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MANAGING HEALTH SERVICE DELIVERY

by Ann Buxbaum

CHAPTER 10 OF *HEALTH SYSTEMS IN ACTION*

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CHAPTER 10

Managing Health Service Delivery

Ann Buxbaum

This chapter explores the ways in which the health service delivery system interfaces with and builds on the management systems discussed in the earlier chapters of this handbook. You will see how improving the management and leadership of the health service delivery system improves access to and the quality of services. You will observe the importance of strong systems in fostering a positive relationship between clients and providers at service delivery sites—"points of care"—at all levels of the health system, leading to desired health outcomes.

This chapter deals with some of the most critical elements of health services:

- establishing and maintaining high-quality services
- assuring equitable access
- providing integrated services
- scaling up
- providing community-based primary health care
- working with the private for-profit sector

The chapter presents issues that health care managers and providers face in managing each of these elements. You will become familiar with tools and approaches that have proven effective in addressing each of these issues and with organizations that have successfully addressed the management issues, strengthened the key elements of health service delivery, and brought better health to the populations they serve.

Introduction

So far in this handbook we've covered topics such as the six World Health Organization (WHO) building blocks of the health system and the people-centered approach that places the human capacity to lead and manage at the core of health systems strengthening (Chapter 1). The following chapters discussed leadership and management competencies and practices that health care professionals can apply in strengthening essential health systems (Chapter 2); gender considerations (Chapter 4); and specific management systems and subsystems related to governance, planning, human resource management, financial management, supply management, and measurement and monitoring and evaluation (Chapters 3 and 4 through 9, respectively).

We now turn to the health service delivery system, which brings all the building blocks, management and leadership practices, and management systems and subsystems together at central, regional, and district levels, as well as at the service delivery site or point of care (see Box 1).

As a health manager or provider of health services at the provincial or district level of government, within an NGO, or in a private-sector facility, you are at or close to the point of care. You can see for yourself how the management systems and subsystems discussed in this handbook affect the relationship between the client and the provider. You can also see how you can use your leadership and management practices to tailor services to local needs by:

- **Scanning** to understand priority health needs of the local population;
- **Focusing** on the health services that have the highest priority and can best be provided with the resources you have available;

BOX 1. Management Systems at the Point of Care

In attempting to improve national-, regional-, and district-level health systems and their management systems, it is easy to lose sight of the individual, day-to-day encounters between clients and health service providers.

These encounters take place at points of care, wherever the client and provider meet. They include the full range of care, such as what's provided by:

- a village health volunteer providing health information to her neighbors in their homes;
- a nurse treating a child's high fever in a community health center;
- a surgeon or other medical specialist caring for patients in a tertiary hospital.

Point of care is where strong management systems and subsystems come together to support high-quality preventive and curative health services. These systems:

- give health managers and providers the capacity to offer each client the best possible health services that are appropriate to his or her needs and desires;
- help clients understand the value of available preventive and curative services and to know when and how to seek those services for themselves and their families;
- help build the foundation for an informed and engaged community that feels ownership of its services, takes on some responsibility for overseeing them, and supports all its citizens in making wise health choices and maintaining healthy behaviors.

- **Planning** strategies and activities that will bring priority health services to the people in your area;
- **Organizing** structure and systems to deliver the priority services;
- **Aligning** local stakeholders and **mobilizing** resources;
- **Implementing** planned activities through integrating systems and coordinating the work flow;
- Engaging local representatives in using data to **monitor and evaluate** services from the community perspective;
- Creating a positive work climate and producing results that **inspire** the commitment of staff and stakeholders.

Elements of the health service delivery system

Six elements of the health service delivery system apply to the other management systems addressed in this handbook. These six are critical to the provision of health services at all levels, as follows.

1. Establishing and maintaining the **quality of services,** in accordance with WHO's definition of quality: "…the proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition" (Kols and Sherman 1998).
2. Ensuring **equitable access** for all people and communities, with an emphasis on gender disparities and the special needs of youth.
3. Providing **integrated services** that offer the many advantages of integration while incorporating the benefits of vertical services.
4. **Scaling up** (expanding services) in the face of limited resources and geographic, political, and sociocultural barriers.
5. Providing **community-based primary health care (PHC)** that promotes active community participation, provides access to community resources, and takes full advantage of the potential of community health workers.
6. Working with the **private for-profit sector** to create a balanced public-private mix that fosters quality, access, and efficiency.

We now explore each element by looking at its key issues as well as the approaches and tools that managers and providers have used to markedly improve in their service delivery systems and the health of those they serve.

Element 1:
Establishing and maintaining high-quality services

> *At first glance, high-quality health services may appear to be a luxury beyond the budgetary limits of most [developing country] health systems. However, improving quality often does not cost, it pays. Attention to quality is essential to the success of primary health care programs, a fact that health managers with restricted budgets cannot afford to ignore.*
>
> Lori DiPrete Brown et al.
> *Quality Assurance of Health Care in Developing Countries*

BUILDING AND MAINTAINING QUALITY SERVICES: THE CONTEXT

Quality assurance (QA) is a familiar term to most health managers and providers. It implies a planned, systematic approach with standards, protocols, and procedures that enable you, as a health manager or provider, to bring high-quality health services to your clients, continuously and within the resources available to you.

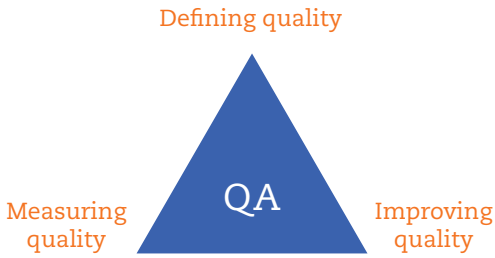
US Agency for International Development's (USAID) Quality Assurance Project (QAP)—predecessor to the current Health Care Improvement (HCI) Project— introduced the Quality Triangle found in Figure 1, a model of the three functions of quality assurance: defining, improving, and measuring quality. The triangle conveys the idea that quality of care is best achieved when all three functions are implemented in a coordinated fashion.

There is no "correct" sequence to implementing these three functions; where you and your colleagues begin depends on the capacity of the health care system or facility and the interests of the providers. You might want to begin with a major effort to define standards, a small quality-improvement activity, or monitoring current activities. Some teams might begin by working on two functions at once.

Under the Quality Assurance Project, University Research Company applied the quality triangle to define, measure, and improve the quality of family planning supervision at the district level in Zimbabwe.

In defining the desired quality, the project relied on supervision standards developed by Zimbabwean stakeholders. A team of supervisors and researchers then measured the performance of supervisors in selected supervisory practices, collecting data from struc-

FIGURE 1. Quality Triangle



Source: Adapted with permission from University Research Company

tured observations, audiotapes of supervisor-provider interactions, and recording supervisory activities and interviews with supervisors and supervisees.

QAP built on the study's results and designed a course that enhanced supervisors' strengths and directly addressed their most salient weaknesses. As a result, the supervisors' performance improved.

> The Health Care Improvement Project website has a report with details of this intervention that you can download.

BUILDING AND MAINTAINING QUALITY SERVICES: KEY ISSUES

This section explores the functions of defining, measuring, and improving quality.

Defining quality: Synthesizing perspectives and setting standards. The quality of services can be viewed through many different lenses, depending on the priorities of different stakeholders. For example:

- **Clients** often emphasize the human aspects of care—respectful treatment, privacy and confidentiality, information, and counseling—in addition to safety, convenient locations and hours, reasonable waiting times, affordable cost, and a clean, comfortable facility.
- **Providers** tend to highlight technical competence, infrastructure, and logistical support. Managers might stress management systems—especially logistics and information systems.
- **Policymakers and donors** take the broader view, which WHO defines as "the proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition" (Creel 2009).

These varied perspectives on quality can be simply stated as "offering a range of safe, effective services that meet evidence-based standards while satisfying clients' needs and desires." To this end, the Quality Assurance Project synthesized ideas from quality experts and defined nine dimensions of quality, as shown in Box 2.

Defining quality involves setting evidence-based standards—expectations of performance—for all these dimensions and at all levels of the broad health care system. Standards are explicit statements of how to perform a health care activity so that it produces the desired outcomes. In some cases, universally accepted standards exist and can be adopted or adapted so that health workers can use them as guides to acceptable performance.

Measuring quality: Identifying gaps and demonstrating changes. Once standards have been developed or updated and communicated, key indicators can be selected, measured at the baseline, and monitored over time to detect changes in quality. You and your team should carefully choose a small number of indicators of the various dimensions of quality for which you can measure small changes over time.

BOX 2. Dimensions of Quality

1. **Technical performance:** compliance with standards—the degree to which tasks carried out by health workers and facilities follow standards or meet technical expectations.
2. **Access to services:** lack of geographic, economic, sociocultural (including gender), organizational, or linguistic barriers to services.
3. **Effectiveness of care:** the degree to which desired results or outcomes are achieved.
4. **Efficiency of service delivery:** the appropriate use of resources to produce effective services.
5. **Interpersonal relations:** effective listening and communication between provider and client that is based on trust, respect, confidentiality, and responsiveness to client concerns. This includes nondiscrimination.
6. **Continuity of services:** delivery of care by the same health care provider throughout the course of care (when feasible and appropriate), as well as timely referral and communication between providers when multiple providers are necessary.
7. **Safety:** the degree to which the risks of injury, infection, or other harmful side effects are minimized.
8. **Physical infrastructure and comfort:** the physical appearance and cleanliness of the environment of care and the comfort and privacy it affords clients and health workers.
9. **Choice:** client choice of provider, treatment, or insurance plan, as appropriate and feasible. Inherent in this dimension is access to information that enables the client to make an informed choice.

As discussed in Chapter 9 of this handbook, you should, as much as possible, find data sources for measuring quality indicators in routine service reports, such as community-based health information (usually collected by health workers or community workers) and facility-based patients' charts, supervisory checklists, logbooks, and inventories.

Three aspects of quality that can be measured against standards of performance: structure, process, and outcomes. All three have advantages and disadvantages as indicators of quality.

