

*Maximizing the Effectiveness of
Partnership Defined Quality*

Technical Advisory Group Meeting May 27, 2008
Program report submitted by

The Social and Behavior Change Working Group at CORE
and Save the Children



Program Report Summary

I. Background and Summary

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 toolbook 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. The first step was to identify PDQ practitioners and develop a basic inventory of current programs. Save the Children began gathering information from PDQ practitioners within SC, and 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. The SBC Working Group 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.

This summary report documents a one-day meeting held in May 2008 that brought together a group of PDQ practitioners from three organizations working in more than 15 countries. The meeting provided an opportunity 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.

This meeting was a satisfying collaborative effort. Next steps include documenting current programming efforts, and developing good process and impact indicators. Better measuring whether and how the PDQ process is improving elements of quality will help create the evidence base from which to advocate for the use of PDQ on a broader scale.

There are three attachments to this report:

1. List of Participants
2. Workshop Agenda
3. (a-f) In-depth interviews: Egypt, Afghanistan, three Central American countries, Philippines, Kenya, Nigeria

II. Objectives

There were three objectives for this one-day meeting:

- 1) To increase understanding of how PDQ is being implemented through a review of data from practitioners regarding specific implementations and lessons learned
- 2) To share PDQ experiences on how the methodology was applied (format), as well as how the activities were implemented once Quality Improvement Teams were formed (sustainability).
- 3) To develop consensus on ways to maximize the use of PDQ as a quality improvement tool. This includes making a joint decision on how to document how PDQ can be best utilized, given the contexts and constraints faced when implementing in the field.

III. Summary of Activities and Decisions

Highlights from Country Presentations and Group Work

The workshop began with a series of PowerPoint presentations by participants from SC Afghanistan, SC Pakistan, AMREF in Kenya, SC Armenia and SC Bolivia. These colleagues had followed the PDQ process from start to finish, implementing the methodology as outlined in the manual. Presentations highlighted the context, the process used, the successes and challenges encountered. Armenia and Bolivia are currently implementing the methodology on a national scale. Colleagues from other SC offices as well as Georgetown Institute for Reproductive Health and Project Hope shared their comments and experiences.

SC Pakistan, presented by Dr. Masood Abbasi

- Maternal and newborn health project in 10 districts
- Purpose of PDQ: to increase access to health services and to increase community involvement to ensure quality of service delivery

- Men's groups and women's groups are influential in PDQ process
- QITs were formed at the Rural Health Unit (subdistrict) and Basic Health Unit (community) levels
- Multilayer community mobilization or "CAM" process including mass media
- Accomplishments:
 - An ambulance procured through community citizen's board in one community
 - Staffing shortage problem solved through advocacy at higher levels
 - Communities mobilized and collected emergency transport funds
- Challenges:
 - Time consuming labor intensive process
 - Involving the least advantaged people on a planning team is an ideological shift
- Next steps
 - Replication in more districts
 - Working to promote sustainability of the QITs
 - Dissemination of lessons learned

SC Afghanistan, presented by Dr. Tariq Ihsan

- Context: low coverage for safe motherhood services, They have used PDQ in IMCI, ACCESS (maternal health project, as well as school health and nutrition projects. This presentation focused on IMCI
- Goal of PDQ: increased access to safe motherhood services, and enhance quality of safe motherhood services
- Extensive building support process using community workshop to determine questions for FGDs with community groups and health providers
- As in Pakistan, separate QITs for men and women
- Accomplishments:
 - PDQ recognized as national quality assurance standard
 - ANC coverage increased from 45% to 62% from 2004 to 2006
 - PNC increased from 29% to 41% from 2004 to 2006
 - PDQ scaled up in ACCESS/HSSP project to 5 provinces and soon will go to 13 provinces

SC – Bolivia, presented by Ms. Sdenka Cespedes

- National adolescent RH project in 9 capital cities and 9 medium sized departments, reaching 18,000 adolescents
- Problem: Even though the MOH has a strategy for adolescent RH, there are few programs implemented at the community level.
- By March 08 there were 32 QITs working with health facilities that had action plans developed
- Accomplishments:
 - Determined appropriate hours for adolescent services in health centers
 - Completed national training workshops for providers in youth friendly services
 - Lower costs for services for youth in the health centers

- Adolescents are starting to promote youth friendly services within their communities (advocacy!)
- Youth sign in sheet available in health centers to improve monitoring
- Challenges:
 - Need to strengthen the relationship between the “youth zones” (friendly spaces for youth) and the health centers
 - Scale up process needs a permanent monitoring system
 - Time consuming process; must be flexible so that both youth and providers can participate on QIT Discussions:
 - SC Bolivia used the BEHAVE methodology with a doer/non-doer analysis to provide formative research, which they then adapted to develop messages.
 - They modified the PDQ manual for use with youth based on this experience. There was agreement about the challenge of working with kids when support/permission is needed from the parents.
 - Georgetown IRH shared their success with town hall meetings in the community as well as the need to get IRB approval locally in the country where they will work with youth.

