Guidance for Program Staff

Integrating Best Practices for Performance Improvement, Quality Improvement, and Participatory Learning and Action to Improve Health Services

New York, NY
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ACRONYMS

ACQUIRE	Access, Quality, and Use in Reproductive Health
CDQ	Community-driven quality
COPE	Client-oriented, provider-efficient
BC	Breakthrough collaboratives
FP	Family planning
FS	Facilitative supervision
IBP	Implementing Best Practices
IUD	Intrauterine device
MAQ	Maximizing Access and Quality
MOH	Ministry of Health
MQI	Medical quality improvement
NGO	Nongovernmental organization
PI	Performance improvement
PLA	Participatory learning and action
PMTCT	Prevention of mother-to-child transmission of HIV
PNA	Performance needs assessment
PRA	Participatory rural appraisal
PVO	Private voluntary organization
QI	Quality improvement
QMT	Quality Measuring Tool
RH	Reproductive health
STI	Sexually transmitted infection
TOT	Training of trainers
USAID	U. S. Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization
WST	Whole-site training

Executive Summary

The ACQUIRE Project brings together partners with proven, effective approaches to improve provider performance and quality of services and to mobilize communities to drive improvements in health care: performance improvement (PI), quality improvement (QI), and participatory learning and action (PLA). ACQUIRE programs are not limited to these three approaches, but PI, QI, and PLA are prominent features of the capacity reflected in our partnership and therefore are the focus of this guidance.

All of these approaches originated outside the health sector, but they are applied and recognized as "best" practices (i.e., evidence-based, replicable, transferable, and sustainable) in international health.[1] The ACQUIRE Project provides opportunities for the partners to further develop expertise and create synergies between the three approaches. Blending the approaches will help catalyze and reinforce improvements in provider performance and service quality, while simultaneously improving clients' and communities' knowledge and awareness of reproductive health (RH) services, all of which will help to better meet clients' needs and achieve the ultimate results of increased access and use of RH and family planning (FP) services. It is essential for ACQUIRE project staff to understand and be able to combine the PI, QI, and PLA approaches and tools that the partners bring to the project.

These approaches can be blended because they share key attributes and because their differences are complementary. All three approaches are participatory, all rely on a step-by-step process to identify gaps and solutions, all include root-cause analysis of gaps, and all promote stakeholder involvement and empowerment. The main difference is in where (and with whom) to focus the assessments and interventions to improve health and health services. PI emphasizes the provider's perspective (human performance); QI emphasizes the client's perspective (teamwork and team processes), and PLA focuses on the community perspective and addresses community empowerment broadly, beyond health needs (community development).

All three of these perspectives are important within ACQUIRE. There is some variation, however, in when and at what levels each approach should be applied:

- The PI approach refined by IntraHealth International, Inc., is most appropriate at the national, regional, and district levels, but it can also be applied to specific cadres of providers and even at the facility level. Specific job aids and tools support each stage of the PI process. The performance needs assessment (PNA), an essential part of PI, is a diagnostic process for identifying performance and programming needs. The data-gathering methods used to define desired performance and describe actual performance include interviews, observations, surveys, and reviews of performance data. A PNA is typically conducted prior to program design or as a first step in program implementation, so that subsequent interventions can be better targeted. The factors that ensure good performance are important inputs throughout program implementation.
- EngenderHealth's QI package includes approaches and tools to address supervision and medical monitoring, training, continuous problem solving, and direct costs of service

[1] See the Implementing Best Practices Initiative (www.ibpinitiative.org), USAID's Maximizing Access and Quality (www.maqweb.org), and Advance Africa's Compendium of Best Practices (www.advanceafrica.org/compendium).

delivery. The majority of the interventions focus on the facility level, particularly the clients, health care providers, and supervisors within facilities. Emphasizing clients' rights and staff needs, the QI processes and tools serve to continuously diagnose and address gaps in provider performance and service quality, exploring needs and practical solutions.

- The PLA approach**,** as implemented by CARE, is an ongoing process and long-term commitment to develop community capacity by identifying needs and planning and carrying out interventions to meet them. (Ideally, the community completely takes over the process.) PLA includes a wide array of tools and techniques, including mapping, Venn diagrams, transect walks, ranking and scoring, causal-impact analysis, trend analysis, matrix ranking, case studies, life histories, drama and role plays, and brainstorming, among others. In the ACQUIRE Project, PLA addresses community perceptions and priorities related to FP/RH, health behavior and use of services, access to services, and the quality of care provided in health services. PLA supports mobilization by communities to address health issues and link more effectively to health facilities. Although it is easier just to incorporate participatory methods in the needs assessment stage of a project, to achieve true community empowerment and sustainable change, PLA requires an iterative process throughout the life of the project, with community involvement in all project stages, including implementation, monitoring, and evaluation.

There are many ways in which the approaches can be integrated. All three approaches include steps for identifying needs and selecting interventions. At the data-gathering stage, consider the usefulness of borrowing and adapting tools from the other approaches (e.g., apply PLA methods or the Quality Measuring Tool within a PNA). When selecting and implementing interventions, consider the applicability of incorporating any of the other approaches (e.g., if a PNA identifies gaps in performance feedback and motivation, consider implementing facilitative supervision and COPE®[2]; conversely, when implementing facilitative supervision, reinforce the supervisor's role in ensuring that all PI factors are in place). The situation often determines which approach to use and how to initiate activities. It is important to use the approaches and tools in a flexible manner.

[2] COPE, which stands for client-oriented, provider-efficient services, is a registered trademark of EngenderHealth.

Purpose of This Guidance

This guidance was developed to help staff of the ACQUIRE Project understand and explain to counterparts and field partners the improvement approaches and tools used by ACQUIRE. ACQUIRE brings together partners with proven, effective approaches to improving provider performance and the quality of services and to mobilizing communities to drive improvements in health care: performance improvement (PI), quality improvement (QI), and participatory learning and action (PLA). Although many staff are already familiar with PI, QI, and/or PLA, they do not always recognize the similar purposes of these approaches and how the approaches are related. These approaches and tools can be used alone or in a complementary manner, depending on the situation and on the program level being addressed.

