Toolkit Two

Communities Defining the Issues, Exploring Strengths, and Setting Priorities

Breakthrough ACTION South Sudan

TOGETHER FOR EACH OTHER

USAID
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Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

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ACRONYMS

CAC	Community Action Cycle
CAG	Community Action Group
FGD	Focus Group Discussion
GVH	Group Village Head (man/woman)
HCC	Health Centre Committee
HSA	Health Surveillance Assistant
IDI	Individual In-Depth Interview
MNCH	Maternal, Neonatal and Child Health
NGO	Non-Governmental Organisation
PLHIV	People Living with HIV
WASH	Water, Sanitation and Hygiene

ABOUT THIS TOOLKIT

1. Introduction

Active engagement of communities and their leaders, and health service providers in a process of identifying quality issues and defining quality can contribute to sustained change in behavioural and social norms. This will also help to strengthen the capacity of communities and HSP to carry out activities in a *participatory* and *sustained* basis to improve their health and other needs on their own initiative in future to promote and sustain social and behaviour change. Community leaders, religious leaders, and other influencers in the community – play a critical role in regulating normative behaviours at both the household and community level.

The **Communities Defining the Issue, Exploring Strengths and Setting Priorities** phase aims to identify critical behaviours and social factors that contribute to ill health and act as barriers to effective access and utilization of family planning and reproductive health services by different segments of the populations, some of whom are socially marginalized.

Quality health services are not "one size fits all." Instead, perceptions of and expectations for quality comes from peoples' own understanding and personal experience. During this phase CAG's 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 facilitate open and free discussions it is recommended to explore health worker and community members' perspectives separately. Both perspectives must be thoroughly explored, to understand where potential barriers to the provision of quality care
and use of services exist. This will be important to:

- Gain a better understanding of the community and health worker perspectives on the quality of care
- Identify potential problems as well as strengths in the delivery of existing services.
- Establish concepts of client and health worker rights and responsibilities.

2. Guide to facilitator

This document provides guide to the facilitation of a series of meetings with communities and HSP to identify quality issues and to define quality together, which are elements of the Partnership Defined Quality. The issues identified here will be address in the community action plans.

Preparations for the exploration meetings

1. CMTs and project staff to meet a week before the first meeting to prepare meeting agenda, select venue for the meeting, review and translate exploration tools in local language, arrange for materials and supplies needed, and share responsibilities.

2. Call for the meeting one week in advance. Ensure that all members are informed including influential people e.g., local leader for the area, religious leaders, health worker for the area, etc. Remember to have a manageable group of people.
3. Verify this with the CAG chair three or two days before the day
4. Copy the program in local language and important information e.g., meeting agenda on the flip chart.
5. Prepare interactive ice breakers and energizers.
6. Arrive at the venue on time
7. Before the meeting, arrange the tables and benches in U-form so that all participants interact.
8. Please observe all COVID-19 safety guidelines.
9. The meeting schedule should be flexible and can be organized to meet participants' schedules. Meetings can be held either in the morning or in the afternoon. It is critical that participants are engaged in group discussions.

Materials and supplies for the meeting may include:

- Tables, benches, or mats
- Blackboard or flipcharts and flipchart paper
- Chalk or Markers
- Writing materials for CAGs
- Snacks and drinks if possible
- Others as relevant

PARTICIPATORY EXPLORATION OF UNDERLYING SOCIAL NORMS AND BEHAVIORS THAT CAUSE OR CONTRIBUTE TO HEALTH PROBLEMS WITH COMMUNITIES

The following information should provide guidance on how to facilitate community explorations; however, it should not restrict your creativity and relevant adaptation.

OBJECTIVES:

The main objective of the participatory exploration phase is to facilitate the identification of the main issues to quality and defining quality for family planning and reproductive health issues, and quality of care issues, their root causes and set priorities on how to address these problems with communities.