SC Armenia, presented by Dr. Iren Sargsyan

- Project NOVA is a USAID-funded 5 year health initiative to increase use of appropriate and safe RH/FP and MCH (2004-2009)
- PDQ as adapted for Armenia is called CPH. Primarily rural settings.
- CPH build partnership among providers, community leaders, and local authorities to empower communities to improve quality.
- Objectives: Increase community knowledge, demand and use for RH/FP services
- Developed province level advisory board in the building support phase
- QITs are called Health Action Groups (HAGs)
- Developed health education booklets, training for counterparts, conducted community education workshops on RH/MCH/FP
- Accomplishments:
 - Significant increases in access, utilization, quality, awareness and sustainability –over 30,000 reached with MCH messages
 - Communities’ perception of access and quality improved
 - 120 HAGs formed;120 Health posts rejuvenated and health libraries added
 - SC/Armenia will be writing its own PDQ manual
- Challenges:
 - Community-specific mentality and behavior
 - Gender, customs, norms
 - Health care not seen as priority
 - Relationships between stakeholders
- Discussion:
 - A discussion followed about the comparison between SC’s work renovating the health posts with \$1500 and 80% community match and the large amounts and nicer renovations being done by WV in nearby districts. This raised questions of sustainability
 - The final evaluation will take place next year for Armenia project

AMREF – Kenya, presented by Mr. Bill Yaggy

- PDQ is part of the Busia Child Survival Project in Kenya 2005-2010 Rural communities, high MMR, U5MR, IMR and NMR
- Newborn care (40%) , malaria (40%) and HIV/AIDS (20%)
- Worked in 13 MOH and dispensaries in Butula and Funyula subdivisions
- Goal of PDQ: to increase uptake of MNC services at HF's in the project areas through improved provider care and increased demand for MNC
- Bridging the Gap completed in 3 HF's; initiated in another 10HF's; 1 QIT formed thus far in project
- Accomplishments
 - Positive stakeholder response
 - Some provider performance improvements
 - Working to test cost and effectiveness of PDQ with a quasi-experimental, pre-post intervention design; work was derailed by the political situation, but is now getting back on track
- Challenges
 - Clashes between newly formed QIT and an already established community group
 - Sustainability of QITs is a concern; facilitator attrition
 - PDQ is time consuming and intensive –and requires more financing than anticipated . It may be better to have it as the main focus of a future project
- Discussion:
 - Related to costing -- there are two different calculations depending on whether PDQ is used to design the project or is used to improve quality within a project. The first time PDQ is implemented, the cost will be higher than for subsequent implementations.

Draft list of Key Elements for Maximizing the Effectiveness of PDQ

Following the individual presentations, participants worked in small groups to identify the elements that they felt made the difference between effective and ineffective PDQ applications. These responses were grouped by phase of PDQ and developed into the list below.

Pre-phase: Planning and Design

1. **Planners should have clear purpose, goals and objectives for PDQ.** As you determine whether the community is ready for PDQ, make sure that there is a consensus in the community that improvement of quality of care is a common goal. The PDQ manual states that PDQ is an appropriate intervention when both community and providers want change, when there is a willingness to be flexible, when there is support from key stakeholders, and when there is time enough to properly implement the process.
2. **Planners need to anticipate added value of PDQ**
 - Determine which indicators PDQ helps achieve (process and impact)
 - Need to involve community within the project
3. **Build in the staffing needs, time and financial resources that are needed for PDQ.** Build staff capacity in PDQ before implementing the process. Designate a PDQ “Go to” person whose responsibility is to train, manage, direct and delegate PDQ activities so that objectives are met. Budget in anticipation of these needs. Keep in mind that the average duration for a full PDQ process in a community is three months.
4. **Map the community to learn about existing structures and services.** Explore the current relationship between the community and health facility. It is especially important to be cognizant of health facilities that may not support the PDQ approach/objectives. Think about how a QIT could incorporate into pre-existing (or emerging) quality improvement work
5. **Start small:** Perfect the process by focusing on PDQ in a few communities before trying to replicate in other communities.
6. **Build PDQ into an existing project rather than create a separate project.** This keeps costs down and best uses the human resources of staff you have working in the same communities. The quality goals of the larger project are generally met in communities where the PDQ process is successful.

Phase I: Building Support

7. **Show how the process is effective and give examples.** Develop a list of examples/case studies of successful PDQ experiences in order to prove effectiveness and secure more funding or support. With local authorities, advocate for the need to include/listen to poor people in the community, using specific examples where PDQ

helped increase participation by poorer groups, such as lower castes in Nepal. Of course you will also need to use the clear explanation of the step-by-step process in the PDQ manual. Make it relevant to the community so they will want to implement it.

8. **Get buy-in from stakeholders at all levels early on in the project, especially at the DIP stage.** Share the PDQ methodology of quality improvement with the community health unit board members as well as local, district and national government, if appropriate. Developing an advisory board of stakeholders or seeking out a national-level advocate are ways to involve leaders in the process.
9. **Involve community groups in building support.** Community groups can direct you to key stakeholders, both internal and external. Make sure you involve them in developing tailored questions for the focus group discussions (FGDs) with various community and provider groups.

Phase 2: Exploring Quality

10. **Involve the community when adapting/finalizing the quality exploring tools** (questions for the FGDs), and also share lessons learned from FGDs between facilitators and committees.
11. **Make sure that some analysis of the Exploring Quality results is done by the implementation teams prior to the Bridging the Gap session.** This pre-analysis will facilitate discussion during the Bridging the Gap session.
12. **Strive for achieving and maintaining representation from the poorest of the poor.** With minimal representation in a group, these individuals often don't feel comfortable speaking. In Nepal, project staff found that these individuals needed to be the majority within a group in order to feel comfortable speaking. Research documented in the PDQ manual suggests that a minimum of 33% of participants need to be from marginalized groups for their voice to be heard.

