action of QI teams and the overall QC in during the demonstration phase. Demonstrating success in the first phase of a collaborative, and establishing tested approaches to share in the refined IP, are important factors contributing to the overall success of the QC overtime.

Region	District	Health Centres	Cell Coordinators	CHWS
UBURASIRAZUBA	**NGOMA**	14	64	473
UBURENGERAZUBA	**NYABIHU**	12	73	473
UBURENGERAZUBA	**RUTSIRO**	13	62	485
		39	199	1,431

3.F. Monitoring and Evaluation

Monitoring visits will be made evenly across the 3 intervention districts to randomly selected resupply health facilities (HC) and associated CHWs who manage products, as well as their cell coordinators (CCs). Selection of sites will be done by project staff, at random within each district so that all sites have the same chance of selection each time. HCs will be selected first at random, and then a cell coordinator will be selected at random, two CHWs associated with the Cell coordinator will be visited.

At CHW level, monitoring data collection will include interviews, observation of reports, product inventory and storage conditions. Visits at CC level will capture indicators related training on QIT roles, possession of tools to carry out QC functions ,indicator data collection and reporting and regular execution of reporting. Even though CCs are also CHWs, and could answer questions for both persons, it is preferable to sample and collect data from CHWs separately because CCs are the most capable of their group and may produce a positively skewed picture of the community level. At HC level, records will be reviewed and interviews held with individuals including CHW supervisor (i.e. the QIT leader), pharmacy manager, data manager. At District level, district supervisors and coaches will be interviewed.

Monitoring visits are expected to take place at the end of the quarter, however the project collects periodic data earlier through the QIT Monthly Synthesis Reports and the Coaching evaluation forms to detect challenges with rolling out interventions and act quickly to address them. (More Details on the M and E Strategy are available from the Rwanda Monitoring Protocol. (Available on Request)

3.G. Coaching Strategy

District based coaches will support the work of QIT teams, a number of district staff were trained on the QC implementation package and have the potential to be used s district coaches:

- District Hospital Monitoring and Evaluation Officer
- Monitoring and Evaluation Officer from Mayor's Office
- District Pharmacist

- District Data Manager
- District CHW Supervisor

Coaches will have a monthly meeting with the project staff prior to each week of QIT meeting activity in their district. There they will review the performance of the health centres based on the submitted QIT Monthly documentation journals.

The coaches select 4 to 5 health centres per month to visit and Use the coaching evaluation form to both facilitate the meeting and document any challenges that the QC is facing.

See appendix 3 for guidelines for the coaching meeting and strategy and Appendix 2 for the Coaches Evaluation Report.

After the coaching visits each RLA will enter data into the Coaching Evaluation and Desk Monitoring Template.

Appendix 1 Figure 1

Overview of QC Process with Timeline Dates: SC4CCM/Rwanda

1. Preparation Phase

- Situation Analysis/ Baseline Assessment
- Mobilize national and district leadership and stakeholders
- Develop CQ Organizational Structure
- Form Technical Leadership Group & Management Group
- Identify Topic Area/Gaps
- Develop initial implementation package
- Select regions and participating sites
- Develop training materials

2. Implementation Phase

2.a Demonstration Phase
3 Districts

2.b Spread/ Expansion Phase
X New Districts

Action Period

Action Period

Action Period

Action Period

Launch Workshop Begin QIT Action Planning

Mobilize & Prep Phase at District & Cell Local Level

Baseline at Local Level

Sensitization of CHWs

Collaborative Learning **Session 1**

Collaborative Learning **Session 32**

Collaborative Learning **Session 3**
(Collect Best Practices)

Refinement of Implementation package

Preparation & if needed, baseline new districts

Collaborative Learning *(New Districts And Champions)*

DURING ACTION PERIODS / LIFE OF COLLABORATIVE

Regular QI Team Meetings and Team Work to apply Implementation Package
Identify problems & use of Plan-Do-Study-Act Cycle to test solutions
On-going exchange of progress / experience between QI/QC Teams
Coaching Visits for QI teams
Work with CHWs

Appendix 1 Figure 2: Calendar of Monthly Meetings and Learning sessions for each district

