Partnership Defined Quality:
Giving the Community a Voice in Service Delivery

A Learning Tool for use with the instructional video

Focus Group Discussion, Gondama community. Photo by Beth Outterson

The instructional video *Partnership Defined Quality: Giving the Community a Voice in Service Delivery*, and accompanying Learning Tool were developed in 2017 by Medical Teams International *(MTI)*. The key author of these materials is Beth Outterson, Capacity Building Advisor at Medical Teams International, with support from Tyler Graf, Marketing Coordinator. Special thanks to Andrew Hoskins, Country Director, MTI Liberia, and the following MTI Liberia staff: George Kaine, Richard Zeogar, Senesee Williams, Boakai Kamara, Peter Robinson, Gabriel Johnson, Fekade Solomon Arega, and, Romax Zizi. We also thank members of the communities of Bendaja, Bambalah, Karnga and Gondama in Grand Cape Mount County, Liberia for their participation and flexibility. The video was shot, edited and produced by Ibex Communications. All photos in this Learning Tool were taken by MTI staff.

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Quality Improvement Team meeting, Bambalah community

About the PDQ Instructional Video and Learning Tool

The instructional video, *Partnership Defined Quality: Giving the Community a Voice in Service Delivery*, and accompanying **Learning Tool** were developed by Medical Teams International *(MTI)* in order to facilitate understanding of the Partnership Defined Quality *(PDQ)* process, and demonstrate how it has been applied in communities within Grand Cape Mount County, Liberia.

PDQ was developed by Save the Children in 2003, and since that time, it has been used at the community level in more than 15 countries. It is an innovative methodology that engages community members as partners with health facility staff in defining, implementing and monitoring the quality of health service delivery. MTI staff built on Save the Children's guidance documents to develop its own country specific resources when it began implementing PDQ in 2014.

In order to facilitate learning and scale up of PDQ, MTI received a small grant from Save the Children through its USAID-funded TOPS project to develop an instructional video and Learning Tool. The video is intended to be used as a complement to, and not a replacement for, attending a PDQ training workshop. The ultimate aim of the video is to share the Liberia experience and generate interest in implementing PDQ in other countries.

The Learning Tool is intended to be used by a facilitator to use after presenting the video in order to enhance learning of the viewers. Its main components are a list of Frequently Asked Questions *(FAQs)* and a set of Discussion Questions that can be used after the video is viewed to provide clarification and enhanced understanding of PDQ. Following the questions, there are two annexes*: 1) the narrative script from the video that can assist viewers to remember what took place in the video; and 2) a list of important resource documents, such as the original PDQ Manual and M and E Toolkit developed by Save the Children, and country specific facilitator's guides developed by MTI.*

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Frequently Asked Questions *(FAQs)* about Partnership Defined Quality *(PDQ)*

This information is more fully explained in the PDQ reference publications listed in Annex 2.

How long does it take to implement the PDQ Process?
The length of time it takes to implement PDQ depends on the number of staff dedicated to the process. The process can take from six weeks up to three months to get through Phases 1-3 until the QIT is launched and trained. However once the QIT is formed, we generally say that six months of follow up using the monitoring and evaluation tools are needed to ensure that the QIT is functioning well.

How many staff are needed to implement PDQ?
MTI conducted Phases 1-3 and then followed up the QIT for three to four weeks using one full-time staff person, one half time staff person and one 25 percent staff person over a six month period of time. It is important to start small with one or two communities before starting to expand to more communities.

Do you have to do PDQ in each catchment area?
Yes, one great aspect of PDQ is that individual communities feel that their needs are being addressed. This requires that the PDQ process needs to be repeated in each catchment area of a given health facility. In larger catchment areas, you may feel that a larger number of focus group discussions are needed to have better representation of the needs of marginalized groups. PDQ does not require perfect representation when selecting the individuals for participation in the focus group discussions.

How can members of the QIT be motivated to participate in meetings?
Not every community is motivated in the same way or by the same factors. And there are varying various levels of stress on populations that may encourage or discourage participation in QITs even after a very successful Phase 1, 2, and 3. It is critical that the implementing NGO monitor the progress of the QIT for six months after it is formed to guide progress. Monitoring tools such as the Quality Improvement Verification Checklist can help troubleshoot issues within and external to the QIT that may be inhibiting progress. A key factor in the motivation level is the acceptability by the stakeholders in the Building Support phase and the degree to which they embrace and promote the PDQ process from the beginning.