Phase 3: Bridging the Gap

13. **It is critical to have PDQ leaders with good listening and facilitation skills.** It is often difficult to recruit and train good facilitators. Staff, who are knowledgeable about quality issues in facilities, may come in with their own ideas about how to improve quality, and therefore don't make good facilitators. The role of a facilitator is significantly different from that of community mobilizer and each requires a different skill set. Facilitators need to be aware of issues related to gender and power in the community. This also depends on the definition of community and subcommunity and the awareness the facilitator has in including disenfranchised groups. External facilitator could be very important for this purpose. Some projects have sought out staff with more organizational development expertise and with skill in learner-centered adult education. Some projects have tried selecting more facilitators than needed in order to weed out the ones who won't work out during

the training phase. It is important to budget for the skill level needed in facilitation and mobilization.

- 14. Within the context of facilitating the process with communities and facilities, it is still appropriate to bring in quality assurance standards.** The competencies required of providers is as important as the perceptions of quality by providers and community. Tools such as supervisory checklist can be used to monitor provider performance. Provider and client satisfaction with the quality of the care provided can also be gathered through exit interviews.

Phase 4: Working in Partnership

- 15. Determine whether other preexisting Quality Assurance (QA) or health committees are in place in the community.** The community needs to know who is on the QIT, to whom they are accountable, and how the QIT relates to preexisting structures. There are challenges of working within a dysfunctional system versus creating a parallel system. Potential clashes can be counteracted by:
- Inviting health committees to join the QIT
 - Having the QIT be a subset of the preexisting health committee
 - Using the Village Development Committee (VDC) or other existing structure to tap into resources
 - using the QIT to strengthen and improve health committees
- 16. Build strong partnerships within QITs for mutual ownership for tackling community issues.** Team building workshops have been shown to be effective within new QITs to jumpstart the communication process and solidify roles and a feeling of teamwork in the group. This is especially true when QITs include individuals who normally do not communicate with each other (older women with physicians, for example).
- 17. Promote sharing among QITs.** Project leaders should coach and guide QIT facilitators with positive encouragement. Have facilitators meet regularly to celebrate successes and share challenges of QIT teams, through workshops and meetings
- 18. Think ahead about sustainability:**
- *Process:* Does the QIT continue to meet and address new issues? It is important to assess and monitor the quality of relationships within the QIT. Team building exercises may be needed to build trust and confidence in order to have a strong equitable partnership.
 - *Outcome:* Does the quality that was improved continue to exist? There is a need to monitor both process and impact indicators. The process must be documented (logs, meeting minutes) along with the outcomes (decisions, survey findings).
 - *Community:* The more the community is involved, the more sustainable the quality improvements will be.

Preliminary Draft list of Indicators from PDQ that lead to Social Change

In an effort to seek out behavior change related indicators that PDQ helps to improve, a preliminary list was started of the indicators/domains for indicators mentioned in the presentations. Although this task was not completed due to lack of time in the meeting, it is worth mentioning that the interest was extremely high in developing a complete list that would lead to the development of a pathway type of diagram that shows the process from the accomplishment of each QIT to the achievement of a health outcome. A draft PDQ pathway is currently in development with staff at the Pakistan country office. The items on the preliminary list include:

- Coverage of ANC and PNC - Afghanistan, Armenia, Kenya and Pakistan
- Coverage of deliveries by Skilled Birth attendant
- DTP3 coverage -Afghanistan only
- Client satisfaction
- Provider performance
- Provider satisfaction
- Quality (define this):
- Accessibility
- Responsiveness
- Environment

IV. Next Steps (as of November 1, 2008)

Next steps for this process include the following activities:

1. Participants in the TAG will review and contribute to the above draft list of key elements for maximizing the effectiveness of PDQ so that a complete list is finalized by July 31, 2008. *completed.*
2. Participants will review the initial list of indicators discussed and contribute more process and impact indicators used by their projects to measure the social change that PDQ helped them achieve. This list will be finalized by July 31st, 2008. *To be discussed at future TAG meetings regarding a PDQ pathway toward health outcomes.*
3. Participants will update and/or create a PDQ monograph for each completed PDQ experience in accordance with instructions and examples provided at the meeting. Monographs will be submitted to Beth Outterson electronically by July 31, 2008. Monographs were developed or updated for Armenia, Pakistan, Afghanistan, Bolivia, and the Philippines. *Older monographs for previous projects that could not be updated (Uganda, Peru, Rwanda, Bangladesh, Georgia, Nepal) will also be catalogued and saved. These will be posted on the CORE and Save the Children websites in November/December 2008. In addition to the previously noted monographs, the Egypt country office is currently writing a monograph based on experiences described in the attached interviews.*

4. The TAG planning committee will meet to discuss options for sharing lessons learned including the development of user-friendly document which a) describes the PDQ TAG meetings (2003 and 2008); b) lists the essential elements for the effectiveness of PDQ methodology as described above, and c) documents the accomplishments of PDQ practitioners in a compendium of brief monographs (or another agreed upon document) that outline PDQ experiences. A date for the completion of this document has not yet been set. The group may also include in the document d) a modified set of process and impact indicators for social change that PDQ enabled projects to achieve. *This completed summary and list of essential elements is the final document and record of this meeting, along with documented questionnaires from interviewed personnel from over 15 countries.*

Please also note that in December 2008 an Elluminate session will be held for CORE members to learn more about PDQ and how it has been applied in various countries. TAG member will assist in this session.

