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RESEARCH AND EVALUATION REPORT

Assessing How Quality Improvement Teams Function at the Community Level: The Case of the DREAMS Initiative

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Simon Sensalire, University Research Co., LLC
Astou Coly, University Research Co., LLC
Esther Karamagi, University Research Co., LLC
Juliana Nabwire, University Research Co., LLC
Jacqueline Calnan, USAID Uganda

DISCLAIMER
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Recommended citation

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### Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AGYW</td>
<td>Adolescent Girls and Young Women</td>
</tr>
<tr>
<td>ASSIST</td>
<td>USAID Applying Science to Strengthen and Improve Systems Project</td>
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<tr>
<td>CDO</td>
<td>Community Development Officers</td>
</tr>
<tr>
<td>DREAMS</td>
<td>Determined Resilient Empowered AIDS-free Mentored and Safe</td>
</tr>
<tr>
<td>HCT</td>
<td>HIV Counseling and Testing</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>IID</td>
<td>Improvement Indicator Database</td>
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<tr>
<td>QI</td>
<td>Quality improvement</td>
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<td>QIT</td>
<td>Quality Improvement Team</td>
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<td>VHT</td>
<td>Village Health Team</td>
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EXECUTIVE SUMMARY

Introduction
The Determined Resilient Empowered AIDS-free Mentored and Safe (DREAMS) initiative has the potential to reduce risky behaviors, increase access to and utilization of HIV prevention and care services in Northern Uganda, and reduce the number of adolescent girls and young women (AGYW) acquiring HIV. However, community quality improvement (QI) teams such as those involved in DREAMS face many challenges when measuring and improving quality because unlike facility-based QI teams’ members, they often have a low level of education and are volunteers. It is therefore important to assess how these QI teams function at the community level.

Methodology
We conducted an evaluation to assess how improvement methods are implemented at the community level and what evidence-based interventions AGYW were receiving from community QI teams (QITs). Data collection methods included in-depth interviews, observations, data extraction from journals/forms/notebooks, and abstraction of program monitoring data.

Findings
On average, QITs included a diverse group of 10 stakeholders. The USAID Applying Science to Strengthen and Improve Systems (ASSIST) project provided support to Community Development Officers (CDOs) to facilitate a community meeting with community leaders and other members nominated by the AGYW to select QIT members. Selection criteria included willingness to volunteer, being a role model in the community, and residing in the community. Observations revealed that QIT meetings were participatory and conducted in the community’s local language. Minutes were captured using notebooks or plain paper. QITs documented their work in one of the following: work plan, documentation journal, HIV Counseling and Testing (HCT) forms, and minutes and registration lists for previous meeting. All QIT members interviewed reported that work plans were developed during meetings. This was confirmed during meetings observations. Five out of the 8 QITs had work plans detailing gaps to address, activities, responsible persons, and timelines. All QITs reported use of personal notebooks for data collection and for documentation. Reduction in risky sexual behavior, unwanted pregnancy, and increase in the number of AGYW tested for HIV and involved in income-generating activities were the main measures of successful changes. AGYW received important evidence-based gains from the work of QITs including changes in risk behaviors, involvement in small-scale businesses, reduction in gender-based violence, parental involvement, and partners receiving HCT. QITs reported walking long distances as a key challenge and team work as the main facilitator of QIT work.

Conclusion and recommendations
Community QITs such as those of the DREAMS Initiative rely on existing infrastructures and systems and are able to adapt QI activities to the community context. The DREAMS QITs can have a great impact as they focus on multicomponent interventions to address issues such as risky behaviors and poverty which are not typically addressed by health interventions. Since communities may differ, we recommend flexibility in aspects such as team composition based on contextual factors. In addition, data use should be further promoted among community QITs and alternative mechanisms of support for DREAMS QITs explored to replace the support formerly provided by ASSIST.
I. INTRODUCTION

From January 2016 to September 2017, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) project implemented the Determined Resilient Empowered AIDS-free Mentored and Safe (DREAMS) initiative in the post-conflict Northern Uganda districts of Gulu, Omoro (Acholi sub-region), Oyam, and Lira (Lango sub-region) among adolescent girls and young women (AGYW) at risk of HIV infection. The intervention consisted of skills building and peer-to-peer support in topics such as saying no to sex and negotiating condom use; holding service delivery camps to provide HIV prevention services and commodities to AGYW, their partners, and other community members to stop risky behavior; and setting up functional community quality improvement teams (QITs) to mobilize community resources to support AGYW. In October 2017, the DREAMS program was transitioned from ASSIST to implementing partners, but ASSIST has continued to provide support to 8 improvement teams to use data to identify and address needs and gaps in the access and utilization of HIV prevention and care services by AGYW and their partners.