1. **Structural indicators** include material characteristics (physical infrastructure, medicines and health products, number of assigned personnel, tools, technology); organizational resources; and financing of care (levels of funding, payment schemes, and incentives). Because structural measures are relatively easy to obtain, these are used most often in studies of quality in developing countries. However, structural indicators give only a partial picture of quality when used by themselves.
2. **Process indicators** track the completion of activities. They describe the interactions between caregivers and patients and are measured by the provider's accurate diagnosis and clinical treatment that conforms to guidelines, as well as by "softer" indicators such as counseling skills; demonstrated respect for the client; and provision of accurate, understandable information and clear instructions. Many studies have shown that certain processes generally lead

to better health outcomes, but it is not easy to measure the processes that take place during the private interaction between client and provider.

3. **Outcome indicators** are measures of change in a beneficiary population as a result of a set of activities. They can be long term (e.g., use of health services; changes in clients' knowledge, attitudes, and behaviors) or short term (e.g., client satisfaction, adherence to recommended treatment). Long-term outcomes may not be the best measure of quality: a patient may receive poor-quality care and make a full recovery or, on the other hand, receive high-quality care and not recover from a chronic or fatal illness. Short-term outcomes—client satisfaction and response to treatment—offer the client's perspective but may not fully reflect other dimensions of quality.

A combination of these three dimensions can yield useful quality measures at relatively low cost.

The traditional facility audit reveals the presence or absence of the essential physical requirements for quality services. Record reviews can be supplemented by observations of client-provider interactions or written vignettes in which providers are asked to take a history, do an examination, order tests, make a diagnosis, and specify a treatment plan.

These observations may give an imperfect picture of what actually happens in unobserved encounters, but they do demonstrate the provider's skills in coping with a variety of clinical conditions. Exit interviews can be used to obtain the client's perspective on the visit and his or her understanding of the diagnosis and recommended treatment.

Improving quality: Meeting or surpassing standards of performance. Improvements can pertain to all the dimensions of quality above. To be useful, national standards must be current, evidence-based, and relevant to the services being offered. They should be developed in a process that involves providers, thereby encouraging ownership and adherence by those who are expected to work to the standards.

The standards must be readily available and communicated not only to providers but also to individual clients and community members. It is important for health care providers to tell a client when his or her specific treatment request fails to meet standards of care, to fully explain the reasons, and to recommend the appropriate treatment alternative.

For example, if a patient requests an antibiotic injection to relieve the symptoms of a cold, a health provider can cite the standards for administering antibiotics, explain the reasons for those standards, and offer other options (relief of symptoms) that conform to the standards.

Improving quality in decentralized settings. Quality improvement is a particular challenge in settings where decentralization is taking place. Decentralization means that, to varying degrees, central-level managers set policy and plan strategically while local managers take increasing responsibility for providing health care and are held accountable for the health of the populations they serve.

As responsibilities are transferred to managers at peripheral levels, these managers must build experience and acquire new technical and managerial knowledge. The central government, in turn, must build its capacity to set clear national standards and service norms and establish a system for ongoing monitoring of performance.

These new roles should be clearly delineated and agreed to, and the priorities of all levels should be acknowledged. Otherwise, there will be duplication, confusion, and conflict—hardly conducive to improvements in the quality of services.

Experience with decentralization in many countries has shown that it is possible to improve services rapidly while strengthening the capabilities of local health teams. With facilitators from the central or provincial Ministry of Health (MOH) or from NGOs, district or municipal teams engage in a logical, sequenced performance improvement process. They use available data to assess current health conditions and service performance and then select one or two high-priority health concerns to work on. They define desired performance against standards, identify gaps, analyze the causes of the gaps, design their own solutions, mobilize support for implementing the solutions, and monitor their progress to measure changes in performance.

Many of these teams have never worked together systematically to address specific health problems. The performance improvement process gives them experience in a new methodology as well as the gratification of a real achievement: a realistic plan for improving performance in areas that they consider priorities.

BUILDING AND MAINTAINING QUALITY SERVICES: APPROACHES AND TOOLS

This section briefly describes five approaches that you may find useful in building and maintaining the quality of services in your organization: performance-based financing, from improvement collaboratives, partnership defined quality, COPE (client-oriented, provider-efficient services), and standards-based management and recognition.

Performance-based financing (PBF). PBF is a powerful mechanism for improving the quality and increasing the use of health services by setting performance goals based on agreed-upon standards and indicators. The cornerstone of PBF is "payment for performance," based on a negotiated contract between the funding agency and a service-providing organization. This contract establishes indicators of performance that clearly define performance targets. It requires the organization to complete a set of actions or achieve a measurable performance goal before receiving a transfer of money or goods.

While rewarding the completion of activities and the accomplishment of immediate outputs, PBF capitalizes on these short-term results to achieve longer-term health outcomes. In this way, it encourages governments, NGOs, other private service-delivery organizations, and funding agencies to strengthen management capacity, estimate costs, set fees, and bolster systems for financial and information management.

PBF empowers health managers to allocate resources in a way that rewards meeting health goals. By improving financial and information management capacity and expertise, PBF strengthens the sustainability and performance of ministries of health, district and

Performance-Based Financing in Action—An Example from Rwanda

Applying PBF in Rwanda. PBF is at the core of USAID's flagship HIV/Performance-Based Financing Project in Rwanda, a collaboration between the Rwandan Ministry of Health and Management Sciences for Health (MSH) and its partners. The goal of the project was to support both the quality and quantity of services delivered through health facilities in all of the country's districts.

Initially, the project contracted directly with 85 health facilities to provide incentive payments for quantity in the delivery of specific HIV & AIDS and related services, and with districts to monitor indicators of quality of care. In fewer than two years, the project surpassed its objectives. In comparison to control districts where PBF had not been introduced, the PBF districts achieved significant improvements in the services delivered.

To support this incentive system based on performance, MSH provided technical assistance to build staff capacity, strengthen systems (especially data flow and analysis), and improve QA policies and protocols. For the final two years of the project, PBF was established throughout the national health system, including its more than 400 health centers. The project transferred all its PBF contracts to five partners and concentrated on helping the MOH continue to strengthen its quality improvement management systems, management structure, operations, and information systems.

The HIV/PBF project ended in 2009, but the team has continued to work, via a follow-on project, with the MOH on health systems strengthening.

You can read more about PBF in a handbook on the subject as well as in the PBF/HIV project's end-of-project report.

community institutions, and NGOs. Performance-based grants or contracts have proven effective in increasing the use of health care services, stabilizing or decreasing costs of these services, contributing to the wise use of limited resources, and improving staff motivation, morale, and retention.

The improvement collaborative approach. This methodology is designed to rapidly achieve significant—often dramatic—improvements in a focused technical area such as treatment of multidrug-resistant tuberculosis, provision of neonatal care, or management of a chronic disease. Improvement collaboratives supplement the elements of traditional public health interventions (standards, training, job aids, supplies, and equipment) with modern quality improvement features (teamwork, process analysis, monitoring of results, and client satisfaction).

This approach engages large numbers of teams working in different health facilities and geographic areas in a joint effort to improve quality and access by achieving shared objectives in the specified area. These collaboratives seek not only to improve quality at each facility but also to rapidly disseminate successful practices to multiple settings through the efforts of all the teams.

To this end, there are two types of collaboratives.

1. **Demonstration collaboratives** are the initial facility-based teams that work out the details of implementing agreed-upon best practices and then carry out those practices at their sites. The participating teams work together to develop a common set of indicators to measure their desired outcomes. Each team collects data on the indicators for its facility and regularly reports these data to the other teams. Because they track progress and results and share their experiences, teams can quickly benefit from the knowledge gained from both successful and unsuccessful changes by any other team.
2. **Expansion collaboratives** seek to scale up proven improvements, spreading them beyond the initial teams to their facilities and then to a larger group of organizations. In meeting these objectives, participating teams are taking on a challenge, and they can draw on all the managing and leading practices described in Chapter 2 of this handbook.

For more information on improvement collaboratives, the Quality Assurance Project provides information, as does the Institute for Healthcare Improvement.

Partnership Defined Quality (PDQ). PDQ is an easy-to-use tool that can bridge the gap in perceptions of health care providers and community members and make health care more responsive to the needs of communities. It engages communities in defining, implementing, and monitoring the quality-improvement process while helping eliminate social and cultural barriers to better health, strengthening the capacity of communities to improve health, and creating a mechanism for rapid mobilization around health priorities.

PDQ helps community members and providers develop a shared vision of quality improvement that involves agreement on standards of performance, and it empowers them to work together to achieve their vision.

PDQ encourages health care providers and communities to look beyond the health system and seek solutions to health care deficiencies at the community level. Individuals, communities, health-facility staff, and district-level managers form partnerships and take on shared responsibility for improving health services.

Users of the PDQ tool generally form quality improvement (QI) teams so they can help communities continue monitor their own form of quality and maintain improved access to and use of services. Once community members become empowered to work together, they often achieve additional nonhealth benefits in such areas as food security, education, and economic opportunity.

You will find more information about PDQ from the Extending Service Delivery project website.

COPE (client-oriented, provider-efficient services). COPE is a quality-improvement process that enables service providers and other staff at a health facility to work with their supervisors to assess their services using self-assessment guides based on international standards and known best practices.

With the guidance of a facilitator, staff and supervisors draw on a variety of mechanisms—especially structured interviews with clients, nonusers of services, and internal customers—to identify problems, find root causes, seek effective solutions, and create realistic action plans. This self-assessment approach creates ownership of and continuing involvement in the quality-improvement process.

Many COPE activities are carried out while staff are doing their routine work, to avoid interfering with the regular work day. Site supervisors are trained to facilitate the COPE process so that they can conduct follow-up sessions and introduce COPE at new sites. Ongoing COPE committees ensure long-term follow-up and ongoing institutional support of the process.