This document includes:

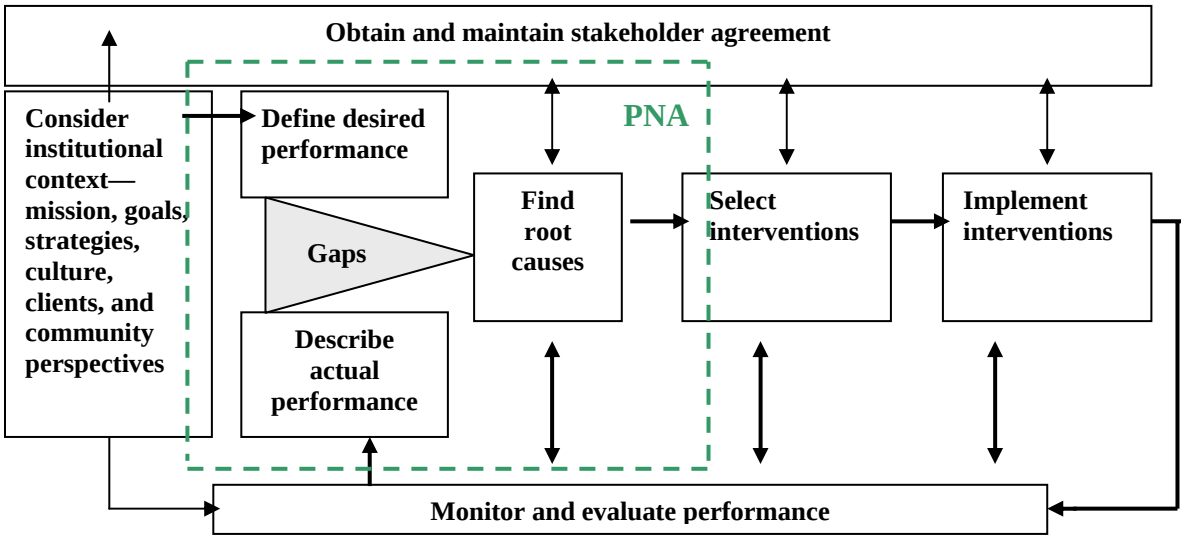
- A brief overview of approaches and tools
- A discussion of similarities and differences
- An explanation of how these approaches and tools can be used together to maximize benefits
- A summary and recommendations
- A resource section, including references for materials containing in-depth information about the approaches and instructions for use and lessons learned about their use

Section 1:
A Brief Overview of the Approaches and Tools

The Performance Improvement Approach

Organizations seeking to solve provider performance problems frequently implement training and other interventions without fully understanding the nature of the performance gaps and whether the chosen interventions are appropriate for closing the gaps. The PI approach adapted by PRIME II (McCaffrey et al., 1999), which is in Figure 1, uses a systematic and holistic step-by-step process to assess providers' performance and identify the root causes of the performance gap.

Figure 1. The Performance Improvement Process



The **Performance needs assessment (PNA)** is a critical part of the PI process. Subsequent implementation follows usual program implementation guidelines, including monitoring and evaluation to ensure that the interventions have closed the performance gaps. The PNA (shown in Figure 1, outlined with dotted line) begins with consideration of the institutional context in which PI will occur and emphasizes the following stages and important elements:

- Establishing desired performance
- Collecting data related to a performance problem to assess actual performance and comparing it with desired performance to determine the gaps and their scale
- Analyzing the root causes guided by five performance factors to uncover the principal reasons behind the performance gaps (see box) (This helps the stakeholders select the most

Performance Factors

Job Expectations: Do providers/staff know what is expected of them?

Performance Feedback: Do providers/staff know how well they are doing?

Physical Environment and Tools: Do providers/staff have what they need to perform?

Motivation: Do providers/staff have a reason to perform as they are asked to perform? Does anyone notice?

Skills and Knowledge to Do the Job: Do providers/staff know how to do the job? Are they able to do it?

appropriate interventions to close the gaps.)
- Selecting the most appropriate interventions for addressing the root causes identified through stakeholder analysis
- Involving stakeholders from different levels (A good mix of in-country or institutional stakeholders helps ensure representation of different perspectives and insights, as well as the ability to propose and act upon appropriate solutions during the process. Involving stakeholders from the outset of the process, including facility-level staff, increases the likelihood that selected interventions will be supported and will be sustainable.)

The PRIME II Project developed the following guides to support facilitation of the PI process and selection of interventions during a PNA:
- *Stages, Steps, and Tools for Performance Improvement: A Practical Guide to Facilitate Improved Performance of Healthcare Providers Worldwide* (PRIME II Project, 2000) gives instructions, job aids, and sample forms for facilitating the PI process.
- *Cost and Results Analysis, Volume 1: Strategy* (PRIME II Project, 2003a) is an approach for costing and analyzing the costs and results of activities designed to improve the performance of primary providers of FP/RH services.
- *Cost and Results Analysis, Volume 2: Toolkit* (PRIME II Project, 2003b) contains cost and results tools and analyses of program and policy options to complement training and nontraining interventions for improving provider performance.

Within a typical PNA, the tools shown in the box below are developed or adapted to address the specific context.

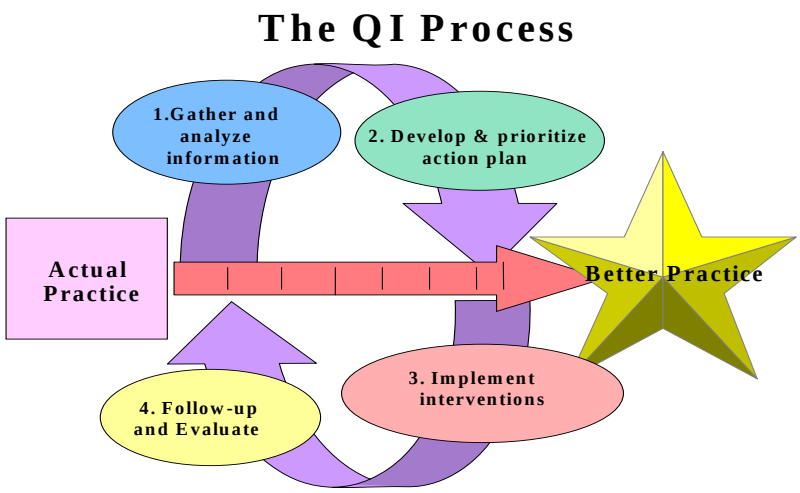
PI Tools for Assessing Desired and Actual Performance
* Interviews with providers/staff (including supervisors and managers)
* Observation of client-provider interactions
* Facility audits/assessments
* Review of service statistics
* Client interviews
* Group discussions in the community

Interventions selected at the end of a PNA may range widely in size and scale, based on the needs identified. Typical interventions focus on strengthening the performance factors and may come from any source of knowledge, experience, and best practices.

Quality Improvement Approach

EngenderHealth's QI package has been developed and refined in collaboration with developing-country institutions since the 1980s (Dohlie et al., 1999). The goal of this integrated package is to help service-delivery programs and providers improve the quality of RH/FP services through a systematic and continuous process. Institutions continuously determine what needs improvement and implement needed interventions to move from actual to better practice, using a four-step process (see Figure 2).

Figure 2. The Continuous QI Process



In addition to an overarching process, the QI package contains a set of approaches and tools based on the framework of clients' rights and staff needs (see box). These are most successful when used together, continuously reinforcing the same underlying values. Staff are able to focus on clients' rights when effective systems and processes are in place to meet their needs and support their performance.

