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STANDARDS-BASED MANAGEMENT AND RECOGNITION

A FIELD GUIDE

A Practical Approach for Improving the Performance and Quality of Health Services

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JHPIEGO, an affiliate of The Johns Hopkins University, builds global and local partnerships to enhance the quality of health care services for women and families around the world. JHPIEGO is a global leader in the creation of innovative and effective approaches to developing human resources for health.
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INTRODUCTION

Some time ago, the authors of this field guide met with the recently appointed Minister of Health of a developing country. During the conversation, the Minister described one of his first experiences in his new position—a visit to several provincial hospitals. The managers and staff of the hospitals had been notified of the Minister's visit in advance and made every effort to make their hospitals shine for him. The Minister, an experienced medical doctor, expressed with concern that in spite of all this preparation, he was quickly able to see several aspects of care that were not functioning appropriately. The managers and providers, however, did not seem aware of them. They seemed to accept as normal the visible shortcomings in hospital cleanliness, traffic flow and client-provider interaction, among others. The Minister mentioned that he could see the disappointment and sadness in the faces of the hospital staff when he pointed out some of these shortcomings. Reflecting on his experience, the Minister said, "How can they perceive these issues if they do not have a pattern of reference? They have gotten used to their routine; they do not have updated and practical standards of care that could guide them in their daily work." He decided that as one of his first tasks as Minister he was going to make sure that the country's health facilities had such standards. He considered this task as important as the provision of other types of support such as resources or training.

This field guide is intended to provide some help with the task of improving the delivery of health services using standards of care as the basis for improvement. This guide is designed to answer questions such as: What types of standards are really useful to local providers and managers? How can they be implemented in a practical way? How can the improvement process be supported?

Like the Minister in the case above, most health managers are continually trying to improve the performance and quality of health services to better achieve health goals. The results of quality improvement initiatives in health, however, have often been limited, or even disappointing. These efforts are often seen, by already overstretched health workers, as complicated tasks and an additional burden on their shoulders. To the usual concerns related to the complex nature of health care and financial and managerial bottlenecks, new challenges such as health reform, achievement of global health goals, new technologies and increasing client expectations about quality of care are now added. In addition, in many countries the HIV/AIDS epidemic is not only creating an additional burden on health services but also decimating and demoralizing the health workforce.

Efforts to strengthen and improve health care under these circumstances can be very difficult. Nevertheless, we believe that it is not always necessary to resort to sophisticated solutions in order to achieve meaningful improvements in health service performance and quality.

PURPOSE

Over the last several years, JHPIEGO has been working in the field to develop a practical approach for performance and quality improvement, here called Standards-Based Management and Recognition (SBM-R). Often working with partner organizations, we have obtained very encouraging results in the achievement of standardized, high-quality health care through the use of a streamlined, step-by-step methodology, the creative management of the process of change, and the joint and active involvement of providers, clients and communities in the improvement process. The promising success and inspiring power of experiences such as PROQUALI in Brazil, the Infection Prevention Ukhondo Ndi Moyo initiative in Malawi, CaliRed in Guatemala and other programs have

resulted in requests by health managers and providers for a practical guide for implementing or scaling up this approach. This field guide provides a framework and methodology to guide program managers and health facility staff in adapting and implementing similar programs tailored to their own settings. The aim of this field guide is to present a step-by-step process, practical tools and other resources for improving the performance and quality of health services using the **standards-based management and recognition** approach.

This field guide is designed for managers and frontline providers of service delivery organizations in both the public and private sectors. The guide has also been developed for use by central, provincial/regional or district health managers who want to improve the services for which they are directly responsible. Other potential users of this material include advocacy groups that represent the health interests of clients and communities, and organizations that provide technical assistance for performance and quality improvement.

HOW TO USE THIS FIELD GUIDE

This field guide is organized as follows:

- **Standards-Based Management and Recognition: What Is It and How Is It Unique?** defines SBM-R and describes its added value for program managers and providers.
- **Step One: Setting Standards of Performance** describes how to develop operational performance standards for the services that need to be improved.
- **Step Two: Implementing the Standards** describes how to determine what the performance gaps are and how to identify and implement the interventions to close them.
- **Step Three: Measuring Progress** gives examples of different types of assessments that can be used to measure progress and support the implementation process.
- **Step Four: Recognizing Achievements** explains the conditions that enhance motivation and the types of incentives that help facilities meet their performance goals.
- **Defining the SBM-R Initiative** shows how to ensure that the characteristics of the SBM-R initiative respond to the needs of institutions and programs.
- **Facilitating SBM-R** explains who facilitates and supports the process and how these resources should be developed.
- **Managing the Change Process** presents the activities needed to prepare, strengthen and reinforce the implementation of the SBM-R initiative.
- **Strengthening Demand and Participation** explains the critical role of clients and communities in the success and sustainability of SBM-R.
- **The Role of Communication** outlines some key strategies and methods to raise awareness about the SBM-R process and effectively engage participation of the general public, providers and program managers.
- **Evaluating an SBM-R Initiative** describes how to evaluate an SMB-R program, focusing on volume, quality and efficiency of services.
- **Scaling-Up and Sustaining SBM-R** presents lessons learned about the challenges and opportunities for assuring sustainability of large-scale SBM-R efforts.
- The matrix in the **Appendix** gives descriptions of SBM-R programs implemented in seven countries. Sample assessment tools and training materials used in these programs are included in an accompanying CD-ROM.

STANDARDS-BASED MANAGEMENT AND RECOGNITION: WHAT IS IT AND HOW IS IT UNIQUE?

THE FOUR STEPS OF SBM-R

Standards-Based Management and Recognition (SBM-R) is a practical management approach for improving the performance and quality of health services. It consists of the systematic, consistent and effective utilization of operational performance standards as the basis for the organization and functioning of these services, and the rewarding of compliance with standards through recognition mechanisms. SBM-R follows four basic steps (See **Figure 1**):

1. Setting standards of performance in an operational way
2. Implementing the standards through a streamlined and systematic methodology
3. Measuring progress to guide the improvement process toward these standards
4. Recognizing the achievement of the standards

Figure 1. Steps of the SBM-R Process

The fours steps of SBM-R are an adaptation of the widely know Deming's cycle for quality improvement: **1) plan**; **2) do** (implement); **3) study** (check or measure); **4) act**. In SBM-R, these steps have been modified to the cycle: **standardize-do-study-reward**. The purpose of the modification of Step 1 is to provide workers with encompassing and detailed standards that need only to be implemented, reducing the need for case-by-case problem analysis and plans design and thus simplifying the improvement process. The modification of Step 4 (reward), seeks to go beyond the introduction of adjustments to the improvement process after measurement, to the creation of consequences of performance for workers, which is essential to initiate and manage the changes required.

HOW SBM-R IS UNIQUE

There are three basic types of quality improvement methodologies: standardization, continuous or incremental quality improvement, and breakthrough quality improvement (see **Table 1**). Each

methodology requires the involvement of different types of organizational elements and has characteristic rationales, processes and tools. SBM-R falls into the category of standardization methodologies, and it is not exclusive of the other two types of approaches because each one of them may be most useful depending on the circumstances of the organization or processes to be improved. Problem-based, incremental quality improvement may be more appropriate in situations in which there is reasonable standardization of processes and availability of required data, and specific, high impact improvements are sought. Breakthrough quality improvement can be the best choice when innovation is required. In most developing countries, however, health services lack basic standardization and that is why approaches such as SBM-R can be comparatively more useful and easier to implement.

Table 1. Approaches to Quality Improvement

	STANDARDIZATION	CONTINUOUS IMPROVEMENT	BREAKTHROUGH IMPROVEMENT
Organization	Individuals	Improvement teams	Breakthrough teams
Mental model	Regularity	Problem solving	Creation
Process	SDSA	PDSA	"What if"
Tools	Process mapping	Continuous process improvement, benchmarking	Out of industry benchmarking
Progress review	Biannually	Monthly	Monthly
Examples	SBM-R, FFSDP, accreditation, certification	TQM, CQI, Six Sigma	IHI "Breakthrough series"

Adapted from: Hacker, Jouslin de Noray, and Johnston 2001.

Key: CQI: Continuous Quality Improvement; FFSDP: Fully functional service delivery points; IHI: Institute for Healthcare Improvement; PDSA: The Plan-Do-Study-Act Cycle; SDSA: The Standardize-Do-Study-Act-Cycle; TQM: Total Quality Management.

Standardization methodologies can be used for quality assurance or quality improvement purposes, depending on the emphasis placed on external verification of compliance with standards. Quality assurance methodologies such as accreditation or certification require external verification as an essential element, and this may require the creation of a complex and expensive infrastructure, which many countries cannot afford. SBM-R, on the other hand, puts more emphasis on internal assessment of compliance. In SBM-R, most important is the internal process of change and thus it requires less external operational infrastructure.

SBM-R has the following distinguishing characteristics:

- SBM-R is a very focused approach that does not begin with the discussion of performance or quality methodologies in general. Rather, the **improvement process is built around a specific content area**, making the process more concrete and meaningful for frontline health workers. Typically, knowledge updates, skills standardization and development of operational performance standards on a specific aspect of health service delivery are the starting point of the process.

- SBM-R uses a **proactive approach**, focusing not on problems but on the desired level of performance and quality to be attained. This desired level of performance is stated in objective terms as performance standards that are presented in practical assessment tools.

- In SBM-R, substantial work is invested during the initial development of the operational performance standards, which show providers and managers, in detail, not only **what to do but also how to do it**. This "cookbook" approach diminishes the need for analyzing and redesigning processes during the implementation phase. The resulting reduced burden on service providers and managers makes the process more easily accepted and sustainable.

- The **motivational element** is considered essential for the success of the SBM-R process. The recognition of achievements in improving service delivery is a key element of the approach. SBM-R assumes that managers, providers and other stakeholders do not adopt improvement initiatives just because they make rational sense, but because they see that they have something to gain from the experience.

- **Continual measurement** is used as a mechanism to guide the process, inform managerial decisions and reinforce the momentum for change. Assessment and measurement are undertaken at the individual and facility levels, creating a system of multiple checks for the process. This characteristic is particularly relevant for settings in which external supervision is weak or non-existent.

- The **power of the clients and communities** is an important element of SBM-R. Through the establishment and dissemination of clear and objective standards of care, SBM-R facilitates the empowerment of clients to act as informed consumers and enables partnerships among service delivery personnel and clients and communities.

- In SBM-R, those involved in the process develop **change management skills** gradually. The implementation methodology has built-in challenges of different levels of complexity, and implementers are encouraged to put **emphasis on action and achievement of early results** (reaching the "low-hanging fruit" first) to create momentum for further change.

- SBM-R triggers and reinforces a process of **continual individual and organizational learning**, in which providers are encouraged to adopt a variety of dynamic roles during the implementation process, assessing their own work and performance as well as the performance of peers and organizational systems.

- SBM-R promotes the development of **networks of facilities**, which can exchange experiences and provide mutual support for implementing the improvement process.

- The SBM-R methodology is conceived to be fully **incorporated into the day-to-day management** and provision of health services. SBM-R is not a quality and performance improvement methodology that can be implemented only by specialized quality experts or units, but is directly built into the normal managerial and service delivery processes. Quality thus becomes a regular function of the organization and an on-going responsibility and task of every health worker.

THE VALUE ADDED BY SBM-R

In many countries, the health industry is experiencing a significant transformation designed to improve its functioning and performance and ultimately the health status of the population. This transformation, often called health sector reform, is greatly affecting the way in which health services are provided. Some of the main characteristics of this transformation include:

- Emphasis on **evidence-based** health care
- A more **preventive and integrated** approach to health care
- Greater emphasis on the **active role of clients and communities**
- Increased focus on **quality, regulation and accountability** within an environment of **efficiency and cost control**
- **Decentralization** of managerial functions, increasing decision-making power at the local level

How can SBM-R be particularly helpful in addressing the challenges presented by health reform?

Use of scientific evidence, best practices and performance standards as the basis for quality health care delivery. Evidence-based knowledge and best practices do not reach many health facilities and providers because of shortcomings in dissemination of information. Even in developed countries such as the United States, studies show that routine care only partially follows recommended procedural standards of care. In many developing countries, service delivery guidelines are often placed on a shelf and are not used for day-to-day service provision. SBM-R "translates" scientific and technical reference materials such as guidelines and protocols into **operational tools** containing performance standards that can be used as **job aids** or guides by frontline providers and managers in their daily work. In this way, SBM-R helps in the implementation of evidence-based health care and dissemination of best practices.

Strengthening of an integrated approach to health care. Most current health approaches are moving away from vertical and isolated programs toward more integrated and holistic strategies. SBM-R does not focus on isolated aspects or problems of service delivery but rather addresses a minimum set of components and processes that are relevant for the delivery of "packages" of health services. This systemic approach creates opportunities for building more **integrated and sustainable platforms for service delivery** and helps to find synergies among health processes. Working in a systemic way, SBM-R avoids finding solutions for isolated aspects of care that create new issues in other areas.

Promotion of community and client awareness and involvement. Democratization and increased access to global information have raised the average person's awareness of human rights—including the right to quality health care. Local health committees, women's groups and community groups are well-positioned to represent community interests in health care, as well as help leverage increased resources for quality improvement. That more individuals are paying for health services and increasingly have a number of options from which to choose puts them in a position with more bargaining power. SBM-R provides a strategy that effectively builds on this new environment and **empowers consumers of health care**. SBM-R provides a systematic means of informing communities about quality of care, putting into practice indicators of quality that the layperson can observe and understand. In addition, SBM-R provides a role for communities to help define the actual quality expected in a health facility.