How can PDQ be taken to scale, given the intensity of work and time needed?
The results of the PDQ process have not been well-documented, since it has often been part of the reporting on quality within larger projects, rather than as process that itself should be measured. In a few countries, however (Armenia, Pakistan, Bolivia, Nepal) Save the Children and partners took PDQ to scale and documented the added value of PDQ in improving health service delivery. When we say scale here we are referring to coverage in all geographic areas. In Liberia, MTI is experimenting in Sinoe County with a schedule of two teams each adding one new health facility each month and continuing QIT mentorship.

Because PDQ is about hearing the voice of the marginalized, each catchment area of a health center *(could be several villages or communities)* should receive the PDQ process rather than trying to combine communities that pertain to several health centers. This is why the process can take time. However, the attention to each community empowers its members to take ownership of their health facility.

What other methodologies are similar to PDQ?
There are several community based quality improvement methodologies, each with its unique approach. They include COPE *(Community Oriented Provider Education)* developed by EnGender Health, *CVA (Citizen Voice and Action), developed by World Vision, and Community Scorecard, developed by Care. CORE group conducted a comparison of these approaches in an article on social accountability (see end of this document for the link).*

Why are role plays sometimes used with community members (in addition to FGDs) to gather information about barriers to quality services?
When PDQ was adapted for use with adolescents and youth, the element of the role play *(also called a socio-drama)* was added so that young people would have another way to share how they felt when they went to the health center for information and services around adolescent reproductive health *(in addition to being asked).* Later, MTI included the role play as an option with all communities, since they seemed to elicit more sentiment from the participants versus the focus groups. So it currently used as an option if community members would like to do it.

How can low-literacy QIT members be equipped to mobilize their communities for social change?
Community members can be very resourceful. If they are motivated, they will be eager to learn. As part of the Facilitator's Guides for Haiti and Liberia, MTI has developed the following short lessons for building capacity of QIT members as they prepare to mobilize their community:

1) How to Work as Part of a Team, 2) How to Mobilize Your Community, 3) How to Facilitate a Session, 4) How to Gather PDQ Information *(conducting Exit interviews and gathering data from health centers)*, and 5) How to Use Your Networks to Solve Problems.

How will the QITs be managed after the implementing NGO departs?
During the planning and design period, it is important to identify existing entities in the community that address health and development. In some countries, local health and development committees have integrated the QITs into their work, and in others they have been adamantly opposed. Decisions about managing the QIT need to happen with local leaders and according to their terms. This will help ensure its sustainability.

Quality Improvement Team meeting, Bambalah community

Questions for Discussion

Instructions for the Facilitator:

After showing the video, the following questions can help illuminate viewers' understanding about PDQ. There are 11 questions listed. The questions are listed in chronological order of the steps of PDQ. However if you have limited time, just focus on the following five questions: 1, 2, 6, 9 and 10. Before viewing the video, select the questions that make the most sense for your audience (for example, if they are all working on the same project, you would not ask about different countries). Allow 30 minutes to discuss the five questions if done in plenary. If you prefer to divide into small groups, allow 10 minutes to discuss each question and time for a brief two to five minute report back from each group.

1. **Have you implemented the PDQ process before in any sector?**
   If so, please share your experiences.
   a. **Who were the two "partners" in the partnership within your context or in your sector?**

2. The PDQ process attempts to address issues and barriers that the community has tried to overcome but has not had success. Most of these barriers are social barriers that keep people from accessing services.
   a. **What were some of the barriers mentioned in the video?**
   b. **What other barriers do you see in the communities you work in?**

3. There are other methodologies similar to PDQ that promote the rights of community members to hold providers accountable to do their job.
    a. **Have you used such methodologies?**
    b. **If so, what were some of the Lessons Learned?**
    c. **If so, what are the differences you notice in PDQ?**

4. PDQ has four phases, but there is also a Planning and Design component described before Phase 1.
    a. **Why do you think that planning and design might not be considered a separate phase?**

5. In the Building Support Phase *(Phase 1)*, community stakeholders are asked to identify the three most vulnerable groups, meaning those who need the clinic services the most.
    a. **Why is it important for community members *(and not the implementing NGO)* to identify these groups?**

6. During Phase 2, Exploring Quality, the facilitator starts the focus group discussion with a story about buying cassava in the local market. Much time is spent helping community members think through how they select who they will buy from.
    a. **Why do you think that understanding the meaning of quality is important?**

7. For Phase 3, the Bridging the Gap session requires the skills of a neutral facilitator.
    a. **What do you think we mean by "neutral" and why do you think that might be important?**

