Partnership Defined Quality

a tool book for community and health provider collaboration for quality improvement

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Foreword

Save the Children/US has more than 70 years of experience empowering communities to solve their own problems. Our work in the health sector focused significant attention on improving community understanding of and demand for key health services. Recognizing that we were often mobilizing demand for services which were of poor quality or sometimes even non-existent, Save the Children launched our "Community Defined Quality" (CDQ) initiative in 1996 to document the results of community involvement in efforts to improve quality and the availability of health services.

The CDQ effort began with field level research in Haiti which confirmed our hypothesis - communities and their health service providers had somewhat different definitions and priorities in terms of the quality of care provided. This field research helped us define the preliminary and the follow up steps to gather the differing perspectives and share the various understandings in a way that led to a collaborative plan for improving access and quality.

Save the Children's Field Office in Nepal volunteered to integrate this quality improvement methodology into their program in Siraha District in the terai of Nepal. Despite a number of years of community mobilization and district level strengthening work, coverage of preventive health services was low and many disenfranchised, minority groups rarely used health facilities. Moving people from being passive, periodic recipients of health care services toward active engagement and advocacy for the improvement of health services took time. The complete process, re-named "Partnership Defined Quality" to recognize that the effort requires a partnership between health providers and the community, was developed in Nepal and Peru, and subsequently utilized in Pakistan, Uganda, Rwanda, Armenia, the West Bank, Georgia and Ethiopia.

We hope others will be able to use this manual to develop a rights-based approach to programming. We hope that people will adapt it to their program needs – both in health and others. We hope that people will use the approach creatively so that every community member understands and is able to exercise their right to quality services and that clients and providers recognize their own responsibility to maintain and improve the health care delivery, and in doing so, achieve better health status and quality of life for all. That is our end goal for creating this process.

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Save the Children/US

PARTNERSHIP DEFINED QUALITY

A tool book for participatory quality improvement

CONTENTS

What is PDQ?

Partnership Defined Quality is a methodology to improve the quality and accessibility of services with community involvement in defining, implementing, and monitoring the quality improvement process. Partnership Defined Quality (PDQ) links quality assessment and improvement with community mobilization. While it began by addressing health services, it has subsequently been adapted to other sectors such as education.

Why was PDQ developed?

- Often, despite system strengthening efforts that equip facilities and train staff, lasting improvements in the quality of services are not achieved.
- Central or National level quality improvement initiatives do not always reach peripheral field settings.
- Many settings lack sufficient top-down supervisory support, limiting provider accountability.
- Efforts to improve quality may not consider community concerns and perspectives about service quality; therefore improvement efforts can fail to meet the needs of the community.
- There is frequently a social distance/ culture gap between service providers and the communities they serve. This gap can affect relations between clients and providers and is evidenced by the lack of mutual understanding of both modern health and education services, traditional concepts of health and illness, and traditional values around education.
- Solutions to service or facility deficiencies can be found beyond the health and education systems. Remedies for service quality issues may rest within the community, or in other public or private sector entities.
- The responsibility for better health or education goes beyond the health and education systems. Individual and communities to some extent control their own health. A partnership process can involve community members more fully in the struggle for better health.
- Our guiding assumption: Equitable use of services should increase as the perceived quality, accessibility for all, and acceptability of those services increases.

Who should use this manual?

This manual offers tools that can be used by project managers, health service managers, school administrators or facilitating agencies. It can also be used by health workers, teachers, or community advocates, who would like to work to make a difference in the quality of services available in their area. The tools in this manual can help the users to plan programs that will mobilize both service providers, and communities to work toward better service quality and availability.

How to use this manual

This manual was designed to be a resource and guide for exploring and planning quality improvement activities through partnership activities involving service providers and the community members that they are meant to serve. The chapters reflect the different phases of the PDQ methodology. The goals for each phase are listed in the beginning of the chapter. The tools and exercises are not meant as a prescription for what must be done but instead should be used as suggestions. We encourage you to be creative and use tools with which you are familiar or have found to work well in a particular culture. There are also many excellent resources in the areas of team building and problem solving that you may wish to use. When appropriate, other references are listed for further exploration.

Tabs: The tab colors correspond to the phase. A visual model of the methodology can be found on page 5.

Boxes: Field Experience, Facilitation Tips

Shaded boxes reflect PDQ field experience in Nepal, Peru, Haiti and Nigeria. The variation of implementation strategies displays the flexibility of this methodology to local culture and needs.

The Non-shaded boxes contain tips, suggestions, and pitfalls to avoid for the facilitators.

Open Book: Gives the reader suggested references for further exploration of ideas or tools.

Overview of PDQ

THE PDQ PROCESS STEPS

Phase 1 – Building Support

The PDQ process is a collaborative process, which requires commitment from key members of the community and the service delivery system. Building Support involves presenting the process and obtaining commitment for participation from these groups. For community support, this involves identifying and meeting with community leaders and other groups that may potentially be mobilized to represent the community voice in quality improvement.

As with most innovations, the process needs to have the approval and support of the decision makers at the local level and district levels, and maybe even at the national level depending on the country. However, it is even more important that health center and school staff understand the process and are willing to participate, since they will be active partners on the quality improvement team.

Phase 2 – Exploring Quality

The definition of quality is not fixed, it comes from peoples' own understanding of their needs, rights and responsibilities. This step provides the opportunity to understand different perspectives on quality within a community, it's health system and its schools. During this step meetings are held separately with community members and service providers to explore their ideas in an open and safe environment. The tools provided in this step have been developed to facilitate this exploration.

Additionally during this step, the benefits of a community and provider partnership are explored. This is particularly important because service providers often are not accustomed to working with community partners, and need assurances that this process will be beneficial for both.

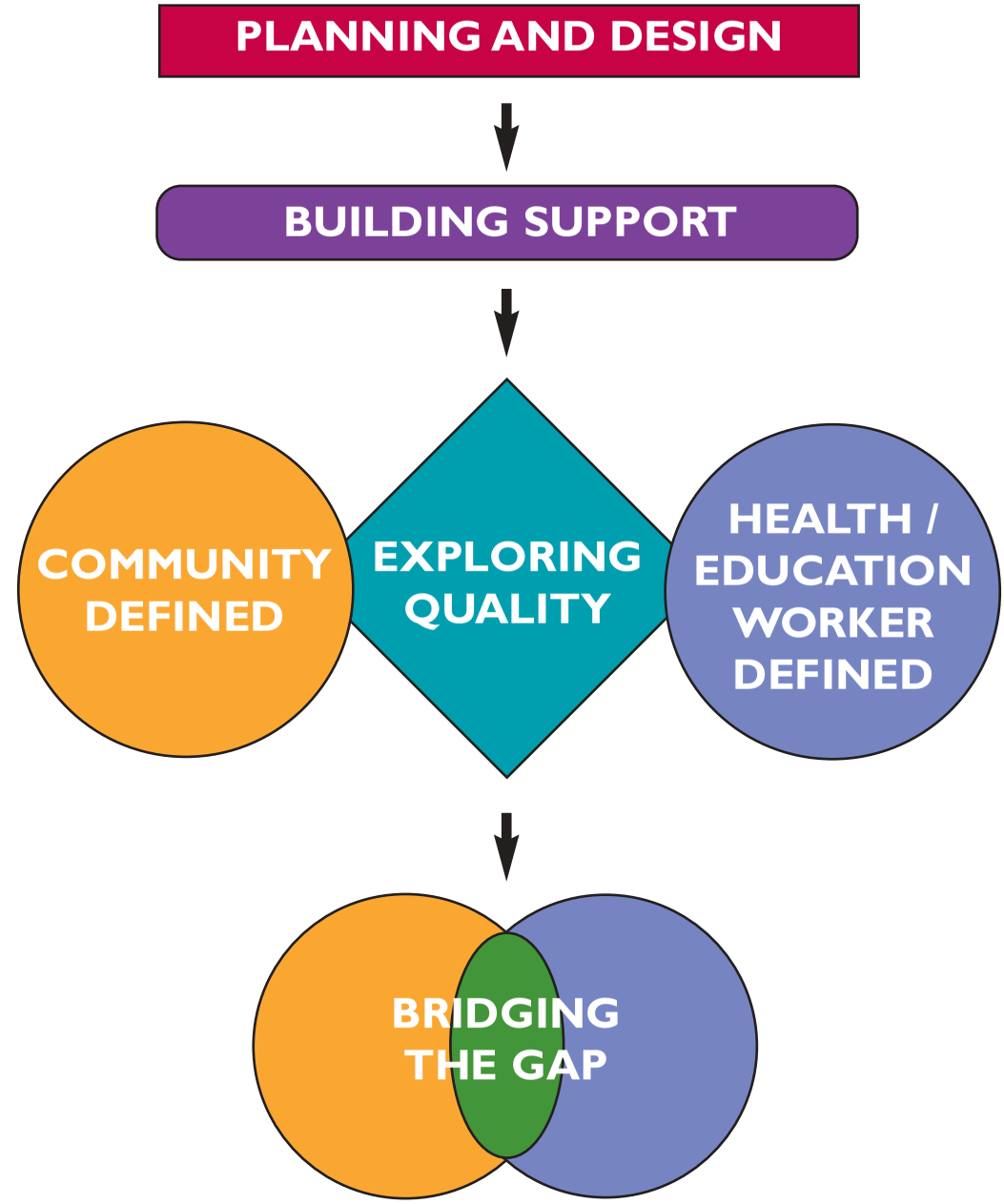
The findings from these meetings are then organized for presentation during the next phase – Bridging the Gap.

Phase 3 – Bridging the Gap

This key step initiates the partnership necessary for subsequent activities in quality improvement. Each group has separately defined characteristics and issues of quality services. Now, health workers, teachers and representative community members come together to hear each others' ideas. Through discussion they begin to work as a team to develop a shared vision of quality. Together they identify and prioritize problems and constraints that make it difficult to achieve quality health services. Participants of this meeting also establish a quality improvement team comprised of both community members and service providers. This team will continue to work on the quality improvement issues identified.

Phase 4 – Working in Partnership

The PDQ process is now in the hands of the quality improvement team. Through the Bridging the Gap workshop, the team has a greater understanding of various viewpoints and is sculpting a collective vision of what quality in health care and schools means for their locale and some gaps in achieving that vision. But the improvement process moves beyond identifying the issues to solving them. Through dialogue and analysis the group looks at the issues to determine root causes and identify solutions for achieving the desired level of quality. The group also establishes indicators to monitor progress and determine when a given problem has been adequately addressed. This cycle of identifying, analyzing and acting requires a productive team that can work well together. This manual also addresses team management skills needed for the team to sustain productivity, diversity and respect.


PLANNING AND DESIGN
BUILDING SUPPORT
COMMUNITY DEFINED
EXPLORING QUALITY
HEALTH / EDUCATION WORKER DEFINED
BRIDGING THE GAP


Analyze Results
Assessment
WORKING IN PARTNERSHIP
Action

PDQ in Relation to Other QI Initiatives

The scope and tools for quality improvement (QI) and quality assurance (QA) efforts are extensive. In addition most governments have adopted standards and technical guidelines for both health care and school services. Although PDQ contains QA components, the initial input and assessments are from the communities' and service providers. These perspectives provide essential information for a quality improvement process that will lead to greater participation in and use of activities and services. PDQ is not a substitute for a technical assessment of quality. An understanding of the current practices and problems with service delivery from a technical perspective is an important part of a successful QI effort. Many tools for standardized quality assessment at the facility level are available.

PDQ in Relation to Other Sectors

While PDQ was originally developed for health, its approach and goals are applicable to any development activities seeking to involve community people in responsibility for their own lives and the factors that affect their health and well-being. The process can be used to address service delivery issues in a variety of sectors, and to address different quality issues within these sectors.

In Uganda, the PDQ process was used in their education program to involve parents, teachers and students in addressing issues around safety. Participants subsequently signed agreements to adhere to safety expectations, and QI teams were formed to enforce and support the changes.

Useful References: There are many tools available from each of these organizations. More information about tools developed for specific service areas or quality improvement efforts is available on their web sites.

COPE- Client Oriented, Provider-Efficient Services. EngenderHealth
www.engenderhealth.org

QAP Health Managers Guide – Monitoring the Quality of Primary Health
www.QAProject.org

Health Facility Assessment collection of tools on the CORE web site
ww.coregroup.org/tools/monitoring/HFA_table.html

EDUCATION RESOURCES:

www.unesco.org – Monitoring Program Quality or Monitoring Learning Achievement (MLA)

www.sacmeq.org – Southern and East Africa Consortium for Monitoring Educational Quality

PLANNING AND DESIGN

Planning and Design Considerations

Before beginning the PDQ process many decisions must be made. This section will guide planners through the program design process. These decisions are the essential groundwork for the quality improvement process.

Components

- Identifying needed skills
- Defining your goals
- Identifying the level of service
- Identify the community
- Health services, schools and community mapping
- Planning for participation & representation
- Identifying other QI initiatives or partners

IDENTIFYING NEEDED SKILLS

As with any program the PDQ process requires dedicated and motivated staff to initiate the effort. In addition, the PDQ implementation team needs staff with specific skills and experience to succeed.

Identify staff with facilitation skills

The PDQ process depends on open communication and interaction. Without experienced facilitators this can be difficult to achieve in situations where gender and power relationships are entrenched or where there is unresolved conflict. A good facilitator can encourage participation and invites all ideas to be expressed. It is recommended that the facilitator of the discussion groups be neutral and not be viewed as part of the government systems nor have a political role in the community. Additionally, all facilitators should be provided training on the PDQ process because a clear understanding of PDQ is also crucial for facilitation.

Language

The implementation team can face some of the same language and cultural barriers faced by the service providers and the community. Often, people do not speak a common language; translation adds an additional layer onto the process. In instances where portions of the community speak a different language or dialect, it is recommended that creative solutions be explored to maximize input from all members throughout the process.

Once the PDQ Implementation Team has been established it is important they review the manual as a group and select the tools they want to use.

Working with Communities

In PDQ, the community is not asked just for their views or opinions, they are asked to participate and share responsibility and efforts for quality improvement. This requires implementation team members who have experience with community mobilization and who know how to reach the broad membership of the community, including the marginalized members.