The DREAMS Initiative has the potential to reduce risky behaviors and increase access and utilization of HIV prevention and care services in Northern Uganda and reduce the number of AGYW acquiring HIV. However, community improvement teams such as those involved in DREAMS face many challenges when measuring and improving quality. Unlike facility-based improvement teams, members often have a low education level and are volunteers. It is therefore important to assess how these QI teams are structured, how they function in the community, and the gains from QI work. Findings can help formulate recommendations to strengthen and institutionalize the implementation of improvement methods at the community level.

We aimed to assess how improvement methods are implemented at the community level. Specifically, we sought to address the following questions:

- How are community improvement teams established?
- How do community improvement teams conduct their meetings and document meetings/discussions?
- How do community improvement teams develop their work plan?
- How do community improvement teams use their work plan to implement improvement activities?
- How do community improvement teams collect, document and use data?
- How do community improvement teams measure results?
- How do community improvement teams know that a test change resulted in improvement?
- What results have the community improvement teams achieved?
- What are the barriers and facilitators to the implementation of improvement methods at the community level?

II. METHODS

To assess how community improvement teams function, we collected data from all 8 QITs in the ASSIST-supported DREAMS communities. Data collection methods included: 1) in-depth interviews with the community QI teams; 2) observation of community improvement teams’ meetings that took place during the data collection period; 3) review of ASSIST project documentation (improvement teams documentation journals, improvement teams’ work plans); and 4) ASSIST improvement data from the Improvement Indicator Database (IID). The various data were collected for the period from October 2017 to September 2018.
In-depth interviews were conducted with the leader of each improvement team along with 3 other members, as team leaders and team members can provide different perspectives. In-depth interviews included questions that allowed an in-depth exploration of how community improvement teams function and a description of barriers and facilitators to their effective implementation of improvement methods. Improvement team members who had served in the target population for at least six months consecutively at the time of the evaluation were eligible to be interviewed. In addition, observations of improvement teams’ meetings occurring during the data collection period were conducted to collect information on how community improvement team meetings are run and document meeting discussions. Qualitative data were organized into categories based on themes. These data were triangulated with ASSIST project documentation including documentation journals, improvement teams’ work plans as well as DREAMS data from the ASSIST IID. Inbuilt analytics in the IID were used to obtain to run charts, while additional data were exported to Excel for further analysis. Data were linked to the improvement changes tested by the improvement teams to assess successful changes.

III. FINDINGS

Findings are based on observing six QIT meetings, conducting 32 in-depth interviews with QIT members and reviewing the documents of 8 QITs.

How are community improvement teams established?

**QIT selection criteria:** ASSIST provided support to Community Development Officers (CDOs) to facilitate a community meeting involving community leaders and other members nominated by the AGYW to select a team that would constitute a QI committee whose role is to support the AGYW to identify and address the challenges that increase risk to HIV. Respondents reported that community members were selected to be members of QITs based on the following criteria: perceived respect from the community, willingness to volunteer, regard as role models in the community, holding a leadership role in the community, having permanent residence in the community, having knowledge of health issues affecting the community, being a peer, having shared sense of community problems, and having basic knowledge of English. The selected committee members were oriented on their roles. All respondents argued that the voluntary nature of the QIT work means that members would likely continue to devote time and energy to QI work if they share a strong sense of community and a shared identity. The teams utilize the various network within the QIT such as religious leaders to communicate their activities and information.

Twenty-four out of 32 respondents stated that criteria for being a QIT leader should include being capable of keeping the team together, energizing the team to perform voluntary work, mobilizing resources for the community, and be knowledgeable about the problems facing his/her community.

