



Center Publication No. 101

IMPROVING THE QUALITY OF CARE

*Quality Improvement Projects
from The Johns Hopkins University
Bloomberg School of Public Health
Center for Communication Programs*

Population Communication Services



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*Quality Improvement Projects from
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February 2003

The Johns Hopkins University
Bloomberg School of Public Health
Center for Communication Programs



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On the Cover: Health workers in Nepal take part in an interactive listening forum in the Distance Education Radio Communication Project.

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Preface and Acknowledgments

In the mid 1990s, public health agencies around the globe engaged in a concerted effort to maximize access to quality health care. With major funding from the United States Agency for International Development (USAID), Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs (CCP) worked actively with numerous agencies in more than 20 countries worldwide to contribute to this effort. Specifically, in implementation of the Population Communication Services (PCS) project, CCP and its partners developed and tested various strategies to improve the quality of reproductive health care and family planning and access to those services. More than a decade of CCP field experience has produced evidence that various communication strategies provide practical and cost-effective ways to increase the quality of care in numerous reproductive and family planning service delivery systems and social contexts. It is with much gratitude that we thank the following people and organizations for their support of the quality initiative, which made the projects described in this publication successful.

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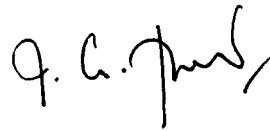
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Introduction

Improving the Quality of Care in Developing Countries

Providing high-quality care in reproductive health and family planning services is the right thing to do. Quality health care attracts clients to clinics and keeps them coming back. It increases job satisfaction, motivates health workers, and minimizes waste of valuable resources. Quality family planning and reproductive health care supports clients' ability to choose an appropriate contraceptive method, use it correctly, manage side effects, and discuss related reproductive health issues openly with their provider and partner. Ultimately, it contributes to improving women's health.

CHALLENGES

Improving the quality of health care services in developing countries is not easy. Quality is a nebulous concept that can mean different things to clients and providers and vary by place and over time.¹ Yet the concept of quality must be defined and made operational to create the service standards and performance indicators that drive quality programs. Formulating service standards should address clients' concerns and providers' needs, as well as biomedical issues. The standards must be realistic and achievable given local resources, and they must serve as a guide for measuring the actual quality of services delivered. Those concerned with improving quality must clearly formulate and effectively communicate service standards to all that play a role in achieving them.

Although health workers and clients recognize problems in health care, they typically feel powerless to change the system. Providers and other front-line staff often lack the authority, motivation, and resources to correct even simple problems while clients tend to accept the prevailing level of care, no matter how poor. Effective quality initiatives empower providers by meeting their needs for equip-

ment, supplies, and training; creating mechanisms for performance feedback and staff problem solving; and promoting a collaborative relationship with supervisors. Effective programs also empower clients by raising their expectations, encouraging them to play active roles in quality improvement by demanding better health care, and teaching them how to participate actively in consultations with health workers.

Improving health care in a comprehensive manner requires not only empowering community members and service delivery staff, but also enabling them to work together at multiple levels, despite barriers often created by differences in education, ethnicity, socioeconomic class, and language. Quality improvement professionals can bridge the social gap between these two groups by helping each group understand and communicate with the other, thus increasing use of reproductive health and other services. In the process, community members can contribute to producing and sustaining that increase by working with providers to identify and prioritize service delivery problems, as well as assisting in the design and implementation of appropriate and effective solutions at the local level.

Sustainability, scale, and integration pose further challenges for quality initiatives. Effective quality improvement is a multifaceted process; it is not the result of a short-term intervention. Once providers achieve standards, continual attention and monitoring are required to maintain and ultimately exceed them. Quality improvement advocates must design initiatives so that they can be implemented on a large scale to affordably and effectively reach large populations without losing impact. Ideally, these efforts should be multisectoral to include a range of groups affecting provision of reproductive health care: private and public providers at various levels, policymakers, local decision-makers, and pharmacists. In some instances,

¹ Kols, A.J. and Sherman, J.E. (November 1998). *Family Planning Programs: Improving Quality*, Population Reports, Series J, No. 47. Baltimore: Johns Hopkins Bloomberg School of Public Health, Population Information Program.

activities that focus on a single aspect of quality, such as counseling or infection prevention, are adequate. But often a more integrated and comprehensive approach is needed for greater impact.

PROVEN STRATEGIES

Experience demonstrates that communication is pivotal in quality improvement. Based on work with partners in over 20 countries and participation in such global efforts as the Maximizing Access and Quality (MAQ) Initiative launched by the United States Agency for International Development (USAID), the Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs (CCP) has identified a number of innovative and effective applications of strategic communication to improve reproductive health care. This document describes programs that demonstrate the value of five communication strategies used to improve quality. Each of the five strategies reflects the evidence-based principle that impact is greatest, and more likely to be sustained, when initiatives address both supply of and demand for quality health services:

Build partnerships among communities and providers. The Puentes project in Peru showed how opening lines of communication sensitized health workers to the real needs of people and allowed community members to see the challenges faced by providers. Improving communication between community members and providers induces short- and long-term changes that benefit both parties.

Enable providers and empower clients. Interpersonal communication and counseling (IPC/C) skills are as critical to quality care as clinical technical skills. Providers require training, supervision, and continuing support to strengthen those skills. Research in Indonesia showed that quality improved most with reinforcement of provider IPC/C skills and coaching of clients in the skills they needed to demand good care and play an active role in consultations.

Harness the power of the mass media. Mass media can be used to influence provider, client and community behaviors that influence the quality of health care. It is a powerful tool for behavior modeling and can raise expectations regarding quality. As exemplified in Nepal, the combination of two synergistic radio serial dramas—one aimed at health providers, the other at the general public—focused on quality of service delivery and demand for quality services. A distance education radio drama focusing on providing quality service reached remote and scattered health care providers while the second radio serial drama modeling positive behaviors to increase demand for quality services reached communities.

Create marketable brands of quality health care. Promoting marketable brands that convey a promise of quality service can help establish a culture of quality among a service delivery organization's staff and increase access and use of services. Filipino businessmen demonstrated the effect of promoting health services that offer quality care by giving them an easily recognizable symbol or logo. The symbol or logo made it easy to promote the facilities and clients to find them.

Certify and recognize quality. Certifying quality service provision based on performance against a set of pre-established standards, coupled with publicly recognizing those certified, provides an overarching strategy that can pull together multiple quality improvement interventions. This approach effectively influences a full range of mutually reinforcing factors related to both supply of and demand for quality health services. Projects in Brazil, Egypt, and West Africa showed how certification systems prompted administrators to renovate and re-equip facilities, train staff, and overhaul management systems. Communication campaigns then promoted those changes, raised client expectations, and provided recognition for progress made.

The profiles that follow illustrate how each of these strategies was implemented in quality initiatives around the world.

1

Build Partnerships Among Communities & Providers

PERU

The Puentes Project: Building Bridges for Quality

The Puentes Project: Building Bridges for Quality used a community mobilization approach to improve the quality of health services in three rural communities in Peru, where cultural, psychosocial, and language barriers contributed to a deep divide in communication between health care providers and clients. Before the project began, clients were dissatisfied with their treatment, and providers were critical of perceived client shortcomings²

The Puentes Project brought community members and health providers together to create an action plan for improving quality—one that was based on shared goals brought about by respectful dialogue between the two groups.

The Puentes Project began to bridge the communication gap between clients and providers in 1998 through a joint initiative between the Peru Ministry of Health (MOH) and the Population Communication Services (PCS) project. To lay the groundwork for partnership between rural communities and health providers, the MOH field team received training in community mobilization, facilitation, interpersonal communication, and participatory techniques.