DEFINING YOUR GOALS

Any program that is considering implementing PDQ has an interest in quality improvement. But different programs may have different specific goals for the PDQ process. Although they may seem obvious, it is important that they are stated to be sure that they are shared and understood by the implementers and supporters of the project. People must be supportive of the goal in order to be willing to participate and take action.

Goals should be formulated at the beginning of the process. It is important to be able to state your goals when you are presenting the PDQ process to others. Additionally, your goals will become the basis for evaluating your quality improvement initiative.

Examples of PDQ goals:

- To mobilize advocates for improved health and education services among the community who can assist providers in finding solutions to problems in quality service delivery and access.
- To increase equitable use of health services and schools services by all members of the community, regardless of gender or economic status.
- To improve interaction and communication between clients and health service providers.
- To create local accountability for service providers and shared responsibility between communities and providers for better health and education services.
- To reduce waste and rationalize use of available resources.

IDENTIFY THE LEVEL OF SERVICE

There are multiple levels in the health system from the central and state ministry of health to local government departments and hospital authorities to hospitals and health centers / dispensaries. For education, there are primary and secondary schools, the local government education authority, and the State Primary Education Board. Your goals and the reason you were interested in PDQ will help you determine on which levels of services to focus your efforts. Who you work with will also depend on the scope of your program and your access to resources for supporting this initiative.

Level of Service: National, District or Health Center Level

Decide what level(s) of health care services you are seeking to improve.

- Community based care and outreach
- Health post or health center
- Back-up or referral health center
- District level hospital

Decide what level(s) of education services you are seeking to improve.

- Primary School
- Secondary School
- School Administration

Selection of Target Health Centers:

Determine whether all health centers and schools in a region will be selected or only selected ones.

Program Focus:

Determine whether you are going to focus on service quality in general, or a particular area of services. The advantage of a narrower focus is a more limited list of topics and problems to address. However, many service delivery problems are broad and cross cutting and service delivery is integrated, thus, the focus on one component may be unnecessarily limiting.

IDENTIFY THE COMMUNITY

Like quality, "a community" does not have a fixed definition. The community in this case is the people who live in the catchment area that the health services or schools were designed to serve. This is most likely comprised of many smaller "communities". Ask people who are already in the community to identify participants willing to work constructively and who are potentially interested in improving services. The particular population groups to be selected will depend on social and cultural factors in the community, as well as on the kinds of services you are targeting for quality improvement. Examples of possible groups might be parents, women of childbearing age, fathers, mothers-in-law, youth, or marginalized people. These groups may need to be segregated in order for all group members to feel comfortable with participating in discussion groups and sharing their ideas.

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In Nigeria, the project decided to define a community using a functional integrated primary health care center with its catchment area as a nucleus. This meant that there could be several schools and perhaps a dispensary or two that were providing services of interest to the project within one catchment area. It also meant that some of the areas defined as "communities" were quite large. In each community, there are several or more active community based organizations on which the project could also draw.

As a result, the project decided on a two-tiered structure. At the facility level, there is a quality improvement team which focuses of specific facility issues – identifying problems in quality and working to address them. However, there is also an "umbrella organization" at the community level called a community coalition. This group has a range of functions depending on the individual circumstances in the different states. Functions might include assisting with the formation and oversight of quality improvement teams, coordinating activities across different facilities in their areas, and participating in coordinating activities on a larger scale with those of other communities. They also assist the quality improvement teams with implementing their action plans through activities such as advocacy, community mobilization, and fundraising.

HEALTH SERVICE, SCHOOL, AND COMMUNITY MAPPING

An understanding of the existing health and education structures and the communities served, is essential for designing a PDQ program. This information will be the foundation for planning your intervention and for examining whether you have broad representation of both the community and the service providers.

You may have this map already. If not, the questions below can serve as a guide for the information you will need to obtain.

The bullets under each topic are meant as a guide and are neither imperative nor exhaustive.

Existing health structures:

- Formal health system – District health services, health posts, sub health posts, referral sites
- Private providers of health services
- Informal health system - traditional healers, TBA's, community volunteers, etc.

Key service providers:

- Who has formal and informal power? What are the lines of supervision?
- Are the staff from the same region where they work? Do they speak the local language and share the same culture?
- How much staff turnover is there and at what levels?

Key Education Structures:

- Formal Public School System – primary and secondary schools
- Private schools
- Alternative schools e.g. Koranic Schools

Community structures:

- Who has formal power and authority?
- Who has informal power?
- Which key groups in the community should be involved?
- What are different community voices that may need representation in the PDQ process? (marginalized persons, mothers in law, etc.)
- What are the existing community organizations? (committees, political groups, churches, women's groups, literacy groups, etc.)
- What is the role of the local government?

Interface Between Health Services and Communities:

- Where do people go for routine care, acute care, emergencies?
- How does the health system currently involve the community?
- How are parents involved in schools?
- What are barriers to attending schools?
- Who goes to which schools?

PLANNING FOR PARTICIPATION AND REPRESENTATION

Developing a design for adequate representation and participation at each phase in this initiative is a challenge. The design needs to fully represent the catchment area of the health services being addressed. This includes getting representation of key segments of the society including those most in need as well as the gatekeepers. Each phase must include enough people to establish momentum and get the work done, but not so many that the process becomes unmanageable.

THE IDEAL STRUCTURE WILL INCLUDE:

- Representation of women and marginalized groups as well as men
- People from outside as well as inside the existing power structures
- Both users and non-users of services
- A balanced membership between providers and community

SPECIFIC PLANNING CONSIDERATIONS FOR EACH STEP

Planning:

Who will take the lead in the process (a PDQ champion)?

Which organizations and staff are likely to be involved?

How should responsibility be shared?

How can health worker and teacher input be maximized with minimum disruption of service time?

How much time should be allotted to each phase of the process?

Where and when should each meeting be held to permit maximum participation?

Building Support:

How involved will the District level staff be?

Who needs to be convinced to take action?

Who provides support for change at the lower levels and who might be a barrier to change?

ⓘ **In Nepal separate meetings were held with health workers, older women, women of child-bearing age, and men.**

Exploring Quality:

How many group facilitators will be needed?

How many recorders will be needed?

How large should each of the discussion groups be?

Are there language barriers?

How many separate discussion groups should be conducted to represent all the necessary perspectives?

What steps will you need to ensure on-going participation of women?

In the Uganda education program, the meetings were held between parents, teachers, and students for each school.

Pitfall

In countries where previous projects have paid incentives for participation or where the expectation for some kind of remuneration has become the norm, it may be challenging to bring people together. In addition, if there are costs such as transport due to a large catchment area, they may preclude participation of the poorest people, thus threatening the representation the project is seeking. It becomes tempting to succumb to the expectation and offer some kind of incentive to "get the job done".

Similarly, if the promise of grant money or significant donor inputs is people's reason for participating, it will significantly undermine both the level of ownership and the ability of the groups to view problems more superficially.

However, it is vital to return to a key question in this process: "Whose process is this?" If the project takes responsibility for participation from the beginning because they are supposed to "deliver" a certain number of quality improvement teams, the process is likely to fail from the start. However, if project staff are patient, allowing the community time to figure out why they want this process, the question of incentives will be resolved among themselves. This may, however, entail canceling meetings or moving on to other areas while a community organizes itself.

Bridging the Gap

Do you want representatives from each discussion group to attend the Bridging the Gap workshop or should all participants in the discussion groups attend?

How should the demand for allowances or incentives be addressed to ensure that the process can be locally sustained?

In Nepal, the local government structure covers a health center and 3-10 health posts. The original plan was to have one Bridging the Gap workshop and one QI team for the whole area. However, as time went on it became apparent that there were problems with territoriality, ownership, and role clarity for that team.

People decided they really wanted to have a QI team for each health post as well as the health center. While this is more of a challenge for providing technical support and supervision, it fits better with the local authorities and spheres of influence. Now, each QI team is actively working to improve the services in the health post they use, and for which they are responsible. Meetings are now closer to home for most members; thus logistics and refreshments considerations are less costly.

In Peru, while planning occurred at the regional level, the health center was the focus for the activities. The initiative ended up including more than 100 people throughout the process, ending up with a sub-group for implementing activities during the team phase, but with everyone still involved in an advisory and oversight capacity.

In Uganda health workers included lab technicians and porters, as there is limited staff who share responsibility for service provision.

In Haiti, the Bridging the Gap workshop involved more than 60 people, both health workers and community members, from the five sub-areas of the project. People decided they wanted a QI team for each of the sub areas, but they also wanted an "umbrella" team with representation from each which would meet less frequently for coordination and exchange of ideas.

Working in Partnership – QI Teams

How many QI teams should there be?

How large should each QI team be?

Is it possible for each facility in the target area to have a QI team of its own?

How should responsibility be shared between the schools and health facilities?

If QI teams cover more than one facility, how will responsibility and ownership be shared?

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In Nigeria in some states, there were a significant number of existing organizations that could be built upon for determining participants for the PDQ process. The most numerous were the PTAs. These had to be adjusted to assure participation by people who were not attending school, but as the issues (such as increased girl enrollment) came up, it was clear why this adjustment needed to be made.

On the health side, there were also previously existing variations of health committees, with varying levels of actual activity, which became the starting point for identifying participants in the PDQ process. Again, representation by non-users was usually the adaptation that needed to be made.

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In Nigeria, while the goal of forming representative quality improvement teams and community coalitions was consistent, the process for getting there varied widely. The process depended on whether there were previously existing structures to build upon, the predominance of urban or rural settings with differences in population density, and on the staffing structures available relative to the number of targeted local government areas. In some cases, both quality improvement teams and community coalitions were formed out of the exploring quality and bridging the gap process, while in others, coalitions were formed first, then used to facilitate the exploring quality, bridging the gap, and formation of quality improvement teams. Similarly, in some cases quality improvement teams are functioning as "sub-committees" of the coalitions while in others they are only represented on the coalition. There is no "correct" approach as long as the goals of representation and commitment for the membership is achieved.

IDENTIFY OTHER QI INITIATIVES OR PARTNERS

It is important to know if there are other community mobilization, system strengthening or QI initiatives in place. If an NGO is working to improve the supply of medicines in the country or national quality standards are being developed or rewritten, these initiatives could be incorporated into the PDQ program. The PDQ methodology recognizes the need for collaboration. Although this collaboration is predominately between the community and health workers, it should be extended to other QI initiatives currently in place.

Summary of Design Considerations Planning Efforts

KEY PLANNING DECISIONS CHECK LIST

- ☐ What do you want to achieve?
- ☐ Who will facilitate the process?
- ☐ What level of services do you want to affect?
- ☐ Do we have representation of both service providers and support staff?
- ☐ What other health services are available in the community?
- ☐ Who uses health services? Are some groups better served than others?
- ☐ Who attends which schools?
- ☐ Who should be involved to ensure community representatives are truly representative?
- ☐ How many discussion groups will be held and where?
- ☐ How many QI teams will be established?
- ☐ What other system strengthening / QI processes are in place?

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In Nigeria, the PDQ process was embedded in the much larger COMPASS project. The project included interventions in child survival, reproductive health, basic education, institutional capacity building and advocacy. It also had a significant small grants component. These other interventions were in a position to significantly enhance an reinforce the work of the quality improvement team, just as the quality improvement teams were in a position to significantly enhance the activities of these other components. While the number of players made coordination and collaboration more challenging, the potential benefits were also significantly enhanced.

BUILDING SUPPORT

PHASE I: BUILDING SUPPORT

People will take action only on those issues that they understand and perceive as a priority. PDQ needs involvement and action from the service providers, their support system and the community. By explaining the purpose and the benefits of BOTH the quality improvement process, as well as the partnership approach, you begin to build the needed support. A great deal depends on how much is already being done to strengthen services, how much commitment or incentive there is to better serving clients, and whether the services you are working with are public, NGO or private sector.

Purpose:

The purpose of this step is to develop the support necessary to implement the PDQ process from the health and school systems, and the communities involved.

Components:

Determine Who to Contact

Decide How Best to Present PDQ

Present PDQ to Potential Partners

Useful References: Sharma R., *An Introduction to Advocacy – Training Guide*, The SARA Project, HHRAA, USAID

Determine Whom to Contact

Using the results of your communities' health services, schools, and sources map that was completed in the design phase, list key people or groups that should be contacted for project support. To get support and commitment from the service delivery systems, it is necessary to meet not only with health workers and teachers in the local facilities, but also with people in the structures that support the target services (MOH and MOE supervisors, District Health and Education Officers, NGOs...).

Decide How Best to Present PDQ

Using your program goals and structure, provide an overview of what can be achieved through the partnership process. By developing a targeted explanation of the purpose of PDQ to the different stakeholders you acquire the initial interest and support needed for the projects' long term success.

It will be up to the team to decide how much of this kind of mobilization is necessary. While broad efforts at this point may seems like a good idea, they also take time and money when moving more quickly to the community level might be just as effective.

Present PDQ to Potential Partners

This is your chance to convince people that PDQ is beneficial, and explain why they should be willing to contribute some effort toward making it happen. Without developing this kind of initial interest and support, the mobilization process will not happen.

In Uganda a variety of stakeholders were involved in the PDQ initiative such as:

- **District Health Management Committee Representatives**
- **Health Unit Management Committees**
- **Parish Development Committee**

In Nigeria, the health and education members of the Local Government as well as some members from local NGOs worked very closely with the project staff in the initial building support and implementation of the PDQ at the community level. This added considerable credibility to the process and greatly facilitated the level of participation and the formation of the quality improvement teams and coalitions.

The following ideas are a guide to assist you with key points you may want to mention when explaining PDQ to people who are likely partners. This is NOT meant as a script, but rather to provide ideas to describe some of the potential benefits and the reasons for seeking the community out as partners in the quality improvement process.

REASONS WHY YOUR PARTNERS MIGHT BE INTERESTED IN PDQ

Why improve quality?

