Lessons from quality collaboratives for community level supply chains

Using peer-to-peer learning to improve supply chain knowledge and practices among CHWs in Rwanda

Supply Chains for Community Case Management Project
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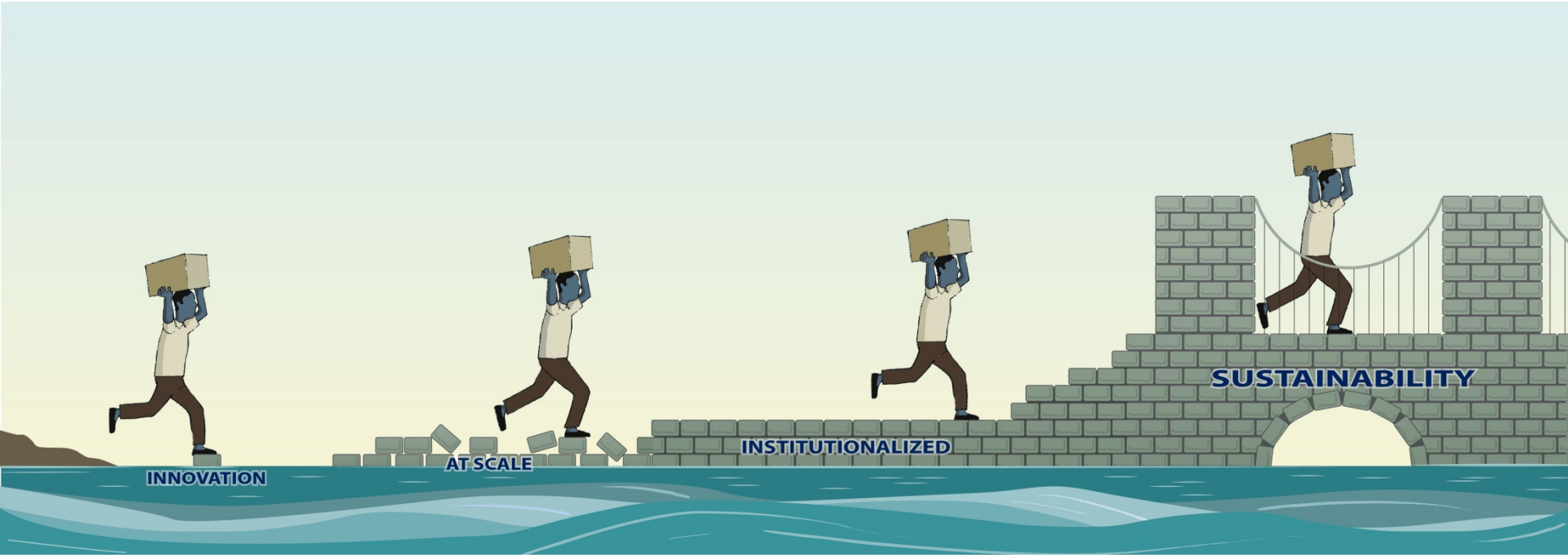
Supply Chains for Community Case Management (SC4CCM) Project

SC4CCM is a learning project that seeks to demonstrate that **supply chain obstacles** at the community level **can be overcome** and identifies **proven, simple, affordable** solutions that address unique supply chain challenges faced by CHWs. The project seeks to foster a **sustainable approach** to scale up to ensure that the MOH can own and adapt successful models to strengthen community supply chain practices.



Identifying Major Supply Chain Bottlenecks Using Baseline Assessments and a Theory of Change in Rwanda

Baseline Results

- **49%** of CHWs who manage health products had 5 CCM tracer drugs* in stock on day of visit
- No standard procedures or formulas for calculating resupply quantities for CHWs
- Information flow **not aligned** with product flow; CHWs report to multiple places, but often not to their resupply point.

Rwanda Context

- 30,000 CHWs (binomes) are trained to provide CCM to children under 5 in their villages
- CHWs organized into cells of 10-12 CHWs/cell
- Each cell has a CHW designated as the cell coordinator, who takes on added coordination responsibilities in addition to being a CHW
- CHWs manage up to six commodities for CCM

Results pointed to a **lack of CHW logistics data visibility** and **weak coordination** between CHWs, health centers (HCs) and districts as **barriers** to community level availability of medicines

* amoxicillin, ACT 1x6, ACT 2x6, ORS, zinc

Rwanda Supply Chain Interventions: Standard Resupply Procedures and Quality Collaboratives

Addressed data visibility challenges by implementing simple **standardized resupply procedures (RSPs)**…

And paired them with **Quality Improvement Teams (QITs)** to test innovations and generate local best practices that can be shared

