

Partnership Defined Quality Technical Advisory Group Meeting
Saturday, June 27, 2009 12:00 pm - 5:00 pm
Save the Children office, Westport, CT

Background

This report documents the discussions, decisions and products of the Partnership Defined Quality (PDQ) Technical Advisory Group (TAG), led by Save the Children staff on June 27, 2009. This was the second annual global TAG meeting held on PDQ.

Most of the 14 participants were SC staff from WWO or from Country Offices; however representatives from AMREF and Project Hope also attended. Participants were asked to bring to the meeting any information on scope of their PDQ activities, accomplishments of QITs, any baseline or endline data, and list of indicators being measured through 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. Save the Children (SC) developed and tested the Partnership Defined Quality methodology in 1996 in response to learning that providers and communities had different definitions and priorities for quality of care. The methodology was expanded and piloted in Nepal, Peru, Haiti, Pakistan, Azerbaijan, the West Bank Gaza, Georgia and Ethiopia. In 2002 Save the Children published the *PDQ Manual: a toolbox for community and health provider collaboration for quality improvement*.

In 2003, CORE Group issued a Request for Proposals to its member organizations for promising child health innovations that could benefit a larger audience if they were diffused beyond the originating organization. There were several criteria for successful proposals, including the relevance to multiple country and cultural situations and the evidence of effectiveness. SC won a Diffusion of Innovation award to expand the PDQ methodology. As part of this award, SC developed the *PDQ Facilitators Guide*, conducted a training at the CORE Spring Meeting and held a Training-of-Trainers workshop in Bangkok, Thailand for participants from eleven countries and eight different organizations.

In 2007, Save the Children and the Social and Behavior Change (SBC) Working Group within CORE Group identified the need to assess and learn from PDQ applications to date in order to further improve the quality and scale of the approach. During that year, PDQ practitioners within SC held a small workshop in Armenia to discuss progress and learning in the region, share methods for monitoring and evaluation and discuss issues related to sustainability and scale. SC, together with the SBC Working Group from CORE sent out a questionnaire to various list serves and email lists, seeking PDQ practitioners. The resulting list included responses from over 15 countries and 4 implementing organizations. In-depth key informant interviews were conducted with six respondents to develop a more detailed understanding of their process the lessons learned.

The first PDQ TAG meeting was held in May 2008, providing an opportunity for practitioners from over 15 countries to share successes and challenges, list elements that maximized success, and discuss strategies for documenting and sharing PDQ experiences in the future. Issues raised include the sustainability of both Quality Improvement Teams (QITs) and quality improvements, indicators for PDQ and how PDQ, as a quality improvement tool, can promote behavior change and social change. Results of that meeting included the completion of 11 monographs of PDQ experiences as well as a document entitled: *Key Elements for Maximizing the Effectiveness of PDQ*.

In December 2008, Save the Children completed an adaptation of the PDQ manual for youth, entitled: *Partnership Defined Quality for Youth: a Process Manual for Improving Reproductive health Services through Youth-Provider Collaboration*. Training workshops for youth programming since then have taken place in Ethiopia and Bangladesh.

As projects continued and results in use of PDQ were emerging, the need was felt to convene another meeting in order to continue the dialogue among practitioners to share successes and challenges, but also to seek better ways of measuring quality improvement within PDQ. This has traditionally been difficult, since PDQ is embedded within larger projects with broader indicators. Draft monitoring and evaluation tools developed in Pakistan were then compiled into a draft toolkit. At the same time, Save the Children was developing indicators for measuring community capacity. Additionally there was a concern that PDQ expertise needed to be maintained regionally. The PDQ TAG meeting which took place on June 27, 2009 thus had several ambitious objectives

- To share progress and challenges in PDQ among our country programs
- To review WHAT we are measuring when evaluating PDQ
- To discuss HOW we are measuring it
- To determine how we can strengthen both what we are measuring and how
- To decide on a strategy for building regional technical capacity in PDQ

Please note that there are three attachments to this report:

- 1. Participant list and meeting agenda (attached at the end of this document)*
- 2. A zip drive with draft PDQ monitoring tools that were discussed and revised at the TAG*
- 3. The Community Capacity Indicators that were reviewed during the meeting with comments in red*
- 4. Powerpoint presentations from Kenya, Pakistan, as (as well as from Bolivia and Armenia which were shared at Health meeting for SC the following week)*

Notes from the PDQ TAG meeting June 27, 2009

After introductions, two country (Kenya and Pakistan) program representatives provided brief updates on their PDQ activities and accomplishments.