The COPE Handbook: A Process for Improving Quality in Health Services offers guidance to COPE facilitators in orienting managers, training site facilitators, guiding facility staff in using COPE tools, and adapting the COPE process and tools to a facility's needs. The handbook is supplemented by COPE tool books that contain the self-assessment guides, record-review checklists, client-interview guides, and client-flow analysis forms.

The EngenderHealth website also offers information about COPE.

Standards-based management and recognition (SBM-R). This is a practical, proactive management approach for improving the performance and quality of health services. Rather than emphasizing problems, SBM-R focuses on the standardized level of performance and quality to be attained by:

- setting performance standards around clearly defined service delivery processes or specific content areas;
- implementing the standards in a streamlined, systematic way;
- measuring progress to guide the improvement process toward these standards;
- rewarding achievement of standards through recognition mechanisms.

Standards-Based Management and Recognition in Action in Malawi

In collaboration with the Malawi Ministry of Health, the international health organization Jhpiego has applied SBM-R to infection prevention and control practices, with the goal of protecting clients and health workers from acquiring blood-borne infections and TB. First implemented at seven hospitals in three regions, the Hygiene is Life initiative has now been expanded to 35 hospitals nationwide. Local media coverage has helped generate demand for the initiative at hospitals in others areas of the country and has elicited interest from local leaders, providers, and community members.

You can go to the Jhpiego website for further information about SBM-R success stories from other countries.

Element 2:
Assuring equitable access for all people and communities

> *…the greatest gains in maternal, neonatal and child survival depend on effectively reaching the poorest and the most marginalized, who suffer the greatest burden of disease.*
>
> Cesar G. Victora
> *Towards Greater Equity in Health for Mothers and Newborns*

EQUITABLE ACCESS FOR ALL: THE CONTEXT

Among the barriers that delay or prevent poor households from accessing health care, the quality of available care is a critical factor. Clients may choose not to go to health facilities if they have to wait for a long time, if the medicines or contraceptives they need are unavailable, if they do not feel welcomed and respected, or if the facility staff lack the skills to provide appropriate treatment.

However, even when the quality of services is acceptable, other serious barriers exist. The most widely acknowledged are distance, geography, and the opportunity cost of lost time and wages. Social and cultural disparities that are equally critical are often less obvious. One of the most complex is class: differences in economic status, education, language, ethnicity, values and customs, and social standing between clients or potential clients and the health providers who serve them.

Disparities in access lead to highly significant disparities in use of services and, consequently, in health outcomes. Recent studies in several sub-Saharan African countries have looked at a package of four essential interventions: prenatal care, skilled attendance at delivery, postnatal care, and childhood immunization. In sub-Saharan Africa and South Asia, use of these interventions was about four times higher among the richest groups than among the poorest groups. It is not surprising that maternal, neonatal, and child mortality follow the same pattern of marked socioeconomic variations (UNICEF 2009).

Economic, social, and cultural inequities are especially daunting for marginalized groups: the rural poor, slum dwellers, those most at risk for HIV and AIDS, and—increasingly—the elderly. The most effective health service managers and providers in both the public and private sectors are alert to the causes of inequitable access in their communities. They pay attention to their own sociocultural biases and make every effort to recognize the dignity of all clients and treat them with respect and courtesy.

As a health manager or health service provider, you can look closely at your organization's management systems and use management and leadership practices to eliminate or reduce the systemic factors that keep certain populations from making full use of services. For example, you can **scan** service data and constantly **monitor** progress to be sure that your services are reaching the poorest citizens; you can formulate the objectives of strategic and operational **plans** to include the underserved; and you can work to sensitize and **align** colleagues and local leaders around values, systems, and daily activities that promote equity.

The barriers to access are not limited to the marginalized populations mentioned above. Two additional factors can stand in the way of access to appropriate services: gender and age. In this context, we will look at the particular needs of both women and men, and of youth.

GENDER EQUITY

> *[G]ender significantly influences a person's ability to access health services. … In many places, most women are still marginalized. Their status—economic, social, and political—has …deteriorated under worsening economic conditions. They often receive far fewer of the benefits from socioeconomic development than do men. The inequities make women more vulnerable to health risks. They are less likely to receive the right services and treatment. … [And] attitudes towards "masculinity" may result in some men continuing sexual practices that affect their own health and endanger the health and lives of their families.*
>
> Management Sciences for Health
> *The Manager, vol. 9, no. 3*

GENDER EQUITY: KEY ISSUES

Defining gender. As discussed in Chapter 2, by "gender" we mean the characteristics, roles, and responsibilities that society expects of women and men, girls and boys. These expectations are based on social attitudes rather than biological differences. Gender is expressed in the relations between the sexes and in assumptions about so-called appropriate behaviors. Attitudes and expectations related to gender are learned and can change from generation to generation, from culture to culture, and from one social, ethnic, or racial group to another within the same culture.

Fostering gender sensitivity. Gender sensitivity moves beyond the traditional focus on inequities that affect only women, without denying a tradition of male dominance that has made women more vulnerable and less powerful. This perspective recognizes that women's ability to benefit from health, education, and economic opportunities cannot be improved without involving men in the process.

If women and men are to be partners in progress, jointly contributing to social and economic development, the goal is not to substitute one group's interests over another's; it is to open up discussion and work toward a new, shared vision in which all will benefit.

This approach takes into account the different roles, social and economic relationships, and access to resources that society imposes on women and men. It recognizes the financial costs, opportunity costs, and social and cultural restraints faced by women and men seeking services. In the realm of health, for example, inequities in influence and power may prevent women from traveling to a health facility for care, or determine their willingness to purchase or use a contraceptive.

On the other hand, societal interpretations of "masculinity" may discourage men from acquiring health information, using condoms, or seeking treatment for sexually transmitted infections (STIs).

Using a Gender Perspective to Reduce Barriers—Country Examples from Afghanistan, Peru, and Jordan

Competency-based education of midwives in Afghanistan. In Afghanistan, maternal mortality—the deaths of women during pregnancy or shortly after giving birth from causes related to childbearing—is among the highest in the world. Geographic barriers and societal restrictions make it extremely difficult for women in rural areas to go to health facilities for prenatal and postnatal care and delivery.

To bring these services to women where they live, USAID's REACH Program collaborated with the Ministry of Public Health and other stakeholders to introduce competency-based education and accreditation of community-based midwives. The program trained more than 700 women who made the commitment to practice in their own communities after training. The program took special care to guarantee a safe living environment for the students, many of whom were away from their homes for the first time. It included a social network that cared for their children during the training period.

***Autodiagnóstico* (self-assessment) in Peru.** The ReproSalud Project, supported by USAID in Peru, was designed to reduce social barriers to women's access to reproductive health services, including limited power to negotiate within sexual relationships, social isolation, domestic violence, lack of cash, and low self-esteem. It targeted the poorest, hardest-to-reach, most underserved Peruvian women, aiming to improve sexual and reproductive health through individual and community empowerment.

The project featured the *autodiagnóstico*—a self-assessment process that groups of women used to identify their greatest reproductive health concerns or problems and to plan small "projects" to address these problems, the most common of which were vaginal infections, "too many children," and "suffering during pregnancy." The results of the *autodiagnósticos* were used to develop training programs for selected community women to qualify as volunteer health promoters and provide basic family planning and reproductive health services in their villages.

The project also worked with village health committees and clinics to incorporate traditional customs (lighting, furniture, position during the birth), creating more comfortable, homelike settings for women during childbirth. The results were impressive: 5,000 women trained and working as health promoters; a contraceptive prevalence rate that increased by 23 percent; and 82 percent of participants having their babies with the assistance of skilled birth attendants.

Male involvement in Jordan. USAID supported Johns Hopkins University's Center for Communication Programs in a six-year initiative that promoted male involvement in family planning and reproductive health in Jordan. By providing credible, accurate information and engaging Islamic clergy, this program counteracted prevailing myths about family planning, reproductive health, and Islamic principles.

Men who were reached through the program significantly increased their knowledge of birth spacing methods, displayed more positive attitudes toward birth spacing, and increased spousal communication and the inclusion of their wives in decisions about birth spacing. A large part of the program's success was attributed to its respect for and adherence to principles in Islamic *Sharia* (law), the Jordanian Constitution, human rights values, and the values of Jordanian society.

As a manager of a health program or health services, you will increase your effectiveness and bring better health results to your clients if you have a gender-sensitive perspective. You will need to consider women's and men's differing health needs and the constraints they face in accessing services within your geographic area and cultural environment. And you will be the most successful if you engage your entire staff in this endeavor.

Mainstreaming and sustaining gender-sensitive services. As a manager or provider, you can take a leadership role in bringing a gender-sensitive approach to your services. You will not need to devote a separate program to gender equity; the most successful organizations mainstream gender across all their programs and services by building and maintaining a core set of skills and attitudes among all staff:

- awareness and understanding of gender issues;
- a commitment to address gender issues that obstruct access to services;
- the ability to adapt systems and procedures to accommodate a gender perspective;
- the ability to design, implement, and evaluate gender-sensitive services and activities.

Your organization should also work to maintain gender equity as much as possible within the local context. This means an appropriate distribution of male and female managers and providers, as well as the assignment of tasks that are appropriate to the skills of staff and the needs of clients, rather than to any traditional gender roles.

GENDER EQUITY: APPROACHES AND TOOLS

Gender analysis. This is a systematic approach you can use to examine factors related to gender in the use of your services, or to design, implement, and evaluate projects. Appendix A contains a framework for gender analysis that defines the most critical factors that affect the health of women, men, girls, and boys. These include the general environment; the activities of these groups (including paid and unpaid labor); their different levels of decision-making power; their access to and control over resources; and the prevailing gender norms.

With your staff, you can use the gender analysis framework to discuss how each of these factors affects your clients and potential clients, to be sure that your organization's health services fully address the roles, needs, and participation of both males and females.

Checklist for managing health services with a gender perspective. You and your staff can use a simple checklist to assess gender sensitivity in your organization and begin to make improvements. The checklist in Box 3 should cover the steps you will take to bring a gender perspective to health services.