Quality of care, regulation and accountability. Different types of health insurance and market-oriented health care systems are on the rise in many countries. Health financiers and provider institutions are interested in getting the best quality of care for their members—at the lowest cost. As public funding of primary health care proves insufficient, more public service delivery systems are experimenting with cost-recovery mechanisms. Simultaneously, the private sector is growing in a number of developing countries, thus creating an environment of competition among health care providers. As these trends develop, there is increased concern about the need to create systems that ensure compliance with proper standards of care, including accreditation and certification of health services, for regulatory and accountability purposes. SBM-R provides a streamlined mechanism for

improving the performance and quality of health services and a **steppingstone for developing quality assurance systems**, promoting a culture of continual measurement of performance based on objective standards of care.

Decentralization. In public sector health organizations, decentralization or devolution of administrative and fiscal responsibilities has resulted in increased decision-making power at the local level. Local managers, however, often lack the essential knowledge and skills to deliver health services appropriately. In addition, funding for health care is not fully guaranteed by central level decision-makers, nor do the local managers have the information and knowledge to effectively advocate and lobby for it. Budget allocations made at the local level often reflect the political priorities of those in power and their most influential constituencies. Primary health care, often considered a concern of women and children, frequently lacks the advocacy effort necessary to ensure adequate funding. SBM-R clearly states the inputs needed for the provision of health care, the processes to be followed and the outputs to be achieved. It provides a **tool for increasing the managerial capacity** and for raising the prominence of quality of care concerns and **mobilizing resources at the local level**, thereby reducing the burden on external supervision.

SBM-R is not the only possible way of dealing with performance and quality improvement challenges, but it can be a powerful and practical mechanism to orient and strengthen local providers and managers in the fulfillment of their tasks.

STEP ONE: SETTING STANDARDS OF PERFORMANCE

DEFINING THE DESIRED LEVEL OF PERFORMANCE

The first step of the SBM-R process is to **define, in the clearest and most objective terms, the level of performance desired**. This is accomplished by developing operational performance standards for the services that need to be improved, following these principles:

- The focus must be kept on the **desired level of performance** to be achieved (a proactive or forward-looking attitude) and not on problems (a reactive attitude). In a discussion of problems that does not refer to the desired performance, only the most obvious issues may be brought up and important ones may be overlooked. Moreover, focusing on problems is likely to be demoralizing for workers who have to face many of them in their daily activities, and can lead to paralyzing mutual blaming.

- The performance standards must be presented in an **operational way**, constructed around concrete processes of service delivery. Reference standards, normally included in service delivery guidelines, are structured around specific technical procedures. For instance, there are technical guidelines for the management of maternal care, prevention of mother-to-child transmission of HIV, family planning or infection prevention. One single, concrete process of service delivery, however, can integrate aspects of all of the procedures. Moreover, this integration happens in a facility setting that has unique characteristics. Operational performance standards must reflect this concrete integration of service delivery processes.

- The performance standards must show providers and managers not only **what to do, but also how to do it**. This means that detailed verification criteria (input/structure, process and output/outcome indicators) should be used along with the performance standards. For instance, it is not enough just to tell providers that they have to conduct a rapid initial assessment of a pregnant woman in labor before admitting her. The verification criteria of this performance standard tell them, in addition, how to do it correctly.

- The performance standards should cover a **complete area of service delivery** and not just an isolated aspect of it. This systemic approach creates opportunities for building more integrated and sustainable service delivery infrastructures and facilitates synergies among health processes. For example, a very focused improvement process for family planning services may address only the specific aspect of provider knowledge and skills for recommending a contraceptive method. The SBM-R operational performance standards will address instead the whole set of service delivery processes needed for strengthening the provision of family planning in a more comprehensive way, including aspects such as counseling, followup visits, logistics systems, service delivery information systems and infection prevention.

- The performance standards must be based on scientific evidence and must also incorporate the **opinions of frontline providers, managers and clients**. For instance, client privacy during procedures may not have a big impact on the final outcome of a technical procedure, but it is important from the clients' point of view. Likewise, providers may have choices based on local

conditions. For example, instead of leaving the service provision area to wash their hands between patients, providers may prefer to use a waterless hand rub.

Developing standards that define the level of performance considered desirable includes:

- Identifying the services to be improved
- Defining in detail the core and support processes for the provision of these services
- Elaborating operational performance standards for each process

IDENTIFICATION OF SERVICES TO BE IMPROVED

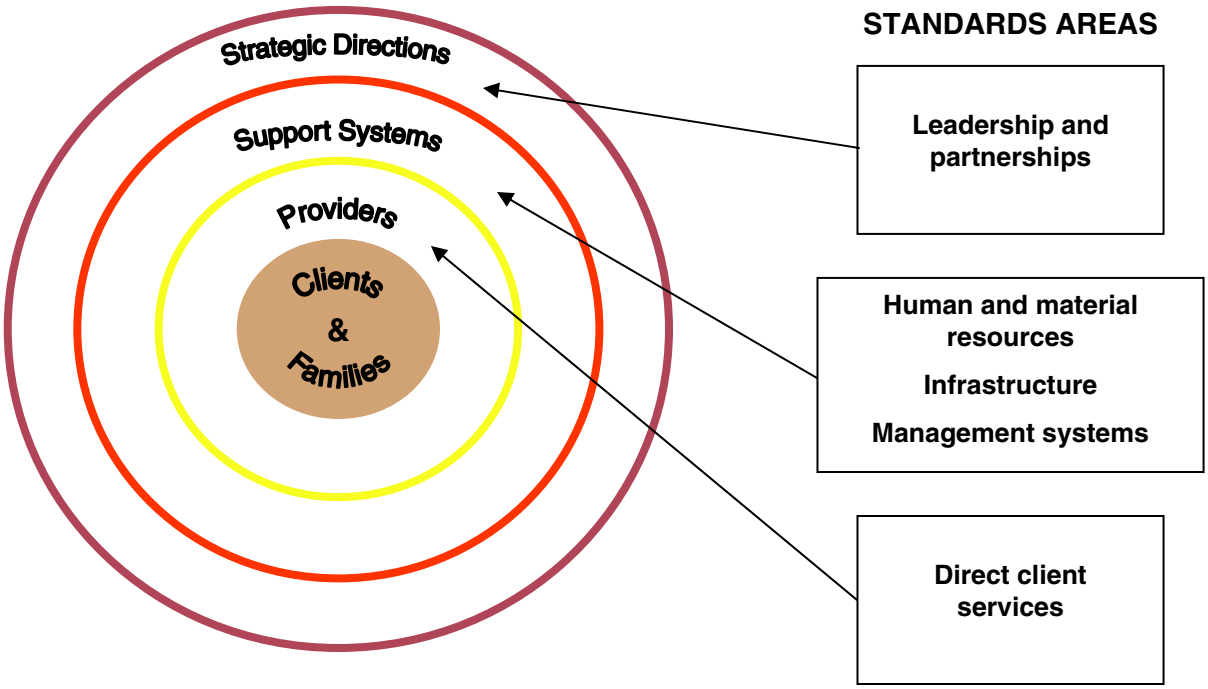
The first question a health care organization should ask is: What services need to be improved? Maternal and neonatal health services? Child health services? HIV/AIDS-related services? An integrated package of basic services? Do these services need to be improved in district hospitals? In primary health care settings? Throughout a network of services? The answers to these questions will depend on the **goals and strategies of each health organization**.

The priorities for health service delivery are usually established at the national level by ministries of health, taking into account the main causes of mortality and morbidity, burden of disease, and economic and financial information. Private health organizations may decide also to include market considerations such as demand or willingness to pay in the establishment of their goals and strategies, particularly if they are for-profit. With decentralization of processes taking place in many countries, regional or local authorities sometimes make important decisions about goals and strategies of the health services. Recently, organized communities have been exerting more and more influence on the setting of priorities for health services. As discussed in "Defining the SBM-R Initiative" (page 29), when multiple stakeholders are involved in the identification of the set of services to be improved, a systematic and participatory process must be conducted to build consensus and ensure the most constructive contribution of all parties.

DETAILED DEFINITION OF THE SELECTED CORE AND SUPPORT PROCESSES OF SERVICE DELIVERY

The successful provision of a given set of services (identified during the step above) requires the implementation of aligned functions at different levels of a health facility. There are three main levels of functions: **direct services to clients or core functions** (preventive services, acute and chronic clinical services, with interactions between providers and clients), **support functions** (managerial systems such as human resources, supply chain and others, ancillary services, etc.), and **strategic direction** (strategic leadership, planning, alliances and partnerships, etc.). All of these functions are important for high-quality service delivery. Because of its operational focus, however, SBM-R concentrates on the direct services to clients and support functions. (See **Figure 2** for a graphical representation of these three levels of functions.)

Figure 2. Organizational Infrastructure of Health Services



Adapted from: The Canadian Council on Health Services Accreditation 1995.

The core functions or direct services to be selected are those that are essential for the effective provision of a given set of services. For instance, if the purpose of the initiative is to improve maternal and neonatal health services, the core functions might be: antenatal care, labor and delivery, postpartum care and newborn care, including the management of complications. Likewise, the support systems required for the successful implementation of these core functions have to be identified. In the case of maternal and neonatal health, examples of key support functions are: blood bank, laboratory, instrument sterilization and other infection prevention practices, supply chain for drugs and medical supplies, and client information and education.

Process Mapping

Once the core and support functions to be improved have been identified, the processes involved in each of these functions have to be understood. For this purpose, a method called **process mapping** is useful. Process mapping helps people think in a rigorous and methodical way about the processes that must be in place to correctly perform the functions critical to the delivery of health services.

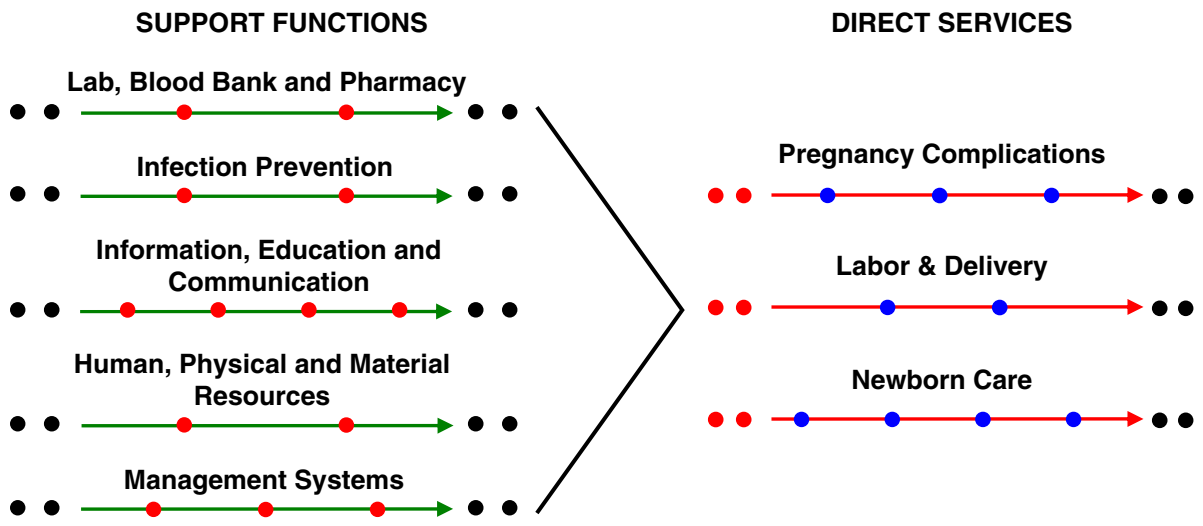
Process maps are diagrams that show, in varying levels of detail, what an organization should do and how it should deliver its services. **The mapping should show the major processes to be in place, their key activities, the sequencing of these activities, the inputs required and the outputs to be produced.** We can use process mapping to represent the core functions (or direct services to the clients) and the support functions of service delivery. A simple way to draw a map of a process is a linear or sequential graph:

INPUTS ---------- PROCESS----------OUTPUTS

We can first elaborate a general representation of the main processes for the core and support functions for the delivery of a given set of services. For example, for maternal and neonatal health services, we could have the following general representation (see **Figure 3**).

Figure 3. Sample General Process Map of Core and Support Functions

* Dots represent inputs, process steps (on the arrow) and outputs.



Then, we need to specify in detail the inputs, steps and outputs of each process. For instance, for the core process of antenatal care or for the support process of drugs logistics, there can be the following representation:

INPUTS (staff, equipment/materials, physical infrastructure required)---------- PROCESS (steps to be followed)---------- OUTPUTS (results expected)

Once we have identified the right inputs, steps of the processes, and the outputs of the core and support functions, we are ready to develop the operational performance standards.

ELABORATION OF OPERATIONAL PERFORMANCE STANDARDS

The operational performance standards are the specifications or requirements for the inputs, steps of the processes and outputs for each core and support function identified. These specifications or requirements are found in technical reference materials, service delivery guidelines and norms. In addition, the opinions of experienced service providers and the expectations of clients must be incorporated, as will be detailed in the following sections.