Specifically, we want the community, and community health workers to:

- Identify and define quality issues to care for family planning and reproductive health and **issues to quality care**, and contributing factors in their community and in health facilities
- Identify the behavioral and social norms that fuel the identified family planning and reproductive health issues in respective communities
- Bridge the issues within the community and within health facilities to explore community strengths and set priorities together, to be addressed with Community Action Plans during the 'Communities Develop Local Solutions' phase of the CAC

EXPLORATION PROCESS:

The process of the explore phase takes three to four days and is broken into four meetings:

1. **Meeting 1**: CMT and CAG **plan** the exploratory phase. They will discuss how to conduct and facilitate FGD with community members and with FGD with HSP, define the number of groups will have on the community and their composition; and 1 FGD with HSP and their composition. They will discuss how to use the tools to explore quality
2. **Meeting 2:** CMT and CAGs will use FGD and participatory tools to **explore quality** with Community Members, and with Health Service Providers.
3. **Meeting 3:** CMT and CAGs will meet to analyse the information from the **exploring quality** discussions with communities and with HSP, and prepare to bridge the gap with both groups together
4. **Meeting 4:** CMT and CAG's will hold joint meeting with Community members and with HSP together to **bridge the gap**, including root cause analysis and prioritization of issues to address in the next phase.

Reminder: CMTs should facilitate the whole process

MEETING 1: CMT AND CAG PLAN THE EXPLORATORY FGD WITH COMMUNITIES, AND WITH HEALTH SERVICE PROVIDERS.

Objective:

By the end of the session, the participants will have planned out the exploration phase with communities and health service providers.

Duration: 120 minutes
Method: Discussion
Participants: CAG, CMT members – however invite 1 or 2 KEY community leaders and health facility staff, not all staff, so that they can participate in the broader discussions in the next sessions.
Materials: Masking tape, markers, flipcharts

Preparation:

- Ensure CAG and CMT members are invited and available for the meeting several days in advance
- Be clear about the venue and time for the meeting

Activities:

Step 1: Ensure all participants introduce themselves and their roles, if they are new to the group.

Step 2: Discuss as a group, the communities with which you will have the exploratory meetings, and which health facilities will be included.

Step 3: Discuss how to conduct and facilitate FGD with community members and FGD with HSP.

- Talk about the number of groups within the community and their composition.
- Discuss that there will be 1 FGD per HSP and their composition.

Step 4: Review the tools they will use to explore quality.

Step 5: Discuss how to facilitate the discussion when they bridge the gap, since this session may become heated; good facilitation will be necessary to ensure a

productive and constructive discussion with it becoming emotional and to ensure that the two sides do not feel like the other side is attacking them.

MEETING 2: EXPLORING QUALITY WITH COMMUNITIES AND WITH HSP

Objective:

By the end of the session, community members, and HSP will have listed the main family planning and reproductive health issues and their contributing factors.

Duration: 3 - 4 hours
Participants: CAG, CMT members, HSP group, broader community groups
Method: Role Play, reflection, group discussions
Material: Flipchart, marker, copies of technical standards for health

Preparation:

schedule meetings with communities, and with HSP

Tools for Health Service Provider Defined Quality

EXERCISE 1: Why WE Became Health Workers

EXERCISE: WHY WE BECAME HEALTH WORKERS 45 minutes

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

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

Methods:
Reflection

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

Reflection

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

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

DISCUSSION:

- Group members should share some of their personal reflections
- Note the similarity in reasons for becoming health workers.
- 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?

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.

EXERCISE 2: Health Worker Perspectives on Quality

EXERCISE: HEALTH WORKERS 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. This exercise provides healthcare 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 healthcare.

Preparation:

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

Methods:

- Written list
- Role play
- Categorizing and summarizing responses

Written List Suggested time: 15 minutes

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

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

Role Play Suggested time: 15 minutes

As an alternative to the written list exercise, the participants can act out a scenario when they received good quality care or provided good quality care. They can do the same with poor quality care. 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.

Categorizing & Summarizing Responses

Suggested time: 30 minutes

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

These lists will be used during the exercises that follow.

EXERCISE 3: Review of Technical Standards

REVIEW OF TECHNICAL STANDARDS 60 minutes

While the PDQ process is a participatory approach that uses health worker and community perspectives when considering issues on quality, there is also the consideration of technical quality. There are certain basic practices that must be in place for safety and rational 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 groups exploration of technical standards
- Large group discussion
- Identifying current documented standards

SOURCES OF THIS INFORMATION COULD INCLUDE:

- **Standards and guidelines**
- **Treatment protocols**
- **Facility check lists**
- **Guidelines of Nursing and Midwifery Association**
- **Job descriptions**

Small Groups Exploration Of Technical Standards – 30 minutes

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

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

Large Group Discussion – 15 to 30 minutes

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

Identifying Current Documented Standards 15 minutes

This step provides the health workers 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?