There are many examples of creative approaches to addressing gender inequities in health care. Here are three initiatives that brought needed health services to underserved clients by incorporating a gender perspective.

BOX 3. Checklist for Managing with a Gender Perspective

- Review the reasons for a gender perspective in managing health services.
- Review gender concepts and issues.
  - Introduce gender awareness, conduct a gender analysis, and scan organizational characteristics and systems that have relevance to gender-sensitive services.
- Look at prejudices, biases, and preconceptions that you and others may hold, and examine the evidence that refutes those stereotypes.
  - Set gender-related goals and objectives for your services.
  - Identify strategies, activities, and indicators of success.
- Sustain the gender perspective whenever you undertake new services or activities.
- Share your results and experience with other organizations that could benefit.

MEETING THE SPECIAL NEEDS OF YOUTH

> *The young are the future of society, but they are also very much its present. …As evidence from statistics and the experience of youth-serving NGOs shows, adolescents who are healthy and happy are better equipped to contribute to their communities as young citizens despite the major shifts occurring in the world they are about to inherit.*
>
> United Nations
> *World Youth Report 2003*

THE NEEDS OF YOUTH: KEY ISSUES

The reproductive health burden for youth. USAID's Fact Sheet on Youth Reproductive Health Policy points out that young people in developing countries bear a disproportionate share of unintended pregnancies, sexually transmitted infections (including HIV), sexual violence, and other serious social and reproductive health problems. Young women are particularly vulnerable because of their immature reproductive tracts and societal norms and pressures to have early and unprotected sex.

USAID has set forth policy goals for the reproductive health of youth:

- encouraging healthy, wanted pregnancy
- preventing STI/HIV infection
- improving nutritional status
- reducing harmful cultural practices
- reducing human trafficking and sexual abuse/coercion
- stimulating economic development and reducing poverty

To contribute to meeting these six policy goals, organizations that are concerned with youth need to recognize that young people tend to have less access to accurate information about HIV and other STIs, family planning options, and other reproductive health issues than adults do. They are less likely to seek services because of stigma, societal pressures, cost, and fear that they will be looked down on by health providers.

In fact, many health providers refuse to diagnose and treat youth with STIs or other reproductive health concerns, or to offer family planning advice and methods either because of restrictive policies (local or donor driven) or because they disapprove of sexual activity among young people.

THE NEEDS OF YOUTH: APPROACHES AND TOOLS

Community education and advocacy. As a manager or provider of health services, you can make a major contribution to the health of the young people in the communities you serve by recognizing and explaining that pregnancy, HIV, and STIs are health concerns rather than moral issues. You can advocate for comprehensive sexuality education programs in schools, which give youth the information they need to make sound reproductive health choices while respecting local values.

The Interagency Youth Working Group (IYWG) is a useful resource in this effort. Funded by USAID, this is a network of NGOs, donors, and cooperating agencies that provides global technical leadership to advance the reproductive health and HIV & AIDS outcomes of young people.

IYWG shares research and lessons learned with the reproductive health, HIV, and youth development communities; promotes strategies that move promising research findings and best practices into programs and policies; and advocates for greater focus on youth within reproductive health and HIV programs. The IYWG network brings information to those working with young people through Youth InfoNet, a monthly electronic publication with program resources and research summaries.

Youth-friendly services. Youth-friendly reproductive health care is best provided through stand-alone clinics or "youth corners," where nonjudgmental providers make sexually active, unmarried youth feel welcomed and comfortable. These facilities should provide comprehensive, confidential reproductive health services that include STI care, family planning, and voluntary counseling and testing for youth. They should have staff skilled in counseling young people on sexuality, safer sex, pregnancy prevention, and STI and HIV prevention.

The most youth-friendly settings engage young people as full partners in planning and implementing projects. They seek recommendations from youth—both clients and nonclients—on changes to make services more comfortable and responsive. They involve youth in making decisions about how services are delivered through focus groups, interviews, or membership on advisory committees. And they recruit, train, and supervise peer counselors, providing nonmonetary rewards for good performance.

You can find a helpful guide in "A Rapid Assessment of Youth Friendly Reproductive Health Services." This hands-on tool is designed for managers and providers to assess and improve youth services. Staff can record data covering background information, client volume, range of services provided, schedule of available services by each day, and details related to personnel and supervision. The guide includes sections where staff can record information on 12 youth-friendly characteristics: location, hours, facility environment,

staff preparedness, services provided, peer education/counseling, educational activities, youth involvement, supportive policies, administrative procedures, publicity/recruitment, and fees.

Introducing youth-friendly services may require cross-sectoral or cross-departmental planning at the central level of the Ministry of Health and other ministries, with some redistribution of line items in the budget.

Young People in Action—Country Examples from Haiti and Mozambique

Leadership development for youth in Haiti. In Haiti's Cité Soleil, young people have participated in the first Leadership Development Program (LDP) for young people, supported by USAID and cofacilitated by MSH with two local organizations, *Fondation pour la Santé Reproductrice et l'Education Familiale* (FOSREF) and *Maison l'Arc-en-Ciel* (MAEC), as well as Haiti's Ministry of Health.

Over several months, participant teams learned the practices of leadership and management and applied these practices to HIV & AIDS and other sexual and reproductive health challenges in their communities. They set measurable goals, drew up action plans, and reached out to mobilize other community members. By the time they completed the LDP, the teams had trained 4,450 young people on HIV prevention; trained another 252 youth on issues related to HIV & AIDS discrimination and stigmatization; and trained 90 youth as peer educators to do further outreach on HIV prevention, sexually transmitted infections, and teen pregnancy prevention.

Excerpts from a rap song created by young LDP participants (translated from Haitian Creole)

AIDS is our biggest challenge and its spread has caused much suffering.
Confronting this challenge will not stop the disease
But it is a way to prevent others from being infected. …

Listen to why leadership and management go hand in hand:
If you're informed, you can plan, you can concentrate, organize.
One must have vision, clarity, support to confront challenges.

Young people, stand up! Let us engage in this struggle together."

Preventing HIV among youth in Mozambique. Pathfinder International's Youth in Action project strengthened school- and community-based initiatives to prevent HIV among adolescents and other youth in Mozambique. Working through local youth associations and NGOs, the project enabled young people in one district to not only protect themselves from STI/HIV infection but also develop and maintain healthy lifestyles; it engaged the youth as advocates for change in their communities, capable of impacting the knowledge, attitudes, and practices of their generation. The project, supported by Trocaire, an Irish NGO, emphasized building the capacity of youth associations to develop and maintain their own sustainable programs and to advocate for local and national policies and programs favorable to youth-oriented services.

Element 3: Providing integrated services

> *The limited evidence available suggests that integrated approaches to delivering health services, compared with vertical approaches, improve outcomes in selected areas. . . . In practice, most health services combine vertical and integrated elements, with varying degrees of balance between them.*
>
> WHO European Ministerial Conference on Health Systems
> *Policy Brief, 2008*

PROVIDING INTEGRATED SERVICES: THE CONTEXT

The debate about the advantages and disadvantages of integrated and vertical services has persisted throughout the history of foreign assistance. Those who are in favor of **vertical services**—those which focus on a specific demographic population, disease, or health intervention—point out the following advantages to vertical services:

- Staff roles and responsibilities can be clearly defined and focused on a set of tasks that individual staff can reasonably master.
- It is easier to make rapid decisions, monitor progress, and evaluate results.
- Vertical services can usually muster more resources to address public health crises.
- Integrated services can require systems and skills that place too great a burden on service providers, supervisors, and managers, leading to a decline in the quality of care in all services.

Those who support **integrated services**—packages of preventive and curative health interventions that address interrelated health problems for large populations—respond with the following:

- Integrated services offer more convenient and comprehensive services to the client.
- They make possible more streamlined and cost-effective management systems and subsystems (supervision, clinic schedules, logistics, etc.) at the service delivery site.
- Integration is already a reality at lower-level facilities, where one or two people provide all services.
- The formal integration of systems supports providers in sharpening their counseling and clinical skills.
- Top-down vertical programs foster confusion, duplication, and waste by imposing different funding mechanisms, training curricula, supervisory systems, information systems, and reporting requirements on providers.

The WHO website offers more information about integrated services, as do two issues of *The Manager*, one about managing integrated services, and the other about integrating STD and HIV Services into reproductive health settings. In addition, an MSH position paper describes a systems approach to combating HIV & AIDS.

PROVIDING INTEGRATED SERVICES: KEY ISSUES

Defining integration. Integrated health services can be defined along a continuum, ranging from the narrowest sense—the combination of two formerly separate services into a single, coordinated service—to a full package of preventive and curative health services available at a multipurpose service delivery point under one manager.

The definitions also vary with the different perspectives of clients, providers, health managers, and policymakers.

- For the **client**, integration means health care that is seamless, easy to navigate, and coordinated. It means not having to make separate visits to a health facility to address different health concerns. It means both health workers who care for the whole person rather than for one particular illness and good communication among health workers at different levels of the health structure.
- For **providers**, integration means coordination of the management systems for different technical services, particularly management of medicines, information, and finances. This coordination differs at different levels of the system. At the primary level, where there is often only one health worker, integrated delivery of services is a reality, but his or her job may be made easier or harder depending on how management support systems are organized. A tertiary hospital, at the other end of the spectrum, will be staffed by several specialists who need to communicate well to coordinate the care of each patient and to use equipment, supplies, space and staff efficiently.
- For **health managers and policymakers**, whether at district, provincial, or national levels, integration happens when leaders of different technical programs in public, private, and voluntary health sectors break through the walls that divide them and make joint decisions on policies, financing, regulation, and delivery.

Blending integrated and vertical services. Despite the arguments for and against integrated and vertical services, the trend throughout the developing world is toward integration of related services, even within vertical programs. Good examples are the integration of HIV prevention, treatment, and care with TB services under the US President's Emergency Plan for AIDS Relief (PEPFAR), or the addition of Vitamin A or bednets to national immunization days.