8. During the Bridging the Gap session, after all similar complaints have been matched up between the provider and community groups, there may be some important items listed by the community that were not listen by the providers *(such as lack of water in the clinic*).
    a. **What might the facilitator do in this case?**

9. PDQ can work in a variety of settings, including humanitarian settings, as long as there is a cohesive community within a catchment area and providers who are responsible to provide a service to community members. PDQ is based on social barriers to services, whether that can be seen as health services, educational services, agricultural services, etcetera. PDQ has been used most frequently in communities where there is strong community motivation for change. It may be more difficult in communities where there is strong NGO saturation and less motivation to volunteer, versus receiving an incentive.
    a. **What are some country or program contexts where you think PDQ may work well?**

10. When MTI started implementing PDQ in Liberia, many adaptations were made to take into account the local culture. For example, exit interviews were adapted to be administered by pairs of QIT members *(one literate, one non-literate).* In some communities, the team building game may need to be changed if you are in a community where it is not appropriate for men and women to have any physical contact. In Pakistan, QITs were held separately for men and women.

a. **What kinds of adaptations do you foresee you might need to make to the PDQ process in the communities you are working in?**

11. The PDQ M and E Toolkit was developed by Save the Children to standardize how PDQ is measured.

a. **What were some of the tools mentioned in the video to measure quality improvement?**
b. **What other kinds of tools do you know of to measure "quality"?**
c. **What kind of challenges do you face *(or foresee)* in measuring "quality"?**

Annex 1: Narrative Script of the PDQ Video

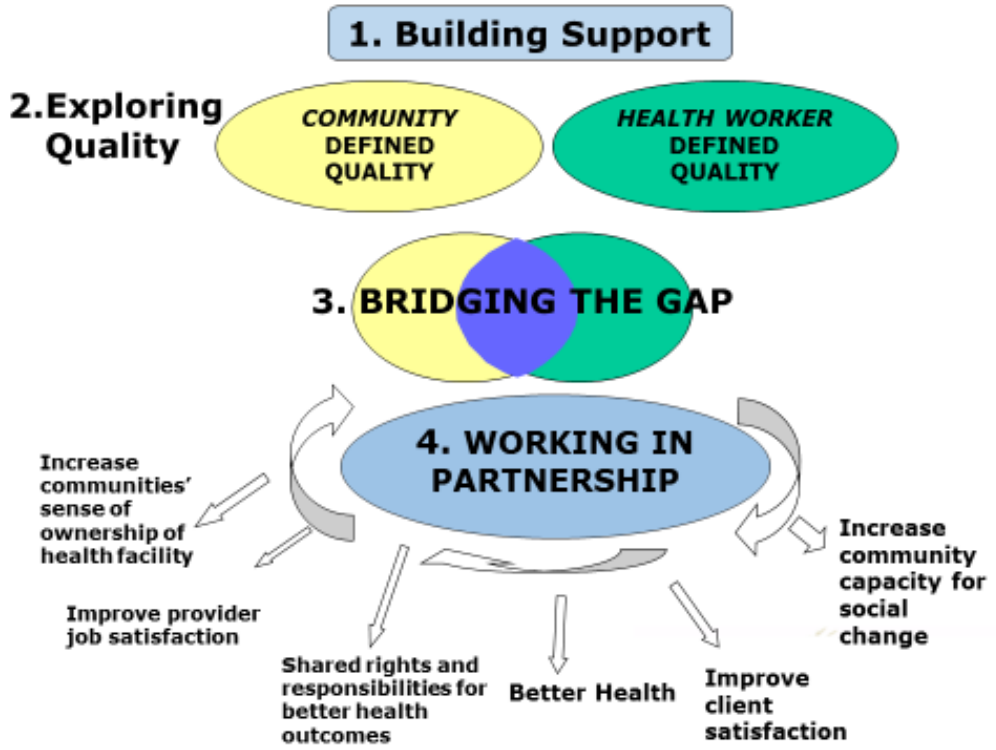
Partnership Defined Quality *(PDQ)* is a methodology to improve quality and accessibility of services by engaging community members in defining, implementing and monitoring the quality of service delivery. Through the PDQ process, service providers and community members are empowered to develop local solutions together.

Why should communities be engaged? For a variety of reasons, many efforts to improve quality may not consider community concerns and perspectives about quality of care. As a result, improvement efforts can fail to meet the needs of community members. Since PDQ was developed by Save the Children in 2003, it has been implemented in over 15 countries, linking health quality improvement efforts with community mobilization.