CALENDRIER DES REUNIONS DES EQUIPES D'AMELIORATION DE LA QUALITE AU NIVEAU DES CENTRES DE SANTE -NYABIHU

N0	Name of Health Facility	QIT for April, 2012	QIT for May, 2012	QIT for Jun, 2012	QIT for July, 2012	Learning Session 6th August 2012	QIT for Sept, 2012	QIT for Oct, 2012	Learning Session 5th November 2012	QIT for Nov, 2012	QIT for Dec, 2012	QIT for Jan, 2013	Learning Session 4th February 2013	QIT for July, 2012	QIT for Aug, 2012
1	SHYIRA	21 May	11 June	16 July	13 Aug		17 Sept	15 Oct		12 Nov	10 Dec	14 Jan		11 Feb	11 Mar
2	NYAKILIBA	21 May	11 June	16 July	13 Aug		17 Sept	15 Oct		12 Nov	10 Dec	14 Jan		11 Feb	11 Mar
3	NYAKIGEZI	21 May	11 June	16 July	13 Aug		17 Sept	15 Oct		12 Nov	10 Dec	14 Jan		11 Feb	11 Mar
4	GAKAMBA	22 May	12 June	17 July	14 Aug		18 Sept	16 Oct		13 Nov	11 Dec	15 Jan		12 Feb	12 Mar
5	RUREMBO	22 May	12 June	17 July	14 Aug		18 Sept	16 Oct		13 Nov	11 Dec	15 Jan		12 Feb	12 Mar
6	JOMBA	22 May	12 June	17 July	14 Aug		18 Sept	16 Oct		13 Nov	11 Dec	15 Jan		12 Feb	12 Mar
7	MWIYANIKE	23May	13 June	18 July	15 Aug		19 Sept	17 Oct		14 Nov	12 Dec	16 Jan		13 Feb	13 Mar
8	BIREMBO	23 May	13June	18 July	15 Aug		19 Sept	17 Oct		14 Nov	12 Dec	16 Jan		13 Feb	13 Mar
9	RAMBURA	23 May	13 June	18 July	15 Aug		19 Sept	17 Oct		14 Nov	12 Dec	16 Jan		13 Feb	13 Mar
10	ARUSHA	24 May	14 June	19 July	16 Aug		20 Sept	18 Oct		15 Nov	13 Dec	17 Jan		14 Feb	14 Mar
11	KABATWA	24 May	14 June	19 July	16 Aug		20 Sept	18Oct		15 Nov	13 Dec	17 Jan		14 Feb	14 Mar
12	BIGOGWE	24 May	14 June	19 July	16 Aug		20Sept	18 Oct		15 Nov	13 Dec	17 Jan		14 Feb	14 Mar
13	RWANKERI	25 May	15 June	20 July	17 Aug		21 Sept	19 Oct		16 Nov	14 Dec	18 Jan		15 Feb	15 Mar
14	KAREBA	25 May	15 June	20 July	17 Aug		21 Sept	19 Oct		16 Nov	14 Dec	18 Jan		15 Feb	15 Mar
15	KORA	25 May	15 June	20 July	17 Aug		21 Sept	19 Oct		16 Nov	14 Dec	18 Jan		15 Feb	15 Mar

