Partnership Defined Quality for Youth

A Process Manual for Improving Reproductive Health Services Through Youth-Provider Collaboration

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Cover photo taken in Bolivia by Michael Bisceglie

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This document is an adaptation of *Partnership Defined Quality: a tool book for community and health provider collaboration for quality improvement*, for use with youth, ages 15-24 and health providers to improve youth access to quality health services. The information and ideas for this manual came from the innovations of colleagues in our field offices as they implemented the PDQ process. Save the Children staff modified several sections of the PDQ manual so that it would be more user friendly for practitioners working specifically with youth. Although many examples refer to PDQ-Y, some of the issues and success stories presented in the original PDQ manual still are applicable to PDQ-Y, so some have remained. Most of the examples relate to health care improvement, but may be modified for use in other sectors.

The youth focus in this manual largely came from the solid work of our field offices and their experiences with youth programming. Information was compiled by Aditi Krishna, with input and review by Beth Outterson, Brad Kerner, Debbie Fagan and Nancy Williamson. Aysha Twose and Sharon Lake-Post helped with formatting. Thanks also to Bharat Shrestra and other Nepal Country office staff for managing the pilot testing of this manual. Contributions also came from experiences in Bolivia, Ethiopia, Haiti, Malawi, and the Republic of Georgia.

We also thank the supporters of the original PDQ manual itself, which was published in 2003 and subsequently updated in 2005. Those supporters include the Hewlett Foundation, USAID's Office of Population in support of the Maximizing Access and Quality (MAQ) Initiative, USAID Nepal, and our partners on the NGO Networks for Health, PRIME II and the Health Communications Partnership. We also appreciate the advice and assistance of colleagues at the Quality Assurance Project. Within the SC family, there are many to thank, especially the Health Team in Nepal: Bharat Kumar Shrestha, Ravindra Kumar Thapa, Laxmi Bhattarai, Ram Ashis Roy, and Naramaya Limbu and other health based in Siraha and Narayan Tamang from the District Health Office Siraha, who agreed to serve as the pilot test site and helped to collect the data to measure changes in the quality of services, customer satisfaction, and increased utilization. Other colleagues who helped develop and field test the methodology include Debbie Fagan, Adelaida Gallardo, Lisa Howard Grabman, Ronnie Lovich, Mary Beth Powers, Marcie Rubardt, Gail Snetro, Laura Wedeen, Amy Weissman and numerous colleagues in Pakistan, Uganda, Peru, Rwanda, Armenia, Georgia, West Bank/Gaza and Ethiopia.

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Foreword

Save the Children/US has more than 75 years of experience empowering communities to solve their own problems. Our work in the health sector focuses significant attention on improving community understanding of and demand for key health services. The Partnership Defined Quality (PDQ) initiative was developed to improve the quality and availability of health services. The success of the PDQ methodology in addressing and finding solutions to community concerns has led to this adaptation which addresses the specific health concerns of youth.

In 2007, the PDQ for Youth (PDQ-Y) approach was field tested in Kanchanpur, Nepal with field level research on modifying the PDQ methodology specifically for adolescents. This project applied the PDQ-Y approach to a long-running project on youth reproductive and sexual health. Preliminary findings confirmed our hypothesis – that youth and their health service providers had somewhat different definitions and priorities in terms of the quality of care provided. This field research helped us define the preliminary and follow up steps to gather differing perspectives and share various understandings in a way that led to a collaborative plan for improving access and quality.

Save the Children's Field Office in Nepal volunteered to integrate this quality improvement methodology into their program in Siraha District in the Terai of Nepal. Despite a number of years of community mobilization and district level strengthening work, coverage of preventive health services was low and disenfranchised, minority groups rarely used health facilities. Moving people from being passive, periodic recipients of health care services toward active engagement and advocacy for the improvement of health services took time.

Currently, PDQ-Y is being utilized in Bolivia, Ethiopia, the Republic of Georgia, Malawi and Nepal. Adaptations for youth within PDQ programs are being made in Guatemala, Mozambique and the Philippines. We hope this manual will further your community-based efforts in improving quality health care for youth clients and providers. We have found it to be an empowering, engaging and rewarding process!

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What is PDQ for Youth?

Partnership Defined Quality for Youth (PDQ-Y) is an approach for improving the quality and accessibility of services whereby young people are involved in defining, implementing, and monitoring the quality improvement process. The PDQ-Y process involves youth, health care providers, and other stakeholders working together to overcome the inadequacies of health services for youth. It was adapted from the PDQ process to increase the utilization and quality of health services for youth. PDQ-Y links quality assessment and improvement with youth mobilization, empowerment and participation.

Why was PDQ-Y developed?

- Youth often feel that when they go to the health center, services are not tailored to their needs. Instead of being treated as adolescents, they are often viewed as children or adults.
- Youth health needs are rarely addressed by community approaches. The original PDQ methodology was revised to provide for the particular needs of youth.
- Efforts to improve quality may not consider youth concerns and perspectives about quality of care; therefore, improvement efforts can fail to meet the needs of the youth. Youth involvement is an integral step toward creating Youth Friendly Health Services (YFHS).
- Youth and adults rarely work together and the power differences between the two groups often make it difficult to truly work in partnership. Building youth-adult partnerships is a key component to a functioning Quality Improvement (QI) team that has ongoing youth participation.
- There is frequently a social distance/culture gap between health workers and the youth populations they serve. Health workers often have negative attitudes towards adolescent reproductive and sexual health issues and toward serving adolescents.
- Many barriers exist, preventing adolescents from obtaining adequate health information and access to care. Barriers include judgmental service providers, lack of confidentiality and inability to pay for services.
- Solutions to health facility deficiencies can be found beyond the health system. Remedies for service quality issues may rest within the youth themselves, if they are engaged and empowered to share their views.
- The responsibility for better health goes beyond the health system. Individuals control their own health to some extent. A partnership process can involve young people more fully in the struggle for better health.
- Our guiding assumption: use of services by youth should increase as the perceived quality, accessibility, and acceptability of those services increases.

Who should use this manual?

This manual offers tools that can be used by project managers, youth leaders, health service managers, or facilitating agencies. It is intended as a framework to plan programs that will mobilize health workers, youth and communities to work toward better service quality and availability for young people.

How to use this manual

This manual was designed to be a resource and guide for planning quality improvement activities through partnership activities involving health providers and youth who need services. The chapters reflect the different phases of the PDQ-Y approach. The goals for each phase are listed in the beginning of each chapter. The tools and exercises are not meant as a prescription for what must be done but instead should be considered suggestions. We encourage users to be creative and use tools with which they are familiar or have found to work well in a particular culture. There are also many excellent resources on team building and problem solving that users may wish to use. Other references are listed for further exploration.

Boxes: Field Experience, Facilitation Tips

Shaded boxes reflect PDQ-Y field experience in the Republic of Georgia Malawi and Nepal, as well as experiences in other countries where youth were involved in PDQ implementation including Guatemala, Haiti and Mozambique. Some PDQ examples from the original PDQ manual have also been maintained. The variation of implementation strategies displays the flexibility of this approach to local culture and needs.

The non-shaded boxes contain tips, suggestions, and pitfalls to avoid.

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

OVERVIEW OF PDQ-Y

The PDQ-Y Process Steps

Phase 1 - Building Support

The PDQ-Y process is collaborative and requires commitment from youth, key members of the community and the health system. The Building Support phase involves presenting the process and obtaining commitment for participation from these groups. For youth support, this involves identifying and meeting with youth stakeholders at different levels – for example, Ministry of Health officials, local NGOs that work with youth themselves, parents, youth leaders, youth clubs and other community groups. This step is imperative for both community leaders and health care providers to work towards change. Having community involvement from the beginning will help ensure the success of adolescent reproductive and sexual health programs and the provision of youth friendly health services.

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

Phase 2 - Exploring Quality

Definitions of quality are not fixed; they come from people's understanding of their needs, rights and responsibilities. This step provides the opportunity to understand different perspectives on quality among adolescents and health care providers. During this step meetings are held separately with youth, community members and health workers to explore their ideas in an open and safe environment. Tools provided for this step have been developed to facilitate this exploration.

Additionally during this step, the benefits of a youth and health worker partnership are explored. This is particularly important because health workers often are not accustomed to working with youth, and need assurances that this process will be beneficial for both.

Community involvement is critically important during this step. Parents of youth as well as other members of the community are encouraged to participate in developing an understanding of youth health needs. At this point, the more participation there is by a cross section of the community, the more the norms of the community can be understood and integrated.

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

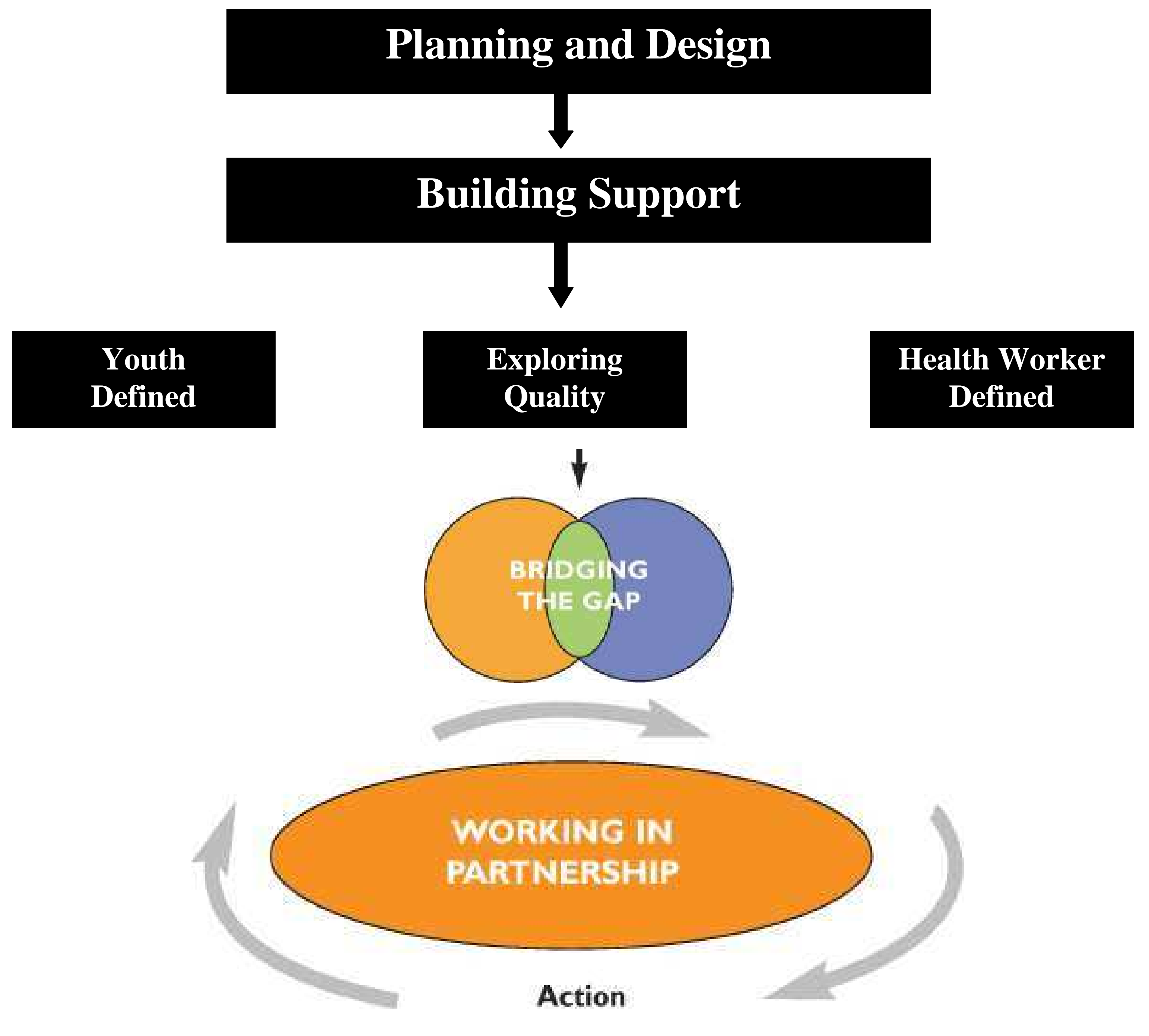
Phase 3 - Bridging the Gap

This key step initiates the partnership necessary for subsequent activities in quality improvemen (QI). Each group has separately defined characteristics and issues of quality health care. Now, health workers and youth come together to hear each others' ideas. Through discussion they begin to work as a team to develop a shared vision of quality. Together they identify and prioritize problems and constraints that make it difficult to achieve quality health services. They identify the barriers which prevent youth from obtaining adequate health care. Participants of this meeting also establish a QI team comprised of youth representatives and health workers. This team will continue to work on the issues identified.

Phase 4 - Working in Partnership

The PDQ-Y process is now in the hands of the QI team. Through the Bridging the gap workshop, the team has a greater understanding of various viewpoints and is sculpting a collective vision of what quality YFHS in health care means for their locale and key gaps in achieving that vision. The improvement process moves beyond identifying the issues to solving them. Through dialogue and analysis, the group looks at the issues to determine root causes and identify solutions for achieving the desired level of quality. The group also establishes indicators to monitor progress and determine when a given problem has been adequately addressed. This cycle of identifying, analyzing and acting requires a team that can work well together. This manual addresses team management skills needed for the team to sustain productivity, diversity and respect as well as team building and youth-adult partnerships that will reduce the power differentials between youth and adults and foster healthy working relationships.

Youth representatives on the QI team need to define their role and responsibilities on the team and within their communitities. They need to establish their positions as members of the QI team and foster positive norms of youth involvement. As liaisons with other youth in the community and the adults on the QI team, they also need to explain their roles and duties to other youth.


Planning and Design
Building Support
Youth Defined
Exploring Quality
Health Worker Defined
BRIDGING THE GAP
WORKING IN PARTNERSHIP
Action

PDQ-Y in relation to other QI initiatives

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

PDQ-Y can also serve as a supplement to ongoing projects. As another approach towards improving quality, it provides a community-focused approach toward identifying problems and finding solutions. It can also serve as a participatory method to develop youth friendly service standard checklists which can be used for ongoing monitoring of services. PDQ-Y requires very few additional resources when it is implemented as part of a larger QI initiative.

In the Republic of Georgia, PDQ-Y was integrated into pharmacist training. Separate sessions with youth to explore quality occurred before the pharmacist training began. The pharmacists spent a session exploring quality during the training. Then the youth were invited to the last day of the training where they conducted the "Bridging the gap" exercise and youth and pharmacists developed a shared vision of quality.

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

For PDQ:

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

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

Health Facility Assessment collection of tools on the CORE web site
www.coregroup.org/tools/monitoring/H FA_table.html

For PDQ-Y:

Guidelines and training curriculum for providing Youth Friendly Services (YFS) from EngenderHealth http://www.engenderhealth.org

Clinical assessment for Youth Friendly Services, from Pathfinder www.pathfind.org

Methodology of on-going YFHS projects in Africa Available at the African Youth Alliance
http://www.ayaonline.org/Strategies/PDFs/YFS.pdf

Annotated Resources for YFHS available from Family Health International/Interagency Youth Working Group
http://www.fhi.org and www.infoforhealth.org/youthwg

PLANNING AND DESIGN

PLANNING AND DESIGN CONSIDERATIONS

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

Components

- Identifying needed skills and resources
- Defining goals
- Identifying the level of service
- Understanding youth and their role
- Mapping by youth and health service providers
- Planning for participation and representation
- Identifying other QI initiatives or partners

IDENTIFYING NEEDED SKILLS AND RESOURCES

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

Identify staff with facilitation skills

The PDQ-Y process depends on open communication and interaction. Without experienced facilitators, this can be difficult to achieve in situations where gender and power relationships are entrenched or where there is unresolved conflict. Because there are many power dynamics and misconceptions between youth and adults, a good facilitator must know how to encourage involvement and participation. It is recommended that the facilitator of the discussion groups be neutral and not be viewed as part of the health system nor have a political role in the community. Additionally, all facilitators should be provided training on the PDQ-Y process because a clear understanding of PDQ-Y is also crucial for facilitation, especially when working with youth.