Kenya - AMREF

Bill Yaggy from AMREF provided an update on the use of PDQ in Kenya which resulted in some successes. These included:

- The community started paying fees to go to the health center when they realized that these funds were needed in order to improve the services for them
- Water was now available in the health facility
- Better maintenance of the yard around the health facility where women would gather for their prenatal or well-baby exams.

accomplishments

- Improved HW attitude, and improved perceptions toward HWs improved
- Higher attendance
- higher HF income
- Better allocation of resources through QIT advocacy
 - District provided funds to repair water system
 - HF committee reallocated funds to pay to maintain and run generator, and
 - To pay CHWs to take on some routine tasks at HF to free up professionals to see patients

Challenges

- Mobilizing resources to execute action plans with huge costs (e.g. ambulance)
- Poor attendance at regular QIT planning, monitoring and review meetings
- Creation of new district - new DHMT did not understand need for PDQ
- Established health facility committees see QIT as a threat

Lessons Learned

- PDQ approach was successful at one HF where entire process was completed
- Projects need to plan and budget adequately for PDQ
- Joint planning, implementation, monitoring, and review helps to overcome communication barriers between providers and clients

Although PDQ was successful in improving one facility and overall was seen to be effective there, it was a very time consuming process.. Costs for PDQ were difficult to separate from costs for the larger project because data for the HFA and MNCH assessment were not budgeted separately in the outset of the project.

Pakistan – Save the Children

Dr. Amanullah Khan from SC Pakistan also shared preliminary results from the use of PDQ as part of the national maternal and newborn health project, entitled PAIMAN. This project encouraged community mobilization support of the Lady Health Workers (LHWs) and use of male committees to promote the household to hospital continuum of care. Media events promoted messages of health seeking behavior and overall awareness about the issues.

Accomplishments

- increase in the number of outpatient clients in the district of Khaniwal in PDQ versus non PDQ communities
- Increase in the number of ANC clients Khaniwal

- Increase in number of children immunized
- Increase in TT vaccinations
- Exit interviews showed a significant difference in client satisfaction especially regarding the cleanliness of the health facility in PDQ communities versus non PDQ communities

Challenges

- Involving the least advantaged people and poor in a planning team requires a lot of efforts
- Process is intensive and time consuming.
- Frequent postings and **transfers** of health facility staff and district health managers

Lessons Learned:

- If the MOH could be engaged to help lead the QITs, this will promote sustainability in the long term.
- Strong facilitators are needed.
- Sustainability needs to be instilled into the project from the very beginning. PDQ needs to be institutionalized within the government structures.
- Support is needed over time to be able to ensure representation of the marginalized groups in the QITs.
- No matter how tempting it may be, it is not beneficial to use shortcuts in the PDQ process because valuable steps in community empowerment are lost.

What are we Currently Measuring?

The group then engaged in an exercise to think about what we are currently measuring through our PDQ implementation. Participants listed two indicators they currently measure and then posted it under the appropriate column heading (choices were quality improvement, health outcomes --impact, behavior change, community capacity and "other.")

Although we had different definitions of "quality improvement" and "outcomes," we all agreed that there was very little being measured in the area of community capacity. Since PDQ generally is embedded within a larger project, the process indicator data is sometimes measured, but when it is, there is very little measurement of the activities within the QITs as they work to mobilize communities for social change. It is the increases in capacity of the QIT with the support of the larger community that are the changes which result in the achievement of items on action plans. The satisfaction (or empowerment) that communities feel as they realize that they do have resources and capability to solve their own problems spurs them on to tackle other problems in the communities that are barriers to service and access. This internalized empowerment is sustainable much beyond the life of the project.