Attachment #1**PDQ Technical Advisory Group Meeting May 27, 2008****Participant List**

Name	Organization/country	Email address
1. Iren Sargsyan	Save the Children Armenia	iren@save.airnet.am
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3. Sdenka Cespedes	Save the Children Bolivia	scespedes@savechildren.org.bo
4. Adelaida Gallardo	Save the Children Indonesia	adegregorio@savechildren.or.id
5. Jennifer Nandu	Save the Children Philippines	jnandu@savechildren.org
6. Siham Yassin	Save the Children Egypt	syassin@savechildren.org
7. Masood Abbasi	Save the Children Pakistan	mabbasi@savechildren.org.pk
8. Aysa Saleh Ramirez	Georgetown Institute for Reproductive Health Washington DC	As596@georgetown.edu
9. Bill Yaggy	AMREF USA New York	Yaggy@amrefusa.org
10. Jennifer Mason	Project Hope Millwood VA	jmason@projecthope.org
11. Bonnie Kittle	Consultant Virginia	bonnieleekittle@hotmail.com
12. Erika Lutz	USAID Washington DC	elutz@usaid.gov
13. Lynette Walker	CORE Group Washington DC	lwalker@coregroupdc.org
14. Debbie Fagan	Save the Children Richmond VA	dbsfagan@comcast.net
15. Beth Outterson	Save the Children Washington DC	boutterson@savechildren.org
16. Anna West	CORE Group Washington DC	awest@coregroupdc.org

Attachment #2

PDQ Technical Advisory Group Meeting
Maximizing the Effectiveness of Partnership Defined Quality
Save the Children and CORE Group's Social and Behavior Change Working Group
May 27, 2008

AGENDA

Time	Activity	Facilitator
9:30-10:00	Welcome and introductions	Beth Outterson, Debbie Fagan and Lynette Walker
10:00-10:30	Purpose and rationale for meeting Objectives Steps taken to date	Beth and Debbie
10:30-10:45	Sharing of PDQ Experiences: SC Pakistan	Masood Abbasi
10:45-11:00	SC Afghanistan	Tariq Ihsan
11:00-11:15	BREAK	
11:15-11:30	SC Armenia	Iren Sargsyan
11:30-11:45	SC Bolivia	Sdenka Cespedes
11:45-12:00	AMREF Kenya	Bill Yaggy
12:00-1:00	LUNCH	
1:00-1:30	Overview of the other programs interviewed but not present and discussion of other experiences not presented. Any common usages? Common LLs?	Beth and Debbie Discussion
1:30 – 2:15	Group work: What was essential in making your PDQ experience work –or not?	Debbie
2:15-2:30	Report outs	All
2:30 – 3:00	key elements for maximizing effectiveness	Beth
3:00 – 3:15	BREAK	
3:15- 3:45	M and E Sustainability Indicators for PDQ	Beth and Debbie
3:45-4:15	Next steps	Beth, Debbie and Lynette
4:15-4:30	Summary and Conclusion	Beth and Debbie

Attachments #3. Indepth interviews

A. Afghanistan

Country	Afghanistan
What region	Kabul, Herat and Paktia province
What organization was responsible for the implementation of PDQ? Where their multiple organizations?	STEP and MOVE (Kabul), CHA and MOVE (Herat) and Ibn Sina (Paktia)
What was the main program or broad program in which PDQ was implemented or which PDQ complemented	Health Services Support Project (HSSP) where SC/USA has partnership with two other organizations (JHPIEGO & CONSTELLA FUTURE) has responsibility to provide technical assistance to USAID funded NGOs. HSSP developed national quality assurance standards with the cooperation of MoPH and other stockholders and PDQ is complementary part of national QA tools.
What were the specific objectives in applying the PDQ methodology?	When we analyzed the existing approach for community involvement/community mobilization we found that community is not involved functionally in improving health services (action plans were mainly developed by health services implementing NGOs for community health counsels) So, that is why our main objective is: <ul style="list-style-type: none"> To improve community and service providers involvement for improving the quality and accessibility of health services in defining, implementing and monitoring of identified issues.
How were you going to measure whether you achieved your objectives? What was the time frame between implementation and completion/ evaluation for a particular site?	In national quality assurance tools we have developed 7 standards for PDQ (which are integrated in the existing health system). Current plan is to conduct internal evaluation of the QA standards quarterly by implementing NGOs and conduct semi annual external evaluation by HSSP and MOPH. The final evaluation will be conducted in early 2010.
What kind of facilities was the project targeting? Or what type of providers? Where did those providers work	HSSP has responsibility to provide technical assistance to USAID funded NGOs and aforementioned NGOs are implementing health services in 356 health facilities. In this fiscal year (Oct, 07 – Sep, 08) we are providing TA (training to build their capacities) to 28 health facilities staff and NGOs management staff. They are working in five different provinces (Kabul, Herat, Paktia, Takhar and Bamyan).
Specific focus target population or community (if any)	The target population is the catchment area of the health facility (for BHC 15-30,000 and for CHC 60-100,000 population). Both male and female health shuras (community health councils) participate in the PDQ process and in the QI team.
Were all the major PDQ steps followed? If no how was it changed and why?	Yes
Who facilitated the different PDQ steps? If it was a team,	Health services implementing NGOs staff, who were trained in PDQ methodology. All of them have medical background and working as health facility supervisors.