Because PDQ-Y involves working with youth, special considerations need to be made for the power dynamics between youth and adults. Skilled facilitators are needed to make sure that youth feel comfortable to participate in the process. Skills needed include:

- Ability to ask clarifying questions
- Ability to rephrase what people are saying
- Ability to actively listen
- Ability to create a safe environment so people feel comfortable talking
- Ability to encourage everyone to share.
- Ability to make sure everyone is understood
- Ability to relate the discussion to people's reality
- Ability to be reinforcing, even when people are wrong
- Ability to manage differences of opinion

Identifying staff with mobilizing skills

Individuals who are skilled in mobilizing communities ought to be integrally involved. Often providers do not see the value of working with youth. Skilled mobilizers can navigate through these obstacles to bring together youth and providers.

Who is the PDQ implementation team?

The PDQ implementation team consists of staff as well as selected community leaders and youth who will together plan, facilitate and guide the PDQ-Y process.

Once the PDQ-Y Implementation team has been established, it is important that they review this manual and select the tools they want to use.

In PDQ-Y, youth are not only asked for their views or opinions, they are asked to participate and share responsibility and efforts for quality improvement. This requires that PDQ Implementation team members have experience with youth issues and youth mobilization.

Who are youth?

Defining young people

Term	Age	Endorser(s)
Children	0-18	Convention on the Rights of Children
Adolescent	10-19	UNFPA, WHO, UNICEF
Very Young Adolescent	10-14	UNICEF, UNFPA
Youth	15-24	UNFPA, WHO, UNICEF
Young People	10-24	UNFPA, WHO, UNICEF

Because of the maturity level needed in working in partnership with adults, critical analysis and problem solving skills, we recommend involving youth 15-24 years old in the PDQ-Y process. It is also important to recognize that youth need different teaching methodologies from adults. It is important to keep sessions as interactive as possible and include icebreakers that promote youth and adult interactions.

Appoint youth as "interns"

Youth involvement in the PDQ-Y process is critical. To encourage and sustain youth participation, one or more positions for youth representatives may be created. These interns will help the adult facilitators talk to other youth and will ensure that a young person's perspective is expressed throughout the whole PDQ-Y process. Interns could be male or female (or a mix) and should have a strong commitment to helping other youth.

Language

The PDQ implementation team may have some of the same language and cultural barriers faced by the health workers and the community. Often, people do not speak a common language; translation adds an additional layer onto the process. Youth also have a different mode of communicating from adults, often using slang that is incomprehensible to older community members. In instances where communication is problematic, it is recommended that creative solutions be explored to maximize input from all members. For example one member could volunteer to pay attention to words that may need defining or translating. The group would then define and discuss for clarity.

DEFINING GOALS

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

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

Be reasonable and realistic in the development of your goals given the resources you have. The time needed for PDQ-Y implementation may take up to three months or more from start up to sustainability of QI teams.

Examples of PDQ-Y goals:

- To improve the youth-friendliness of reproductive health services.
- Mobilize youth to advocate for improved health services through increased civic participation.
- To train youth leaders to assist health workers in finding solutions to problems in quality care delivery and access.
- To reduce barriers and increase use of reproductive health services by youth.
- To reduce the reluctance of providers to offer reproductive health services to youth.
- To increase interaction and improve communication between youth and health service providers.
- To create local accountability for health workers and shared responsibility between youth and health providers for better health and better health services.

IDENTIFYING THE LEVEL OF SERVICE

There are multiple levels in the health system from the central ministry to district hospitals to remote health posts. Your goals and the reason you were interested in PDQ-Y will help you determine the level of health care services on which to focus your efforts. Who you work with will also depend on the scope of your program and your access to resources for supporting this initiative.

Level of Service: National, District, or Health Center Level

Decide which level(s) of health care services you are seeking to improve:

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

Selection of Target Health Centers

Determine whether all health centers in a region will be selected or only selected centers. It is important to select a health center/facility that serves the population you are targeting in your initiative.

Program Focus

Determine whether you are going to focus on service quality in general, or a particular area of health services. The advantage of a narrower focus such as family planning or reproductive health is a more limited list of topics and problems to address. It also means you will be able to examine this issue in greater depth. However, many service delivery problems are broad and cross-cutting and service delivery is integrated, thus, the focus on one component may be unnecessarily limiting.

UNDERSTANDING YOUTH AND THEIR ROLE

Like quality, "youth" has a variable definition, depending on the goal of a particular program. It also varies by country. Because PDQ-Y focuses on improving and increasing access to reproductive health services for youth, youth are defined as individuals who are sexually active or could potentially be sexually active. Generally, these are individuals between the ages of 15-24. Within this age group, there is a broad range of maturity levels, needs, and concerns. Sub-groups within the 15-24 age range can be created in order to provide more focused and effective discussion groups. These can also be further sub-divided by gender, health service users and non-users, and rural and urban youth.

In group discussions with youth, ask them to identify peers who are leaders among their friends. Ask them to identify mature individuals who are willing and able to work constructively with adults. In addition, be aware of youth in the discussion group who are especially vocal or who express insightful comments. Choosing both male and female leaders is very important. Boys and girls may need to be segregated in order for all group members to feel comfortable participating in discussion groups and sharing ideas.

In understanding youth dynamics, it may be helpful to utilize rapid appraisal tools such as the "transect walk" or conduct informal interviews with youth. These steps can allow the facilitators to gain a better idea of the role of youth within the community.

A transect walk is a way to learn about a community by walking through it in order to observe the people, surroundings and resources. Transect walks are planned by drawing a "transect line" through a map of the community that goes through, or "transects" all zones of the community to provide a representative view. As the observation team walks through the community, they observe conditions, problems and opportunities, and talk to the people they meet to obtain additional information. Transect walks can be used to observe different things such housing conditions, presence of "street children" (urban areas), availability of public transportation, presence of health facilities, types of organisations, and interactions between men and women.

Before conducting a transect walk, it is helpful to develop an observation guide to provide a reminder of general themes for the walk. Information gathered during transect walks is presented to the community afterwards.

Source: Thies, J. and H. Grady. 1991. Participatory Rapid Appraisal for Community Development. Save the Children and IIED.

HEALTH SERVICES AND YOUTH MAPPING

An *understanding of the existing health structure and the youth served is essential for designing a PDQ-Y program. This information will be the foundation for planning your intervention and for examining whether you have broad representation of both the youth population and the health service providers.*

The next step is to literally draw a map of your community and mark on it the places young people receive attention and services for sexual and reproductive health. As you chart each service, write down relevant aspects related to their function. You may have this map already. If not, the questions below can serve as a guide for the information you will need to obtain.

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

Existing health structures:

- Formal health system – district health services, health posts, sub health posts, referral sites
- Private providers of health services
- Informal health system – traditional healers, TBAs, community volunteers, etc.
- Pharmacies

Key members of health service provision:

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

Community structures:

- Who has formal power and authority?
- Who has informal power?
- Which key groups in the community should be involved?

- Whose voices in the community need representation in the PDQ-Y process? (marginalized persons, mothers-in-law, etc.)
- What are the existing community organizations? (committees, political groups, churches, women's groups, literacy groups, etc.)
- What is the role of the local government in health services? In youth programs?

If PDQ-Y is being implemented in a community that has already implemented PDQ, this step is not necessary. Insights from the PDQ process can be used.

Youth Structures:

- What ages are considered "youth" in the target community?
- How do youth interact with adults? What are the power dynamics between youth and adults, men and women (i.e. gender roles)?
- Are all youth enrolled in school? What is their relationship with their teachers?
- How do out-of-school youth spend their time? Where do they hang out?
- How involved are parents in the lives of youth?
- Are most families extended or nuclear?
- What youth focused organizations exist? Are there clubs or committees that serve youth or are made up of youth?
- How aware are local leaders of youth needs?

Interface between Health Services and Youth:

- Where do adolescents go for routine health care, acute care, and emergencies?
- Where do they go for reproductive and sexual health services?
- If youth are in school during most of the day, do they still have access to health care facilities? Are there school-based facilities or afternoon clinics?
- How does the health system currently involve youth? Are there any youth advocates serving as intermediaries between staff and youth users?
- Are there other community-based structures, such as referral networks or guidance counselors from which youth can obtain services?
- Where do youth get health information (could be radio, TV, internet, peers or other source)?

PLANNING FOR PARTICIPATION AND REPRESENTATION

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

THE IDEAL STRUCTURE WILL INCLUDE:

- Representation of youth of all ages within the 15-24 range
- Both girls and boys
- Youth from rural and urban areas
- Both users and non-users of services
- A balanced membership between health workers and youth
- Participation of parents and other adult community members will also be involved in addressing health community issues

Planning

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

What organizations and staff are likely to be involved?

How should responsibility be shared?

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

How can youth input be maximized with minimal disruption to their school or work schedules?

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

Where and when should meetings be held to permit maximum participation?

Building Support

How involved will the District Health Officer be?

Who needs to be convinced to take action?

Who provides support for change at the lower levels?

Who might be a barrier to change?

In Nepal, ten separate focus group discussions were held with health service providers and with adolescents.

In Malawi, quarterly meetings were already being held between health care providers, health surveillance assistants, and youth community-based distribution agents. These individuals decided to integrate the QI team into this established meeting structure.

In Nepal, 55 adolescents, health service providers and social leaders participated in a one day Bridging the gap workshop. During the workshop, four Quality Improvements Teams (QI teams) were formed; one in each of the four health institutions. QI teams were comprised of adolescents, teachers, representatives from village development communities and health workers.

Exploring Quality

How many group facilitators will be needed?

How many recorders will be needed?

How large should each discussion group be?

Are there language barriers?

How many separate discussion or role play or mapping groups should be conducted to represent all the necessary perspectives?

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

How will you make sure that youth are not intimidated by the presence of adults? How will you create a comfortable environment in which they can voice their concerns and needs?

Bridging the Gap

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

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

Working in Partnership – QI Teams

How many QI teams should there be?

How large should each QI team be?

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

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

Who will be in charge of team building and youth-adult partnership building exercises for newly formed QI teams? How will youth-adult partnerships be encouraged?

In Nepal, during the formation of QI teams, the need for creating a "partnership" structure between youth and healthcare providers became apparent. Team building activities were used to improve comfort levels in communication between youth and providers Inspiring trust between youth and adults is imperative.

Other approaches to quality improvement use assessment teams instead of QI teams. QI teams have been shown to work well because they encourage the participation of youth, who are typically more reticent than other community members.

In Nepal, the local government structure features a health center and three to ten health posts. The original plan was to have one Bridging the Gap workshop and one QI team for the whole area. However, as time went on, it became apparent that there were problems with territoriality, ownership, and role clarity for that team for each health post as well as the health center. While this is more of a challenge for providing technical support and supervision, it fits better with the local authorities and spheres of influence. Now, each QI team is actively working to improve the services in the health post they use, and for which they are responsible. Meetings are now closer to home for most members; thus logistics and refreshments are less costly.

PLANNING AND DESIGN

IDENTIFY OTHER QI INITIATIVES OR PARTNERS

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

In Bolivia, during the Bridging the Gap session, it became apparent that there were strong and overt tensions between some youth and providers. They realized that more sensitization of the community at the building support phase would have eased these tensions. Increasing awareness among community members will also help increase stakeholder buy-in during the Working in Partnership phase.

Summary of Design Considerations Planning Efforts

KEY PLANNING DECISIONS CHECKLIST

- ☐ What do you want to achieve?
- ☐ Who will facilitate the process?
- ☐ What level of services do you want to alter?
- ☐ Do you have a monitoring and evaluation plan?
- ☐ Do you have representation of both service providers and support staff?
- ☐ What other health services are available in the community?
- ☐ Who uses health services? Are some youth better served than others?
- ☐ Who should be involved to ensure that youth representatives are truly representative?
- ☐ How many discussion or role play or mapping groups will be held and where?
- ☐ How many QI teams will be established?
- ☐ What other system strengthening/QI processes are in place?

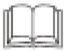
PHASE 1: BUILDING SUPPORT

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

Purpose: To develop the support necessary to implement the PDQ-Y process from the health system and youth.

Components:

- Determine whom to contact
- Decide how best to present PDQ-Y
- Present PDQ-Y to potential partners



Useful References:

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

Advocacy Matters: Helping Children Change their World: An International Save the Children Alliance Guide to Advocacy. Produced by: The International Save the Children Alliance, 2007 http://www.savethechildren.net/alliance/resources/publications.html

Determine Whom to Contact

Using the results of the youth health service resource maps that were completed in the design phase, list key people or groups that should be contacted for project support. To get support and commitment from the health care system, it is necessary to meet with not only health workers in the facility, but also people in the structures that support the target services (MOH supervisors, District Health Officers, NGOs).

In Malawi, a variety of stakeholders were involved in the PDQ-Y initiative such as:

- **Ministry of Health officials**
- **Youth Community-Based Distribution Agents**
- **Youth Zone Coordinators**

In Bolivia, the Ministries of Health and Education, a national NGO network, and local NGOs worked together to gain support from stakeholders including formal and nonformal providers, parents, and other area NGOs.

In Haiti, SC realized the need for practice and mutual support within the PDQ implementation team as they obtained support from community groups for PDQ-Y. Simply providing one training session for the PDQ facilitation team will not always guarantee that it will result in effective implementation. Be sure to include formal and nonformal providers, parents, and other area NGOs.

Decide How Best to Present PDQ-Y

Using program goals and structure, provide an overview of what can be achieved through the partnership process. By developing a targeted explanation of the purpose of PDQ-Y to the different stakeholders, you acquire the initial interest and support needed for the projects' long term success. With youth, it is particularly important to present PDQ-Y in an interactive manner that encourages participation. It should not be an intimidating prospect to youth. Rather, they should perceive it as a non-threatening way to voice their own needs.

Present PDQ-Y to Potential Partners

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

Even if an existing project has a strong community or youth mobilization component, the importance of getting support for the PDQ-Y process is paramount for success.

In Mozambique, the various community leadership councils have been shown to be much more effective in drumming up support for the process than the singular actions of the given community leader. This is not only because there are more people to help facilitate this process, but that they are usually members of institutions such as schools, churches, or businesses where community health is an important factor to their daily lives. Therefore, they have been much more enthusiastic in assisting the PDQ-Y team.

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

REASONS WHY YOUR PARTNERS MIGHT BE INTERESTED IN PDQ-Y

Why improve quality for youth?

- Improved quality means that safer, more effective health care is provided.
- Improved quality leads to increased satisfaction for both the client and the provider.
- Improved quality potentially leads to increased utilization and improved health.

What is the cost of poor quality for youth?