CALENDRIER DES REUNIONS DES EQUIPES D'AMELIORATION DE LA QUALITE AU NIVEAU DES CENTRES DE SANTE –NGOMA District

N0	Name of Health Facility	QIT for May, 2012	QIT for Jun, 2012	QIT for July, 2012	Learning Session 6th August 2012	QIT for Aug, 2012	QIT for Sept, 2012	QIT for Oct, 2012	Learning Session 5th November 2012	QIT for Nov, 2012	QIT for Dec, 2012	QIT for Jan, 2013	Learning Session 4th February 2012	QIT for Feb, 2013	QIT for Mar, 2013
1	SANGAZA	14 May	11 June	16 July		13 Aug	17 Sept	15 Oct		12 Nov	10 Dec	14 Jan		11 Feb	1 Mar
2	JARAMA	14 May	11 June	16 July		13 Aug	17 Sept	15 Oct		12 Nov	10 Dec	14 Jan		11 Feb	11 Mar
3	KIBUNGO	14 May	11 June	16 July		13 Aug	17 Sept	15 Oct		12 Nov	10 Dec	14 Jan		11 Feb	11 Mar
4	RUKOMA SAKE	15 May	12 June	17 July		14 Aug	18 Sept	16 Oct		13 Nov	11 Dec	15 Jan		12 Feb	12 Mar
5	RUKUMBERI	15 May	12 June	17 July		14 Aug	18 Sept	16 Oct		13 Nov	11 Dec	15 Jan		12 Feb	12 Mar
6	KIRWA	16 May	13 June	18 July		15 Aug	19 Sept	17 Oct		14 Nov	12 Dec	16 Jan		13 Feb	13 Mar
7	MUTENDERI	16 May	13 June	18 July		15 Aug	19 Sept	17 Oct		14 Nov	12 Dec	16 Jan		13 Feb	13 Mar
8	REMERA	16 May	13 June	18 July		15 Aug	19 Sept	17 Oct		14 Nov	12 Dec	16 Jan		13 Feb	13 Mar
9	NYANGE	17 May	14 June	19 July		16 Aug	20 Sept	18 Oct		15 Nov	13 Dec	17 Jan		14 Feb	14 Mar
10	ZAZA	17	14	19		16	20	18		15	13	17		14	14

		May	June	July		Aug	Sept	Oct		Nov	Dec	Jan		Feb	Mar
11	GITUKU	18 May	15 June	20 July		17 Aug	21 Sept	19 Oct		16 Nov	14 Dec	18 Jan		15 Feb	15 Mar
12	RUKIRA	18 May	15 June	20 July		17 Aug	21 Sept	19 Oct		16 Nov	14 Dec	18 Jan		15 Feb	15 Mar

CALENDRIER DES REUNIONS DES EQUIPES D'AMELIORATION DE LA QUALITE AU NIVEAU DES CENTRES DE SANTE –Rutsiro District															
	Name of Health Facility	QIT for Jun, 2012	QIT for July, 2012	QIT for Aug, 2012		QIT for Sept, 2012	QIT for Oct, 2012	QIT for Oct 2012		QIT for Nov 2012	QIT for Dec 2012	QIT for Jan 2013		QIT for Feb 2013	QIT for Mar, 2013
1	Biruyi	11 June	16 July	13 Aug	Learning Session 3rd Sept 2012	10Sept	1Oct	15Oct	Learning Session 5th November 2012	12Nov	10Dec	14Jan	Learning Session 4th February 2012	11Feb	11Marc
2	Bitenga	11 June	16 July	13 Aug		10Sept	1Oct	15Oct		12Nov	10 Dec	14Jan		11Feb	11Marc
3	Congo Nil	11 June	16 July	13 Aug		10Sept	1Oct	15Oct		12Nov	10Dec	14Jan		11Feb	11Marc
4	Cyimbili	11June	16 July	13 Aug		10Sept	1Oct	15Oct		12Nov	10Dec	14Jan		11Feb	11Marc
5	Kabona	12 June	17 July	14 Aug		11Sept	2Oct	16 Oct		13 Nov	11Dec	15Jan		12Feb	12Marc
6	Karumbi	12 June	17 July	14 Aug		11Sept	2Oct	16 Oct		13 Nov	11Dec	15Jan		12Feb	12Marc
7	Kayove	12 June	17 July	14 Aug		11Sept	2Oct	16 Oct		13 Nov	11Dec	15Jan		12Feb	12Marc
8	Kibingo	12 June	17 July	14 Aug		11Sept	2Oct	16 Oct		13 Nov	11Dec	15Jan		12Feb	12Marc
9	Kinihira	13June	18 July	15 Aug		12Sept	3Oct	17 Oct		14 Nov	12 Dec	16Jan		13Feb	13Marc
10	Kinunu	13 June	18 July	15 Aug		12Sept	3Oct	17 Oct		14 Nov	12Dec	16Jan		13Feb	13Marc
11	Kivumu	13 June	28 July	15 Aug		12 Sept	3Oct	17 Oct		14 Nov	12Dec	16Jan		13Feb	13marc
12	Mukura	14 June	19 July	16 Aug		13Sept	4 Oct	18 Oct		15 Nov	13Dec	17Jan		14Feb	14Marc
13	Musasa	14 Jun	19 July	16 Aug		13Sept	4 Oct	18 Oct		15 Nov	13Dec	17Jan		14Feb	14Marc
14	Murunda	14 Jun	19 July	16 Aug		13Sept	4 Oct	18 Oct		15 Nov	13Dec	17Jan		14Feb	14Marc
15	Mushubati	15 Jun	20 July	17 Aug		14Sept	5 Oct	19 Oct		16 Nov	14Dec	18Jan		15Feb	15Marc
16	Nyabirasi	15 Jun	20 July	17 Aug		14Sept	5 Oct	19 Oct		16 Nov	14Dec	18Jan		15Feb	15Marc
17	Rutsiro	15 Jun	20 July	17 Aug		14Sept	5 Oct	19 Oct		16 Nov	14Dec	18Jan		15Feb	15Marc