RSPs

- CHWs provide stock on hand data to Cell Coordinators (CCs)
- CCs use resupply "calculator" to determine resupply quantities
- HCs collect resupply worksheets from 10-15 CCs instead of 100+ CHWs to fill orders
- CCs collect products and distribute to CHWs

Quality Collaboratives

- Quality Improvement Teams consisting of CCs, HC and district staff (coaches) aimed at implementing RSPs, and improving product availability
- CCs collect data during supervision
- QITs use data and structured approach to problem solving and action planning

Results

- ✓ QIT groups in Rwanda had **25% greater product availability** than the comparison group
- ✓ **99% CCs** report no problems completing resupply worksheets
- ✓ 75% of expected members attended quality improvement team meetings
- ✓ Greater than **90%** availability of stock cards for most products

Health Centre QIT team members: CHW Supervisors from HC level, Pharmacy Store Managers, Data Manager and Cell Coordinators (generally 7-10 CCs per HC)

Supported by District Coaches: District Hospital Monitoring and Evaluation Officer, Monitoring and Evaluation Officer from Mayor's Office, District Pharmacist, District Data Manager, District CHW Supervisor

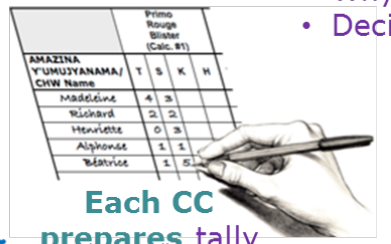
Quarterly Learning Sessions: All QITs from one district
- Monthly journal
- Action plan

District COACHING

QIT Monthly Meeting at HC (CCs, CHW Supervisor, Pharmacist, Data Mgr)
- Why-Why analysis
- Decision matrix

QIT prepares/ reviews action plan, monthly journal

QIT implements action plan through supervision, monthly HC meeting with CHWs
- Supervision checklist
- Coaching guide



Each CC prepares tally sheet, bar graph

CC collects data from CHWs on common SC problems
- Supervision checklist
- Coaching guide

Quarterly Cycle

Monthly Cycle

44 QITs in 3 districts:
Ngoma – 12
Nyabihu – 15
Rutsiro - 17

Monthly Allowances to:
- District coaches for coaching
- CCs to facilitate supervision

Quality Collaborative: Tools

1 Coaching guide and supervision checklist

Supervision Checklist: Resupply and Storage

Name of Person Completing this Checklist _____ Date of Visit: _____

Name of CHW visited: _____ Name of village/town where the CHW lives: _____

What to look for	Primo Rouge		Primo Jaune		Amoxycillin 125mg		Zinc 10mg		ORS		Gloves		RDT Kits		Actions taken during supervision visit	Actions to be taken before next Supervision visit
	√	X	√	X	√	X	√	X	√	X	√	X	√	X		
RESUPPLY PROCERDURES																
Checking the Stock Card supply																
1 Do you have a stock Card for each product?																
If the CHW does not have a stock card for each product skip to question 3.																
	√										X					
2 Do you have at least two extra stock cards to use when your current cards are filled up?																
3 Observe if all the stock cards are in good condition																
Completeness of the Stock Card																

2 Tally Sheet

II.2.Imicungire y'imiti n'ibikoresho		
Imiti	UDUKONI	IGITERANYO
Ifishi y'ububiko irahari?		
Umujyanama afite byibura ingano y'umutiwavura umwana umwe		
Ingano y'imiti yanditse kwifishi y'ububiko ingana n'iri mugasanduku k'imiti?		
Reba ko Imiti yose igifite manda?		
Ibitsweneza		

3 Decision Matrix

Decision Matrix: Example

Criteria 1: Solving the problem is within the team's power

	Criteria		Total Score
Item to be prioritized	C2: The problem is common among CHWs	C3: Risk of harm due to not addressing the problem	
Problem 1: CHW does not have a stock card for each product			

4 Root Cause Analysis

5 WHYs

Problem Statement:

Why is this happening?

1. _____ Why is that?
2. _____ Why is that?
3. _____ Why is that?
4. _____ Why is that?
5. _____

If your last answer is something you can not control or change, go to the previous answer as a root cause.

5 Action Plan

Quality Improvement Action Plan for Improving Resupply Procedures and Practices

A. Problem statement: Stock Cards are not available
B. Performance Gap: 70% of CHWs have no stock cards for at least one product.
C. Data Source: Supervision visit checklist ,Tally sheet and Bar Graphs
D. Root causes: Stock Cards are available at the health centre but have not been distributed to the CHWs.