- Perception of poor quality health services can cause delays in seeking and receiving appropriate service, which can lead to greater morbidity and mortality.
- Poor quality can lead to complications due to ineffective treatment or unsafe practices.

Why include youth?

- Youth are resourceful and have many creative, new ideas to share.
- Youth can work with health providers to help develop solutions.
- Youth members can favorably influence the use of the health facility by their peers, and can help improve the delivery of health services.
- Youth members and leaders can advocate for assistance from other levels and institutions when health workers have not been able to mobilize needed resources.
- Youth members have responsibility for their own health and share responsibility for the care received at a facility and patient compliance at home.
- Some resources for improving quality are available within the community.
- Youth become empowered from their engagement in the QI process. In the future, as confident adults, they will be able to act as positive role models in the community. The entire community benefits from a new generation of empowered youth.

YOUTH DEFINED

EXPLORING QUALITY

HEALTH WORKER DEFINED

PHASE 2: EXPLORING QUALITY

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

To help facilitate open and free discussions, it is recommended that you explore health worker and youth perspectives separately. Both perspectives must be thoroughly explored in order to understand where potential barriers to the provision of care and use of services exist.

Purpose

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

Components

Health Worker Defined Quality
Youth Defined Quality
Preparation for Bridging the gap

Preparation

How will the results be recorded?

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

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

HEALTH WORKER DEFINED QUALITY

Although the health workers have already had the PDQ-Y process explained to them, they are probably not yet clear as to exactly how the process will work and how it can benefit them and their work. The activities in this section will not only provide an opportunity for the health workers to discuss quality issues but to understand the process and to determine what they can learn from it. These activities may be approached as a 1-2 day workshop, or as a series of meetings.

Suggested Activities:

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

The Goals of these activities are:

- To continue to build interest in, and ownership of, the QI process
- To explore health worker views on quality, especially quality issues specifically for youth
- To explore health worker perceptions of the obstacles to quality health care for youth
- To mobilize health care workers who will remain involved in the partnership process

In Guatemala: This session initially involved only the nurse at the local health center, who had no assistant. Later it was realized that health promoters and midwives could also be seen as providers although they were not based at the health center.

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

WHY WE BECAME HEALTH WORKERS 45 minutes

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

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

Methods:
Reflection

Preparation:

- One piece of paper for each participant
- Crayons for each participant
- A notepad for the note-taker
- Large sheets of paper for the facilitator

REFLECTION

Think back to the time you were young. When you were a child, what did you want to do when you were older? When did you first begin to think about becoming a health worker? Was there an event in your life that helped you make this decision? Did something happen to you or someone in your family? Was there a person who influenced you? How was the experience of becoming a health provider? Was the training as you expected it to be? What was better than you had imagined? Now think about your first job as a health worker…What was as you imagined it to be? What was different? Now consider your work now…How does it compare with the vision you had when you were younger?

Tips on Conducting Focus Group Discussions

- Groups can be representative of all individuals working at health care facilities, not just doctors and nurses. In general, focus groups must represent the demographics of the community.
- The degree of familiarity within the group is important. Often, an ice-breaker is needed before beginning the actual discussion. A relaxed and casual environment is essential.
- Participants should be compensated if possible, if only with refreshments.
- A good moderator or facilitator is critical to the success of the FGDs. This person should immediately establish their position of leadership and set the tone of the discussion.
- General open-ended questions are best. As participants become more comfortable, more specific and probing questions can be posed.
- At the end of the discussion, the moderator or facilitator should summarize the discussion clarify what the participants actually said and how to interpret it.
- Lastly, the participants should be thanked for their involvement and assured of confidentiality.

DISCUSSION:

- Group members should share some of their personal reflections
- Note the similarity in reasons for becoming health workers.
- How does the vision you first had for yourselves as health workers differ from the image you have now? Why?
- Do you feel respected by the community?
- What do you think about health services for youth? What do you think about reproductive issues involving youth such as sexual development and family planning? What do you think about providing reproductive and sexual health services to youth?

KEY POINTS:

- Many people enter into health care with the goals of service and helping others.
- This is influenced both positively and negatively by our experiences and opportunities.
- Morale can be a problem where the system is not functioning well, and where resources are lacking. However, health workers can sometimes work collectively to improve their working conditions.
- Many health workers also have stigmas and negative attitudes about providing reproductive and sexual health services to youth, especially younger youth.

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

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

Exercise: Health Worker Perspectives on Quality 60 minutes

Quality health care means many things to many people. To those who deliver services, quality is often determined by standards created by others. Also, youth have particular demands for quality that need to be specifically addressed. For example, they may need extra reassurance when receiving vaccines or physical exams. This exercise provides health workers the opportunity to provide their own perceptions of the elements of quality healthcare.

Purpose: To explore health workers' thoughts on the elements of quality health care for youth

Preparation:

- Six to seven index cards (or paper divided in half) for each health worker
- Hang newsprint or signs below the eight headings. There should be one heading on each page.
- Keep the headings covered until you are ready to use them, so that you do not influence the responses of the group.

Methods:

- Written list
- Role play
- Categorizing and summarizing responses

SUGGESTED HEADINGS:

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

Written List Suggested Time: 15 minutes

Provide each participant with paper or index cards. Ask each person to write down two or three characteristics of good quality health care. Then, ask each person to write down one or two characteristics of good quality care specifically for youth. Then ask them to do the same for poor quality health care.

Youth-specific information can be elicited by asking questions like: "What issues are involved in providing for the reproductive and sexual health needs of youth in your community? What are the main problems? Why are youth not being served?"

After a few minutes of writing, the participants should share their lists orally. Then, the entire group of health care providers discusses and clarifies their concerns as needed. Have the group rank their issues according to importance. Keep a record of this list on newsprint paper or notepaper.

(Note: If you have more than 10 or 12 participants then it is suggested that you only request two or three responses from each participant. Otherwise the amount of information to sort becomes excessive and repetitive. It is also important to make the distinction between general definitions of quality as well as specific youth needs for quality).

Role Play Suggested Time: 15 minutes

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

For this exercise, please note that as an audience member, the facilitator must surmise perceptions from the drama and must discuss and clarify with the group which issues may complicate or enable the provision of health services to youth. This requires step by step discussion of the role play with questions to participants about how they felt about each scenario – about how things are (and why) and how things could be improved. The outcome of this exercise is a prioritized list of issues, similar to the previous exercise.

Categorizing and Summarizing Responses Suggested Time: 30 minutes

By this point the facilitator has compiled a list of many different aspects of quality, based on the group responses. Many of these are unique aspects of quality, while others are different variations of the same thing. For example, if someone had listed a characteristic of quality as "having privacy during examination" and another person had listed "no separate exam room" as a characteristic of bad quality, these basically describe the same characteristic, which is the need for a private place for examination. In this session, the group will have the opportunity to review the list, make any changes and summarize the responses. It may be preferable to start without categories, and group the components as you go along. You may want to start with general headings (such as facility and surroundings), and modify them as you gain descriptions from the group that pertain to that element. The facilitator then reads each participant's response cards or list and, with the help of the group, decides in which category the item belongs. Use the suggested category heading lists on page 33 as a guide. More specific definitions of each category are found on page 63. It is important to note when the same response has been made by another participant but in the end, only unique characteristics should be listed. The categories are not meant to be restrictive but instead to provide some structure for grouping.

These lists will be used during the exercises that follow.

Review of Technical Standards 60 minutes

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

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

Preparation:

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

Methods:

- Small group exploration of technical standards
- Large group discussion: identifying current documented standards

SOURCES OF THIS INFORMATION COULD INCLUDE:

- **Standards and guidelines for Youth Friendly Health Services**
- **Treatment protocols**
- **Facility checklists**
- **Guidelines of Nursing and Midwifery Association**
- **Job Descriptions**

Various youth technical resources are available at the Interagency Youth Working Group: www.infoforhealth.org/youthwg/

ⓘ In Myanmar, it was not necessary to approach the subject of quality indirectly with the providers because of their familiarity with the concept of quality health services. They were instead asked to individually identify quality standards and then categorize elements they considered to be priority for good quality youth services. However community members and even some providers do not always focus on the technical elements of quality. For this, a separate exercise was used to name international standards and compare them with their own center's practices. Finally, it was important to think about advocacy messages because providers tended to be skeptical about the process.

Small Groups Exploration of Technical Standards 30 minutes

The participants should be divided into three groups, with the assignment to discuss the minimum technical standard for quality. Explain that while the first exercise asked for their personal view of what is good or bad quality, this exercise asks for their understanding of the minimum standards they should follow as professionals. Each group should take one of the three following categories for this exercise: 1) safety, 2) communication and information, and 3) diagnosis and treatment. At the end of the discussion, the groups are asked to write their answers on a flip chart, and post them.

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

Large Group Discussion 15-30 minutes

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

Identifying Current Documented Standards 15 minutes

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

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

Discussion Topics

- Are the standards available and widely used?
- Areas of discrepancy between standards and practice
- Which ones impact your work?
- How specific are they for youth? Is that relevant or acceptable for you?

Problem Identification for Quality 55 minutes

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

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

Methods:

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

Explain Exercise 5 minutes

Using the list compiled by the group in the previous exercise, explore which elements of quality health care services are being met and what areas have problems in your area facilities and outreach work. The group can think of the quality characteristics they created as a check list, and apply this checklist to their setting.

Groups should identify which areas of quality are being met by the health services, and which are areas where improvement is needed. Briefly explore the reasons why there is a gap between the ideal and what typically happens at the facility. Stress that Quality Improvement is a continuous process.

Break into Subgroups for Analysis 30 minutes

You may want to divide into work groups by health facility, or depending on the time available, each group could be assigned a few of the characteristics of quality as compiled on the lists. Each group should record notes on their discussions.

Group Discussion of the Results 20 minutes

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

Facilitation Tips

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

Discussion: Rights and Responsibilities for Quality 45 minutes

Health workers have differing views on what the rights and expectations of their youth clients and their community should be. Depending on the socialization during basic training as health workers, the support received (or not received) from the health care system, and the attitudes of coworkers, health workers perceive their relationships with clients and the communities through many different lenses. It is hoped that by the end of these discussions there will be some understanding of the potential value that the community's input can have in the quality improvement process. Particularly for youth, it is important for health workers to overcome their social stigmas and negative attitudes about the reproductive and sexual health concerns of adolescents.

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

Methods:

- Small group discussion
- Large group conclusions

Small Group Discussion

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

Note to facilitators:

1. *Some of these concepts are abstract enough that they may be difficult to understand. It is important to take special care to see that they are well translated and explained if necessary.*
2. *It may be necessary for all groups to discuss all questions. An alternative would be to have each group select three questions out of a hat.*

QUESTIONS TO BE DISCUSSED:

1. What rights do we as health workers have in our practice?

2. What rights or expectations do patients have when they come for services and information? What can they expect from the care that is available? What should they be able to expect?

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

4. How can youth be made to feel comfortable in clinics? How can their use of health services, especially reproductive health information and services be increased? What can we do to make them feel safe and comfortable enough to voice their concerns?

5. How do we take community beliefs and practices into consideration when we provide services to youth? How will we interact with parents and other adults involved in adolescent lives?

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

7. What responsibilities do youth have in obtaining better health?

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

Large Group Discussion

What conclusions do we want to make about:

- What rights do we as health workers have in our practice?
- How can this process help us achieve our rights and help communities understand our challenges?
- What are youth rights to quality care?
- What does this mean for health worker job performance?
- Potential roles for adolescents in the improvement of services.

What Do We Want to Gain From This Process? 30 minutes

By understanding PDQ-Y and exploring how the process can be beneficial to them and to the youth, health workers are likely to have more ownership of the quality improvement process. This exercise is valuable for health workers to think about what kinds of things they might want to learn from youth and what the youth can learn from them.

Purpose: To have health workers understand the PDQ-Y process and determine what they would like to gain from the process.

Methods:

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

Overview of the PDQ-Y Process

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

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

PHASE 2: EXPLORING QUALITY

What Do We Want to Learn from Youth?

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

What Do We Gain From This Process?

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

The goal is for the participants to realize there are benefits to providing good quality and that youth can help them achieve quality health service provision. These changes could also create a better working environment, and impact their job satisfaction. Often, when communities become empowered from the QI process, their willingness to commit resources increases significantly. The same can be said about communities when their youth become engaged with providers and other partners for improved youth friendly services.

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

In Armenia, the mayor contributed from community funds to pay for rebuilding the existing health center. Carpenters stepped forward. Shelves, tables, lamps and other fixtures were donated by community members to furnish the dilapidated center. In one community, once the health center was rebuilt, community use of the center increased dramatically and the district level doctor made more frequent visits. The QI team, now empowered, continued to work together on another project – building a preschool for the community's children.

Selecting Health Worker Representatives for the QI Team

Each health center should choose two or three individuals to act as their representatives during the Bridging the gap phase. These individuals will also go on to form the QI team. The number of people chosen is not important, however each QI team must be representative of the different types of health care providers i.e. doctors, nurses, pharmacists, etc.

These individuals should practice voicing the concerns of all of the health care providers. They should be able to express these concerns so that youth will be able to understand them. The representatives should practice in front of the entire group in preparation for the next phase.

YOUTH DEFINED QUALITY

Youth are a diverse group with varying needs, concerns, maturity and development levels, and sexual experience. Definitions of "youth" also differ. Generally, they fall between the ages of 15-24. Age is not the only determinant of differences in youth, however. Gender, proximity to urban areas, family structure, and community environment also influence the needs of youth. Throughout the Planning and Design Considerations section, which preceded the PDQ-Y phases, you were asked to determine who the youth are, and how to plan representative discussion groups to talk about quality. Now is the time to ask these subgroups of youth for their definitions of quality.

Suggested Activities:

- Icebreakers and Introduction
- When You Are the "Customer"
- Youth Perception of Quality Health Care
- Categorizing and Summarizing

Preparation:

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

The goals for these activities are:

- To continue to build interest in and ownership of the youth-provider partnership process
- To explore youth views on quality
- To explore youth perceptions of barriers to quality health care
- To mobilize youth who will remain involved in the partnership process

Introductions 10 minutes

The need to have an ice breaker will vary depending on the culture and the comfort level of the discussion groups. However, it is essential to go through some kind of settling in process - introductions, explanation of the purpose, and clarification of the group "rules" or norms. These steps set the ground for group discussions and warm-up for the mapping and drama sessions. You may have to form groups based on existing divisions within communities.

Discussion Guide:

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

Suggested Rules:

- Everyone's input is important. It is important to involve the shy, quiet youth.
- There are no wrong answers. Make youth feel comfortable.
- Sincere dialogue does not just happen. There must be trust and respect.
- The ice breaker should be a simple activity.
- This is not an exercise to find blame.
- This is an opportunity to find new ways to solve problems.

Suggested Activities

- In order to explain the purpose of the activity and the PDQ-Y process, pick one outspoken youth to act as a sick person, and then ask the other youth: "How do we make this person better?" Go through the steps of diagnosis, treatment, and recovery.
- For introductions, pairing youth and having them introduce one another may reduce the unease that youth may have about introducing themselves.
- Depending on the level of familiarity and comfort within the group, having the pairs ask silly questions of one another may effectively reduce tensions.

When You Are the "Customer" 20-30 minutes

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

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

Methods:

Market Place Discussion

Market Place Discussion

Before we talk about health services, we should think about times in our daily lives when we already have the right to determine what good quality is. Think about the market place. When you are the customer, you decide what quality is. This discussion can be preceded by defining quality so that everyone is on the same page about the meaning of the word.