PDQ practitioners know that the process is effective intuitively and by the increase in numbers of clinic users. However few tools have been used to measure these changes and show that they are not only significant but that they can be attributable to PDQ process. Further, there is no standardization to date about what such tools should look like not

how they should be shared and housed. With this aim, SC and its partners have been attempting to compile M and E tools being used in PDQ implementation. In 2009, the SC Pakistan country office developed a comprehensive set of tools which include

- PDQ Pathway Diagram
- Mapping tool for health facilities
- Checklist for Analysis of PDQ Tools
- Monthly Outcome Indicator Data form
- Supervisory checklist for PDQ process
- Supervisory Checklist for QIT function
- Team Effectiveness Questionnaire
- Exit interview
- PDQ quarterly report form (optional)
- PDQ Action Planning Table
- PDQ Tracking Table

These tools were shared amongst TAG members to review and will be further reviewed before they are finalized. The idea is that once these tools are thoroughly vetted, they will serve as a basic standard which can be modified as needed by PDQ implementers from any country or program context. This will build the evidence base and also provide a standard reference by which programs can be measured. These tools will form part of a PDQ toolkit. Plans are also in place for this toolkit to be modified as well for youth programming.

Measuring Community Capacity

As a group we reviewed indicators and questions from the attached Measuring Community Capacity indicators document developed by Save the Children. Our task was to review each for its relevance to PDQ. Some of those areas that are relevant already have a corresponding question within the PDQ monitoring tools. Others require that a question be added to an existing tool or phase of PDQ. Some of the changes can be monitored by the QITs themselves while others will need to be assessed from the outside observers and supervisors. One suggestion was to add to the tools in the PDQ toolkit an Equity Checklist

We made changes to the list of domains and definitions (in red in the attached document). Additionally, we felt that the following were critical to be measured:

- % of community contribution, \$ and in-kind
- # of barriers overcome. # of meetings facilitated. How can we capture a group's initiative or drive??
- What is the difference between community capacity and empowerment??
- We could perhaps measure community contribution to problem solving
- Measure \$ contributions of the provider etc as compared to amount of money raised within the community.
- Note: Community perception of ownership is very important and needs to be measured; need evidence that the plan is being implemented.

Gail Snetro-Plewman is the lead at Save the Children on the review of the community capacity indicators. She clearly explained the link between measuring community capacity and measuring quality improvement:

The PDQ approach works to reach marginalized populations and address the underlying causes of health problems such as discrimination, social and economic, cultural and political and organizational conditions through addressing the quality of health services. An integral part of this process involves providing community members and health facility providers with the skills and systemic support they need to improve health service quality and access to these services.

The PDQ process encourages and supports communities so that they can actively participate in their own health and social change. Organizations using community empowering approaches are now increasingly seeking how to measure and document changes at the community level (beyond measurable changes in individuals' behaviors and knowledge). Within the PDQ approach the definition of "community" applies to that of the health facility providers, and those PDQ quality teams that are composed of both community members and providers.

SC/US recognizes the need to measure community capacity (CC) because : (1) SC/US invests heavily to achieve CC in nearly all community-based programming: (2) SC/US is a recognized leader in the allied process of community mobilization (3) case studies suggest that CC helps communities sustain results and successfully confront other social challenges; and (4) SC/US fails to get due recognition for the CC that it facilitates because there is no concise and accepted way to describe it, let alone quantify it.

Through PDQ we have the opportunity to actually measure community capacity as well as quality improvement. This can help us demonstrate empowerment of the community which is more sustainable than just an improvement coming from the outside. We briefly reviewed the domains and selected one that we all agreed would pertain to PDQ and need to be measured. Some domains, such as Community Participation and representation of marginalized groups (at QIT meetings) are already being measured with existing tools, but perhaps were not thought of as community capacity indicators. Others can be easily added within tools such as the Supervisory checklist on QIT function. Still others may need to be added as we refine our needs.