- Improved quality means safer, more effective health care is provided.
- Improved quality means increased access to education and improved learning.
- Improved quality leads to increased satisfaction for both the client and the provider.
- Improved quality potentially leads to increased utilization of services and improved socio-economic and health status.

What is the cost of poor quality?

- Perception of poor quality health services can cause delays in seeking and receiving appropriate service which can lead to greater morbidity and mortality.
- Poor quality can lead to complications due to ineffective treatment or unsafe practices.
- Perception of poor quality education services means parents don't send their children to school and don't make the investment in raising education levels.

Why include the community?

- Community members can work with providers to develop shared responsibility for problem solving.
- Community members can favorably influence the use of the services by their neighbors.
- Community members and leaders can advocate for assistance from other levels and institutions when health workers have not been able to mobilize needed resources.
- The community members have responsibility for their own health and education, and share responsibility for making good use of the services provided in their daily lives.
- Some resources for improving quality are available within the community.

PHASE 2 – EXPLORING QUALITY

Quality services are not "one size fits all." Instead, perceptions of and expectations for quality comes from peoples' own understanding and personal experience. During this phase you will begin to explore the perceptions of quality from the people that provide services, those that use them, and those that never or no longer use the services in question.

To facilitate open and free discussions it is recommended you explore health worker, teacher, and community members' perspectives separately. All these perspectives must be thoroughly explored, in order to understand where potential barriers to the provision of quality care and use of services exist.

Purpose:

- To gain a better understanding of the community, health worker and teacher perspectives on the quality of care.
- To identify potential problems as well as strengths in the delivery of existing services.
- To identify people who would like to work as part of a team to improve quality in their health center and schools.
- To establish concepts of client and provider rights and responsibilities.

Components:

Health Worker Defined Quality
Teacher Defined Quality
Community Defined Quality
Preparation for Bridging the Gap

Preparation:

How will the results be recorded?

It is critical to accurately record the results of the discussions.

In Peru, the use of video was chosen because it enabled each group to not only hear the words but see the people and their expressions as their opinions were conveyed. Each group was able to view their video and decide if they wanted to use it. The use of video was labor intensive but proved to be key in bridging the cultural gap that existed.

SERVICE PROVIDER DEFINED QUALITY

Although the health workers and teachers have already had the PDQ process explained to them, they are probably not yet clear as to exactly how the process will work and how it can benefit them and their work. The activities in this section will not only provide an opportunity for these providers to discuss quality issues but to understand the process and to determine what they can learn from it. These activities may be approached as a 1-2 day workshop, or as a series of meetings. It probably makes sense to go through the process separately with teachers and health workers since their situations and cultures are different enough that you will get more information if they are treated separately.

Suggested Activities:

- Why We Became Health Workers / Teachers
- Health Workers'/Teachers' Perspective on Quality
- Review of Technical Standards
- Problem Identification for Quality
- Rights and Responsibilities for Quality
- What Do We Want to Gain from this Process

The goals for these activities are:

- To continue to build interest in, and ownership of, the QI process
- To explore health worker and teacher views on quality
- To explore health worker and teacher perceptions of the obstacles to delivering quality services
- To mobilize health workers and teachers who will remain involved in the partnership process

FACILITATOR TIP

People's first take on quality will likely be to think about the activities or infrastructure associated with the health center. However, as facilitator, if there are data that suggest specific problems such as high maternal mortality, low family planning usage, or low girl enrollment in primary school, this information might also feed into the exploring quality process.

In Nepal: This session was held as two afternoon meetings - making it easier for all health post staff to attend since they could provide services in the morning and still attend the meetings. It also kept expenses down.

EXERCISE: WHY WE BECAME HEALTH WORKERS / TEACHERS 45 minutes

Often, the farther a person gets in their career, the more distance they find between their original vision for their work, and the realities they face in their day to day duties. The satisfaction felt in daily work may be influenced by the gap between expectations and reality. The goal of this exercise is to achieve reflection on the original vision we had for our work. It can be done as a two part exercise, or either can be done on it's own.

Purpose: To explore issues around our motivation to become health workers or teachers, and our original vision of our jobs compared to the current reality.

Methods:

Reflection

Preparation

- One piece of paper for each participant
- Crayons for each participant
- Large sheets of paper for the facilitator

Reflection

Think back to the time you were young. When you were a child, what did you want to do when you were older? What did you expect for yourself? When did you first begin to think about becoming a health worker / teacher? Was there an event in your life? Did something happen to you or someone in your family? Was there a person who influenced you? When did you decide to seek training?

How was that experience? Was the training as you expected it to be? What was better than you had imagined? Were there things that disappointed you? Now think about your first job as a health worker…what was as you had imagined it to be? What was different? Now consider your work now….how does compare with the vision you had when you were younger?

DISCUSSION:

- Group members should share some of their personal reflections
- Note the similarity in reasons for becoming health workers or teachers.
- How does the vision you first had for yourselves as health workers or teachers differ from the image you have now? Why?
- Do you feel respected by the community?

KEY POINTS:

- Many people enter into health care or teaching with the goals of service and helping others.
- This is influenced both positively and negatively by our experiences and opportunities.
- Morale can be a problem where the system is not functioning well, and where resources are lacking. However, providers can sometimes work collectively to improve their working conditions.

In one case, several of the health workers indicated that the primary reasons they became health workers were economic and parental influence. If this is the case, you should further explore ways they could benefit by providing quality services or doing a good job.

Useful References: Similar exercises can be found in, *Health Workers for Change: A manual to improve quality of care*. Women's Health Project. Johannesburg, South Africa / UNDP (WHO: TDR\GEN\95.2)

EXERCISE: HEALTH WORKERS / TEACHERS PERSPECTIVES ON QUALITY 60 minutes

Quality health care or education means different things to different people. To those who deliver services, quality is often determined by standards created by others, or by test results. This exercise provides service providers the opportunity to provide their own perceptions of the elements of quality for the services they provide.

Purpose: To explore health workers' and teachers' thoughts on the elements of quality services.

Preparation:

- Six to seven index cards (or paper divided in half) for each health worker
- Hand newsprint or signs with headings
- Keep the headings covered until you are ready to use them, so that you do not influence the responses of the group.

Methods:

- Written list
- Role play
- Categorizing and summarizing responses

HEADINGS THAT EMERGED IN NEPAL:

- **Client – Provider Relations**
- **Communication / Information**
- **Safety**
- **Facility**
- **Equipment and Supplies / Medicines**
- **Systems (Support and Supervision / Policies / Processes and Procedures)**
- **Access / Availability**
- **Cultural Compatibility/Comfort**

Similar headings are also relevant for education.

In Uganda, where the focus was on safety, the headings included pregnancy, defilement, discipline, and community involvement.

Written List Suggested time: 15 minutes

Provide each participant with seven pieces of paper or index cards. Ask each person to write down three or four characteristics of good quality services. Then ask them to do the same for poor quality.

(Note: If you have more than 10 or 12 participants then it is suggested that you only request two or three responses from each participant. Otherwise the amount of information to sort becomes excessive and repetitive.)

Role Play Suggested time: 15 minutes

As an alternative to the written list exercise, the participants can act out a scenario when they received or provided good quality health care or identifying good quality education. They can do the same with poor quality service. Not all participants need to do the role play but everyone can be involved in the discussion about what elements of quality service were shown.

Categorizing & Summarizing Responses Suggested time: 30 minutes

By this point the facilitator has compiled a list of many different aspects of quality, based on the group responses. Many of these are unique aspects of quality, while others are different variations of the same thing. For example, if someone had listed a characteristic of quality as "having privacy during examination" and another person had listed "no separate exam room" as a characteristic of bad quality, these basically describe the same characteristics which is the need for an a private place for examination. Similarly, if someone listed teachers yelling at students and someone else mentioned lack of respect, these could both be considered part of teacher / student relations. In this session, the group will have the opportunity to review the list, make any changes and summarize the responses. It may be preferable to start without categories, and group the components as you go along. You may want to start with general headings (such as facility and surroundings), and modify them as you gain descriptions from the group that pertain to that element. The facilitator then reads each participant's response cards or list and, with the help of the group, decides in which category the item belongs. It is important to note when the same response has been made by another participant but in the end, only unique characteristics should be listed. The categories are not meant to be restrictive but instead to provide some structure for grouping.

These lists will be used during the exercises that follow.

REVIEW OF TECHNICAL STANDARDS 60 minutes

While the PDQ process is a participatory approach that uses provider and community perspectives when considering issues on quality, there is also the consideration of technical quality. There are certain basic practices that must be in place for safety and rational service provison. These must be incorporated when prioritizing activities for quality improvement. In this section, health workers and teachers draw on any existing technical standards, guidelines or protocols to enhance the definition of quality services.

Purpose: To identify and incorporate technical standards necessary for quality.

Preparation:

- Obtain the most recent version of technical standards documents (if available).
- Choose guidelines, treatment protocols, or standards that relate to the particular areas of service that are the focus of the QI efforts.
- Flip charts or large poster size pieces of paper.

Methods:

- Small groups exploration of technical standards
- Large group discussion
- Identifying current documented standards

SOURCES OF THIS INFORMATION COULD INCLUDE:

- **Standards and guidelines from MOH or MOE**
- **Treatment protocols**
- **Facility or supervision check lists**
- **Job descriptions**

Small Groups Exploration Of Technical Standards – 30 minutes

The participants should be divided into 3 groups, with the assignment to discuss the minimum technical standard for quality. Explain that while the first exercise asked for their personal view of what is good or bad quality, this exercise asks for their understanding of the minimum standards they should follow as professionals.

For teachers, standards and guidelines may be more focused. Groups can therefore review these in light of what they think should be their minimum standard.

For the health providers, each group should take one of the three following categories for this exercise: 1-safety, 2-communication/information, and 3-diagnosis and treatment. At the end of the discussion, the groups are asked to write their answers on a flip chart, and post them.

The diagnosis and treatment group should be provided guidance on which practices or interventions they should focus otherwise the category can be too broad. The topics could be particular health areas, such as Family Planning, or general areas such as appropriate examinations and case management.

Large Group Discussion – 15 to 30 minutes

Reconvene the whole group to review each of the small groups' answers. This can happen either as a poster session where other participants circulate for review and comments, or as a general group discussion. All participants are asked to provide suggestions, additions, and/or alterations to the standards proposed by the small groups. However it is done, it is important for the group to review the suggested standards and come to a preliminary consensus on their acceptance as a guideline for practice.

Identifying Current Documented Standards 15 minutes

This step provides the health workers and teachers with the opportunity to learn what documented standards are available and how they compare to the list developed by the group.

If available, compare the answers given to the current documented standards.

DISCUSSION TOPICS

- Are the standards available and widely used?
- Areas of discrepancy between standards and practice
- Which ones impact your work?

PROBLEM IDENTIFICATION FOR QUALITY 55 Minutes

Now that you have lists of quality components - created during "Service Providers' Perspectives on Quality" and the "Review of Technical Standards" sessions, the group can explore the barriers that prevent some of these quality elements from being achieved. Even though this step will be revisited during problem analysis and solving exercises in later phases of the PDQ process, this step will help the providers understand the process and it's potential benefits. This step should highlight areas of both achievement of standards or elements of quality as well as areas that are lacking.

Purpose: To begin to identify challenges and gaps in service quality from the service provider perspective.

Methods:

- Explain exercise
- Break into subgroups for analysis
- Group discussion of the results

Explain Exercise – 5 minutes

Using the list compiled by the group in the previous exercise, explore what elements of quality are being met and what areas have problems in your area facilities and outreach work. The group can think of the quality characteristics they created as a check list, and apply this check list to their setting. Groups should identify which areas of quality are being met by the health services or schools, and which are areas where improvement is needed. Briefly explore the reasons why there is a gap between the ideal and what typically happens at the facility. Stress that Quality Improvement is a continuous process.

Break Into Subgroups For Analysis 30 minutes

If multiple facilities are represented for these discussions you may want to divide into work groups by health facility or school. If time is short, each group could be assigned a few of the characteristics of quality as compiled on the lists. Each group should record notes on their discussions.

Group Discussion Of The Results 20 minutes

Have each subgroup report their conclusions to the entire group allowing time for discussion. Depending on the time available, the facilitator may also suggest that the group select one or two problems for further problem definition. A choice of several more detailed problem definition exercises such as fishbone analysis are suggested in the "Working in Partnership" section. Remind the group that deeper exploration of the causes of the problems will happen in the next step of the PDQ process as well.

FACILITATION TIPS

- **Help the groups state the underlying problem. Sometimes the "problem" listed is really a cause or a potential solution. By starting with the cause/solution first the group may lose the chance for more analysis and creative action later. For example, "not enough health post staff " is suggesting a potential solution. Further exploration could find that the problem really is "trained staff not giving the injections". Using this definition of the problem can reveal other possible solutions beyond hiring more staff. This is covered in more depth under "Tools for Problem Analysis" in the section "Working in Partnership."**
- **Try to help participants avoid assigning blame for problems. "patients don't take their medicine correctly because they don't listen". It would be better to start with "patients don't take their medicine". Once the groups analyze the problems together they may have additional understanding of the causes.**
- **It is sometimes easier to focus on problems that are beyond our control. However, it is hoped through these activities that it will be possible to identify problems for which we can make a difference, or make a difference with the additional support the community partnership can bring.**

DISCUSSION: RIGHTS AND RESPONSIBILITIES FOR QUALITY 45 Minutes

Service providers have differing views on what the rights and expectations of their clients and their community should be. Depending on the socialization during basic training as professionals, the support received (or not received) from the administrative systems, and the attitudes of coworkers, service providers perceive their relationships with clients and the communities through many different lenses. It is hoped that by the end of these discussions there will be some understanding of the potential value that the community's input can have in the quality improvement process.

Purpose: To clarify service provider values and create a favorable climate for the concept of a client's right to quality care.

Methods:

- Small group discussion
- Large group conclusions

Small Group Discussion

Instructions: Singly or in twos or threes, begin to think about the following questions (see list). Please take notes. After discussing all the questions, choose two or three significant points concerning what rights you feel your patients or students should have regarding their health care, what rights you as providers have, and how client views and ideas might contribute to improving services. These will be shared the large group at the end of this exercise.

