

Spring 2005

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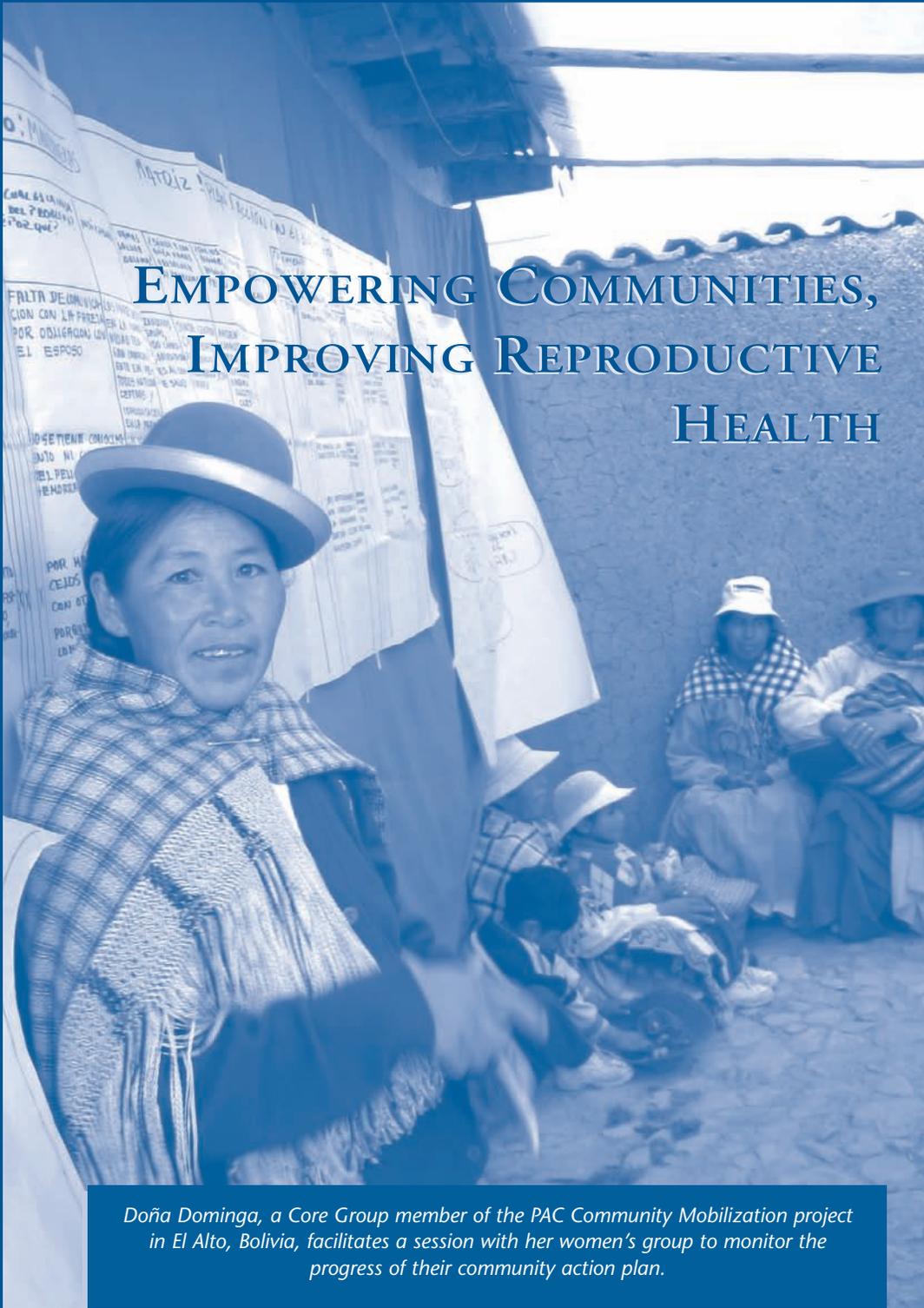
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THE MICHIGAN FELLOWS

N e w s l e t t e r



EMPOWERING COMMUNITIES, IMPROVING REPRODUCTIVE HEALTH

Doña Dominga, a Core Group member of the PAC Community Mobilization project in El Alto, Bolivia, facilitates a session with her women's group to monitor the progress of their community action plan.

Photo credit: Kiyomi Tsuyuki

A number of organizations use the fellowship as an opportunity to launch new projects. These placements often provide fellows with a key role in project development and implementation. Many of the projects that they pilot adapt existing methodologies to address local issues. The following articles capture all of these elements of the fellowship experience. Fellows Bernice J. Pelea and Kiyomi Tsuyuki describe how their work has allowed their host agencies to explore new approaches to quality of care through the adaptation of existing models that best meet the needs of local communities.

PUTTING THE “CALIDEZ” BACK INTO QUALITY OF CARE: FOSTERING DIALOGUE FOR QUALITY IMPROVEMENT

Fellow Bernice J. Pelea describes PCI's efforts to improve client-provider relations in Bolivia

Bolivia is one of the poorest and most diverse countries in the Western Hemisphere.¹ Although key health indicators have improved in recent years, including reductions in maternal and infant mortality and fertility levels, progress remains slow. Large differences in modern contraceptive use and total fertility rate continue to exist between urban and rural populations.² There are also growing health disparities between the wealthy and the poor — infant and child mortality rates are more than twice as high for poor Bolivians.³ Contributing to these differential health outcomes are insufficient medical services, service delivery limitations (e.g., logistics, infrastructure, supplies), and geographic isolation, all of which limit the availability of adequate health care, particularly reproductive health and family planning services, to marginalized populations.

These factors are further compounded by Bolivia's social, cultural, and linguistic diversity, often resulting in challenges to communication and mutual understanding between health providers and the communities that they serve — contributing to a sense of fear and mistrust toward providers. Poor indigenous women often report that they feel discriminated against and unfairly treated at public health facilities, particularly when wearing traditional Indian attire.⁴ Despite ongoing efforts to improve quality of care (QOC), poor client-provider relations continue to be a major obstacle to client satisfaction and increased service utilization in Bolivia.

My host agency, Project Concern International (PCI), has worked in Bolivia since 1980 with programs in health, agriculture, education, water and sanitation, gender equity, youth leadership, and income generation, and has been implementing QOC projects

since 1999. Like many traditional quality improvement approaches, the methodologies used in these projects focused on strengthening providers' technical skills, adherence to national norms, and standards for quality of care. The standard QOC approach used by PCI (and most NGOs in Bolivia) consisted of a one-time, 3- to 4-day workshop with health personnel that defined good quality of care (based upon standards determined by outside experts) with little or no follow-up.

While these projects initially demonstrated positive changes in quality, results were not sustainable due to frequent staff turnover and a lack of incentives to change health worker practices and attitudes. More importantly, strategies to address the “calidez”⁵ (or human relations) component of quality of care were lacking and the community's perspective was largely ignored. In effect, these activities were not addressing the core problem related to low service utilization in Bolivia: poor client-provider relations. Eager to address this issue properly, PCI decided to focus project activities specifically on improving the “calidez” in quality of care.

They began looking for QOC approaches that would address a wide spectrum of quality-related issues, including poor client-provider relations and the exclusion of community members in improving their own health. One approach that had been effectively applied in different settings was the Partnership Defined Quality (PDQ) methodology, developed by Save the Children/USA.



A health worker presents her group's results during the “Exploring Definitions of Quality” phase of the PDQ process in the Municipality of Vacas.

Bolivia at a Glance

Location: Central South America

Population: 8,724,156

Growth rate: 1.56%

Total fertility rate: 3.08 children born/woman

Contraceptive prevalence rate: 27.2%

Maternal mortality rate: 390 deaths/100,000 live births

Infant mortality rate: 54.58 deaths/1,000 live births

Age Structure: 0-14 years: 36.4%;
15-64 years: 59.1%; 65 years and over: 2.5%

Ethnic Groups: Quechua 30%, Mestizo (mixed White and Amerindian) 30%, Aymara 25%, White, 15%

Religions: Roman Catholic 95%, Protestant 5%

***Living Below Poverty Level:** 59%

Source: CIA World Factbook, 2004 est., *2001 est.