PDQ can be applied to solve a variety of community problems, and improve services, including education, food security, HIV and AIDS, and Health care. It has most often been used to increase access to health services by marginalized groups. This video illustrates how Medical Teams International is using PDQ to improve quality of health care services in Grand Cape Mount County, Liberia.

The process includes four phases. Phase 1 involves Building Support among stakeholders to engage in the PDQ process. Phase 2 is all about Exploring Quality, as information is gathered from vulnerable community groups and service providers to learn what quality health services mean to them. In Phase 3, called Bridging Gap, Community groups and service providers come together to examine and agree upon a set of problems. Phase 4 continues indefinitely, as a community level Quality Improvement Team Works in Partnership to address the identified problems.

On the following page you will see a diagram of the PDQ process.



Save the Children, 2003

Before You Start: Planning and Design

A successful PDQ process requires thorough planning and design in advance of beginning the four phases of implementation. It starts with determining whether PDQ makes sense to use in a given community, and by assigning roles among NGO staff based on individual skills and aptitudes.

Critical planning components include:

- Identifying the needed skills & resources amongst your staff
- Defining your NGO's goals for PDQ
- Identifying the level of service for implementing PDQ
- Defining the type of services and mapping the community needs and resources
- Planning for participation & representation
- Identifying other Quality Improvement initiatives in your community or region, and other partners who are implementing them.

Once these planning and design steps have been taken, and you have the information you need, the PDQ process begins with Phase 1: Building Support.

Phase 1: Building Support

In a small village within Grand Cape Mount County, facilitators from MTI begin the PDQ process by conducting meetings with different community stakeholders. Sometimes this can be done as one joint stakeholder's meeting.

There are two reasons for this initial meeting. The first is to gain consensus on the existence of the problem, and the second is to gain the support from community leaders to use PDQ to help address the problem. In the case of Liberia, one of the main problems was that pregnant women were not delivering in the health facilities. The stakeholders agreed that this was a problem they could not address on their own. Once MTI explained the PDQ process, the stakeholders agreed to give their support to implement it in their community.

It is also critical to the success of the Building Support phase that community members identify and agree on who are the most vulnerable groups in their community who are not fully utilizing services. Hearing the voices of these vulnerable groups will be crucial as the PDQ process moves forward.

Access to health centers is difficult since the distances are far to walk.

Phase 2: Exploring Quality

Once support for the PDQ process has been established, and the process has been thoroughly explained, focus group discussions are conducted to explore how quality services are understood by each of the parties involved.

Separate meetings should be held for each of the vulnerable groups identified in the Building Support phase. In Liberia, vulnerable groups were identified as pregnant women, women with

small children and the elderly. Focus Group discussions were also held with clinical and nonclinical staff, community health workers, community health volunteers, and trained traditional midwives.

Quality services are not “one size fits all.” Perceptions and expectations of quality are shaped by peoples’ own understanding and personal experience. One way to guide participants in their understanding of what constitutes “quality” is to use an analogy that is familiar in daily life. For example, how one chooses quality food in an open marketplace.

Because PDQ is a rights-based approach, sometimes role playing in a brief socio-drama can also be used in the Exploring Quality phase. In Liberia, participants demonstrate how they feel when receiving services that they have the right to receive at the health center.

Focus Group Discussions are a powerful way of hearing the voice of people who may not be using the health facility, As they listen to each other they become more aware of their common concerns. When facilitated properly, these focus group discussions allow for a free, open exchange of ideas that will begin to define obstacles that can diminish quality, as well as identify strengths in the delivery of existing services.

Throughout these discussions, staff from the NGO conducting the PDQ process must accurately record the issues and concerns raised. These important notes will form the agenda for the next phase of the process: Bridging the Gap.

Discussions with community members and providers.

Preparing for Bridging the Gap

To prepare for the day-long Bridging the Gap session, NGO staff meet to summarize and analyze what was learned through the focus group discussions. They make lists of complaints and concerns raised from each community or provider group. Each list is reviewed to remove duplicate responses. Then the community lists are grouped into one “community list”, and the provider lists are grouped into one “provider list.” It may also be helpful to group responses into categories such as: place and environment issues, medical supplies and equipment, technical competence of providers and client/provider relations and others.

Once the NGO team has synthesized and grouped the complaints and concerns from the community and provider groups, they then write or print out individual sheets for each complaint to present to participants during the Bridging the Gap session.