Framework of Clients' Rights and Staff Needs (AVSC International, 1995)

Clients Have the Right to:
Information
Access to services
Informed choice
Safe services
Privacy and confidentiality
Dignity, comfort, and expression of opinion
Continuity of care

Health Care Staff Need:
Facilitative supervision and management
Information, training, and development
Supplies, equipment, and infrastructure

EngenderHealth's QI approaches include:

- **Facilitative supervision (FS),** which is an approach to supervision that emphasizes mentoring, joint problem solving, and two-way communication between supervisors and staff. Supervisors lead staff in the QI process.
- **Whole-site training (WST)** and **inreach** form an approach to addressing the learning needs of a site. WST links training and supervision and includes orientations, updates, and skills trainings, which can take place either on-site or off-site but promote both on-the-job and on-site training. Inreach includes staff orientations, referrals, and signage to help staff ensure that clients get all of the services they need when attending a health facility.
- **Medical quality improvement (MQI)** represents an ongoing focus on the quality of medical services through medical monitoring, the development and revision of medical guidelines, standards, and job aids, the removal of detrimental practices and policies, the analysis of medical data, the monitoring of informed decision making and informed consent, and the enhancement of local capacity to carry on these processes.

The tools to help staff and supervisors practice the above approaches and to assess and improve the quality and efficiency of their services are shown in the following table:

Figure 3. QI Tools for Gathering and Analyzing Information

COPE • Client interviews • Provider self-assessment guides • Record-review checklist • Client-flow analysis Medical monitoring checklists Cost Analysis Tool	Community COPE • Individual interviews • Focus-group discussions • Mapping exercises • Site walk-throughs Quality Measuring Tool (a participatory type of facility audit)

Notably, the tools are based on international standards and practices and serve to remind or update staff about best practices in health care. They also help clarify performance expectations and program goals. The tools are tailored to FP and other RH services (see resource section for complete references). Together, the approaches and tools in the QI package serve as both tools to identify gaps in quality of care and also as interventions to close the gaps and support clients' rights and staff needs. Other interventions for improving care come from any source of knowledge, experience, and best practices, with an emphasis on using local resources to solve problems.

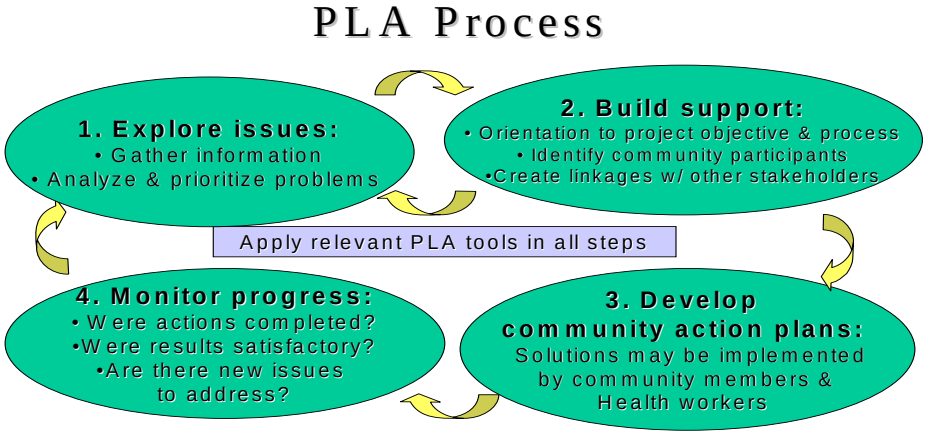
Participatory Learning and Action Approach

PLA is an umbrella term that refers to a wide range of approaches and methodologies that incorporate the *participation* of people in the processes of *learning* about their needs and the *actions* required to address them (IIED, 2000). It is important to note that the focus of PLA is community development (see box), so even when it is applied in health projects, it may result in community-led interventions outside the health sector

Definition of PLA
A long-term commitment to ongoing development of a community's capacity to identify its own needs and implement action plans to improve its own conditions.
(CARE, 1999, p. F-1)

The four main steps of the continuous PLA process are shown in Figure 4.

Figure 4. The Continuous PLA Process



The first two steps of the PLA process (exploring issues and building support) tend to be interchangeable, depending on the project, but a proper PLA begins with exploring issues. Within a health project context, the facilitator guides this exploration of issues according to the project's interests and/or limitations, to avoid raising expectations that cannot be addressed with project support. PLA offers a wide array of verbal and visual tools that are applied in all steps of the process. New methods continue to be designed to meet specific needs in particular contexts. Figure 5 does not represent an exhaustive list of tools.

Figure 5. Tools for use in the PLA process

• Social mapping • FP or sex census mapping • Transect walks • Venn diagrams (Human resource and community organization, Social networks and sources of information, Household relations/decision making) • Matrix ranking (e.g., choice of caregiver by type of maternal health and RH need) • Trend analysis (e.g., reproductive life-line) • Ranking and scoring (e.g., contraceptive preference) • Causal-impact analysis (flow diagrams)	• Pocket chart (situational assessment/analysis) • Three-pile sorting • Picture stories/cartooning • Drama (open-ended/closed-ended) and role plays • Critical incident analysis using visuals • Flexi-flans as creative materials • Unserialized posters • Carts and rocks (analysis of resources and constraints) • Two-circles exercise • Semi-structured interviews • Focus-group discussions • Case studies, stories, portraits
Note: This list shows selected PLA tools applicable to RH issues, adapted from CARE, 1999.	

There are many levels of participation and different terms to refer to the processes applied. For the purposes of ACQUIRE, the two most important terms to distinguish are participatory learning and action (PLA) and participatory rural appraisal (PRA). The key difference between these is that in a true PLA process, the participatory methodologies are used in all phases of the project: assessment, project design, implementation, and monitoring and evaluation. This continuous process builds capacity and empowers communities to undertake ongoing self-development in a larger holistic environment and context. By contrast, in a PRA, the participatory methodologies are used only to extract information from communities for the purpose of an assessment and (usually) to inform project design. A PRA can be conducted in a few days, while PLA requires an ongoing commitment over many months or years.

Organizations can use PLA when they can commit to supporting community-planned and -led activities and can maintain relationships with the community over a long time. If a donor requires that a project be developed and designed by an outside agency, that agency can feasibly use PLA tools to get community input, participation, and buy-in during start-up and implementation, but the "community" project is then categorized as being on the low end of the continuum of community participation and empowerment.

Origins of the Approaches and their Use in FP, RH, and Other Health Services

All of the approaches described here originated outside the health sector, and all have been successfully applied to international health. The PI approach originated in the for-profit field of human resources and instructional design, as a process to address performance gaps beyond training. Over nearly a decade, PI has been increasingly applied to health services in low-resource settings, particularly to identify performance gaps in numerous areas of RH and other services, such as integrated management of childhood illnesses (IMCI). During PRIME II, 28 PNAs were conducted in 18 countries (Luoma and Nelson, 2003). To promote wider use and understanding of the PI approach, the U.S. Agency for International Development (USAID) and several cooperating agencies formed the Performance Improvement Consultative Group. More recently, in international conferences, the World Health Organization (WHO), in its Implementing Best Practices (IBP) Initiative, has applied the PI framework to link the identification of program and performance gaps with the adaptation of best practices to address those gaps.