IMPLEMENTING BOLIVIA'S FIRST PAC COMMUNITY MOBILIZATION MODEL

Fellow Kiyomi Tsuyuki discusses recent efforts by Pathfinder International and PROSALUD to improve reproductive health through community participation

A Need for Community Action

Of all the public health issues in Bolivia, maternal mortality is a salient, yet preventable problem. While more developed neighbors like Chile and Argentina have maternal mortality ratios of 23¹ and 41² per 100,000 live births, respectively, in Bolivia it is 390 deaths per 100,000.³ This number increases significantly when one considers that maternal mortality estimates in Latin America are believed to be underreported, overlooking as many as 70% of all maternal deaths.⁴ There are an estimated one million child deaths worldwide each year as a direct result of a mother's death.⁵ The Bolivian Ministry of Health (MoH) documents that 27 to 35% of all registered maternal deaths in Bolivia are caused by complications due to miscarriage and unsafe abortion;⁶ although this figure is likely to be low, making the exact contribution to maternal death uncertain. In addition, Bolivian women are at an increased risk of experiencing unintended pregnancies due to a low prevalence of modern contraceptive use (27.2%)⁷ and a high unmet contraceptive need (26.1%).^{8, 9}

In response to these alarming figures, the Bolivian MoH introduced an integrated postabortion care (PAC) program, to which Pathfinder International¹⁰ began providing technical assistance in 2002 through the CATALYST Consortium^{11, 12} — a global reproductive health initiative of USAID committed to increasing the use of sustainable FP/RH services and healthy practices through clinical and non-clinical programs. This integrated PAC program adopts USAID's model for the *Core Components of Postabortion Care*,¹³ which include: 1) emergency treatment, 2) family planning counseling and provision and referral for selected reproductive health services, and 3) community awareness and mobilization around PAC.

Through my Population Fellowship work first with Pathfinder International/Bolivia (11/03-1/05) and currently with PROSALUD/Bolivia, I have been charged with providing technical assistance on program design, monitoring and evaluation, and qualitative data management on the third component — Bolivia's first PAC Community Mobilization Model. This article describes how the model has been successfully implemented in Bolivia and outlines the methodology and results obtained thus far.

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Setting the Stage

To assess the quality of PAC services in Bolivia, Pathfinder International/CATALYST first conducted a qualitative study to investigate the community's knowledge, perceptions, and needs regarding family planning, unintended pregnancy, miscarriage, unsafe abortion, and PAC services. The study, called "Opinions of Women and their Partners about Abortion and Postabortion Care Services," gathered data from focus groups with adolescents, women of reproductive age, and married men.¹⁴ Data from the study revealed many socio-cultural factors, occurring at both the community and health services level, were limiting the use of modern contraceptives to prevent unintended pregnancy and the timely access to PAC services. Barriers to the use of modern contraceptives included poor access to family planning counseling, myths about contraceptive side effects, and a lack of partner support. Most participants disclosed that, although illegal, many women have abortions to hide unintended pregnancies from their families and partners. Most were unaware of PAC service availability and that it is covered by Bolivia's universal health insurance for women and children (SUMI), but even those familiar with PAC services feared discrimination and poor treatment by healthcare providers. From these initial results, it was clear that the implementation of a community mobilization (CM) component was crucial to overcome barriers posed by cultural dynamics and the stigma of postabortion complications.

The PAC Community Model

In April 2004, Pathfinder International/CATALYST adapted the first CM Model around PAC with the objective of empowering communities to mobilize in an effort to reduce maternal mortality and morbidity caused by miscarriage and unsafe abortion. The PAC Community Model uses the WARMI methodology's community action cycle¹⁵ (Figure 1.) developed by Save the Children/Bolivia. According to this cycle, CM is defined as a capacity-building process where, in a participatory and sustained manner, communities: 1) identify and prioritize needs, 2) plan together, 3) implement their plans, and 4) evaluate together. In this model, communities mobilize to address the "three delays" of safe motherhood: 1) recognizing the problem, 2) deciding to seek care and reach the facility, and 3) resolving the problem at a health facility.¹⁶ With each pass through the cycle, it is hypothesized that the community will become increasingly empowered and will take greater responsibility in program implementation.

Step 1: Organize Community for Action

Two regions of Bolivia — the altiplano city of El Alto served by the Health Network *Los Andes* and the llano city of Santa Cruz served by the Health Network *Metropolitana Norte* — were selected to field-test the PAC CM Model because PAC services are available in these areas, they have large populations with high maternal mortality ratios, and they provide contrasting socio-cultural contexts. A total of 50 diverse community groups such as mother's clubs, neighborhood organizations, youth groups, micro-credit groups, and literacy organizations were identified to participate, directly reaching more than 1,000 community members. Each community group selected their own representative and these representatives formed the "Core Group" in each community.

Step 2: Explore Health Issues and Set Priorities

Each Core Group was trained to facilitate talks using a participatory auto-diagnostic (ADX) tool that I helped to develop with Pathfinder International/CATALYST, which facilitated community dialogue, debate, and negotiation around problems of preventing unintended pregnancy and treating postabortion complications. I also developed

matrices for the collection of information during the ADX sessions. Through activities such as *Life Histories* and *Interviews with Community Members*, the communities identified key causes and consequences of unintended pregnancy, miscarriage, and unsafe abortion in their

Figure 1. The Community Action Cycle



communities (see box at right). The ADX tool also included *Followed Routes* and *Socio-Drama* activities where community members act out how a woman, her family, and her community would approach the problem of unintended pregnancy, miscarriage, and unsafe abortion to illustrate the "three delays" of safe motherhood from the community's perspective (see box at right). Through activities such as *Mapping of Health Services* and *Interviews with Health Personnel and Clients*, the community gathered information on hours and services provided by health centers, traditional healers, and pharmacies. While the data collection process gave community members a greater understanding of the services available, this process also created an initial link between the

The Community Perspective

Identifying Problems

As a fellow working on the PAC Community Model, one of my key contributions has been the qualitative analysis of data collected during Step 2 of the cycle — “Explore Health Issues and Set Priorities.” Here are some findings from the ADX sessions in El Alto and Santa Cruz. Both regions cited the following factors as:

Causes of unintended pregnancy:

- Lack of information about RH and FP
- Lack of communication among couples and families
- Lack of partner support for FP
- Religious beliefs (perception that God determines fertility)
- Rape and forced sex
- Poverty and low levels of education

Consequences of unintended pregnancy:

- Rejection from partner, family, or community
- Economic hardship
- Violence toward the pregnant woman
- Unmet education goals; forced marriage
- Unsafe abortion
- Neglected and mistreated children

Causes of miscarriage and unsafe abortion:

- Working, lifting heavy things, or accidents/falls
- Malnutrition, no prenatal care
- Lack of communication between couples and family
- Inadequate financial resources
- Violence against the pregnant woman by her partner (El Alto)
- Strong emotions/despair of the pregnant woman (Santa Cruz)

Consequences of miscarriage and unsafe abortion:

- Maternal death
- Infant death
- Sickness
- Infection
- Psychological problems
- Sterility



A diverse set of Core Group leaders encourage an inter-generational exchange of ideas during the focus groups.

Setting Priorities

Below are the “**Three Delays**” of **Safe Motherhood** as defined by participants in the ADX sessions in El Alto and Santa Cruz. These “three delays” were used to form the basis of their CM efforts.

Both communities mentioned that women can (1) **recognize the problem** of miscarriage or unsafe abortion with the help of their mother, friend, neighbor, or partner. Women often relate their hemorrhage to a previous incident (falling, lifting something heavy, being hit, etc.) and frequently do not recognize the urgency of the situation, waiting until symptoms either pass or worsen. According to the community, many women (2) **decide to seek services** with the help of their partner, a family member, or a friend and often wait until all other care options have been exhausted before accessing a health facility. When commenting on how to (3) **resolve the problem**, both communities noted poor care in health facilities, emphasizing that it took hours to receive services, regardless of the urgency of the problem. Many times a doctor was not present to refer the patient to a primary level hospital, further delaying the reception of services. In other cases, patients with postabortion complications were discriminated against by healthcare providers.

community and health establishments, and sensitized healthcare providers to the CM effort. I was charged with the qualitative data analysis of information collected from the ADX sessions. Using the qualitative analysis package *Ethnograph*, the data was coded and analyzed to track community perceptions about unplanned pregnancy, complications of hemorrhage during pregnancy, quality of care in the health facilities, and the three delays of safe motherhood. In June 2004, each community presented the results from the participatory needs assessment to local health authorities. This was the first official step involving health authorities in the process.

Step 3: Plan Together

In August 2004, the national program coordinator and I developed an action-planning matrix to help the communities develop solutions for the health needs they had identified and prioritized during the ADX sessions. This matrix prompted community groups to brainstorm the causes of each problem and to arrive at feasible solutions to address these issues. Final action plans from El Alto and Santa Cruz included activities to improve community access to services and to improve the quality of care received at local health facilities.