Appendix 2-Coaching Evaluation Form

QIT MEETING EVALUATION REPORT

District :________________________ Health Centre: ________________________

Date of Visit: _________________ Name of Coach: ________________________

===

1: Have all QIT Team members been trained to perform their roles and responsibilities on the QIT?

Possible responses:

- ☐ Yes
- ☐ No

b. If no please list the name and title of the QIT member who is in need of training.

____

____

____

2: Have the QIT team members used the Supervision and Coaching Guide to identity the SC performance problems?

Possible responses:

- ☐ Yes
- ☐ No

b. If no take the team through the Supervision Coaching Guide Tally sheet and Bar graph and ask them to plan to visit all binomes before the next meeting so that they can identify the performance problems.

(Record the actions you have taken here and proceed with meeting)

____

____

____

3: Does the QIT have a QIT Action plan? If yes, did you see them using it?

- ☐ yes Seen as per prescribed format
- ☐ yes seen on a different format
- ☐ no not seen

4. If an action plan is not available, why not?

____

____

____

b. If the action plan is not present give the QIT Team leader a copy of the action plan and ask him if he remembers how to use it. Document the actions that have been taken with regards to putting in place the action plan.

____

____

____

5:If an action plan is available, is there evidence that the QIT has used it to document the performance gaps (Table 1.1 in Action Plan) of supply chain performance problems?

- ☐ yes

☐ no

6:If yes can you please briefly list those performance gaps the QIT has identified?

____

____

____

7: If no ask the QIT which performance gaps they have collected data on in the last month. Lead the QIT in tallying up the data on the performance and then lead a brainstorm or 5 why analysis to document the root causes of the performance problems.

b. Document the performance problems that were identified.

____

____

____

8: Has the QIT selected and documented one or more SC Objectives for this quarter?

Possible responses:

☐ Yes

☐ No

What are the Objectives for this QIT?	**Is the Objective SMART?**	**b. If not SMART please help the QIT make the objective SMART.** **(Write the new objective here)**

9:Has the QIT selected and documented SC improvement indicators for each Objective?

Possible responses:

☐ Yes
☐ No

10:Has the QIT documented a 3-month target for each improvement indicator?

Possible responses:

☐ Yes

☐ No

11: If yes give one example of an indicator for each objective:

Objective	Indicator

b. If no, help the QIT develop indicators and targets for each objective. Write down an example of 2 indicators that you helped the QIT to develop here:

____

____

____
_

12: Has the QIT identified any changes they would like to make for performance improvements?

Possible responses:

☐ Yes
☐ No

13: Write down the one new solution the QIT will try to make for performance improvements:

14: **Ask the QIT how they are going to recognize the CHWs if they show improvements (Make sure they write down their ideas)**

After meeting, the Coach should ask to examine a copy of the QIT meeting attendance lists, QIT action plan, and QIT documentation journal and answer the following questions based on these documents:

15:Do they have the QIT documentation journal?

Possible responses:

- ☐ Yes seen
- ☐ No not seen

16:Are attendance records from QIT meetings available in the journal? (Check to see for previous meetings and the current meeting)

Possible responses:

- ☐ Yes both attendance records are seen
- ☐ Only one attendance record is seen
- ☐ No not seen

b. If the attendance records are not present please write an action that needs to take place:

____

____

____

17: Based on team composition, did at least half of the expected team members attend this QIT meeting?