The QI approach originated in the engineering and manufacturing industries, but it has been applied to other sectors worldwide for decades. Since the late 1980s, EngenderHealth has developed its QI approaches and tools, which were originally for FP services but over time have been applied to other health services. FS, WST, and MQI interventions have been applied to hospital-wide practices (such as infection prevention), and COPE tools have been adapted for a range of services, including maternal care, child health, cervical cancer prevention, adolescent RH services, and prevention of mother-to-child transmission of HIV (PMTCT). New COPE tools are being adapted for voluntary counseling and testing for HIV (VCT), and sexually transmitted infection (STI) services. The COPE tools have been used by facilities in the public and private sectors—in the for-profit and nonprofit sectors, including mission hospitals. COPE is categorized as a best practice in Advance Africa's compendium of best practices, and USAID's MAQ initiative promotes the "supportive supervision" approach and defines it as synonymous with "facilitative supervision" (Marquez and Kean, 2002). The WST approach was included among

the interventions promoted in a “Best Practices in Training” international conference held in Africa.

PLA, which originated as a community development process, particularly in the agricultural sector, has been used for and by the community at the community level and has been applied worldwide. CARE has used PLA in its development work, including RH efforts, for more than 10 years in both rural and urban settings. In CARE projects in Africa, Asia, and Latin America, PLA has proved to be crucial in involving the community in addressing family planning, maternal health, adolescent health, and prevention of STIs and HIV, as well as in establishing linkages between health, education, and economic opportunities. USAID’s MAQ Initiative supported the implementation of PLA by promoting “Community-Driven Quality,” defined as “a methodology to improve quality and accessibility of health care with greater involvement of the community in defining, implementing, and monitoring the quality improvement process” (MAQ Exchange, no date). Likewise, the IBP Initiative promotes wider use of PLA as a best practice by disseminating the approach through its conferences and global library.

Section 2:
Comparing the PI, QI, and PLA Approaches

PI, QI, and PLA all are effective approaches, and which one is selected depends on the problem to be addressed, the context or situation, and program level. However, familiarity with a given approach and personal preference may influence and actually limit the choice. ACQUIRE staff are encouraged to learn more about the different approaches and to seek opportunities to integrate and apply them, as appropriate.

This guidance has already alluded to similarities and differences between the approaches.

The PI, QI and PLA approaches and tools represented by the ACQUIRE partners' collective expertise share the following **similarities:**

- *The approaches all have common goals*. Within the ACQUIRE Project, all three approaches support the goal of improving performance and quality to increase access and use of RH services.
- *Active stakeholder participation is involved, to ensure a sense of ownership*. All three approaches are highly participatory in nature, involving in the improvement process a wide range of staff, stakeholders, counterparts, and community members.
- *The approaches use step-by-step processes to identify areas that can be strengthened or improved.* All three use such processes, including root-cause analysis.
- *All three approaches depend on facilitators to introduce the process*. However, the goal is always to build capacity among local stakeholders, in the health facility, the overall system, or the community, to take over as facilitators and ensure continuity and sustainability. Facilitators must invest time, effort, skills, and commitment to carry out their important role of ensuring that stakeholders remain motivated to participate.
- *Success ultimately depends on empowerment.* Unless the stakeholders—be they at the facility, community, or other levels—are genuinely empowered and consider the process to be their own, improvements and success are difficult to achieve.

Particular similarities between PI and QI

USAID established the Performance Improvement Consultative Group in January 2000 to promote processes and activities in health service delivery organizations to support and improve performance. The group was instrumental in creating agreement related to the PI process. The following is taken from the Frequently Asked Questions on the group's website, at www.pihealthcare.org/pi_faq.htm:

> "While their origins and orientation may be different, there are significant similarities between the QI and PI models. Both are cyclical problem-solving processes. Both advocate the establishment of standards and the continual quest to meet those standards. Both seek to establish the root causes of identified problems. Both identify and select appropriate actions that are intended to address performance problems. Both QI and PI seek the same ends: high-quality products or services. Both models draw from the same toolbox, although the use of the

tools may vary. The approaches are complementary and the strengths of each should be brought to bear in implementing reproductive health interventions."

The **differences** between PI, QI, and PLA create complementarities that make it worthwhile to blend the approaches. These differences include a different focus:

- ***PI focuses on provider performance and the provider perspective***. Desired performance is defined for providers, and actual provider performance is determined through observations of providers and through interviews to understand their enabling environment. However, providers are certainly not the only stakeholders and participants in the process. Typical PNAs seek the client's perspective through interviews and seek the community's perspectives through group discussions.
- ***QI focuses on clients' rights and the client perspective.*** Quality health services are defined as services that meet the clients' rights. Providers' needs are those that enable providers to ensure clients' rights. Even health care staff and supervisors are encouraged to see each other as "internal clients" within the health system. The QI approaches and tools address different stakeholders, but the majority of the tools focus on clients and providers *within health facilities*. FS is an intervention focused on building the capacity of supervisors (including supervisors within individual facilities and those who support multiple facilities), and Community COPE addresses community members in particular (and views community members as current, former, or potential clients, as well as agents in the process of improving health services).
- ***PLA focuses on community empowerment and the community perspective***. With its broader goals of community development and primary health care, PLA focuses on community ownership of the process as well as the product, which can include improved health services. Although the process revolves around community member participation, it can relate to other stakeholders in several ways: by defining desired provider performance and quality of care, by providing feedback on existing health services, and by mobilizing resources (both financial and in-kind) to support health services.

The dual purpose of the QI approaches and tools

The QI package includes approaches and tools that serve a dual purpose: identifying gaps and serving as ongoing interventions to close those gaps. EngenderHealth's QI package includes approaches that constitute possible interventions to meet staff needs, close performance gaps, and improve quality. In PI, the PNA identifies performance problems and the most appropriate interventions to effectively address root causes and looks outside to select from the realm of possible interventions. The relevant solutions may include FS, WST, or MQI.

Particular similarities and differences between PLA and Community COPE

There are particular similarities and differences between PLA and Community COPE. Both emphasize the community perspective. Community COPE is a variation on the COPE process that applies the PLA approach and includes a subset of the PLA tools, focused on involving communities in improving facility-based health services. Community COPE requires the participation of both health care staff and community members. PLA includes more tools and addresses community empowerment more broadly (e.g., even when PLA is focused on health issues, community participants typically raise needs related to economic or educational

opportunities). PLA implies that control, ownership, facilitation, and maintenance of the process reside in the community.

In Community COPE, health care staff remain important stakeholders in the improvement of facilities and services. Although Community COPE could act as a catalyst for initiating overall community development, making a commitment to facilitating this process is probably too much to ask of health care providers, and it is not an effective use of their scarce and much-needed technical skills. Other organizations and community members are better positioned for this task. PLA facilitation requires people who are well-versed in this approach and who have practiced it. It also is intensive at first, although project involvement tapers off as facilitation roles are taken on by community facilitators. Recently, the ACQUIRE partners applied PLA methods to tailor information, marketing materials, and referral systems based on community perceptions of underutilized methods.