Note to facilitators:

1. Some of these concepts are abstract enough that they may be difficult to understand. It is important to take special care to see that they are well translated and explained if necessary.

2. It may not be necessary for all groups to discuss all questions. An alternative would be to have each group select three questions out of a hat.

QUESTIONS TO BE DISCUSSED:

1. What rights do we as health workers or teachers have in our work?

2. What rights or expectations do patients or students have when they come for services and information? What can they expect from these services? What should they be able to expect?

3. Do clients have a right to information about their health problems? Treatment? How to prevent problems? Is the amount of information they need different than what is normally provided? How should this kind of information be given?

4. Do parents have a right to information about their children? Is the amount of information they need different than what is normally provided? What, if any information should be confidential?

5. How do we take community beliefs and practices into consideration when we provide services to people?

6. Does it matter how the community views our services? Why or why not?

7. What responsibilities do clients have in obtaining better health? Do students have in their own learning?

8. What could be gained by including community members in the quality improvement process? What roles could they play?

Large Group Discussion:

What conclusions do we want to make about:

- What rights do we as providers have in our work?
- How can this process help us achieve our rights and help communities understand our challenges?
- What are client's rights to quality care?
- What does this mean for provider job performance?
- What are potential roles for community members in the improvement of services.

WHAT DO WE WANT TO GAIN FROM THIS PROCESS? 30 minutes

By understanding PDQ and exploring how the process can be beneficial to them and the community, providers are likely have more ownership of the quality improvement process. This exercise is valuable for providers to think about what kinds of things they might want to learn from the community in order to do a better job and what the community can learn from them.

Purpose: To have providers understand the PDQ process and determine what they would like to gain from the process.

Methods:

- Overview of the PDQ process
- What do we want to learn from the community?
- What can we gain from this process?

Overview Of The PDQ Process

Present the phases of PDQ to the participants. On a flip chart, write the phases of the PDQ process and describe each one. The description of each step in the introduction section of the manual can be helpful.

As an alternative to listing the steps, you can write each step with a short description on a separate piece of paper, then request four volunteers to work together and determine in what order they should be addressed. It is quite possible that the group will come up with a different order than what is suggested here. There is no wrong answer. You can then take the opportunity to explain what is meant by each step, and why this process follows the steps in the order it does.

What Do We Want To Learn From The Community?

This discussion can be introduced with an example of how different people see things differently and how we can benefit from different perspectives. Think about what we have been talking about for the past two days. Are there attitudes or beliefs in the community you would like to understand better? Do they think the same things contribute to quality services as you do? Do communities value the services that you provide? How does your work have an impact on the lives of community members?

What Can We Gain From This Process?

Take some time to brainstorm as a group about what you would like to gain from this process.

The goal is for the participants to realize there are benefits to providing good quality and that the community can help them achieve quality health and education service provision. These changes could also create a better working environment, and impact their job satisfaction.

ⓘ

In Peru, during the action phase, health facilities paid for new signs and other materials/ equipment to upgrade services. Community members paid for transport and materials to go to sub-regional MOH office to request MOH assistance on various occasions. Community members contributed gasoline for motorcycle and other transport in cases of emergency transport. Women established an emergency fund in one community. One community contributed funds and labor to put in a water system that benefited both the community and the health post and they are now working on getting electricity.

COMMUNITY DEFINED QUALITY

The community is a diverse group of people with varying roles and voice in their society. It is comprised of men and women, elders and children and typically a variety of races, religions and socio-economic status levels. Throughout the Design Considerations section, you have been asked to determine who is the community, how are they structured and how to plan representative discussion groups to talk about quality. Now is the time to ask the those groups for their definitions of quality.

Suggested Activities:

- Icebreakers and Introduction
- When You are the Customer
- Community's Perception of Quality Healthcare
- Community's Perception of Quality Education
- Organizing and Summarizing

Preparation:

- Finalize the number and type of groups
- Select a location
- Determine transportation needs by the participants
- Schedule meetings

The goals for these activities are:

- To continue to build interest in, and ownership of, the partnership process
- To explore the community views on quality
- To explore the community perceptions of the barriers to quality for education and health
- To mobilize community members who will remain involved in the partnership process

ICE BREAKER AND INTRODUCTION 10 minutes

The need to have an ice breaker will vary depending on the culture and the comfort level of the discussion groups. However, it is essential to go through some kind of settling in process – introductions, explanation of the purpose, and clarification of the group "rules".

Discussion Guide:

1. Why we are here?
2. Introductions
3. What is going to be done with the information?
4. The purpose of the recording or note taking

Suggested Rules:

- Everyone's input is important
- There are no wrong answers
- Sincere dialogue does not just happen. There must be trust and respect
- This is not an exercise to find blame
- This is an opportunity to find new ways to solve problems

WHEN YOU ARE THE CUSTOMER 20-30 minutes

Often participants do not feel they have a lot of choice about the quality of services they receive, but they do make choices for quality in material goods. Linking quality to purchasing decisions helps community members see their role in health and education services as consumers not just patients. By exploring areas where the concept of quality is more familiar, participants will be better prepared to describe the elements of quality that they value in health and education services.

Purpose: To help participants think about other situations where they are setting standards for and demanding quality. To help participants realize that they do exercise a right to quality in the market place.

Methods:

Market place discussion

Market Place Discussion

Before we talk about health services or schools, we should think about times in our daily lives when we all have the right to determine what is good quality. Think about the market place – when you are the customer, you decide what is quality.

Think about when you go to the market to buy something, for example, onions (or any other commonly available local food). What is it about the onions you choose that makes you want to buy them? Facilitator probe for specific information, but don't make suggestions – (e.g., color, smell, freshness….)

Review what has been said. Can anyone add anything?

When the group feels satisfied with the list, ask about what they expect from the seller or the vendor?

For instance, if ten vendors are selling the same thing, what makes you go to the one that you do? Are there those you avoid? Why?

COMMUNITY'S PERCEPTION OF QUALITY HEALTH CARE 60 minutes

Depending on the services available to the community – traditional, non-traditional, public, or private, the term "healthcare" can mean many things. Still, most community members have accessed some kind of health care in their lifetime. By exploring their role as consumers of health care services, community members can better understand their rights and potential contribution to the quality improvement process.

Purpose:

- To examine the communities' views on good and poor quality health services.
- To identify problems or barriers to quality services.
- To explore the concept of patient's rights.

Method:

- Facilitated Group Discussion on Quality Health Services or Role Play

Facilitated Group Discussion On Quality Health Services

This discussion branches from the local market to health setting. Below are suggested questions to help facilitate the discussion about health care quality. It is important that the participants feel free to talk about any form of health care they seek (traditional and modern) when discussing quality. The conversation can later be focused on the health services and level that are the focus of the QI efforts.

Now that we have discussed quality in the market, lets talk about quality in health care.

- Like the market, do you feel like you make choices about your health care?
- What are the most important factors in deciding if and where to go for health services?
- Where is your first choice of places to get health services? Why?
- Are there places you will not go for health services? Why?

- How would you describe good services?
- How would you describe poor services?
- Some people prefer to use traditional health services. What are the reasons?
- Do you pay for those services?
- Do you feel you receive good quality from those practitioners?
- What prevents people from getting services at the formal system?
- Do they have to pay for those services?
- Do you feel you have a right to good quality health services whether you pay or not?

Facilitated Group Discussion On Quality Education for our Children

Now let's talk about the schools and the education your children are getting. Below are suggested questions to help facilitate the discussion on the quality of the education. It is important that the participants feel free to talk about any aspect of education, or any of the schools.

- Like the market, do you feel like you make choices about the education for your children?
- What are the most important factors in deciding if and where to send them to school? Is it different for boys than girls?
- Where is your first choice of schools to send your children? Why?
- Some people prefer to use traditional schools or private schools instead of government ones. What are the reasons?
- How would you describe good education?
- How would you describe poor education?
- Do you pay to send your children to school?
- Do you feel your children are getting a good education? Why or why not?
- What makes it difficult for parents to send their children to school?
- Do you feel you have a right to good quality health services whether you pay or not?

Potential areas to discuss during discussion groups or role plays

- Providers – private versus public, traditional versus nontraditional
- Cultural sensitivity and compatibility.
- Other barriers to accessing services
- Technical aspects
- Equipment, supplies

Probe for more information as needed – why is this important to you? What makes this good? Can you explain further? If something negative is raised, ask – what would make this better?

FACILITATOR TIP

Balance between developing a carefully defined problem list without slipping into a complaining session. It is equally important for people to highlight what aspects of the care being provided are good or positive.

Guide For Role Plays

For certain groups role play is easier than discussion. Again with role play, the participants should be told they can role play health care from any type of service provider.

Role Play for "Bad/Poor Quality Health Service"

Think about a time when you received health care you were not happy or satisfied with.

How can you illustrate this? How can you show this? You can do whatever you want – one person can be a nurse, doctor or any other provider and another person a client.

Allow the group to spend about 10 minutes together reflecting on how they are going to show "poor quality service".

Not everyone has to participate. Even if they don't want to participate in the role play, they can participate in the analysis and discussion afterward.

DISCUSSION:

What did you see in the role play? What was presented?

- **Probe anything else you noticed that made it "bad service"?**
- **Probe whether there are other elements of quality that were covered in the role play.**
- **Probe whether there are other elements of quality that were not covered in role play.**

Role Play for "Poor and Good Quality Education"

Depending on the availability of time and the representation of the participants, similar role plays can be carried out representing quality education, or it may make sense to do a mixture of the two.

Role Play for "Good Quality Service"

Now think about a time when you received health care that you were happy or satisfied with. We would like to ask you to do a role play to show this "good quality service". Again, you can show whatever roles or activities are necessary to demonstrate what you believe is good quality service.

DISCUSSION:

Does everyone agree that the client received good quality service? What did you see that made you feel that way?

- **Probe "Is there anything else that made it good service?"**
- **Probe whether there were other elements or aspects of quality that were not covered.**

ORGANIZING & SUMMARIZING

Because the recorder had to summarize what the participants were saying or doing (role play), it is necessary to review the information with the participants to be certain it accurately portrays their perceptions of quality. As was done with in the section on Provider Defined Quality, it is important to consolidate and summarize this list. Also if the QI efforts are focused on a particular aspect of health or education services, now is the time to consider how the identified elements are relevant to the services that are the focus of this QI initiative. Which of the mentioned elements of quality are met my the targeted services and which elements are lacking?

Refer to the Provider Defined Quality section for suggestions on grouping and summarizing the information obtained.

ⓘ **In Nepal, while facilitators had been quite complete in their probing for explanations and causes for participants' comments, they were quick to generalize the responses. While this is often a necessary skill for program planning and development, in this situation it led to the loss of important information and some inaccurate definitions of problems and solutions. It is important that the groups have the opportunity to make sure the information collected accurately represents their perceptions.**

WHAT IS PDQ?

The group should understand that they have completed the first step of a process for working as partners with health center and school staff to identify and address problems and concerns regarding their health centers and schools. This step will help provide a better understanding of the PDQ process beyond this initial community input.

Purpose: To provide an understanding of the PDQ process, and elicit participation for the Bridging the Gap workshop.

Components:

- Overview of PDQ
- Next Step

Overview Of PDQ 15 minutes

There are many ways to convey the PDQ process to the community. It is important for the community to understand their role extends beyond this initial input. They will be partners with the providers in analyzing problems and determining the causes and solutions to the identified quality issues.

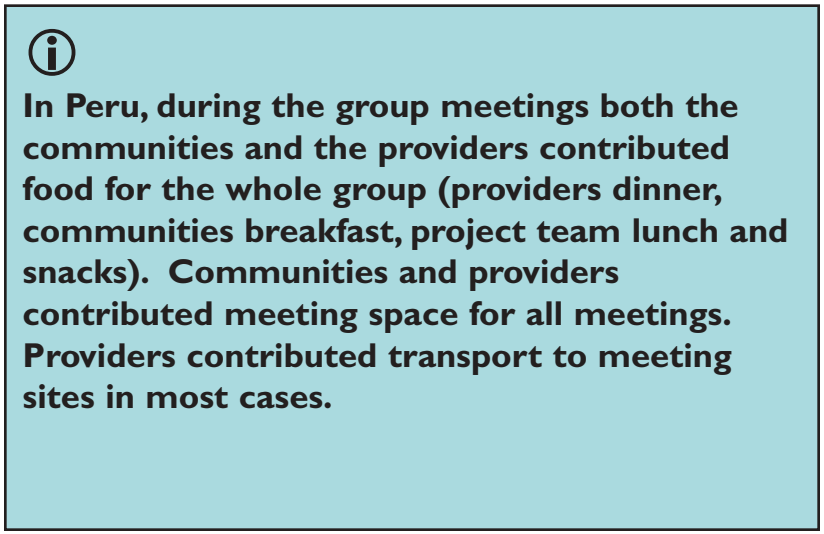
FACILITATORS TIP

You can also introduce the QI Action Cycle as shown in "Working in Partnership"

Next Step 15 minutes

The group should understand that this is the first step of a process. Next there will be a workshop with participants from other communities and school and health center staff to review what was learned from these discussions and to begin to develop ways to work towards improving identified problems.

Depending on the initial thinking done in the planning and design phase, each group will need to have a certain number of representatives who would be able to come to this Bridging the Gap workshop. Those participants should be nominated now.



In Peru, during the group meetings both the communities and the providers contributed food for the whole group (providers dinner, communities breakfast, project team lunch and snacks). Communities and providers contributed meeting space for all meetings. Providers contributed transport to meeting sites in most cases.

- Summarize what we have learned.
- Ask for participants comments and thoughts about what has been said.
- Ask group to nominate participants to represent their viewpoints for the next PDQ meeting.

Other Considerations:

The issue of allowances or per diems is likely to become an issue for continuous participation in these meetings. It is probably preferable to limit this to the extent possible, since payment of allowances will significantly determine how sustainable the PDQ process will be. We recommend sharing of costs and effort to the greatest extent possible.

