

- Weak referral systems reduce access to and use of needed services.
- Comprehensive health services are not offered to MSM and FSW (e.g. family planning for FSW).

Lessons Learned and Challenges

The experience applying the PDQ process to improve VCT services resulted in valuable lessons for bringing together providers and clients to improve VCT services which include:

- Involving MSM and FSW garnered support for program activities. Findings from the mapping conducted earlier in El Salvador, Nicaragua, and Guatemala revealed concern among these groups about the failure to include their perspectives in program development and monitoring.
- Building relationships between health providers and the communities they serve is a critical first step in the quality improvement process. This should be an integral component of the intervention rather than a preparatory step of the program.
- Good facilitation skills and a high degree of cultural sensitivity, throughout the PDQ process, are necessary to manage the different agendas of participants, address conflict between and within the groups, build trust and ensure that the goals of the consultation process are achieved (i.e., produce results instead of turning the exercise into complaint sessions).
- The PDQ process created a forum for vulnerable groups and health providers to voice their concerns, needs, and priorities regarding quality VCT services.
- The PDQ methodology was an effective tool for addressing negative perceptions and practices of providers and vulnerable groups and to begin the process of sensitizing all stakeholders to widespread stigma and discrimination.
- Providers were more inclined to collaborate with vulnerable groups than anticipated. The PDQ process facilitated open dialogue and consensus building between different perspectives.
- To maintain motivation among advisory committees that result from PDQ, strategies to actively involve the committee in quality improvement are needed.

An outcome of the PDQ process was the development of client and provider defined quality indicators for VCT services. These indicators are now being used to evaluate an intervention to improve the performance of VCT providers, with a focus on reducing stigma and discrimination toward vulnerable populations. The goal of this intervention is to build provider counseling skills and ensure that every VCT client of affiliated clinics receives non-judgmental, confidential, personalized risk reduction counseling.

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The Institute for Reproductive Health conducts research and provides technical assistance on expanding access to family planning and HIV/AIDS services and improving options for women and couples worldwide.

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PDQ

Partnership Defined Quality¹ A Methodology for Improving VCT Services for Key Groups in Central America

Overview

In Central America, where HIV is gaining a stronghold among populations in most vulnerable circumstances, widespread use of good quality VCT services is key to containing the spread of the epidemic. The Partnership Defined Quality (PDQ) methodology was adapted to develop a shared vision of high quality VCT services among providers and community members as the first phase of a quality improvement initiative. Implementation of the methodology helped to build support for initiatives to reduce stigma and discrimination in VCT services.

The PDQ process involved a series of workshops with public and private-sector providers, commercial sex workers (CSWs) and men who have sex with men (MSM), to explore attitudes and practices related to the provision and utilization of services. This process provided a forum to address negative perceptions and practices and initiate the process of sensitization to existing stigma and discrimination. PDQ participants were involved in planning, implementation, and evaluation, thus establishing an ongoing quality improvement process.

Lessons learned from the PDQ process guided the development of training and behavior change communication (BCC) strategies aimed at improving the quality of VCT services and increasing their use among populations at high risk for HIV/AIDS.

Why improve quality?

- Safer, more effective counseling and health care is provided, leading to behavior change (i.e. reduction of risk behaviors among both HIV+ and HIV-clients).
- Increased satisfaction for both the client and the provider and word-of-mouth referrals.
- Increased utilization leads to improved health and behavior change.

What is the cost of poor quality?

- Delays in seeking and receiving appropriate services can lead to greater morbidity, mortality and spread of the disease. Early testing can lead to timely access to care and treatment (for HIV+ individuals and discordant couples).
- Poor quality counseling can result in a lost opportunity to promote behavior change.

Background

The Institute for Reproductive Health (IRH) at Georgetown University, in collaboration with Population Services International (PSI) and the Pan American Social Marketing Organization (PASMO) is implementing a four-year USAID-funded project in Central America and Mexico to reduce the incidence of HIV/AIDS. The intervention has two primary components: 1) improving quality of and access to VCT services for at-risk populations; and 2) behavior change communications (BCC). BCC efforts are intended to increase the use of services, while quality services promote healthier behaviors. Further, satisfied VCT clients can promote services through word-of-mouth, thus increasing their utilization. IRH provides training and support to providers who are geographically, economically and otherwise accessible to high-risk groups.

To guide the development of strategies to strengthen the quality of VCT services and reduce stigma and discrimination against FSWs and MSM by healthcare providers, IRH applied the PDQ in Guatemala, Nicaragua and El Salvador. The PDQ methodology involved the community in defining, implementing, and monitoring quality improvement processes for VCT services.

The PDQ process brings together clients and health workers to jointly address fears, misperceptions and other challenges and to develop a shared vision of quality VCT services. The assumption is that MSM and FSWs will increase use of VCT services as the perceived quality and accessibility of these services improve.