In El Alto, action plans addressed problems of family violence, the lack of information about family planning and reproductive health, health education for men, and information about services offered at health centers. In Santa Cruz, they aimed to improve quality of care in health centers, to increase community awareness about SUMI benefits, to provide education about reproductive health, and to increase coordination between community organizations and health centers. Community action plan development was completed in October 2004 and then presented to local authorities to garner support of plan implementation. The activity successfully raised awareness about maternal mortality and postabortion complications in the communities and helped to destigmatize the issue, along with promoting community mobilization and collaboration with health authorities. Comments from participants reflected these outcomes:

“I have seen the women taking part in the project become much more conscious of their health care options and of the importance of their health.”

– Coordinator, Health Center Wara Wara of the Catholic Church

“We have learned how to take care of ourselves during pregnancy, and how to prevent and recognize problems. Many times, women lift heavy things when they are pregnant not knowing that it may cause hemorrhage. Now I know if there is bleeding, one should immediately seek care at a health center.”

– A Core Group leader from El Alto

Step 4: Act Together

PROSALUD/Bolivia, a national NGO that provides technical assistance to development projects, joined the PAC Community Model efforts in November 2004. It was also at this time that community action plan implementation began with the goal of improving linkages among community organizations, the community, and health facilities. To help with action plan implementation, Core Group members participated in an intensive training workshop on the new Bolivian Health Model¹⁷ to build their capacity in working with the Local Directors of Health. In this step, I helped to develop action plan monitoring tools with community groups in order to facilitate the documentation of action plan completion. The use of these tools helped to train the community groups in monitoring and evaluation activities that they will eventually carry out without project staff support.

Looking at the activities completed in each community, it has become evident that the PAC Community Model has helped to create an environment that promotes communication and collaboration between the community and health facilities.

The following outcomes were achieved by the participating communities:

El Alto

- Several health fairs addressing the topics of RH and FP were held at schools to increase knowledge among students. More than 1,500 adolescents were reached by these activities.
- Pharmacies agreed to expand their hours of service to 24 hours on a rotational basis to improve community access to medicines, contraceptives, and information.
- The director of the Health Network agreed to have all health centers provide at least eight hours of service daily. Many health centers had only provided a few hours of service before the PAC CM activities began.
- Several workshops were held by Centro de Salud Integral de la Mujer, a local NGO, addressing gender-based violence (GBV) with the goal of reducing GBV prevalence in the community. Community members had recognized GBV as a key cause of miscarriage. These workshops trained more than 500 people in GBV awareness and prevention.

Santa Cruz

- Improved access and quality of health care by increasing the quantity and location of signs (in and around health centers) describing patients' rights and clarifying what services are offered.
- Most of the training activities (ex. workshops to improve communication between parents and their adolescent children, informational classes about the benefits of SUMI, and free courses on prenatal care and danger signs during pregnancy) proposed by community groups have been included in the Municipality's Operative Plan of Action (POA). This inclusion has secured the Municipality's financial and logistic support in completing the activities.
- Several workshops have taken place to increase community awareness about the services and rights covered by the SUMI benefit.



Core Group leaders in Santa Cruz receive certificates for their participation in community needs-assessment sessions (Kiyomi is seated third from left in the first row).

- The community has organized several health fairs to increase community consciousness of the problems of miscarriage and unsafe abortion. Through these fairs, community groups designed and distributed flyers that reached an estimated 1,500 community members.

Step 5: Evaluate Together

We are currently in the participatory evaluation phase. The project staff, along with my support, has developed qualitative participatory evaluation tools to assess the level of success in action plan implementation, the amount of communication and collaboration between the community and health facilities, and the degree of community empowerment achieved. Each Core Group will use these tools to evaluate program success with their respective community groups and health authorities. To date, we have found that the CM process has facilitated changes in social norms and structures by improving access to information and services. Participants are now more aware of their rights as clients of health facilities and as members of their communities — empowering them to improve their reproductive health care.

Next Steps

Through this process it is believed that the completion of three community action cycles with the same groups will result in an empowered community — with program staff responsibilities decreasing and community group responsibilities increasing with each pass of the cycle. The initial groups in El Alto and Santa Cruz are finishing up their first cycle and will complete two more cycles by August 2006. We have expanded the program to neighboring Health Networks in both El Alto and Santa Cruz where the first cycle will begin soon. Also, in August 2005 we will begin working in Cochabamba, the third largest city in Bolivia. International replication of the model includes an adjusted version already in Peru and plans for an exact replication in Kenya later this year.

Thus far, my experience as a Population Fellow working with the PAC Community Mobilization Project has fostered both personal and professional growth. I have seen my team's efforts in proposal writing and planning blossom into a national project that has received international praise for its participatory approach to PAC. Most importantly, I have witnessed the communities that we work with transform into self-changing agents. They are now working in collaboration with government and health officials to increase, diversify, and improve the services available to the community — they are working together to improve the health of Bolivia.

REFERENCES

- 1 United Nations Development Programme, 2003 and World Bank, 2003.
- 2 United Nations Development Programme, Human Development Indicators, 2002.
- 3 1994 National Demographic and Health Survey (DHS) is the most current data on maternal mortality. Although a DHS was conducted in 1998, complete data on maternal mortality was not included in the survey.
- 4 Pan American Health Organization, 1990, 1992.
- 5 World Health Organization, 2003.
- 6 "Manual de Normas y Procedimientos Técnicos para el Manejo de Hemorragias de la Primera Mitad del Embarazo," Ministry of Health and Social Security, National Office for the Care of the Individual (Ministerio de Salud y Previsión Social, Unidad Nacional de Atención a las Personas), Bolivia 2001.
- 7 National Demographic and Health Survey (DHS), 1998.
- 8 Unmet contraceptive need includes fertile women between 15 and 49 years old, either married or living with a partner, who either do not want more children or are spacing two or more years between children, and do not use a contraceptive method.
- 9 National Demographic and Health Survey (DHS), 1998.
- 10 A U.S.-based cooperative agency of USAID that has worked in Bolivia since 1970 to improve access to quality sexual and reproductive health services.
- 11 The CATALYST Consortium (CATALYST) is a partnership of five organizations: the Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International, and PROFAMILIA/Colombia.
- 12 Pathfinder supports PAC programs in five departments of Bolivia, whereas the U.S.-based NGO Ipas supports the remaining four departments of the country, as well as selected hospitals in the department of La Paz.
- 13 The "Core Components of Postabortion Care" are outlined in the USAID Postabortion Care Strategy (2003).
- 14 The study was conducted in six departments of Bolivia, including the five in which Pathfinder/CATALYST provides technical to the PAC program.
- 15 Howard-Grabman L. and Snetro G. "How To Mobilize Communities for Health Change and Social Action," page 3.
- 16 The "Three delays" is a concept created by the Global Initiative for Safe Motherhood.
- 17 In April 1994, the Law of Popular Participation mandated a health sector reform in Bolivia, which included the decentralization of health services and the institutionalization of three levels of care. The reform also led to the creation of The Local Directors of Health (DILOS), which are entities composed of the municipal government, the Network of Health Providers, and the Committee of Vigilance (comprised of community members) that determine health goals and the Operative Plan of Action for the municipality.



Kiyomi served as a Population Fellow with Pathfinder International/Bolivia from November 2003 to January 2005. She continues her fellowship work with PROSALUD/Bolivia through November 2005. After the completion of her placement, Kiyomi plans to continue working in the field doing research. For more information on PAC Community Mobilization efforts in Bolivia, please e-mail her at ktsuyuki@prosalud-socios.org.bo.

In addition to this work, Kiyomi also received a Population-Environment Small Grant from the Population Fellows Programs in 2004 to implement a PE project while she was a fellow with Pathfinder International/Bolivia (see page 17 for details).

Fellows' Briefs

Four fellows share details of recent projects.

CARA HONZÁK World Wildlife Fund/USA Population-Environment

One focus of Cara's work at the World Wildlife Fund (WWF) is to provide guidance within the WWF network on how to effectively link reproductive health and girls' education initiatives to conservation outcomes. Developing robust monitoring and evaluation (M&E) systems and indicators that demonstrate these linkages has been a significant challenge faced by practitioners in the population-environment (PE) field. Recently, Cara has been assisting WWF PE projects in Kenya, Madagascar, and the Philippines to develop time-sensitive M&E systems. She is working in Kenya and Madagascar with local partner, the African Medical and Research Foundation, and in the Philippines, with the local government unit of Roxas District in Palawan. The process began with all groups attending a PE strategic planning workshop organized by the Population Reference Bureau and sponsored by USAID in Bangkok, Thailand, in November 2004 (*see p. 16*). Throughout her fellowship, Cara will continue to work with these projects and outside of the WWF network to hone these systems, and to shape a learning agenda for WWF that will address these and other challenges in the field of population and environment.