The three communities chosen for the pilot program—Colque, Azangarillo, and Casani—had poor health



Health providers and community members watch a drama during a “Dialogue of Knowledge” session.

indicators and low clinic use, and most importantly, had expressed interest in being part of the project.³ About 50 participants were recruited at each site—half from the community, half from the health care staff. Community participants represented a mix of typical clinic clients—men, women, young, old, and traditional and informal leaders. Health staff participants

came from local health posts, health centers, and hospitals and included service directors, doctors, nurses, midwives, social workers, and technicians.⁴

The MOH field team met separately with community members and health staff to facilitate discussion about what characterizes quality health services. Following that, each group under the technical guidance of the MOH team produced a powerful video with interviews, group discussion, testimonials, skits depicting real and ideal client-provider interactions, and ideas for improvement.

Joint presentation of the videos to the community and providers did not take place, however, until the groups developed some trust toward each other. The MOH team was concerned that sharing the videos might further the gap between the two groups and make it difficult for the partnership to move forward. To foster trust, the groups spent an entire day reciprocating hosting roles for sharing

² Howard-Grabman, L., Ainslie, R., Aguilar, M. (2001). Building Bridges for Quality: A Community Mobilization Project to Improve Quality. Unpublished report. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

³ JHU/PCS. (1999). Metodología Puentes hacia la calidad de atención. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

⁴ JHU/PCS. Metodología Puentes: Manual Para Facilitadores de Campo.

meals and socializing. Community members gave providers a map and guided tour of their village since most of the providers live outside the community they serve. Providers hosted community members by giving them a tour of health facilities.

The following day, in an atmosphere of trust, the groups presented their videos and engaged in participatory exercises. The presentations and exercises allowed providers to recognize their adverse treatment of clients, and community members gained insight about the difficulty of being a provider. This understanding of each other's perspective helped begin to bridge the gap between providers and community members, and both groups were able to move forward working together. Jointly, they defined the key elements of quality health care, set priorities, and developed strategies to improve local health practices and services. These discussions became the basis of an action plan to improve the quality of care.

All three pilot sites developed action plans. Each plan sought to improve: the way people are treated, communication between client and provider, access to reasonably priced drugs, schedules, equipment, facility infrastructure, and transportation. The plans specified negotiating strategies, shared rights and responsibilities, resources, and mechanisms to achieve desired goals as well as indicators to measure progress. Each site formed a joint committee to oversee the implementation of the action plan and held general meetings to keep the community informed.

CHALLENGES

The Puentes experience presented some particular challenges as it required effective mobilization of two groups with very different world views. At times, overcoming the strained relations between providers and community members proved difficult and much energy was expended in trust-building activities. The pilot sites chosen for Puentes expressed an interest in participating in the experience

from the beginning. Replicating the project in a context with less enthusiasm up front may be less feasible.

ACHIEVEMENTS

Information from clinics and results from the initial evaluation of the participatory process of implementing the action plans were encouraging. Less than one year after implementation of the action plan, improvements in local health care services were visible, including the provision of:

- 24-hour coverage at the health post;
- complete drug stocks;
- an emergency fund;
- a complaint system for clients and providers;
- publicly posted price lists; and
- walkways, lighted areas, fences, and general remodeling of the physical structures.

The MOH reported that such improvements resulted in measurable increases in the use of family planning and child survival services and attendance at health education sessions.

Equally important was the change in attitude between providers and community members. The Puentes Project helped build a sense of teamwork and greater accountability. By developing a shared vision, shared goals, and shared objectives, the project helped foster equity and shared responsibility between community members and providers.

Community members and health staff also found many areas of common interest. They remain committed to working together and appreciate the support they offer each other. The Puentes Project proved as empowering for providers to make changes in the health system as it did for clients in communicating with their provider about their health needs.

Neighboring towns took notice of the three sites and learned from them. Accordingly, the Ministry of Health is replicating the Puentes process in other regions and is considering a nationwide program based on this methodology.



Poster at a Ministry of Health clinic listing the rights and responsibilities of clients and health providers.

2

Enable Providers – Empower Clients

INDONESIA

Provider Self-Assessment and Client Education

Improving the quality of interpersonal communication and counseling (IPC/C) skills of trained providers while empowering clients to communicate with their providers was a challenge in Indonesia. Providers' newly learned IPC/C skills erode over time when not reinforced. Close supervision to help providers maintain their IPC/C skills is neither economically nor logistically feasible in Indonesia.



A “Smart Patient” coach preparing a Muslim client for a counseling session in Indonesia.

Indonesia's National Family Planning Coordinating Board (BKKBN) and CCP addressed the issues of sustaining behavior change in interpersonal communication in 1998 by developing and testing a low-cost, dual approach intervention: 1) reinforcing provider training through self-assessment and peer review and 2) coaching clients to communicate more effectively with providers.

The intervention to reinforce IPC/C training for providers consisted of four months of self-assessment with or without peer review following the workshops.⁵ This effort was designed to magnify the impact of BKKBN's new national IPC/C curriculum. With support from the USAID-funded Quality Assurance Project (QAP), CCP conducted operations research to test the effectiveness and feasibility of self-assessment and peer review as alternatives to direct supervision. CCP conducted the research in 191 clinics in the ethnically diverse provinces of East Java and Lampung in 1998.

Using a simple form, the self-assessment activity consisted of providers taking 15-20 minutes weekly to rate their communication performance and identify behaviors that needed improvement. The peer review activity, which comprised half of the providers, entailed weekly meetings of three or four providers who discussed their counseling

concerns using a discussion guide book. In addition, they also completed the self-assessment activity. The self-assessment forms and peer review guide focused on a different skill area each week such as listening, being responsive to clients, or encouraging client participation.

To improve and expand the quality of counseling, CCP implemented a client education intervention with support of the Population Council's project entitled Frontiers in Reproductive Health (FRONTIERS), two years after initiating the provider self-assessment intervention. Sixty-four of the initial 191 clinics participated.⁶

The intervention consisted of trained client educators coaching individual family planning clients for 20 minutes in the clinic waiting room before they met with a clinic provider. The coaching sessions attempted to help clients communicate with the provider more effectively and focused on three key client communication skills: asking questions, expressing concerns, and requesting clarification. Educators helped clients formulate, write, and

⁵ Kim, Y.M., Putjuk, F., Basuki, E., and Kols, A.. (March 2000). Self-assessment and peer review: Improving client-provider communication in Indonesia. *International Family Planning Perspectives* 26(1): 4-12.

⁶ Kim, Y.M., Putjuk, F., Basuki, E., and Kols, A. Increasing patient participation in reproductive health consultations: An evaluation of “Smart Patient” coaching in Indonesia. In press at *Patient Education and Counseling* for publication in 2003.

rehearse their questions and concerns. In addition, educators assured clients they had the right to ask questions and reminded them of the slogan, “The nurse is waiting to hear from you.”

CHALLENGES

The intervention demonstrated the importance of training all providers at a clinic and orienting the rest of the staff to the intervention to ensure they support provider efforts to change IPC/C behaviors and to conduct self-assessment. It was also important to keep demands on the providers reasonable and to motivate them to continue applying the self-assessment methodology. A successful intervention requires brief, simple, easy-to-use self-assessment forms and sufficient training so providers feel comfortable filling them in on their own. The client coaching proved to be rather labor intensive and will require modification in the future to increase reach of the intervention. For greater impact, client coaching could also be enhanced with more difficult skills, such as self-disclosure, verification, and asking follow-up questions.