how many people and what were their backgrounds?	
How was the PDQ implementation team trained?	They received five-day training which included theory and 3 half day field work (to have better understanding of four PDQ implementation phases and its major steps).
Describe the Quality Improvement Teams that were established? What type of members were part of the team? What types of action plans did they develop? Are they provided any technical assistance? How many were established for the entire program?	<p>Health council at health facility level was already the part of the health system which consists both from health providers and influential people from the community, we tried to increase the number of health facility staff (in the past we had just 2) and have representation from different sects of the community specially to have more influential people. The members of health council includes; health facility staff, and community representative both male and female from different sects.</p> <p>Based on identified issue they developed their action plans.</p> <p>NGO staff has provided technical assistance in developing action plans.</p> <p>We have one health counsel (QI) team in each health facility.</p>
Results – what are the results so far	<p>They have developed their action plans recently but some finding till now is:</p> <ul style="list-style-type: none"> • In Basic Health Center (BHC) there is no ambulance to carry the pregnant women to deliver in health facility so, community identified available vehicle in the community and prepared a schedule in monthly bases. They have responsibility to carry the pregnant women it is very important especially during the night deliveries. • Despite of having well trained midwife the number of deliveries were low in one health facility (Kotgai) in Kabul. During exploring quality exercise one of the cultural barriers identified was lack of partition between male and female waiting rooms. After addressing this problem, the number of deliveries have increased
Was the project or QI teams more successful in some sites than others? Why?	Yes, based on the shared information in some sites there is more committed teams than others. Level of commitment depended on their existing relationship with Shuras (community health councils) and know of community.
Were there benefits to using an approach like PDQ in your project? If so what were they	Yes, this methodology is complementary part of QA tools, which will help us know the quality from community/ service provider perspectives and their needs.
Challenges faced or draw backs?	As we are not implementing the process directly but provide technical assistance to the partners so, getting appropriate commitment of some partners in its implementation is a challenge.
Lessons Learned	In identified quality issues almost 75 % problem has internal solutions (within community and service providers) with no need of considerable cost.
Future Plans	<ul style="list-style-type: none"> • To ensure proper PDQ implementation in QA selected HF's (who got PDQ training) by providing TA and follow up. • To ensure that PDQ standards in QA selected HF's are in place. • To provide TA and financial assistance to NGOs to replicate PDQ training in non QA selected HF's to take advantage of this methodology as a quality improvement tool.

B. Indepth Interview Philippines

Country	Philippines
What region	Bikol Region5. 6 barangays in the town of Piwi (Abay Province)
What organization was responsible for the implementation of PDQ. Where their multiple organizations?	SC with the staff of the Rural Health Unit and Barangay council
What was the main program or broad program in which PDQ was implemented or which PDQ complemented	Emergency Health and Nutrition program
What were the specific objectives in applying the PDQ methodology.	PDQ was integrated into the ACM (appreciative community mobilization) process. Phases: Discovery, Dream, Design, Deliver. PDQ highlighted the Design phase and paralleled the program PDQ added the face to face dialogue of bridging the gap
How were you going to measure whether you achieved your objectives? What was the time frame between implementation and completion/ evaluation for a particular site?	Spoke with midwife, barangay officers and mothers Indicators: # health workers # consultations Existence of health center instead of waiting outside for vaccination Time frame was 3 months
What kind of facilities was the project targeting? Or what type of providers? Where did those providers work	Health centers at barangay level Barangay health officials , midwives Came up with schedules. Midwife travels from place to place
Specific focus target population or community (if any)	Mothers
Were all the major PDQ steps followed? If no how was it changed and why?	Did not do FGDs Health workers and midwives made a drawing of their vision on the wall = DREAM Asked: what are the gaps to attaining the dream? (list of needs) Rather than discuss the dream in the bridging the gap. They did it already in the dream stage.
Who facilitated the different PDQ steps? If it was a team, how many people and what were their backgrounds?	Doc Mads and Babes Chue did a total of 6 sessions to train staff. PDQ was inserted into design phase
How was the PDQ implementation team trained?	See above
Describe the Quality Improvement Teams that were established? What type of	Village leader + midwife + some mothers > QIT 5-6 people in each QIT Health center staff

members were part of the team? What types of action plans did they develop? Are they provided any technical assistance? How many were established for the entire program?	Village leader, midwife, health center staff would decide together in QIT team meeting in the village. Similar to ACM phase 4 Delivery They had 1 QIT per village x 6 villages
Results – what are the results so far	New Health workers are trained. Vaccinations have increased. Village has different problems now.
Was the project or QI teams more successful in some sites than others? Why?	Don't know because after the program, new village leaders were elected
Were there benefits to using an approach like PDQ in your project? If so what were they	Was great, wants to introduce it into other projects. ACM has problems with design phase so PDQ helps this.
Challenges faced or drawbacks?	Weather conditions, long time to finish health center
Lessons Learned	Facilitator needs to know to listen well, be respected. Skills. Problems are not exactly what they seem. Bridging the Gap really brings people together. Midwife really wanted to help so that made a difference. Face the face dialogue makes people listen.
Future Plans	Project has already ended. Don't know next steps, but he wants to introduce this to other regions.

1. Discovery = In ACM, Building Support phase is like their Discovery : tell a story about your community. Ask : What are you proud of ? Tell about factors that made things work. Recall a village party. Keep it positive. Having these discovery « gems » are characteristics of the community that will help us toward the dream.

2. Dream = exploring quality : what do we want ? (ex : kids free of worms, have a midwife 24/7). Draw a scenario of that the community wants

3. Design = Similar to bridging the Gap
Partnership Designed quality

4. Delivery = Similar to Working in Partnership

Ex. problem: we need place for health vaccinations.

Solution : they created a health station (barangay officials and health workers)

As a result they recruited new workers and more mothers got involved.