EXERCISE 4: Problem Identification for Quality

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 process, this step will help the health workers to understand the process and it's potential benefits. This step should highlight areas of both achievement of standards or elements of quality as well as areas that are lacking.

Purpose: To begin to identify challenges and gaps in service quality from the 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 what 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 check list 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. A choice of several more detailed problem definition exercises such as fishbone analysis are suggested in the "Working in Partnership" section. Remind the group that deeper exploration of the causes of the problems will happen in the next step of the PDQ process as well.

FACILITATION TIPS

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

EXERCISE 5: Discussion – Rights and Responsibilities for Quality

DISCUSSION: RIGHTS AND RESPONSIBILITIES FOR QUALITY 45 Minutes

Health workers have differing views on what the rights and expectations of their clients and their community should be. Depending on the socialization during basic training as 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.

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). Please take notes. After discussing all the questions, choose two or three significant points concerning what rights you feel your patients should have regarding their health care, what rights you as health workers have, and how client views and ideas might contribute to improving health care. These will be shared the large group at the end of this exercise.

Note to facilitators:

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

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

QUESTIONS TO BE DISCUSSED:

1. What rights do we as health workers 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 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 do we take community beliefs and practices into consideration when we provide services to people?

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

6. What responsibilities do clients have in obtaining better health?

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

Large Group Discussion:

What conclusions do we want to make about:

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

EXERCISE 6: What Do We Want to Gain From This Process

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

By understanding PDQ and exploring how the process can be beneficial to them and the community, health workers are likely 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 the community in order to do a better job and what the community can learn from them.

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

Methods:

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

Overview Of The PDQ Process

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

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

What Do We Want To Learn From The Community?

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

What Can We Gain From This Process?

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

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

WHAT IS PDQ?

The group 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 the health services. This step will help provide a better understanding of the PDQ process beyond this initial community input.

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

Components:

- Overview of PDQ
- Next Step

Overview Of PDQ 15 minutes

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

FACILITATORS TIP

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

Next Step 15 minutes

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

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

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

Other Considerations:

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

Tools for Community Defined Quality

EXERCISE 1: Ice Breaker and Introduction

ICE BREAKER AND INTRODUCTION 10 minutes

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

Discussion Guide:

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

Suggested Rules:

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

WHEN YOU ARE THE CUSTOMER 20-30 minutes

Often participants do not feel they have a lot of choice about the quality of services they receive, but they do make choices for quality in material goods. Linking quality to purchasing decisions helps community members see their role in health 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 other situations where they are setting standards for and demanding quality. To help participants realize that they do exercise a right to quality in the market place.

Methods:

Market place discussion

Market Place Discussion

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

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

Review what has been said. Can anyone add anything?

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

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

EXERCISE 2: Community's Perception of Quality Health Care

COMMUNITY'S PERCEPTION OF QUALITY HEALTH CARE 60 minutes

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

Purpose:

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

Method:

- Facilitated Group Discussion on Quality Health Services or Role Play

Facilitated Group Discussion On Quality Health Services

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

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

- Like the market, do you feel like you make choices about your health care?
- What are the most important factors in deciding if and where to go for health services?
- Where is your first choice of places to get health services? Why?
- Are there places you will not go for health services? Why?
- How would you describe good services?
- How would you describe poor services?
- Some people prefer to use traditional health services. What are the reasons?

- Do you pay for those services?
- Do you feel you receive good quality from those practitioners?
- What prevents people from getting services at the formal system?
- Do they have to pay for those services?
- Do you feel you have a right to good quality health services whether you pay or not?

Potential areas to discuss during discussion groups or role plays

- Providers – private versus public, traditional versus nontraditional
- Cultural sensitivity and compatibility
- Technical aspects
- Equipment, supplies

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

FACILITATOR TIP

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

Guide For Role Plays

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

Role Play for "Bad/Poor Quality Service"

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

How can you illustrate this? How can you show this?

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

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

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

DISCUSSION:

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

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

Role Play for "Good Quality Service"

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

DISCUSSION:

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

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

ORGANIZING & SUMMARIZING

Because the recorder had to summarize what the participants were saying or doing (role play), it is necessary to review the information with the participants to be certain it accurately portrays their perceptions of quality. As was done with in 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. What elements of quality mentioned does the health service provide, what elements are lacking?