Table of action Plan

A. Objective	B. Activites	C. Indicators	D. Lead Responsible	Month 1				Month 2				Month 3			
				Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4
Objective 1: Improve availability of stock cards at the CHW level so that each product managed by CHWs should have a stock card by March 2012.	1. Ask Pharamcy store manager if he can allocate 10 stock cards to each binome.	Indicator: Target:	Pharmacy Manager		x	x			x	x			x	x	
	2. Show binomes how to start stock cards on supervision visit and 3. Check that all binomes maintain stock cards at each supervision visit.	Indicator: Improve availability of stock cards at the CHW level so that each product managed by CHWs should have a stock card by March 2012. Target: 90% of binomes visited have a stock card	Cell Coordinators		x	x			x	x			x	x	
	3.														

6 Monthly journal

Part 1: What is your QIT trying to achieve?

Background: From the QIT Action plan please fill in the information below

Problem Statement:

Performance Gap:

Improvement Objective:

Monthly Report Table

Month 1	Planned Activities for the month	Did Activity Happen?		Comments
		Yes	No	
Month 2	Planned Activities for the month	Did Activity Happen?		Comments

Quarterly Learning Sessions

Learning Sessions I, II, & III - Brought together participants from all QITs in each district to share experience, challenges, achievements over the past quarter and coaches reinforced key elements of the resupply procedures and quality collaborative processes

Final Learning Session – brought together participants from all 44 QITs to share experience and recommendations for the continuation of quality collaboratives and best practices

Quarterly Learning Sessions: perceived to be very important, valuable, and cited as a favorite part of the process

100% of those who attended LS reported learning something that helped **improve supply chain performance** in the district

FGDs: What we liked most in QC process was the L/S. In fact the L/S was one of the best schools I have ever attended. (Pharmacy Manager, Ngoma)

Enabled peer to peer learning

FGDs: Learning Sessions (L/S) were very important. Each group would exhibit their achievements and challenges. This allowed us to learn from those who had faced a similar challenge in the past and how they solved it… (CHW Supervisor, Nyabihu)

Enabled QIT self-assessment

FGDs: The L/S were a mirror in which we looked at ourselves and see our nakedness. They helped us learn how to work smart and pushed us to our service delivery every month. (CC, Ngoma)

Increased skills in advance planning, achievement of plan, problem prioritization and resolution

FGDs: They helped me learn the biggest problems facing various CHW groups and how to resolve them. We were able to learn what we could handle and what we should refer as one can never manage all problems. (CC, Ngoma)

Motivating; a forum for MOH/district stakeholders to **resolve and be held accountable** for product availability

FGDs: Sometimes people from the district and Ministry of Health were always present during the learning sessions. This helped us as they worked to solve issues of products stock-out and would work to address most issues affecting supply chain of product, also to prevent what would put them to shame. (Data Manager, Ngoma)

Results from QITs: Best Practices for Scale Up (examples)

Issue	Example Objective	Strategies Recommended for Scale up
Stockouts	Reduce the stockout rates and levels from 39% to 0% within three months	Submit the requisition for drugs in time as a strategy to reduce the stockout rates
Filling of stock cards	At the end of the quarter 100% of the CHWs should be very comfortable with completion of the stock card. Closing a gap from 31.6 % to 100%.	(i) Stock card completion will be taught on induction of every new CHW and during all refresher training (ii) This skill will be reinforced through regular supervision visits and mentorship
Ability of CHWs to read expiry dates	Increase the number of the CHWs who know to store medicines according to first expiry first out	Prepared simple tools in local languages to aid in understanding expiry dates
		Training, supervision and mentorship with simple tools

Quality Improvement Teams are an effective **strategy to improve teamwork and communication** between different level of the health system

The QC approach improved attention to supply chain practices and resulted in **significant improvements in product availability among CHWs** (63% of CHWs had all 5 CCM product in stock on day of visit in QC group compared to 38% in non-intervention districts)

Quality Improvement Teams can be effective with CHWs, but **tools and practices need to be tailored to community level context and needs**; we altered out tools and providing additional guidance:

- Revised and simplified tools
- Clear guidelines for holding meetings and proposed agenda

Organizing quarterly learning sessions with opportunities to share across QITs and across districts are very resource intensive and **may not be sustainable for governments to adopt**

FGDs: ...the QIT has built such a good relationship along the entire chain. For me the biggest prize has been to learn how to work on plan and be able to achieve it every month. (Pharmacy Manager, Ngoma)

Questions for Discussion

What is your experience with quality improvement processes?

What level of the health system did they include?

What were some of the biggest achievements? Challenges?

What opportunities did you include for information sharing across teams?

Do you feel that these processes are sustainable for government health systems?

The next step is to broaden the scope of the QITs to cover more than just resupply procedures – do you think broadening the scope will dilute the impact?

Thank you! Visit us at sc4ccm.jsi.com