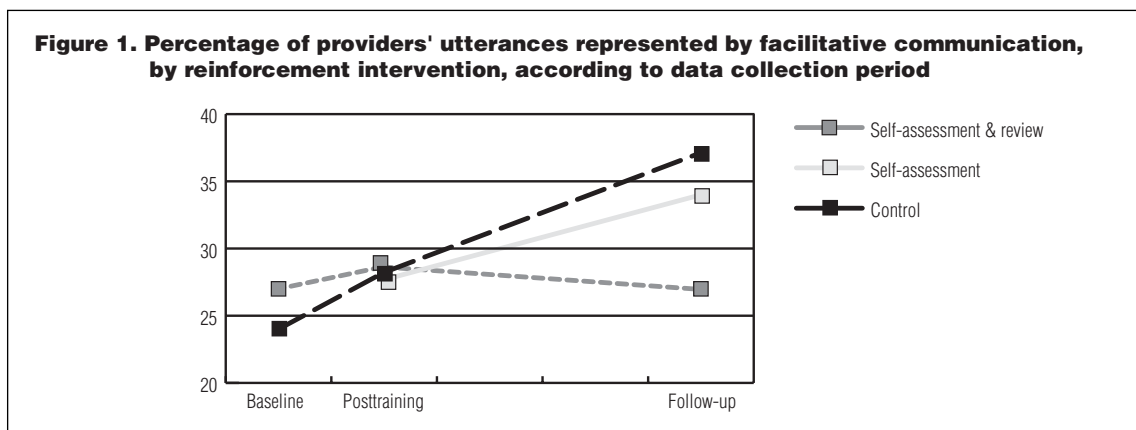
ACHIEVEMENTS

CCP researchers audio taped and analyzed the consultations to evaluate the impact of the interventions. Results confirmed that BKKBN’s IPC/C training improved providers’ communication skills. Without reinforcement,

however, the improvements dwindled over time. In contrast, training plus four months of self-assessment with or without peer review led to further gains in provider-client communication (Figure 1). In addition, reinforcement proved inexpensive and cost-effective relative to training: for four months it cost U.S. \$2 per provider for self-assessment and U.S. \$9 for peer review, compared to U.S. \$70 per provider for training.⁷

Results of the intervention for clients were similar. Client coaching resulted in each client writing down 2.5 questions and 1.5 concerns, on average, almost all of which clients brought up during consultations. Clients who received coaching raised significantly more questions (6.3 versus 4.9) and more concerns (6.7 versus 5.4) than clients who did not receive coaching. Clients reported that the educators’ encouragement and the rehearsal process increased their confidence to articulate concerns. The positive results, however, were due only in part to teaching communication skills to clients. Equally important was the clients’ new understanding that they had permission to ask questions of the provider.

Based on the results of these studies, the Sustaining Technical Achievement in Reproductive Health and Family Planning (STARH) project is scaling up these approaches in Indonesia. The effort to scale up involves adaptation for use of mass media and community mobilization in order to expand reach and empower many clients in a more cost-efficient manner.



⁷ Kim, Y.M., Putjuk, F., Kols, A., and Basuki, E. (2000). Improving provider-client communication: Reinforcing IPC/C training in Indonesia with self-assessment and peer review. *Operations Research Results* 1(6). Bethesda, MD: Quality Assurance Project for the United States Agency for International Development.

3

Harness the Power of Mass Media

NEPAL

The Radio Communication Project

The unique ability of radio to reach, entertain, and educate all types of audiences—including women with limited mobility, people with low literacy, and people living in rural areas—makes it an ideal medium for use in the mountainous and remote areas of Nepal for interventions to improve the quality of health services and increase client demand.⁸ With support from USAID, CCP's PCS project, the Nepal Ministry of Health, and the National Health

Education, Information, and Communication Center in Nepal developed an ambitious project harnessing the power of radio. The goal of the project was to simultaneously satisfy the large unmet need for contraception in Nepal, strengthen the quality of services and service delivery including the IPC/C skills of health workers, and increase client demand for quality reproductive health services. Because the needs of service providers and community members are different, the Radio Communication Project (RCP) produced two complementary radio serial dramas for each audience. Reinforcing materials for the RCP included radio spots, program booklets, resource



Health workers participating in an interactive listening forum in the Nepal Distance Education Radio Communication Project.

manuals, flipcharts, posters, pamphlets, workbooks, and a Nepali-language version of the GATHER counseling tool.⁹

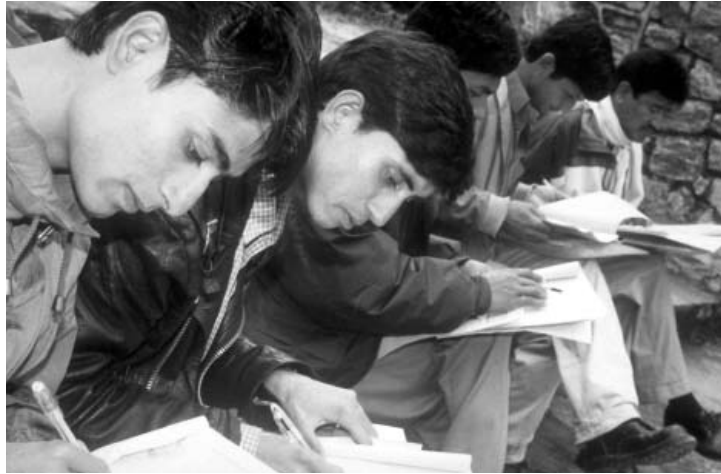
The radio drama for health service providers, *Service Brings Reward*, used an entertainment-education approach in a distance education program aimed at improving IPC/C skills. The drama followed the lives of two health workers—the head of a local health post and a home visit health worker—who modeled effective

interpersonal communication and client-oriented service provision while talking about the technical aspects of reproductive health issues. The radio serial aired in the Dang district of Nepal during 1996 and has been nationally broadcast weekly to grassroots health workers since 1997. Providers listened to broadcasts at their health post at the end of their clinic hours so they could discuss the show before going home. Interactive question-and-answer periods and quizzes reinforced the lessons illustrated by the drama. The program focused on specific counseling and technical skills that baseline research indicated were weak. Project staff distributed support materials and a dis-

⁸ JHU/CCP (January 1998). Distance education works. *Communication Impact!* No. 1. Baltimore: Johns Hopkins Bloomberg School of Public Health, Population Communication Services.

⁹ Rinehart, W., Rudy, S., and Drenan, M. (December 1998). *GATHER Guide to Counseling*. Population Reports, Series J, No. 48. Baltimore, Johns Hopkins Bloomberg School of Public Health, Population Information Program.

cussion guide to all health workers in the monitored districts—which throughout the project included Dang, Chitwan, Sunsari, Dhankuta, Kailali, Bardiya, and Kapilvastu. Staff also sent the materials upon request to health workers outside those areas.



Male health workers taking posttest during the closing of Phase III of Nepal's Distance Education Radio Communication Project.

The second radio serial drama also used an entertainment-education approach, since previous CCP projects showed such approaches effectively engage attention, motivate behavior change, and ultimately influence social norms. *Cut Your Coat According to Your Cloth* has been broadcast nationally once a week to the general public since 1997. This drama was designed to enhance the image of health workers, promote spousal communication about family planning, and educate the public about service quality, thereby heightening expectations of and demands for quality reproductive health services. About 45 percent of villagers queried at two rural clinics in Dang listened to the tale of “Salghari,” a fictional village where typical families received help from a client-oriented community health worker. It also modeled desired health-seeking behaviors such as clients asking questions of their providers about family planning methods.