Possible responses:

- ☐ Yes
- ☐ No

18:List the title(s) of any absent team members for the last QIT Meeting

19: Has the data manager filled in the graph after the last QIT meeting?

Possible responses:

- ☐ Yes
- ☐ No

b. What action have you taken to help the data manager fill in the graph?

____

____

20. Is the pharmacy manager trained in resupply procedures?

☐ Yes

☐ No

21: Does the pharmacy manager have last month's copies of the resupply worksheets for all of the cells?

☐ Yes

☐ No

b. If no describe the actions you have taken to correct the situation

22: Write down any challenges the pharmacy is facing in resupplying CHWs with products:

23: Please write down any other suggestions and follow up items from the QIT meeting here.

Appendix 3-Suggested Guidelines for Coaches Meeting prior to QIT Meetings

Objective of Coaching the Quality Improvement Teams at Health Centres:

- Provide technical and moral support to team in order to improve the team's performance.
- Help the team carry out its work and will assist the team leader to guide the team to carry out its work effectively,
- Provide on-the-job training in content and QA,
- Verify monitoring data and provide support to the monitoring process,
- Help the team to see other opportunities to improve how they do things.

Tools for Coaching:

Action Plan – Electronic and Hard Copy (One per coach)

QIT Monthly Documentation Journal Electronic and Hard Copy

Ensuring Product Availability- Coaching and Supervision Guide

Coaching Evaluation Form – One for each health facility to be visited

Process for Coaching Visits:

1. Call the district and arrange to meet the coaches on a specific date within the coaching week. Ensure that you have the acknowledgement of the district administration that their staff can leave their work stations for 1-2 days each for the coaching activity.
2. Have a meeting with the district coaches:

- Go through the Coaching Evaluation form as a team in the district. Discuss the key components of the form and ensure all the coaches understand what each question means.
- Go through the results of the Desk Monitoring of the QIT Monthly Meetings that was done at the project office. Use this opportunity to identify areas of weakness together and the priorities for the coaching visits.
- Spend 20 minutes on a QIT or Logistics topic for the meeting.
    - Suggested topics for coaching meetings in Quarter 1:
    - QIT Action Plan
    - Ensuring Product Availability- Coaching and Supervision Guide
- Ensure all the coaches have the necessary tools to carry out the coaching activity.
- Plan the logistics for the coaching. Will all coaches be able to visit one health centre each as they have the QIT meetings? – Plan to visit at least 4-5 health centers a month/district. Each coach can visit 1 to 2 health centres depending on availability. For the first QIT meetings the criteria for visiting health facilities will be random selection however for subsequent coaching visits there will be purposeful selection of the health centres especially to assist those health centres which

are perceived as weaker or those where there has been a change in a key QIT member is where there is a new data manager, CHW supervisor or pharmacy manager. Where a new staff has joined the district coach responsible for that staff should visit that district to support the new member of staff to carry out his coaching responsibilities.

3. With the coaches discuss the process for obtaining electronic copies of the QIT documentation journal at the end of the month. This is very important as all coaches will not be able to visit all the QITs.
4. After the coaching visits ensure that you obtain the copies of the coaching evaluation forms after the visits of the coaches to the health centres.

Appendix 4 – Agreement with Health Centres

The following agreement is between JSI Research & Training Institute, Inc. and the ………..Health Center to provide services for the Improving Supply Chains for Community Case Management of Pneumonia and Other Common Diseases of Childhood (SC4CCM) Project.

I. Purpose of Agreement

JSI Research & Training Institute, Inc. ("JSI") and …………. ("Health Center") in the ……………. District agrees to support the implementation of the Quality Improvement Collaborative, focused on strengthening the resupply procedures for CHWs, by conducting supervision to CHWs, collecting data during supervision using the provided tools and participating in quality improvement team (QIT) meetings once a month.

II. Period of Performance

The period of performance of the agreement will commence as of 1 April 2012 and to continue through 31 March 2013. The Health Center shall submit all Reporting Requirements no later than 30 April 2013. Both parties reserve the right to cancel this agreement at any time. The Health Center is required to reconcile any outstanding advance within 30 days of cancellation of the agreement.