Section 3:
Recommended Ways to Integrate the Approaches to Maximize Benefits

All three approaches—PI, QI, and PLA—have proved to be effective in various contexts and settings when they are implemented individually. The following guidance is based on lessons learned to date and developed for ACQUIRE Project staff who are expected to use the three approaches to help ensure more sustainable interventions. The most appropriate approach to apply depends on the **program level** where it will be used and the **context** or **situation**. You may choose to use either PI or QI or to blend the approaches, because they can stand alone or be used in a complementary manner. When used together, they represent a more comprehensive methodology. In this way, a country program, for example, could maximize the potential of each methodology to achieve an environment in which high-performing, effective providers are supported by their organizations or systems to provide high-quality services that meet the expressed needs of client populations, who participate actively along with Ministry of Health (MOH) stakeholders in these processes. Similarly, Community COPE and PLA complement each other and can strengthen both PI and QI.

Various field applications indicate that the three approaches are relatively easy to introduce and use, provided that motivation and support exist to do so. Staff and stakeholders can build local capacity to use the approaches and tools through training of trainers (TOT), orientation sessions, and hands-on application in the field. Once a person masters one approach, becoming adept at applying a second approach may not prove to be very difficult, due to their considerable similarities. All three approaches require a willingness to empower people.

The following are specific recommended ways to integrate the approaches:

- ***Use PI and the PNA to identify needs at a higher programming level (national, regional, and district levels).*** PI is a useful process for identifying systemic needs in health services, because it addresses the performance of institutions and of entire cadres of providers. Performance problems encountered in one facility are often common at facilities throughout the region and can only be addressed by working with higher levels in the health system. Key stakeholders include representatives from the national-level MOH, regional directors and supervisors, district-level directors, a sample of facility directors and department heads, providers and staff from selected health facilities, representatives of NGOs and private voluntary organizations (PVOs), donors, clients, and community members. It is important to include those who best know the issues and who can facilitate the implementation of interventions, as well as those who have decision-making authority. The sample of sites should be representative, not exhaustive, and existing data should be used as much as possible.
- ***The QI tools address multiple levels, but they are mainly applied at the facility level.*** This includes FS, MQI, WST and inreach, COPE, QMT, medical monitoring and the Cost Analysis Tool. FS is an approach for supervisors at any level (including those who supervise multiple facilities), and Community COPE is a process for linking service providers with community members, so it spans both levels.

- ***Community COPE and PLA are complementary and are applied at the community level.*** Thus, any of the PLA tools can be adapted for conducting Community COPE.
- ***When implementing any of the approaches, at the data gathering stage, adapt tools from any of the other approaches, as appropriate.*** For example, in a PNA, consider using the QMT, the COPE client interview guide, or any of the PLA tools. Within PLA, consider using some of the Community COPE tools.
- ***At the stage of selecting and implementing interventions, consider the applicability of any of the other approaches or tools to meeting the needs that were identified***. For example, if a PNA reveals gaps in performance feedback, train supervisors in the FS approach. When implementing FS, reinforce the supervisor's role in ensuring all the PI factors are in place to enable good performance. Even if a formal PNA is not done, it is useful for supervisors to apply some form of the PI process as part of interactions and meetings among supervisors at different program levels (Mane et al., 2003).

  It is useful to link training in FS with the introduction of COPE, which provides supervisors with a tool for involving staff in improving performance and quality through teamwork. For example, if a PLA reveals poor client-provider interaction and long delays for services at a hospital, consider introducing COPE. On the other hand, if a facility has fewer clients than expected, use PLA or Community COPE to understand why people are not seeking services there and propose ways to improve the link between facilities and communities.

The following two descriptions and illustrations depict scenarios where the three approaches are successfully integrated.

Scenario I (Figure 6) presents an illustrative example of the complementary use of all three approaches to maximize improvements in performance and quality of service delivery, based on real programming experiences in West Africa. The MOH requested an exploration of performance problems in FP service delivery. Using the PI approach, a PNA was conducted in a selected sample of health facilities in different regions to identify performance gaps. At subsequent meetings, stakeholders discussed performance gaps identified by the PNA, analyzed root causes, and selected the most appropriate interventions. Root causes included staff's lack of skills and knowledge in FP and infection prevention, unclear expectations around FP, and minimal feedback on performance due to weak supervision. Stakeholders selected the following interventions:

- Update staff on contraceptive technology and infection prevention through WST
- Develop and disseminate standards and job expectations for providers in the area of FP
- Implement the FS approach, with an emphasis on MQI

These interventions were implemented, but monitoring revealed that some facilities needed additional assistance in improving their quality, so COPE was introduced. COPE client interviews revealed that community members were misinformed about FP and perceived health facilities to have poor quality of care. PLA exercises were then applied to involve the community in actively helping to define and improve the quality of service provision and become more informed about FP.

Continued monitoring and evaluation illustrated that using the approaches in this way improved FP service delivery at the facilities and regions involved in the PI and QI efforts.

Notably, the integration can begin with any approach at any level. For example, in Ethiopia (see **Scenario II**, Figure 7), EngenderHealth provided technical assistance to introduce QI approaches in health services in a CARE-supported community RH/HIV project that was working to improve RH information and services at the community and primary health care levels. In this effort, community extension and mobilization activities formed the basis upon which other participatory activities for improving RH were layered. One of the first activities of EngenderHealth was to provide training in FS and orient district/woreda and health facility supervisors in the QI approaches. Subsequently, the participating facilities introduced COPE. The facilities have experienced good results, and community feedback about services is being sought. Then, new issues can be addressed, including an identified need to improve the quality of and access to IUD services. To better understand specific performance gaps, root causes, and appropriate interventions, there are plans to conduct a PNA with providers in these and other facilities.

Similar scenarios can be developed starting with any of the approaches.

Figure 6. Scenario I—Complementary Use of PI, QI, and PLA, Beginning at a National Programming Level