Each core and support function should have its inputs, process and outputs standards identified and presented in a sequential way. The performance standards thus developed are organized by core and support functions in a performance assessment tool that expresses the desired level of performance to be achieved. See **Table 2** for examples of performance standards for the core function of labor and delivery for maternal and neonatal health, and **Table 3** for a sample of an assessment tool general outline for maternal and neonatal health, showing the total number of standards developed by areas representing core and support functions.

Table 2. Examples of Performance Standards for Labor, Delivery and Newborn Care

Inputs: ▪ The facility has the minimal human resources necessary for labor and delivery services 24 hours a day. ▪ The area for labor and delivery has appropriate physical infrastructure, furniture and equipment. ▪ The area for immediate newborn care has appropriate furniture and equipment. ▪ The facility has a designated area for immediate postpartum care. ▪ The operating room has adequate physical space and equipment for performing cesarean sections and other obstetric emergency procedures. ▪ Medications to provide essential obstetric care are available and accessible in the labor and delivery area.
Process: ▪ The facility has a system to perform a rapid initial assessment of the pregnant woman in labor to identify complications and prioritize admissions. ▪ The provider receives the pregnant woman in labor in a cordial manner. ▪ The provider properly reviews and fills out the clinical history of the woman in labor. ▪ The provider properly conducts the physical, obstetric and vaginal examination. ▪ The provider prepares and implements a plan according to the clinical history and physical examination findings. ▪ The provider uses the partograph to monitor labor and make adjustments to the birth plan. ▪ The provider assists the woman to have a safe and clean birth. ▪ The provider properly performs active management of the third stage of labor. ▪ The provider properly performs the immediate postpartum care. ▪ The provider properly conducts a rapid initial assessment and provides immediate newborn care. ▪ The provider properly disposes of the used instruments and medical waste after assisting the birth. ▪ The provider properly identifies and manages complications during labor and delivery. ▪ The provider properly identifies and manages newborn asphyxia.
Outputs/Outcomes: ▪ The partograph is properly used in 100% of labor and delivery cases. ▪ Active management of the third stage of labor is performed in 100% of the deliveries. ▪ The maternal and neonatal morbidity and mortality are within desired range or target.

Table 3. Sample of Assessment Tool Outline for Maternal and Neonatal Care (including the total number of performance standards by area)

AREAS	STANDARDS
Core Functions	
Pregnancy complications	16
Labor, delivery, immediate postpartum and newborn care	27
Support Functions	
Support services (lab, blood bank, pharmacy)	24
Infection prevention	18
Information, education and communication	5
Human, physical and material resources	23
Management systems	10
Total	**123**

Defining the performance standards is not enough, however. The operational performance standards basically define **what to do**. The performance assessment tool must also detail **how to** achieve the standards, and present this information in an objective way and so that it can be easily followed and verified in the form of a checklist.

Therefore, in the performance assessment tool, each performance standard has objective verification criteria, organized as a practical checklist, that guide us in determining whether the standard is being met or not. To facilitate their implementation and the objective interpretation of results, the verification criteria normally used in the performance assessment tool have a dichotomous answer: yes (if the characteristic being observed is present) or no (if the characteristic is absent or is being performed incorrectly).

The performance assessment tool is organized in four columns: performance standards, verification criteria, answers for the verification criteria and comments (see **Table 4**).

Table 4. Sample of Performance Standard with Verification Criteria

AREA: CARE DURING LABOR AND DELIVERY			
Performance Standard	**Verification Criteria**	**Y, N, N/A**	**Comments**
1. The facility has a system to perform a rapid initial assessment of the pregnant woman in labor to identify complications and prioritize admissions.	Observe in the registration/admission and/or emergency room during a period of time that allows you to see more than one woman in labor. Verify whether: ■ The provider assesses priority for admission according to danger signs and not according to the order in the waiting line ■ When individually assessing each woman, the provider: – Asks duration of pregnancy – Determines if birth is imminent – Asks the woman how she feels and whether she has or has had: - Vaginal bleeding - Rupture of membranes - Convulsions - Severe headache - Blurred vision - Severe abdominal pain - Respiratory difficulty - Fever ■ The provider grants priority admission in the event of any of the above complications or if the birth is imminent ■ The provider records the information on the woman's clinical history		

Several methods are used to determine whether the performance standards and verification criteria are met: direct observation of clinical procedures and physical facilities, structured interviews with providers and facility managers, and review of clinical and administrative records. The instructions on the verification method that should be used for each performance standard are included in the assessment tool. Guidelines for using data collection methods are presented below:

GUIDELINES FOR DATA COLLECTION METHODS

When using direct structured observation:
- Introduce yourself and explain the reason for the assessment.
- Use the assessment tool to guide the observation.
- Do not provide feedback during the assessment.
- Be objective and respectful during the assessment.

When doing document review:
- Introduce yourself and explain the reason for the assessment.
- Identify correct sources of information (e.g., administrative forms, statistical records, service records).
- Review the documents using the assessment tool.
- Question individuals responsible for these areas to complement and/or clarify information.
- Be objective and respectful during the assessment.

When conducting interviews:
- Introduce yourself and explain the reason for the assessment.
- Identify the staff member who typically carries out the activities or procedures.
- Interview the staff member using the assessment tool.
- Probe to get the precise information; do not assume responses.
- Ask the person to show documents, equipment or materials as appropriate.
- Be objective and respectful during the assessment.

A performance standard is achieved when all of its verification criteria are met. We can then see how many performance standards have been achieved and express it in a score (in absolute numbers and/or as a percentage of the total). To facilitate the presentation of results, the performance assessment tool includes summary forms that show the number/proportion of standards achieved by area and in total. **Table 5** is a sample of a form that summarizes results of counseling and testing for HIV.

Table 5. Sample of Summary Form

AREAS	TOTAL OF STANDARDS BY AREA	STANDARDS ACHIEVED	
		Number	Percentage
Pretest group education	6		
Pretest one-on-one counseling	7		
HIV testing	9		
Post-test one-on-one counseling	12		
Support systems for counseling and testing	11		
General Total	**45**		

The performance assessment tool presents standards of different levels of complexity. As shown below, stringent but achievable challenges motivate those involved in the process. And those less complex, the "low-hanging fruit," create opportunities for early successes, which also motivate health workers.

Examples of assessment tools used in different programs and countries are presented in a CD-ROM that accompanies this field guide. These programs were developed following the process outlined in this field guide. Health managers and providers may find it easier to review and adapt these tools to their specific situations than to develop new tools from scratch.

STEP TWO: IMPLEMENTING THE STANDARDS

After the operational performance standards are developed, the next task—the most important one—is to put them into practice. The process of implementing the performance standards is a straightforward one. First, we have to be aware of how the services are currently being delivered, compared with the desired performance, and identify whether there are shortcomings in performance and, if so, what these gaps are. Then, we examine the potential causes of these gaps and identify interventions to correct them. Finally, we have to implement these interventions.

BASELINE ANALYSIS AND IDENTIFICATION OF PERFORMANCE GAPS

A baseline analysis is conducted using the performance assessment tool to show how the services are performing. During this analysis, we have to determine which standards are being met and which are not, and whether all the verification criteria for each standard are present. When recording the findings in the assessment tool, the assessor must not only determine whether a verification criterion has been met but also use the space for comments to record any detail that could help later in identifying the causes of the gap.

photo by: Lucy Ramirez

Analysis of baseline results in Mozambique

The results of the baseline analysis are presented quantitatively: number of standards met and percentage of standards met with regard to the total. This quantitative presentation of results (a score) offers a basis for the future monitoring of activities (see **Table 6**).

Table 6. Sample of Summary Form with Baseline Assessment Results

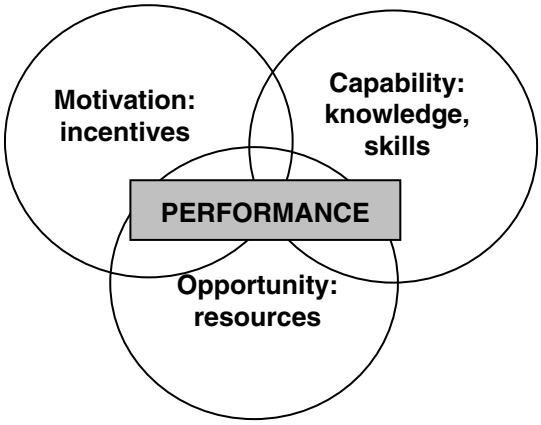
AREAS	TOTAL OF STANDARDS BY AREA	STANDARDS ACHIEVED	
		Number	Percentage
Pretest group education	6	4	67
Pretest one-on-one counseling	7	5	71
HIV testing	9	8	89
Post-test one-on-one counseling	12	6	50
Support systems for counseling and testing	11	8	73
General Total	**45**	**31**	**69**

The standards that are not met constitute performance gaps. The verification criteria in the performance assessment tool will show if these standards are completely or partially missed, thereby facilitating the identification of causes of the gaps and corresponding interventions. As in the example of baseline results in **Table 6**, it is possible to get a "snapshot" of the magnitude of the total gaps by area and in general, and present the results of the baseline assessment as percentages.

THE CAUSES OF PERFORMANCE GAPS

What are the most frequent causes of gaps in performance? Three conditions influence performance: capability, opportunity and motivation. There is capability when the performer **knows what to do** or, in other words, possesses the information, knowledge and skills to carry out the job. Opportunity means that the performer is **enabled to do** the job, having, for instance, the appropriate resources and tools for this purpose. Motivation is present when the performer **wants to do** the job; motivation is related to the performer's inner drive to accomplish a task. These three conditions must be present in a balanced way—none of the factors should be ignored/omitted nor overemphasized—in order to achieve the desired performance (see **Figure 4**).

Figure 4. Influences on Performance



In each of these three areas there are factors that are related to the individual performers and other factors that correspond to the environment in which they work. This distinction is important because often most of the issues in performance are related to the organizational environment. For instance, in the area of capability, having the right knowledge and skills is something that corresponds to the individual performer, but providing the right information on the nature of the job, performance expectations and feedback on the job done correspond to the organizational level. Similarly, in the area of opportunity, the provision of resources and tools is the responsibility of the organization, but each individual provider has different levels of physical, mental and emotional capacity to produce. Likewise, motivation is an intrinsic factor that corresponds to each individual, but providing the right incentives to reinforce it is an organizational responsibility. The causes of the gaps that we identify using the performance assessment tool during the baseline analysis will most likely correspond to one of the six categories identified by Gilbert (1996) or to a combination of them (see **Figure 5**).

Figure 5. Gilbert's Performance Factors

	Capability	Opportunity	Motivation
Environment	Information	Resources	Incentives
Individual	Knowledge	Capacity	Motivation

Adapted from: Gilbert 1996.

Methods for identifying causes of performance gaps

How can we know which factor among all of these potential causes is creating the gaps? There are several methods that can help in this task. The cause analysis can begin with the simpler and less expensive, less structured, methods.

The simplest approach is to ask the question directly: What could be the cause of this gap? And this question could be asked of oneself, colleagues or experts. The techniques that help us in this case are intuition, networking and expert experience. (See the definitions below.)

Sometimes it may not possible to obtain a useful answer to the direct question and we will need to begin identifying and examining a range of possibilities. Techniques such as brainstorming, nominal group technique, fishbone diagrams, force-field analysis and flowcharts help us to systematically explore a number of potential causes linked to a performance gap. Other techniques, such as the run chart or the Pareto chart, which require using data, allow us to establish connections of potential causes with other temporal events or with frequency of occurrence. (See below for a brief description of these techniques.)

LESS STRUCTURED TECHNIQUES FOR CAUSE ANALYSIS

Intuition: Is the immediate knowledge of something without the conscious use of reasoning. The mind is able to capture small variations or details that are apparently not important, but that in fact might be the key to solving an issue. It appears to be a highly personal trait and not everybody has it.

Networking: Is a technique demonstrating that it is not necessary to repeat the same type of analysis every time the same type of performance gap is observed. Talking to others who faced the same or similar constraints and overcame them can be useful.

Experience: Cannot be taught, can only be acquired through learning. One way of benefiting from the experience of others is to consult individual experts or groups of experts. To obtain a good orientation on a specific issue and to avoid biases, it is important to consult several opinions.

Brainstorming: Allows the generation of a large number of ideas on a subject, without criticism or judgment of them.

Nominal group technique: Allows a team to quickly come to a consensus on the relative importance of issues by individually ranking them and pooling the results.

Fishbone diagram: Presents in graphic form all of the possible causes related to an issue or condition to help reveal its root causes.

Force field analysis: Helps to identify the forces or factors that are in favor of or against the solution of an issue.

Flowchart: Facilitates the understanding of a process by identifying its events and their sequence.

Run chart: Allows a team to study observed data for trends or patterns over a specified period of time, using a simple linear graph.

Pareto chart: Helps to focus efforts on the issues that offer the greatest potential for improvement by showing their relative frequency or size in a descending bar graph (80/20 rule: 80 percent of the performance gaps are due to 20 percent of the causes).

The advantages of the less structured techniques are that they are faster, allow the detection of hidden issues and permit the user to reach abstract conclusions. Their disadvantages are that they are prone to subjectivity, are difficult to train others in because they depend on personal characteristics, require familiarity with the subject matter and have a higher probability of failure. Nevertheless, these techniques can be very helpful in trying to find the causes of the gaps identified.