Phase 3: Bridging the Gap

The Bridging the Gap session is a critical component of the PDQ methodology. The purpose of this extensive meeting is to share with the community members who participated in the various Exploring Quality focus group meetings what was learned from all the discussions.

Each group has the opportunity to express their own views on quality. The groups must now bridge the language, cultural, user and provider gaps to engage in sincere dialogue about the priority problems they have identified in their community. This phase is the launching point for the ongoing Quality Improvement initiative.

After a warmup exercise, the lists of complaints and concerns that were prepared by the NGO implementation team are considered, discussed and arranged by the participants. Issues raised by community members - the vulnerable groups - are placed on one side of a wall, and those identified by service providers are placed on the other side with empty space available between the sides.

Participants are asked to read the complaints and concerns on both the community side and the provider side. Participants then select problems from each side that look similar. If everyone agrees that these two complaints are similar, the facilitator guides the group to state the actual problem, and then adds it to the list in the middle of the wall. There are many ways to do this, and communities can get very creative.

There can be some tension or defensiveness among participants as problems are discussed, so it's critical for these sessions to be led by a neutral facilitator, who can gently remind people they are all in this for the common goal of improving their community. Once a number of problems have been agreed upon, the group takes a break. This reduces communication barriers and creates a relaxed and positive atmosphere for working together.

In the next step of the Bridging the Gap session, participants identify common problems and align related sub-problems, as they arise, to better understand patterns and explore associations between issues. Please note that this is often a messy process. This is okay. If there are significant problems addressed on the community side that were not mentioned by providers, or vice versa, participants need to discuss if it is actually worth addressing.

The list of identified problems in the middle of the wall represent the joint decisions made by all present. Once they have a good number of problems identified, they're ready to move toward to the next step of solving these problems. Most communities identify six to eight problems during the Bridging the Gap phase.

QIT Members should:

- Be well-respected,
- Have an interest in promoting the health of the marginalized, and
- Have time to come to monthly meetings

Key Responsibilities of QIT members:

- Attend monthly meetings
- To be cooperative
- To volunteer work to complete the action plan

At this point, an NGO facilitator describes the concept of a Quality Improvement Team. This team is selected by the participants, with special attention paid to gender equity, inclusion of members from each vulnerable group, as well as community members and service providers. Generally, there should be equal numbers of QIT members from each group, for a total of around 15 people.

The facilitator asks the participants to select the Quality Improvement Team *(QIT)* members, based on three criteria *(see text box).*

This Quality Improvement Team, or QIT, will work together on an ongoing basis to address the issues defined through the Bridging the Gap session.

The new QIT members then make a formal pledge to support their communities and take on their first task: to determine when and where the group will hold their first meeting.

Phase 4: Working in Partnership

The fourth phase of the PDQ process is: Working in Partnership. This phase begins with the first meeting of the Quality Improvement Team.

To get things started, a culturally appropriate team building game is organized by the facilitator. This exercise creates and atmosphere of fun for the meeting, and can help remove social barriers between members of a diverse group. As the task of fitting on to a shrinking sheet of paper grows more difficult, the facilitator suggests an innovative approach that works within the guidelines of the game.

With the ice broken, the QIT then begins the process of organizing themselves. Ground rules are established. Team leaders are selected, including a chairperson, and a secretary who will be responsible for recording minutes of the meetings.

Now the fundamental work of the QIT begins. The group discusses the challenges that were agreed upon at the Bridging the Gap session, the relative priority of each issue, and selects one on which to focus first. As the group learns to work together, the NGO facilitator provides tools

for problem analysis and action planning, starting with a diagram to guide discussion about the root causes of the problem

The QIT then creates an action plan to guide their work, and a tracking table to keep tabs on progress as the project moves forward. While demonstrating these tools for discussion and problem solving, the implementing NGO should emphasize that the QIT is engaging in a continuous process of problem identification, proposal of problem solutions, implementation and assessment. As QITs become more adept at problem solving together, and see their progress, they understand the importance of their ongoing role as agents of change.

After guiding the community through the four phases, the implementing NGO can contribute to the long-term success of the QIT through monitoring and evaluation.

Monitoring and Evaluation

Monitoring tools can include careful observation of a QIT meeting in progress, while completing a Quality Improvement Verification Checklist, and then sharing feedback based on the observation with QIT members. A Team Effectiveness Questionnaire is another tool that assess the functioning of the QIT, but from an individual's member's perspective. This gauges whether they feel that their contribution is valued. One way of monitoring change in client satisfaction at the health clinic is to conduct confidential exit interviews with community members after they leave the health facility. These results are then fed back to the QIT each month.