III. Health Center Role and Responsibilities

- Disburse allowances to Cell Coordinators on a monthly basis.
- Collect signatures from Cell Coordinators to verify that they received the allowances on a monthly basis. The date and amount of allowance must be specified in the documentation (Annex A).
- Collect attendance signatures from Cell Coordinators at the QI Team Meeting to certify they attended the meeting on a monthly basis.
- Collect supervision checklists from Cell Coordinators on a monthly basis (Annex B).
- Submit documentation cited in the Reporting Requirements to the District Hospital Supervisor of Community Health Workers on a quarterly basis.

IV. JSI Role and Responsibilities

- JSI will provide an allowance to the Health Centers to disburse to Cell Coordinators, in advance, on a quarterly basis.
- JSI will reconcile the advance on a quarterly basis by reviewing the reports.

V. Cell Coordinator Allowance Amount

Each Cell coordinator will receive 6,000 RWF each month (18,000 RWF on a quarterly basis) for their attendance at the QI Team meeting and to conduct supportive supervision including data collection, to all CHWs in the cell at least once a quarter.

The total quarterly allowance amount for the ………Health Center will not exceed ……………FRW which is based on the number of Cell Coordinators in the …………. Health Center catchment area.

VI. Payment Procedure

Payment will be made, in advance, on a quarterly basis to the ………… Health Center in the following account information:……………………
Upon reconciliation of the previous quarter advance per the Reporting Requirements, JSI will make an additional transfer for the next month. If the Health Center does not reconcile the entire advance by providing the required documentation, the amount which is not reconciled will be deducted from the next month's advance. If the Health Center fails to reconcile less than 60% of the quarterly advance, JSI will not provide any additional funds until 60% of the quarterly advance is reconciled.

VII. Reporting Requirements

- Cell Coordinators are required to sign for the allowances by certifying the amount received and that date received (Annex A).
- Cell Coordinators must complete the supervision checklist to certify that supportive supervision was completed, including data collection, to a minimum of 80% of CHWs in the cell each quarter (Annex B).
- Cell Coordinators must sign in at QI Team meeting to certify attendance.

All reporting documentation must be submitted quarterly to the District Hospital Supervisor of the Community Health Workers by the Health Center for review by JSI. The Health Center should collect the supervision checklist from the Cell Coordinators on a monthly basis. JSI has the right to inspect records at any time.

VIII. Acknowledgement

The Health Center shall not make any statement or otherwise imply to donors, investors, media, or the general public that you are a direct grantee of the Bill & Melinda Gates Foundation ("Foundation"). You may state that JSI Research & Training Institute, Inc. is the Foundation's grantee and that you are supporting JSI Research & Training Institute, Inc. for the Project.

IX. Liability

JSI does not assume liability with respect to any third party claims for damages arising out of work supported by this Agreement. The Health Center/Hospital shall exercise all reasonable skill and care in the performance of the Agreement and shall indemnify and hold JSI harmless from any and all loss, damage, claims, and suits whatsoever that arise out of the Health Center's negligence under this Agreement.

JSI Representative	Health Center Representative
……………………………………………...	…………………………………………………
Project Director	Health Center Director

Appendix 5 – Agreement with District Hospitals

The following agreement is between JSI Research & Training Institute, Inc. and the ………..District Hospital to provide services for the Improving Supply Chains for Community Case Management of Pneumonia and Other Common Diseases of Childhood (SC4CCM) Project.

I. Purpose of Agreement

JSI Research & Training Institute, Inc. ("JSI") and …………. ("District Hospital") in the ……………. District agrees to support the implementation of Quality Improvement Collaboratives focused on strengthening the resupply procedures for CHWs, by providing coaching visits to quality improvement team at all health centers in the district each quarter.

II. Period of Performance

The period of performance of the agreement will commence as of 1 April 2012 and to continue through 31 March 2013. The District Hospital shall submit all Reporting Requirements no later than 30 April 2013. Both parties reserve the right to cancel this agreement at any time.The District Hospital is required to reconcile any outstanding advance within 30 days of cancellation of the agreement.