The decision to integrate is generally made at the highest levels of donor and government agencies. However, you need to work productively under whichever approach prevails at your level. The challenge is to make sure that the basic package of health services—however that package is defined in your setting—is available to all those who come to a service delivery site.

The availability of a basic package of health services would mean that, at the service delivery site, health workers are trained and supervised to provide the full range of services—or to refer clients to a higher-level facility—in a way that assures access, makes effective use of service staff, guarantees privacy, and minimizes costs (including time lost) to those who seek those services. At higher levels, it requires a coordinated, multisectoral approach to support and reinforce the services.

Preventing missed opportunities. One of the strongest arguments for integrating services is the potential for using a client visit to recommend or provide interventions beyond those that the client is seeking. For example:

- When a mother brings in a sick child, a nurse who has been trained to provide integrated services can give nutritional advice, provide or schedule immunizations, and counsel the mother on family planning. He or she can inquire about the health of other family members and identify warning signs of potential problems.
- A patient who comes for curative care can be offered a wide range of preventive services for her/himself and other family members.
- A prenatal visit can be the occasion for STI diagnosis and treatment, HIV counseling and testing, and, if appropriate, services for prevention of mother-to-child transmission (PMTCT).
- A patient who is receiving HIV services of any kind is a candidate for STI prevention and detection, family planning counseling, services to help prevent HIV transmission, and diagnosis and treatment of tuberculosis.

There are many instances where two or more existing vertical programs are brought together into an integrated package of services; two are shown in Box 4.

All forms of integration will require changes that may be difficult for managers, providers, and other stakeholders. The shift from vertical to more integrated programs cannot take place without political, technical, and administrative action throughout the broad health system, beginning with commitment from donors and the top tier of government.

BOX 4. Shifting from Vertical to Integrated Programs

Integrating management of childhood illness. Integrated management of childhood illness (IMCI) is a strategy to address the five major causes of under-five death in the developing world: diarrhea, pneumonia, malaria, measles, and malnutrition. The IMCI strategy is based on the realization that many children present with overlapping signs and symptoms of diseases, making a single diagnosis and treatment inappropriate.

Under IMCI, health workers are trained to assess, classify, and treat the whole child, rather than dealing with only one specific health problem. The strategy includes facility-based care, home care and care seeking, treatment at the community level, and referrals to and supervision from facilities. IMCI also recognizes the importance of improving the management systems that support these workers: drug supply, supervision, financial management, and information systems. In India and some other countries, neonatal care has been added to the package, and IMNCI has become the new acronym for this integrated approach.

Integrating HIV prevention and family planning. Another recent instance of integration is between HIV and family planning, two programs that have traditionally been quite separate. The benefit of integrating these services is to avoid the missed opportunities that have become increasingly apparent as more women and men of reproductive age become infected with HIV or are at risk of infection.

Key messages about unprotected sex and the communication and negotiation skills that people need to make responsible choices are at the core of successful efforts to reduce HIV transmission and avoid unintended pregnancy.

The shift may place a severe strain on programs that have been receiving financial and technical assistance focused on one health issue. Within a decentralized system, management and leadership skills are required at each level to support and coordinate the needed changes in policy and financing, and in institutional systems, processes, roles, and responsibilities.

Those who have worked under a mostly vertical system are likely to be loyal to it and resistant to changes in practices with which they have become comfortable. Managers of newly integrated programs must have the understanding and determination to help stakeholders (including staff) through the change process. Providers of integrated services will need solid training and ongoing supervision to master the new skills to search for, diagnose, and resolve complex problems covering a range of health components.

providing integrated services: approaches and tools

Guidelines, frameworks, and checklists for integrating HIV and family planning. A K4Health Toolkit includes links to guidelines, research, job aids, and other resources and tools for integrating family planning and HIV services.

A 2007 USAID document, *A Framework for Integrating Family Planning and Antiretroviral Therapy Services,* includes comprehensive charts of entry points and levels for integrated family planning and HIV information and services.

Many programs are a combination of vertical and integrated systems and services. The Electronic Resource Center section on Managing Integrated Services includes the Sample Integration Assessment Checklist, which you can use to analyze the extent to which your organization's or program's management systems are integrated.

This tool covers eight systems: planning/budgeting, internal organization, staff roles and responsibilities, training, supervision, logistics (including vehicles), management information systems/monitoring, and client services. It describes the characteristics of fully vertical, mixed, or fully integrated management for each of these systems and offers suggestions for improving the systems to make an integrated program more effective.

Integrating TB and HIV testing in Rwanda. Tuberculosis is the most common opportunistic disease and leading cause of death among people who are HIV-positive. Testing HIV-positive people for TB and TB patients for HIV enables them to be treated for and counseled on living with both diseases.

With funding from PEPFAR, Rwanda has developed national protocols for integrating TB and HIV testing. HIV-positive clients in all health centers are being tested for TB, and between 2005 and 2006, the percentage of TB patients tested for HIV rose from 40 percent to 75 percent. PEPFAR/Rwanda's success in rapidly integrating TB and HIV &AIDS interventions is credited to cooperation with the Government of Rwanda, the ability to do HIV testing in TB wards, and the widespread use of community-based education and case management.

Integrating family planning into HIV care and treatment in East Africa. In the mid-1990s, Pathfinder International recognized that many HIV-positive women in East Africa were not obtaining contraception at health facilities because providers felt that they should not be sexually active. To combat this discrimination, Pathfinder added a multi-country community home-based care (CHBC) program into its community-based family planning distribution.

Under the integrated program, volunteers in Ethiopia, Kenya, and Tanzania have been trained to provide HIV-positive clients, their households, and community members a full spectrum of HIV prevention and AIDS care and support services. The volunteer CHBC providers are especially suited to address the family planning needs of HIV-affected households because many of them are HIV-positive themselves. This integrated service is building synergies for safer sex education, promotion of dual protection, and reduced stigma.

Element 4: Scaling up

> *At times, good ideas spread of their own accord. They may be so groundbreaking, involve such pioneering technology and meet such pressing needs that they proliferate seamlessly. Most good ideas, however, do not spread with such ease. They require the backing and energies of committed individuals and organizations to design and carry out strategies for expansion that are carefully tailored to the realities of their settings. The question of sustainable scaling up is at issue.*
>
> Ruth Simmons, Peter Fajans, and Laura Ghiron
> *Scaling Up Health Service Delivery*

SCALING UP: THE CONTEXT

There are many definitions of scale-up. A WHO Technical Brief, "Scaling Up Health Services: Challenges and Choices," offers one of the clearest and most comprehensive: "the effort to magnify the impact of health service innovations successfully tested in pilot or experimental projects, so as to benefit more people and to foster policy and programme development on a lasting basis" (WHO 2008b).

This definition implies that equity and sustainability are essential elements of scale-up. The definition applies not only to innovative pilot programs; it is equally applicable to increasing coverage for well-recognized interventions such as immunization and birth spacing.

WHO delineates scale-up at four levels that mirror the results levels discussed in this handbook in the section of Chapter 9 titled "Frameworks for the Design and M&E of Health Services":

- **inputs/resources:** mobilizing more funds, more staff
- **outputs:** providing more services (access, range); performing better (quality, efficiency)
- **outcomes:** reaching more people (coverage), attracting more clients (utilization)
- **impact:** reducing morbidity or mortality

SCALING UP: KEY ISSUES

Choosing and adapting evidence-based practices. You will want to gather information on practices that have been successfully scaled up in comparable service delivery contexts. You are likely to find many appealing examples from a variety of settings. Your task is to select the most appropriate practices from those that you have considered—practices that you and your staff have the capability and resources to adapt for your organization's needs.

You may then need to make the case for your choices with decision-makers in and beyond your organization, persuasively communicating the results of your search and the justification for choosing to adopt new practices.

Finding freely available information about evidence-based practices on the Internet requires you to seek accurate, trustworthy sources and weed out those that might seem convincing but are actually biased, inaccurate, and misleading. Start with focused searches of reputable websites such as those listed in Box 5.

Here are some tips for getting the information you want from a website.

- Using the subject headings provided on websites, rather than searching for key words, will often unearth information faster.
- If you must use key words in your search, define your topic as precisely as possible. For example, a search for "children HIV AIDS Africa programs 2007 to 2010" will return more pertinent information on current interventions than simply "children HIV AIDS Africa."
- Search engines such as Google or bing! may point you to subscription-only journals, which limit the amount of information you can obtain at no cost. You can work around this challenge by using "information portals"—sites that consolidate different types of information from many sources. WHO's **Global Health Library** (www.globalhealthlibrary.net) and the US Government's **Partners in Information Access** (www.phpartners.org) are good examples, as are the **Cochrane Library** and **Knowledge for Health** websites described in Box 5.
- Not all journals are subscription-based. **The Directory of Open Access Journals** (www.doaj.org) links to numerous public health journals whose contents are peer-reviewed and made freely available around the world. Many of these journals are included in the information portals noted above.

Identifying and addressing constraints. If change in general is so prevalent in the health sector, why is scale-up so difficult and successful scale-up so rare? In general, failures are attributed to limited resources and formidable geographical, political, and sociocultural barriers. These general constraints are manifested in four areas:

- **disbursement of funds:** the lack of funds or, even when funds are available, the absence of an efficient system for disbursing them;
- **communication:** unshared technical and financial information, which otherwise would allow people in many places to adapt the intervention(s) to suit their own local values or circumstances;
- **demand:** the failure of demand for services to match the scaled-up supply;
- **the political and legal environment:** policies or laws that block progress.