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

Review what has been said. Can anyone add anything?

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

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

For those of you who do not go, why not?

Facilitators should feel free to pick a product or place that is applicable to the youth in the community. An alternative example could be a hair salon and/or barbershop. Gender-neutral examples are best.

In Myanmar, in order to facilitate discussion of quality, which is a subject that otherwise may be too abstract for people to easily grasp, SC staff started with a topic that is familiar to everyone – the participants' favorite tea shop. Tea is a "product" that the participants will consume regularly and it is quite easy for them to list the characteristics of a good tea shop. It then became easier to move into a discussion of characteristics of good health services. The tea shop analogy had the added benefit that many of the considerations for quality (cleanliness, quality of the product, environment, cost, etc) are similar to those for health services.

Youth Perception of Quality Health Care 60 minutes

Depending on the health services available to youth - traditional, non-traditional, public, or private - the term "health care" can mean many things. Some youth have never used a health care service in their lives or only went for a minor problem like a stomachache or flu rather than for reproductive health information and services. They may be unaware of what is available. However, they do have certain questions and concerns which can be collected through a brainstorming process to determine the gaps in health care provision. By defining bad quality health care, a definition of good quality can be found. By exploring their role as consumers of health care services, youth can better understand their rights and potential contribution to the QI process.

Purpose:

- To examine the youths' views on good and poor quality health services.
- To identify problems or barriers to quality services.
- To explore the concept of patient's rights.
- To identify a smaller group of youth who will help categorize the prioritized list of issues mentioned.
- To identify youth representatives for the Bridging the gap phase.

Methods:

- Role play with short discussions after each scene.
- Community mapping

Note: Group Discussions (GDs) are usually used in the Exploring Quality phase of PDQ. However we have found that young people respond more to active participatory methods such as role plays and mapping. For more information on how to conduct GDs, please refer to the PDQ Facilitator's Guide (www.savethechildren.org)

Note: It is important to do separate mapping/role play exercises with each subgroup in the youth population so that voices of all subgroups are represented in the community (such as boys, girls, older, younger, pregnant teens, marginalized groups, and different religions).

Picking an individual to act as a note-taker during the role plays is essential. This person will also observe the way youth act and behave in the groups and in role plays.

Role Play for "Bad/Poor Quality Service"

Not everyone has to participate. Even if some youth do not want to participate in the role play, they can participate in the analysis and discussion afterward.

Scenario 1: What happens in a health care facility?

Go back to that first sick youth from the ice breaker scenario. Pretend that that individual is taken to the local health care facility. Pick a few more youth to play doctors, nurses, other health care providers or other individuals working at the facility. Ask them to act out how the health care providers might treat the patient. Have the other adolescents watch carefully. This exercise can illustrate a "typical" interaction between an adolescent patient and a health care provider in their community.

FACILITATOR TIP
Keep the youth focused on the purpose of the activity. Maintain the objective of each scenario. Do not let youth get distracted by the acting of their peers.

DISCUSSION:

- **Why did that person go to the clinic or health care facility?**
- **How do you choose when and where to go for health care information and services?**
- **What is your first choice place?**
- **Are there places that you would not go?**
- **Some people prefer to use traditional services? Why?**
- **How realistic is this scenario at your local health care facility?**
- **Would you say this scenario is consistent with the experience of most youth, some youth, or only a few youth?**

Scenario 2: Bad Quality Care

Ask another group of youth to come act out another scene. One person will play the patient. Two or three will play the health care providers. Tell this group privately that they should act out a scene where bad quality care was provided, based on what was identified earlier. Ask the other youth who are not involved to identify what went wrong. What are the problems?

DISCUSSION:

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

Scenario 3: Good Quality Care

Have another group of youth come up and reenact the scene that just occurred. Have the youth participants fix the problems and provide good quality care. Ask the entire group to identify what was done correctly.

DISCUSSION:

- **What kind of care did the client receive? What makes you think that it was good quality or bad quality?**
- **Ask "Is there anything else that made it good service?" Probe for specific information.**
- **Ask whether there were other elements or aspects of quality that were not covered. Probe for specific information.**

Still in groups, now move on to the issue of use and payment: Why do some youth use health services and others do not? What are the biggest barriers of care? Is one of them payment? How do your parents pay for care? Do you feel that you should get access to healthcare even if you cannot pay?

Community Mapping

The purpose of the mapping exercise is to get youth involved in identifying and describing problems with health care services. It is an interactive way for youth to express their concerns. We recommend these steps for conducting the process:

1. Provide flip chart paper and pens and an open space where a map can be prepared.

2. Ask participants in each group to draw a simple map of their community showing all of the places where youth can get reproductive health information and services. This could include community centers, pharmacies, schools, church/mosque, etc. Participants can use different symbols to signify different types of facilities. Allow the group to prepare the map on their own while the facilitator observes the process.

3. After the map is completed, ask participants to list the types of services that are provided at each health facility. This list should be written on the map next to each health facility.

4. Once the map and list of services have been completed, ask the group to answer the following questions:

    - Is it easy or difficult to get health services from each of these facilities?

    - Are there some facilities from which it is easier or more difficult to get health services? Does the answer differ depending on the type of person (young male, pregnant adolescent girl, a person of a particular ethnicity, etc)?

    - What makes it easy to get health services from these facilities? For participants who have received services, what did they like about the health facilities? Remember to capture aspects that make it easy for young people in particular to get health services and what young people like about the health facilities.

5. Based on the discussion, the group should make two lists. Ask the participants to prioritize the items on their lists.

    - All the aspects participants mentioned that make it easy to get health services and what they like about the health facilities, by target population, if appropriate.

    - All the aspects participants mentioned that make it difficult to get reproductive health services and what they dislike about the health facilities, by target population, if appropriate.

As an example, participants can make their lists using the chart below.

☺ (things we like or that make it easy to get services)	☹ (things we don't like or that make it difficult to get services)

After the role plays and community mapping, work with youth to refine their broad concerns into a prioritized list. Having a clearly defined list of concerns will help in the Bridging the gap phase of the PDQ-Y process.

Identifying Youth as Representatives

After generating a list of concerns from the role play and community mapping, have each group select a few individuals as their spokespersons for the Bridging the gap phase. Depending on the number of youth involved, each discussion group should appoint three to five youth. If more youth want to participate in the next phase, this is okay. No one should be excluded from participating in any part of the process.

Let the youth know that you will contact them later about the date and time of the Bridging the gap workshop. This is important in case there are any organizational or logical difficulties.

These representatives should understand that they are being selected to share the concerns of youth and quality health care as defined by their peers. They should have time to practice how to express their concerns in front of adults. They should stand up in front of the entire group and practice their public speaking skills until they feel comfortable. Facilitators may wish to assist the youth in practicing the presentation in front of the group or they may refer the youth to another adult who can work with them. A teacher, parent, or coach may be effective in this role.

Involving Other Stakeholders in the Process

Although the focus of PDQ-Y is on youth and providers, PDQ-Y facilitators also need to do some group discussions with parents, teachers and other stakeholders in the community (separate discussions for each) in order to hear their opinions regarding adolescent reproductive health. This is important because these stakeholders know youth well and can provide insights about youth that might not have been articulated by the youth themselves. They also care deeply about the welfare of youth and need to be given the opportunity to voice their concerns. Finally, the information from stakeholders helps the facilitator for the Bridging the gap workshop so that he/she has the full understanding of the context in which the youth live. Discussion questions for stakeholders should be similar and seek their opinion of whether there is a need for youth friendly health services and if so, why.

A small number of stakeholders will be asked to represent the larger group of stakeholders at the Bridging the gap workshop. Their role at the workshop will be to observe and provide support when called upon by the facilitator to help make sure the youth voice is well articulated and represented.

Categorizing and Summarizing Responses

Althoughe the recorder summarized what the participants were saying or doing (role play), it is necessary to review the information with participants to be certain the summary accurately portrays their perceptions of quality. As was done with in Health Worker Defined Quality, it is important to consolidate and summarize this list. Also if the QI efforts are focused on a particular aspect of health services, now is the time to consider how the identified elements are relevant to the services that are the focus of this QI initiative. Which elements of quality mentioned does the health service provide? Which elements are lacking?

Refer to the Health Worker Defined Quality section on page 30 for suggestions on grouping and summarizing the information obtained into the eight categories on page 33.

In Mozambique at aPDQ-Y workshop, the categorizing process was facilitated by putting each concern on a separate piece of paper. Youth could move around these pieces of paper, arranging them in columns under eight category headings that were posted on a wall. Because low literacy levels were a concern in Mozambique, each issue needed to be described and discussed in detail. Drawings may be used to help others understand the concepts discussed.

In Guatemala, the community was sensitized about family planning through a pictorial diagram of a "cause-effect tree" with the roots representing the causes, the trunk representing the problem and the leaves representing the effects. Each cause and each effect was represented by a picture, which greatly facilitated understanding of the issues in a low literacy community.

THE Y IN PDQ-Y

Youth should understand that they have completed the first step of a process for working as partners with health center staff to identify and address problems and concerns regarding health service quality for youth. This step will help provide a better understanding of the PDQ-Y process beyond this initial youth input.

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

Components:
- Overview of the PDQ-Y
- Next Steps

Overview of PDQ-Y Process 15 minutes

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

Problem-solving exercises and team building activities can demonstrate the importance of working together. Through active participation, youth will be able to see the benefits of cooperation. The activities suggested in the boxes below can be interspersed through the discussion sessions to keep youth focused and prevent them from becoming restless. A number of ice breakers are also suggested but youth themselves may have other ideas.

OTHER GAMES AND ICEBREAKERS

SITTING ON KNEES

Ask everyone to stand in a circle. Then everyone should turn to his or her right so that they are facing the back of someone else. Ask all to put their hands on the shoulder of the person in front of them. Explain that you are going to call out "1,2,3, SIT!" and that everyone should call it out slowly with you. On the word "SIT," everyone should sit down slowly on the lap of the person behind him or her, still holding onto the shoulders of the person in front of them.

This exercise is fun and creates a healthy team feeling. However this should not be done with persons who are not physically able to do the exercise. Also use your judgment as to whether this exercise is appropriate for the group (age, culture, etc) you are working with. If the group is really brave, try having everyone shuffle around the circle together. Have a processing session afterwards to discuss how that felt and how it related to real life experiences.

From p. 63, *Stepping Stones: A Training Package on HIV/AIDS, Communiciation and Relationship Skills*. Alice Welbourn and Glen and Alison Williams, authors. ActionAid, London.

HUMAN KNOT

Have youth stand closely in a circle facing inward. Ideal size is 10-12. Tell the youth to extend one hand and grab the hand of another person who is across from them in the circle. Have them extend the other hand and grab the hand of a different person. Ask youth to untangle their "human knot" by unthreading their bodies without letting go of other people's hands. This may take several minutes. Most groups can fully untangle themselves into a circle again. If they cannot fully untangle themselves, they will at least be able to bring the knot to a simple loop.

This activity helps a group learn about teamwork, communication, problem solving trust and persistence. It involves people standing close together. If this is a constraint for your participants, you can modify the activity to single sex groups.

THE COUNTING GAME

Have youth stand in a circle. Count the number of youth. The goal of the game is to count up to that number, having each person speak once. Only one person can speak at one time. If two people start to utter a number at the same time, start all over again. Keep working at the process until you succeed. This is a good exercise in patience. It helps youth calm down and focus.

Perhaps these could even involve health workers to have youth feel comfortable and at ease with adults

THE STRAIGHT LINE

Provide a blindfold or a scarf. Invite a volunteer to come forward and walk slowly in a straight line across the meeting area. Put a blindfold on him or her and turn him or her around a few times before he or she sets off in a straight line across the meeting area. Instruct the rest of the group to stay completely silent, giving no encouragement or guidance at all. They should also not touch him or her.

When the blindfolded person reaches the other side, ask him/her to take off the blindfold. Compare how close he/she is to where he/she intended to reach. Ask him/her to replace the blindfold and repeat the exercise, this time with the verbal encoragement of others. They should still not touch him or her. Then finally you can ask the volunteer to repeat the exercise with participants using their hands to guide the blindfolded person and talk to him/her. Process the differences in how it felt during each stage. Emphasize how safe someone can feel with the support and guidance from others. This is a great exercise when discussing issues of people living with HIV.

From p. 63, *Stepping Stones: A Training Package on HIV/AIDS, Communiciation and Relationship Skills*. Alice Welbourn and Glen and Alison Williams, authors. ActionAid, London.

LOOK DOWN LOOK UP

This is a fun ice breaker game. Have youth stand in a circle. Tell them to all look down at the ground. And then when the facilitator says, "Look Up," everyone raises their heads and looks another person in the eyes. If you are looking at the same person who is looking at you, both of you yell loudly in surprise and then are out of the game. Then, the facilitator says, "Look Down." And the game starts again. It continues until there are only one or two people left.

I LIKE PEOPLE WHO

Everyone sits in a circle facing inward (you can also do this standing if there are no chairs). There should only be enough chairs for the people who are sitting. The person who is "it" stands in the center. He/She yells "I like people who…(are wearing back shoes, who are wearing glasses, wearing a skirt, who like peanut butter, or whatever the person thinks of). All of those people have to move out of their seats to another seat, including the person who is it. There will always be one person who is "it" again who did not find a seat. That person then stands in the middle again and is "it." Continue the game for several rounds.

INDTRODUCTION: RHYTHM CLAP

Start off a rhythmic clap by clapping your hands, slapping your thighs, snapping your fingers to introduce yourself (your name, where you live, etc) Go around and have each other person introduce themselves in this way.

WHO'S THE LEADER?

Ask the group to stand in a circle. Ask for one volunteer and send that person out of the room. The group should secretly choose a "leader." The leader starts and action such as hand clapping, dancing or stomping feet. The action should change very 15 seconds or so. The other members of the group should follow the leader's movements, without looking at the leaders and giving him or her away. The volunteer is brought back in the room while these actions are taking place. The volunteer has three chances to guess who the "leader" is.

Next Step 15 minutes

The group should understand that this is the first step of a process. Next there will be a workshop (Bridging the gap) with youth of other ages and health center staff to review what was learned from these discussions and to begin to develop ways to work towards addressing identified problems.

Depending on the initial thinking done in the planning and design phase, each group will need to have several representatives who are able to attend this Bridging the gap workshop. Those participants should be nominated now.

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

Other Considerations:
The question of allowance or per diems is likely to become an issue for continuous participation in these meetings. It is preferable to limit this to the extent possible, since payment of allowance will significantly determine how sustainable the PDQ-Y process will be.

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

You can have several facilitators to most effectively conduct this process. One can work as a recorder and the other can guide discussions. In mixed gender groups, it is often beneficial to have a male and female facilitator

In Guatemala, the Ministry of Health provided a meeting room in the district hospital where the youth could meet on Sundays. This contribution came about because the doctor at the hospital attended a PDQ training and became convinced of the importance of this initiative for youth.

PREPARING FOR BRIDGING THE GAP

In this step the facilitators of the group discussions should summarize the diverse list of concerns that was generated during group discussions, role plays, community mapping, etc. For each group discussion, a prioritized list of concerns should be developed. In some countries, this has been done at the end of the group discussion together with the youth or provider participants. In other countries the facilitator and note taker summarize afterwards. There will be some duplication which is fine. Also in this step is the categorization and analysis of the type of concerns raised. This step is important in preparing facilitators in a smaller setting to think about the concerns raised prior to the Bridging the gap workshop.