CHALLENGES

Nepal's Radio Communication Project encountered some challenges including prevailing cultural attitudes. For example, preference for a son proved to be a key barrier to adoption of contraceptive methods for birth spacing and family planning. Poor access to health services, a lack of health care staff, and a lack of commodities also limited the impact of the project. Finally, the Nepalese government requires national broadcasts to be in Nepali. While populations that speak other languages did not understand the radio program, evaluation results show some impact among these populations as a result of indirect exposure through interpersonal communication.¹⁰

ACHIEVEMENTS

Distance education through radio proved to be an efficient training tool: providers' scores on written tests after listening to Service Brings Reward increased significantly in every area of knowledge compared to their scores on the test before viewing the program.¹¹ In addition, results of structured observations of client-provider interactions, in which observers used a checklist to record the occurrence of various behaviors, demonstrated the radio

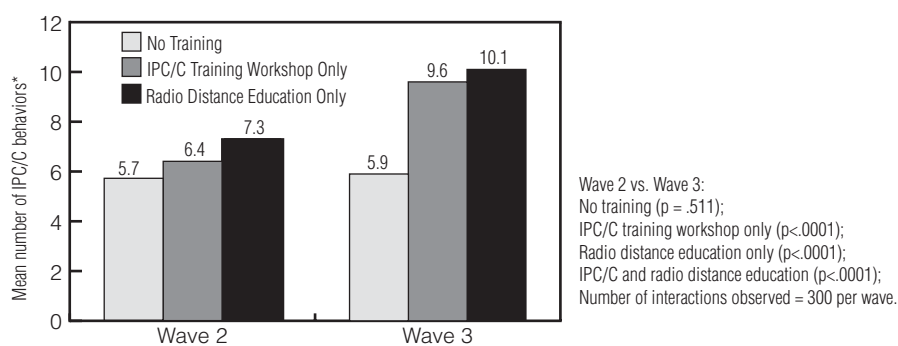


Women health workers taking notes during the Phase III orientation of Nepal's Distance Education Radio Communication Project.

¹⁰ Boulay, M., Storey, J.D. and Sood S. (in press). Indirect exposure to a family planning mass media campaign in Nepal. *Journal of Health Communication*.

¹¹ Storey, D. Successful dissemination and promotion of MAQ guidelines (Maximizing Access & Quality) through the Radio Communication Project in Nepal. Presented at the MAQ Guidelines to Action Conference, Washington, DC, May 12-13, 1998.

Figure 2. Positive provider skills per interaction by type of training received



*Mean number of IPC/C behaviors is an additive index measuring the presence of positive behaviors and the absence of negative behaviors.

Source: MOH/PCS Monitoring Study, April and October 1996

serial drama significantly increased client-centered counseling practiced by providers. The number of positive provider IPC/C skills almost doubled, from a baseline average of 5.3 per consultation to an average of 10.1 after providers listened to the distance education serial.¹² The performance of providers who listened to the distance education program compared favorably to providers from less isolated posts in the same district who only attended formal training workshops that focused on the same skills. Overall, distance education helped overcome the difficulty of reaching providers in remote areas and proved equally or slightly more effective than workshops (Figure 2).

The entertainment-education drama for clients also had a positive impact. A 1997 panel study found a significant association between exposure to *Cut Your Coat According to Your Cloth* and the likelihood of current family planning use: 81 percent of women who listened to the drama were using modern family planning compared to 33 percent of women who did not listen. Service statistics supported this association by showing increased client flow at sentinel health posts after each round of radio broadcasts and radio spots. Exposure to the radio program also was linked with greater spousal communication about

family planning: 87 percent of men who listened to the serial drama discussed family planning with their wives compared to 64 percent of men who did not listen. A multivariate analysis found that exposure to the radio drama was linked with several other important intervening variables including positive attitudes toward family planning, discussion of family planning with health workers, and perceived normative support for family planning.

Finally, results showed an increased impact on positive client-provider interaction when both clients and providers were exposed to the RCP. The impact demonstrated the synergy of the radio serial dramas. Trained providers offered a more supportive environment in which clients were more comfortable seeking information and services. Clients exposed to the RCP were more likely to attend a clinic, demand quality reproductive health services, and have a greater appreciation of the provider's role in assisting their family planning choices. Thus, the quality of family planning consultations increased when providers participated in the distance education radio drama and clients listened to the complementary entertainment-education radio serial drama.

¹² Storey, D., Boulay, M., Karki, Y., Heckert, K., and Karmacharya, D.M. (1999). Impact of the integrated Radio Communication Project in Nepal, 1994-1997. *Journal of Health Communication* 4: 271-294.

4

Create Marketable Brands

PHILIPPINES

The FriendlyCare Foundation

In the Philippines, a significant portion of the population is willing to pay for quality family planning services.

FriendlyCare is a private-sector provider of accessible and affordable quality family planning and reproductive health services in the Philippines. Founded in 1999 by top Filipino business leaders, FriendlyCare fills the market niche between free government health care and expensive private clinics by providing services to middle- and lower-income families that are willing to pay for affordable, high-quality family planning services.¹³

Establishing and marketing a brand of quality that responds to middle- and lower-income families' definition of quality was at the core of FriendlyCare's strategy of developing a national network of family planning and health clinics.¹⁴ International standards for quality in health care and extensive market research guided the design of service delivery in this private sector effort. FriendlyCare's innovative retail approach to health care included clean, brightly colored storefronts located in retail areas with service and product prices clearly posted in the waiting area.¹⁵ Media and community-based campaign



One of the Philippines' first FriendlyCare clinics.

activities promoted FriendlyCare's promises of quality family planning services at an affordable price and the promise that every client, regardless of social class, receives the same friendly, respectful care.

Quality service provision began with recruiting competent and compassionate physicians from top medical

schools. They, along with all other personnel, were trained in protocols and standards of practice for providing quality customer service, counseling, and care. Fully integrated quality assurance systems were designed to ensure every facility and every provider in the FriendlyCare system offered consistent, high-quality care.

The marketing of FriendlyCare as a quality brand not only generated demand for services but also served to solidify a common vision of quality among FriendlyCare staff. Strategic communication was also used for such specific performance issues as increasing client-provider discussion about family planning. The Let's Talk (About Family Planning) campaign incorporated family planning material such as waiting room videos, leaflets, flipcharts, and posters.

¹³ McKenzie, S., et al. (1999). *New Directions: Proposal and concept for a new NGO in the Philippines – Executive Summary*. Unpublished report. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

¹⁴ FriendlyCare Foundation, Inc. *Business Plan* (February 1, 2000).

¹⁵ Roby, A. (2000). *The FriendlyCare Story*. Manila: FriendlyCare Foundation, Inc.

FriendlyCare is now experimenting with several strategies to ensure services remain affordable. Specialized services are priced at higher levels to subsidize family planning, preventive health, and other commonly used services. FriendlyCare offers discounted packages of services such as a Family Planning Special, which includes full physical exams with appropriate family planning method counseling and distribution. A recently introduced membership card offers clients prepaid medical care and discounted laboratory and diagnostic services for an annual fee. In addition, FriendlyCare is collaborating with corporations to provide employees with family planning services and routine check-ups at discounted prices.

CHALLENGES

The Catholic Church has tremendous influence in the Philippines. In this predominantly Catholic culture, FriendlyCare management experienced passive opposition among clinic personnel early on in implementing an active family planning program. This obstacle to service delivery is now improving. FriendlyCare also underwent a major restructuring to cut costs because the original development plan was based on funding that did not materialize. FriendlyCare continues to work on its relationships with potential investors in the hopes of returning to the original plan.