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

EXERCISE 3: What Is PDQ?

WHAT IS PDQ?

The group 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 the health services. This step will help provide a better understanding of the PDQ process beyond this initial community input.

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

Components:

- Overview of PDQ
- Next Step

Overview Of PDQ 15 minutes

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

FACILITATORS TIP

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

Next Step 15 minutes

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

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

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

Other Considerations:

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

MEETING 3: PREPARE TO BRIDGE THE GAP

Objective:

By the end of the session, the CMT and CAG will have reviewed the discussions from the meetings with HSP and communities to identify the issues for each, and to prepare for the Bridging the GAP meeting.

Duration: 3 - 4 hours
Participants: CAG, CMT members, HSP group, broader community groups
Method: Role Play, Reflection, Group discussions
Materials: Flipchart, marker, copies of technical standards for health

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

Methods:

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

Categorizing Information

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

Put the group determined 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, it should be noted with a check mark.

PREPARATION FOR BRIDGING THE GAP

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

Place/Environment: This covers the physical setting as well as the location for health services 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 by or taken into consideration by the formal medical services.

Group Activity: Categorizing and Summarizing Responses (60 min)

Step 1: Form into two groups.

Step 2: Review the case study below. One group will work on synthesizing the Community Issues, while the second group will work on synthesizing the HSP issues.

Step 3: As a group, defining possible categories. Group observations to better show patterns and key elements and define problems. See list of some possible categories, below.

Step 4: It is important that this grouping and labelling not cause the details provided regarding each issue be lost.

Step 5: Place each category the group identified on separate sheet of flip chart paper and place on the walls around the room. Use different coloured paper to indicate community versus health worker responses.

Step 6: Each team reviews and synthesize their own observations and notes. They will copy one quality element on a coloured paper and place the information under the most appropriate category heading.

Step 7: If there is an associated quality problem/issue with this element it can be written below. This way both the quality elements and associated problems can be discussed together.

If multiple discussion groups come up with the same observations, it should be noted with a check mark.

Step 8: Each group will write a synthesis of the information that they would present to a group at the beginning of a real Bridging the Gap session with communities. The groups have 20 minutes to write down how they will synthesize the information and 10 min to present.

Step 9: After the groups have completed synthesis of the issues, ask one group to present their synthesized list. Ask them to explain why they made the choices they made.

Step 10: Ask the other group if they have difference in the way they categorized and or placed a quality problem in a different category. If yes, ask them to explain and share their synthesis.

Step 11: Ask the group in plenary the questions.

Quality Perceptions Case Study

Community defining quality exercises conducted with the following groups separately:

1. Married women
2. Mothers-in-law
3. Husbands
4. Marginalized women
5. Marginalized men

Community Issues Identified:

- Health Workers discriminate by caste
- Health Workers are rude when you can't pay
- They don't take us in order –we have to wait a long time
- Injections are sometimes given by untrained staff
- The facility is not open on time
- You come and nobody is there except the cleaner
- No one available during emergencies
- I could not get anyone to help during the night when my wife was in labor
- There is no queue
- They were rude when I brought my child there yelling at me for waiting so long
- The prices vary for the same service
- They charge me more for the same medicine they gave my neighbor
- There is no drinking water available
- The providers give the same white tablets for all problems
- Health Workers sell the medicine allocated to our health post at their private clinics
- I can't wait all day for the health worker to show up, I have to work
- You have to wait a long time
- Some of the staff is rude
- Long wait for service
- Don't post office hours and change them all the time
- Health workers have the medicine but don't give it out because the sell it to private patients
- Health workers don't come to the facility on time
- They do not respect "our" ways
- Health personnel do not explain clearly about use of drugs and treatment
- They don't really examine me they just give me the same medicine for everything
- I don't get any information
- The health worker never looks at me
- I have to travel a long way to reach the health post
- My husband has to come with me when I go because he doesn't trust the health workers

Health defined quality exercises carried out with:

6. Nurses from the HP
7. Support staff including cleaners is this an appropriate term?
8. Management staff including Health Post In-charge
9. Community Health Volunteers

HSP Issues Identified:

- May not receive salary for several months
- I (cleaner) sometimes am the only one available and they demand I help them
- The roof leaks into our supply during heavy rains
- No supervision
- Don't have proper sterilization equipment
- We do not get equipment that the MOH promised us
- People can be rude
- People want me to be available in the middle of the night – I cannot work for free
- Inadequate supply of drugs
- People want free medicines
- People don't follow instructions so they don't get better
- People come too late for treatment, they wait until they are very sick
- Don't have needed equipment
- Inadequate kerosene supplies for sterilization
- People go to the traditional healers first and don't trust what we tell them
- People are ignorant and they don't understand what we tell them
- I was just sent to this health post last month – this is not where I want to work
- Many clients are not literate so it is useless writing instructions
- They don't listen to me but they will do what the local healer tells them
- The health post needs repair but we do not have any money to fix it
- I need training
- We received money from a donor for medicines but they are all gone now
- People have to travel a long way to get to the health post
- We don't have any emergency transportation services
- We need more space for examinations
- We do the best with the little equipment we have
- People don't trust us- they think we sell the medicine

Possible Categories

- **Place/Environment**: This covers the physical setting as well as the location for health

services e.g., privacy, 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 capabilities of providers; whether they arrive at appropriate diagnoses and treatment regimens, 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 accepting and/or taking into consideration people's traditional beliefs and practices by the formal medical services.

Discussion Questions:

1. How did your group / summarize / synthesize the information that was given to you? List all the answers in a flip chart. Did anyone do any of the following:
    a. Combine similar issues together to come up with just one issue?
    b. Create general headings and/or categories and put similar issues that are grouped together under these headings and/or categories?

2. Did anyone encounter any difficulties? Or did anyone find it difficult to do this activity? If yes, why?

3. After reviewing other decisions that will be required for the Bridging the gap meeting, do you think you are now well prepared to proceed and conduct this next session on Bridging the gap? If no, what else do you think you need?

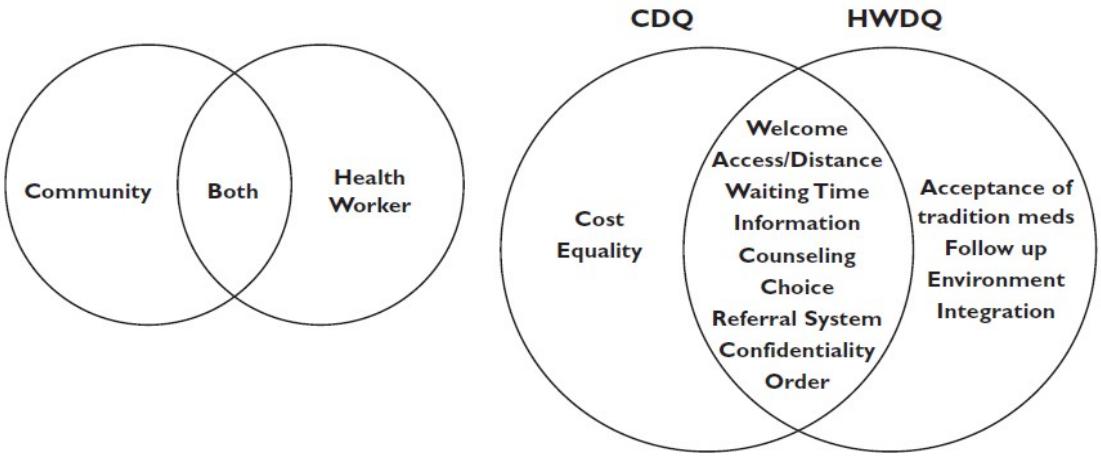
Venn Diagram, Confirm Findings, Bridge the Gap Participation

Analyze The Gaps

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

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

Example From Haiti



Confirm Findings

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

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

ⓘ

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

Bridging The Gap Participation

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

MEETING 4: BRIDGE THE GAP

Objective:

By the end of the session, the CMT and CAG will have facilitated a discussion jointly with HSP and communities to review the issues identified in the exploring quality meetings.

Duration: 3 - 4 hours
Participants: CAG, CMT members, HSP group, broader community groups
Method: Role play, reflection, group discussions
Materials: Flipchart, marker, copies of technical standards for health

Preparation:

Schedule meetings with communities, and with HSP.