**Composition of QITs:** QITs included a diverse group of stakeholders and included on average 10 members (ranging from 8-12). Typically, the QIT was composed of a peer educator, a Local Council member, a religious leader, elders, Village Health Team (VHT), parish coordinator, mentor mothers and fathers (elders who best understand the needs of AGYW), and in some instances, a cultural clan leader. Almost all respondents stated that the ideal number of members for a QIT should be between 8 and 10 people. Eight out of 32 respondents highlighted that teachers, health workers, and security personnel were missing from QITs. They believed these groups could address more technical health issues and extreme forms of violence faced by the AGYW respectively. Two out of 32 respondents felt that cultural leaders should be excluded because they are out of context with the current generation norms.

How do community improvement teams conduct their meetings and document meeting and discussions?

Twenty out of 32 respondents reported that QITs held meetings monthly or quarterly and sometimes weekly depending on the task at hand. There were differences in actual versus planned meetings. All respondents viewed meetings as a means to plan and reflect on improvement work. In districts where
QITs were most active, respondents further elaborated that meetings were scheduled monthly by the QI team leader or even weekly depending on need.

Based on observations, the procedure of QIT meetings was similar across teams. They commence with a prayer followed by welcome remarks from the chair and drafting of the agenda. The QIT then reviews written minutes of previous meeting and discussions ensue on issues affecting the community following their recent and previous field activities. The QIT then collectively agrees on the next steps (for example, combing households to recruit AGYW into the peer group, holding one-on-one health talks in the communities, engaging AGYW in income-generating activities, health education in peer meetings, etc.). Meetings end with a closing prayer.

In all QIT meetings, we observed that members contribute and applaud each other for their contributions with utmost respect. There was a general semblance of consensus amongst members at the end of meetings. All 6 meetings observed were conducted in the local language, thereby remedying the effect of illiteracy. However, most discussions focused on receiving updates on performance (results) of assigned roles (responsibilities), issues to act upon (activities), and less on assessing tested changes. Use of existing data in the notebooks/plain papers to inform the next set of activities was observed in only three out of the 6 meetings attended by data collectors.

In all meetings, we observed the secretary capture minutes using notebooks or plain paper. In most instances, participants took their own notes using personal note books. Each team member registered their presence on a separate sheet of paper that went around during the meeting. It captured the date of the meeting, name of member, role of QI member (e.g., religious leader), and signature. Six out of 8 QITs had a record of minutes for the meetings and attendance lists for previous meetings at the time of data collection.

How do community improvement teams develop their work plans?

We observed from reviewing documents that all QITs had one or more of the following documents on file: work plan, documentation journal, HIV Counseling and Testing (HCT) forms, and minutes and registration lists of the previous meeting. All respondents stated that work plans are developed during meetings. This was confirmed during meeting observations. In all six meetings observed, QIT members discussed what they planned to do (activities) and allocated similar roles and responsibilities. Five out of the 8 QITs had work plans with detailed information including gaps, activities, responsible persons, and timelines. All respondents cited that activities in the work plans were aimed at addressing issues affecting the community of AGYW. However, 3 out of 8 QIT work plans could not be independently verified because they were not written records (1 QIT) or because the files were kept with the CDO (2 QITs). Verified work plans covered a one-month period and included gaps to address, actions to be implemented to close the gaps, as well as responsible persons and timeline.

How do community improvement teams use their work plan to implement improvement activities?

When asked how they use their work plans to implement improvement activities, all respondents stated that each member is tasked with activities to accomplish within their area of operation. They clarified that roles may be uniform depending on the agreed activities for that period or may vary depending on needs. For example, all QIT members are responsible for household visits within their locality while peer leaders and QIT team leaders are in charge of engaging with AGYW on income-generating activities. All respondents indicated that the work plan includes only those activities that the QIT considers pertinent for the AGYW and do not require resources. In 5 out of the 6 QIT meetings observed, QITs made references to the activities on the work plans as a guide to the discussions and provided updates on responsibilities allocated in the work plan. In 2 of the meetings observed, QIT identified activities accomplished and those pending were carried forward to the next period of implementation.
How do community improvement teams collect, document, and use data?

All QITs reported using personal notebooks for data collection and for documentation. Half of the respondents reported using HMIS forms to collect HCT-related data. In reviewing data, we found that HMIS forms were mainly for HCT. Documentation journal containing the various indicators measured by QITs were used to document the QI work.