PREPARATION FOR BRIDGING THE GAP

This step can vary widely depending on the implementation choices made earlier by the PDQ implementation team. Even if each facility is going to have it's own QI team, many different groups within the community provided input. Often these groups provided their views separately (i.e. men, women, community elders). There may be more than one school that fall within the catchment area of the health facility such that one team may target one health facility and several schools. Now is the time for the implementation team to review the information to establish a common voice for the local community. Also determination of who can best represent and present the community perspective and the provider perspective should be discussed.

Purpose: To review information obtained earlier and prepare information for presentation.

Methods:

- Categorize information
- Integrate for presentation
- Analyze the gaps
- Confirm findings
- Bridging the gap

Categorizing Information

By defining possible categories, the observations can be grouped to better show patterns and key elements and define problems. However, it is important that this grouping and labeling not cause the details provided regarding each issue to be lost.

Once the group has agreed upon labels for the different categories, put the labels on separate sheets of flip chart paper and place them on the walls around the room. Using different colored paper to indicate community versus health worker responses versus teacher, have each "facilitator - recorder" team review and synthesize their own observations and notes. They will copy one quality element on a colored paper and place the information under the most appropriate category heading. If there is an associated quality problem/issue with this element it can be written below. This way both the quality elements and associated problems can be discussed together. If multiple discussion groups come up with the same observations, it should be noted with a check mark.

THE FOLLOWING ARE SOME EXAMPLES OF CATEGORIES THAT CAN BE USED:

Place/Environment: This covers the physical setting as well as the location for health services or schools e.g. privacy, distance, waiting space, cleanliness, availability of latrines, etc.

Supplies and Equipment / Medicines: This includes all the materials that are needed in the clinic - e.g. medicines, equipment, soap, furniture, etc. (medicines may be pulled out into a category all its own) or the school – resource materials, books and supplies, chalk boards, desks and furniture, etc.

Providers - Technical Competence: For health, this includes the capabilities of the providers, whether they arrive at appropriate diagnoses and treatment regimens, and whether they practice safe medicine. Appropriate sterile technique would be included here. For education, this primarily includes the capability of the teachers to teach and the administrators to run a school.

Client / Provider Relations: How the provider or teacher treats their clients or students is covered here e.g. respect, greetings, openness, discrimination, fairness, confidentiality, tolerance for traditional beliefs, etc.

Systems and Procedures: This includes cost of services - both formal and informal, staff availability, school and clinic hours, supervision, policies and procedures, etc.

Service Availability: For health this includes types of services available, whether the needed (or wanted) services are available at all, whether services are integrated or provided on different days, whether people have adequate information about the availability of services, hours of operation, etc. For education this includes whether students are being taught what people think is important, and whether students have access to the services they need.

Communication / Information: This includes whether clients get the information they want or need, whether they understand the information, whether they feel listened to, etc.

Cultural Compatibility / Traditional Beliefs and Practices: This includes everything related to how people's traditional beliefs and practices are accepted by or taken into consideration by the formal medical or school services.

Integrate For Presentation

You now have a series of flip chart "categories" with many observations placed on them. The challenge is to synthesize these observations into elements of quality that are considered significant by community members and health workers and teachers.

These synthesized elements or definitions of quality then become the basis for defining the perspectives on quality, how they differ, how they are similar and where quality improvements are needed.

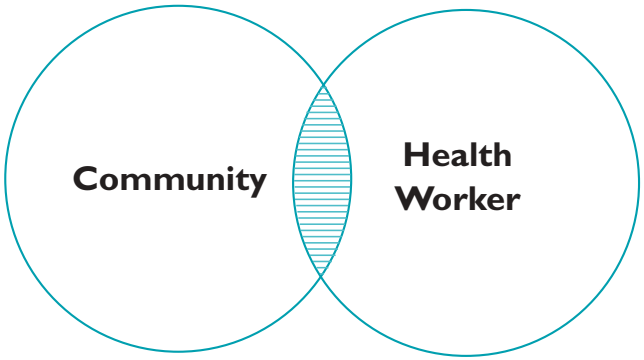
FACILITATOR TIP

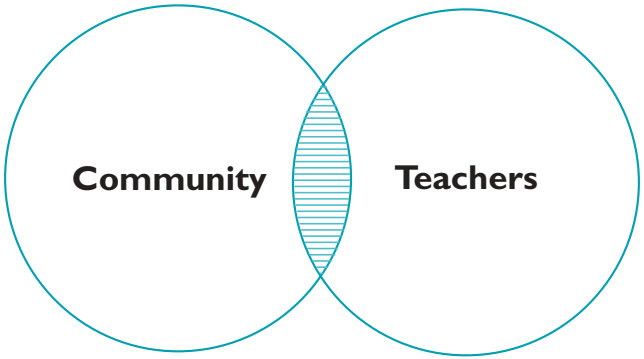
At this point in the process, it is important to write down the original ideas and not merge unique perspectives. For example, if one group commented that there are no medicines, and another group indicated there are no injections and they receive the same pill for every illness these should remain separate observations. If they both become summarized to "lack of medicine" then the focus of the analysis, may lead people to conclude there are problems with the supply system. However, if the original information about injections and same medicine is recorded during the analysis, it can be used during the next phase as part of a more detailed problem analysis.

Analyze The Gaps

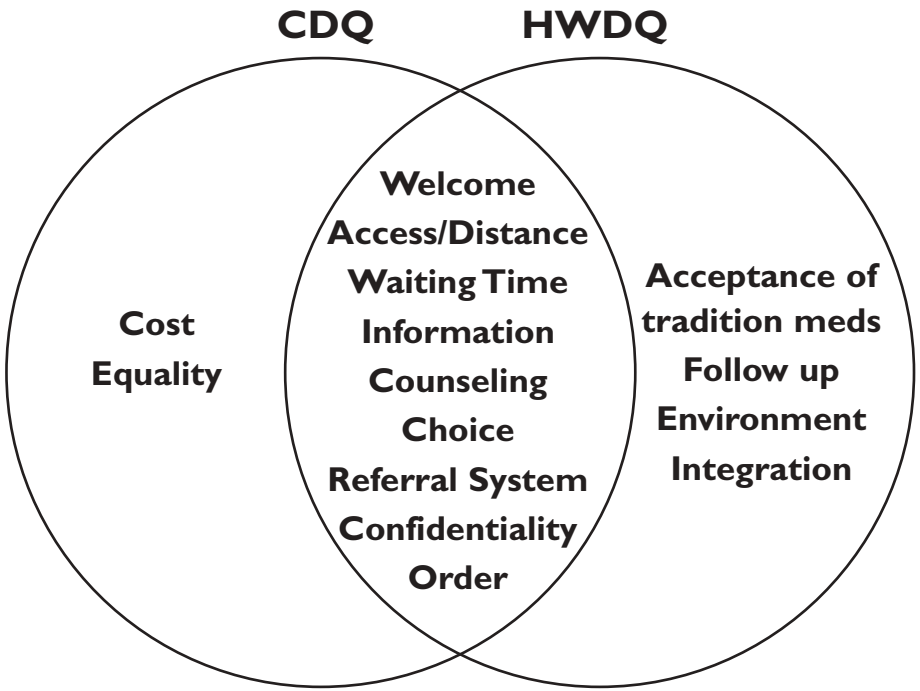
In order to present the two perspectives on components of quality, an analysis of their similarities and differences is needed. This can be done using a Venn Diagram.

Draw two large interlocking circles, using three sheets of newsprint. The middle page will be the area of overlap represents. The area of overlap represents common views of quality between the community and the health workers or teacher. Each non-overlapping section of circle will contain key elements of quality as mentioned by only the community, or only health workers, or only the teachers. This diagram can represent both the key elements of quality and the problems. By highlighting those elements that are perceived as problems, the diagram can show both good and bad quality elements.





Example for Health From Haiti



Confirm Findings

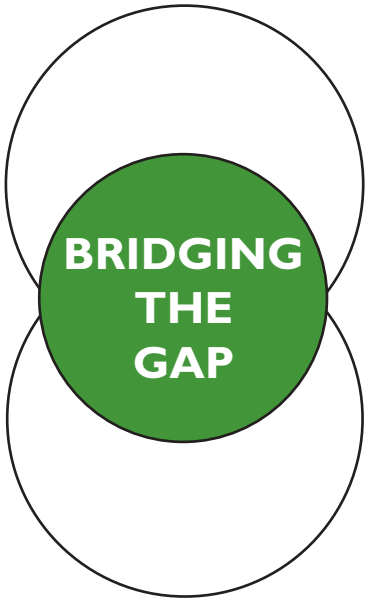
This is the final opportunity to make sure what is being presented to the other group during Bridging the Gap accurately portrays each groups perceptions.

This step can be conducted during Bridging the Gap before the presentations are being made, or a separate meeting can be conducted to present the summary to the community and the health workers. The groups should also determine who will present the gathered information.

In Peru, each group viewed the edited version of their video. This allowed them to see what they had said and make any changes if necessary. After much discussion, the groups decided that the videos did accurately portray their issues and could be shown to the other group.

Bridging The Gap Participation

If all discussion group participants will be attending the Bridging the Gap session, then you can skip this step. But if participation will be comprised of a few representatives from each discussion group, it is important to make sure that likely persons who may join the Quality Improvement Team are participants at the workshop. The decision on the number of participants for each step of the process was determined during the planning phase, but it would be valuable to make sure that the numbers have not grown beyond what is manageable. The goal is to have appropriate representation from different segments of the community and from health workers and teachers so that quality improvement teams can be developed.



PHASE 3: BRIDGING THE GAP

Each group has had the opportunity to express their own views on quality. The groups must now bridge the language, cultural, user and provider gaps to engage in sincere dialogue about their definitions of quality. Then they must develop a shared vision and begin working as a team. This phase is the launching point for the ongoing QI initiative.

A fundamental question that will need to be answered is whether it makes sense for groups to work on both education and health issues at once, or if the quality improvement process will now mostly follow two parallel paths with one section working on education while the other one works on health. This will depend on how many of the issues and interested people overlap.

Purpose: To provide an understanding of the varying perspectives of quality and to integrate those perspectives into a shared vision of quality.

Components:

- Team Building
- Developing a Shared Vision
- Problem Identification
- Select QI Teams

The goals for these components are:

- To engage in sincere and respectful dialogue about quality concerns
- To create a new definition of quality as a team
- To mobilize participants who will remain involved in the QI process

TEAM BUILDING

For all groups, creating a common understanding and common ground is essential to PDQ. The concept of health workers, teachers and community members working together can be intimidating for some community members and can be threatening to the health workers and teachers. If social and cultural barriers were one of the quality issues, then team building has added importance.

Purpose: To begin to create a non-threatening environment, reduce barriers to communication, and create a positive atmosphere for working together.

Methods:

- Introduction excercise
- Tour of the community
- Tour of a health facility

Exercises are examples of tools/icebreakers that were used during PDQ implementation. There are many others that can be used or be creative and design one of your own.

These types of exercises can be reintroduced throughout the process, especially once the final QI teams have been established.

Useful References: PACA: *Participatory Analysis for Community Action*, Peace Corps Information Collection and Exchange, December 1996

Training for Transformation, A Handbook for Community Workers. Anne Hope & Sally Timmel, Mambo Press

Introduction Exercise:

This exercise provides the opportunity for participants to meet and learn a little bit about each other. It requires that you have items that have at least two of all items. This can be fruit, pictures, squares of colored paper. You randomly distribute fruit, pictures, or colored paper. Have the participants find the person who has a matching item and introduce themselves. Each person should tell the other a little bit about himself or herself. Then each will introduce the other person to the group.

Tour Of The Community:

"To understand me you must understand where I come from and how I live".

This exercise can be as simple as having the community present their community map to the group. Or the interaction can involve sharing a meal at the homes of community members.

Tour Of A Health Facility / School:

For the health workers, their setting is their health facility, as the schools is for the teachers. By bringing the community through their facility, they can "introduce" them to their services and the challenges they face. For some members of the community this may be the first time they have entered these facilities.

In Peru, the health workers actually spent the night in the homes of community members. This was unprecedented because health workers had rarely spent any time in the community, let alone staying overnight in a community members home.

The major pitfall to avoid in Bridging the Gap is setting up a situation where community members and service providers are confronting or blaming each other for the problems that were identified. The previous exercises are examples of ways to begin to develop trust and get each group working with the other to address the problems. At no point is it desirable to have one group address the other or posing questions to the other directly.

DEVELOPING A SHARED VISION

Until now, quality of services has been explored separately through the eyes of the health worker, the teachers, and the community. As a first step to developing a shared vision, it is necessary to understand each other's point of view. Although the views are most often different, many things are the same. This is the time to merge the visions.

Preparation:

There are many options for presenting the viewpoints on quality. The presentations can made by representatives from health worker, teacher and community groups, or a neutral person may present, such as the facilitator of those discussion groups.

Methods:

- How the community defined quality
- How teachers defined quality
- How health workers defined quality
- Developing a shared vision

How The Community Defined Quality

After the community presentation time should be allowed for discussion.

How Health Workers Defined Quality

Suggested discussion topics after the presentations: Does anyone want to add to what has been presented here? What is similar between the two views? What is different?

In Peru, each group's video was shown at this time. This allowed the other group to hear and see the people's viewpoints in their own words and in their own setting.

In Nigeria, where education and health were both being addressed, the teams used the Bridging the Gap workshop for both interventions. While different small groups were working on different issues, the shared forum allowed people to recognize that many of the problems were similar between education and health, and that their issues could be addressed in an integrated way at the community level.

How Teachers Defined Quality

Suggested discussion topics after this presentation: Does anyone want to add to what has been presented here? What is similar between the teacher and community views? What is different? Are there common issues between health services and schools that can be addressed together?

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In Nepal the MOH presented the health workers views and the community discussion group facilitator presented the community's views.

ⓘ

In Haiti, the Bridging the Gap workshop involved more 60 people, both health workers and community members, from the five sub-areas of the project. People decided they wanted a QI team for each of the sub-areas, but they also wanted an "umbrella" team with representation from each which would meet less frequently for coordination and exchange of ideas.