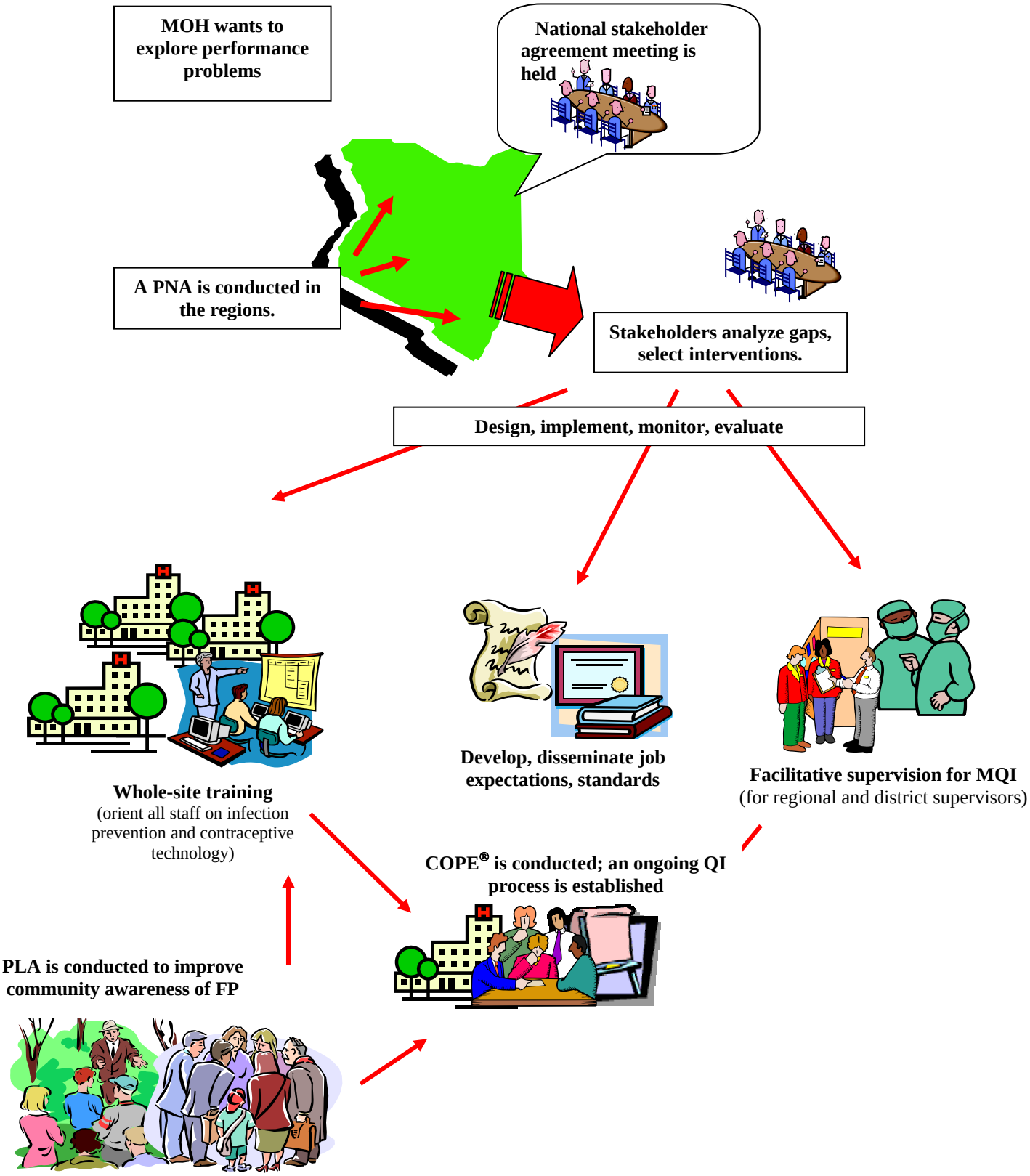


Figure 7. Scenario II: Complementary Use of Approaches Beginning at the Community Level

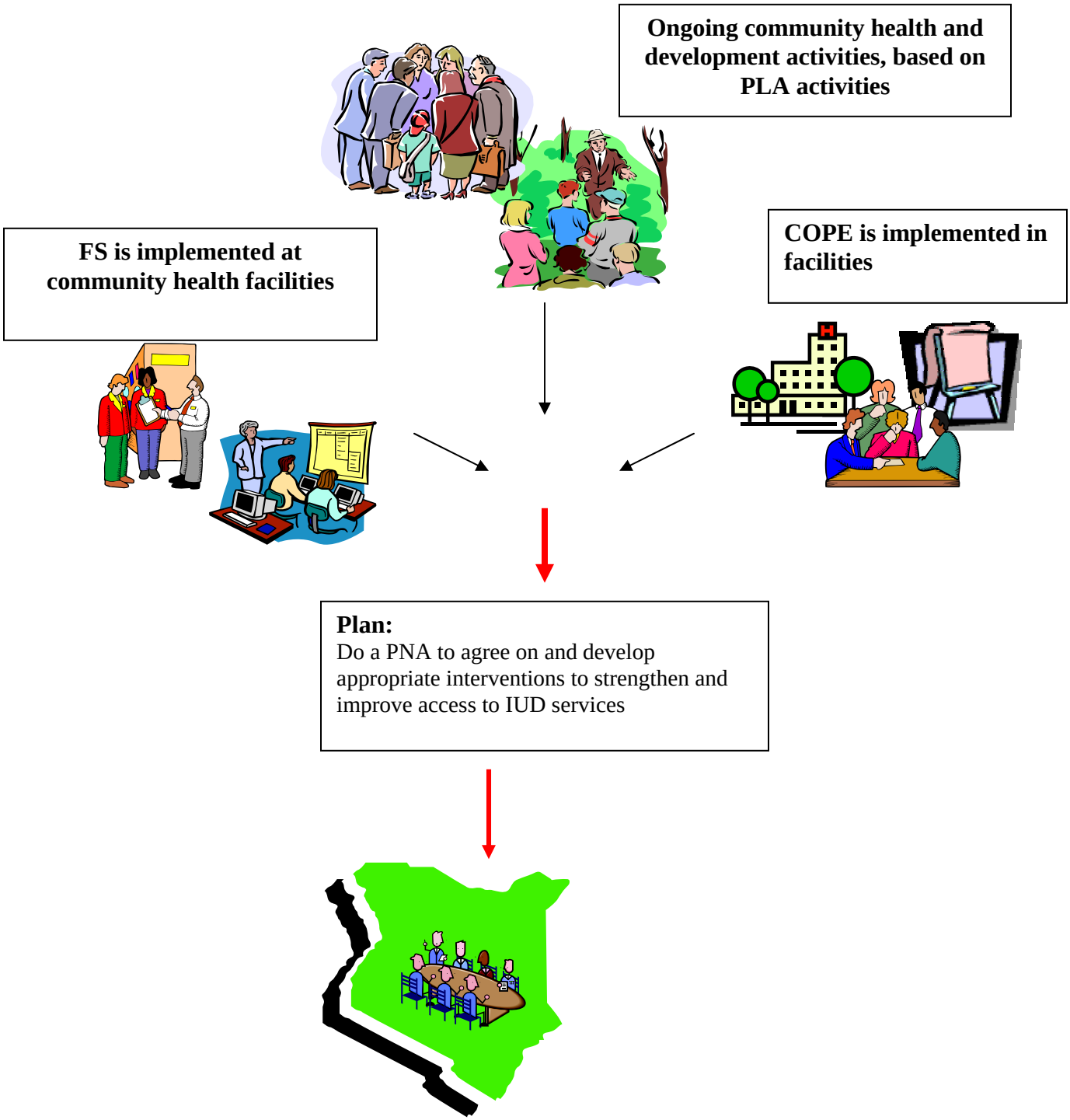


Figure 8 summarizes the levels at which we recommend the different approaches and tools be applied in health programs.

Figure 8. Approaches and Tools to Be Used at Selected Levels of the Health Care System and at Selected Types of Institutions

Level	Approaches and Tools		
	PI	QI	PLA
National	X		
Regional	X		
District/prefecture	X	X (FS)	
Institution	X	X (any approaches)	
Hospital		X (any approaches)	
Department or ward		X (any approaches)	
Community		X (Community COPE)	X

Where multiple approaches address the same levels, refer to the recommendations in Section 3 for advice on how to integrate them.