In some situations, the identification of the cause of a performance gap requires a more specialized and sophisticated analysis. This can be done using more structured techniques that explore more rigorously the relationship between a suspected potential cause and the performance gap. Methods such as change analysis, barrier analysis, events and causal factor analysis, or tree diagrams can be helpful for this purpose but may require specialized support. (See below for a brief description of these techniques.)

MORE STRUCTURED TECHNIQUES FOR CAUSE ANALYSIS

Change analysis: Consists of systematically examining the effect of a change in a system (e.g., the introduction of a new clinical procedure, or of new staff).

Barrier analysis: Is conducted by analyzing the behavior of barriers designed to prevent unwanted events (e.g., the safety barriers designed to prevent accidents during anesthesia).

Events and causal factor analysis: Is performed by examining the sequence and chronology of events and the related resulting conditions (e.g., analysis of intra-hospital maternal deaths).

Tree diagrams: Are graphical displays of an event, of each of its contributing factors, and the causes that in turn lead to the contributing factors, like a tree that branches successively, until the final contributing factors are found.

The advantages of more structured techniques are their clearer definitions of the process being analyzed, repeatability, better documentation and the availability of literature describing them. The disadvantages are the training, time and cost requirements, and the possibility of obtaining outcomes influenced by the methods used or biases introduced by their structure.

We can identify the cause or causes of the performance gaps observed using a combination of techniques, beginning with the easier ones. When analyzing causes of the gaps, we have to be aware that there are different levels of causes:

- **Symptoms:** Are not really causes; they are manifestations of something wrong. For instance, if the sterilization equipment in a hospital breaks down, the symptom is a lack of sterilized medical equipment and materials. Symptoms can be remedied with **quick fixes**. In the example presented, the medical equipment and material could be sent to another hospital to be sterilized.

- **Apparent cause:** Is the immediate or obvious reasons for a gap. Following on the previous example, the apparent cause is that the sterilization equipment broke down. The solution would be to repair the equipment. Apparent causes can be solved with **corrective measures**.

- **Root cause:** Is the most basic reason for a performance gap. In the example above, the root cause might be that the sterilization equipment is not operated correctly and does not receive appropriate maintenance. Only eliminating the root cause will **prevent the reoccurrence** of the gap.

Getting to the root cause is frequently a trial-and-error process, and it is often difficult to know the real causes of a gap. In these cases, it is important to act upon the apparent causes and even the symptoms. Corrective measures and quick fixes can help to obtain rapid and visible results and create momentum for change.

IDENTIFICATION OF APPROPRIATE INTERVENTIONS TO CORRECT THE PERFORMANCE GAPS

Once the causes of the performance gaps have been identified, the next step is to decide what are the appropriate interventions to correct or eliminate these causes. Following are some of the interventions that address gaps related to capability, opportunity and motivation:

- **Capability:** When the performer lacks the knowledge and/or skills to perform the tasks, or lacks information about the task, including communication of performance expectations or the provision of feedback on the work done, the appropriate answer is to implement **learning interventions, provide information on the task or give feedback**.

- **Opportunity:** When the performer lacks the tools and/or resources to do the tasks, or the tasks or jobs are poorly organized or do not correspond to the performer's capabilities, the appropriate interventions would be to **provide resources**, **redistribute the workload or redesign the work processes**.

- **Motivation:** When the performer lacks the motivation to perform the job, or a meaningful system of consequences of performance does not exist, the appropriate intervention would be to **enhance motivation or create a system of consequences of performance, including incentives**, aligned with the performance goals stated.

Table 7 shows in more detail the characteristics of interventions that can be implemented in response to specific causes identified.

Table 7. Examples of Interventions by Performance Factor (type of cause)

TYPE OF CAUSE	EXAMPLE OF INTERVENTION
Related to Capability	
Lack of information	■ Creation of standards for the job ■ Setting of job/performance expectations ■ Communication of job/performance expectations ■ Provision of feedback ■ Provision of job aids (including the utilization of information technology)
Lack of knowledge and/or skills	■ Natural experience learning (internship, assignment to a team) ■ On-the-job training/structured on-the-job training ■ Simulation exercises/role play ■ Classroom training/laboratory practice (seminars, workshops, skills practice with anatomic models) ■ Self-study/distance learning (programmed instruction with printed materials, interactive multimedia learning systems) ■ Mentoring from an experienced coworker or supervisor
Related to Opportunity	
Lack of resources and/or tools	■ Provision of resources (time, tools, equipment, personnel, procedures) ■ Provision of managerial and technical support (supervision, regular monitoring and support systems)
Inadequate capacity	■ Selection of personnel (the right people for the right job) ■ Redistribution of responsibilities/workload ■ Elimination of task interferences ■ Redesign of work processes
Related to Motivation	
Lack of incentives	Provision of incentives/consequences of performance: ■ Feedback ■ Positive reports on file ■ Social recognition (ceremonies, certificates, symbolic rewards, improvement of status) ■ Opportunities for professional development ■ Material rewards (promotions, performance-based payments, bonuses) ■ Provision of additional resources
Lack of motivation	Strengthening of motivation: ■ Highlighting of the impact of actions and performance and the value of the job ■ Opportunities for personal growth ■ Job security ■ Rigorous but achievable challenges ■ Healthy competition ■ Opportunities for achieving results

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IMPLEMENTATION OF INTERVENTIONS

The implementation of interventions starts with the development of operational plans. These plans are relatively simple tools that outline what the gaps are and the causes that need to be eliminated, the specific intervention to be conducted, the person(s) in charge, the deadline for the task and any special support that may be needed. The identification of the responsible person(s) and the setting of the deadline are extremely important because they allow a more effective followup of the activities included in the plan. Teams of facility providers/managers working in the different areas of

service provision should develop operational plans after they have conducted their baseline analysis. A sample of an operational plan form is shown in **Table 8**.

Table 8. Sample Operational Plan Form

GAP/CAUSE	INTERVENTION/ACTION	RESPONSIBLE	SUPPORT	DEADLINE

During the implementation phase, it is important to consider the following important points:

- The improvement process is usually initiated by a small group of **change agents and committed champions**. It is very infrequent to find widespread support for a new improvement initiative. On the contrary, it is more typical to find resistance and skepticism ("there is no time, no resources....") growing from health workers' frustrating experiences in the past. It is therefore key to identify committed champions for the initiative and include them in the initial improvement efforts. In addition, it will be important to select and prepare a group of change agents who can act as coaches for the improvement efforts. (See "Facilitating SBM-R" on page 33 for a suggested process for selection and training of coaches.)

- Implementation is based on **team action**. Most service delivery processes do not depend on the actions of single providers; they are the result of team efforts. It is therefore important to expand the group of committed people beyond the initial champions. Teams can be organized by specific area or process of service delivery. Each area team should analyze the results of the performance assessment, develop an operational plan accordingly, and implement and monitor improvement activities.

- It is desirable to work with **networks of services**. Implementing improvement processes is a more difficult task for a person working alone. Working in networks of similar services or facilities, which can exchange experiences and provide mutual support, usually favors the achievement of positive changes.

- The process emphasizes **bottom-up action and client and community involvement**. A key purpose of the SBM-R process is to provide local health workers and the clients and communities they serve with practical tools that empower them and increase their control over the process of delivering health services. Clients and communities are not seen as passive recipients of health activities but as essential partners in the health care process. To the maximum extent possible, client and community representatives should be part of the improvement teams, plans and activities.

- It is important to remember that **change management skills develop gradually**. Beginning the process by addressing the areas of less resistance avoids staff becoming demoralized early on by the complexity of the challenges faced. Beginning in this way, taking advantage of the "low-hanging fruit," helps to obtain quick results that motivate and empower the local teams and develop their change management skills, increase the visibility of the initiative and create

momentum for change. Rapid interventions and even quick fixes may be helpful at the beginning of the process.

- When additional external support is needed to address some performance gaps, it should be provided where and when required by the local teams ("just-in-time" technical assistance). During the improvement process, health care facilities and individual workers should be able to access different types of technical assistance to identify the causes of performance gaps and design and implement the appropriate interventions. To the maximum extent possible, however, this assistance should be provided upon request of the local level. Local teams aware of their needs for technical assistance can request and use it more effectively and efficiently.

photo by: Escolastica Moura

"Just-in-time" technical assistance in PROQUALI in Brazil

STEP 3: MEASURING PROGRESS

Continual measurement of progress is used as a mechanism to guide the process, inform managerial decisions and reinforce the momentum for change. Through continual measurement, managers, providers and even organized communities can monitor the process, assess success of interventions, identify resistant gaps and introduce necessary adjustments to their plans. Measurement also gives managers and providers quantitative targets. Achieving sustained progress on quantitative targets has an important motivating effect for those involved in the improvement process.

TYPES OF ASSESSMENTS

Continual measurement is based on the periodic implementation of followup assessments using the performance assessment tool. The assessments can take several forms:

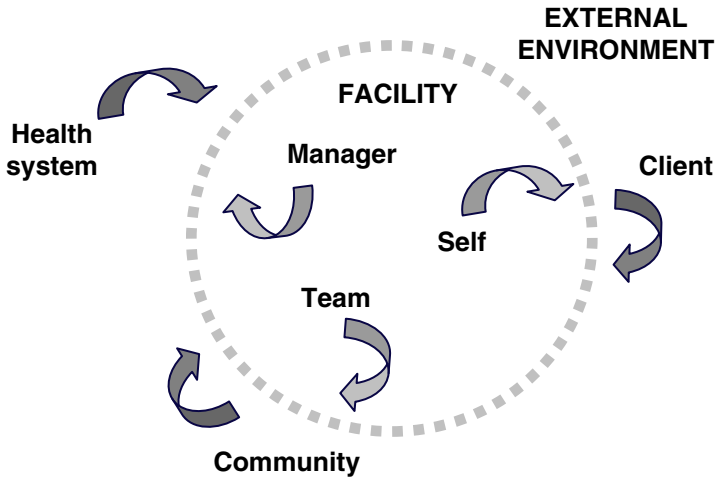
- **Self-assessments** are conducted by the individual providers of their own work. The providers use the performance assessment tool as a job aid to verify whether they are following the recommended standardized steps during the provision of care. These assessments can be performed as frequently as desired or needed.

- **Internal assessments** are implemented internally by facility staff. They can take the form of **peer assessments**, in which facility staff use the assessment tool to assess one another's work, or **internal monitoring assessments**, in which managers or providers use the tool more comprehensively to periodically assess the services being improved. It is recommended that this latter assessment occur every 3–4 months.

- **External assessments** are implemented by persons external to the facility. Central/regional/ district level ministries of health, management personnel of private health organizations or other authorized bodies usually conduct these assessments. They can take the form of **facilitative supervision** when the purpose of the visit and assessment is to provide support for identification of performance gaps and interventions, or **verification assessments** when the purpose of the visit is to confirm compliance with recommended standards of care for recognition purposes. In the case of verification assessments, it is desirable that representatives of the clients and communities served are involved in the process in an appropriate way. For example, they could have representatives on the team conducting the assessment of the facility. Although it is not a form of assessment, client feedback (provided during or after the provision of services) can be considered part of the external inputs on facility performance and should be taken into account by providers and managers.

These different types of assessments at several levels create a system of multiple sources of support and control for the process, which can be called a **multidimensional supervision system** (see **Figure 6**). This system assumes that no single support mechanism is perfect. Therefore, it builds redundancies or back-up mechanisms to allow for different perspectives and continuity of monitoring and support for the process. This kind of supervision system, relying on multiple mechanisms, internal and external to the facility, operating simultaneously, is also more sustainable.

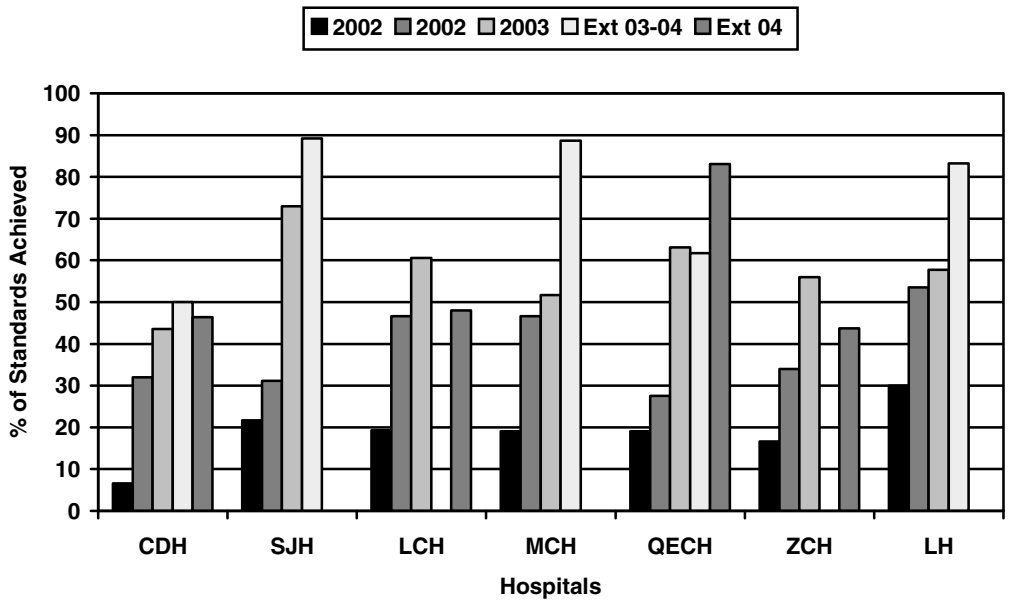
Figure 6. Multidimensional Supervision



The use of quantitative and comparable data to assess performance levels has another very important consequence: based on objective information, health facilities are able to share best practices and benefit from one another's experiences. This process is known as **benchmarking**. (See "Managing the Change Process" on page 40 for more information on benchmarking.)