In another community the problem was that the midwife did not visit villagers enough – because she had not transportation. Solution : the community got a motorcycle for h

C. Indepth Interview Central America

Country	Guatemala, Nicaragua, El Salvador
What region	urban and peri-urban in all three countries
What organization was responsible for the implementation of PDQ. Where their multiple organizations?	IRH dc trained facilitators in country and contracted them to lead the process.They helped design and adaptation of manual. independent
What was the main program or broad program in which PDQ was implemented or which PDQ complemented	HIV prevention program in collab with PSI as prime, PASMO other partner. To increase quality for and access to VCT pre and post test counseling FSW and CSW First did and facility assessment using PDQ PASMO did baseline and this is a component of the project
What were the specific objectives in applying the PDQ methodology.	Increase utilization and quality of VCT pre and post testservices for MSM and FSWs
How were you going to measure whether you achieved your objectives? What was the time frame between implementation and completion/ evaluation for a particular site?	Used PDQ like formative research but did not really continue on QIT, not this is a difference from other groups. More as a assessment tool 3 months Still ongoing, but PDQ is not
What kind of facilities was the project targeting? Or what type of providers? Where did those providers work	MOH clinics and NGO clinics VCT providers that do counseling Stigma and discrimination is a part of just getting them through reception parking places attendant Based on this info they come up with a strategy. They did not continue because of project constraints.
Specific focus target population or community (if any)	MSM FSW
Were all the major PDQ steps followed? If no how was it changed and why?	They followed the same steps and brought together MSM and FSW together , then sent reps to meet with h providers
Who facilitated the different PDQ steps? If it was a team, how many people and what were their backgrounds?	Same facilitators No inclusion of community members from NGOs in QITs User perspective No FGDs with general community, but PASMO and PSI did the soc marketing with them. Worked with FBOs
How was the PDQ	How long course 3 days

implementation team trained?	
Describe the Quality Improvement Teams that were established? What type of members were part of the team? What types of action plans did they develop? Are they provided any technical assistance? How many were established for the entire program?	none
Results – what are the results so far	Plans to maybe Publishing a book adapted to their needs, few resources
Was the project or QI teams more successful in some sites than others? Why?	n/a. Methodology was more appropriate with MSM because more educated and mobilized. CSW are poor and like being consulted but difficult for them to understand the methodology. Time issues. No real difference between countries
Were there benefits to using an approach like PDQ in your project? If so what were they	Assessment tool They provided food and transportation
Challenges faced or draw backs?	SOW limited what we could do with the tool. Limitations of participation depending on target group
Lessons Learned	Lessons learned wish we could have done QITs, better not by itself, some of the participants were adolescents Any confrontation –none in bridging the gap. Gender mayplay role How to keep people motivated –incentives? Need more support need \$ to do infrastructure –like if set up another room. CSWs felt empowered.
Future Plans	Not within HIV prevention but within other project Would like to do more work with the CSWs because their needs are greater.

D. Indepth Interview Egypt

Country	Egypt
What region	Minia – Samalout district
What organization was responsible for the implementation of PDQ. Where their multiple organizations?	Save the children and CDAs partners Asdekaa El-Mardaa Association amberalla NGO Their multiple organizations in Samalout district
What was the main program or broad program in which PDQ was implemented or which PDQ complemented	Asdekaa El-Marda Association cover 6 CDAs Together for better health initiatives project <u>CHL projects</u> – 6 partners
What were the specific objectives in applying the PDQ methodology.	Improving MCH services Increase community participation Encourage community initiatives
How were you going to measure whether you achieved your objectives? What was the time frame between implementation and completion/ evaluation for a particular site?	Through follow up plans Quality improvements teams reports Community satisfaction form Methodology evaluation through external firm Implementation and completion 1year Completion and evaluation 1 year
What kind of facilities was the project targeting? Or what type of providers? Where did those providers work	We depend on provide technical assistance to health units staff in rural areas especially doctors, nurses and lab. technicians Through our partnership with MOHP (ministry of health and population they assist in health units staff on job training and regular supervision Exchange visits between health units Community seminars to increase the link between health providers and community Asdekaa El-Marda Association assist in sonar maintenance ,analysis kits)
Specific focus target population or community (if any)	Pregnant women and children We applied the methodology in 21 rural community in samalout district
Were all the major PDQ steps followed? If no how was it changed and why?	Yes
Who facilitated the different PDQ steps? If it was a team, how many people and what were their backgrounds?	It is team composed from 5 persons 2 from MOHP they have medical background 3 from Asdekaa El-Marda Association they have development background especially in community mobilization and sustainability
How was the PDQ implementation team trained?	They trained on PDQ methodology (2 workshops contains advocacy – community mobilization – quality – planning an management – M &E) And on job trainings through external consultant

<p>Describe the Quality Improvement Teams that were established? What type of members were part of the team? What types of action plans did they develop? Are they provided any technical assistance? How many were established for the entire program?</p>	<p>They established through community seminars and selected through community they are 7 and have voluntary spirit</p> <ol style="list-style-type: none"> 1- community leaders 2- teachers 3- local popular councils member 4- women 5- youth <p>after community focus group discussions they listed problems and prioritize it and then developed shared plan with health providers</p> <p>the plans contains (community seminar to encourage community to visit health units and gets its services – buying health equipments through community and private sector or MOHP – pregnant frequency)</p>
<p>Results – what are the results so far</p>	<p>Some health units upgraded through governmental support Increase community frequency to health units especially pregnant women Increase MOHP supervision and support Private sector donations Improve quality of health services</p>
<p>Was the project or QI teams more successful in some sites than others? Why?</p>	<p>Yes those communities that had CDAs because they are in more link with health units board members and local popular councils.</p> <p>The CDAs play an important role in mobilizing the community and support the QIT also some CDAs have grants to support health interventions in some villages so they can support QIT to make community health initiatives</p>
<p>Were there benefits to using an approach like PDQ in your project? If so what were they</p>	<p>Increase link between health providers and community Improve quality of health services Increase governmental support</p>
<p>Challenges faced or draw backs?</p>	<p>Sustainability -sustaining the changes made Doctors turnover</p>
<p>Lessons Learned</p>	<ul style="list-style-type: none"> • importance of protocols between MOHP –Local popular councils and CDAs <ul style="list-style-type: none"> ➤ protocols that achieved 1st step of PDQ (building support) ➤ protocols that determine the roles and responsibilities of partners to support PDQ methodology ➤ assist in supporting health units upgrading ➤ community interventions • sharing community in needs and monitoring and right based approach • Community selected quality improvement teams <ul style="list-style-type: none"> ➤ to others whom will implement the PDQ methodology it is very important step that community select QIT and this may support sustainability of QIT ➤ And some organization work in the same field and applied similar methodology and they selected the teams by them selves finally the methodology failed • building support with governmental official • link methodology and QI with health units board members and local polar councils • strengthen the capacity of health units board members and local popular councils • ensure methodology sustainability