Section 4: Conclusion

The ACQUIRE Project's mandate is to increase access to quality RH/FP services, improve the performance of service-delivery providers, and strengthen the environment for RH/FP service delivery. Our three strategies for achieving these results are:

- A focus on the fundamentals of clinical care (ensuring informed choice, assuring medical safety, and providing for quality assurance and management)
- A strong customer orientation to guide our work with host country counterparts, USAID, and other stakeholders
- The use of data and evidence-based programming for the strategic selection of interventions that address each program's particular context and stage of development

By integrating the three proven approaches (PI, QI, and PLA), we are putting into practice our use of data and participatory processes to drive strategic choices and develop relevant interventions. Whether we are planning at the national level, providing assistance at the institutional level, or working with clinic managers and staff at the site level, ACQUIRE's approach is strategic, relevant, evidence-based, and participatory. We work to enhance community involvement in RH/FP service provision by facilitating links between community members and facilities and by engaging community groups in exploring barriers to RH/FP services and solutions to the problems identified. With our package of tools and approaches, we are able to channel community input and expectations into other best practices for supporting provider and facility change to meet those needs.

The ACQUIRE Project partners' tools and approaches complement each other. Our aim is to encourage creativity and seek appropriate opportunities to create synergies between the approaches, all to maximize improvements in health. We do not simply recommend the use of all approaches in all places. We hope that this guidance contributes to a lasting ACQUIRE legacy of effective programming for strengthened provider performance and service quality. This document should be considered a starting point, based on the best practices and expertise the partners have brought to the project. As the ACQUIRE Project continues to unfold, we expect to adapt and apply additional best practices and approaches as the need arises. For example, we plan to apply Breakthrough Collaboratives to effectively address key FP service-delivery issues and to scale up improvements.

This guidance does not provide extensive information for the introduction and application of the tools discussed here. For that reason, we include two types of resources in Section 5; the first set contains guidance on implementing each of the approaches and tools, and the second provides descriptions of program experiences and lessons learned from the implementation of these approaches and tools.

Section 5:
Resource Materials

Guidance on How to Implement Each of the Approaches

AVSC International. 1995. *COPE: Client-oriented, provider-efficient services.* New York.

AVSC International. 1999. *COPE for child health: A process and tools for improving the quality of child health services*. New York.

Ben Salem, B., and Beattie, K. J. 1996. Facilitative supervision: A vital link in quality reproductive health service delivery. *AVSC Working Paper* No. 10. New York. AVSC International.

Bradley, J., et al. 1998. Whole-site training: A new approach to the organization of training. *AVSC Working Paper* No. 11. New York. AVSC International.

CARE. 1999. *Embracing participation in development. Wisdom from the field: Worldwide experiences from CARE's RH Program, with a step-by-step field guide to participatory tools and techniques.* Atlanta.

EngenderHealth. 2000. *Cost analysis tool: Simplifying cost analysis for managers and staff of health care services*. New York.

EngenderHealth. 2001. *COPE® for maternal health services: A process and tools for improving the quality of maternal health services*. New York.

EngenderHealth. 2001. *Facilitative supervision handbook.* New York.

EngenderHealth. 2001. *The Quality Measuring Tool for reproductive health services: A manual for using the Quality Measuring Tool for health care managers, supervisors, and providers.* New York.

EngenderHealth. 2002. *Community COPE®: Building partnership with the community to improve health services*. New York.

EngenderHealth. 2003. *COPE® handbook: A process for improving quality in health services.* New York.

EngenderHealth. 2003. *COPE® for reproductive health services: A toolbook to accompany the COPE® handbook*. New York.

EngenderHealth and Mailman School of Public Health, Columbia University. 2003. *Quality improvement for emergency obstetric care leadership manual: An adaptation of COPE® (client-oriented, provider-efficient services).* New York. EngenderHealth.

EngenderHealth and Mailman School of Public Health, Columbia University. 2003. *Quality improvement for emergency obstetric care toolbook: An adaptation of COPE® (client-oriented, provider-efficient services).* New York. EngenderHealth.

IIED. 2000. *PLA Notes 37: Sexual and reproductive health.*

Lynam, P. F., et al. 1994. Inreach: Reaching potential FP clients within health institutions. *AVSC Working Paper* No. 5. New York: AVSC International.

McCaffery, J., et al. 1999. *PRIME's reproductive health performance improvement approach: A source document*. Chapel Hill, NC. INTRAH.

PRIME II Project. 2000. *Participant manual for PI short course*. Chapel Hill, NC. INTRAH.

PRIME II Project. 2002. *Stages, steps, and tools for performance improvement, A practical guide to facilitate improved performance of healthcare providers worldwide*, CD-ROM, Chapel Hill, NC. INTRAH.

PRIME II Project. 2003a. *Cost and results analysis, volume 1: Strategy.* Chapel Hill, NC. INTRAH.

PRIME II Project. 2003b. *Cost and results analysis, volume 2: Toolkit.* Chapel Hill, NC. INTRAH.

Schoonmaker Freudenberger, K. *Rapid rural appraisal and participatory rural appraisal, a manual for CRS field workers and partners*. Catholic Relief Services.

Srinivasan, L. 1990. *Tools for community participation: A manual for training trainers in participatory techniques*. New York: PROWWESS/UNDP.

Materials that Describe Experiences and Lessons Learned

Each resource is listed, with a brief description to guide readers.

Askew, I. 1989. Organizing community participation in family planning projects in South Asia. *Studies in Family Planning* 20(4):185–202. Describes PLA experiences in FP projects.

Beattie, K. et al. 1994. Introducing COPE in Asia: A quality management tool for FP services in Bangladesh *Innovations* 1:16–29. Describes early results of using COPE in Bangladesh.

Bradley, J., et al. 1998. Using COPE to improve quality of care: The experience of the Family Planning Association of Kenya. *Quality/Calidad/Qualité.* No 9. New York: Population Council. Description of use of COPE in the NGO sector.

Bradley, J., et al. 2002. *COPE® for child health in Kenya and Guinea: An analysis of service quality*. New York: EngenderHealth. Report on a two-year study of the introduction and results of the COPE process in a non-FP area of health in the public sector.

Bradley, J., et al. 1998. *Quality of care in family planning services: An assessment of change in Tanzania 1995/6–1996/7* New York. AVSC International. Presents early results of changes in quality (according to clients' rights and providers' needs) as measured with the QMT, and describes other QI interventions that were implemented to achieve those improvements.

Bradley, J., et al. 2000. *Family planning services in Tanzania: Results from a project to improve quality, 1996-1999.* New York. AVSC International. Presents changes in quality as measured with the QMT, and describes the other QI interventions that were implemented to achieve those improvements.

Bradley, J., et al. 2002. Participatory evaluation of reproductive health care quality in developing countries. *Social Science and Medicine* 55(2):269–282. Describes the use of the Quality Measuring Tool as a key intervention to improve quality of care in RH services in Tanzania.

Butta, P. 1995. US and Canadian clinics learn to "COPE," *Focus,* Vol. 2, No. 2. New York: AVSC International. Describes the experience of both U.S. and Canadian health facilities in implementing COPE to improve FP services.