ACHIEVEMENTS

To date, FriendlyCare has opened ten clinics nationwide and is working to establish links with organized and independent midwife clinics and other service providers to increase the operating capacity of the network. FriendlyCare increased the number of family planning acceptors and improved operational sustainability.

In its first two years of operation, FriendlyCare provided more than 60,000 clients with reproductive health and child survival services and served over 200,000 clients. Based on service statistics, in the first 18 months, family planning acceptors represented approximately 11 percent of all FriendlyCare clients.

In developing a self-sufficient organization, FriendlyCare clients continue to grow at about 4 percent each month, creating a positive impact on clinic revenue. To date, FriendlyCare clinics that have operated for two years have sustainability levels of about 60 percent, and clinics in operation for one year show a similar trend at a 25 percent sustainability level. Most recently, FriendlyCare entered into an agreement with PhilHealth to provide health care coverage for members by financing family planning methods, including sterilization. This agreement will allow FriendlyCare to provide a variety of family planning services including permanent family planning methods, while continuing to improve sustainability.



A happy child in a play room at the Masinag Intermediate Service Center, one of the Philippines' FriendlyCare Clinics.

5

Certify and Recognize Quality

BRAZIL • WEST AFRICA • EGYPT

Quality certification and accreditation programs provide particularly powerful approaches to quality improvement. While traditional quality certification and accreditation tends to be regulatory in nature and focus on external, standards-based evaluation of organizational or facility performance, application of these models in the developing world has produced a number of variations. Since the mid-1990s, CCP and partners have implemented quality certification and accreditation programs in a number of countries. The programs evolved with time and are adapted to each country context. Common to all CCP experiences to date, certification is part of a larger strategy designed to be facilitative in nature, complemented by a communication strategy that recognizes desired performance, and builds upon a number of essential quality improvement interventions.¹⁶

In the area of service delivery, quality improvement activities typically focus on such things as improved infrastructure, management systems, supervision, job aids, and provider training. Once a minimum level of quality is established, these supply-focused interventions are complemented with activities to generate demand for quality. Demand generation interventions have included media campaigns to inform the public of their right to quality health care, establishing quality brand recognition, promoting quality certified sites and providers, and mobilizing communities to participate in efforts to meet quality standards. The program examples highlighted here demonstrate how standards-based evaluation coupled with internal and external recognition can serve as an umbrella strategy that pulls together a number of quality improvement interventions.

BRAZIL

PROQUALI Clinic Accreditation

PROQUALI began as a collaborative effort by PCS, JHPIEGO, Management Sciences for Health, and the State Secretariats of Health of two states in northeastern Brazil, Bahia and Ceará to improve the quality of reproductive health services in the public sector.

When the PROQUALI project began in 1996, many Brazilian states were decentralizing health management systems as the administration of health services



devolved from state to municipal levels. PROQUALI responded with a low-cost, integrated management system to improve quality by accrediting health services at the clinic level. The management system was tested and refined at five health clinics in Bahia and Ceará and was used later in 24 additional clinics.

PROQUALI used a clinic accreditation system that actively involved clients and providers in identifying

¹⁶ Three Models for Quality Improvement. Poster. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

problems and solutions in delivering quality health services.¹⁷ The clinics and staff were evaluated on 61 criteria that measured quality in five core areas:

- 1) clinical services;
- 2) infection prevention;
- 3) IPC/C and information, education, and communication (IEC) materials;
- 4) management systems; and
- 5) facilities, equipment, and supplies.

Sites achieved accreditation when they met 90 percent of the criteria, after which they were awarded a plaque.

Upgrading services to meet the new standards required an integrated approach. To standardize clinical practices, professional staff received competency-based training in family planning, women's health, and infection prevention. To improve IPC/C skills, the PCS team supervised staff members, who received on-site training and a family planning informed choice kit.¹⁸

Managers received training and technical assistance to learn how to use data to make decisions, prepare job descriptions, standardize service delivery procedures, create scheduling systems, improve client reception, and organize medical records. Changes in client satisfaction were tracked using qualitative research methods. Health centers were remodeled with municipal support.

To improve decision-making and overall performance, PROQUALI introduced to the health services TOQUES (Técnica para Orientar a Qualidade e Eficiência dos Serviços de Saúde/Orientation Technique for Quality and

Efficiency, a new management tool adapted from COPE). Using TOQUES, the entire clinic staff met quarterly to identify gaps between desired and actual performance, analyzed their causes, designed and implemented interventions to close the gaps, and evaluated their impact.¹⁹ Monthly self-assessments were used to monitor staff progress in knowledge, skills, and practices required for accreditation. TOQUES, a team-building tool, allowed staff the opportunity to work together, often for the first time, to solve problems. TOQUES also helped improve service quality by addressing a key indicator—client perceptions.

As service delivery improved under PROQUALI, the PCS team launched a community communication campaign at each site to

generate demand for quality care. The first phase of each clinic's communication campaign was designed to stimulate client interest and motivate providers. The slogan "Health for you, satisfaction for us" was displayed on banners and



The community of Redenção celebrates improvements in their health center during a PROQUALI Quality Improvement Team visit.

providers' T-shirts, hats, and buttons. The second phase of the communication campaign consisted of launch events in the community to celebrate the accreditation of health centers as their performance improved and met the established standards. The third phase included local media and community campaigns to promote awareness of improved health services, encourage client demand for better care, and publicize providers as caring professionals. This phase used the following materials and activities to support the promotion: radio vignettes, street theater, murals, referral cards, posters, signs, and a range of interpersonal communication aids.

¹⁷ PROQUALI: Accreditation model for primary health care in Brazil.

¹⁸ PROQUALI Technical Document. May 9, 2000.

¹⁹ Merritt, A.P., Said, R., Ainslie, R., and Lewis, G. PROQUALI: Best practices to achieve decentralization.

CHALLENGES

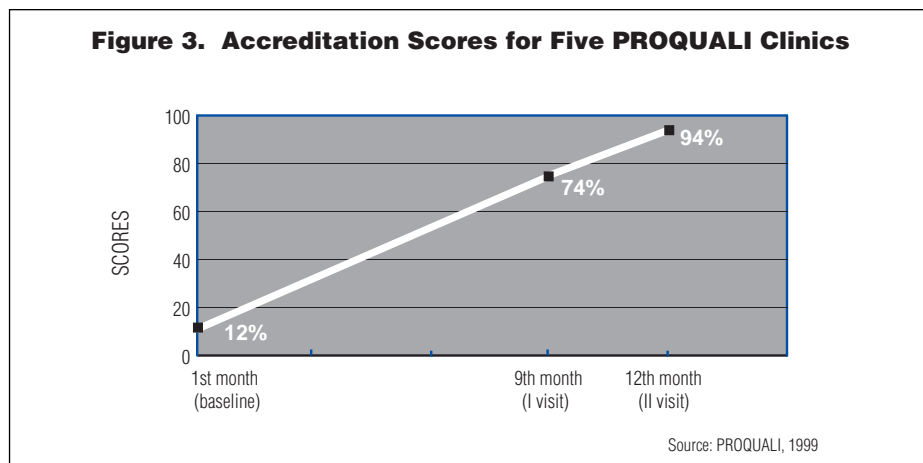
Quality improvement requires time to achieve sustainable changes in quality. PROQUALI did not have the time to expand to as many health centers as originally designed. Political commitment at the state and municipal levels is necessary to ensure that quality improvement is successfully implemented. This commitment needs to be reflected in resource allocations for equipment, supplies, materials, and pharmaceuticals. In some cases, the Municipal Secretariats of Health did not give priority to PROQUALI activities over other municipal needs. Finally, sustaining quality is a challenge. During the pilot phase, four of five health centers were accredited, but sustaining quality improvement in the accredited health centers required even greater commitment than reaching quality the first time.