BOX 5. Some Internet Sources of Information on Evidence-Based Practices

- **Cochrane Library** (http://www.thecochranelibrary.com/view/0/index.html) provides information on the effects of clinical practices and reviews interventions that are intended to help health workers make informed decisions.
- **Knowledge for Health** (https://www.k4health.org) offers information on practices for family planning/reproductive health and HIV & AIDS, with toolkits for training, policy, knowledge, and advocacy. The site houses five free online courses on specific diseases, policies, and practices. Within this site, you will find Family Planning: A Global Handbook for Providers, which contains up-to-date information and guidelines for all family planning methods.
- **The Lancet Series** (http://www.thelancet.com/series) is a collection of related articles that address clinically important topics and areas of health and medicine often overlooked by mainstream research programs and medical publications. For example, the Series theme in January 2010 was neglected tropical diseases.
- **MedLine Plus** (http://www.nlm.nih.gov/medlineplus/healthtopics.html) is jointly produced by the National Institutes of Health and the US National Library of Medicine. MedLine Plus provides basic information on numerous health topics; links to up-to-date research, including clinical trials; and dictionaries and glossaries.
- **MSH Health Manager's Toolkit** (http://erc.msh.org/toolkit) is a compendium of tools developed and tested by organizations throughout the world that are helping health professionals provide accessible, high-quality, sustainable health services.
- **The Joint United Nations Programme on HIV/AIDS (UNAIDS) Knowledge Center** (http://www.unaids.org/) provides many resources related to HIV and AIDS. The site provides a wealth of information about UNAIDS policies, each of its 10 targets and HIV/AIDS elimination commitments, regional and national data, publications, and other resources.
- **World Health Organization Health Topics** (http://www.who.int/topics/en/) contains general and technical information and recent publications about a wide range of health topics, as well as information about WHO programs that focus on particular health areas.

Underlying these constraints may be not only a lack of managerial or technical capacity on the part of potential adopters of an intervention but also the absence of a political commitment or local ownership.

The conference on Scaling up for Health organized by BRAC (an international NGO primarily focused on economic development), the Gates Foundation, and the Rockefeller Foundation (IDS 2008), defined key requirements for overcoming barriers to scale-up:

- Planning for scale-up at the outset of an intervention;
- Drawing on a set of skills different from those needed to develop the intervention. These include political analysis (to know who will win or lose from the proposed changes); institutional analysis (to assess the capacity of organizations to scale up and regulations to change, as needed); mobilization (to generate demand); communication (to craft messages that explain and encourage effective use); risk assessment (to allow for and manage unanticipated events);

- Acknowledging failure and learning from it. This requires the ability to solve problems as they arise and the flexibility to move in new directions when events do not work as planned;
- Conducting monitoring and evaluation during both the trial and scale-up, to distinguish between the effectiveness of the intervention itself and the effectiveness of the scale-up process, as well as to track costs in both phases.

The call for intersectoral collaboration. Recent sources of health funding—the Global Fund to Fight AIDS, Tuberculosis and Malaria; PEPFAR; the President's Malaria Initiative (PMI); the World Bank—reflect an understanding that no single sector can successfully address all constraints and bring about all needed changes.

Collaboration for scale-up usually involves both the public and private sectors, which make their unique contributions by reaching different population groups, working in different settings, providing different kinds of technical and management expertise, and developing innovations geared to different needs. Intersectoral collaboration for scale-up of health practices can also bring to bear the contributions of all the economic/social sectors—not only health care but also education, agriculture, and industry.

Scale-up and change. Scale-up at any level requires changes in clinical practices, health care providers' practices, management practices, and management systems. Resources must be reallocated and roles adapted, possibly resulting in loss of status for some people. Larger scale-up may involve changes in organizational strategies and structures. Over the years, health and development professionals have learned that successful change takes time and strong leadership.

All who are working to improve health—from international donors to clinic nurses to village leaders—are involved in encouraging, leading, or implementing change. According to Everett Rogers, pioneer of the diffusion of innovations theory about how new ideas, products, or behaviors spread, there are five kinds of adopters (2003). The characterizations that follow apply to both individuals and organizations.

- **Innovators.** Innovators are relatively rare; they are the first to embrace a new idea, technology, or approach, even if it involves risk.
- **Early adopters** are not far behind, and they adopt new ideas as soon as benefits are apparent. They are quick to see how a new practice can help them reach their goals and are also willing to take on risk.
- **Early majority** and **late majority.** Together, these groups include more than half the population. The early majority wants proof of benefits, ease of adoption, and reasonable cost. The late majority dislikes risk, is uncomfortable with new ideas, and is even slower and more reluctant to adopt innovation.
- **Slow changers**. These laggards are usually a small percentage of any group. They might resist the change until they can no longer discount improved results or are required to adopt the new practice if they are to keep their jobs.

You are likely to find that people react to change in a variety of ways. Key roles in the diffusion of innovations follow.

- **Opinion leaders.** Opinion leaders can spread ideas through their social networks, and their ideas and behaviors are important to others. The support of an opinion leader will help you implement change.
- **Change agent.** If you are convinced that a practice or set of practices that has worked in one setting can be scaled up to improve services in other settings, you can act as a change agent, transmitting your commitment and enthusiasm and gaining the buy-in of those staff members who will do the hard, day-to-day work of implementing the change.
- **Change team.** The task will be much easier if you work with a change team that shares your view of the importance of the new practices. The majority of staff need to become aware of how the changes will help meet an organizational challenge and improve the care of clients.

No matter which category they fit into, potential implementers must be convinced that the new practice:

- addresses identified challenges and offers clear benefits to them and to the people they serve;
- can be tested without a huge investment or risk;
- is consistent with organizational values;
- can be carried out without seriously disrupting current services.

SCALING UP: APPROACHES AND TOOLS

A conceptual framework and steps for a scaling-up strategy. The publication *Practical Guidance for Scaling Up Health Service Innovations* provides a framework that offers a context and process for scale-up efforts (WHO 2009). This conceptual framework encompasses five essential elements of successful scale-up:

1. The **innovation** (a health intervention or package of interventions);
2. The **user organization** (the organization that is expected to adopt the innovation);
3. The **external environment** (conditions and institutions that affect the prospects for scaling up);
4. The **resource team** (individuals and organizations that will promote wider use of the innovation);
5. The **strategic choice areas** (plans, actions, and strategic choices for establishing the innovation in policies, programs, and services).

These elements translate into the steps needed for successful scale-up. The framework is grounded in the principles of "respect for, fulfillment of and promotion of human rights. This means integrating human rights norms into scaling-up initiatives, including human dignity, attention to the needs and rights of vulnerable groups and an emphasis on ensuring that quality health services are accessible to all" (WHO 2009).

Building on Experience, Data, and Enthusiasm to Scale Up—Country Examples from Senegal and Egypt

Scaling up postabortion care (PAC) in Senegal. In the late 1990s, the Ministry of Health of Senegal initiated a pilot study of a postabortion care model based on community and service provider partnerships; counseling; treatment; contraceptive, family planning, and reproductive health services; and other health care services. The pilot study showed that the PAC model could work well in secondary and tertiary settings. Later studies conducted by IntraHealth and EngenderHealth in a few rural districts showed that the model could also succeed at primary and community facilities.

On the basis of these studies, MSH collaborated with the Ministry of Health to implement the model in 23 rural health districts that covered more than half the population of Senegal. The scale-up had four phases. It began with an assessment of availability and quality of postabortion treatment in rural areas. It then provided training geared to the capabilities and needs of providers and supervisors, nearly 90 percent of whom were midwives, nurses, and counselors at health posts and health centers. Data were collected through a PAC register at all intervention facilities.

Finally, the scale-up effort incorporated supportive supervision that engaged providers, district health care management teams, and well-educated community members in planning and implementing PAC improvements. This carefully phased scale-up more than doubled the number of women seeking and receiving PAC services at health posts and clinics and quadrupled the number leaving the facility with a modern family planning method.

Scaling up good leadership and management in Egypt. When the Aswan Governorate in Egypt completed MSH's leadership development program in 2003, the 10 participating teams—doctors, nurses, and outreach workers from hospitals and clinics throughout the region—were so enthusiastic about the results they had achieved that they continued the program with their own resources.

By applying leadership and management practices to health care service challenges, they had significantly improved service delivery indicators and the operations of primary health units.

They saw striking changes in the way staff worked with their coworkers and the way clients were being cared for.

One and one-half years later, the program had spread to cover 78 rural health units in five districts of Aswan, and the ground was laid to scale up the program nationally. Participants in the second year of the LDP increased the volume of prenatal and child care visits, created a new medical information system, and increased the use of contraceptives. Program materials were standardized, new LDP facilitators were recruited and trained, and management systems were strengthened to provide continued support for the effort in other governorates across Egypt.

In 2005, 15 doctors from Afghanistan visited the Aswan program, saw the similarities in the concerns and cultures of Afghanistan and Egypt, and returned to initiate a highly successful leadership development program in their own country.

The improvement collaborative approach. As described under Element 1: Establishing and Maintaining High-Quality Services, this approach engages teams at different sites in a joint effort to meet common objectives. In addition to the focus on quality, improvement collaboratives are designed to scale up improvements by rapidly disseminating successful practices to the organization(s) participating in the collaborative and eventually to other organizations as well.

The change process. To scale up relatively small changes, health managers and providers can implement the change process in phases that reflect the management and leadership practices:

- **Phase 1:** Recognize a challenge—the gap between desired achievement and actual achievement. (**Scan**)
- **Phase 2:** Identify promising practices for improving services. (**Focus**)
- **Phase 3:** Adapt and test one promising practice or set of practices to make sure it fits the context and to work out any difficulties in a limited setting. (**Organize**)
- **Phase 4:** Implement the new practice(s), building a support base that will make it possible to move from adaptation to actual application. (**Organize, align/mobilize, implement**)
- **Phase 5:** Scale up the successful new practice(s) and the systems that underpin it. (**All managing and leading practices**)

Element 5: Providing community-based primary health care

> *The gathering of health ministers from around the world at Alma-Ata, Kazakhstan, in 1978 was arguably the most influential meeting of its kind in the history of public health. The Declaration of Alma-Ata remains one of the most influential yet debated documents in the field of health, with its call for meaningful involvement of communities in the design and control of affordable health services. Can it work for the billions of poor today?…Surely yes!*
>
> Jon Rohde and John Wyon
> *Community-Based Health Care: Lessons from Bangladesh to Boston*

COMMUNITY-BASED HEALTH CARE: THE CONTEXT

What are the characteristics of successful, lasting community-based health services?