FACILITATOR TIP

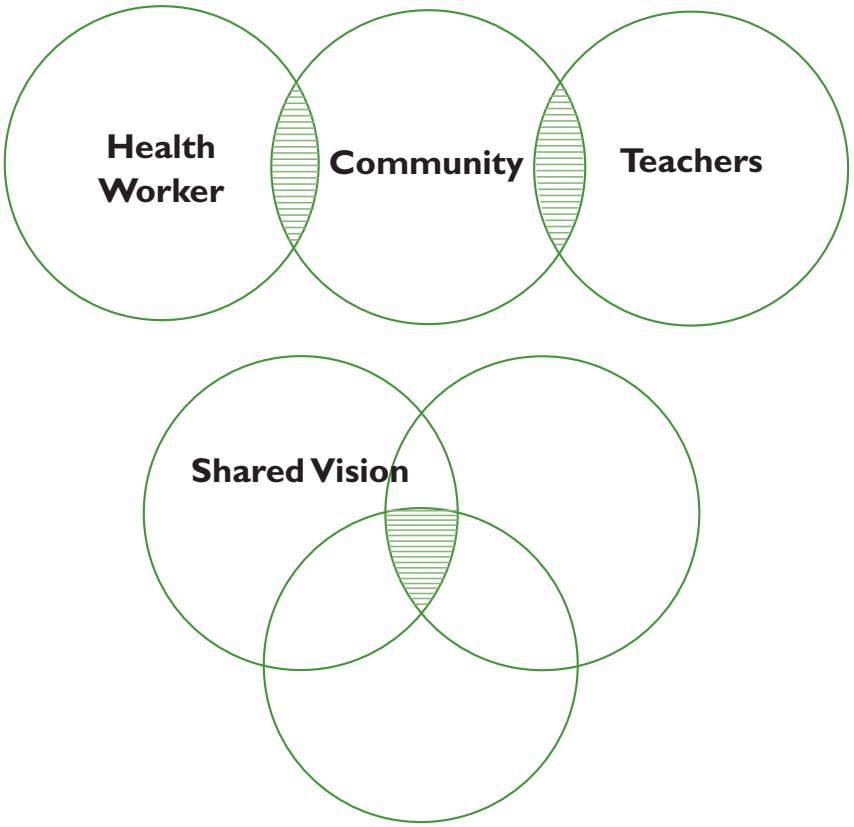
If there are specific data that might also influence the development of the vision for quality and /or the action plan to follow, now might be a good time to introduce it. For example in Nigeria, the COMPASS project has data to indicate there is a problem with girls' enrollment, immunization coverage, family planning use, etc. Some of these problems may be partly due to issues with the local facility that could be improved by an organization such as a QI team or coalition.

Alternatively, a specific situation might recently have come up, such as a maternal death or a disease outbreak, that could be used as a talking point to spur discussion and consideration during the bridging the gap process.

Developing A Shared Vision For Quality

This may take sometime but it is important that the vision reflect the aspects of quality important to all groups. It may be easier not to go into the causes of why certain aspects and understanding of quality are lacking. But instead develop an integrated vision of quality that reflects each group's viewpoint.

Display the Venn diagram that was created in preparation for this workshop. Be sure it still accurately portrays what has been presented or changed during the last discussions.



DISCUSSION

- **How are the perceptions of quality the same?**
- **Where do the views on quality differ?**
- **How has hearing the presentation from the other perspective affected your thinking on what is important for good quality care? Has anything changed for you?**
- **Now that we have heard quality defined from both perspectives, what would a shared vision of quality include?**

PROBLEM IDENTIFICATION

Depending on how the quality presentations were approached, the groups may have already presented both their views on the elements of quality and the problems. (Remember not all elements of quality will be described as problematic.) If the problems with the quality have not been fully discussed, they should be identified now.

Purpose:

1) provide an overview of problems or gaps identified through the exploratory discussions
2) to validate the problems
3) prioritize those that need attention

Methods:

- Introduction
- Review problems

Introduction

Before presenting the problems identified, it may be helpful to review some key points about this process. As problems are discussed, it will be important to remember that exploring problems is as a first step toward solving them.

Key points:

- We all share the same goals – better quality care / better health / better education
- Focus on the problems – not individual blame
- Respect that people can have different viewpoints on the same issue

Review Of Problems

Divide into small working groups. If more than one health facility catchment area or school is participating then you could divide by geographic division with health workers, teachers and community representatives from each village or catchment area working together. An alternative is to divide into different groups for health or education.

Within each group, review identified quality elements and any associated problems through exploratory dialogue with community members' health workers and teachers.

DISCUSSION

1) Do the problems identified exist in our facilities?

2) Do some problems need to be restated?

3) Are these the main problems?

4) Do you want to add anything?

5) How do the HW, teacher and community descriptions of a given problem overlap?

6) How are they different?

7) Are there any trends that we can see in the types of problems that each group has identified?

Regroup and present any changes from the subgroup's discussions.

Useful References:

A Modern Paradigm for Improving Healthcare Quality, The Quality Assurance Project
www.QAProject.org

In Nepal the original design called for four Quality Improvement Teams, each would represent a health center and the associated health post. After the "bridging the gap" workshop each health post group felt that it would be better for them to have their own QI team. Now there are 30 QI teams instead of four. But each team feels more empowered and locally driven than the original design.

In Uganda, each school had its own QI team with its own agreement for school safety under which participants were working on improvements and monitoring changes.

SELECT QI TEAMS

Before completing the "bridging the gap" workshop, a concrete plan for the QI teams should be addressed. Who will be on the team, and where and when they will meet should be discussed among the participants. The original design can be changed to meet the participants' needs.

It is important that the QI Team be able to represent the diverse viewpoints of both the community and health workers and teachers. Unfortunately, diverse groups often have diverse needs. Barriers to participation such as transportation, convenient meeting times, and locations need to be addressed.

ⓘ

In Nigeria, if the community coalition had not already been formed, the Bridging the Gap meeting served as the opportunity for forming both the QI teams and the community coalitions. In some instances, QI team that were responsible for both education and health were formed with sub-committees for each, while in others separate teams for education and health were formed. For education, the QI teams clearly have significant involvement from the PTAs.

PHASE 4: WORKING IN PARTNERSHIP

The groups have agreed on a common vision of quality and some challenges that they face. Now the creativity and ingenuity of the QI teams is needed to determine causes, solutions and action plans. This requires a creative team working together in cooperation and respect. In this step, the tools are provided for problem analysis and action planning as well as to strengthen the group process necessary for the QI teams to continue the cycle of change. Some of this problem analysis work may initially take place during the "bridging the gap" workshop but those results will need to be reconsidered by the Quality Improvement Teams in this cyclical process. Most of these tools and processes are generic and can be used in a variety of situations not specific to either health or education.

Purpose:

- To provide tools necessary for the QI teams to implement a continuous quality improvement process.
- To establish a process for ongoing review of progress including a mechanism to determine when problems are resolved and to identify new challenges to address.

Components:

- The QI Action Cycle
- Tools for Problem Analysis
- Solutions and Strategies
- Reviewing Progress
- Tools for Self Management

Although these tools will be reused many times by the teams in the ongoing quality improvement process, initially the teams will need technical support to expand their action planning skills.

THE QI ACTION CYCLE

It is important for the quality improvement teams to review all they have achieved to this point and to understand how this fits into the quality improvement cycle. By discussing this as a continuous process, of problem identification, proposal of problem solutions, implementation and assessment, the teams can see their permanent role in the QI process.

Method:

Review a diagram of the action cycle

Preparation:

- Draw the action cycle on large paper for display
- If literacy is an issue, include pictorial representations of each stage

Discussion Guide:

Provide an overview of the action cycle using the diagram. It is important the team understand that this is a continuous process for improving quality.

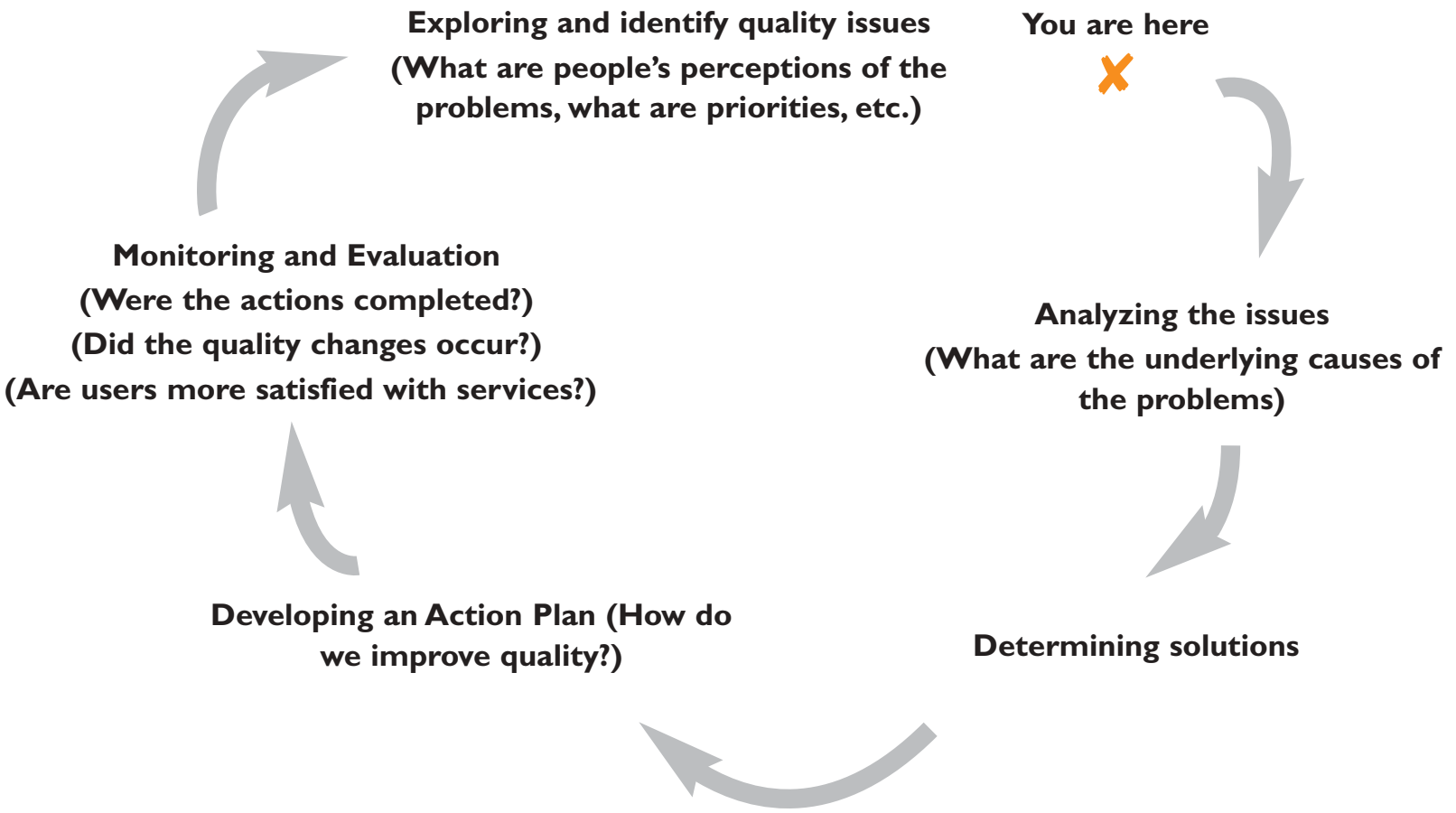
Use the following questions as guide to facilitate discussion.

Where are we in this cycle?

And what is next?

Can this process be used for new problems?

QI ACTION CYCLE DIAGRAM



FACILITATOR TIP

Once these steps are outlined on the board, you may want to facilitate a discussion in the group on how this applies to their work as a QI team.

TOOLS FOR PROBLEM ANALYSIS

Many eyes can look at one thing and see something different. This is a benefit of the PDQ QI Teams' diverse perspective when analyzing problems. Problem solving is a skill that the team can develop together. Although a problem can appear to be due to one cause, further analysis usually reveals that there are many contributing factors or causes to each problem. Often by really exploring problems and gaining a better understanding of the root causes, solutions and strategies become more visible. This section provides a series of tools that can be utilized to explore a problem more fully.

Purpose: to identify the root causes of problems

Methods:

- Fishbone Analysis
- Tree Analysis

* there are many methods for helping groups discover root causes of problems. These are two examples that we found useful. The reference section lists sources for additional tools. Some problems are easier and do not require complex analysis while others will require a lot of exploration.

Key Points:

- For each of the selected priority problems, the participants should ask themselves:
- What is the problem as we see it?
- Why is it a problem?
- Is there something else causing the problem?

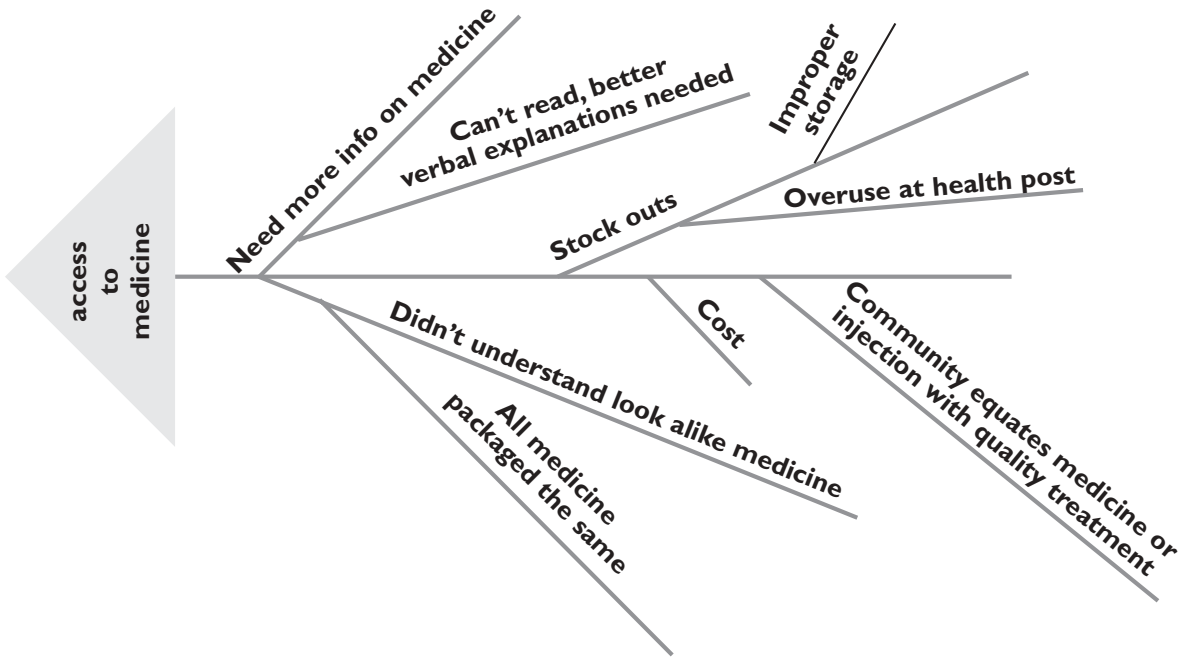
FACILITATOR TIP

To be able to determine effective solutions and actions, underlying causes must be identified. You will find yourself repeatedly asking the group "but why".
Asking but why helps the group identify all the contributing factors, and root causes.