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

Methods:

- Categorizing information
- Integrating for presentation
- Analyzing the gaps
- Bridging the gap participation

Categorizing Information

By defining possible categories, such as those on pages 33 and 63, the observations can be grouped to better show patterns and key elements and define problems. However, it is important not to summarize too much at this point so you don't lose nuances in meaning. It may be better to use quotes from some participants.

We recommend that you start with the eight catgories we have listed and then adapt them as appropriate. Put the eight category labels on separate sheets of flip chart paper and place on the walls around the room. Using different colored paper to indicate community versus health worker responses, have each "facilitator - recorder" team review and synthesize their own observations and notes. They will copy one quality element on a colored paper and place the information under the most appropriate category heading. If there is an associated quality problem/issue with this element, it can be written below. This way both the quality elements and associated problems can be discussed together. If multiple discussion groups come up with the same observations, this should be noted with a check mark.

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

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

Supplies and Equipment/Medicines: This includes all the materials that are needed in the clinic, e.g. medicines, equipment, soap, furniture, etc. (medicines may be pulled out into a category all its own)

Providers – Technical Competence: This includes the capabilities of the providers, whether they arrive at appropriate diagnoses and treatment regimens, and whether they practice safe medicine. Appropriate sterile technique would be included here.

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

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

Service Availability: This includes types of services available, whether the needed (or wanted) services are available at all, whether services are integrated or provided on different days, whether people have adequate information about the availability of services, hours of operation, etc.

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

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

FACILITATOR TIP

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

Example of a Categorizing Exercise

Each facilitator takes information from his/her list of priority concerns and posts it on the wall under its appropriate heading. One set is done for providers and another is done for youth. Discussion among facilitators arises about which category a concern falls under. It is fine if the concern overlaps two categories. The below examples are from the categorization of community responses. You would also do this with provider responses.

Place / Environment

- The clinic is unsanitary
- There is no queue
- The facility is not open all the time

Supplies and Equipment / Medicines

- The clinic runs out of supplies

Providers – Tech Competence

- There is no one available in emergencies
- Injections are given by untrained staff

Client / Provider Relations

- Health workers are rude when you can't pay
- The costs of different services are not posted

Systems and Procedures

- Nurse does not post the office hours; they also change them frequently
- Prices vary for the same service

Service Availability

- The clinic is only open during hours when we (youth) are in school
- You have to wait a long time to be seen

Communication / Information

- I don't get any information
- Health workers give us all the same white pills

Cultural Compatability / Traditional Beliefs & Practices

- Health workers do not respect "our ways"
- Health workers discriminate because of our ethnic group

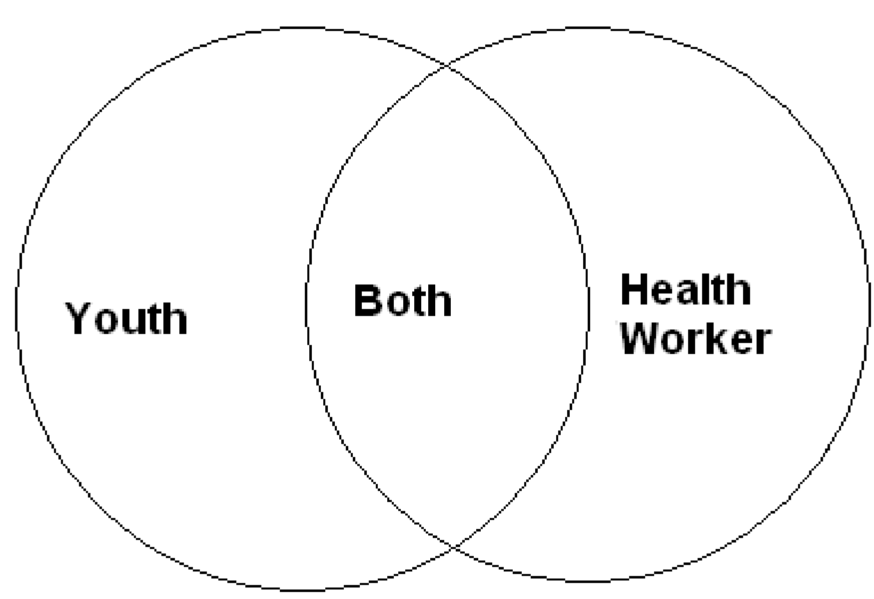
Integrating for Presentation

You now have a series of flip chart "categories" with many concerns or quotes placed under them which come directly from either youth or providers. These categories as well as the original lists of concerns for each discussion group will be presented by a representative from each discussion group at the bridging the gap session. After these are presented, the youth and providers will tell the workshop facilitator where the similarities are in the concerns between the two groups. At this point, a skilled facilitator should be identified to lead the Bridging the gap workshop. The facilitator will guide youth and providers through the workshop and listen well to concerns and possible points of conflict. The facilitator needs to be able to help bring the two groups to consensus on shared priorities and needs in the community.

Analyzing the Gaps

This exercise is only for the facilitators as the final activity they do to prepare themselves for the Bridging the gap workshop. This is an optional activity that some implementors feel is not needed. The purpose is to present the two perspectives on components of quality, and to analyze similarities and differences. This can be done using a Venn Diagram (below).

Draw two interlocking circles, using three sheets of newsprint. The middle page will represent the area of overlap. The area of overlap represents common views of quality between the youth and the health workers. Each non-overlapping section of circle will contain key elements of quality as mentioned by only youth or only health workers and complete the circle

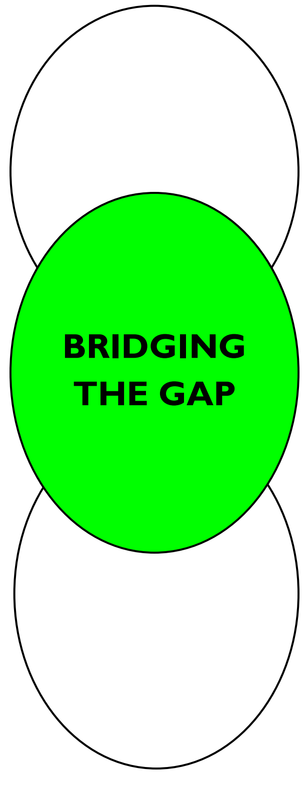


Bridging the Gap Participation

If all discussion group participants will be attending the Bridging the gap session, then you can skip this step. But if participation will be comprised of a few representatives from each discussion group, it would be valuable to make sure that the numbers have not grown beyond what is manageable. The goal is to have appropriate representation from different segments of the health workers and from youth so that QI teams can be developed. Keep in mind that the Bridging the gap workshop should also include some youth supporters such as teachers or parents.

To make sure the voice of youth is heard during the Bridging the gap session, it is great to have the young people who are selected to present the Youth Defined Quality finding to have time to practice. Role play the Bridging the gap session with youth so they know what to expect and who will be present at the session. This will reduce any nervousness they may feel. Discuss with the youth representative the cultural aspects that prevent them from sharing their views with adults. Develop a strategy that will help them overcome these barriers and effectively share the youth findings. Practicing will help build their confidence.

PHASE 3: BRIDGING THE GAP



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

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

Components:

- Team building
- Developing a shared vision
- Defining youth friendly health services
- Problem identification
- Developing an action plan
- Select QI teams
- Keeping youth involved and interested
- Peer Education Training

The goals for these components are:

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

TEAM BUILDING

For all groups, creating a common understanding and common ground is essential to PDQ-Y. The concept of health workers and youth working together can be intimidating for youth and can be threatening to health workers. Team building is a critical step in making youth comfortable and keeping them involved throughout the entire process. It will also accustom health workers to working with younger community members.

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

Methods:

- Introduction exercise
- Tour of the community
- Tour of a health facility
- Paper game

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

The exercises listed here are examples of tools/icebreakers that have been used during PDQ-Y implementation. There are many others that can be used. Or be creative and design one of your own!

Useful References:

PACA: *Participatory Analysis for Community Action*, Peace Corps Information Collection and Exchange. December 1996.
Training for Transformation, A Handbook for Community Workers. Anne Hope & Sally Timmel, Mambo Press.

Introduction Exercise

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

Tour of the Community

This exercise is informed by the common saying: "To understand me you must understand where I come from and how I live."

This exercise can be as simple as having the community present their community map to the group. Or the interaction can involve sharing a meal at the homes of community members or having youth and health workers tour the community together.

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

Tour of a Health Facility

For the health workers, their setting is their health facility. By bringing youth through their facility, they can "introduce" them to their services and the challenges they face. For some youth, this may be the first time they have entered the facility.

Paper Game 30 minutes

1. Divide participants into mixed groups of four or five individuals and give each a piece of cloth or flip chart paper about 3'x3'. Explain that they have a problem for which they need to work to find a solution. They need to get all group members completely onto the sheet of paper/cloth **with no parts of their feet touching the floor. Reiterate that this is the only rule for the game.** They should tell the facilitator when they achieve their goal.

2. When all groups have succeeded, congratulate them. Then instruct them to step off, fold the piece of paper in half and repeat the exercise. Continue in this manner, repeating the exercise by folding the paper in half again each time, until only one group is able to stay inside the bounds of their piece of paper. Facilitators should be fairly strict about judging each group's attempts to complete the task correctly (portions of feet/shoes should not be off the cloth). Congratulate the winning group(s).

3. In large group, discuss what the winning group did, that the others didn't, to allow them to solve the problem.
   - What did they have to do succeed? (be innovative, work together, problem solve, etc)
   - What was easy or hard about this exercise?
   - How does this exercise relate to our work in PDQ? (we need to work in partnership, understand other viewpoints, be flexible, collaborate and share)

Note: You could also do this with the rule being that no part of their WHOLE BODY could be off the paper. However, if you do it the way described above, with the rule that no part of their FEET can go off the paper, you will sometimes see innovations such as the whole group sitting on the ground with only their feet on the paper (that is still following the rules!!)

Adapted from the Peace Corps Life Skills Manual, US Govt Printing Office, 2000.

ⓘ

In Uganda, the PDQ the Bridging the gap session provided a forum for a discussion of mutual perspectives on quality. Following the event, health workers remained suspicious of the process and feared that it was developed to assign blame. Considerable time was spent reviewing the process and its objectives in the following weeks. In PDQ-Y, early and thorough sensitization of both youth and health workers to the process is essential prior to initiating the approach.

DEVELOPING A SHARED VISION

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

Preparation:

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

Methods:

- How the youth defined quality
- How the health workers defined quality
- Developing a shared vision

How the Youth Defined Quality

After the youth presentation, time should be allowed for discussion.

How Health Care Workers Defined Quality

Suggested discussion topics after the presentations:

Does anyone want to add to what has been presented here?

What is similar between the two views? What is different?

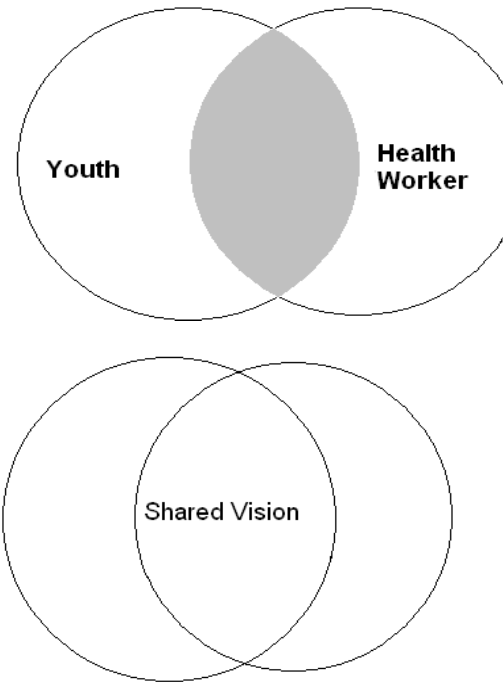
WHAT ARE THE COMMONALITIES?

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

DISCUSSION

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

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



Because the PDQ-Y process involves working with youth, it is important to have them participate equally with adults in the shared vision exercise. Although they are not directly participating, parents and teachers should attend the Bridging the gap session. Their role is to encourage and support youth as they articulate their vision and their concerns in the presence of the providers.

Example of Another Type of Categorizing Exercise

Write Shared Vision Here

Common Problems to Address

Provider Issues / Concerns		Youth Issues / Concerns
ISSUE	Write a Common Issue Here	ISSUE
ISSUE	Common Issue	ISSUE
ISSUE		ISSUE

Have everyone stand in front of the room near the wall. Ask people to look for similarities in issues and concerns among providers and youth (these are quotes directly from providers and youth in this community). Ask individuals to place similar boxes and papers next to each other in the middle column. Together, come up with a way to state the joint issue. Some groups choose to write the common vision rather than the agreed upon concern. The categorizing exercise previously done by facilitators may help the group think of common areas of concern.

DEFINING YOUTH FRIENDLY HEALTH SERVICES

Now that youth and health providers have already explored their views of how they define quality health services, it might be useful for the group to collectively define Youth Friendly Health Services. This might also help identify problems for improvement in the next section. Defining the characteristics of Youth Friendly Health Services together can also serve as a monitoring checklist for the Quality Improvement team.

Preparation: Review the key characteristics for Youth Friendly Health Services.

Methods: Brainstorm a list of characteristics that make up Youth Friendly Health Services. Have the participants group the characteristics by themes. Provide guidance and input from list above.

Discussion: Using PDQ-Y can help make health services more youth friendly, so more youth will access and use key health services to improve their reproductive health. Does the list of characteristics seem feasible for your health centers? What would be a more realistic list of characteristics that could be improved? Do any of these characteristics differ from the perceptions of quality explored by youth and health workers?

Useful Resource:

The African Youth Alliance website, see section on Youth Friendly Health Services: http://www.ayaonline.org

A Rapid Assessment of Youth Friendly Reproductive Health Services, Paththfinder 2003: www.pathfind.org

CHARACTERISTICS OF YOUTH FRIENDLY HEALTH SERVICES

Provider Characteristics

- Specially trained staff
- Respect for young people
- Privacy and confidentiality honored
- Adequate time for client and provider interaction
- Peer counselors available

Health Facility Characteristics

- Separate space and special times set aside for youth
- Convenient hours when you can access services
- Convenient location
- Adequate space and sufficient privacy
- Comfortable surroundings

Program Design Chaactereists

- Youth involvement in design and continuing feedback
- Drop-in clents welcomed and/or appointments arranged rapidly
- No overcrowding and short waiting times
- Affordable fees
- Publicity and recruitment that informs and reassures youth
- Boys and young men welcomed
- Wide range of services available
- Necessary referrals available

Other Possible Characteristics

- Educational materials available
- Group discussion available
- Delay of pelvic examination and blood tests
- Alternative ways to access information, counseling, and services

Pathfinder (2003): A Rapid Assessment of Youth Friendly Reproductive Health Services

PROBLEM IDENTIFICATION

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

Purpose:

1. Provide an overview of problems or gaps identified through the exploratory discussions
2. To validate the problems
3. Prioritize those that need attention

Methods:

- Introduction
- Review Problems

This exercise may be as simple as asking representatives of some groups to explain what they mean by their responses.

Introduction

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

Key points:

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

Review of Problems

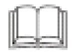
Divide into small working groups. If more than one health service area is participating, then you could divide by geographic division with health workers and youth from each village or area served working together. An alternative is to divide into groups by category or type of problem.