DEVELOPING A SHARED VISION

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

Preparation:

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

Methods:

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

How The Community Defined Quality

After the community presentation time should be allowed for discussion.

How Health Workers Defined Quality

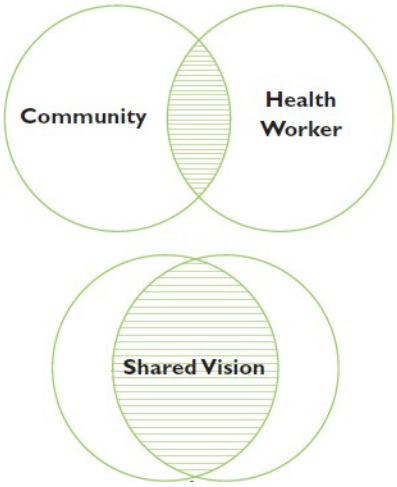
Suggested discussion topics after the presentations:
Does anyone want to add to what has been presented here?
What is similar between the two views?
What is different?

EXERCISE 1: DEVELOP A SHARED VISION

Developing A Shared Vision For Quality

This may take sometime 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.

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



DISCUSSION

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

EXERCISE 2: PROBLEM IDENTIFICATION

PROBLEM IDENTIFICATION

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

Purpose:

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

Methods:

- Introduction
- Review problems

Introduction

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

Key points:

- We all share the same goals – better quality care / better health
- 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 community representatives 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 community members 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 community descriptions of a given problem overlap?
6) How are they different?
7) Are there any trends that we can see in the types of problems that each group has identified?

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

EXERCISE 3: PRIORITIZING ISSUES

What is it:

The Priority Ranking Matrix, (also known as a Decision-Making Matrix), is a tool that is used to help communities prioritize family planning and reproductive health issues to be addressed through Community Action Plans in the following phase. The matrix allows you to focus discussions when there are several options to consider. Criteria for choosing priority issues are identified. For each criterion, the issue is given a score. Thus, for this tool it is necessary:

- To clearly explain each criteria
- To explain how to calculate the score for each problem
- Explain the totals column
- Give example from a different field and then continue with the group work

How to do it:

Step 1: Inform participants that it is time now to identify their top 6 health problems (priorities) they will be working on. Ask them to identify the top 6 priorities.

Step 2: If they don't reach a consensus after 5 minutes, ask the participants to come up with 3 or 4 criteria, which according to them, signifies that an issue or a problem is important. (Magnitude of the issue; resolution of issues that allows one to solve other problems, local vulnerability of an issue etc.)

Step 3: After coming up with a consensual criterion, tell them that to ease the work, they are going to work on small group of 5-8 people using the matrix for decision making.

Step 4: Show how to use the decision-making matrix to prioritize between several issues, make sure that everybody has understood the matrix utilization and ask the working groups to go back and identify 3-5 family planning/reproductive health issues to prioritize in their community.

Step 5: After the end of the allotted time, call the working groups for the plenary. After the report of each group, propose a summary on what can be retained as the community top 6 health problems (priorities).

Step 6: Thank the participants for their achievement and inf**orm the**m that it is time to look at the root causes of their top 6 health problems (priorities) to look later for solutions.

A template for the decision-making matrix is provided below:

Problems	C1	C2	C3	C4	TOTAL
Issue 1					
Issue 2					
Issue 3					
Issue 4					
Issue 5					

Key:

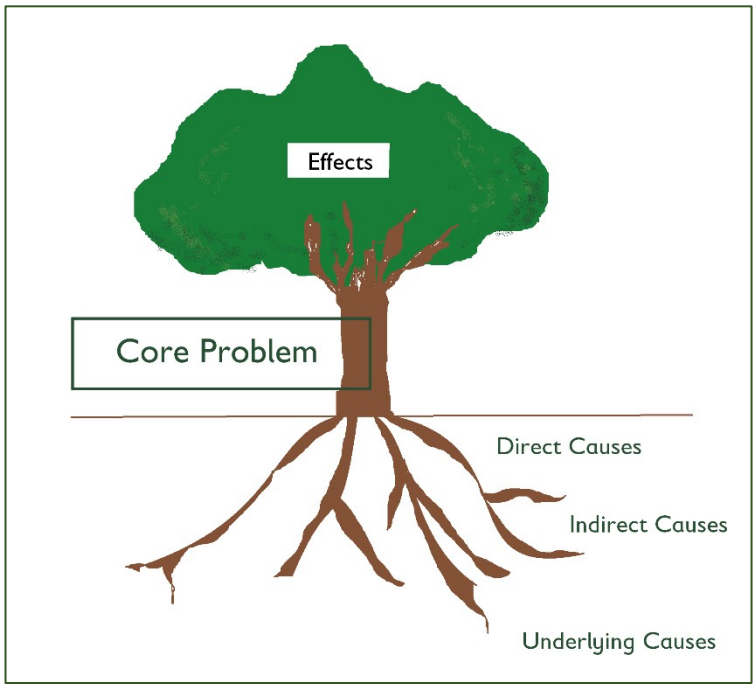
Criteria 1 (C1) = number of people affected by the problem
Criteria 1 (C2) = problem whose solution will bring about the solution of other problems
Criteria 1 (C3) = capacity to solve the problem locally
Criteria 1 (C4) = cost of solving the problem is affordable
Score: 0 = low 1 = medium; 2 = high
To be inserted

Reproduced from *Save the Children, Aug 2009 Draft, mobilising Communities for Education, Health and Social Change*

EXERCISE 4: IDENTIFY ROOT CAUSES

What it is:

The Problem Tree is a type of tool we can use to explore the issues in your community, including digging deeper to understand the causes and effects of an issue in a structured manner. Using the problem tree, the problem can be broken down into manageable and definable chunks and enables a deeper understanding of the problem with the interconnected issues, establishes who and what the actors and processes are, to help with clearer prioritization of factors. A problem tree also helps establish whether further information, evidence or resources are needed to make a strong case or build a convincing solution. The process of using a problem tree helps build a shared sense of understanding, purpose and action.



How to do it:

Step 1: The facilitator explains that we will simulate this as if participants are the Community Action Group. Therefore, we will ask participants to play the role of the CAG during this simulation.

Step 2: Introduce this tool by saying that the Problem Tree is a type of tool we can use to explore the issues in your community. Let's develop a Problem Tree together.

Explain that the problem tree demonstrates the "root causes" and consequences or results of an issue.

Step 3: To do a problem tree related to an issue, ask group members to draw a tree with roots, a trunk, and branches. On the trunk, write one of the problems in that community.

Step 4: Ask group members to think about **why** this issue is a problem. Every response they think of is written on one of the roots (add roots as needed).

Step 5: Take one cause at a time, explaining that people can also look at the underlying causes of a problem by asking the question "Why". For example, if the problem on the tree trunk is that pregnant mothers are not aware of danger signs, ask Why? And then to that answer, ask Why? Continue this until community members feel that all the causes have been discussed, and the roots get deeper and deeper.

To help probe more deeply, consider asking prompting questions around the issue. For example, in health programs for increased seeking of health services, the following questions could be asked:

a. Why might communities not value practices that promote good reproductive health?
b. Why do communities have low utilization of family planning and reproductive health services?
c. Are there health centers/health promoting centers (e.g. clubs, football grounds) in our community that are being underutilized? If so, why?

Step 6: Next, ask about a potential result or a consequence if people do not follow the desired practices. Put these as branches. Every response becomes a new branch. For each branch, keep asking: What does that lead to? So that they have painted a full picture of what the effect is to their families, communities, district, and country when they do not follow the practices to prevent the issue.

Step 7: When no further responses are given, ask the following debrief questions:

d. From this Problem Tree what do we see as the main causes of the family planning and reproductive health issues in our community?
e. What have we learned overall from the Problem Tree?
f. Now ask participants to come out of the simulation. Explain that they will now have time to practice developing a 'Problem Tree' for themselves.

GROUP WORK: Develop a Problem Tree

- Split the CAG into smaller groups to carry out the Problem tree exercise. (20 minutes). Place the Issue on the trunk of tree, such as:

    - Low utilization of family planning services
- Once completed, post on the wall in preparation for review by others.
- To conclude this Participatory Tool, ask participants to take a Gallery Walk (as if visiting a museum or art collection) – 30 minutes. Once seated ask:
    - What observations did you make about the sample Problem Trees?
    - What questions do you have about this tool?
    - Would you be able to train a CAG how to use? If so, why. If not, why not?
    - What further questions do you have about this tool?