Building and Maintaining Expertise in PDQ

Although PDQ was developed by Save the Children, many other organizations are utilizing the methodology. Most turn to Save the Children for technical assistance but often we are not able to provide it due to a limited number of available experts. Our hope is to have more regional/global experts from the many ongoing projects. Thus a questionnaire was developed prior to this meeting to get a list of the current PDQ expertise across organizations and gauge the comfort level of those individuals in being able to evaluate, train, and help adapt PDQ for other programs. Our hope is to use this information to develop a low cost method to build global capacity in PDQ.

Results

- Of the over 45 questionnaires were mailed out, 27 people responded. Two rankings were added by Debbie Fagan to try to summarize people's experience in implementing PDQ and their experience in evaluating PDQ. The questionnaire provided more information about people's implementation rather than evaluation experience:
- The staff responses were organized by regions since it was our hope to have regional experts.
- Although regionally we have staff that have implemented PDQ, many do not currently feel confident to be the PDQ expert and be able to train other and evaluate other programs. Providing the skills need to elevate their confidence is a challenge but would elevate the staff skills for all projects.
- Of the three non-Save respondents, there is also a broad spectrum of expertise. The challenge is how to best collaborate with these experts.

Our goal at this meeting was to review in aggregate the responses to the PDQ expertise questionnaire and then decide on a capacity building strategy. The group concurred with the following recommendation for increasing capacity of global PDQ experts:

1. Use current and upcoming implementations and evaluations as an opportunity for local/regional staff to observe or be mentored. This would only require regional travel by the staff member but it would allow them to see the program or evaluation in action rather than via a TOT
2. Develop more tools and protocols that would help a new "expert" feel more confident in performing a new task
 - Criteria for approval as an "expert" are that the person needs to
 - i. Have been trained in PDQ
 - ii. Needs to have implemented PDQ in their own cultural context
 - iii. Has experience applying PDQ in at least one other context
 - iv. Preferable also: skills in documenting and evaluating PDQ
3. Keep a current global implementation map and make it available to all so that they know where and when PDQ programs are occurring
4. Develop a strategy to work with our partner experts to collaborate in building PDQ expertise.

Other comments:

- We need to make sure that cost information from PDQ implementers is shared so that those writing proposals have an idea for how much to budget for these activities (remembering that this includes the time of staff to implement the process)
- AMREF offered their Africa training site as a location where PDQ training could take place

Please note that since this meeting took place, a monitoring trip to Vietnam will now also include PDQ staff from Pakistan and possibly Indonesia in order to have increased participation and learning from that experience.

Attachment 1: Participant List and Meeting Agenda

| Name | Organization | Country | Email address |
|-------------------|---------------------|-----------------|-------------------------------------|
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AGENDA -- PDQ TAG
Saturday June 27, 2009, 12:00-5:00 pm
Save the Children Office, Westport, CT

Objectives

- To share progress and challenges in PDQ among our country programs
- To review WHAT we are measuring when evaluating PDQ
- To discuss HOW we are measuring it
- To determine how we can strengthen both what we are measuring and how
- To decide on a strategy for building regional technical capacity in PDQ

12:00 -1:00 pm Lunch, welcome, introductions, meeting objectives and agenda for the day

1:00-1:45 Brief updates on PDQ accomplishments

- AMREF in Kenya (Bill Yaggy)

- SC in Pakistan (Dr. Aman)

1:45 -2:00 Break

2:00 - 2:30 What are we Measuring? (Exercise)

2:30 - 2:45 – What should we be measuring that we are not?

2:45 - 3:30 Review and Sharing of tools

3:30 - 4:30 Measuring Community Capacity

Questions for discussion:

- How do we capture the changes in community capacity that lead to sustainable outcomes? (use of domains/capacity areas to guide indicator development)
- Can we use/ adapt the work that is being done for the PDQ context

Review indicators and questions from CC (handout) for relevance to PDQ

4:30 -5:00 Building capacity in PDQ

- Review responses to PDQ expertise questionnaire
- Decide on a capacity building strategy