Four out of 8 QITs had documentation journals that detailed when the QIT met since the last visit, changes put in place by the QIT to address gaps, core indicators measured by the team, the data for each indicator, and minutes of the meetings.

Use of data varied across QITs but was generally low. Respondents mentioned the following ways of using data: reviewing minutes from the previous meetings to see what has been accomplished and reviewing registers of those who have come for HIV testing to identify and follow up AGYW that have not tested.

How do community improvement teams measure results?

Respondents mentioned various ways to measure results. The most common measures included determining increase in the numbers of AGYW turning up for HIV/AIDS testing and repeat testers, number of AGYW that have been enrolled in peer groups, number of AGYW that have been registered for income-generating activities, and using field reports during the meetings.

Six out of 8 QITs documented results in different forms using notebooks, papers or HCT forms. In the case of HCT, numbers were directly input into forms. This was observed in 4 out 8 QITs. The rest of the QITs captured numbers directly into their notebooks or paper. In these 4 QITs, numbers were recorded without any illustrative graphs or charts. Interviews with members of QITs revealed that the responsibility of documenting results was primarily on the QIT leader who also maintained custody of the QIT files. Documentation for 2 QITs could not be analyzed at the time of data collection because the files were in the CDO office for purposes of CDO reporting on community level activities.

How do community improvement teams know when a tested change resulted in improvement?

All respondents reported that a tested change was successful when it resulted in changes in risky sexual behavior notably AGYW quitting transactional sex, reduction in the number of AGYW with multiple sexual partners, and reduction in the number of AGYW attending discos.

In addition, all respondents mentioned the increased number of AGYW engaged in income-generating projects instead of transactional sex as another common measures of a successful change. Respondents further explained that as more AGYW are recruited into peer groups and educated about HIV, they are motivated to join income-generating activities especially agriculture for self-reliance instead of depending on multiple partners and transactional sex for survival.

The increase in the number of AGYW tested for HIV and the reduction in the number of AGYW testing HIV-positive was reported by all respondents as measures of successful changes. They elaborated that once AGYW were mobilized into peer groups, they are encouraged to test and to stay negative. They added that, in the recent past, the majority of the AGYW tested for HIV were negative even after repeat testing. In some instances, respondents reported an increase in the number of spouses testing for HIV as evidence of a successful change.

Finally, 18 out of 32 respondents were of the view that the reduction in the number of AGYW having an unwanted pregnancy was a measure of a successful change. They attribute the reduction in unwanted pregnancy to abstinence, reduction in multiple partners, and the increased access to family planning information and products, especially condoms.
What results have the community QI teams achieved?

Respondents were asked about the positive results QITs had achieved with respect to the target population (AGYW). The gains were categorized as both direct and indirect gains. Direct gains benefit AGYW directly while indirect gains are a consequence of such activities. The findings were validated using routine data on QIT activities using run charts. The quotations included in the text best represented the range of ideas voiced around the gains. The evaluation revealed important evidence-based HIV prevention gains that AGYW received from QITs as follows.

1. AGYW receive HIV prevention education and information in peer groups

All respondents expressed that QITs understand the larger context of risk behaviors in the community and mapping these risks allows targeted mobilizing and recruitment of AGYW into peer groups. Thirty out of 32 respondents indicated that peer groups are a direct means of educating AGYW about HIV and providing information on HIV prevention and sexual behavioral change in ways that are socially and culturally acceptable in that community and AGYW context. All respondents highlighted that AGYW have set their own socially accepted code of conduct tailored towards minimizing the risk of getting HIV. Within groups, AGYW are accountable to each other and work against bringing disgrace and shame to the group. AGYW are kept together and closely monitored on different aspects of their health based on their unique needs. The following quotations support these findings.

“*We put these AGYW in groups and [they] all agreed to behave well in the community. If the AGYW notice any one of them going around with men, they tell her to stop shaming them [and] if she doesn’t change, they tell her to leave their group,”* QIT member.

2. AGYW receive targeted HIV prevention services, especially HCT and ART

All respondents mentioned HCT as a direct gain from QITs. They reported that all their AGYW have tested for HIV including repeat testing through QIT liaison with health facilities in and around their communities. This is expressed in the following citation representing common views about HCT.