NICOLE JUDICE Central Research Institute for Skin and Venereal Disease (CNIKVI)/Russia STI/HIV Prevention and Family Planning

Nicole is currently working with colleagues to launch an assessment of the quality of care provided at CNIKVI and two STI clinics in Russia. This assessment will be used to inform quality assurance and assessment tools for STI clinics throughout Russia. It will also include sections focused on determining the level of integration of FP services into the STI clinic setting. It is the first comprehensive assessment of the quality of STI care in Russia on this scale. As a part of this effort, CNIKVI has requested that Nicole develop a curriculum for training institute staff, residents, and interns on the importance of focusing on quality of care and techniques to assess and address the quality of care at the facility level. Clinicians in Russia have traditionally focused on the quality of diagnosis and treatment from a medical point of view that does not take into account client's concerns and needs. While USAID and WHO-funded projects have provided quality of care training to different specialists in Russia, CNIKVI has not participated in this process to date, and plans to use this opportunity to bring attention to problems that exist specifically in their field of specialty.

KATHLEEN MOGELGAARD Population Reference Bureau/USA Population-Environment

Through her fellowship work in Washington, D.C., and the Philippines, Kathleen supports the activities of PHE Sigue, a coalition of organizations interested in promoting population, health, and environment (PHE) linkages in the Philippines. In November 2004, PRB and other coalition members organized the First National Conference on Population, Health, and Environment in Antipolo City, Philippines, a three-day event that brought together more than 200 representatives from the Philippine government, NGOs, the private sector, and the media. The conference included plenary sessions and skill-building workshops that were designed to raise awareness about PHE linkages, to identify potential PHE models applicable in the Philippine setting, and to draft a common declaration of commitment promoting integrated PHE approaches as a development strategy. Kathleen wrote a policy brief for the conference titled "Breaking New Ground in the Philippines: Opportunities to Improve Human and Environmental Well-Being" that was used in press releases, presentations, and in parts of the opening ceremony speech delivered by a representative of Philippines' President Gloria Macapagal Arroyo. The brief is available on PRB's Web site at: www.prb.org/template.cfm?template=InterestDisplay.cfm

MEGAN WYSONG PATH/Kenya Adolescent Reproductive Health

One of Megan's first activities with PATH/Kenya was to participate in the revision of an Adolescent Reproductive Health Life Skills Curriculum for the Kenya Adolescent Reproductive Health Programme (KARHP) that is supported by the Population Council's FRONTIERS Program. During the pilot phase of this project in 2000, a curriculum was developed with three government ministries and implemented in two of the eight districts in Kenya's Western Province. The most recent curriculum revision in which Megan participated incorporated input from trainers, teachers, community leaders, and adolescents involved in the program scale-up throughout the remaining six districts in preparation for its national roll-out. The curriculum is tailored to serve the needs of in- and out-of-school adolescents, faith-based groups, as well as teachers who use the lessons to plan different activities that focus on improving reproductive health knowledge and decrease risky sexual behaviors. Throughout the revision process, Megan took part in pre-testing the manual with youth groups, focus group discussions with religious and community leaders, and with teachers and youth participating in the program. The ultimate goal of the KARHP is to institutionalize reproductive health information into the national primary and secondary school curriculum and to offer a multi-sectoral approach to reproductive health education for adolescents throughout Kenya.

New Fellows



KATHRYN BORYC

USAID/Guyana

Adolescent Reproductive Health (Pop)
MPH, Tulane University

Placed with USAID/Guyana in April, Kathryn works with the Ministry of Health serving as the Adolescent Health Advisor for the recently formed Adolescent and Young Adult Health and Wellness Unit. She is tasked with overseeing the Youth Friendly Health Services, Peer Education, and Health Promoting Schools Initiatives, as well as developing educational and health promotion outreach activities for young people.

Prior to her fellowship, Kathryn completed an internship focused on monitoring and evaluation at AMREF Headquarters in Kenya. Kathryn is pleased to continue building the capacity of the Ministry of Health's adolescent reproductive health programs in Guyana as she hones her technical skills and expertise in the field.

Kathryn's placement is funded with non-population, field support funds.



STACY FEHLENBERG

Jane Goodall Institute/Tanzania

Monitoring and Evaluation (PE)
MPH, Columbia University
MS, Georgia Institute of Technology

In March, Stacy began working with the Jane Goodall Institute (JGI) in Tanzania on the Lake Tanganyika Catchment Reforestation and Education (TACARE) project, a program designed to address poverty and support sustainable livelihoods in villages in the Lake Tanganyika area. She works closely with TACARE's family planning coordinator to develop a long-term monitoring and evaluation system for the project and will regularly collaborate with ACQUIRE (Access, Quality, and Use in Reproductive Health) Project staff at EngenderHealth to ensure synergies among family planning efforts in the region. Stacy will also assist in the supervision and training of community-based distributors, staff training needs, data management, report writing for donors, and project proposal development.

Before joining JGI, Stacy worked as an intern for the International Rescue Committee/Sudan where she evaluated the community worker's program and developed a national monitoring and evaluation strategy for the Sudan country office. She looks forward to fostering sustainability and addressing population-environment issues with the TACARE Project.



BILL FISCHELIS

Save the Children/Philippines

Program Development (PE)
MEd, University of Washington

Bill recently joined Save the Children (STC)/Philippines' West Visayas Program office. His work focuses on the development and enhancement of population, health, and environment (PHE) programming through collaboration with STC staff and local partners. He will participate in the conceptualization and design of PHE case studies with local government units, community residents, and program staff. He will also develop awareness campaigns with PHE SIGUE, a coalition of organizations working to link PHE efforts throughout the Philippines (see Kathleen Mogelgaard's Brief on p. 8).

Bill comes to his fellowship from Vision Leadership in Seattle, Washington, where he designed and facilitated capacity building programs. He has also consulted on population-environment projects for Conservation International/Bolivia. Bill is eager to draw upon these experiences as he raises awareness about the health of the environment and the health of communities in the Philippines.



CATHERINE HASTINGS

USAID/Rwanda

Program Coordination, HIV/AIDS (Pop)
MS, London School of Economics

In November, Catherine was placed with USAID/Rwanda as an HIV/AIDS Community Services Specialist for the President's Emergency Plan for AIDS Relief Team. She is responsible for coordinating community HIV/AIDS services that occur outside of clinical health facilities. She works closely with 10 cooperating agencies involved with HIV-prevention, community-based care, and support to people living with the effects of HIV/AIDS. In addition, Catherine assists in the development of new procurement for HIV/AIDS community services. She tracks and reports program results to the Office of Global AIDS Coordinator in Washington, D.C., and serves on the Orphans and Vulnerable Children Technical Working Group.

Prior to her fellowship, Catherine served as a program officer for Family Health International where she supported HIV/AIDS projects and monitored country program implementation in Francophone Africa. She is pleased to take her professional expertise in this area to a new level through her fellowship with USAID/Rwanda.

Catherine's placement is funded with non-population, field support funds.



LAURA HURLEY

University Research Corporation/Eritrea
Maternal and Reproductive Health (Pop)
MPH, Johns Hopkins University

Laura recently began her placement with University Research Corporation (URC)/Eritrea serving as a member of the team that works on a USAID-funded bilateral health project implemented by URC. The project works to strengthen the capacity of the public sector to provide quality primary health care services and to actively engage communities in improving health behaviors and increasing demand for critical health services. Its main focus is on reducing infant and under-five mortality and morbidity, improving maternal health, and stopping HIV at an early stage. Laura is tasked with providing technical and managerial support to the maternal and reproductive health portions of the project. She will also work closely with USAID's Health Strengthening Team, senior Ministry of Health clinicians, and officials at central and regional levels to integrate maternal and reproductive health topics into health activities at the community and facility level.

Prior to her fellowship, Laura worked as a research assistant on Project CONTACT, an STI study for Johns Hopkins School of Medicine, and as a postpartum doula. She looks forward to bringing these maternal and reproductive health experiences to her work with URC/Eritrea.

Laura's placement is partially funded by non-population, field support funds.



RACHEL KEARL

USAID/Washington, D.C.
Program Coordination (Pop)
MA, Columbia University

In January, Rachel joined USAID's Office of Professional Development and Management (PDMS) in Washington, D.C. She is charged with developing synergies among the three PDMS units: Human Resources, Management Support, and Professional Development by focusing on performance management and improvement activities. In this role, she will develop and coordinate an internship program, formalize a GH training strategy, and provide monitoring and evaluation support for GH's training and professional development activities. Rachel is also a member of the working group tasked with building the organizational capacity of in-country President's Emergency Plan for AIDS Relief Initiative teams.

Before joining PDMS, Rachel served as a regional assistant with USAID's Bureau for Global Health, Office of Regional Country Support where she provided technical assistance to USAID mission health programs in Europe and Eurasia. She looks forward to applying her training in organizational development and expanding her knowledge of global health issues through her fellowship at USAID.