ACHIEVEMENTS

PROQUALI improved the quality of reproductive health care in the project clinics. Among the clinics to pioneer the approach, the average assessment score rose from 12 percent at baseline to 74 percent over nine months.²⁰ After one year, the average score was 94 percent, and four of the five clinics had achieved accreditation (Figure 3). Staff teams solved 70 percent of service quality problems within three months of the TOQUES exercise. In the 18-month expansion phase, 15 of 24 clinics achieved accreditation.

PROQUALI also succeeded in increasing client satisfaction and demand for services. Accreditation and community campaigns were associated with a 74 percent increase in clinic visits, gains that were not seen at matched, non-participating health centers. Data also showed that family planning talks drew more participants in PROQUALI sites than in matched health centers in Bahia. According to focus group discussions, clients perceived many service improvements over the course of the project, including better communication between providers and clients and more consistent availability of a wider range of contraceptive methods. As the quality of services improved and clients' basic needs were met, clients became more specific about their expectations of quality. Providers too perceived a change; they felt pride in their work as they were empowered to solve health center problems and subsequently satisfy clients' expectations.

Both Bahia and Ceará states created Quality Improvement Teams to replicate the PROQUALI model in other clinics, and some municipal secretariats of health joined the states as partners. In addition, Ceará extended the PROQUALI approach to primary health care services, while Bahia designated a Reproductive Health Reference Center to stimulate dissemination of the PROQUALI model via the Internet and CD-ROM (PROQUALI 2000). The federal Ministry of Health is adapting the PROQUALI model to improve the quality of HIV/AIDS services.



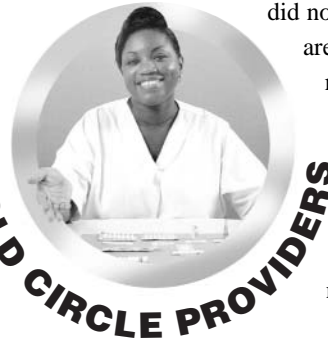
²⁰ JHU/CCP (April 2000). PROQUALI improves health services in Brazil. *Communication Impact!* No. 10. Baltimore: Johns Hopkins Bloomberg School of Public Health, Population Communication Services.

The SFPS Gold Circle Initiative

The Family Health and AIDS in West and Central Africa project, also known as Santé Familiale et Prévention du SIDA (SFPS), launched the Gold Circle (GO) campaign in December 1998 to promote reproductive health and HIV/AIDS prevention. The initiative was initially implemented in four countries—Burkina Faso, Cameroon, Côte d’Ivoire, and Togo. The 206 participating SFPS clinics included a mix of NGO, private, and public facilities.

SFPS first focused on improving service quality by training clinic personnel in clinical skills, interpersonal communication, and logistics management.²¹ The program managers created systems for improved supervision, data collection, and reporting. After essential improvements were achieved, GO publicly launched the program with a campaign to promote the certified sites and their services. Even after certification, quality improvement continued with efforts to sustain contraceptive supplies, reinforce providers’ technical and counseling skills, and strengthen infection prevention measures.

The assessment tool developed to monitor GO clinic performance covered six areas critical to quality care: 1) access and availability of services, 2) interpersonal communication during the client-provider interaction, 3) medical barriers to family planning, 4) infection prevention, 5) provider skills and training, and 6) logistics management. While some of the 66 criteria for certification measured the technical quality of care, such as disinfecting instruments, others focused on client-defined standards of quality, such as waiting time and respectful treatment from providers. GO supervisors, who also served as trainers of clinic personnel, rated performance on a 7-point scale to determine if certification was to be awarded. Clinics that



did not meet the standards received feedback on areas to be strengthened and specific recommendations for improvement. Certified clinics displayed their new status with a GO logo plaque. Ongoing supervision and monitoring allowed clinic staff and supervisors to devise joint solutions to maintain quality while providing opportunities for further training.

The GO logo was a smiling provider with an outstretched hand inviting clients inside with the slogan, “We are here to listen to you.” This image responded to clients’ definition of quality care and was therefore the most heavily promoted element in the GO community mobilization and mass media campaign. Formative research found that clients’ top indicator of quality was the presence of a friendly, caring provider who listened to their needs. GO regional communication campaigns invested in community mobilization, mass media, and distribution of support materials to teach clients they have the right to demand high standards of care and to promote certified clinics.

Quality Teams, made up of health staff and community representatives, played a critical role in the GO effort.²² They served as an interface between the health facility and the community and allowed joint problem identification and solving. They encouraged dialogue between providers and clients, increased clinic staff accountability to the community, and empowered the community to participate in service improvements and their maintenance. The joint participation of providers and community members on Quality Teams also brought about a better understanding of each others’ values, roles, and needs.

Quality Teams planned and carried out a myriad of community activities. They held launch events to celebrate

²¹ Vondrasek, C. (1998). 1, 2, 3, GO! The Gold Circle Initiative. Unpublished report. Abidjan, Côte d’Ivoire/Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

²² JHU/CCP (March 2001). Community participation is key to supporting quality in Gold Circle clinics. *Communication Impact!* No. 11. Baltimore: Johns Hopkins Bloomberg School of Public Health, Population Communication Services.

a clinic's certification; organized outreach activities, such as open clinic days and community health talks; held fund raisers for clinics; and planned advocacy events with traditional, religious, and administrative leaders. The teams also organized anniversary ceremonies for sites that successfully maintained their GO award and celebrated the accreditation of new clinics. These events brought attention to all clinics and reinvigorated the campaign and the providers.

CHALLENGES

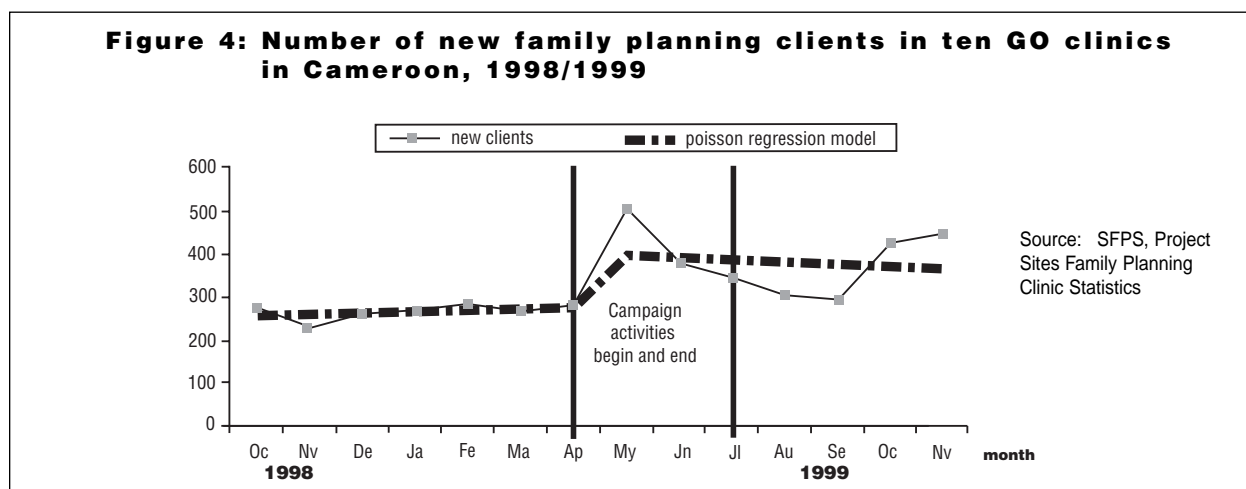
The joint participation of providers and community members in committees brought about a better understanding of each other's values, roles, and needs, leading to a greater impact. But such committees were difficult to form and sustain. Also, while regular supervision and monitoring allowed for joint and efficient problem-solving that prevented small problems from becoming big ones, it was a challenge to overcome the weaknesses in existing supervisory systems. Finally, keeping providers motivated was a challenge. Building motivational techniques such as incentives and or professional recognition into new quality programs may help maintain provider motivation over the long term.