Within each group, review identified quality elements and any associated problems through exploratory dialogue with youth and health workers.

DISCUSSION

1. **Do the problems identified exist in our facilities?**
2. **Do some problems need to be restated?**
3. **Are these the main problems?**
4. **Do you want to add anything?**
5. **How do the HW and youth descriptions of a given problem overlap?**
6. **How are they different?**
7. **Are there any patterns that we can see in the types of problems that each group has identified?**

Regroup and present any changes from the subgroup's discussion

 **Useful Resources:**

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

Once the common areas of concern have been identified, action plans or at least provisional action plans can be developed. This process can be aided by posting or distributing a list of standards for youth friendly health services (see page 76).

DEVELOPING AN ACTION PLAN

Working in smaller, mixed groups is the best way to develop concrete and detailed plans. Each small group can develop action plans for one to three issues.

First, have the groups develop a "fishbone diagram," (see page 90) which is a visual display created to help identify the factors that lead to a concern or problem identified by youth and providers. The fishbone diagram helps youth and providers to outline possible factors, solutions and actions to be taken. Then, circulate the plans among the groups so that groups may critique each others' plans. This can be done in groups or as a "Gallery Walk" exercise, where plans are displayed around the room. Groups circulate around the room to briefly review and add to each plan already developed by other groups.

SELECTING QI TEAMS

After forming an action plan or provisional action plan, QI teams can be created. This is the last activity that takes place during the Bridging the gap workshop. Who will be on the team and where and when they will meet should be discussed among the participants. The original design can be changed to meet participants' needs.

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

The best way to select members for the QI team(s) is by recommending and voting for individuals based on respect in the community, knowledge, experience and sometimes on influence in the community. There needs to be at least 30% participation of minority and marginalized groups for those groups to have a voice.

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

ROLES AND RESPONSABILITIES OF THE QI TEAMS

During this process, the norms of the PDQ-Y process should be emphasized once again. One of the primary responsibilities of the QI teams is to identify local norms and definitions of quality of care. Evaluating whether quality care is being provided to youth is the main role of the QI team. In some countries, the PDQ-Y facilitators guide and supervise the QI team meetings.

Responsibilities of the QI team may include:

- Serving as a liaison between youth and providers
- Attending weekly or bi-monthly meetings
- Implementing the action plan once it is finalized.
- Other duties decided by the group

KEEPING YOUTH INVOLVED AND INTERESTED

Within the QI teams, youth participation must be maintained. It is critical that youth do not drop out of the process, but instead continue to express their ideas and concerns. Facilitators must check in with youth members even after the completion of the PDQ-Y process.

In order to make the PDQ-Y process succeed, youth involvement must be expanded. The youth involved in the QI teams are only a few individuals within the entire youth population. These individuals must act as liaisons to the entire youth community, empowering individuals. Youth on the QI teams must be trained in facilitation and communication skills so that they are able to go to schools, youth clubs, and other such organization and reach out to more youth. They must be able to organize and facilitate activities that mobilize the larger youth population.

A common pitfall in the sustainability of youth involvement in the QI teams is related to the times when the QI teams meet. Experience has shown that QI teams that truly value the youth participation and quality improvement for youth friendly health services will find times when both youth and the health care workers can meet. Compromises often have to be made as working hours for the health care workers are not always convenient for youth participants, especially if they are still in school or engaged in work.

PHASE 4: WORKING IN PARTNERSHIP

The groups have agreed on a common vision of quality and challenges they face. Now the creativity and ingenuity of the QI teams is needed to determine causes, solutions, and action plans. This requires a creative team working together in cooperation and respect. In this step, tools are provided for problem analysis and action planning as well as to strengthen group process necessary for QI teams to continue the cycle of change. Some of this problem analysis may initially take place during the Bridging the gap workshop but those results will be reconsidered by the QI teams in this cyclical process.

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

Purpose:

- To establish youth-adult partnerships among QI team members.
- To provide tools necessary for QI teams to implement a continuous quality improvement process.
- To establish a process for ongoing review of progress including a mechanism to determine when problems are resolved and to identify new challenges to address.
- To maintain a positive, honest, and open atmosphere between youth and adults on the QI team.

Components:

- Establishing youth-adult partnerships
- The QI Action Cycle
- Tools for Program Analysis
- Tools for Self Management
- Team Effectiveness Evaluation
- Facilitation Exercises
- Mobilizing Resources
- Representation

ESTABLISHING YOUTH-ADULT PARTNERSHIPS

In order for a QI team comprised of youth and adults to unction well, and in recognition of the fact that youth and adults rarely work together on shared tasks, it is important to establish a working partnership from the outset that can enhance the expectations and success of the QI team.

A series of activities can help youth and adults gain trust and open communication and establish expected levels of youth participation and roles throughout the life of the QI team's quality improvement process. The following activities can be done in their entirety or tailored for the group. The goal is to get the group to know each other better, break down communication barriers, and develop trust and a relationship based on collaboration.

A healthy youth-adult partnership is one that:

1. Integrates youth's realistic perspectives and skills with professional adults' experiences and wisdom
2. Offers each party the opportunity to make suggestions and decisions
3. Recognizes and values the contributions of each
4. Allows youth and adults to work in full partnership envisioning, developing, implementing, and evaluating programs

From the Youth Participation Guide, Youth –Adult Partnership Training Curriculum, YouthNet

Activities that can help build youth-adult partnerships between the QI team members:

Activity 1: QIT Resource Wall (15-20 minutes)

Objective: To acknowledge experience and skills each participant brings to the group

Materials:

- Flip chart paper entitle: "What I bring to the QI team"
- Large-size notecards or stick-on notes and pens for each participant

Instructions:
Distribute the note cards or stick-on notes. Ask the participants to write their names and what skills. talents, experiences they bring to the QI team on the notes. Remind the group that young people might not have work experience but do have talents and skills that will contribute to the functioning of the QI team. Ask them to stick their notes to the flip chart paper on the wall. Give everyone time and the opportunity to read the wall chart. Reconfirm that everyone has a voice and something to contribute to the QI team and that appreciating each other's skills, talents, and experiences will help the group work together for improved quality health services for young people.

Adapted from Youth Participation Guide: Youth – Adult Partnership Training Curriculum, YouthNet

Activity 2: Youth-Adult Fishbowl

Objective: Give young people a voice to share their concerns and hopes for working with adults and have these views heard by adults

Instructions: Ask youth to sit in a circle in the middle of the room; arrange the adults in a larger circle around the youth. Lead a discussion with the youth in the middle of the room based on the questions below, asking the adults to listen but not interrupt with comments or questions.

Discussion questions:

- What would you like adults to know about youth?
- When have you worked in partnership with adults in the past?
- What are you most hopeful about as being a member of the QI team?
- What are some of your concerns about working on the QI team?
- What ground rules would help youth and adults work well together?
- How can the QI team ensure youth participation?
- What could adults do to make this a positive experience for you?

When the youth are finished with the discussion have the youth and adults switch places so the adults are in the inside of the circle and youth are in the outside of the circle. Invite the adults to participate in the same type of discussion, guiding them through the same questions:

- What would you like youth to know about adults?
- When have you worked in partnership with youth in the past?
- What are you most hopeful about as being a member of the QI team?
- What are some of your concerns about working on the QI team?
- What ground rules would help youth and adults work well together?
- How can the QI team ensure youth participation?
- What could youth do to make this a positive experience for you?

When the adults are finished, ask the group to form one big circle. Take time to process how everyone feels about the comments that emerged form the activity by asking:

"What new insights have you gained from listening to youth and adults talk about their experiences?"

Based on the discussions, document the key tips for youth and adults to work together.

Adapted from Youth Participation Guide, Youth – Adult Partnership Training Curriculum, YouthNet

Activity 3: Perspectives

Objective: A brief exercise to show that everyone's opinion should be respected and valued

Instructions:

1. On one piece of flip chart paper, write a very large "W" that is rounded on the bottom points.
2. Ask for 4 volunteers, and ask each volunteer to stand facing one of the four sides of the paper. Have the entire group stand around to see as well.
3. Ask each volunteer to describe what they see from their persepective. It could look like a 3 from one side, like an "M" from another side, perhaps an M from one side or an "E" from another side. Perhaps one person says he/she sees something completely different.
4. Ask the larger group which volunteer is correct? The answer is that all or correct, because they are providing the reality from their perspective.
5. Ask the larger group why we did this exercise? (to share and be open to the diversity of perpectives from one person to another). We all have our individual viewpoints, just like the story of the blind men who all touched an elephant, each coming away with a completely different description of what they experienced (one who touched the tail said it was a rope, another who touched the ear said it was leather, one who touched the skin said it was sandpaper, but they were all valid viewpoints). This exercise is important when building collaboration in a team.

THE QI ACTION CYCLE

It is important for the quality improvement teams to review all they have achieved to this point and to understand how this fits into the quality improvement cycle. By discussing this as a continuous process of problem identification, proposal of solutions, implementation and assessment, the teams can see their permanent role in the QI process. Please note that there is no fixed end date for QI teams.

Method:
Review a diagram of the action cycle.

Preparation:

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

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

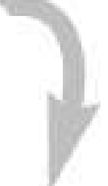
Use the following questions as guide to facilitate discussion:
Where are we in this cycle?
What is next?
Can this process be used for new problems?

PHASE 4: WORKING IN PARTNERSHIP

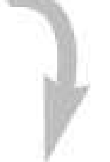
QI Action Cycle Diagram

Exploring and identify quality issues
(What are people's perceptions of the problems, what are priorities, etc.?)

You are here

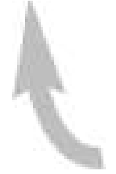


Analyzing the Issues
(What are the underlying causes of the problems?)



Determining Solutions

Developing an Action Plan
(How do we improve quality?)



Monitoring and Evaluation
(Were the actions completed?)
(Did the quality changes occur?)
(Are users more satisfied with services?)

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

TOOLS FOR PROBLEM ANALYSIS

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

Purpose: To identify the root causes of problems

Methods:

- Fishbone analysis
- Tree analysis

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

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

Key Points:

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

FACILITATOR TIP

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

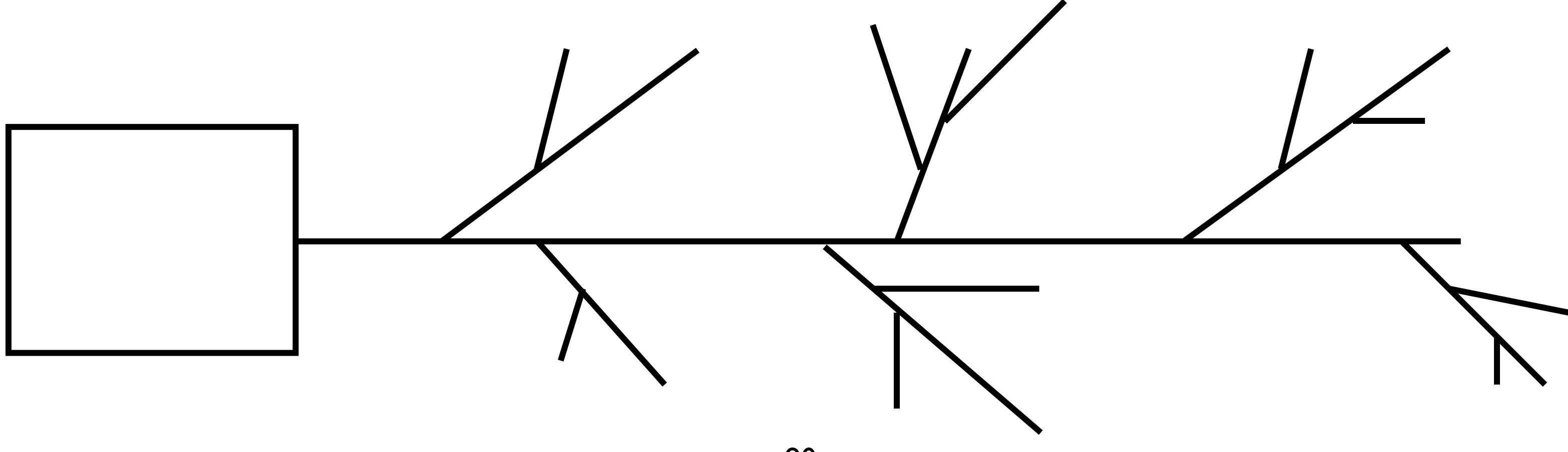
Fishbone Analysis

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

FACILITATOR TIP

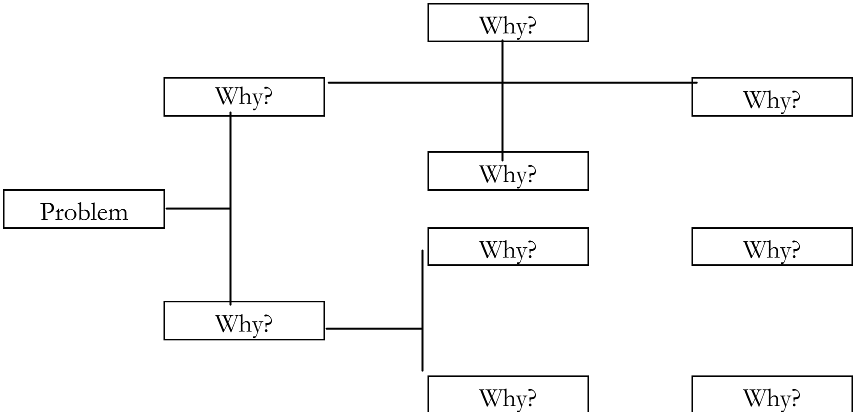
There is no right way or right answers to the problem identification process. If you have too many bones or it has become too complicated, your problem may be too broad. You may want to break it down into more specific problems and analyze each separately.

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



Tree Diagram

This diagram reaches out with each, "But Why?"



Example of Flow

Problem: Infection prevention procedures are not being followed

Why? Because we lack kerosene for sterilization.

But why? Because there was no money budgeted to buy kerosene

What are other reasons for the problem? Because unqualified persons are administering the injections.

But why? A qualified health worker is not always available.

But why? Because they are supplementing their salaries with private consultations.

SOLUTIONS AND STRATEGIES

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

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

Key Points:

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

Methods:

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

Develop Solutions Based on Identified Causes

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

FACILITATOR'S TIP

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

Develop an Action Plan

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

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

Problem	Contributing Factors	Solutions (for each factor)	Action	Who is responsible	Resources/ Materials Needed	When	Status
1.		A.______ B.________	1. 2. 3.				
2.							
3.							