“*Sometimes we call the health workers to come and test our AGYW for HIV when we meet as a group. Many of our AGYW will be testing the second time. We found one AGYW with HIV and [was] started on drugs and I keep talking to her to take her medicine. She is now free and it’s okay with her to take her drugs.*” QIT member.

Seventeen out of 32 respondents cited family planning as a complementary service received by AGYW while 28 out of 32 respondents reported that their AGYW no longer get unwanted pregnancies due to increased access to family planning information and products. Routine monitoring data on QIT work documented between November 2017 and June 2018 was used to validate responses of QIT and show a steady increase in the percentage of AGYW receiving a minimum of 3 DREAMS core package services.

3. AGYW have been organized into feasible small-scale business enterprises and saving schemes (mainly agriculture)

According to 30 out of 32 respondents, the income-generating activities act as incentives to keep the AGYW together and a channel to recruit more AGYW wishing to benefit like their peers. Respondents reported that that the idea of economic empowerment of AGYW is premised on the understanding that targeting individual-level behaviors without addressing the larger contextual and structural landscape that give rise to these risky behaviors would all be efforts in vain. The following citation represents it best:

“*We have managed to keep these AGYW together by helping them to start simple projects where they can get some money for themselves. They mainly do farming together and save money every month [and] now other AGYW are joining them because they see that their peers are benefitting,*” QIT member Oyam.
Routine monitoring data from QITs show that over time, the number of out of school AGYW with an income-generating activity increased consistently (Figure 1).

**Figure 1: Percentage of out-of-school AGYW with an income-generating activity, 8 sites**

![Graph showing percentage of out-of-school AGYW with income-generating activity over time.](image)

**4. AGYW and their partners receive services that prevent risk to both**

All respondents mentioned that QITs target partners of AGYW to reduce multiple risks. It was reported that partners of AGYW are diverse in their demographic characteristics and in the locations where they meet with AGYW and that men are reached through their partners (AGYW) to address gender-based issues or mobilize them at their hot spots for services including HCT and circumcision. More than sixteen out of 32 respondents mentioned that QITs facilitated linkage of AGYW and their partners to services such as ART. They mentioned that male partners are linked to circumcision camps and that community linkages and camps are also convenient for men who cannot go to the health facility. Routine monitoring data of QITs improvement activities and particularly on involvement of male partners showed that the proportion of males who knew their HIV status improved over the period (Nov 2017-June 2018) (Figure 2).
5. QITs have addressed gender-based violence (GBV) perpetuated by men

At least half of the respondents mentioned addressing GBV. All instances of gender-based violence reported by QITs were perpetrated by male partners and were mostly caused by a man going out with other women or demanding that AGYW sells her agricultural products by force to meet expenses for the second partner. Respondents mentioned that they have visited the men and engaged both partners into a mutual discussion where instances of violence were reported. In all cases, the intervention restored harmony among both parties. In many instances, the violence ended once the male partner left the secondary partner. All violence-related cases were reported for young women who were married and living with partners.

6. QITs supported monitoring adherence to HIV treatment

QITs supported monitoring adherence to HIV treatment of all AGYW in their group who tested positive and enrolled on drugs especially within the first months of enrollment on ART. This supplemented health facility efforts of early and permanent retention in care.

7. QITs have attracted the involvement of parents in the affairs of AGYW

Seventeen out of 32 respondents mentioned that because of the benefits from peer groups such as income-generating activities and social and sexual behavior change of their AGYW, parents were motivated to support the activities of QITs and peer groups. Sixteen out of 32 respondents expressed that, underlying parents support is the fact that QITs are composed of persons well known and respected in the community.

8. What are the facilitators to the implementation of QI at the community level?

Twenty-eight out of 32 respondents highlighted the formation of peer groups as a facilitator to their work on the account that it helps them closely monitor AGYW behavior as a group since members subscribe to standard code of behavior such as not engaging with men for sex, not engaging in transactional sex, and not going to night clubs.
All respondents underscored self-motivation and concern for the wellbeing of the community as a driver of the QIT work in the community. QITs are self-motivated by the knowledge that they are working for the betterment of the community. A sense of unity and team work was largely echoed by all QITs.