ELAINE MENOTTI

Futures Group/USA
Contraceptive Security (Pop)
MPH, University of Michigan

In January, Elaine was placed with the Futures Group in Washington, D.C., to work on the POLICY Project, USAID's initiative focusing on reproductive health and HIV/AIDS policy. She will support POLICY's contraceptive security efforts in Latin America by conducting market segmentation studies, creating projections of contraceptive requirements, and collaborating with in-country counterparts on contraceptive security strategic planning. She will also write policy briefs on specific areas of contraceptive security, develop secondary analysis papers linking family planning with child survival, carry out awareness-raising activities, as well as develop staff capacity at the country level through field visits to El Salvador and Peru.

Elaine brings to her fellowship recent experience in technical writing and data collection for an independent contractor evaluating the National Institute of Child Health and Human Development's Reproductive Medicine Network. She has also worked in Latino immigrant communities in the U.S. and with multiple maternal and infant health projects in Latin America. Elaine is eager to continue working in the region and collaborating with other professionals in the field throughout her fellowship.



KRISTEN PATTERSON

SantéNet/Madagascar
Integrated Program Development (PE)
MS, University of Wisconsin-Madison

In early spring, Kristen began working as a technical advisor in the area of population, health, and environment (PHE) at SantéNet's Fianarantsoa office in Madagascar. In this role, she provides support for SantéNet's community level health initiative, as well as develops and integrates environmental components of the project. Kristen will work closely with the Voahary Salama Association, a consortium of funding, technical, and implementing partners that promote sustainable natural resource management and address the health and production needs of communities living around biodiverse forest corridors in Madagascar. She will also evaluate the effectiveness of PHE integration in central Madagascar and assist with the documentation and dissemination of results.

Prior to her fellowship, Kristen worked as a research project manager with the International Livestock Research Institute and served as a training workshop facilitator for the United States Peace Corps in Niger. Kristen is pleased to develop her expertise in sustainable development while gaining population-environment field experience through her fellowship in Madagascar.



JENNIFER RUBIN

USAID/Rwanda

Program Coordination, HIV/AIDS (Pop)
MPH, Yale University

Placed in November, Jennifer serves as the HIV/AIDS Clinical Health Specialist for the President's Emergency Plan for AIDS Relief Team with USAID/Rwanda. She is charged with providing technical assistance to cooperating agencies to ensure services are implemented in accordance with the vision of the Rwandan and U.S. governments. Jennifer works closely with her clinical care counterpart, and is the technical lead for all activities related to prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT), and commodity management. She acts as the lead clinical-community care liaison, and works regularly with the community services specialists on the Emergency Plan Team. Jennifer will also serve as a member of the National PMTCT/VCT Technical Working Group and the U.S. Government Strategic Information Team.

Prior to her fellowship, Jennifer worked as a monitoring and evaluation specialist for The Academy for Educational Development's LINKAGES Project, a global program that raises awareness about maternal/reproductive health, family planning, and HIV/AIDS. She plans to draw upon these experiences while meeting new challenges with the Emergency Plan Team at USAID/Rwanda.

Jennifer's placement is funded with non-population, field support funds.



SIRI SUH

Management Sciences for Health/Senegal

Monitoring and Evaluation (Pop)
MPH, Columbia University

In February, Siri began her placement with Management Sciences for Health (MSH) in Senegal. As part of the team working on the Maternal Health and Family Planning project, she coordinates activities to introduce the Standard Days Method into family planning options offered by selected health facilities in Senegal. Siri will also take the lead in supporting the Senegalese Ministry of Health's pending initiative to launch a campaign promoting the IUD contraceptive method. Additionally, she is tasked with assisting MSH's technical team in supervision at health facilities in program districts, participating in the accreditation process, developing journal articles about MSH's recent work, and data management and analysis activities.

Before joining MSH, Siri worked with the United Nations Population Fund on the Maternal Mortality Update 2004, along with several other projects related to maternal health. She looks forward to honing her technical skills in the field while supporting efforts that promote family planning and reproductive health in Senegal.



THE PROGRAMS WELCOME FOUR PEAK FELLOWS IN 2005

The Professional Exchange for Applied Knowledge (PEAK) Initiative was launched in 2001 to build the capacity of professionals and organizations from developing countries by providing professional development opportunities. The following professionals from Latin America (PEAK alternates its regional focus annually between Latin America and sub-Saharan Africa) will begin 2- to 4-month fellowships during summer 2005 (*each listing includes their title, organization, and area of interest*):

EDUARDO ORTIZ

Regional Supervisor • PROSALUD/Partners for Development/Bolivia
Monitoring and evaluation (funded by USAID)

MARIA ISABEL TAFUR

Regional Coordinator • Minga Peru/Peru
Behavior-change communication (funded by USAID)

CARLOS LOPEZ

Coordinator • Center for Human Development – Sololá/Guatemala
Adolescent reproductive health (funded by the Compton and William and Flora Hewlett Foundations)

EDNA NADAL BARGALLO

Health Coordinator • Women in Development (MUDE)/Dominican Republic
Adolescent reproductive health (funded by USAID)

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are available on our Web site at:
<<http://www.sph.umich.edu/pfps/>>.

Application deadlines are
April 1 and November 1 each year.

There are also opportunities for
informational interviews at our booth
during the Global Health Council and
American Public Health Association conferences.

continued from p. 2

PCI identified the PDQ as one that fit their quality improvement objectives. They were able to adjust the methodology to meet their specific project objectives, context of project sites, and population characteristics while still remaining faithful to the PDQ principles (*see overview below*). Through my work as a Population Fellow, one of my primary duties has been to spearhead PCI's current quality improvement initiative — providing technical assistance, coordinating activities, and documenting lessons learned. This article describes PCI's experience with the PDQ during the first year, focusing on its implementation, preliminary results, challenges, lessons learned, and next steps.

THE PDQ IN ACTION

Since April 2004, PCI has implemented the PDQ in five project sites in the Department of Cochabamba. At each site, quality improvement was a component of a larger,

comprehensive health project that focused on maternal, neonatal, child health, or family planning and quality indicators focused primarily on improving interpersonal relations (or “calidez”) between health workers and patients.

Community members were invited to participate if they were:

- 1) part of the project target population (e.g., if the focus was maternal/child health, men and women who were expecting a child or had children under five were invited);
- 2) community and municipal leaders; or
- 3) individuals who had influence in the community.

Health workers were invited according to:

- 1) relevant health project area; and
- 2) the preferences of the health director (e.g., if they wanted all health workers to participate).

PDQ: A Brief Overview

In implementing community-based quality of care activities, Save the Children/USA often found that health providers and communities had different definitions and priorities for quality. In response to this, they developed and tested the Partnership Defined Quality (PDQ) methodology in 1996. PDQ is defined as a methodology to improve the quality and accessibility of services with greater community involvement in **defining**, **implementing**, and **monitoring** the quality improvement process. By using activities that promote intercultural understanding, shared responsibility for community health, and a more equitable, participatory process in quality improvement and service provision, PDQ is able to “link quality assessment and improvement with community mobilization.”⁶ PDQ is made up of four phases, as shown below:⁷

A key principle behind PDQ is that quality improvement should be a **collaborative**, **inclusive**, and **empowering** process that takes into consideration the perspectives of both health workers **and** the community. When quality improvement is approached from this perspective, it goes beyond improving health services; it addresses other issues that are often overlooked or not fully addressed in quality improvement, but still play a key role in the sustainability, accountability, and ultimately, the success of any quality improvement initiative. By facilitating the opportunity for sharing, clarification, and collaboration around quality issues, the PDQ has the potential to eliminate social and cultural barriers that may impede access to health services and better health; strengthen the community's capacity to play an active role in improving their health; and create an established mechanism for rapid mobilization around health issues and priorities.⁸



“It brings the eyes of the community into the health center and the eyes of the health center into the community.”

– A former community participant describing the PDQ method

At each project site, a 3-day workshop was implemented — one day was spent with community members alone, one day was spent with health workers alone, and the third day brought both groups together to share definitions of quality, to set priorities, and to create quality improvement (QI) teams. Once the QI teams were formed, they generally met on a monthly schedule. These workshops were based upon the four PDQ phases (*see box at right*). The initial meeting with individual groups addressed phases 1 and 2: “Building Support” and “Exploring Definitions of Quality.” The meeting with both groups addressed phase 3: “Bridging the Gap.” Once the QI teams were established they continued to carry out phase 4: “Working in Partnership” through monthly meetings. While each site presented challenges and offered opportunities for lessons learned, preliminary results show that the PDQ methodology is helping PCI to achieve desired quality improvement goals.