CARE. 1999. *Embracing participation in development. Wisdom from the field: Worldwide experiences from CARE's RH program with a step-by-step field guide to participatory tools and techniques.* Atlanta. In addition to explaining the PLA process, this reference also describes lessons and results from the use of PLA in projects (including health projects) in many countries.

Dohlie, M. B., et al. 1999. Using practical quality improvement approaches and tools in reproductive health services in East Africa. *Joint Commission Journal on Quality Improvement* 25(11):574–587. Description of the EngenderHealth QI package, including FS, WST, COPE, and the QMT.

Dohlie, M. B., et al. 2000. COPE, a model for building community partnerships that improve care in East Africa. *Journal for Healthcare Quality* Vol. 22, No. 5. Description of the EngenderHealth QI package, including an early Community COPE experience in a mission hospital.

Dohlie, M. B., et al. 2002. Empowering frontline staff to improve the quality of FP services: A case study in Tanzania. In *Responding to Cairo: Case studies of changing practice in reproductive health and family planning*, ed. by N. Haberland and D. Measham. New York: Population Council. Description of QI package and results of use, including early use in the area of maternity services, in the public sector.

Dwyer, J., et al. 1991. COPE: A self-assessment technique for family planning services. *AVSC Working Paper* No. 1. New York. AVSC International. Describes the self-assessment process and the earliest experiences with the use of COPE in Kenya and Nigeria.

Dwyer, J., and Jezowski, T. 1995. Quality management for family planning services: Practical experience from Africa. *AVSC Working Paper* No. 7. New York. AVSC International. Describes early experience with COPE and FS in Africa.

EngenderHealth. 2002. Improving provider performance: Results from Guinea and Kenya. *Compass,* No. 1. Describes a quasi-experimental study of improvements in provider performance, client satisfaction, and caregiver knowledge related to child health services as a result of implementation of COPE for Child Health Services in two countries.

International Society for Performance Improvement. 2003. *Performance Improvement.* Volume 42, No. 8, September 2003. Examples of PI used in international settings.

Jaskiewicz, W. 2000. *PI approach raises reproductive health to a new level*. PRIME Pages: PI-2. Results of use of PI in the Dominican Republic.

Jezowski, T., et al. 1995. A successful national program for expanding vasectomy services: The experience of the Instituto Mexicano del Seguro Social. *AVSC Working Paper* No. 8. New York. AVSC International. Describes how no-scalpel vasectomy services were expanded in Mexico, in part due to the WST approach for training providers.

Kaim, B., and Ndlovu, R. 2000. Lessons from 'Auntie Stella': Using PRA to promote reproductive health education in Zimbabwe secondary schools. *PLA Notes 37* (February). Describes use of PRA to understand effective sources of health information for adolescents.

Kaniauskene, A., Mielke, E., and Beattie, K. Improving reproductive health services through whole-site training. Paper presented at the annual meeting of the Global Health Council, May–June 2001, Washington, D.C. Summarizes the WST approach and provides data on training results from Moldova and Tanzania.

Luoma, M., et al. 2000. Dominican Republic performance improvement project evaluation. *Technical Report* No. 19. Chapel Hill, NC. INTRAH.

Luoma, M, and Nelson, D. 2003. *Lessons learned in improving provider performance*. PRIME Pages: RR-28. Brief review of the lessons learned and recommendations for introducing and implementing successful PI around the world.

Lynam, P., et al. 1992. The use of self-assessment in improving the quality of family planning clinic operations: The experience with COPE in Africa. *AVSC Working Paper* No. 2. New York. AVSC International. Describes follow-up evaluation of COPE in 11 African clinics.

Lynam, P., et al. 1993. Using self-assessment to improve the quality of FP services. *Studies in Family Planning* 24(4):252–260. Description of early experiences and results from the use the COPE process.

Lynam, P., Smith, T., and Dwyer, J. 1994. Client flow analysis: A practical management technique for outpatient clinic settings. *International Journal for Quality in Health Care*

6(2):179–186. Describes results from use of the Client Flow Analysis tool to reduce client waiting time for services (part of COPE).

Mane, B., et al. 2003. *Final evaluation of the supervision intervention in Kebemer District. Final project report.* Dakar, Senegal. IntraHealth. Describes how PI was introduced as part of an FS intervention after the interventions had been selected.

Marquez, L., and Kean, L. 2002. *Making supervision supportive and sustainable: New approaches to old problems*. USAID MAQ Paper, Vol. 1, No. 4. Describes the supportive/facilitative approach to supervision, benefits of the approach, and lessons from its use in international low-resource settings.

Mielke, E., and Beattie, K. 2001. COPE: A process and tools for healthcare. *QA Brief*, Vol. 9, No. 1. Provides a brief overview of COPE process, purpose, results, and new adaptations of the materials.

Mielke, E., Bradley, J, and Becker, J. 2001. Improving maternal and child health services through COPE®. *QA Brief*, Vol. 9, No. 2. Provides a review of experience and tools for COPE for Maternal Health Services and COPE for Child Health Services.

PRIME II. 2002. Measuring provider performance: Challenges and definitions. *PRIME II Better Practices* No. 1. Summary of a technical meeting sponsored by PRIME II and MEASURE Evaluation to shape and advance the dialogue on performance measurement among family planning and reproductive health professionals and organizations.

RACHA (Reproductive and Child Health Alliance). 2000. The COPE process: Improving the quality of services in Cambodia's public health facilities. *RACHA Photobook No. 2.* – Describes site-level improvements (e.g., for infection prevention) as a result of COPE in Cambodia.

Stanley, H., et al. 2001. The quality of care management center in Nepal: Improving services with limited resources. *AVSC Working Paper* No. 13. New York: AVSC International. Describes a comprehensive approach to quality of care, addressing management, flow of funds to clinics, maintenance of facilities and equipment, training, supervision, and monitoring, all leading to improvements in care. Interventions included COPE, FS, and WST.

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Dohlie, M. B., et al. 1999. Using practical quality improvement approaches and tools in reproductive health services in East Africa. *Joint Commission Journal on Quality Improvement* 25(11):574–587.

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Mane, B., et al. 2003. *Final evaluation of the supervision intervention in Kebemer District. Final project report.* Dakar, Senegal. IntraHealth.

MAQ Exchange. No date. *Community defined quality (CDQ): Creating partnerships for improving quality.* Accessed at

Marquez, L., and Kean, L. 2002. *Making supervision supportive and sustainable: New approaches to old problems*. USAID MAQ Paper, Vol. 1, No. 4.

McCaffery, J., et al. 1999. *PRIME's reproductive health performance improvement approach: A source document*. Chapel Hill, NC. INTRAH.

PRIME II Project. 2002. *Stages, steps, and tools for performance improvement, A practical guide to facilitate improved performance of healthcare providers worldwide*, CD-ROM or www.prime2.org/sst. Chapel Hill, NC. INTRAH.

PRIME II Project. 2003a. *Cost and results analysis, volume 1: Strategy.* Chapel Hill, NC. INTRAH.

PRIME II Project. 2003b. *Cost and results analysis, volume 2: Toolkit.* Chapel Hill, NC. INTRAH.