Future Plans	Document the methodology and Applying it in new impact area in Assuit governorate – Abnoub district

E. Indepth Interview Kenya

Country	Kenya
What region	Butula and Funyula divisions of Busia district in Western province
What organization was responsible for the implementation of PDQ. Where their multiple organizations?	AMREF in partnership with Ministry of Health (Busia)
What was the main program or broad program in which PDQ was implemented or which PDQ complemented	Child survival program
What were the specific objectives in applying the PDQ methodology.	Improving Quality of maternal and child care services in the project area
How were you going to measure whether you achieved your objectives? What was the time frame between implementation and completion/ evaluation for a particular site?	<p>Conduct a pre-intervention study and a post-intervention study</p> <p>The expected outcomes in the study include: (i) improved quality of maternal and newborn care offered at health facilities: where quality is defined as the desired outcomes or standards (The technical quality of maternal and newborn care aspect will assess whether facility health workers and CORPs provide newborn care according to the national MoH maternal and newborn care protocol (MOH, 2004) and Minimum Activities for Maternal and Newborn Care (MAMAN) during pregnancy, delivery and post delivery)</p> <p>(ii) increased uptake of maternal and newborn care services at health facilities: Increased uptake refers to more women using the maternal and newborn care services provided in the health facilities. These services are Antenatal care, delivery services and postnatal care. The PDQ approach is expected to lead to more women attending ANC, more women delivering in health facilities and more women taking their newborns for postnatal care</p> <p>(iii) Improved maternal and newborn outcomes</p> <p>Originally six months</p>
What kind of facilities was the project targeting? Or what type of providers? Where did those providers work	Dispensaries, health centres and hospitals
Specific focus target population or community (if any)	Health workers and CHWs and WRA, pregnant women and mothers of CU5 and their husbands, health facility committees,

Were all the major PDQ steps followed? If no how was it changed and why?	Currently in the process: Different facilities are at different stages of PDQ implementation: building support (all the 13 facilities have completed this stage); exploring quality (12 facilities have completed this stage); bridging the gap (3 facilities have completed this stage); Working in partnership (one facility in already at this stage)
Who facilitated the different PDQ steps? If it was a team, how many people and what were their backgrounds?	Health facility workers and community members
How was the PDQ implementation team trained?	PDQ team was trained for 3 days and they eventually trained the facilitators and note takers for five days
Describe the Quality Improvement Teams that were established? What type of members were part of the team? What types of action plans did they develop? Are they provided any technical assistance? How many were established for the entire program?	Not reached this level yet
Results – what are the results so far	We shall have the PDQ results after the post-intervention study as indicated in the PDQ OR protocol
Was the project or QI teams more successful in some sites than others? Why?	The three QI teams that were formed during the bridging the gap stage have yet to meet. We suspended PDQ activities before they could convene for the working in partnership stage. I can therefore not discuss about their successes or failures when they had not undertaken any activities of identifying the causes of the QI gaps, solutions, developing action plans and evaluating implementation.
Were there benefits to using an approach like PDQ in your project? If so what were they	We are yet no reap any benefits as none of the facilities has gone through the entire PDQ implementation cycle
List two accomplishments/successes What was needed to achieve this success (or how was it achieved and why)	<ol style="list-style-type: none"> 1. all the community representatives bought the idea of PDQ during the building support sessions as they will at least be involved in quality issues affecting them 2. there is a common understanding of the varying perspectives of quality among community members and health workers <ol style="list-style-type: none"> 1. competent facilitators with good facilitation skills, accepting failures by community representatives and health workers during bridging the gap
List one thing that was not successful/ or obstacle that was not overcome What would have been needed to achieve success (or why was it not successful)	<ol style="list-style-type: none"> 1. participants to willingly attend and participate in PDQ sessions without allowances (transport/lunch) <ol style="list-style-type: none"> 1. To have used the existing health facility development committees or MOH to initiate and own the process. The community expect payment for any process associated with NGOs
Challenges faced or draw	At this stage of implementation, the major challenge is attrition of the facilitators and

backs?	note-takers due to transfers outside the project area (so far three have been transferred), secondly, is lack of time for the health workers during the exploration of quality session-due to shortage of staff the few health workers break to attend to patients
Lessons Learned	?
Future Plans	?