Preliminary Results

At this time, all preliminary results are based on the feedback of PCI field staff, community members, and QI team members. One focus group has been conducted with a QI team.

Increased collaboration

With the help of PDQ activities, willingness and commitment to collaborate between community members and health workers around quality issues has increased. Members of the QI team and community health volunteers (who are not part of the team but support QI activities) coordinate follow-up on action plans developed by the team. Community health volunteers collect information from fellow community members and visit health facilities to measure the progress of action plans and then report their findings to the QI team. For instance, one QI team procured a television and VCR through local municipal government funding to provide health education videos in a clinic waiting area after learning of the need from community members.

Improved communication

According to follow-up conducted by the QI teams, community members report increased health worker attentiveness and friendliness, as well as improved communication between medical interns and patients. A common challenge in rural Bolivia is that hospital interns come from other parts of the country (or other countries) and do not speak the local language, creating a communication barrier. One solution has been to provide interpreters (usually a staff member) for interns during consultation and all outreach activities in the community. This solution requires a certain amount of sacrifice and teamwork among health workers, given that the staff member translating normally supports the intern at the expense of his or her own duties.

The Four PDQ Phases

1: BUILDING SUPPORT

Promotes the idea of creating a partnership and co-responsibility for improving community health services and health practices between health workers⁹ and community members. Develops support and commitment from the health system and the community in order to successfully implement later phases of the PDQ.

2: EXPLORING DEFINITIONS OF QUALITY

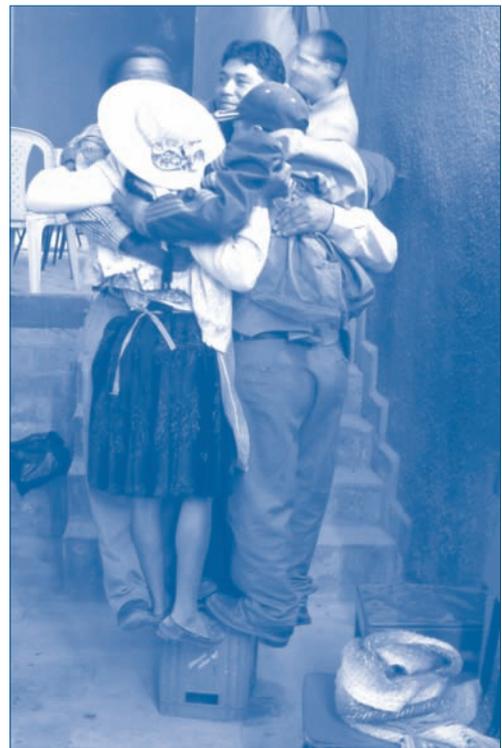
Introduces the concept of “quality health services” and defines “quality” from the perspective of health workers and community members who use, stopped using, or never used health services. Introduces the concepts of patients’ rights, the benefits of partnering to improve health services, and identifies gaps in service quality.

3: BRIDGING THE GAP

Provides an opportunity for health workers and community members to share their definitions of “quality health services,” to develop an understanding and agreement on quality issues, priorities, or challenges, and to develop a shared vision of quality. Establishes a continuous quality improvement (QI) team, who will move from the list of prioritized quality issues to solutions and action plans.

4: WORKING IN PARTNERSHIP

A continuous QI team made up of health workers and community members determines the causes, identifies potential solutions, and designs action plans to address the quality issues addressed during the “Bridging the Gap” phase.



As part of a team-building exercise during the “Bridging the Gap” phase, groups of community members and health workers try to balance on a box for 15 seconds; above is a winning team.

Increased service utilization

Health workers and community members have been reporting an increased utilization of health services. In one area, increased utilization was a result of an effort by QI team members and community health volunteers to promote the benefits of SUMI, Bolivia's national insurance for pregnant and post-partum women and children under five,¹⁰ and the use of health services through radio spots and flyers at health fairs, community meetings, and other public gatherings. A reduced waiting time for services has also been credited as a factor in the increase. During the PDQ process, rural community members expressed that they felt they were kept waiting for longer periods of time than other patients. Since these community members tended to use health services on market days when transportation was readily available, the QI team prioritized these days in their action plan. By negotiating with health services staff, they secured additional appointment slots for patients from distant communities on market days. This action has helped to reduce the waiting time for patients and, according to participating health workers, to increase utilization of health services.

Challenges and Lessons Learned

Despite initial improvements brought about by the PDQ, PCI encountered several challenges while implementing the methodology.

Maintaining interest and commitment

Ideally, participants in the PDQ process are a mixture of decision makers and marginalized members of the community and health system. However, securing the participation of a wide variety of individuals can often pose challenges. Issues such as busy schedules, transportation limitations, distance, and concerns about time away from families or work can narrow representation. PDQ organizers need to dedicate sufficient time and resources for the successful implementation of the "Building Support" phase of the methodology to ensure community and health worker buy-in and the commitment of the QI team. PCI approached this issue by personally inviting community members with formal invitations, promoting the importance of improving health services through community collaboration, and conducting short "interviews" to gauge each community member's perspectives on health services in their community in preparation for the PDQ workshops. Ideally, these "Building Support" activities should be done in the presence a community leader, and if possible, with health workers as well. During the QI team selection process, it is also important to address issues of time and commitment before selecting QI team

members. To accomplish this, PCI solicited criteria from participants for team selection and facilitated a discussion on the importance of available time and commitment of QI team members as one of the necessary requirements.

Ensuring true representation and participation

Frequently, the same individuals (usually the decision makers or other authorities) represent the community or health workers for different meetings and events. For the PDQ to be successful, however, other community members and health workers also need to be represented. This group often includes individuals who are not accustomed to sharing their opinions publicly. Thus, throughout the process, PDQ facilitators must be aware of potential dynamics that may limit or facilitate the participation of certain individuals and be prepared to handle different strategies to encourage participation. For example, organizers should consider the manner in which work groups will be divided or how plenary sessions should be facilitated; whether men and women should have individual "exploring quality" sessions; and how local authorities should be encouraged to participate without limiting the voices of others, etc. PCI approached this issue by preparing for potential group dynamics with PDQ facilitators before each session and by inviting participants to develop the criteria used for selecting QI team members, to ensure a relevant and varied spectrum of participants.



Community participants perform a skit depicting good quality health care from their experience and perspective.

Getting an accurate translation (representation) of quality issues

PCI conducted all PDQ workshops in both the local language (Quechua) and Spanish, which created challenges in terms of translation, particularly in regard to capturing an accurate representation of quality issues in either language. Because Quechua can have different interpretations depending on a variety of factors (the words selected, the pronunciation, and the local context, etc.), this posed a challenge for PDQ facilitators, who at times struggled to find the most accurate translation from Quechua to Spanish (or vice versa) without changing the original meaning of a comment. When results are translated once again to English, the potential for losing or misunderstanding information is compounded. PCI tried to minimize this challenge by triangulating the information from different sources. All participants' comments were written down by facilitators and this information was later compared with notes taken by an observer and a videotape of the meeting, if available. The final report was written based upon this triangulation, with facilitators having the final word on the accuracy of the report.

Finding common ground

A key step in the PDQ process is when health workers and community members come together to voice their perspectives on quality issues during the "Bridging the Gap" phase. One of the goals of this session is to find common elements of quality between the two perspectives, that are later prioritized by the two groups to form the basis of QI team action plans. The challenge here has been to consolidate common elements without losing key quality issues. For example, health workers often want to include "provide consultation in the patient's language" under "respect for culture and traditions of patient." Community members, however, usually want to keep the language component separate out of fear that it will be lost during the action planning process if put under that component. To address this concern, PCI ensures that its facilitators are not only well-versed in quality of care issues, but also able to be flexible when defining proposed quality issues and pragmatic when coming up with a clear and manageable list of issues that satisfies both community members and health workers. Despite excellent facilitators, this issue continues to be a challenge for PCI throughout the PDQ process.

The PDQ and Reproductive Health

One of the strengths of the PDQ is that the quality issues that are prioritized during the PDQ process are often cross-cutting; if these issues are adequately addressed by QI teams through their action plans, they should ultimately have a positive effect on many health issues and services offered within a given health facility, including family planning and reproductive health. For example, previous experiences with the PDQ in Nepal have resulted in the increased utilization of family planning services, where visits by continuing family planning users more than doubled for all methods. QI teams were also able to access local government resources for sterilization procedures, clinic improvements, outreach activities, and the purchase of medicines.¹¹



Health personnel lead a tour of the labor and delivery room for community members at a hospital in the Municipality of Vacas.