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

Sample Action Plan:
Save the Children Armenia NOVA Project (National PDQ Project)

Goal: Improvement of health care services of Fantan Community

Problem	Influencing factors	Solution	Actions	Responsible person	Implementation deadline
I. Insufficient health care services provided by health post	1. Bad condition of building Absence of water, heating and sewage system	1 Provision of normal building conditions Provision of water and sewage system	1 Estimate calculation. Organization of works, provision of materials. Building of water and sewage system. Internal renovation.	1. Village mayor – Yeghiazaryan Gagik NOVA Hovsepyan Paytsar	1. Up to March 24
II. Inaccessibility of health care services	2. Lack of furniture	2. Provision of furniture	2. Procurement of furniture	2. Community, Charentsavan policlinic, NOVA	2. During the project implementation
	3. Lack of medical supplies	3. Provision of medical supplies	3. Provision of medical supplies	3. NOVA	3. During the project implementation
	4. Absence of regular doctor visits from supervisory health facility	4. Organize regular doctor visits once a month	4. Inform the community, make announcements about the doctors' visits, and organize the visits	4. Nurse, Charentsavan policlinic	4. From March 25
	5. Lack of essential drugs at the health post	5. Provide essential drugs	5. Provide essential drugs	5. Charentsavan policlinic	5. From March 25

III. Lack of health knowledge and information	1. Absence of regular visits of doctors from supervisory health facility 2. Absence of health talks/seminars 3. Lack of literature and information sources	1. Organize regular visits of doctors once a month 2. Organize health talks/seminars 3. Provision of literature	1. Inform the community, make announcements about the doctors' visits, and organize the visits 2. Choose topics for talks, inform community people 3. Obtain literature, establish health library, put a box of anonymous questions, provide consultancy	1. Charentsavan policlinic 2. Charentsavan policlinic Nurse 3. NOVA, Community Charentsavan policlinic	1. After provision of building conditions 2. During project implementation 3. During project implementation
IV. Lack of knowledge and skills of nurses in reproductive health sphere	Lack of seminars in reproductive health	Provide knowledge in reproductive health	Involve nurses in the training courses in reproductive health	NOVA	During project implementation

REVIEWING PROGRESS

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

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

Key Points:

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

Methods:

- Tracking progress
- Create a tracking table
- Evaluation tools

The indicators identified in this section can be included in an "additional" indicators column in the action plan or in a separate indicators document.

TRACKING PROGRESS

It is important to know whether the problem was not resolved because the solution was not right or because the action was never implemented or completed.

That is what the "status" column was designed for in the action matrix. During QI team meetings, the status of the actions can be reviewed.

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

CREATING A TRACKING TABLE

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

TRACKING TABLE FOR QI TEAM

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

SAMPLE TRACKING TABLE FOR QI TEAM

PROBLEM	WHAT SHOULD BE? (Quality standard)	PROOF OF CHANGE? (Indicators)	HOW WILL YOU MEASURE?	HOW GOOD IS GOOD ENOUGH? (Benchmark)
Clients lack necessary information	• All clients receive complete and understandable information about care • All clients receive information about how to take medicine • All clients receive information on how to prevent problem in future	Client can explain care Client can explain use of medicines Client can explain preventive actions to take	Possible methods: Exit interview by QI team member or Health Post Coordinator or In-Charge	More than half of clients interviewed indicate they received information about their diagnosis XX% of clients could explain how to take their medicine correctly XX% of clients knew of prevention strategies
Clients feel there is discrimination	All clients treated equally	No jumping of queue unless urgent care needed Clients feel they are treated with respect	Client Voting Jar – After receiving care, client places a stone or bean in the jar with a happy face or a sad face corresponding with good or bad performance	No jumping of the queue observed No reports of unfair treatment to the QI team or Health Post Staff

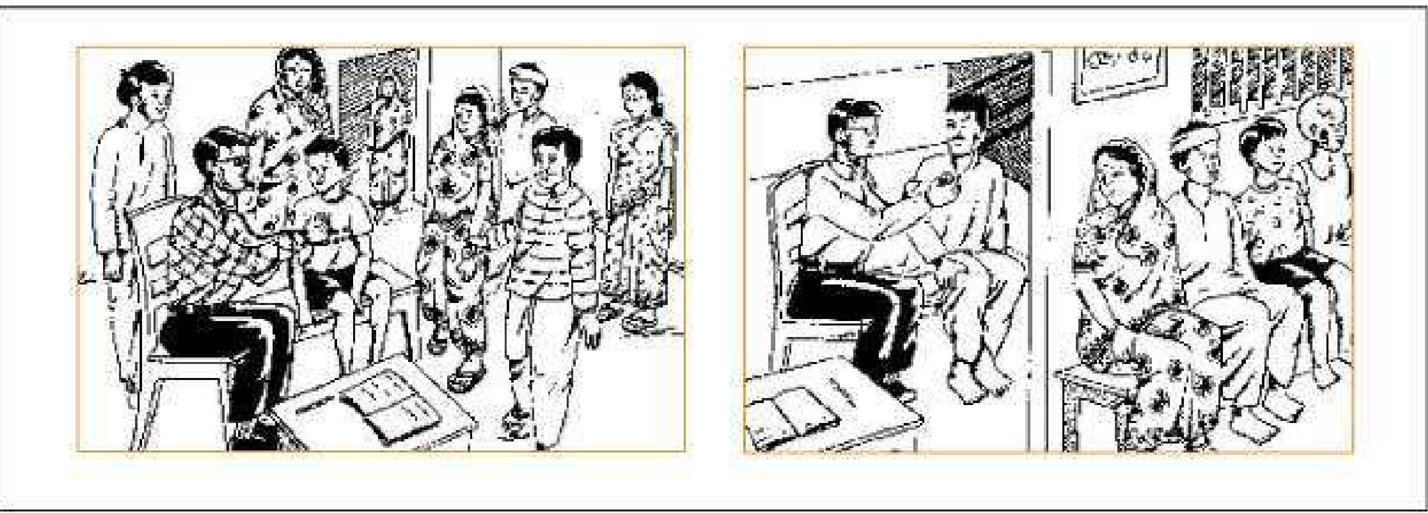
EVALUATION TOOLS

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

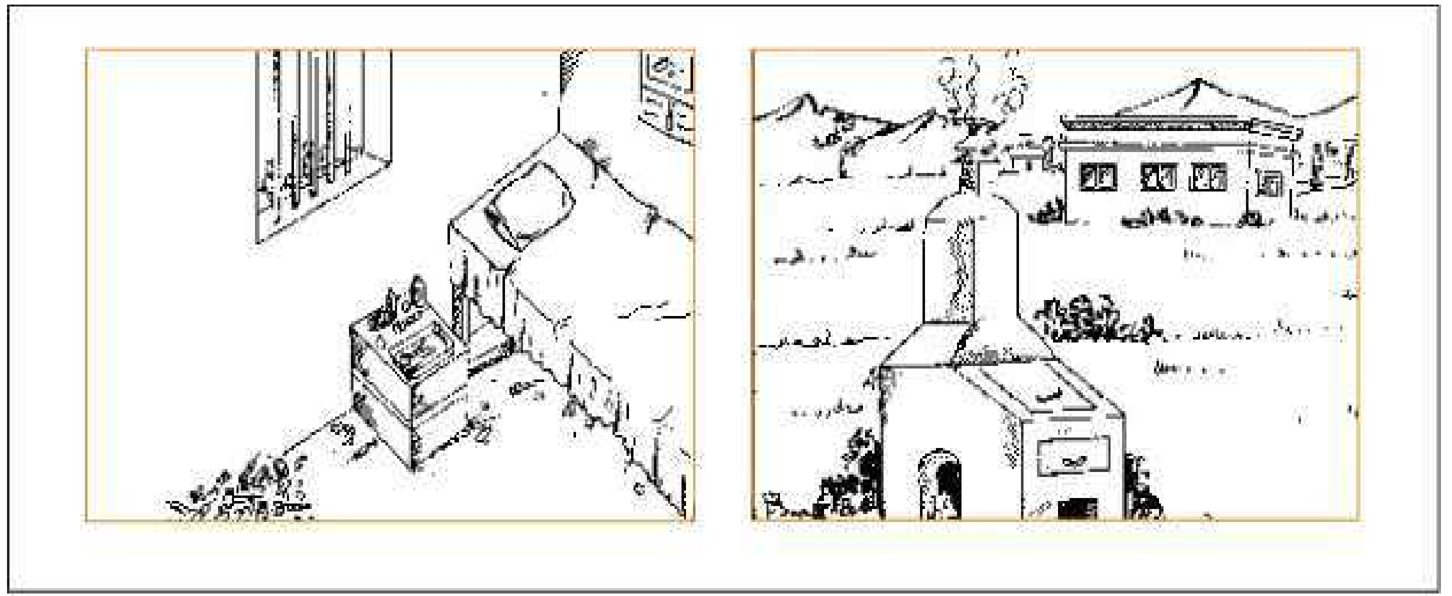
1. Happy Face / Sad Face Jar
2. Suggestion Jar that is placed in a health center or youth centers
3. Simple exit interviews – asking clients open-ended questions about the quality of service
4. Simple observation checklist which QI team members or health workers can administer
5. Health worker self-assessment
6. Client evaluation form

PICTORIAL EVALUATION TOOL

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



Maintenance of Queue



Proper Disposal of Medical Waste

Just as quality improvement is a learning process, so is working together as a team. Sustaining a cohesive and productive QI team requires skills in group process, team building, and facilitation. The goal is to have a group of diverse volunteers working together as a team with the skills to set agendas, run meetings, problem solve, and develop and implement action plans. As with quality definition and improvement, the group together can determine what is needed to strengthen the group process. The exercises are designed to help the group become more independent and successful.

Components:

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

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

Useful References:

Training for Transformation, A Handbook for Community Workers. Anne Hope & Wally Timmel, Mambo Press (Chapter 6 – Leadership and Participation).

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

UNDERSTANDING HOW LEADERSHIP CAN WORK IN OUR TEAM

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

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

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

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

Formal and Informal Leaders

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

Roles of Leaders

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

FACILITATOR TIPS

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

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

ROTATING LEADER/CHAIRMAN FOR QI TEAM

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

In Myanmar, while staff were concerned about involving providers, they had not thought about the challenges of involving out-of -school youth in an environment of educated adults. Some of the participants' ideas for facilitating their involvement included:

- **Use of the in-school and medical student participants to reach out to out-of-school youth as peers, giving in-school youth the role of facilitating the successful participation of out-of-school youth.**
- **Develop unique roles and responsibilities for the QIT for out-of-school youth. This will facilitate their sense of importance.**
- **Provide additional training for youth in organizational and communication skills.**

In Uganda, four QITs were formed in two sub-counties. Power sharing between the health center staff and the community was promoted through the sharing of QIT leadership positions, such as the chairperson and vice-chairperson positions. Gender equality among team members was promoted through representation of women and men. QI team members acknowledged the added benefit and importance of working in partnership to achieve QI goals.

FACILITATION EXERCISES

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

Purpose:

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

Methods:

- Facilitation Role Plays
- Managing Participation
- Defining the Facilitator's Roles

Facilitation Role Play (I) 35 minutes

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

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

Discussion Questions:

- What functions did the facilitator serve?
- What did he or she do that really helped the group discuss in an open and participatory way?
- Where did the facilitator have difficulties? Why?
- Were there things he/she could have done in order to overcome these difficulties?
- What other situations could be encountered that the facilitator would have to deal with?
- What do you think are the best ways to deal with those situations?
- Does the rest of the team agree with that approach?
- How is facilitating different from managing or leading?
- Why do we want to understand other people's realities and perceptions?
- What are some of the things a facilitator needs to do?

Facilitation Role Play (II) 45 minutes

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

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

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

Discussion Questions:

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

TEAM EFFECTIVENESS EVALUATION

Establishing and maintaining an effective QI team can often be the largest challenge faced by communities for ongoing quality improvement. It is important that the QI teams assess their own process and interactions from a quality improvement perspective. The team can apply their skills in problem solving to resolve issues identified during feedback.

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

Pictorial Team Effectiveness Evaluation Tool

Active Participation Monitoring and Follow-Up Mutual Cooperation

Team Effectiveness Questionnaire

How involved do you feel with what this team is doing?

0	1	2	3	4	5
Not at all					Very involved

Do all members contribute to the decision-making?

0	1	2	3	4	5
No, only a few			Some	Most	All contribute to decision-making

How often do members participate in making decisions?

0	1	2	3	4	5
Never		Sometimes			Always

How fully do we use the resources and creativity of our members for accomplishing our goals?

0	1	2	3	4	5
Not at all					Fully

Are you satisfied with the progress the team is making?

0	1	2	3	4	5
Not at all					Very satisfied

Are all members treated with respect for their ideas and opinions?

0	1	2	3	4	5
No	Most are not		Most are		All are

Questionnaire adapted from Training for Transformation, Volume 2

MOBILIZING RESOURCES

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

Purpose:

- To help identify resources
- To mobilize identified resources

Methods:

- Mapping resources
- Selling the QI process

Mapping Resources Exercise 45-60 minutes

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

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

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

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

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

When completed, ask the group to discuss:

Discussion Questions:

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

Selling the QI Process 60 minutes

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

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

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

Discussion Questions:

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

REPRESENTATION

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

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

Key Points:
The privilege to represent people comes with responsibilities:

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

Methods:
- Group Discussion
- Plan for Next Steps

Group discussion to answer the following questions:

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

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

EVALUATING THE PROCESS AND OUTCOMES

DETERMINING THE BASELINE

The usual purpose of PDQ-Y is to increase youth utilization of health services and to improve the quality of health services for young people. It also aims to involve and mobilize youth in making health facilities more youth friendly. In this way, the PDQ-Y approach provides a forum where youth can put forward their expectations, work hand-in-hand with providers in improving quality and by far, develop a sense of ownership and rights to quality health care.

To ensure that these goals guide the process, the existing conditions at health facilities must be assessed. A baseline evaluation of the quality of services being provided and the number of clients utilizing the services must be conducted. In order to do so, client registers must be obtained from health centers in order to find out how many youth are using the facilities. If these are not available immediately, an adult community member must be trained as a register-keeper. Ultimately, figures from attendance registers will help determine whether the PDQ-Y process is working to improve quality and increase use within the community. A different approach is to conduct mystery client exercises to determine changes in provider performance.

MONITORING THE PROCESS

The second component of the monitoring and evaluation process occurs throughout the process. The entire PDQ-Y process needs to be monitored at all stages. For example, facilitators should keep track of which individuals attend the various stages of the process. Youth interns could assist in this process. Creativity can be used to engage youth in monitoring quality improvements.

Monitoring and evaluation must occur throughout the PDQ-Y process. It is discussed in the Working in Partnership section, starting on page 82.

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In Ethiopia, youth members of the QI team conducted exit interviews with youth clients every quarter to assess young peoples' satisfaction with the services being offered to youth. The results of these interviews were presented at the QI team meetings and were used as a way to monitor the quality of youth friendly services. This methodology worked well since youth clients felt more comfortable talking to peers honestly about their experiences.

TOOLS FOR MEASURING QUALITY IMPROVEMENT

While the quality improvement effort is underway, it is important to monitor the process itself as discussed in the Working in Partnership chapter. In addition, changes in quality need to be measured through indicators established at the beginning of the project. There are many ways and tools that that can be used to measure the impact of the quality improvement efforts. In particular, you may want to look at:

Client satisfaction monitoring tools, such as exit surveys or printed anonymous questionnaires, may result in greater honesty in the responses compared to asking clients the questions just outside the clinic door.

Standard measures of the quality and availability of health services tools and techniques such as health facility assessments, checklists and protocols can be administered to check progress and highlight areas in need of attention. These tools are developed locally or are government issued standards. References for health facility and service assessment tools, which can be locally adapted, can be found on page 75.

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

Improved equity in health service delivery can be measured if intake records or other facility or community level data specifically track utilization by disenfranchised or low-income groups. The PDQ process may help reach these groups that are consistently under-represented among users of health services, and build their interest and trust in the health care providers and the services they deliver.

Whatever combination of approaches to evaluation and documentation of the effectiveness of the PDQ effort that is chosen, it is important to regularly review the goals that the team set at the beginning of the process and to ensure the involvement of the youth in the evaluation process.

HOW DO WE MEASURE SUCCESS IN PDQ-Y?