The goals established during the PDQ process help determine appropriate process indicators and mechanisms to assess progress in the quality improvement effort. Indicators include client satisfaction, availability of quality services, changes in attitudes among providers, and utilization of VCT/STI screening services by MSM and FSWs.

¹ Partnership Defined Quality (PDQ), a methodology developed by Save the Children, is intended to improve the quality of and access to health services through better community involvement.

The Partnership Defined Quality Process



Phase I – Building Support

Explaining the purpose and the benefits of the quality improvement process, as well as the partnership approach, is the initial step toward building support for improving VCT services for vulnerable populations.

Phase II – Exploring Quality

Understanding the perceptions of quality, from the perspective of the VCT service providers as well as current and potential clients, is critical for quality improvement. Preliminary “caucus” meetings with each group (health workers, MSM and FSWs) facilitated open and free discussion and helped explore and contribute to a clear understanding of the perceptions and needs of MSM, FSWs and health workers. During this phase of the PDQ process, participants were able to:

- Gain a better understanding of MSM, FSW and health providers perceptions and needs
- Identify potential problems and strengths in current VCT services
- Identify individuals to participate in a team to improve the quality of VCT services
- Establish concepts of client and health worker rights and responsibilities

In workshops with service providers during this phase, participants discussed:

- Why We Became Health Providers
- Health Workers’ Perspective on Quality
- Review of Technical Standards for VCT services
- Quality Problem Identification
- Client and Provider Rights and Responsibilities
- What We Want to Gain from this Process

Workshops with service providers helped build interest in, and ownership of the quality improvement process; explore health provider views on quality and their perceptions of the obstacles to quality health care and counseling; and mobilize a core group to remain involved in the partnership process.

The workshops with groups of MSM and FSWs focused on:

- When You are the Customer
- Community Perception of Quality Healthcare
- Organizing and Summarizing

Through these workshops we were able to build interest in, and ownership of, the partnership process; explore the community’s views on quality, understand barriers to service utilization and identify elements that would motivate MSM and FSW to use VCT services; and mobilize to participate in the quality improvement process.

Workshops included reflection and analysis of group discussions and prepared participants for the next phase of the PDQ process. Information was reviewed to establish a “common voice” and determine who could best represent the groups and their perspectives.

Facilitators involved participants in organizing the information, analyzing gaps and identifying possible solutions to bridge differences between providers and clients, and developing their final presentations.

Phase III – Building the Bridge

Having articulated their group views about quality VCT services in the previous phases, representatives of each stakeholder group came together in Phase III to share and reconcile their perspectives. Expert facilitators were identified locally and PDQ tools were adapted to facilitate the development of a common vision of quality for VCT services that all groups could embrace and support.

During this phase, groups were able to bridge linguistics, cultural, social and professional gaps while engaging in sincere and respectful dialogue about their definitions of quality. As a result, representatives from all groups developed a shared vision and began working as a team. This phase, in which representatives of health providers, MSM and FSW groups participated, was the launching point for the ongoing quality improvement initiative. It provided a better understanding of the needs and the differing perspectives of quality among MSM, FSWs and service providers. “Building the Bridge” involved team building, developing a shared vision, identifying problems, and selecting members for an Advisory

Committee that would stay involved in the quality improvement process.

Phase IV – Working in Partnership

The common vision developed in Phase III as well as the overall results of the PDQ process were shared with programs in each country to help secure buy-in and foster cooperation and respect between the different groups. The Advisory Committee, composed of representatives of each participating group, helped develop action plans and a process for monitoring continuous quality improvement.

The overall goal of the PDQ process is to engage in sincere and respectful dialogue about quality concerns and create a shared definition of quality.

Key Findings

The key findings from the PDQ process shared with stakeholders in each country included the following:

- VCT personnel discriminate against MSM and FSWs. Discrimination includes inappropriate comments/gestures and unfair practices such as making clients wait long periods of time.
- MSM and FSWs are not empowered to request quality services. FSWs in particular expressed fear to speak out, are not aware of their rights, and have low expectations of quality.
- Factors affecting provision of quality services include overworked staff, providers’ multiple responsibilities, and lack of support to prevent burn out.
- Many providers have not received training in counseling. Frequent staff rotation and lack of supervision exacerbate this problem.
- Providers lack knowledge of existing norms and protocols related to VCT. Job aids to support VCT services are not available.
- Testing is often provided without counseling, and follow-up is rare:
 - No risk assessment
 - No consistent demonstration of condom use
 - Limited correct information provided
 - Difficult to understand language used by providers
- Lack of privacy in counseling areas and disregard for confidentiality when providing test results is common in most sites.
- Test results are not given to clients in a timely fashion – it often takes weeks or even months.
- Condoms and lubricants are frequently unavailable to MSM and FSW.
- Limited availability of biohazard protection kits exacerbates unease of providers who are concerned for their safety.