III. District Hospital Role and Responsibilities

- Disburse allowances to District Coaches prior to coaching visit.
- Collect signatures from District Coaches to verify that they received the allowances at the time of collection. The date and amount of allowance must be specified in the documentation (Annex A).
- Collect reports from District Coaches after they return from their visit to certify each coaching visit occurred A Coaching visit to a QI team involves attending QI monthly meetings at the Health Center to provide assistance in reviewing and interpreting data and developing and revising action plans (Annex B).
- Submit documentation cited in the Reporting Requirements to the District Supervisor of Community Health Workers on a quarterly basis.

IV. JSI Role and Responsibilities

- JSI will provide an allowance to District Hospitals to disburse to the District Coaches, in advance, on a quarterly basis.
- JSI will reconcile the advance on a quarterly basis by reviewing the reports.

V. District Coach Allowance Amount

Each District Coach will receive 24,000 RWF per coaching visit.

The total quarterly allowance amount for the ………District Hospital will not exceed ……………FRW which is based on the maximum number X trips to be made each quarter (X per month).

VI. Payment Procedure

Payment will be made, in advance, on a quarterly basis to the ……….. District Hospital in the following account information:……………………..

Upon reconciliation of the previous quarter advance per the Reporting Requirements, JSI will make an additional transfer for the next month. If the District Hospital does not reconcile the entire advance by providing the required documentation, the amount which is not reconciled will be deducted from the next month's advance. If the District Hospital does not reconcile the entire advance by providing the required documentation, the amount which is not reconciled will be deducted from the next month's advance. If the Health Center fails to reconcile less than 60% of the quarterly advance, JSI will not provide any additional funds until 60% of the quarterly advance is reconciled.

VII. Reporting Requirements

- District Coaches are required to sign for the allowances by certifying the amount received and that date received (Annex A).
- District Coaches must complete the required report to certify that each Coaching trip was completed (Annex B).

All reporting documentation must be submitted quarterly JSI Research & Training Institute, Inc. The District Hospital should collect the reporting documentation after each Coaching visit. JSI has the right to inspect records at any time.

VIII. Acknowledgement

The Health Center shall not make any statement or otherwise imply to donors, investors, media, or the general public that you are a direct grantee of the Bill & Melinda Gates Foundation ("Foundation"). You may state that JSI Research & Training Institute, Inc. is the Foundation's grantee and that you are supporting JSI Research & Training Institute, Inc. for the Project.

IX. Liability

JSI does not assume liability with respect to any third party claims for damages arising out of work supported by this Agreement. The Health Center/Hospital shall exercise all reasonable skill and care in the performance of the Agreement and shall indemnify and hold JSI harmless from any and all loss, damage, claims, and suits whatsoever that arise out of the District Hospital's negligence under this Agreement.

JSI Representative	District Hospital Representative
…………………………………………...	…………………………………………………
Project Director	District Hospital Director

[i] CORE Group, Save the children, BASICS and MCHIP, 2010. *Community Case Management Essentials: Treating Common Childhood Illnesses in the Community.* A Guide for Program Managers. Washington DC
[ii] SC4CCM Intervention Strategy in Rwanda, August 2011, JSI, Inc.
[iii] ORS, amoxicillin, zinc, primo rouge (ACT 1x6) and primo jaune (ACT2x6).
[iv] Pneumonia, diarrhea and malaria.
[v] CCM Supply Chain assessment, Rwanda 2010; Supply Chains 4 Community Case Management, JSI, Inc.
[vi] Adapted from J Øvretveit *et al*, Quality Collaboratives: lessons from research. *Quality and Safety in HealthCare* 2002; 11:345-351.
[vii] Implementation package: sometimes called 'change package'.
[viii]Catsambas TT, LM Franco, M Gutmann, E Kenbel, P Hill and Y-S Lin. 2008. Evaluating Health Care Collaobratives: The Experience of the Quality Assurance Project. *Collaborative Evaluation Series.* Published by USAID Health Care Improvement Project. Bethesda MD University Research Corporation LLC (URC)
[ix] Adapted from: Aleidis Skard Brandrud *et al*. Three success factors for continual improvement in health care: an analysis of the reports of improvement team members. *BMJ Qualith and Safety*. 2011; 20:251-259.
[x] Corresponds with SC4CCM's main country level objective and the needs identified in the baseline assessment.