It is important to note that the measurements conducted with the performance assessment tool are useful for managerial purposes, as long as they are a reasonable approximation to the reality, but they are not scientific evaluation. The level of certainty of the assessments increases progressively with repeated measurements over time. This is because each subsequent assessment probably captures additional or different pieces of the reality. **Figure 7** below shows the percentage of standards achieved in seven hospitals in Malawi in three internal and two external assessments. A clear advantage of this type of managerial information is its quick turn-around time, which makes it very useful for on-going decision-making. Information of a scientific level of certainty is nevertheless essential when performing more in-depth or specialized assessments of quality and performance.

Figure 7. Example of Measuring Progress in Compliance with Infection Prevention Standards over Time in Seven Malawi Hospitals



STEP 4: RECOGNIZING ACHIEVEMENTS

The motivational element is key for SBM-R. Health workers, communities and other stakeholders do not adopt service delivery improvement initiatives just because they make rational sense. They must see that they have something to gain from the experience. Many excellent managerial models for improving performance and quality fail because of their exclusive focus on the methodology itself, without paying enough attention to the motivational aspect of the process. The answer to the question: "What's in it for me?" lies in the area of motivation.

MOTIVATION

Motivation is the inner drive, the morale to perform a task and reach a goal. It is an internal response to external events, and that is why it is called an intrinsic factor. Motivation is something that lies within the performer and therefore cannot be created from the outside. We can, however, create conditions that enhance motivation.

There are many theories about motivation, and most of them agree that motivation is related to a sense of growth and meaningfulness. Motivation is greater when performers feel that they are more empowered and have more control over their tasks and the processes under which they work. It is also stronger when people appreciate the challenges they face and the impact their achievements will have, and when they strongly believe that they will be successful.

SBM-R helps to create conditions that enhance motivation:

- The performance assessment tool is, in fact, a practical job aid that clearly outlines what managers and providers must do to accomplish their work and gain **more control over their jobs**. Experience with the process has shown that this enhanced knowledge of and control over their jobs has motivated many health workers to participate in the SMB-R process.

- The consistent use of the performance assessment tool increases the **empowerment of local-level workers** who become more familiar with external supervisors and are more able to present their priorities and advocate for resources. It has also been observed in SBM-R initiatives that the sense of personal and **professional growth** experienced by local staff is another factor that increases their motivation.

- As was mentioned above, the SBM-R process presents workers with stringent but achievable **challenges**. This increases the **value of the process** in the eyes of health workers who feel challenged in a meaningful way.

- Working in networks and the continual measurement and benchmarking create an atmosphere of **healthy competition** that is positive for motivation.

- The process allows for **early successes**, gradually increasing the levels of workers' **self-confidence**. Workers also experience a sense of **achievement** when they reach their established performance goals.

- The systemic point of view in SBM-R, in which the interrelationship of all performance factors is considered, helps to develop a **work environment** more **conducive to good performance**, which in turn affects motivation positively.

These are examples of "built-in" mechanisms within the SBM-R process aimed at enhancing motivation. There also are other elements from outside that can strengthen motivation by creating meaningful consequences of performance. These consequences of performance must be established in such a way that workers clearly know what they get out of the process, depending on how they perform. Consequences of performance can be both positive and negative. SBM-R emphasizes the positive kind in the form of provision of incentives.

INCENTIVES

Incentives are elements provided by the external environment to increase motivation. The provision of incentives has to be aligned with the meaningful achievement of performance standards. SBM-R considers several types of incentives for facilities that fulfill performance milestones and goals:

- **Feedback** is the most direct and least costly way of acknowledging good performance, but its impact is considerable. To be effective, feedback must be timely, specific, continual and interactive. It can be provided both orally and in writing and can be directed toward individual providers, teams and facilities.

- **Social recognition** consists of the provision of rewards of symbolic value. According to some authors, social recognition is important for workers because it is a good predictor of future material rewards. In addition, social recognition immediately helps to improve the morale of workers. Social recognition can be given to individual providers, teams or whole facilities. It can adopt the form of commendations, trophies, diplomas or celebrations. The improvement in the status of health workers through increased levels of authority and positive reports that are placed in their personnel files are other forms of social recognition.

photo by: Ministry of Health Honduras

Internal social recognition in a hospital implementing an SBM-R initiative in Maternal and Neonatal Health in Honduras

- **Material recognition** can be provided as monetary and in-kind rewards. It can also be awarded to individual providers, teams or whole facilities. Individual monetary rewards can adopt the form of systematic performance-based payments or one-time bonuses. Teams can also get monetary prizes. For facilities, examples of monetary rewards are performance-based budgets or the provision of additional financial resources due to superior performance. In-kind rewards for individual providers can be given in the form of opportunities for professional development. For facilities, rewards can be additional equipment or supplies.

Peers, direct supervisors, facility managers and institutional leaders should provide feedback and recognition. Clients and the community can also give recognition. In SBM-R, the global achievement of performance standards is emphasized with recognition that involves a combination of institutional and community response.

Facilities operating in a competitive market environment may also find an incentive in the increased client base or market share (and profit) that improved service performance and quality bring.

Implementing incentives is not free of challenges. Unwisely or carelessly applied, they can produce undesired distortions in service delivery. Also, negative consequences of performance, linked to the concept of accountability, also have a place in SBM-R, but they are often difficult to enforce in an effective and equitable way in the absence of well-developed national regulatory and quality assurance systems.

DEFINING THE SBM-R INITIATIVE

The SBM-R initiative must respond to the needs of a specific institutional and programmatic health context. To ensure that this happens, it is important to clearly define the characteristics of the SBM-R initiative from the onset of the process and address the following questions:

- What is the primary purpose of the SBM-R initiative?
- On what type/range of health services will the SBM-R focus?
- In what type of facilities will performance be assessed and recognized?
- Which sectors will be included?
- What is the geographical scope of the program?
- What incentives—or consequences—will be built in to reward improved performance?
- Who will assess and recognize performance?
- Will the initiative be proactively supported and facilitated?
- How will the program be managed?

The answers to the above questions have to reflect the local reality. There is a range of potential options for each question.

PURPOSE

One of the first questions to address in designing an SBM-R initiative is: What do we hope to achieve through this initiative? The purpose can range from a relatively short-term promotion of a specific type of service to a long-term, institutionalized process, closer to formal certification or accreditation schemes. The latter focuses on assuring consistent compliance with quality or regulatory/legal requirements of health care provision, usually linked to financing mechanisms. An intermediate goal would be establishing a model that serves as a mechanism to improve service performance, quality and utilization. The majority of the program examples presented in this field guide in fact represent this intermediate option. Defining the overall purpose is a prerequisite for determining such aspects as the potential life span of the recognition effort.

TYPE/RANGE OF SERVICES

The type/range of services to be covered has a significant impact on the level of complexity and resource requirements of the initiative. Based on institutional priorities and resource availability, it may be necessary to restrict the process to one type of service and related functions. This focused approach has been implemented, for example, for quality in family planning services, infection prevention practices, maternal health, counseling and testing for HIV, and prevention of mother-to-child transmission of HIV. Sometimes, however, it is programmatically difficult to completely focus on only one type of service. In the Brazil PROQUALI initiative, for example, a core set of quality standards for family planning was complemented by other standards for selected reproductive health services such as prenatal care and prevention of sexually transmitted infections. As service delivery programs increasingly aim to integrate services across health areas, more programs are attempting to develop SBM-R designs that include a broader range of health services, or basic health care packages, provided at a given facility level.

TYPE OF FACILITIES

SBM-R focuses assessment and recognition at the health facility level rather than on individual providers. The focus of the initiative may be on networks of facilities of different levels of complexity in order to ensure an effective continuum of care. The CaliRed initiative for maternal and neonatal health in Guatemala adopted this approach and further expanded it to include assessment and recognition of communities in the catchment area of participating facilities. Alternatively, the initiative may focus on one particular type of health facility. For example, SBM-R can focus on primary care clinics if the purpose of the initiative is to strengthen preventive and primary health care, or on district hospitals if the goal is to provide essential referral services or to encourage a more rational use of expensive curative care.

SECTORAL COVERAGE

To date, many performance and quality improvement programs in developing countries have been restricted to the public sector of health care provision, but there is some experience with programs designed to implement SBM-R across sectors. For example, in the West Africa Gold Circle program, both ministry of health and NGO clinics are assessed and recognized using a common set of standards. In other cases, different but complementary recognition strategies may be implemented across sectors using different sets of standards for private and public facilities.

GEOGRAPHICAL SCOPE

The design may focus on a limited geographic area or have national scale coverage. A locally implemented strategy may focus on one or more districts in a selected number of provinces. This approach is particularly appropriate when a particular model is first being tested with the intention of scaling up later. Other models seek greater coverage and are implemented on a regional, state or provincial scale. This option is relevant in decentralized environments in which provincial or state units have significant levels of political, technical and administrative decision-making power. Schemes implemented for national coverage throughout a given country may be linked to nationwide schemes for health provision and financing.

CONSEQUENCES OF PERFORMANCE/INCENTIVES

Another essential aspect of SBM-R is the formulation of a sustainable yet meaningful scheme of incentives and consequences. Some designs use non-monetary incentives exclusively, such as social recognition, performance feedback and skill-building opportunities. Others build in additional incentives like provision of equipment, increased operational budgets for the facility or even small monetary rewards. Still others offer monetary incentives provided through performance-based budget allocations or health worker remuneration systems.

RECOGNITION BODY

The group of people who assess performance and grant recognition can be either internal or external to the institution that owns or manages the unit being assessed. Use of internal recognition bodies is usually linked to institutional supervision structures, and is part of an internal quality improvement effort. Other recognition models seek to maximize objectivity of the assessment and use external assessors. An external recognition body reinforces the credibility of the process. An intermediate option that increases the credibility of recognition processes, yet allows for closer followup in areas where standards are not met, is an accrediting body made up of a combination of internal and external assessors.

SUPPORT AND FACILITATION

An effective SBM-R program requires planning, coordination and technical support. The SBM-R initiative can be implemented with different levels of facilitation, which will determine the type of infrastructure required. For the more proactively facilitated SBM-R initiatives, it will be necessary to identify and develop or strengthen technical assistance bodies and coaches. The need for facilitation will depend on the nature of the intervention and the level of development of the infrastructure of the related health services, including the human resources.

MANAGEMENT

Management of an SBM-R initiative can be performed in a centralized way, from just a managerial unit at the organizational headquarters, or in a decentralized manner. In decentralized programs, while central level bodies may lead the development of performance standards and tools for program rollout, the actual implementation and ongoing management are delegated to the regional, provincial or district level. In the latter case, local authorities assume control of the process or have significant responsibilities. The central, provincial and district levels can also jointly manage the recognition program. This information is summarized in **Table 9** below.

Table 9. SBM-R Design Options

ASPECTS TO BE CONSIDERED	RANGE OF OPTIONS		
Purpose	Short-term promotion of specific services	Improve performance, quality and utilization of services	Ensure consistent level of quality/meet regulatory standards
Type/range of services	Focused on core set of services (e.g., family planning, infection prevention, services for adolescents)	Core set of services plus related other services (e.g., HIV/AIDS services plus related maternal care, voluntary counseling and testing)	Comprehensive
Type of facility	One type of facilities (e.g., health centers or hospitals)	Networks of facilities of different levels of complexity	Networks of facilities and communities
Sectoral coverage	One sector (public or private)	Different but complementary standards for each sector	One set of standards applied across sectors
Geographical scope	Selected facilities	Regional/provincial	National
Consequences of performance/incentives	Feedback	Feedback plus social recognition	Material recognition associated with social recognition and feedback
Recognition body	Internal	Combined	External
Support and facilitation	Intensively facilitated	Partially facilitated	Not facilitated
Management	Centralized	Shared	Decentralized

Choosing an option for each one of these categories will help to define the profile of the SBM-R initiative, an important element of the common vision that will guide the process. The decision on these options, however, is not the task of any single person. It is usually the product of a negotiated agreement among several stakeholders who may have different views of what is "best." For this reason, it is essential to skillfully manage a consensus-building process among the stakeholders to reach a solid agreement of the characteristics of the SBM-R initiative.

This consensus is typically achieved through a facilitated dialogue and decision-making process. One or more informational meetings with the stakeholders may be necessary to discuss the initiative with them and to obtain their points of view. After this preparatory phase, it is usually useful to have a meeting (preferably not more than one) including all of the key stakeholders to formalize an agreement on the profile of the SBM-R initiative. It is advisable to go to this meeting with a draft proposal on the SBM-R profile, developed with the stakeholders' inputs during the preparatory meetings, which should serve as a basis for the discussion.

An example of a typical activity for achieving consensus on SBM-R characteristics is shown in **Table 10**:

Table 10. Typical Activity for Achieving Consensus

WHAT TO DO?	WHO WILL PARTICIPATE?	WHAT WILL THE RESULT BE?	HOW LONG IT WILL TAKE?
Stakeholders' meeting to design the SBM-R program	Main stakeholders and SBM-R advisors	Agreement on the SBM-R initiative design/profile	1-day meeting(s) Varies depending on size of group and ease in achieving consensus

FACILITATING SBM-R

The implementation of SBM-R requires the development of some infrastructure for coordination and facilitation purposes. **The required infrastructure will be determined by the scope of the process and the amount of facilitation envisioned for it**. For the SBM-R initiatives that require more effort and are more intensely facilitated, this infrastructure has to be more developed.