M & E STRATEGIES

What do we want to measure?

- Utilization rates
- Demand
- Capacity
- Provider performance
- Provider satisfaction
- Youth participation
- Client satisfaction

Indicators and Tools Used in PDQ-Y Operations Research

VARIABLES	MEASUREMENT TOOL USED	FREQUENCY OF MONITORING & WHO WERE RESPONSIBLE
Quality of Care a. Provider Performance b. Youth-defined Quality c. Client/youth Satisfaction	• Supervisory Observation checklist tool • Group Discussions (using a guide) • Exit Interview tool –e.g. the Pictorial Quality checklist	• Conducted every three months for each Health Center by QIT member and PDQ-Y facilitator • Conducted at baseline and endline by QIT members and PDQ-Y facilitator
Utilization of health services	Utilization Data from Health Information System (HIS) data	Monthly collection of service utilization data from the HPs/Sub-HPs by QIT leader from the health worker side and PDQ coordinator
Community–initiated changes and level of effort of the QIT	• CDQ/QI Monitoring Tool • QIT Self-Assessment Tool (Optional) • Process log	Bi-monthly filling-up of the self-assessment tool by the QIT leader.

Supervisory Observation Checklist

Based on the improvement action points determined in the QI teams action plan, a checklist can be developed and used quarterly to see if there is any progress on the quality standards. Here is an example:

Quality Improvement Issue	Comment/Action Step
1. Full-time presence of health worker in Health Post	
2. Proper disposal of waste/trash	
3. Use of incinerator for waste disposal	
4. Trained health worker providing injection	
5. Trained health worker providing dressing	
6. Sterilization of syringes before use	
7. Observation of queue during consultations (except in emergencies)	
8. Respectful behavior of health worker towards clients	
9. Health worker asked and listened to client's problems	
10. Health worker gave opportunity to client to ask questions & to solve client's problems	
11. Health worker provided clear information to clients	

Exit Interview Tool

To encourage youth participation in the monitoring of youth friendly health services and to inform the youth members of the QI team about the QI process. Youth QI team members can conduct exit interviews once per quarter before QI team meetings. Here is an example of an exit interview:

Question	Response
1. Service provider who saw the client	
2. Reason for visit	
3. "Do you feel that you got what you came for?"	
4. "How did you find the behavior of your health provider?""	
5. "Were you taken according to turn?"	
6. "Did the HW give you the opportunity to explain your problem clearly?"	
7. "What advice or treatment was given to you by the health worker?"	
8. "Can you explain what you are supposed to do when you go home (next steps)?"	
9. "Do you feel you fully trust the HW regarding the care you received?"	
10. "If you had a choice, would you return for service here or go somewhere else?"	

How often to measure?

- Do we have the staff to monitor programs?
- Do we continue measuring after the funding ends?

PDQ Evaluation Framework

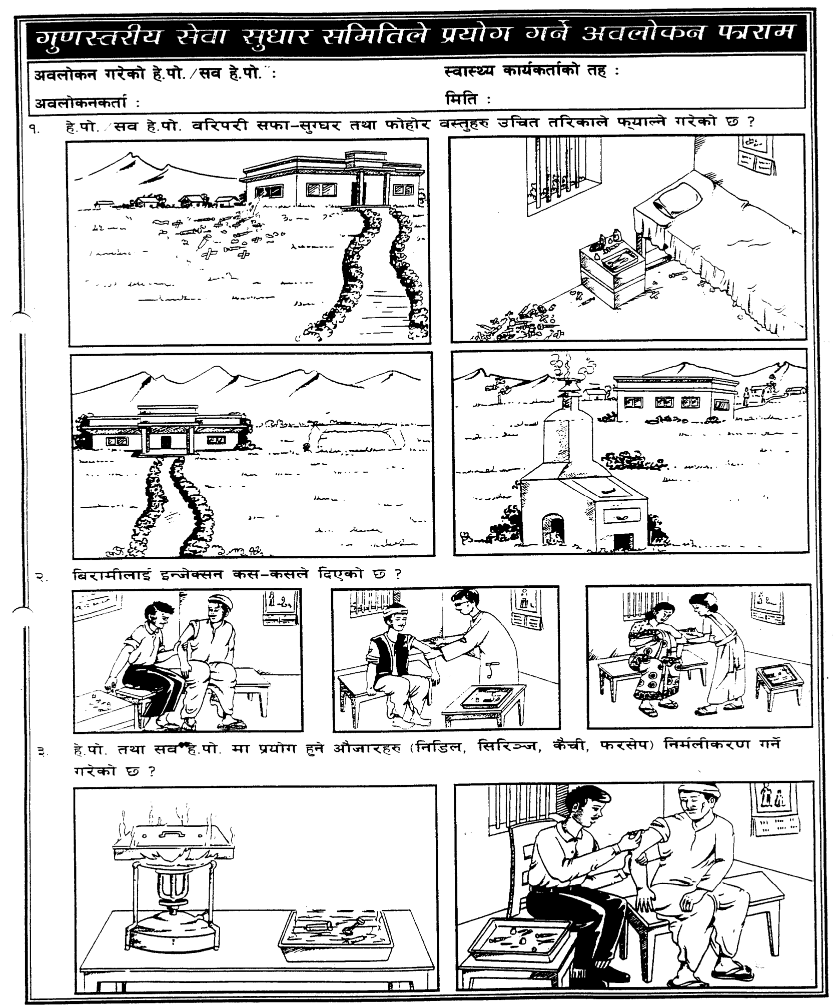
CATEGORIES	**Meets Established Quality Standards**	**Meets Client Standards (As Articulated by Community Members)**	**Changes in Service Utilization Patterns**	**Changes in Community Accountability and Involvement/Empowerment for Health**
EVIDENCE	• Consistent supplies • Technical competence (standards followed) • Managerial competence • Infrastructure improved	• Client satisfaction • QI plans implemented	• CPR • Discontinuation rate • New users • Appropriate levels of EOC sought • Coverage of TT, PNC, EPI	• Awareness/advocacy re: the right to quality • Increased feedback from health service users • Increased civic participation • Continued community participation in PDQ-Y process • Improved health status (difficult to measure)
SOURCE OF DATA	Using situation analysis, COPE, supervisor checklist/observation supply reviews	Monitoring system established by program with youth input	Existing clinic and outreach records	• Specialized studies • Process evaluation

CPR =Contraceptive Prevalence Rate; EOC=Emergency Obstetric Care; EPI = Program on Immunization; PNC = prenatal care; TT = Tetanus Toxoid

- Established quality standards met
  - Health facility assessment
  - Exit interview
- Client standards met (as articulated and monitored by youth and providers)
  - Group discussions
  - Pictorial monitoring tool
- Utilization patterns changed, coverage improved
  - Monthly collection data
- Community capacity increased
  - Observe QI meetings and discussion with community
  - Self-assessment tool
- Analysis of actions taken and results
  - Process documentation from QIT meeting minutes and diaries

PDQ Pictorial Monitoring Tools Developed

Examples from Nepal: Low literate exit interview tools



गुणस्तरीय सेवा सुधार समितिले प्रयोग गर्ने अवलोकन पत्राम

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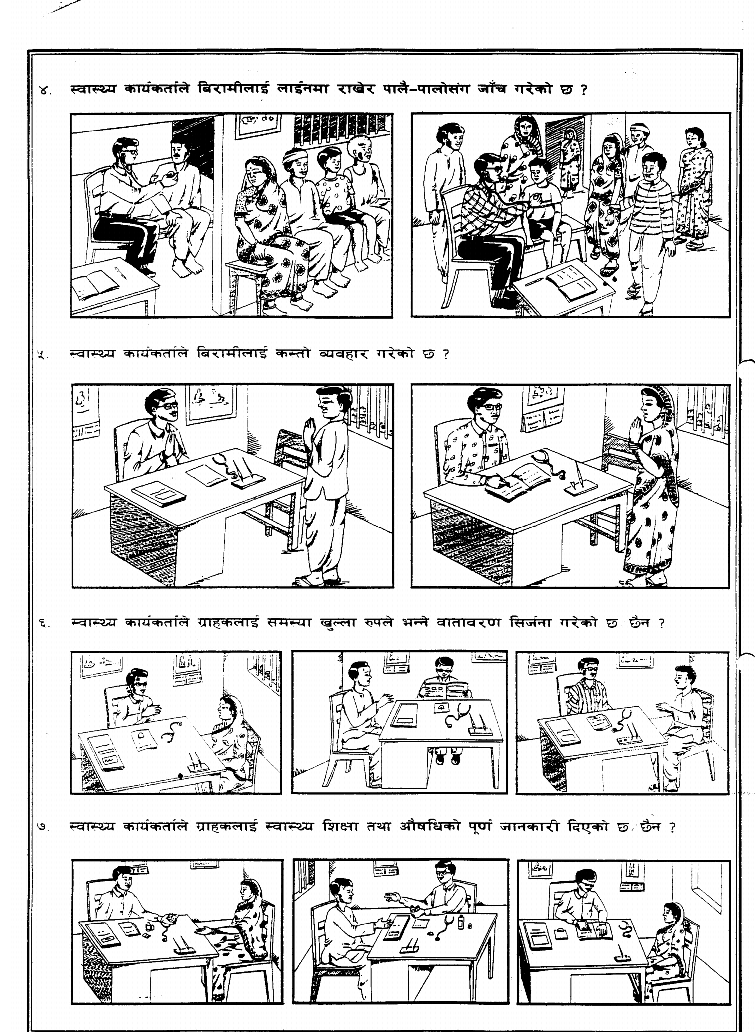
अवलोकनकर्ता :

मिति :

१. हे.पो. /सव हे.पो. वरिपरी सफा–सुग्घर तथा फोहोर वस्तुहरु उचित तरिकाले फ्याल्ने गरेको छ ?

२. बिरामीलाई इन्जेक्सन कस–कसले दिएको छ ?

३. हे.पो. तथा सव हे.पो. मा प्रयोग हुने औजारहरु (निडिल, सिरिन्ज, कैची, फरसेप) निर्मलीकरण गर्ने गरेको छ ?



४. स्वास्थ्य कार्यकर्ताले बिरामीलाई लाइनमा राखेर पालै–पालोसंग जाँच गरेको छ ?

५. स्वास्थ्य कार्यकर्ताले बिरामीलाई कस्तो व्यवहार गरेको छ ?

६. स्वास्थ्य कार्यकर्ताले ग्राहकलाई समस्या खुल्ला रुपले भन्ने वातावरण सिर्जना गरेको छ /छैन ?

७. स्वास्थ्य कार्यकर्ताले ग्राहकलाई स्वास्थ्य शिक्षा तथा औषधिको पूर्ण जानकारी दिएको छ /छैन ?

PDQ Operations Research in Nepal: Significant Results

Please note that these results were from a PDQ study, not a PDQ –Y study. We anticipate this level of results from operations research using the PDQ-Y approach.

- Utilization of the health facilities
- Increase in number of sick children brought in for treatment
- Increase in FP utilization
- Increase in visits by children seeking specific care for Pneumonia or Diarrheal Disease
- Increase in service utilization for lower caste children

Quality of Health Services

- Improvements in the presence/attendance of HWs
- Increase in appropriate infection prevention (disposal of biohazard waste and sterilization of syringes)
- Improvements in the quality of procedures done in the clinic (injections and wound dressings by HWs)

Health Worker Behavior

- Improvements on health worker's politeness to clients and HW's provision of clear information to clients

TAKING PDQ-Y TO SCALE

What Does Going to Scale Mean?

There are many definitions of scale. The Health Communications Partnership (HCP), in a study on empowerment, defined scale as "*The amplification of an existing program in additional geographical sites or the application of a successful model in a new context or realm of activity.*" [(1)]

For PDQ as well as for PDQ-Y, this means starting small, building capacity of local staff and seeing small successes. Then slowly, the project is replicated in more and more communities. In reality, however, the situation is not as simple and there are numerous obstacles that do not permit replication or expansion. Often projects are not scaled up for a variety of reasons, including:

- Projects are often not really pilots or even demonstrations, rather they replace missing services
- Few pilot projects are designed with scale-up in mind
- Few projects are managed so as to maximize likelihood of successful scale-up
- Few projects have funding for scale-up (resources including staff time)

So What Does It Take to Go to Scale?

Based on a study of empowerment projects, HCP developed a list of 14 strategies for scaling- up [(1)] *:*

1. Have a vision for scale
2. Choose pilot sites carefully
3. Aim for high impact
4. Develop solid relationships
5. Involve partners from other sectors
6. Work with and foster the emergence and growth of a dynamic community
7. Strengthen systems and organizational capacity
8. Promote horizontal networking
9. Test the approach
10. Consolidate, define and refine
11. Document with guides and tools
12. Continuously monitor and evaluate
13. Recognize achievement and publicize program results
14. Diversify the funding and encourage community ownership

(1)From "Taking Community Empowerment to Scale: Lessons Learned from three successful Experiences," HCP 2006

For PDQ-Y, it is important to utilize the existing networks of youth as well as the individuals and institutions that support those youth. Do fact finding to make sure you have learned about the history in the community of NGO efforts, government programs and businesses which have worked with youth. Find out also what the results of those projects were on community dynamics and youth empowerment and utilization of services.

How Can We Ensure That the Scale-Up Process is Sustainable?

There is no hard or fast science to scaling-up and each situation must be taken in the context of the local environment.

In Uganda, the PDQ process deliberately sought to include youth. Although youth participation was strong during the Bridging the gap forum, participation slowly fell away mostly due to youth not having a voice during "adult meetings." However, with youth focused QI teams, PDQ has the potential to establish or augment youth friendly services in the district.

Ideas for building sustainability through PDQ-Y: (add to this list for your own community)

- Build capacity of health providers, community leaders and local governors to jointly assess needs, explore solutions and leverage resources
- Increasd consumer demand for quality health services
- Increase health service provider job satisfaction
- Raise sense of ownership and community activism
- Community education about importance of ongoing attention towards women, child and youth health issues
- Build capacity of NGO partners that will continue to help communities with acute needs

In Mozambique, the PDQ process has proved to be adaptable to adverse conditions. This includes being able to recruit new team members when others disappear and shift focus to groups that are receptive to the ideas and potential rewards of implementing PDQ.

Several broad and emerging questions that you might want to discuss regarding scaling up include:

- How can projects be supported to measure changes in community empowerment along with changes in health outcomes?
- When to start "big" and when to start "small"?
- How can three-way partnerships among communities, officials, and outside advisors best function in the context of competition for funding?
- How can organizations help preserve the values conveyed in their original program (equal participation, self determination) while at the same time give up control so their model is adapted during the scale up process?
- How to strike a balance between external support/funding and the fostering of the community self-reliance when a program goes to scale?

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In Armenia, through the NOVA project, SC is taking PDQ to scale nationally. The purpose of PDQ in NOVA is to improve the health facilities at the community level. Starting small, NOVA staff worked in a few pilot communities for the first year, mobilizing communities and health center personnel through PDQ. The following year they phased in additional communities. Once the health centers themselves were physically improved and the initial action plan goals were completed, the community was empowered to build a kindergarten for their community. Also, some QITs from the first year's communities motivated the newer community through visits to share their experiences and successes.

Mission and Strategy

Save the Children is the leading independent organization creating real and lasting change for children in need in the United States and around the world. It is a member of the International Save the Children Alliance, comprising 28 national Save the Children organizations working in more than 110 countries to ensure the well-being of children.

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