A task force of the International Health Section of the American Public Health Association recently completed a study of the effectiveness of community-based primary health care (CBPHC) in improving the health of children in high-mortality, resource-poor settings. The reviewers studied CBPHC programs that had been in effect for 10 years or more and had succeeded in improving the health of children. In all instances they found:

- a broad array of primary health care services, including family planning and reproductive health;
- referral for care at higher levels;
- use of CHWs and support for them through strong training and supervision;

- routine, systematic home visits;
- a strong partnership between the community and the government health program;
- a high level of community trust in the health program;
- treatment of clients with a high level of respect.

The challenge for managers and providers is to bring these characteristics to life in the communities they serve.

COMMUNITY-BASED HEALTH CARE: KEY ISSUES

Building community participation. Communities that engage actively in promoting, delivering, and supporting their health services have a greater understanding of and commitment to healthy choices. Engaged communities establish an environment that encourages more residents to use health services.

Their involvement makes it more likely that they will contribute financially and in-kind and will help identify supplementary funding sources outside the community, enabling health programs to reach new segments of the population. Community participation also brings local solutions to service delivery problems, responding directly to the concerns and needs of clients and potential clients.

To reap these benefits, the participation must be real and meaningful. National policy must actively promote community involvement and give civil society organizations, community advisory committees, formal and informal community leaders, local government, and community-based providers a substantive role in decisions about their health services. To play their roles effectively, these groups and individuals need to build skills in planning, training, supervision, and monitoring of activities and funds.

Community-based delivery of health services. The delivery of health services within the community depends on community health workers (CHWs): community members who are motivated, thoroughly trained, and well supervised, and who have the medicines and supplies they need to provide health education and basic care to their neighbors.

CHWs can perform a wide range of services. They can promote healthy lifestyle choices, provide preventive care, monitor the community's health, identify patients at particular risk, diagnose and treat common conditions, provide basic curative services, and distribute condoms and resupply oral contraceptives and injectables. They can make referrals to health facilities and act as the critical liaison between the community and the facilities, interpreting the social climate to facility-based providers and acting as a first alert for emerging public health issues.

The range of services CHWs are permitted to provide is largely determined by government policy. In many countries, a lack of effective leadership and vision at the national and provincial levels has prohibited CHWs from providing care that could have a real impact. One example is the reluctance of governments to allow CHWs to treat children with pneumonia with antibiotics—despite a joint statement in which WHO and UNICEF endorsed this practice (WHO/UNICEF 2004).

Another example is the refusal of some authorities to allow CHWs to administer contraceptive injections or resupply oral contraceptives.

When doctors or nurses are unavailable and health facilities are inaccessible, these restrictions mean that clients are left without any effective services to meet common health needs.

Community links with health facilities. Health facilities are critical for the performance of several functions that support community-based care: the training and supervision of CHWs, referrals and counter-referrals, lab tests, and, in some settings, the provision of pharmaceuticals and medical supplies.

The quality of CHWs' work depends largely on the quality of training and supervision provided by facility-based staff. Trainers and supervisors need to be secure in their knowledge of all the areas for which the CHWs are responsible. They need specific skills to provide hands-on adult learning experiences geared to the educational levels, culture, and values of CHWs.

Trainers and supervisors also need to be able to provide supportive supervision that features two-way communication as well as performance planning and monitoring. And they need a reliable source of medicines, contraceptives, and other supplies; a safe place to store them; and systems for procuring and distributing them, as detailed in Chapter 8 of this handbook.

The health facility also functions as the repository for the referral of patients for more complex services: long-term contraceptives, treatment of severe illnesses, or response to danger signs. *Community Case Management Essentials: Treating Common Childhood Illnesses in the Community* (CoreGroup, Save the Children, USAID 2009) points out that the most efficient referral systems have proven to be those in which the CHW:

- provides initial treatment prior to referral;
- promotes compliance by counseling families about why referral is necessary and making a formal written referral;
- monitors the referral process by:
  - recording referrals in a register
  - receiving a "counter-referral" from the facility health worker—a note to the CHW stating the outcome and explaining desired follow-up;
  - tracking the referral and counter-referral in a health information system and discussing the process in supervisory visits or monthly meetings;
- addresses geographic and financial barriers to referral by doing one of the following:
  - inquiring about barriers and working with the family to address them;
  - identifying a source of funds or emergency transport at the community level;
  - accompanying the family to the health facility to ensure that they receive immediate care.

COMMUNITY-BASED HEALTH CARE: APPROACHES AND TOOLS

Community case management (CCM). Community Case Management (CCM) is a strategy to deliver lifesaving curative interventions for common childhood illnesses where access to facility-based services is low. The publication cited above, *Community Case Management Essentials: Treating Common Childhood Illnesses in the Community*, is a "how-to" guide for program managers to use in starting a new CCM program, improving an existing one, or expanding CCM to new geographic areas. It provides operational guidance to design, plan, implement, monitor, and/or advocate for CCM that responds to local needs (CoreGroup, Save the Children, USAID 2009).

Community Case Management Essentials was developed by a network of NGO partners that generates collaborative action and learning to improve and expand community-focused public health practices for women of reproductive age and children under five. This guide draws on the experiences of 18 CORE Group member organizations that have worked with Ministries of Health, USAID, and community-based partners to implement long-lasting CCM programs in more than 27 countries.

Community COPE. This approach is an adaptation of the COPE (client-oriented, provider-efficient services) process discussed under Element 1: Establishing and Maintaining High-Quality Services. Community COPE encourages the community to take ownership of quality improvement at facility and community levels. It helps supervisors and staff at service delivery sites gather information from the community about the strengths and weaknesses of the facility's services, and it engages community members in helping remedy the weaknesses. Community COPE involves a participatory process with tools for each phase:

- meeting with local leaders
- identifying community groups to work with
- conducting participatory activities
- developing, prioritizing, and implementing an action plan
- ensuring ongoing quality improvement (EngenderHealth 2002)

Community mapping in Bangladesh. In the late 1980s, Technical Assistance Incorporated (TAI) and MSH worked with field-workers and community volunteers in Bangladesh to develop a type of community mapping known as ELCO maps, showing where ELigible COuples (married couples of reproductive age) lived and what method of contraception they used.

More than 33,000 volunteers, most of whom could not read or write, were trained to talk to their neighbors about family planning and to distribute contraceptives. To track their efforts, they drew simple maps that provided a quick, accurate picture of a community and its family planning needs. ELCO maps proved useful on every level—from the community volunteers and their supervisors to regional health professionals and government officials.

The technique was later adapted in India to enable community health volunteers to track prenatal and postnatal care, immunizations, and child health services as well as family planning. They used ELCO maps to plot the best routes for home visits; track clients' health status; motivate clients to adopt healthy behaviors and use health services; and provide follow-up.

The community mirror in Guinea. In USAID's PRISM Project in Guinea, MSH introduced the community mirror or *miroir de santé communautaire*—a tool that helps communities monitor their health needs so that they can advocate for services to meet those needs.

The "mirror" is a chart that uses pictures to depict health areas that community members feel are most critical. For each area, activities are counted each month and written in columns. For example, in the area of child health, one community mirror provided columns to track the children who came to the CHW with diarrhea and how many of them received oral dehydration salts.

Each month, representatives from several villages come together to compile and compare the information in their community mirrors and provide the results to the regional health center. The community mirror is displayed publicly in the village so that all villagers can see and learn about the status of their village's health. They can then use that information to advocate with their CHWs and health facilities for improvements in services.

Element 6: Working with the private for-profit sector

> *The objective is to use the private sector more effectively to meet public health goals by identifying policies that can improve the quality, distribution, and cost-effectiveness of the private production of health services.… In the simplest terms, the desired public-private mix is often assessed as a matter of balancing efficiency and equity considerations. From this perspective, the private sector is typically seen as being more efficient and the public sector as more equitable.*
>
> Carlos J. Cuéllar, William Newbrander, and Gail Price
> *Extending Access to Health Care through Public-Private Partnerships: The ProSalud Experience*

WORKING WITH THE PRIVATE SECTOR: THE CONTEXT

The private sector covers a broad array of entities, including civil society organizations, nongovernmental organizations, and faith-based organizations with which resource-limited governments often contract to provide services. In this section, however, we are focusing on the for-profit sector, which presents a particular set of opportunities and challenges. This sector comprises:

- commercial suppliers, distributors, wholesalers, and retailers who market and distribute health products or health-related products (soap, fortified foods);
- banks, phone companies, and other large commercial institutions that support health services or their employees, their families, and other population groups;
- private health providers who diagnose and treat a variety of health conditions among rural and poor populations; this includes participants in the informal health sector: traditional healers, midwives, and individual medicine sellers.

Among the poorest populations in the world, a significant and growing proportion of health care is provided through the private for-profit sector. The Global Health Council

reports that in sub-Saharan Africa, more than 40 percent of the people obtain their health care from this sector; the figure rises to more than 50 percent of rural populations in Uganda and Nigeria (Global Health Council 2008).

Private providers are sometimes the only source of health care for the poor. They are often closer than government facilities and may be less expensive once lost working time, travel, and unofficial user fees are taken into account. However, the quality of care is inconsistent, and poor clients may get inadequate services for their money.

WORKING WITH THE PRIVATE SECTOR: KEY ISSUES

Benefits of partnering with the private for-profit sector. Given the prevalence of private-sector care and the limited resources available in the public sector, many governments acknowledge that public health requires actions by both public and private providers through public-private partnerships (PPPs). There is general agreement that the public sector must focus on providing critical health care to the poorest while creating an environment in which the private sector can help the state achieve its public health goals (International Finance Corporation 2007).

Collaboration with the private sector extends the reach of the public sector in the face of severe budgetary constraints. Private-sector services are self-sustaining; they do not require support from donors or governments. Public-private collaboration allows the public sector to devote its resources to those most in need, encouraging those who can pay to use the private sector. In this model, the government acts as a steward, providing guidance to private providers and users of private services.