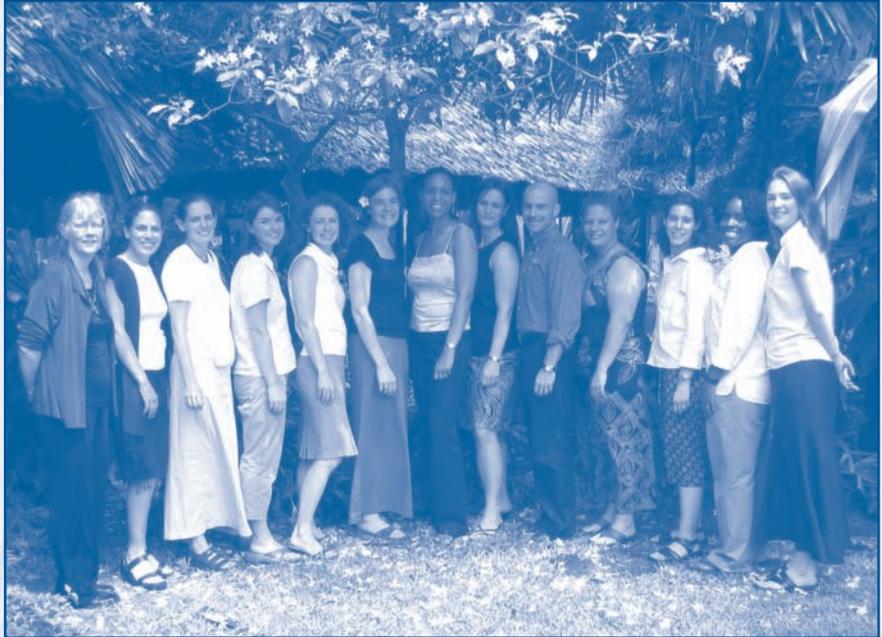
Providing adequate follow-up support

Finally, for the PDQ to be successful, it needs to be done when there is enough time and commitment on the part of the implementing institution for the full and proper implementation of each phase. In two project sites PCI miscalculated the initiation of PDQ activities in relation to other projects, which resulted in limited follow-up and, consequently, limited success of QI action plans. While the creation of a QI team is an accomplishment in itself, it essentially marks the beginning of the process for community members and health workers, who need ongoing follow-up and technical support to address the prioritized quality improvement issues. If this support cannot be guaranteed, an alternative approach needs to be considered.

FELLOWS WORKSHOP Dar Es Salaam, Tanzania

In April, 11 Population Fellows attended a Fellows Workshop in Dar es Salaam, Tanzania. The workshop's focus "*Maximizing the Impact of Your Technical Skills: Challenges for Sustainability*" was explored through individual and team-led peer trainings by fellows on topics such as monitoring and evaluation, intercultural communication, social marketing, and article writing. Highlights also included a career development panel and site visit to a local youth center supported by Fellow Lisa McArthur's host agency, African Medical and Research Foundation (AMREF) and Family Health International's YouthNet program.

The career panel featured field professionals from USAID/Tanzania's HIV/AIDS Team — Jim Allman, Lisa Baldwin, and René Berger — and gave fellows the opportunity to discuss how to make the most of their fellowships, how to develop leadership skills in their current positions, and how to strategically approach their post-fellowship job search. The visit to the Mwananyamala Youth Centre provided fellows the opportunity to view a comprehensive approach to integrated youth programming in an urban setting. The center houses one of AMREF's Angaza (or "shed light") voluntary counseling and testing sites, and provides reproductive health services, life-skills training, and a variety of youth groups dedicated to theater, dance, sports, and other topics.



Left to right: Jane MacKie (Deputy Director, Population Fellows Programs); Jennifer Rubin (USAID/Rwanda); Lisa McArthur (AMREF/Tanzania); Annie LaTour, (USAID/South Africa); Catherine Hastings (USAID/Rwanda); Jennifer Schlecht (EngenderHealth/Tanzania); Siri Suh (Management Sciences for Health/Senegal); Amy Babchek (United Nations Foundation/USA); Eric Ramirez-Ferrero (FHI/Tanzania); Megan Wysong (PATH/Kenya); Madaline Feinberg (USAID/Namibia); Orazio Slayton (Seventh-day Adventist Church/Tanzania); Anna Folsom (Fellows' Support Coordinator, Population Fellows Programs)

"The workshop allowed me to have in-depth conversations with and bounce ideas off of other fellows. I came away with a new support base (both technical and personal) and a better understanding of various organizational cultures and contexts for implementing programs."

— Population Fellow



PE Strategic Planning Workshop in Bangkok, Thailand

In November 2004, the Population-Environment Fellows Program participated in a workshop titled "Healthy People, Healthy Planet: Strategic Planning for Linking Population, Health, and Environment Interventions" organized by the Population Reference Bureau (PRB) and sponsored by USAID. The workshop was conducted in conjunction with the World Conservation Union's World Conservation Congress in Bangkok, Thailand. Four Population-Environment Fellows, a PEAK Fellow, and representatives from several organizations including USAID, the Woodrow Wilson Center, PRB, and Population Action International participated in the event. The conference provided a unique opportunity for fellows to learn more about integrated programs and to interact with PE professionals working on programs worldwide.



2004 PE Small Grants Recipients

Initiated with support by the David and Lucile Packard Foundation, Population-Environment (PE) small grant awards were introduced in 2003 to provide start-up funding for organizations currently hosting or collaborating closely with a fellow to launch PE projects raising awareness about family planning, reproductive health, and the environment. Based upon the small grants early success, USAID supplemented the Packard funding in 2004. To date, PE small grants have supported the development of projects in Bolivia, Brazil, Guatemala, Guyana, Madagascar, and Peru by PE, Population, and PEAK Fellows. During 2004, these grants allowed three fellows and their host agencies to put the following PE projects into action:



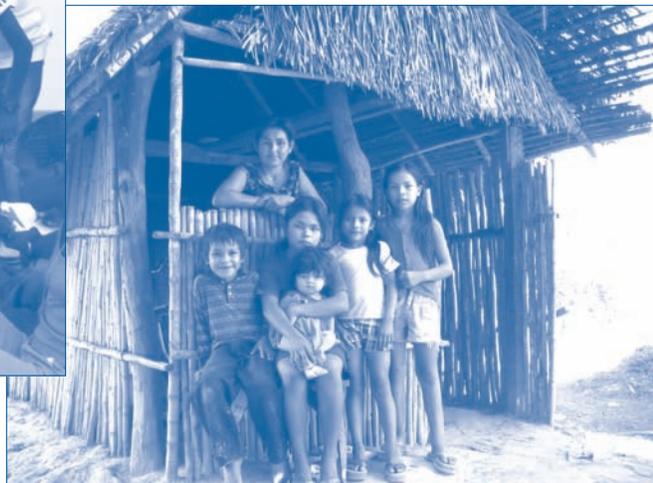
Population Fellow Jennifer Miller and the Ministry of Health of Guyana used PE small grant funding to form the Guyana Youth Forum on Conservation, Ecology, and Population — a project designed to bring youth from environmental and health clubs together for three days to raise awareness about conservation, ecology, and population issues.



Population Fellow Kiyomi Tsuyuki worked with Pathfinder International in Bolivia to develop a PE project designed to improve the quality of life for the indigenous Beni population in the Bolivian Amazonas. Their efforts focused on expanding a community-based PE promoter training program and using radio programs to increase access to reproductive health and environmental conservation information relevant to the region.



Participants at the Guyana Youth Forum discuss ways to reduce, reuse, and recycle trash items. (Photo by Jeremy Keeton, Peace Corps Volunteer)



A mother and her five children in the Beni region of the Bolivian Amazonas targeted by Pathfinder International's PE small grant effort.



PE Fellow Ericka Moerkerken is working with her host agency ProPetén Foundation in Guatemala to develop a training program for male leaders from seven communities located within the Petén nature reserve. The trainings will prepare leaders to teach others about the proper use of natural pesticides and herbicides while raising awareness about reproductive health issues including family planning and safe motherhood.



Population Fellows Programs' Job-Posting Listserve

Our **job-posting listserve** is a free service for posting mid-to senior-level positions in international family planning and reproductive health. Please send announcements to:

[<pop.postings@umich.edu>](mailto:pop.postings@umich.edu)

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PCI AND PDQ: NEXT STEPS

In the next year, PCI plans to continue the implementation and follow-up of PDQ activities to verify that the preliminary qualitative findings are followed by sustainable and quantitative changes in health service provision, service utilization, and client satisfaction. PCI also plans to explore ways to complement and further strengthen the PDQ methodology with other activities.

Conducting formative research

PCI is currently seeking funding to conduct formative research to explore how, despite linguistic, gender, and cultural barriers, an accurate shared definition of “quality” can be reached and appropriate action plans designed through the PDQ process. In addition, they plan to develop and to test simpler quality improvement tools to increase participation among QI team members and to replicate the “Working in Partnership” phase in other settings. PCI also hopes to study the effects of community members’ involvement in the PDQ process, for example, if anyone has experienced positive or negative consequences for expressing their opinions about health service quality.