Useful References: A Modern Paradigm for Improving Healthcare Quality, The Quality Assurance Project
www.QAProject.org

Fishbone Analysis

In fishbone analysis the problem becomes the head of the fish. Contributing causes are assigned to the bones. In instances where the same contributing cause comes up for many different problems, it may be beneficial to analyze that cause as the primary problem. For example if lack of support was a cause listed for many problems, then you could do another analysis where lack of support was listed at the head of the fish and the factors contributing to that problem would be explored. You may also have other factors which contribute to a cause that should be noted as additional "bones" branching from the cause.



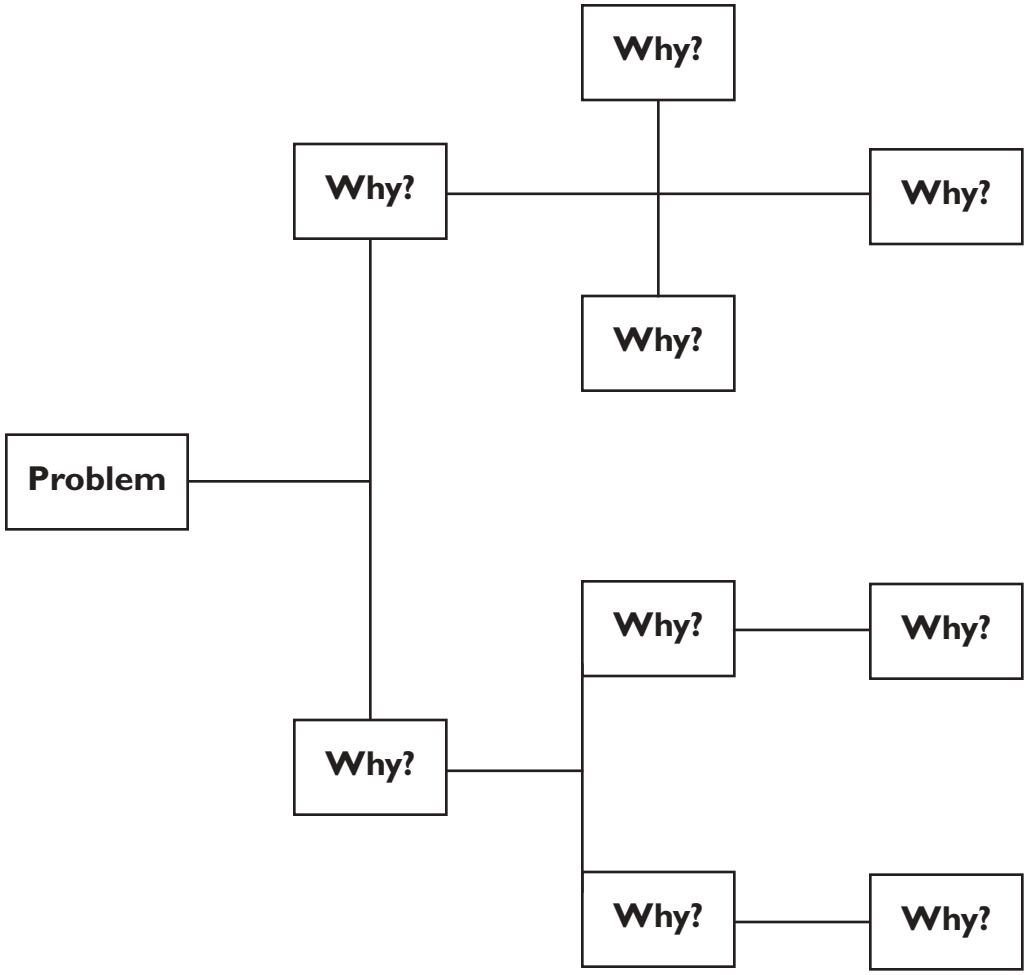
FACILITATOR TIP

There is no right way or right answers to the problem identification process. If you have too many bones or it has become too complicated your problem may be too broad. You may want to break it down into more specific problems and analyze each of those separately.

Remember that the tools are supposed to help. If the team is struggling to use the tool maybe another one would be better.

Tree Diagram

This diagram branches out with each "But Why?"



EXAMPLE OF FLOW

Problem: Girls tend to be underenrolled for school

Why? Because there isn't enough money for everyone and boys take priority.

But why? Because traditional culture has women getting married and having children, even though increasingly women need to be able to support themselves.

What are other reasons for the problem? Girls can't walk as far as boys and the schools are far away.

Why? Girls don't have enough time to walk the distance because they are busy with household chores.

But why? Girls' roles in the household are still traditional while boys are more free.

SOLUTIONS AND STRATEGIES

The problem analysis has revealed that each problem is really the sum of many causes. And within each cause there is a possible solution. Some of the solutions would require action beyond the bounds of the teams but many solutions are achievable. Focusing on what can be accomplished by the team creates the momentum needed for sustaining the quality improvement process.

Purpose: To identify possible solutions and strategies for addressing the problems identified and determining an action plan to achieve change.

Key Points:

- There is likely to be more than one solution for a particular problem.
- As possible solutions are identified, it may be necessary to ask the group, "if that is not possible, then what?"
- Focus on solutions that are realistic and feasible
- Focus on positives, ways to make things better and not on blame.
- Include shared solutions that involve the community

Methods:

- Develop solutions based on causes identified
- Develop an action plan

Develop Solutions Based On Identified Causes

Starting with one problem, use the causes identified in the problem analysis to explore appropriate solutions through brainstorming. The teams can use the chart on the next page to record the problem, contributing factors and suggested solutions.

FACILITATOR'S TIP

Often the initial solutions involve actions from outside sources such as the government or the donor. Initially, the group should be guided to also look for solutions that can be achieved at the local level.

PITFALL

Where the possibility for grants or external resources exists, there is a tendency to think only in terms of problems and solutions that money can fix, and dependence on external resources is reinforced. In contrast, when communities are encouraged to develop low or no cost solutions, or to at least consider which of their solutions they can manage internally, the definition and solutions for problems is greatly expanded.

For example, when money is the driving factor, solutions often refer to improved infrastructure and equipment. ("we need a renovated health facility") However, if internal solutions are also encouraged, people begin to recognize how their own attitudes and practices are contributing to the problems and they recognize they can do something about it. ("we don't have a female health worker because our girls are not in school")

In Nigeria, because the structures included both community coalitions and QI teams, each developed an action plan, but each had a different focus. At the QI team level, the focus was on the specific activities to improve the quality of services in a specific facility. For the coalition, their action plans involved broader activities such as advocacy, community mobilization and sensitization, and fund raising.

With the COMPASS project in Nigeria, the availability of grant money and interventions from other sectors greatly broadened the possibilities for solutions and actions. As a result, QI teams and coalitions were encouraged to come up with solutions they could resolve themselves internally, and solutions which needed additional resources or assistance. They then had the option to advocate for technical or resource assistance from other sectors both within and outside the project and/or to develop proposals for grant assistance through on of their participating community based organizations.

Develop An Action Plan

After solutions have been identified for the problem, the team needs the skills to take the potential solutions or strategies and translate them into specific activities and plans for implementation. Starting with those challenges that have the most feasible solutions, develop a specific plan for how, who and when the activities will occur.

The sample chart below is one way the team can keep track of the issues.

Problem	Contributing factors	Solutions	Action	Who is responsible	Resources/ materials re needed	When	Status
1.		A._____ B._____	1. 2. 3.				
2.							
3.							

There is often more than one solution to a problem, as well as, more than one action for a solution.

REVIEWING PROGRESS

This quality improvement process is a cycle, which includes tracking progress. By creating mechanisms for the teams to evaluate their progress, they can determine whether they are ready to move on to new issues. Or if actions have been implemented but the results in quality were not achieved then the problem can be re-evaluated and new strategies can be explored.

Purpose: To identify indicators that can be used when evaluating QI activities and ways to measure them.

Key Points:

- The indicators or benchmarks of progress and ways to measure these need to be kept simple. Teams want to know if the solutions are working but they don't want to be over burdened by monitoring.
- In order to be able to use the monitoring information the group collects, the team will need to have some way to organize it and draw conclusions
- Upon review the group may note their activities are not leading to changes. They would then need to determine whether their indicator is not the right one (doesn't measure the impact of the activity) or whether the activity is not the right one (doesn't address the real problem). In either case, this would indicate that the team should refine the problem definition, strategies, or monitoring as part of the QI cycle.

Methods:

- Tracking progress
- Creating an tracking table
- Evaluation Tools

Tracking Progress

It is important to know whether the problem was not resolved because the solution was not right or the action was never implemented or completed. That is what the "status" column was designed for in the action matrix. During QI team meetings the status of the actions can be reviewed.

If actions did not meet their completion date the team can decide if it will just take longer than expected or maybe new or additional people could be assigned to the task.

Creating A Tracking Table

The following table provides a framework for the group to begin to consider how they want to measure change as a result of their activities. It may be adapted to whatever column titles or steps make sense in your situation. The main purpose is to come up with indicators that are simple to define and measure but that will accurately reflect a change in the identified problems.

TRACKING TABLE FOR QI TEAM

PROBLEM	WHAT SHOULD BE? (Quality standard)	PROOF OF CHANGE? (Indicator)	HOW WILL YOU MEASURE?	HOW GOOD IS GOOD ENOUGH? (Benchmark)

TRACKING TABLE FOR QI TEAM EXAMPLE

PROBLEM	WHAT SHOULD BE? (Quality standard)	PROOF OF CHANGE? (Indicator)	HOW WILL YOU MEASURE?	HOW GOOD IS GOOD ENOUGH? (Benchmark)
Clients lack necessary information	• All clients receive complete and understandable info about care. • All clients receive info about how to take medicine. • All clients receive info on how to prevent problem in the future	Client can explain care Client can explain use of medicines Client can explain preventive actions to take.	Possible methods: Exit interview by QI Team member or HP coordinator or in-charge.	More than half of clients interviewed indicate they received information about their diagnosis. XX% of clients could explain how to take their medicine correctly. XX% of clients know prevention strategies
Students feel there is discrimination	• All students treated equally • All students spoken to politely	Students receive equal grades for equal work. Students feel they are treated with respect.	Clients Voting Jar – Once a weeks students vote on whether they feel they are respected by placing a bean with a happy or sad face in the voting jar. Committee members periodically review grades relative to work produced.	Students all report fair treatment Outside review indicates grades are given fairly.

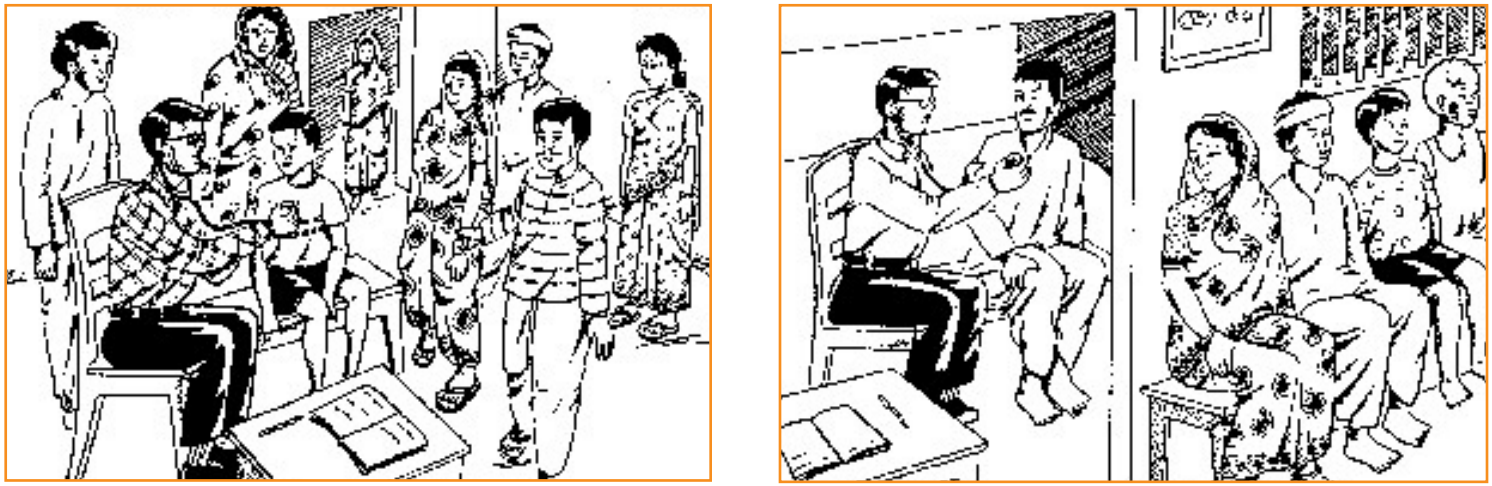
Evaluation Tools

These tools can be adapted to pictorial versions to overcome literacy barriers as was done in Nepal.