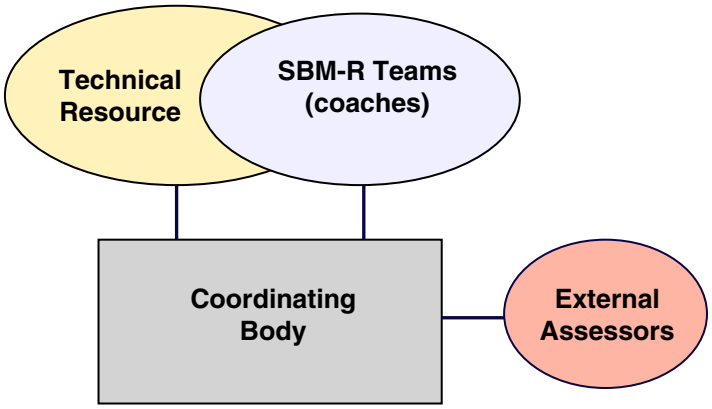
Development of support bodies or groups for four major functions is recommended, as shown in **Table 11.**

Table 11. Functions and Support Bodies

FUNCTION	SUPPORT BODY
General coordination of the initiative	SBM-R coordinating body
Facilitation of the SBM-R process	Teams of SBM-R coaches
Technical assistance in subject matter	Technical advisors
Verification of compliance with standards	Verification team

These four groups have to work in a coordinated fashion to provide appropriate support for the SBM-R initiative (see **Figure 8**).

Figure 8. SBM-R Facilitation Infrastructure



The main functions of each of these entities and how their members are selected and developed are discussed below.

THE SBM-R COORDINATING BODY

The SBM-R coordinating body should be a formal group that guides the SBM-R effort from design through implementation (see **Table 12**). Typically it contributes to initial conceptualization, resource mobilization and advocacy efforts to gain initial buy-in and maintain momentum.

The coordinating body can sit in a structural unit of the ministry of health or other organization implementing the SBM-R initiative, or can adopt the form of a task force with a specific mandate. For longer-term SBM-R efforts, the coordinating body should adopt a more permanent, institutionalized form.

Table 12. Suggested Activities to Establish the SBM-R Coordinating Body

WHAT TO DO?	WHO WILL PARTICIPATE?	WHAT WILL THE RESULT BE?	HOW LONG IT WILL TAKE?
Identify key stakeholder organizations/groups and appropriate representatives from each one to make up the coordinating body	Individual/group spearheading the SBM-R initiative	List of people to invite as members of the coordinating body	Varies
Conduct meeting to constitute the coordinating body	Individual/group spearheading the SBM-R initiative Selected members of the coordinating body	Coordinating body has a clear understanding of the SBM-R process and its functions Verbal or written organizational commitment including names of individuals with time and resources dedicated to work of the coordinating body	Half-day to 1-day meeting May require time after the meeting for organizations/units to formalize their commitment

Typical functions of the coordinating body are:

- Overall coordination and planning of the SBM-R process
- Definition of institutional goals and policies with regard to the SBM-R process
- Approval of performance standards
- Formalization of the recognition system: criteria, process and consequences
- Selection and designation of SBM-R coaches
- Identification of technical advisors in specialty areas
- Selection and approval of the verification team for recognition
- Mobilization of resources
- Overall monitoring, support and evaluation of the SBM-R process
- Advocacy

Membership includes representatives of the major stakeholder organizations or groups that will be part of the initiative or are most likely to be influenced by the SMB-R program. The individuals selected should ideally have decision-making authority within their organization or technical expertise relevant to the various components of the SBM-R model (see **Figure 9**). In general, the members of this group, depending on the characteristics of the initiative being implemented, include but are not restricted to:

- Ministry of health central and regional/provincial level unit representatives
- NGO representatives
- Professional association representatives
- Community representatives
- Private health organizations

Figure 9. Examples of a Coordinating Body for an SBM-R Initiative

National Quality Assurance Task Force, Malawi Ministry of Health

- Ministry of Health, Malawi
  - The Chief Technical Advisor, Chair
  - Director of the Department of Nursing Services
  - Director of the Department of Clinical Services
  - Director of the Department of Health Technical Support Services
  - Director of the Department of Human Resources
  - Director of the Department of Planning
  - Director of the Department of Preventive Services
  - Director of the Department of Finance and Administration
  - Quality Assurance Desk Officer, Department of Nursing Services
- Representative from the Christian Health Association of Malawi (headquarters)
- Registrar from each regulatory body (Nurses and Midwives Council; Medical Council; Pharmacy, Medicines and Poisons Board)
- Community representative (in this case, the director of the Consumers Association of Malawi)
- Representatives of the external technical assistance organizations that support quality improvement/assurance efforts in the country (in this case, JHPIEGO and Management Sciences for Health)

TEAMS OF SBM-R COACHES/FACILITATORS

The SBM-R coaches are the persons who will facilitate the improvement process at the institutional, facility and community levels. They fulfill the role of change agents who facilitate individual and organizational learning. The coaches should be very knowledgeable about the SBM-R process and the reality of the health facilities and the communities they serve.

The coaches provide support for the following main activities:

- Information on and promotion of the SBM-R approach at the local/facility or community level
- Agreements on SBM-R implementation at the local, facility and community levels
- Baseline assessments
- Identification of performance gaps, cause analysis and identification of interventions
- Development of operational action plans and their implementation at the local level
- Mobilization of specialized support from the technical advisors in the different areas (clinical, managerial, community mobilization and communications)
- Mobilization of material and financial resources
- Monitoring of progress through periodic internal assessments
- Promotion and coordination of client and community mobilization and participation
- Recognition process

The team of coaches can be composed of:

- Providers from health facilities
- Local/district/regional managers and supervisors
- Community mobilization facilitators

The coaches should be formally appointed by the corresponding institutional authority to enable them to incorporate their roles as coaches into their formal duties. The number of coaches per region/district, facility and community will vary according to the scope of the SBM-R program, the size of the facilities and communities where it is being implemented, and the level of facilitation

envisioned for the initiative. For more intensely facilitated efforts, it will be desirable to count on having two to four coaches for each large facility (hospitals) or local network of primary care facilities. For the less facilitated processes, two coaches per ministry of health district or per NGO should be sufficient.

Selection: The coaches are the change agents for the SBM-R process and should have personal characteristics and skills such as leadership, motivation, credibility, good interpersonal communication skills, knowledge about the local reality (facility and/or community), team work and the like.

Orientation/training: The training process for the coaches is hands-on and very focused on the steps and activities necessary for SBM-R implementation at the local level. The training is organized in three short modules according to the specific activities/tasks that the coaches are expected to perform during each phase of the SBM-R implementation process. The focus of this modular training is on enabling coaches to spearhead and manage the change process for SBM-R. Content covered during the modules includes: basic concepts of quality and performance, the SBM-R approach, utilization of the tool for conducting performance assessments, gap identification, techniques for cause analysis, design of interventions, change management strategies, resource mobilization, team building, team work, networking, benchmarking, and client and community involvement and participation.

Table 13 shows the steps and activities of SBM-R covered in the training modules for the coaches:

Table 13. Steps in the SBM-R Process and the Activities and Modules That Address Them

STEPS	ACTIVITIES	MODULES	DURATION
Promotion of/agreement on the SBM-R initiative	Information about objectives and methodology of the SBM-R initiative Agreement on implementation	Module 1: preparation and beginning of the process	3–4 days
Measurement of actual performance	Baseline assessment, summary of results, feedback		
Cause analysis	Cause analysis meetings	Module 2: strengthening of the process	2–3 days
Intervention identification	Development of the action plan		
Intervention implementation and monitoring	Resource mobilization Benchmarking Coordination with technical advisors Monitoring and feedback		
Verification	Verification assessment	Module 3: reinforcing and institutionalizing of the process	2–3 days
Recognition	Coordination of recognition		

In general, the modules should be used 3–4 months apart to allow time for facilities to implement changes and measure progress.

For additional information on the training modules for coaches (schedule, objectives, presentations, exercises), see the CD-ROM that accompanies this field guide.

TECHNICAL ADVISORS

The technical advisors are the subject-matter experts in the different types of direct services and support functions who provide specialized guidance and assistance, including training in their specialty areas (clinical, managerial, community mobilization, communications, etc.).

The typical functions of the technical advisors are:

- Training activities and facilitation of learning processes using different methodologies (group-based, on-the-job, etc.)
- On-site or distance technical assistance and support
- Followup to ensure transfer of learning

The members of the technical advisor teams include experts in relevant areas of the SBM-R process being implemented. These areas might be:

- Clinical areas such as reproductive health, maternal and child health, HIV/AIDS, and infection prevention and control
- Management systems
- Communications and mass media
- Community mobilization

The number of technical advisors necessary will vary according to the characteristics of the SBM-R initiative: technical areas covered, level of development needed for the support systems, level of community involvement, etc. For the most intensely facilitated processes, technical advisors may be needed/assigned for a given number of facilities. For the initiatives that require less effort and less facilitation, it may be sufficient to elaborate an inventory of technical resources potentially available on demand in the different areas of expertise and make it available to the facilities.

Selection: The SBM-R process requires specific technical expertise in areas of service delivery and community involvement, which makes the technical experts a crucial resource in this process. It will be important to build these resources upon existing capacity and expertise. The first step will be to identify the technical resources available for each area (clinical, management, community mobilization, communications) as well as their experience providing technical assistance, including training. These experts can exists within the ministry of health or in NGOs, universities or private institutions. It is desirable to select technical advisors from different regions of the country where the SBM-R initiative will be implemented.

Orientation/training: The strategies for orientation and training of the technical advisors vary greatly. Some countries may have excellent technical resources; others may need to develop them, particularly when the SBM-R initiative includes new technical content or new evidence in a given area (e.g., prevention of mother-to-child transmission of HIV). Sometimes the technical advisors will have good training skills but will need technical updates or skills standardization. In other cases, the technical advisors have excellent technical knowledge but do not posses training or mentoring skills. **Table 14** gives examples of orientation and training activities according to specific needs.

Table 14. Orientation and Training Activities for Technical Advisors

SITUATION	ORIENTATION AND TRAINING NEEDS	TRAINING ACTIVITIES	ESTIMATED TIME
Technical advisors proficient in content but not in training/ mentoring skills	Training skills SBM-R approach, tools and methodology	Orientation to the SBM-R approach, tools and methodology Training skills course	1–2 weeks for the training skills course
Excellent trainers but not up-to-date in content	Technical content SBM-R approach, tools and methodology	Orientation to the SBM-R approach, tools and methodology Content update/course	Variable, depending on the technical content area
No local technical capacity	Technical content Training skills SBM-R approach, tools and methodology	Orientation to the SBM-R approach, tools and methodology Content training Training skills course	Variable, depending on the technical content area 1–2 weeks for the training skills course

Several learning/training methodologies can be used to train, orient or refresh the technical advisors. They can include group-based courses, structured or semi-structured on-the-job training, and distance learning education via the Internet, e-mail, videotapes and CD-ROMs. The outcome of these efforts should be strengthened technical capacity to support the implementation of the SBM-R initiative.

Some technical advisors can also be coaches and vice versa. This overlap often increases the efficiency in the use of resources and ensures a more integrated perspective of the SBM-R process.

VERIFICATION TEAM

The verification team assesses facilities' compliance with performance standards for recognition purposes. The team performs this verification by means of external assessments at the request of the facilities. Assessment of the facility by an external team confers credibility to the recognition process.

photo by: Débora Bossemeyer

SBM-R coaches in Malawi

The functions of the verification team are:

- Coordination and preparation of the verification visits with the facilities and SBM-R coordinating body and coaches
- Implementation of the verification assessment
- Recommendation on recognition for the facilities that achieved the required level of performance
- Provision of feedback to the facilities on the results

The members of the verification team usually come from:

- Central/regional/district level of the ministry of health
- Management level of NGOs or private organizations

- Community representatives
- Professional associations
- Universities
- Women's groups and health consumers' advocacy groups

The specific characteristics of the members of this team will vary according to the type of verification/recognition process being implemented, but in general the team should be multidisciplinary and include representatives of the community.

Selection: The main objectives of the verification assessment are to confer credibility to the recognition process and to enhance motivation at the local level. For this reason, the members of the verification team should be carefully selected. Ideally, the individuals chosen should be well-known and have authority within their organization and/or technical expertise relevant to the various components of the SBM-R initiative. Usually the coordinating body will identify and invite these individuals to form the verification team. It is important to clarify to the team members their roles and responsibilities in this process. In general, when the SBM-R initiative has a national scope or has been expanded to several regions/districts, this team will need to be expanded or decentralized.

Orientation/training: The objective of this training is to enable the verification teams to prepare and conduct the verification assessments at the facility level and to make the recommendation on recognition for the facilities that reach the pre-determined standards. This goal is usually achieved through a 2-day workshop covering the SBM-R approach and specific characteristics of the model being implemented, performance assessment tool, assessment methodologies, and requirements and procedures for recognition. The methodology used during this training should be highly participatory and hands-on.