ACHIEVEMENTS

SFPS and the GO initiative demonstrated that regional programs can effectively address weaknesses in service quality shared by multiple countries. As of the end of 2002, 86

clinics received the GO certification. Qualitative feedback indicated that Quality Teams at GO clinics continued to apply problem-solving techniques on a regular basis, which helped maintain communication between clinics and surrounding communities. Provider performance and utilization improved for family planning services and, in some clinics, the impact was even greater when Quality Teams systematically applied the GO approach to a broader range of health services.

GO's impact on clients also was substantial. Data from an omnibus survey and panel study in Cameroon, Togo, and Burkina Faso revealed increased discussion, approval, and use of family planning because of the regional communication campaign. Data showed a significant increase in discussion of family planning: from 35 percent at baseline to 43 percent at follow-up. Approval of family planning increased from 28 percent at baseline to 45 percent at follow-up. Twenty-three percent of the women exposed to the GO campaign that were not using a family planning method began using one, compared to 8 percent of women who began using a contraceptive who were not exposed to the campaign. Results from exit interviews in the three countries showed that clients approved of the services they received at GO clinics, and more than 90 percent said they would recommend the services to their friends. Service statistics in Cameroon show a significant increase in new family planning clients subsequent to campaign launch (figure 4) while service statistics in Togo rose from an average of 18 to 28 new family planning clients a month within the six-month period following the campaign.



EGYPT

The Gold Star Initiative

Quality is a high priority for Egypt's Ministry of Health and Population (MOHP). The strong leadership role of the MOHP and interest of other sectors produced quality initiatives in the public and private sectors and among NGOs. While the focus here is on the public sector quality improvement effort, it is important to note that it was implemented in a context that supports a growing, multisectoral culture of quality health care. Models for quality improvement in Egypt include:

Gold Star initiative—a pioneer program for testing applicability of certification to public health facilities in developing countries;

Private Sector Project (PSP)—a project that encourages the involvement of pharmacists and private physicians; and

Clinical Services Improvement (CSI) project—an NGO dedicated to providing high-quality, affordable services.²³

In the early 1990s, the MOHP wanted to improve the quality of public family planning clinics and embarked on the Gold Star initiative, an ambitious program to develop a national certification system to upgrade and standardize the quality of the clinical services. Gold Star was one of the first initiatives to apply a certification system to public sector family planning services and facilities in a developing country.

Gold Star began by formulating new clinic standards and protocols for family planning services. The comprehensive standards were measured by 101 indicators that cover ten areas critical to quality care:

1) client registration, 2) physical exams and counseling, 3) infection prevention, 4) client satisfaction, 5) contracep-



tive commodities, 6) IEC, 7) records and reports, 8) clinic management, 9) equipment and supplies, and 10) the physical structure of clinics.

To overcome providers' initial reluctance to implement the new service standards, the Gold Star team administered an extensive orientation and training plan to explain new procedures, develop a culture of teamwork, and improve technical skills. Additionally, the team strengthened the supervision system.

Over a three-year period from 1995 to 1997, the Gold Star monitoring and certification system was expanded to all 4,200 public-sector facilities in Egypt that offered family planning services.²⁴ District supervision teams visited each of these facilities four times a year and rated them on a list of 101 minimum essential service requirements. Each indicator was scored on a yes-no basis to eliminate confusion and negotiation. Facilities received Gold Star certification after meeting all standards during two consecutive quarters and could then prominently display the Gold Star—a symbol of high quality—on clinic signs and staff badges.

Loss of Gold Star status happened when a facility received less than a perfect score. Supervisors played an important role in working with clinic staff to analyze reasons for substandard performance and developed solutions for problems. This approach to quality improvement was built on earlier efforts to decentralize decision-making and problem solving to the clinic level—a dramatic change in Egypt where lower- and middle-level staff referred all issues to top management. Quality scores were entered into a computerized management information system (MIS) and monitored at the facility, district, and gover-

²³ Ministry of Health & Population, Egypt (1999). Systems Development Project (SDP II).

²⁴ Brancich, C.D., Moshira El Shaffie, Hassan El Gebaly, Kols, A., Boulay, M., Lewis, G., Saffitz, G., and Hess, R. (September 2000). Taking quality nationwide: Egypt's Gold Star family planning clinics. Unpublished report. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

norate levels to help managers assess strengths and weaknesses, help facilities and districts that need attention, and identify common problems that required action at higher levels. To ensure sustainability, the Ministry built the ongoing cost of monitoring and certification into its regular budget.

The Gold Star national communication campaign was implemented in phases. The initial phase of television and radio spots educated the public about elements of quality care such as counseling, cleanliness, client treatment, and clinic management.²⁵ The mass media spots also modeled quality care provision for providers, the secondary audience. After a large number of facilities earned a Gold Star, a second wave of television and radio spots aired to encourage consumers to go to clinics with the Gold Star symbol to receive quality family planning services. The Gold Star team coordinated local level outreach efforts to celebrate a clinic achieving Gold Star status.

CHALLENGES

The Gold Star quality improvement and marketing program faced many operational challenges. The process of decentralizing the supervision of services took significant training inputs and time, but, in the long term, proved a major factor in contributing to sustainability. Creating demand for quality public sector services through field and media-based communication campaigns was also a major program investment. It involved a full-scale and unprecedented level of collaboration between the Egyptian Ministry of Information and the Ministry of Health and Population, building on the comparative strengths of

each. The resulting public demand has sustained both the volume and the quality of clinical services at a local level.

ACHIEVEMENTS

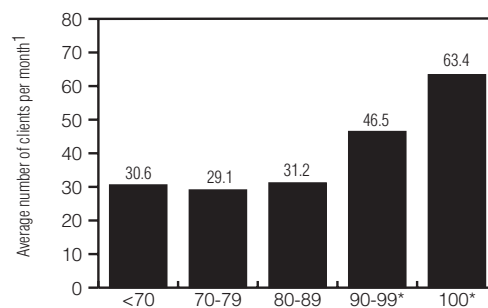
Since the introduction of Gold Star, the organizational culture in the government health system changed profoundly; leaders, managers, supervisors, providers, and support staff were now committed to providing quality services. Service statistics confirmed the change. In the first 21 months after the certification system went nationwide, the proportion of facilities meeting minimum service standards rose from 29 percent to 46 percent. At the same time, regional disparities in the quality of care narrowed, as did disparities between primary and secondary care facilities. Once certified, 60 percent of facilities were able to maintain their Gold Star status for at least 18 months. This suggests that, while achievable, service standards require continuing effort to maintain high standards.

Clients responded positively to the quality improvement initiative. National surveys found more than 70 percent of women and 90 percent of men who saw the public service announcements understood the Gold Star identified quality services. Perhaps the most convincing measure of

success was the increased volume of clients. Improved quality was associated with an increase in the proportion of Egyptian family planning users who sought services at government facilities with client flow highest at Gold Star clinics (Figure 5).