Barriers to PPP. Despite the general acknowledgment of the important contribution the private sector can make to public health, there are major barriers that make it hard for the public sector to ascertain and maintain the quality of private-sector services.

- Ministries of health often lack information on the reach and capacity of the private sector.
- The private health sector tends to be fragmented and disorganized, with weak professional associations and few networks representing private-sector perspective and interests.
- Private-sector providers often lack information on public-sector health priorities and standards of care; they have little access to training opportunities.
- It is difficult to make the profit motive compatible with the public health mission and goals.
- There is a long history of mistrust and poor communication between the public and private sectors.

Although the private for-profit health sector seeks to make a profit, this can be compatible with a concern to deliver quality services and an interest in the clients' well-being. This compatibility with public health goals is not always understood.

Public-Private Collaborations in Action for Better Health—Country Examples from Tanzania and India

Working with private drug shops in Tanzania. For many years the Tanzania Food and Drugs Authority authorized *Duka la dawa baridi* (DLDB), or private drug shops, to provide nonprescription medicines in the private sector. With an estimated 6,000+ stores, DLDB constituted the largest licensed retail outlets for purchasing medicines in Tanzania.

MSH's USAID-supported Accredited Drug Dispensing Outlets (ADDO) program was designed to improve key aspects of the DLDB enterprises: the physical premises, stock maintained by the owner, consumer choices, interactions with dispensers, and recommended treatments. In addition, the government systems in which DLDBs are embedded—licensing, supply, training, and inspection—had to be strengthened.

After gaining support from key stakeholders, the Food and Drugs Authority and regional government collaborated with MSH to implement the ADDO initiative, combining commercial incentives with decentralized regulatory oversight. ADDO provided education, training, and supervision for independent shop owners and dispensing staff. The quality of products and services was assured through accreditation based on the achievement of pre-established standards. Routine monitoring by district and local government and community structures reinforced and helped maintain those standards.

Marketing condoms in India. Through USAID's PSP-One India project, Abt Associates and its media partner, LOWE India, developed a prize-winning campaign to "normalize" the condom, positioning it as a product like any other. The *Condom Bindaas Bol!* (Condoms—Just Say It!) campaign aimed to increase the use of condoms and expand the condom market. The campaign included humorous television commercials, newspaper and cinema advertisements, and community contests built around the TV advertisements.

To supplement the mass media activities, *Bindaas Bol* reached out to more than 40,000 chemists, retailers stocking condoms, and indigenous medical practitioners and asked them to be agents of behavioral change by selling condoms openly and without embarrassment and by encouraging their customers to ask for condoms without hesitation. The project partnered with these condom marketers to enhance retail visibility and access, and to stress the importance of correct and consistent use of condoms. A well-publicized contest rewarded the retailers who had the best display of condoms and openly discussed condoms with their customers.

WORKING WITH THE PRIVATE SECTOR: APPROACHES AND TOOLS

Division of labor between the government and private sector. To determine the best mix of public and private health care provision and financing, it is necessary to define which sets of services each sector can handle most effectively, make certain that complementary work is done in both sectors, and find a public-private mix that reduces differences in health care that are unnecessary, avoidable, and unjust.

The appropriate mix will vary from place to place, depending on the demand for services and the ability and willingness of consumers to pay for care. This division of labor depends on common objectives and complementary resources. Public-sector policymakers must join with professional associations and networks to agree on health goals, standards of care, and indicators of success.

Harnessing the power of the government. To succeed with limited resources, the public sector must devote some of its resources to making the private sector as effective as possible in meeting public health goals. Governments can be effective stewards of the private sector's contributions by applying systems, standards, and protocols to ensure the quality of private-sector services.

Information dissemination and training can improve the case management practices of private practitioners and commercial distributors. Government mandates and regulations pertaining to periodic renewal of licenses and accreditation of practitioners and facilities can be used to guarantee the quality of health services.

Motivating providers. The right incentives can motivate private-sector providers to emphasize essential care over nonessential care, and preventive services over curative services. Public financing can provide powerful incentives for private providers and distributors to conform to treatment standards. In child health services, for example, the government might extend insurance to cover immunization services offered by private providers and make free vaccines available to private-sector providers who deliver immunization services.

A very important nonfinancial motivator is the inclusion of private-sector providers and distributors in appropriate government training programs. All these measures would require mechanisms to monitor progress against shared public health indicators.

In summary

The health service delivery system is the focal point for all the other people-centered management systems discussed in this handbook. The cross-cutting elements described in this chapter are the core ingredients of an effective health service delivery system in which:

- high-quality, integrated health services are available to all, especially those poor and marginalized people who do not now have access;
- successful initiatives are widely known and adopted by decision-makers in new settings;
- skilled community health workers provide an array of services with the support of local health facilities;
- the private for-profit sector provides services that adhere to government standards.

The opportunity and responsibility for bringing about these ideal conditions rests on the shoulders of our intended readers. You are the health managers and providers whose workplaces are physically close to the communities you serve, who are attuned to the health needs and cultural preferences of community members, and who have the commitment and skills to bring about change.

Proven practices

- As a health manager or provider at the provincial or district level of government, within an NGO, or in a public- or private-sector facility, you can join with your colleagues to strengthen the key management systems that contribute to desired health outcomes.

- Scan available information about current best practices through interviews, observation, and reading to increase your understanding of health management systems and guide you in your systems-strengthening efforts. Good leadership and management practices will help you tailor services to manage the six critical elements of health services: high quality, equitable access, integrated services, scale-up, community-based primary health care, and work with the private for-profit sector.

- If you explore the evidence-based approaches and tools and references in this chapter and the earlier chapters of this handbook, you are likely to find several that you and your colleagues can apply or adapt to meet the needs of your clients.

Glossary of service delivery terms

Accredited Drug Dispensing Outlets (ADDO): An initiative to provide nonprescription medicines in the private sector in Tanzania.

Autodiagnóstico: A self-assessment process that groups can use to identify and assess concerns or problems and plan howto address them.

community case management (CCM): A strategy to deliver lifesaving curative interventions for common childhood illnesses where access to facility-based services is low.

Community COPE: An adaptation of the COPE process that encourages the community to take ownership of quality improvement at facility and community levels.

community mirror *(miroir de santé communautaire):* A tool that helps communities to monitor their health needs so that they can advocate for services to meet those needs.

COPE (client-oriented, provider-efficient services): A quality-improvement process that enables service providers and other staff at a health facility to work with their supervisors to assess their services by using self-assessment guides based on international standards and known best practices.

ELCO (ELigible COuples) map: A type of community mapping that shows where married couples of reproductive age live and what method of contraception they use.

gender: The characteristics, roles, and responsibilities that society expects of women and men, girls and boys, based on social attitudes rather than biological differences.

gender analysis: A systematic approach used to examine factors related to gender in the use of services, or to design, implement, and evaluate projects.

improvement collaborative approach: An approach that engages teams at different sites in a joint effort to meet common objectives and scale up improvements by rapidly disseminating successful practices.

integrated health services: Provision of two or more services at the same time and place. Can range from the combination of two formerly separate services into a single, coordinated service to a full package of preventive and curative health services available at a multipurpose service delivery point under one manager.

integrated management of childhood and neonatal illness (IMCNI): IMCI with neonatal health added.

integrated management of childhood illness (IMCI): A strategy to address the five major causes of under-five death in the developing world by training health workers to assess, classify, and treat the whole child, rather than dealing with only one specific health problem.

Leadership Development Program (LDP): A Management Sciences for Health program that strengthens the capacity of health teams to identify and address health challenges using leadership and management practices.

outcome indicators: Measures of change in a beneficiary population as a result of a set of activities.

Partnership Defined Quality (PDQ): A tool that enables community members and providers to develop a shared vision of quality improvement that involves agreement on standards of performance and empowers them to work together to achieve their vision.

performance-based financing (PBF): A mechanism for improving the quality and increasing the use of health services by setting performance goals based on agreed-upon standards and indicators. It requires the organization to complete a set of actions or achieve a measurable performance goal before receiving a transfer of money or goods.

process indicators: Measures of the completion of activities.

quality assurance: A planned, systematic approach with standards, protocols, and procedures that enable health managers and providers to continuously bring high-quality health services to their clients, using available resources that are available to them.

scale-up: "The effort to magnify the impact of health service innovations successfully tested in pilot or experimental projects, so as to benefit more people and to foster policy and programme development on a lasting basis" (WHO definition).

standards-based management and recognition (SBM-R): A management approach for improving the performance and quality of health services by focusing on the standardized level of performance and quality to be attained.

structural indicators: Measures of material characteristics (physical infrastructure; medicines and health products; number of assigned personnel, tools, technology); organizational resources; and financing of care (levels of funding, payment schemes, and incentives).

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APPENDIX A. Framework for Gender Analysis

Gender Differences in Health	Women	Men	Girls	Boys
How does the ENVIRONMENT influence who becomes ill and how they respond to their illness?				
Living conditions: Clean water, sanitation, ventilation, hygiene				
Working conditions: Use of equipment, ventilation, exposure to noise, hygiene arrangements, working hours, exposure to risk				
Geographic location and climate				
Food and nutrition				
General social and economic conditions				
How do the ACTIVITIES of men and women influence their health and use of available health services?				
What males and females do daily				
Health risks associated with particular activities				
Health risks associated with excessive burdens of work				
Health risks associated with lack of work				
How does the DECISION-MAKING POWER of males and females influence their health?				
The extent to which males and females can make independent decisions regarding their health and its protection				
Gender differences in the ability to negotiate with others about their health protection				
How does access to and control over RESOURCES influence the health of males and females?				
Differences in male's and female's access to or control over financial and other resources that affect their health or their ability to protect their health				
How do GENDER NORMS influence health?				
Attitudes toward sexual violence				
Educational disparities				
Cultural norms and practices				

Adapted from: "Guidelines for the Analysis of Gender and Health" The Gender and Health Group at the Liverpool School of Tropical Medicine.