MANAGING THE CHANGE PROCESS

The SBM-R implementation process at the facility level comprises three main phases, each with its own challenges that require the accomplishment of some tasks and activities:

- **Preparation and initiation:** The key objective in the first phase is to **create awareness** about the current situation of the health services and the need for improvement. During this phase, the implementers develop a common vision for the process, ensure stakeholders' involvement, create an initial infrastructure, and begin the work at the facility level. The facilities interested in participating in the process should reach an agreement on their participation and begin by assessing the initial magnitude and characteristics of their gaps in performance. Typical activities at this stage are: development of the performance standards, creation of the coordinating body, initial training of the teams of coaches and technical advisors, promotion of the initiative at the local and facility levels, implementation of a baseline assessment and discussion of its results with the facility.

- **Strengthening:** In this phase, the principal objective is to **build momentum** for change. Here, it is essential to begin concrete improvements, show some initial tangible results, create and strengthen teams and networks of committed implementers, and develop a feedback system. The characteristic activities of this phase are the development and implementation of practical operational plans, organization of improvement teams by areas, initial mobilization of resources, measurement of progress through monitoring assessments and implementation of benchmarking activities among networks of facilities.

- **Reinforcement:** The main objective of this phase is to **consolidate** the changes and the improvement process. To achieve this consolidation, it is necessary to increase and expand the improvements in performance and quality to a meaningful level, institutionalize the SBM-R process, expand the role of clients, community, and other constituencies, and reward and disseminate the achievements. In this phase, the activities that are usually conducted are efforts focused on the persistent or more complex gaps, mobilization of additional technical and financial resources, incorporation of the successful improvements into the organizational systems, increased communication and community mobilization activities, and implementation of the recognition process.

These phases occur over a period that varies according to the characteristics of the local and health context and of the SBM-R initiative. Experience implementing SBM-R processes shows that the simplest and most straightforward initiatives can take approximately 1–2 years to go through these three phases, while the more complex ones could take 3–4 years.

During these three phases, SBM-R becomes a vehicle that triggers and develops an individual and organizational learning process. Individuals are encouraged and helped to adopt new behaviors (best practices) and dynamic roles, and organizational systems are streamlined and adapted to support these new behaviors and achieve results.

PREPARATION AND INITIATION

As mentioned above, the main tasks of this phase are:

- Achieve a common vision for the process
- Ensure stakeholders' involvement
- Create an initial facilitation infrastructure
- Promote the SBM-R initiative at the local and facility levels
- Assess the initial magnitude and characteristics of gaps in performance

Achieving a common vision

The vision is the unifying image of what we want to achieve, the force that will pull everybody toward achievement of the common goal. Building a shared vision is critical because it gives direction to and aligns the different members and components of an organization toward the same goal. Frequently, however, organizations adopt nice vision statements that are neither very concrete nor effectively communicated to employees. In SBM-R, the vision is expressed in concrete terms at two levels: the profile of the SBM-R initiative and the performance standards that must be achieved. In "Defining the SBM-R Initiative" (see page 29), we discussed how to develop the first part of our vision: the specific SBM-R profile. This profile tells us what type of SBM-R model we want to create.

This section discusses the activities that must be carried out in order to develop performance standards that represent the level of performance and quality that is desired. Expressing the vision in concrete performance standards is a very effective way of making it understandable and disseminating it throughout the organization to be used as guidance by every health worker.

The performance standards are based on three main inputs:

- National and/or international scientific information on the technical areas of service delivery that are to be improved (service delivery guidelines, norms and protocols), to ensure that the performance standards are based on sound and updated evidence.

- Provider inputs, to make sure that the performance standards are applicable and feasible at the facility level.

- Client inputs, to know clients' perceptions and incorporate their preferences, which can affect service utilization.

To develop the performance standards, these inputs have to be combined in a balanced way. **Table 15** shows some preparatory activities to accomplish this task, and **Table 16** suggests some activities to be carried out around the development of standards.

Preparatory activities: The purpose of these activities is to update key staff on the evidence-based information in the selected technical areas, map out the core and support processes that will be included in the assessment tool containing the performance standards, collect all of the necessary background information and reference materials required, and develop a draft assessment tool for review by local stakeholders.

Table 15. Preparatory Activities prior to Development of Standards

WHAT TO DO?	WHO WILL PARTICIPATE?	WHAT WILL THE RESULT BE?	HOW LONG WILL IT TAKE?
Technical update workshop (on the areas that will be improved)	One or two trainers, experts on the technical content area(s) Technical officers and selected program managers and providers who will participate in the elaboration of the performance standards; the number of participants will vary according to content area	Core group of technical officers, health care managers and providers updated in the areas that will be included in the performance standards	Two days to 2 weeks; it will vary according to the content area to be covered
One or more coordination meetings to map out the selected core and support processes of service delivery that will be included in the assessment tool and select the supporting technical reference materials	Technical and managerial staff from the ministry of health (MOH), NGO and/or private organization involved in the SBM-R process SBM-R technical advisors	Detailed map of core and support processes of service delivery to be included in the tool Selection of reference materials (national and/or international norms and technical guidelines)	One or more half-day meetings
Development of a first draft of the performance standards assessment tool	Technical and managerial staff from the MOH, NGO and/or private organization involved in the SBM-R process SBM-R technical advisors	First draft of the performance assessment tool (including performance standards and verification criteria)	Varies according to the complexity of the services, experience of the advisors and availability of reference materials Few days to several weeks

The technical update is a key preparatory activity for facilitating an objective review of the draft assessment tool, based on scientific evidence.

Standards development: After the first draft of the operational standards is ready, it has to be reviewed and field-tested before development of a final version. Some of the suggested activities are in the table below.

Table 16. Activities for Developing the Standards

WHAT TO DO?	WHO WILL PARTICIPATE?	WHAT WILL THE RESULT BE?	HOW LONG WILL IT TAKE?
Standards development workshop	MOH, NGO or private organization central/provincial-level technical officers and program managers; selected frontline health care providers and managers; client or community representatives (client feedback should also be obtained through other mechanisms: formative research, interviews, focus groups, etc.) Technical advisors to facilitate the process (no more than 30 people)	Revised draft of the performance assessment tool containing the performance standards and verification criteria to be field-tested	3–5 days
Field-test of the performance assessment tool in selected facilities to check: ■ Format ■ Flow ■ Objectivity ■ Timing ■ Feasibility ■ Practicability	Same as above (it is suggested that a smaller group—five to 10 people—conduct this task)	Performance assessment tool field-tested	5–15 days
Finalization of the performance assessment tool: incorporation of the inputs from the field-test and final editing and formatting	MOH (central, provincial or district level), NGO and/or private health organization technical and managerial representatives	Final draft to be submitted for approval by the MOH, NGO and/or private health organization	5–15 days
Approval of the performance assessment tool	Authorized level of MOH, NGO and/or private health organization	Performance assessment tool formally approved by the MOH, NGO and/or private health organization	Varies, from 2 to several weeks

During the development of the performance standards:

- Involve the relevant stakeholders from the beginning, and keep them informed.
- Select the right participants for the standards development workshop.
- Technically update/standardize the group of participants before the performance standards development workshop to facilitate the evidenced-based review of the standards.
- Prepare a sound "first draft" of the operational performance standards, but be flexible to make changes. It is important to listen to the frontline providers and managers, as they know their workplace and most of the time have valuable suggestions and information.

- Obtain formal approval of the performance standards to increase "authority and credibility" of the assessment tool and the process.

Involving stakeholders

Stakeholders are the individuals or groups of individuals who are likely to be affected (or believe they will be affected), either positively or negatively, by the changes being promoted. The stakeholders will react to the initiative, favoring or opposing it, based on their perceptions of its impact on their interests. The attitude of stakeholders toward the SBM-R initiative can be critical to its success at every stage of the process. That is why it is essential to carefully manage the relationship with these groups and individuals during the whole initiative.

There are two basic types of stakeholders:

Primary stakeholders: those who are directly involved in the processes being changed or improved.

Secondary stakeholders: those indirectly involved in the processes undergoing change.

The primary stakeholders in an SBM-R initiative will typically be: health care providers, facility managers, health administrators and policymakers, and clients. Examples of secondary stakeholders are: professional organizations, universities, civil society organizations (consumers' rights organizations, advocacy groups, etc.), religious organizations, and social and political organizations. Primary stakeholders are more likely to exert greater influence on the process, although sometimes the involvement of secondary stakeholders can take on major relevance.

Each category of stakeholders has distinctive types of interests. (See **Table 17** for examples of stakeholders' interests and **Figure 10** for a matrix to classify stakeholders' levels of interest.) The first task is to take the following steps to learn as much as possible about these interests:

- Identify all main stakeholders (primary and secondary).
- Specify the nature of their interests.
- Assess their level of interest in the initiative.
- Assess the strength of the stakeholders and their potential impact on the project.

Table 17. Examples of Stakeholders' Interests

STAKEHOLDERS	TYPE OF INTEREST
Health care providers	▪ Economic interests ▪ Social and psychological rewards ▪ Freedom from arbitrary decisions ▪ Working conditions ▪ Personal and professional growth and opportunities
Health care managers	▪ Cost of services ▪ Results ▪ Productivity ▪ Personal and professional growth and opportunities ▪ Support from senior management/political level
Clients	▪ Effectiveness and quality of services ▪ Quality assurance ▪ Friendly environment ▪ Technical information on services ▪ Cost of care

Once there is a clear understanding of the stakeholders' interests, we have to manage the situation to obtain their support and work jointly toward common goals, keeping in mind that the stakeholders may have different interests than ours but that they are not our enemies. In managing the relationship with stakeholders, we should try to:

- Start by building upon the support of those who are already in favor of the initiative.
- Neutralize those who are against, incorporating their points of view or negotiating with them.
- Maintain constant contact and communication.
- Monitor carefully the relationships with stakeholders who have more potential influence.

Figure 10. Determining Stakeholders' Level of Interest in the SBM-R Initiative

	In Favor	Against
Very Interested		
Not Very Interested		

Some key points in the process for stakeholder involvement are:

- Design of the SBM-R initiative
- Assembling of the coordinating body
- Development of the performance standards
- Definition of the facilitation infrastructure
- Identification of recognition mechanisms
- Mobilization of resources
- Decisions on institutionalization of the SBM-R initiative

Periodic meetings with key stakeholders should be held to keep them informed about the progress of the initiative, review any potential issues or new developments, and mobilize their support. How often these meetings are held will vary according to the characteristics of the SBM-R initiative and

the stakeholders but, in general, there should be no less than two or three general progress review meetings per year.

During the meetings with stakeholders, it is important to reach specific and concrete agreements on different aspects of the initiative. These agreements could be less or more formal, depending on the issue being addressed. The more relevant the issue is for the SBM-R initiative, the more formal the agreement should be. Most often, the agreements reached in these meetings are based on the voluntary concurrence of stakeholders with the decision being made. In some occasions, however, it may be appropriate to use the influence of some level of formal authority to enforce the agreements. **Figure 11** shows the types of agreements with stakeholders that may exist.

Figure 11. Determining Types of Agreements with Stakeholders in the SBM-R Initiative

	Voluntary	Enforced
Formal	Written Agreement	Written Order
Informal	Verbal Agreement	Verbal Order

Creating an initial infrastructure

The support entities that have to be created or developed at this stage are the SBM-R coordinating body, the technical advisors and the teams of coaches. It is important to ensure that enough technical advisors, proficient in the relevant subject matter area and in training and mentoring skills, are available from the beginning of the process to provide support to the participating facilities.

Training of the teams of coaches begins at this stage with implementation of the first training module. This module provides the teams with the skills necessary to support the activities of the preparation and initiation phase. (For details on the organization of the coordinating body and development of technical advisors and coaches, see "Facilitating SBM-R" on page 33.)

Promoting the SBM-R initiative at the local and facility levels

Participation in SBM-R should be voluntary and, therefore, each health facility must make a decision about its participation in the process. The coaches have to provide information to the health districts/provinces, NGOs and facilities, as appropriate, on the objectives, methodology, tools, activities, advantages, challenges and commitments for the SBM-R process. For this purpose, the coaches should organize meetings at the appropriate level (health districts, NGOs or facilities). After receiving the information, each district/NGO and facility should make a decision about its participation in the SBM-R process and formally notify (e.g., in a letter of agreement) the coaches and/or coordinating body of their decision, including the names of the contact person(s) for the initiative for coordination and communication purposes.

Table 18 shows a guide and list of participants used by trained coaches to conduct promotional meetings at the hospital level for an SBM-R infection prevention initiative in Malawi.

Table 18. Coaches' Guide and Participant List for Infection Prevention Initiative in Malawi

GUIDE FOR THE MEETING	LIST OF PARTICIPANTS INVITED
▪ Greetings and introductions ▪ Why infection prevention is important and the benefits of improving these practices (e.g., protect health care workers, clients and environment, decrease health care facility-acquired infections, increase efficiency, decrease length of hospitalization, decrease costs) ▪ Summary of the SBM-R process (including steps, advantages, requirements, etc.) ▪ Assessment tool ▪ Baseline and next steps ▪ How the infection prevention committees and teams will be organized ▪ Support required and commitment from the administration	Hospital director Hospital administrator Heads of departments Chief nurse

Assessing the gaps in performance

The initial identification of performance gaps requires a baseline assessment. In most cases, for the facility's first assessment, trained coaches should actively support the facility teams in conducting it. In some cases, however, the baseline assessment can be totally self-implemented by the facility's following the instructions on how to conduct it that are included in the assessment tool.