F. Indepth Interview Nigeria

Country	Nigeria
What region	5 states, 51 Local government areas targeting 30 million people
What organization was responsible for the implementation of PDQ. Where there multiple organizations?	The Compass Project Pathfinder Prime ... JHUCCP
What was the main program or broad program in which PDQ was implemented or which PDQ complemented	The Compass Project Community mobilization component is a crosscutting component of the five-year COMPASS project, funded by USAID to address health and education in 51 Local Government Areas (LGAs) in five states in Nigeria.
What were the specific objectives in applying the PDQ methodology.	Anti-corruption strategy. Putting money through services had not worked due to corruption. The thought was that community involvement would create more accountability. Low utilization rates
How were you going to measure whether you achieved your objectives? What was the time frame between implementation and completion/ evaluation for a particular site?	Only measured utilization for health. And for education was drop-out rate (by gender) And did qualitative similar to Armenia Results of a population based survey which will measure changes in attitudes and practices are pending. Meanwhile, the assessment drew on routine service utilization monitoring data from health facilities, limited polio monitoring data, and qualitatively reported changes in attitudes. Unfortunately, similar routine monitoring data were not available for education.
What kind of facilities was the project targeting? Or what type of providers? Where did those providers work	Community Level Clinic – government clinics At best a nurse
Specific focus target population or community (if any)	No
Were all the major PDQ steps followed? If no how was it changed and why?	Yes, all that was done was manual was changed to education examples. And use local Nigerian examples.
Who facilitated the different PDQ steps? If it was a team, how many people and what were their backgrounds?	Lead person in each state. Local government team, and a Compass counterpart. A mix of health or education backgrounds.
How was the PDQ	Cascade, 2 states... Marcie trained... then those co-trainers ..trained others

<p>implementation team trained?</p> <p>Describe the Quality Improvement Teams that were established? What type of members were part of the team? What types of action plans did they develop? Are they provided any technical assistance? How many were established for the entire program?</p>	<p>The primary community mobilization interventions were the formation of community based coalitions (CCs) and quality improvement teams (QITs) Coalitions are formed at the community level, are made up of representatives from community associations, traditional leaders, religious leaders, and service providers for both health and education, and tend to serve as umbrella organizations for sensitization, advocacy, fundraising, and coordination of quality improvement activities. The QITs function at the facility level, are made up of representatives from the facility service providers as well as community members, and focus on identification and resolution of problems occurring in their facility. The CCs link to both the QITs, and a Local Government Facilitation Team (LGA Facilitation Team) at the Local government Authority (LGA) level. In addition, coalitions meet together in an LGA forum to exchange ideas and develop advocacy agendas together. As of March 2007, a total of 203 CCs, with 701 QITS both for health and education have been formed. Considering a conservative but ROUGH average of 10 associations per coalition and of 25 members per association, these organizations are likely reaching as many as 51,000 association members who then potentially reach out to the population at large. Some had education and health separate some together.</p>
<p>Results – what are the results so far</p>	<p>The project achieved significant results in terms of impact, infrastructure improvements, other quality improvements, and development of local ownership for the CCs and QITs. Highlights include:</p> <ul style="list-style-type: none"> ? Health service utilization for family planning, antenatal care, facility deliveries, and routine immunizations is considerably higher in facilities with CCs and QITs than in matched facilities without these structures. ? Improvements in infrastructure and service provider/community relations, and regular monitoring of services by the QITs led to better quality education and health services. Specific issues such as confidentiality, client respect, and student absenteeism have also been addressed. ? Funds for health and education improvements (more than \$1million in FY2006) were leveraged through donations and advocacy to contribute to infrastructure, equipment, drugs, and supplies for both education and health. ? Both women and men were sensitized on immunizations, safe motherhood, family planning, and enrollment in school particularly for girls.
<p>Were the project or QI teams more successful in some sites than others? Why?</p>	<p>More in Health and Education. Worked less in urban environments and where there was a less homogenous population.</p>
<p>Were there benefits to using an approach like PDQ in your project? If so what were they</p>	<p>Level of community participation and sense of ownership was markedly different. Health service utilization for family planning, antenatal care, facility deliveries, and routine immunizations is considerably higher in facilities with CCs and QITs than in matched facilities without these structures.</p>

<p>Challenges faced or draw backs?</p>	<p>Lack of commitment to the community process across sectors.</p> <p>Did not allow the time/staff to do community mobilization in each community</p> <p>? People have high expectations for resources from COMPASS both out of their habitual expectations of donors and due to promises made early in the project which were not fulfilled. This said, there are people who acknowledge lack of inputs was a blessing because there is now greater ownership.</p> <p>? COMPASS tends to be “in the driver's seat” There is a tendency to tell community people what to do and how to organize themselves, rather than lightly providing guidance as the community themselves work out their priorities and approaches. This was particularly notable in the formation and management of the LGA Facilitation Teams,</p> <p>? The coalitions are underutilized as a strategy at the community level for implementing the COMPASS technical interventions (Child Survival, Reproductive Health, and Basic Education). They have the potential to take the lead and bring their own understanding and experience to bear in addressing technical concerns.</p> <p>? Although it was a key element of the PDQ process, problem analysis and prioritization is still weak. There has been a tendency to add problems and cursory solutions to the original action plan, rather than continuing to do the more in-depth analysis as part of the community action cycle.</p>
<p>Lessons Learned</p>	<p>Some of the most significant strategies contributing to the success of the community mobilization are:</p> <p>? Use of associations and existing traditional and community-based structures as a foundation for the coalitions has led to their achieving broad reach and scope. This in turn leads to high coverage as well as flexibility and resources in addressing whatever priority problems arise.</p> <p>? The CCs and QITs are highly complementary structures each supporting what the other is trying to accomplish.</p> <p>? The insistence by COMPASS on not paying operational costs has shifted the focus of the coalitions by sending the clear message that the coalitions do not belong to COMPASS. One assessment team member summarized this: “The communities realized they had underestimated what they could accomplish by themselves with little to no inputs from government or donors”.</p>
<p>Future Plans</p>	<p>Still implementing – 2 more years left of funding. Funding ends in 2010</p>



*This monograph is a product of Save the Children/CORE Group’s joint Technical Advisory Group on Partnership Defined Quality.