As a Quality Improvement Team continues to progress, NGO staff should regularly check in on ongoing activities, and review documentation of service records. In Liberia, this step includes analyzing reported clinic data on facility assisted deliveries.

Summary and Conclusion

Engaging community stakeholders through the PDQ methodology has led to ongoing improvements in quality of services and tangible results in underserved communities all over the world.

This rights based approach promotes equity by engaging vulnerable groups who are not usually included in decision making. The process transforms communities by empowering these groups to take charge of their own health and well-being.

Resources that can help implement the PDQ process include: The PDQ Manual, PDQ M and E Toolkit, PDQ for Youth Manual, and MTI Facilitator's Guides developed for Liberia and Haiti.

The QIT of Bambalah is building staff quarters near the clinic which includes 2 rooms for pregnant mothers.

Annex 2: PDQ Resources

Partnership Defined Quality: a tool book community and health provider collaboration for quality improvement, Save the Children, 2003. Principal authors: Mary Beth Powers, Marcie Rubardt, Debbie Fagan and Ronnie Lovich.

This is the original PDQ Manual that was developed by Save the Children, based on the need to address social barriers to health service delivery.

http://www.medicalteams.org/docs/default-source/resource-center/partnership-defined-quality-manual.pdf"

Partnership Defined Quality Monitoring and Evaluation Toolkit, with Youth Annex, Save the Children, CORE, USAID 2010.

This toolkit includes templates for community mapping, and indicators for building community capacity that are linked with questions on the observation checklist and exit interviews. The tools in the toolkit are based on tools used in Save the Children's country programs.

http://www.medicalteams.org/docs/default-source/resource-center/partnership-defined-quality-toolkit.pdf?sfvrsn=2

Partnership Defined Quality for Youth: A Process Manual for Improving Reproductive Health Services Through Youth-Provider Collaboration, Save the Children, 2008. Principal authors: Beth Outterson, Brad Kerner, Aditi Krishna and Sharon Lake-Post.

This is Save the Children's adaptation of the PDQ process to promote adolescent friendly health services. This manual includes more games than the original PDQ manual and also includes the use of socio-dramas with youth rather than focus group discussions.

http://www.medicalteams.org/docs/default-source/resource-center/partnership-defined-quality-youth-manual.pdf?sfvrsn=2

Partnership Defined Quality Facilitator's Guide for MTI Liberia 2016, Medical Teams International, 2016.

This is the facilitator's guide that was developed for implementing PDQ within the context of Liberia and in the operating structure of Medical Teams International. It includes 5 lessons for capacity building of Quality Improvement Teams.

http://www.medicalteams.org/docs/default-source/resource-center/medical_teams_international_pdq_facil_guide_liberia.pdf?sfvrsn=2

Qualite Definie du Partenariat, MTI Haiti, 2016, Guide du Facilitateur, Medical Teams International, 2016.

This is the PDQ Facilitator's Guide for MTI's work at the health post level in Crochu, Haiti. It is in French. It includes 5 lessons for capacity building of Quality Improvement Teams.

http://www.medicalteams.org/docs/default-source/resource-center/pdq-guide-haiti.pdf?sfvrsn=2

Partnership Defined Quality Facilitator's Guide, Save the Children, 2004

This document was developed by Save the Children. It consists of Power Point slides with description of the different phases of PDQ. It is appropriate for a Train the Trainers but does not include guidance for implementation at the field level.

http://www.coregroup.org/storage/documents/Social_Behavior_Change/Save_PDQ_Facil_Guide.pdf

Maximizing the Effectiveness of Partnership Defined Quality, Save the Children, published by CORE, USAID, 2008.

This document is a summary of a PDQ Technical Advisory Group meeting amongst PDQ practitioners from 5 organizations and representing 11 countries. The key component of he document is a set of 18 essential elements for the PDQ process to be effective in a community. The document was the driving force behind the PDQ Monitoring and Evaluation Toolkit.

http://www.coregroup.org/storage/documents/Workingpapers/pdq_tag_summary_finala.pdf

Hoffmann, K.D. **The Role of Social Accountability in Improving Health Outcomes: Overview and Analysis of Selected International NGO Experiences to Advance the Field.** June 2014. Washington, DC: CORE Group.

This journal article is the outcome of a review and analysis of NGO experiences in social accountability in the literature, and includes descriptions approaches that promote social accountability at the community level, including PDQ.

http://www.coregroup.org/storage/documents/Resources/Tools/Social_Accountability_Final_online.pdf