Eighteen out of 32 respondents reported that the initial training of QI teams gave them the skills needed to draft work plans, identify and test changes, and measure results that may result from implementing a change. Observations confirmed this report. QITs which received the initial training had work plans and documentation journals on record.

Fifteen out of 32 respondents mentioned that the division of communities into small communities placed under different QIT members made it convenient to mobilize the community and to map out new AGYW for recruitment in peer groups, health education, and income-generating activities.

Seventeen out of 32 respondents cited the support of parents as an enabling factor. Parents support QIT work upon noticing changes away from risky behavior among their children and the value of income-generating activities.

9. What are the barriers to the implementation of QI at the community level?

QIT members reported they are often mistaken to be performing their traditionally known roles even when performing quality improvement because of a lack of identifying T-shirt or neck tag.

Respondents indicated that technical support supervision for QITs reduced since the end of 2017 (as ASSIST transitioned DREAMS activities in Lango region). According to QITs previous support supervision refreshed QIT strategies and built their confidence and encouragement to perform a voluntary service.

All respondents mentioned that because QIT activities are entirely voluntary, it has been difficult to sustain the costs of stationary materials such as books for QITs to document QI work. Ordinarily, respondents have to walk long distances between communities or use bicycles which makes mobilization of communities tiresome.

Before the close-out of ASSIST, there was massive mobilization of AGYW under the DREAMS project. As the project closed, activities scaled down in the first month following closure. This demotivated the QITs and AGYW who anticipated a successful program. As a result, some AGYW dropped out of the peer groups due to mistrust of QITs or at the caution of parents.

QITs that were not trained by the time ASSIST closed found it difficult to test and measure changes. As a result, their activities were ad-hoc and undocumented. In other instances, despite being highly motivated, QITs struggled to turn plans into action because they lacked the necessary support and training.

IV. CONCLUSION

Community QITs, such as those of the DREAMS initiative, rely on existing community structures and mechanisms and are able to adapt QI approaches to the community context. One potentially valuable feature of QITs is the ability to influence behavior through peer influence and normative pressures using the peer group formation as an enabling factor. QITs include a wide range of stakeholders. QIT meetings are participatory and meetings discussions are documented. QITs have work plans that define gaps, activities, responsibilities, and the time within which to implement activities. QITs use notebooks for data collection and journal to documents results. QITs results are mainly on HCT and income-generating activities. A gradual change process of sexual behaviors was reported by more than half of the QITs since AGYW live within a group that subscribes to set of conduct such as a commitment to drop transactional sex and multiple sexual partners. Most respondents reported that because of services such as health education on family planning and referral to family planning service centers, there were no cases of unwanted pregnancy among AGYW. Reduction in risky sexual behavior, unwanted pregnancy, and increase in the number of AGYW tested for HIV and involved in income-generating activities were the
main measures of successful changes. AGYW received important evidence-based gains from the work of QITs including change in risk behaviors, involvement in feasible small-scale businesses, reduction in GBV, parents' involvement, and partners receiving HCT. QITs reported walking long distances as a key challenge and team work as the main facilitator of QIT work. Community QITs such as those of the DREAMS Initiative are explicitly goal-focused and volunteers from the outset, which arguably gives them an advantage in achieving improvement-related aims. QIT members are united by a shared commitment towards helping AGYW, thus creating a need to ensure the inclusion of appropriate stakeholders especially peers. QITs typically displayed a strong shared identity, and the QIT lead plays an important role in mobilizing an inclusive community of stakeholders and keeping improvement activities going. The DREAMS QITs can have a great impact as they focus on multicomponent interventions to address issues such as risky behaviors and poverty which are not typically addressed by health interventions. However, the close-out of ASSIST support for QITs and scaling down of activities of QITs has demotivated QITs ad AGYW. Alternative support for QITs should be explored to sustain their HIV prevention and empowerment activities.

V. RECOMMENDATIONS

- Since communities may differ, we recommend flexibility in aspects such as team composition based on contextual factors.
- Data use should be further promoted among community QITs.
- AGYW received several important gains from the operations of QITs. QITs are therefore recommended as a one stop center through which AGYW can receive multiple benefits other than having multiple sources providing different services/interventions.
- Interventions that combine HIV prevention with economic empowerment provide a way of addressing drivers of HIV from the main root. Community QITs represent a feasible and practical community approach of achieving these integrated gains.