Addressing both patient and health worker concerns

In its current form, the PDQ explores the concept of patients’ rights separately (with community members and health workers) while health workers’ rights are discussed with health workers alone but not with community members. There are no activities that explicitly discuss these concerns during the “Bridging the Gap” phase when both groups are together. This was a common complaint of health workers throughout the process. While this issue may possibly be allayed with proper facilitation, PCI believes it demonstrates a need for activities that equally discuss the concerns of both groups during the process.

Incorporating social capital activities

In 2003, PCI initiated a pilot project aimed at strengthening social capital,¹² focusing on elements such as trust, civic values, and social cohesion within and among institutions in various sectors, including health. Monthly workshops challenged participants to analyze dysfunctional mental models that lead to prejudices, inequality, and lack of cooperation, and promoted cooperation and collaboration. Currently PCI is implementing social capital activities at three project sites where the PDQ will be applied. Preliminary evidence

shows positive changes among participating health workers, including improved attitudes and more collaborative work efforts. In the future, PCI hopes to incorporate social capital activities as a complement to the PDQ process, focusing on strengthening established QI teams’ cooperation and collaboration.

Implementing competitive mini-grants

Building on lessons learned from a similar mini-grants project, PCI plans to pilot an approach that combines the PDQ with competitive mini-grants, where QI teams would compete for available municipal funding to implement quality improvement projects. QI teams will be trained to develop a simple proposal that will be reviewed based upon criteria determined by competing QI teams and local authorities. With the addition of mini-grants to the process, PCI hopes to create a sustainable mechanism to fund quality improvement projects.



Fellow Bernice Pelea (far right) reviews the month’s PDQ activities during a planning meeting with PCI technical staff and PDQ facilitators, Ruth Bolaños (left) and Lilian Tirao (center).

CONCLUSION

With these initial results, PCI hopes to build on the PDQ and share lessons learned with other organizations. As a first step in documenting these experiences, PCI is developing a PDQ manual for Bolivia in collaboration with Save the Children/USA. This manual will serve as a valuable resource for other organizations that currently implement the

methodology or are interested in quality improvement. PCI’s commitment to improving quality of care using the PDQ methodology has made tangible progress in its first year of implementation. Addressing the “calidez” component of QOC by emphasizing dialogue and mutual understanding between community members and health workers has opened promising new doors that are increasing collaboration, communication, and service utilization at initial project sites. While many challenges remain throughout the process, PCI continues to explore new ways to support and strengthen the PDQ method in an effort to further close the client-provider divide — an essential component for improving health and increasing utilization of reproductive health and family planning services throughout Bolivia.



Bernice's fellowship with PCI/Bolivia is through August 2005. She plans to continue working in the field of international public health and to pursue an advanced degree in nursing, specializing in midwifery. For more information on the PDQ methodology, please check the Web sites noted in the references' footnote 7. For more information about PCI's work with PDQ in Bolivia, e-mail Bernice at: berepelea@yahoo.com.

Bernice extends her gratitude to former Population Fellow Elizabeth Bunde for her insightful comments in developing this article. She would also like to thank the PCI/Bolivia's National Director, Kurt Henne, and PCI field technical staff Ruth Bolaños and Lilian Tirao, whose encouragement, support, and expertise have helped the PDQ methodology become a reality in Bolivia.

Global Health Poster Session

Bernice will be available to discuss PCI/Bolivia's recent PDQ efforts at a poster session during the Global Health Council Annual Meeting in Washington, D.C.:

Wednesday, June 1, 2005, 12:30-2 p.m.

Poster Number: 36

Title: "Response to Social Exclusion in Bolivia: Fostering Dialogue for Quality Improvement in Health Services"

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- 2 Unless otherwise noted, health data presented here are from: Sardan, MG, Ochoa, LH, & Guerra, WC. (2004). Bolivia: Encuesta Nacional de Demografía y Salud 2003. La Paz, Bolivia.
- 3 Ibid.
- 4 Velasco, C., Quintana, C, Jové, G, Torres, L, & Bailey, P. (1999). Calidad de los servicios de anticoncepción en El Alto, Bolivia. Pan American Journal of Public Health, 5, 411-418; Schuler, S, Choque, M, & Rance, S. (1994). Misinformation, mistrust, and mistreatment: Family planning among Bolivian market women. Studies in Family Planning, 25, 211-221.
- 5 In Spanish, quality of care is broken down into two components: "calidad," which includes elements such as infrastructure, medical supplies, technical capacity of health provider, etc., and "calidez," which includes the interpersonal/human relations aspect of QOC and signifies a certain warmth and quality of interaction between health providers and clients.
- 6 Lovich, R, Rubardt, M, Fagan, D, & Powers, MB. (2003). Partnership Defined Quality: A tool book for community and health provider collaboration for quality improvement. Westport, CT: Save the Children.
- 7 Due to space limitations, this article provides only a brief description of PDQ. To gain a fuller appreciation of the experiences presented here and for more detailed information on the PDQ methodology, please refer to the tool book, available at the Save the Children Web site: http://www.savethechildren.org/technical/health/PDQ_Final_Manual.pdf. PDQ materials and information are also available at the CORE Group Web site at: http://www.coregroup.org/diffusion/pdq_save.cfm.
- 8 From CORE Group Web page describing PDQ: http://www.coregroup.org/diffusion/pdq_save.cfm.
- 9 For the purpose of this article, health workers include all personnel who work within a given health facility and may interact with patients, including health providers (e.g., physicians, nurses, nurse assistants), administrators, and other support staff (e.g., kitchen staff, cleaning staff, doorman, etc.).
- 10 SUMI stands for "Seguro Universal Materno Infantil" and is the national insurance policy that covers all pregnant and post-partum women and children under five.
- 11 Profile: Adolescent Reproductive Health in Nepal, MAQ Web site: http://www.maqweb.org/maquevents/maq_cdqday/resources/9_other_resources/CDQ-MAQ_Profile_Nepal.doc.
- 12 According to Putnam, social capital "refers to the collective value of all "social networks" [who people know] and the inclinations that arise from these networks to do things for each other ["norms of reciprocity]" and it emphasizes "trust, reciprocity, information, and cooperation associated with social networks." Putnam, RD. (2000). Bowling Alone: The Collapse and Revival of American Community. New York: Simon and Schuster.

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Unless noted, photos accompanying fellows' articles are courtesy of the fellows themselves.



OUR OTHER PROGRAMS

Though this newsletter focuses on our Population and Population-Environment Fellows, our Programs offer a number of complementary activities with many opportunities for involvement:

Graduate Applied Project (GAP) Mini-Grants of \$2,500 are available to U.S.* graduate students who have unpaid or partially funded internships in international family planning. This is an excellent way for potential fellowship candidates and other promising students to gain relevant overseas experience.

The Summer Certificate Course in international family planning and reproductive health is a short-course held on the University of Michigan campus each summer. Covering the field's key players, programs, concepts, data sources, and evaluation techniques, the course is designed for individuals with relevant skills who have limited graduate-level training in international family planning.

The Professional Exchange for Applied Knowledge (PEAK) Initiative aims to build the capacity of developing-country professionals and organizations that offer leadership in the fields of family planning, reproductive health, and population-environment. Funded by USAID and the Compton, William and Flora Hewlett, and United Nations Foundations, the centerpiece of this initiative is a two- to four-month fellowship for early-career professionals from Latin America and sub-Saharan Africa.

The Minority-Serving Institutions (MSI) Initiative provides internships to students from Historically Black Colleges and Universities, Hispanic-Serving Institutions, and Tribal Colleges and Universities to encourage them to enter the field. If you'd like to help create a cadre of U.S.* development professionals that is representative of the country as a whole, we encourage you to consider hosting an MSI summer intern at your organization.

*U.S. refers to citizens and permanent residents.



2005 MSI Intern Placements

In June 2005, the Population Fellows Programs Minority-Serving Institutions (MSI) undergraduate interns began their summer internships. We encourage fellows to be on the lookout and provide support for them if they're in your community or if you happen to be traveling through their area this summer. *Each intern listing includes their school and host organization.*

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Oakwood College
MUDE/Dominican Republic

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Howard University
ProPetén Foundation/Guatemala

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Byron Hunter
Dillard University
PATH/Kenya

Melissa Nelson
Winston-Salem State University
Population Council/Kenya

PERU

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University of New Mexico
ASDE/Peru

Eryn Mathewson
Howard University
ASDE/Peru

TANZANIA

Glenn Baldwin
Morehouse College
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