Impressed with the results of the Gold Star system in family planning services, the MOHP is expanding quality service standards and media campaign promotion to cover a broader range of reproductive and family health services.

Figure 5. Monthly Client Flow at Government Health Facilities



¹ The average number of clients was calculated by exponentiating the results of a regression model using the log transformation of clinic attendance. Adjusted values controlled for type of health facility and governorate.

* Different from next lower group ($p < 0.05$)
n = 2219 (2.3 observations per facility).

²⁵ El Gebaly, Hassan, Ron Hess, Carol Brancich, and Cynthia Waszak. (November 1998). Improving care and raising expectations. IN: *Family Planning Programs: Improving Quality*, Population Reports, Series J, No. 47, pages 20-21. Baltimore: Johns Hopkins Bloomberg School of Public Health, Population Information Program.

Conclusion

As these profiles demonstrate, communication plays a critical role in improving the quality of reproductive health care in developing countries. Effective communication strategies can disseminate standards of care throughout entire health care systems and effectively reach the clinic level. When applied to training and reinforcement, communication strategies also can enable providers to meet new standards of care and motivate them to improve their job performance. Finally, providers' own communication skills are essential to family planning and reproductive health counseling.

Achieving and sustaining high-quality reproductive health services, however, require the input of clients and the community as well as providers and the larger service delivery system. A number of the projects that were tested and proven effective are innovations that go beyond the health delivery system and engage clients and communities in quality improvement efforts. Community mobilization interventions open lines of communication between communities and providers, allowing them to exchange ideas and jointly decide on what constitutes quality care. Opening lines of communication ensures that reproductive health services are relevant to and valued by community members. IPC/C interventions improve communication skills of clients so that they feel empowered to express their concerns and providers remain focused on clients' needs. This improved communication contributes to informed decision making and improved health and family planning outcomes. Mass media campaigns model desired

health-seeking behaviors, raise clients' expectations, and increase access to and use of facilities that provide quality services.

By working on strengthening providers' ability to provide quality services while building popular demand for those services, CCP and its partners helped contribute to a



Proud Gold Star nurses at one of Egypt's Gold Star Clinic Openings.

new generation of integrated quality improvement projects. As communication campaigns effectively created public demand for quality services, program managers and providers were motivated to solve service delivery problems in order to provide the publicized promises of high-quality care. The campaigns also highlighted the important role that providers play in the lives of community members and rewarded those who provided quality care.

Global public health agencies are applying lessons learned from these experiences in quality improvement initiatives around the world, and constantly expanding their impact. Those concerned with quality improvement are geographically scaling up successful initial pilot projects or replicating them in other countries. Increasingly, programs are moving beyond the public sector to improve the quality of services offered at pharmacies, private clinics, and NGO facilities. Gains made in family planning and reproductive health services are expanding to other areas of health care as managers, providers, and community members apply new skills to a broader range of services. The strategies outlined here are contributing to a worldwide movement to improve the quality of health care around the globe.

References

General

JHU/CCP Quality Working Group (January 2001). *Quality First! Expo: Lessons Learned, Findings, Materials, Resources, Tools*.

Kols, A.J. and Sherman, J.E. (November 1998). *Family Planning Programs: Improving Quality*, Population Reports, Series J, No. 47. Baltimore: Johns Hopkins Bloomberg School of Public Health, Population Information Program.

Three Models for Quality Improvement. Poster. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

Peru: Puentes

Howard-Grabman, L., Ainslie, R., Aguilar, M. (2001). *Building Bridges for Quality: A Community Mobilization Project to Improve Quality*. Unpublished report. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

JHU/PCS. *Metodología Puentes: Manual Para Facilitadores de Campo*.

JHU/PCS (1999). *Metodología Puentes hacia la calidad de atención*. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

Indonesia: Provider Self-Assessment / Client Education

Kim, Y.M., Putjuk, F., Basuki, E., and Kols, A.. (March 2000). Self-assessment and peer review: Improving client-provider communication in Indonesia. *International Family Planning Perspectives* 26(1): 4-12.

Kim, Y.M., Putjuk, F., Kols, A., and Basuki, E. (2000). Improving provider-client communication: Reinforcing IPC/C training in Indonesia with self-assessment and peer review. *Operations Research Results* 1(6). Bethesda, MD: Quality Assurance Project for the United States Agency for International Development.

Kim, Y.M., Putjuk, F., Basuki, E., and Kols, A. Increasing patient participation in reproductive health consultations: An evaluation of "Smart Patient" coaching in Indonesia. In press at *Patient Education and Counseling* for publication in 2003.

Nepal: Radio Communication Project

JHU/CC. (January 1998). *Distance education works. Communication Impact! No. 1*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Population Communication Services.

Storey, D., Boulay, M., Karki, Y., Heckert, K., and Karmacharya, D.M. (1999). Impact of the integrated Radio Communication Project in Nepal, 1994-1997. *Journal of Health Communication* 4: 271-294.

Boulay, M., Storey, J.D. and S. Sood, S (in press). Indirect exposure to a family planning mass media campaign in Nepal. *Journal of Health Communication*.

Storey, D. Successful dissemination and promotion of MAQ guidelines (Maximizing Access & Quality) through the Radio Communication Project in Nepal. Presented at the MAQ Guidelines to Action Conference, Washington, DC, May 12-13, 1998.

Rinehart, W., Rudy, S., and Drenan, M. (December 1998). *GATHER Guide to Counseling*. Population Reports, Series J, No. 48. Baltimore, Johns Hopkins Bloomberg School of Public Health, Population Information Program.

Philippines: FriendlyCare

Roby, A. (2000). *The FriendlyCare Story*. Manila: FriendlyCare Foundation, Inc.

FriendlyCare Foundation, Inc. Business Plan (February 1, 2000).

McKenzie, S., et al. (1999). New Directions: Proposal and concept for a new NGO in the Philippines – Executive Summary. Unpublished report. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

Brazil: PROQUALI

JHU/CCP (April 2000). PROQUALI improves health services in Brazil. *Communication Impact!* No. 10. Baltimore: Johns Hopkins Bloomberg School of Public Health, Population Communication Services.

Merritt, A.P., Said, R., Ainslie, R., and Lewis, G. PROQUALI: Best practices to achieve decentralization.

PROQUALI: Accreditation model for primary health care in Brazil.

PROQUALI Technical Document. May 9, 2000.

West Africa: SFPS Gold Circle

JHU/CCP (March 2001). Community participation is key to supporting quality in Gold Circle clinics. *Communication Impact!* No. 11. Baltimore: Johns Hopkins Bloomberg School of Public Health, Population Communication Services.

Vondrasek, C. (1998). 1, 2, 3, GO! The Gold Circle Initiative. Unpublished report. Abidjan, Côte d'Ivoire / Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

Egypt: Gold Star

El Gebaly, Hassan, Ron Hess, Carol Brancich, and Cynthia Waszak. (November 1998). Improving care and raising expectations. IN: *Family Planning Programs: Improving Quality*, Population Reports, Series J, No. 47, pages 20-21. Baltimore: Johns Hopkins Bloomberg School of Public Health, Population Information Program.

Brancich, C.D., Moshira El Shaffie, Hassan El Gebaly, Kols, A., Boulay, M., Lewis, G., Saffitz, G., and Hess, R. (September 2000). Taking quality nationwide: Egypt's Gold Star family planning clinics. Unpublished report. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs.

Ministry of Health & Population, Egypt (1999). Systems Development Project (SDP II).