1. Happy face / Sad face jar
2. Suggestions jar
3. Simple exit interviews
4. Simple observation check list which QI team members or providers could administer
5. Provider self assessment
6. Client evaluation form

PICTORIAL EVALUATION TOOL

In order to bridge the literacy gap for evaluation, the QI Team in Nepal created a pictorial tool to be used by clients to monitor planned quality improvements. The tool allowed both literate and non-literate clients to give anonymous feedback. The tool included, whether trained staff provided the injections, whether a sterilized syringe was used, whether the provider interacted politely and listened to the patient's problem, whether a queue was maintained, and whether medical waste was disposed of properly. A score was given for each observed case. This information was shared with the QI Team members during their monthly meetings.



Maintenance of Queue.

Proper Disposal of Medical Waste

TOOLS FOR SELF MANAGEMENT

Just as quality improvement is a learning process, so is working together as a team. Sustaining a cohesive and productive QI team requires skills in group process, team building, and facilitation. The goal is to have a group of diverse volunteers working together as a team with the skills to set agendas, run meetings, problem solve, and develop action plans. As with quality definition and improvement, the group together can determine what is needed to strengthen the group process. The exercises are designed to help the group explore several aspects of group strengthening that will contribute to the growing independence and success of the QI team.

Components:

- Understanding how leadership can work in our team
- Facilitation exercises
- Team effectiveness evaluation
- Mobilizing resources
- Representation

The exercises that follow are suggested tools. The people guiding the PDQ process are strongly encouraged to develop their own, or to adapt these or others to the needs of their particular groups.

Useful References: *Training for Transformation, A Handbook for Community Workers.* Anne Hope & Sally Timmel, Mambo Press (Chapter 6 – Leadership and participation)

PACA: Participatory Analysis for Community Action, Peace Corps, Information Collection and Exchange. December 1996

UNDERSTANDING HOW LEADERSHIP CAN WORK IN OUR TEAM

In any team, leadership is an essential component. The team maybe comprised of one or several leaders. By gaining an understanding of how leadership works and establishing a group with shared leadership, the group becomes more self-reliant and can effectively draw on the unique contributions of each of its members.

Purpose: To explore different options for managing QI team leadership in order to assure the most effective function.

Methods: Group discussion of formal and informal leaders, and identification of leadership strengths within the team.

It may be useful for the people who are guiding the PDQ process to work with the group in a self diagnosis process to identify their leaders, their strengths, and ways to be sure the group has the leadership it needs.

Formal and Informal Leaders

There are formal and informal leaders in most groups. The formal leaders are those who have the titles: Chairman, Mayor, Health Services Supervisor, School Principal, etc. However, they may not necessarily be those who have the most influence. Groups will likely function well if the formal leader is also active, committed, and has the respect of the group. If this is not the case, there may be other "leaders" who are helping out, or the group may have difficulties with lack of leadership.

Roles of Leaders/ Shared Leadership

Initially, it is likely that the selected leader (Chairman) may be called on to respond to needs of the group on his or her own. As the group gets to know each other, gradually different members will assume more of the leadership roles themselves. As the group members take more responsibility for the function of the group, the leader can become less active and the role is shared among the team.

FACILITATOR TIPS:

You may want to ask the following questions, or you may just want to offer the leadership framework of formal, informal, and shared leadership suggested above and have a more general discussion. This discussion might be repeated as you notice problems or gaps with leadership during the evolution of the group. Leadership and choices of leaders can be changed as the group matures and the group's needs change.

- Who are the formal leaders in our group? (Chairman, secretary, local government leader) The informal leaders? (the most active people, the people most respected by the group or community, the elders)
- How do the formal and informal leaders work together or complement each other to help the QI team be more effective? (who schedules meetings, shares information with others, seeks out resources, makes decisions, etc.?)
- Is our team able to accomplish the necessary activities to be effective? Do we manage to have regular meetings? Is the discussion useful? Does everyone feel comfortable participating?
- If our team is having difficulties functioning, why is that? Can we identify people (leaders) within our team who might be able to help overcome these difficulties? What are ways we can encourage more shared leadership and responsibility among the members?
- What might be some of the reasons a leader will keep control of the group themselves?

Rotating Leader/Chairman for QI Team

One way to encourage shared leadership, is to assign the chair person job on a rotating basis. This role would probably include development of the agenda, facilitation of the discussion, and a summarizing the tasks and accomplishments achieved during the meeting. Where an outside organization is facilitating or serving as a catalyst for initiating the PDQ process, this may start out as a shared role where one member from the agency works with one or two group members to plan and lead the meetings. As group members become more confident in these processes, agency participation will be less necessary.

FACILITATION EXERCISES

For the QI team, a facilitator's role is to enable open and equitable communication ensuring that all the members are fully committed to the actions taken by the team. Although not defined as such, team members use facilitation skills in their daily lives. By defining the facilitator's roles and exploring the skills needed for their success, the can team will begin to create their own group norms.

Purpose:

- To determine the roles of the facilitator by the team.
- To determine methods for successful facilitation.
- To begin to establish group norms.

Methods:

- Facilitation Role Plays
- Managing Participation
- Defining the Facilitators Role

Facilitation Role Play I — 35 minutes

Using some of the members, role play a meeting with typical facilitation challenges. The facilitator in the role play should be predetermined. Choose a topic for the role play that involves soliciting ideas and agreeing on an approach. The role play does not have to be scripted and the facilitator is not being rated on their success. This is just an opportunity for the group to think about the role of the facilitator.

After 10 minutes, stop the role play and give the group a chance to discuss. Write the feedback on newsprint.

Discussion Questions:

- What functions did the facilitator serve?
- What did he or she do that really helped the group discuss in an open and participatory way?
- Where did the facilitator have difficulties? Why?
- Were there things they could have done in order to overcome these difficulties.
- What other situations could be encountered that the facilitator would have to deal with?
- What do you think are the best ways to deal with those situations?

- Does the rest of the team agree with that approach?
- How is facilitating different from managing or leading?
- Why do we want to understand other people's realities and perceptions?
- What are some of the things a facilitator needs to do?

Facilitation Role Play II 45 minutes

This second role play can be used to further the discussion on how to deal with challenging situations. In the ideal situation, all members in a group feel comfortable and participate equally. Unfortunately, this rarely happens. Depending on the setting and how comfortable we feel, there are times when all of us are able to contribute to the effective functioning of a group, but there are also times when we are not. Sometimes people, for some reason, work against this ideal of equal participation. This may mean they are too dominant or controlling, but it may also mean they are too shy to speak up. It is the facilitator's role to try and limit dominating behavior and to try and encourage non-participants to speak up.

Procedure: Set up the exercise in the same way the previous role play was set up. However, this time in addition to assigning a facilitator, also secretly assign specific challenging behaviors to a couple of the participants in the group.

Carry on role play for 10 minutes as done previously, then stop and discuss. Write down any group norms that are suggested on newsprint for the team to review.

Discussion Questions:

- What were the disruptive behaviors represented in your group? How did they manifest themselves?
- What did the facilitator do to try and manage these behaviors?
- Are there other ways the facilitator could have used to limited these behaviors?
- What responsibility do the participants have to the group?

TEAM EFFECTIVENESS EVALUATION

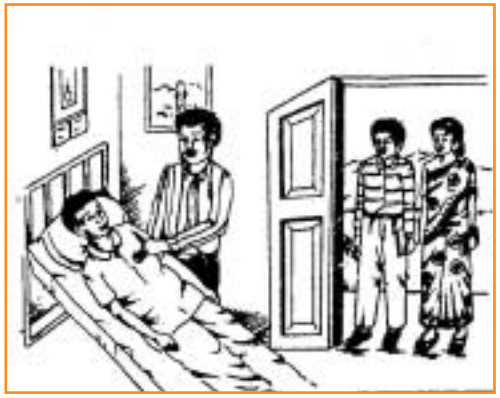
Establishing and maintaining an effective QI team can often be the largest obstacle faced by many of the communities for ongoing quality improvement. It is important that the QI teams take a look at their own process and interactions from a quality improvement perspective. The team can apply their skills in problem solving to resolve any issues that result from feedback.

We encourage teams to develop their own tools together. Again if literacy is an issue than the team can develop a way to pictorially represent the key area of team effectiveness.

PICTORIAL TEAM EFFECTIVENESS EVALUATION TOOL

Due to the varied literacy skills of the QI Team in Nepal, they developed a pictorial evaluation tool to be used by team members to monitor team effectiveness. Each picture, representing an area of team interaction, was ranked on a scale of one to three.

Active Participation



Monitoring and Follow Up

Mutual Cooperation

Questionnaire adapted from Training for Transformation, Volume 2

TEAM EFFECTIVENESS QUESTIONNAIRE

	Not at All, Never	A Few, A Little	Sometimes, Somewhat	Mostly	Always, Strongly
How strongly involved do you feel in what this team is doing?					
Do all members contribute to the decision making?					
Are all members included when making decisions?					
How fully do we use the resources and creativity of our members for accomplishing our goals?					
Are you satisfied with the progress the team is making?					
Are all members treated with respect for their ideas and opinions?					

MOBILIZING RESOURCES

In the process of developing an action plan, the QI team may have identified actions where additional resources - human and/or financial - may be needed. The team will have to identify where they might find those resources, and mobilize the people in charge to support the QI efforts. This could mean persuading local government officials that they should commit funds to a health service improvement project, or convincing community members they should become involved with monitoring quality improvement in the school. It could also mean identifying additional funds and developing a specific proposal for a quality improvement activity. In any case, the first step is to identify potential sources for the resources needed.

Purpose:

- To help identify resources.
- To mobilize identified resources.

Methods:

- Mapping Resources
- Selling the QI process

Mapping Resources Exercise — 45 – 60 minutes

It is said that a picture says a thousand words. In this case by drawing the community and the resources within the community, the team can begin to explore visually what may be potential partners in their QI efforts.

NOTE: This is an exercise that might be worth repeating periodically as part of the assessment step of the quality improvement cycle. It can provide information on whether we are doing the right things to address the problems we have identified.

Purpose: To practice looking at the community and the environment with the goal of identifying potential resources for supporting the QI process.

Materials: poster paper and markers for drawing a map, tape for putting them up

Procedure: Have the team draw a "map" (or diagram) of their community (s) – noting all the different groups, institutions and people they might try to work with, influence, relate to, convince, etc. They should draw the QI team in the picture.

When completed, ask the group to discuss:

Discussion Questions:

- Which of these groups or people are we currently interacting with regarding QI?
- Are there groups or people who we are not currently interacting with who might really be able to help us with our QI efforts?
- Which groups are our best allies? What are we doing to encourage this relationship?
- How well are we relating with the different groups on our map? Are there groups where we are having problems connecting? Why? What might we do differently?

"SELLING" The QI Process 60 minutes

Purpose: To practice identifying key points for convincing groups to become involved with the QI effort.

Procedure: Divide into subgroups, each selecting one of the "target" groups or people identified during the mapping exercise as someone who they might better be able to involve in the QI efforts. They should then review their problem list and action plan to develop a strategy and/or presentation for convincing these people to become more involved with QI.

Each group should select people to role play the different parts in the presentation. They should take time to decide how each person should play their role and to practice once through. Each group can then present their role play to the group as a whole.

Discussion Questions:

- What arguments or strategies did you find particularly convincing? Why?
- What arguments or strategies left you feeling uninterested in the QI efforts? Why?
- What have we learned about presenting QI that will help get more people involved in the effort?
- What are some of the constraints this person or group may have regarding participation?

REPRESENTATION

Since every service provider and member of the community can not be part of the QI Team it is important to discuss what it means to represent others in these teams. This exercise can also help pre-existing development committees reflect on their roles as community and provider representatives.

Purpose: Orient team members to their role and responsibilities as representatives of their respective groups.

Key Points:

The privilege to represent people comes with responsibilities:

- Communication with the people who are represented about what is going on at the health center or the school
- Communication of people's concerns and needs with the QI team and the health center or school

Methods:

- Group Discussion
- Plan for Next Steps

Group discussion to answer the following questions:

1. Who needs to be represented?
2. Who am I representing?
3. How can I best find out the ideas and concerns of the people I represent?
4. How can I best let people know about what is happening with the QI team and the health center and school?
5. How can the people I represent become more involved in the activities at the health center or the school?

Next Steps

Each person (or group of representatives) should consider their answers to the discussion questions and decide upon two next steps that they can take to improve their role as representatives.

EVALUATING THE PROCESS AND THE OUTCOMES

While the quality improvement effort is underway, it is important to monitor the process itself as discussed in the Working in Partnership chapter. In addition to monitoring the process, a review of the goals established at the beginning of the Partnership Defined Quality effort should be reviewed to determine if progress is being made toward the specific objectives. There are many ways and tools that that can be used to measure the impact of the quality improvement efforts. In particular, you may want to look at:

Client satisfaction monitoring tools such as exit surveys or printed anonymous questionnaires may result in greater honesty in the responses than when asking clients the questions just outside the clinic door or asking students questions near school.

Standard measures of the quality and availability of health services tools and techniques such as health facility assessments, checklists and protocols can be administered to check progress and highlight areas in need of attention. These tools are developed locally or are government issued standards. References for health facility and service assessment tools, which can be locally adapted, can be found on page 9.

Student test scores are often a standard measure of quality for schools. Beyond this, there may be checklists for standards and guidelines available in the country that could be used.

Utilization of health services and promoted health behaviors can be monitored through regular review of health services statistics and registers, the logistics management system for contraceptive and drug supplies (as evidence of demand), and knowledge, practices and coverage (KPC) surveys to evaluate adoption of health care practices and use of services by the community.

Improved equity in health services delivery or school attendance can be measured if intake records or other facility or community level data specifically track utilization by disenfranchised or low-income groups. The PDQ processes may help reach these groups that are consistently under-represented among users of health and education services, and build their interest and trust in the service providers and the services they deliver. Whatever combination of approaches to evaluation and documentation of the effectiveness of the PDQ effort that is chosen, it is important to regularly review the goals that the team set at the beginning of the process and to ensure the involvement of the community in the evaluation process.

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