The facility team should adequately plan and prepare the baseline assessment, making sure that:

- The assessment team has sufficient information about the health facility (e.g., hours of operation, client flow).
- The dates of the assessment have been communicated to facility managers and providers.
- Facility managers and workers have been informed about what is included in the baseline.
- Staff members for each area to be assessed have been identified (e.g., laboratory, antenatal clinic, laundry).
- Responsibilities have been clearly defined within the assessment team.
- The necessary materials are available, including copies of the assessment tool, pencils and erasers.
- Procedures and routines of the facility will be respected (e.g., schedules, dress code).
- The privacy of patients will be respected and the assessment team will not interfere with the services provided to the public.

It is important that the assessors have familiarized themselves with the assessment tool in advance of the baseline assessment. Some types of services will require that persons with expertise in specific areas (e.g.; labor and delivery, counseling and testing for HIV) participate on the assessment team.

The team that conducts the baseline assessment must get together to review and score the results as soon as the assessment is completed. (See **Table 19** for a sample of a summary form for scoring achievement of performance standards.)

Scoring the results of a baseline assessment

To fill out the summary form:

- Write the number of performance standards achieved per area and in total.
- Calculate and write the percentage of performance standards achieved per area and in total.

Table 19. Sample Summary Form for Voluntary Counseling and Testing (VCT) Services

AREAS	TOTAL OF PS BY AREA	PERFORMANCE STANDARDS ACHIEVED	
		Number	Percentage
Pretest/group education for HIV/AIDS and VCT	6	2	33
Pre-test one-on-one counseling	7	3	43
HIV testing	9	4	44
Post-test one-on-one counseling	12	2	17
Support systems for VCT	11	4	36
Total	**45**	**15**	**33**

After the assessment tool is reviewed and scored and the forms are filled out, the assessment team will prepare for the feedback meeting to share the baseline results with key facility managers and staff (e.g., facility director, department chiefs, administrator). If necessary, technical advisors should also take part in the feedback meeting. It is very important to set a date for the feedback as soon as possible to capitalize on the expectations generated among facility workers by the baseline assessment. During the meeting, areas of strength and performance gaps should be identified. The idea is to use these results as the basis for implementing changes and improvements.

The duration of the baseline assessment will vary according to the services being assessed, but it should usually be completed in 1–2 days.

WHAT TO DO DURING THE FEEDBACK MEETING

During the feedback meeting, the assessment team should:

- Give their own impressions and not those of others.
- Respect the self-esteem of the facility staff members.
- Provide a copy of the assessment tool with the results and the summary report.
- Present the baseline results to the facility staff in total and by area.
- Be specific and descriptive.
- Always begin with the positive aspects, and congratulate the facility on the areas in which it is performing satisfactorily.
- Present the performance gaps by area.
- Suggest that the facility could begin improvements by addressing relatively simple gaps.
- Inform the staff that support will be provided to address the more complex gaps.
- Be interactive and solicit the suggestions and opinions of the staff members.

STRENGTHENING

In this second phase, the main tasks are:

- Begin improvements and show initial tangible results.
- Create/strengthen teams and networks of committed implementers.
- Develop a feedback system.

Beginning improvements and achieving initial results

One of the most important factors that favor change is the achievement of positive results for the facility. When managers, decision-makers and other stakeholders, including clients and the community, see results, they are more likely to support change initiatives. That is why SBM-R focuses on the achievement of results from the onset of the process. Coaches orient local teams to examine the gaps from the baseline assessment and divide the gaps into three broad categories:

- Gaps that do not require significant cause analysis because the solution is obvious and simple (e.g., designation of a person in charge of a task, minor purchases to replace broken pieces of equipment, minor relocation of supplies and equipment to make them more available at point of use).

- Gaps that are likely to be caused by factors that are under local/facility control and could be eliminated with the mobilization of local resources (e.g., modification of some internal procedures, redistribution of workload within the facility, internal reallocation of resources, some types of training, implementation of some types of incentives).

- Gaps that are likely to be caused by factors that are outside local/facility control and usually require the mobilization of significant external resources (e.g., changes in policies, salary increases, increases in the number of staff, provision of additional budgets, physical plant remodeling/construction).

Managers and providers are encouraged to make immediate changes beginning with the simplest things and with the causes under local control—the **"low hanging fruit."** The emphasis at this initial moment is put on action rather than in-depth analysis. Rapid interventions produce quick results that attract the attention of managers and increase the motivation of implementers of the change process.

Another benefit of rapid interventions is that they allow the gradual development of the change management skills of local health workers. The workers become gradually acquainted with the multiple connections of service delivery and managerial processes and are more able to manage them in favor of change. Also, implementing relatively simple changes and achieving observable results increases the level of confidence of local staff members.

In summary, rapid interventions:

- Produce immediate results
- Produce a sense of empowerment
- Create momentum for change
- Increase change management skills

Usually, after having some experience with implementing changes based on rapid interventions and the solution of causes under local control, the improvement teams are able to deal more effectively

with more complex or root causes that require more careful cause analysis and the provision of external support.

Strengthening teams and networks of committed implementers

To implement the interventions, teams of health workers should be organized at the facility level and by unit/service as appropriate. To create and expand the teams, implementers should:

- Identify champions. In almost every facility, there are individuals who are able to understand the benefits of the proposed improvements sooner that the rest of their colleagues. Known as the early adopters of innovations, they usually are capable, highly self-motivated individuals who command the respect of their colleagues and coworkers. These champions should be the leaders and the backbone of the SBM-R improvement teams in the facilities.

- Expand implementation teams with committed people. In addition to the champions, the teams should expand to incorporate other workers who are open to change, willing to collaborate, and able to assume responsibilities and commitments. They are essential for planning, coordinating and conducting the activities required by the process.

A useful way of organizing the facility teams is to have one central SBM-R improvement team as well as teams from each area addressed by the assessment tool. The central team will have the overall coordinating responsibility for the initiative and the area teams will be in charge of coordinating and implementing the improvements in each area. Building teams around the areas of the assessment tool (e.g., for infection prevention: labor and delivery, laundry, operating room, antenatal care, etc.) helps to clarify the responsibilities, strengthens teamwork and promotes a healthy competition among the areas in the same facility. Community members also can be included in the facility teams if appropriate. Often, community members can act as good advocates and help the local teams in mobilizing resources from the community. (See **Table 20** for a sample matrix for organizing teams for essential obstetric care.)

Table 20. Matrix for Organizing Teams for Essential Obstetric Care

	COORDINATOR	MEMBER	MEMBER
Pregnancy complications			
Labor, delivery, postpartum and newborn care			
Support services			
Information, education and communication			
Human, physical and material resources			
Management systems			

The basic tool for organizing the work of each team is the operational plan. Based on the results of the assessment, each area team should prepare a simple operational action plan outlining what gaps/causes they want to correct, what will be the intervention, who is responsible, what resources are needed, and what are the starting date and the deadline. Deadlines and assignment of responsibilities are particularly important for promoting action. The identification of potential resources needed is useful to guide resource mobilization efforts to make things happen.

The operational plan should be reviewed periodically to check completion of tasks and add new ones. It is recommended that a monitoring meeting to check the progress made on the action plan take place every month, and a broader revision of the plan every 3–4 months. (See **Table 8** on page 22 for a sample operational plan form.)

At the same time that work is under way at the facility level, it is important to develop networks of facilities undergoing the same improvement process. Networks are important mechanisms for mutual support and are a very efficient vehicle for the open exchange of experiences and best practices through lateral, non-hierarchical communication.

Developing a feedback system

Once implementation of the operational plans begins and improvements start to happen, it is important to periodically check on progress toward achievement of the performance standards. This information is useful for those persons directly implementing the improvement activities and also for the stakeholders in the process.

The progress of the process becomes evident through the different types of assessments conducted using the assessment tool. As mentioned above, the self-assessments by providers, peer assessments among colleagues, internal monitoring, facilitative supervision, external verification assessments, and the inputs from clients and communities constitute a multidimensional feedback system that creates multiple sources of support and control for the process.

It is important to encourage managers and providers at the facility level to periodically and systematically carry out these types of assessments. Their results, particularly those from the internal monitoring, facilitative supervision, external assessments, and client and community inputs, should be disseminated, as appropriate, among the implementers of the process and the key stakeholders. For this purpose, it will be important to develop effective communication mechanisms inside and outside the facility, including periodic meetings and written and oral channels. (See "The Role of Communication," page 61, for more information on this topic.)

Some of the challenges of self- and facility internal assessments are related to their credibility. Particularly at the beginning of the process, the staff of the facility may not have been completely familiarized with the assessment tool and the data collection or scoring methodologies, which may introduce inaccuracies in the initial measurements. Additionally, in punitive environments, facility staff may be tempted to falsely inflate their scores. Experience shows, nevertheless, that health workers gradually come to understand the importance of having valid information to guide the improvement process in their facilities. The creation of a more open environment and the existence of other non-hierarchical sources of control of the process help in this regard.

In addition to these mechanisms, the exchange of best practices, or benchmarking, among networks of facilities is another very effective strategy for feedback and support. From the change management point of view, implementing benchmarking has several important advantages. Benchmarking:

- Is an effective "wake-up call" and helps to make a strong case for change.
- Provides a more efficient way of designing and implementing solutions to performance gaps. Often, successful solutions developed in one facility take into account local conditions and can be more easily adapted to others with similar characteristics.
- Has an important motivating effect. It reinforces the morale of staff who share successful experiences and fosters the improvement process in their facilities. Benchmarking also facilitates the task of those who learn from another experience and provides them with a role model and a goal to reach for and surpass.
- Creates and reinforces networks of collaboration and promotes a culture that is receptive to fresh approaches and ideas.
- Reinforces the process of learning through mutual teaching and exchange of experiences.

- Creates an additional source of support and control for the improvement process from colleagues and peers.

Table 21 (see page 55) gives examples of results from several internal monitoring assessments. Such results can be used to conduct benchmarking activities. Facilities with a low score in one area can look for other facilities with outstanding scores in the same area, and try to find out if there are lessons that they can adapt. Facilities can exchange information on their progress and achievements during meetings (such as the training modules for coaches or specially organized periodic meetings) or through written or electronic communication.

Based on the information shared, facilities can organize benchmarking visits to learn about improvements made in other places. To take full advantage of these visits, facilities should follow some recommended steps:

- Identify the subject area to be reviewed and the gap to be closed.
- Identify the "best practices" potential partners.
- Contact the partners.
- Select a "benchmarking team" (appropriate persons familiar with the subject area).
- Prepare for the benchmarking visit (information to be gathered, logistics of the visit).
- Conduct the benchmarking visit.
- Analyze the findings from the visit and make recommendations.
- Implement the recommendations and monitor their outcomes.

REINFORCEMENT

The principal tasks at this stage are:

- Increase and expand the improvements in performance and quality to a meaningful level.
- Institutionalize the SBM-R process.
- Expand the role of clients, the community and other constituencies.
- Reward and publicize the achievements.

Reaching improvement goals

At the reinforcement stage, the simplest and less complex performance gaps have usually been addressed and solved. Most likely, facilities have achieved 60 percent or more of the performance standards. To reach a significant level of quality, however, it is usually necessary to reach at least 80 percent of the standards. Reaching the following step in quality now requires some different types of actions:

- Refocus on selected persistent gaps. At the beginning of the process, the recommendation was to begin with the gaps of less resistance without putting the gaps in order of priority. At this stage, it is important to concentrate the energies of the team on those resistant gaps that are not showing improvement and have a greater impact on achievement of the standards.

- Perform more in-depth analysis of the causes of the gaps. The improvement teams that typically have gained substantial experience promoting and implementing changes in the facility must now devote more attention to analyzing the causes of the persistent gaps to try to find their root causes. This task will often require an expanded team effort to incorporate the experience and opinions of more health workers. More carefully planned meetings and a more systematic analysis of information will also be necessary.

- Set clear improvement targets. At the beginning of the process, the most important consideration was to take advantage of every opportunity to make improvements. At this stage, clear targets must be set, specifying which gaps need to be reduced or closed and in what timeframe.

- Mobilize additional technical and financial resources. The more in-depth analysis of the causes of the gaps and identification of appropriate interventions may require support from specialized technical resources from outside the facility. The improvement teams, with the support of the coaches, must be ready to mobilize such support. Likewise, additional financial resources may be needed, and redoubled efforts to creatively mobilize them, from different potential sources, must be made.

Institutionalizing SBM-R

The interventions needed to close the more complex gaps are usually those that address systemic factors. It is likely that, at this stage, the improvement teams will be dealing with root causes rather than symptoms or apparent causes. The interventions implemented in this phase are typically related to changes in institutional policies that go beyond the boundaries of the facilities to the district/provincial and even national levels. These interventions fall in the areas of broader organizational systems such as human resources management (including staff definition and allocation, or salary and incentives policies), budget allocations, remodeling/construction of the physical plant, service delivery policies and others.

Changing broader organizational systems is difficult, but it is usually essential to close the more complex gaps. Success in fulfilling this task is more likely if we have strengthened our influence by building enough momentum for change and have taken the following actions:

- Obtained visible results of the improvement process. This is important because upper level managers and policymakers will be able to visualize the advantages of the improvement process for the organization as a whole and will be more inclined to provide support to the initiative. The effect of positive results is even greater if it was obtained through the mobilization of local resources, because managers and policymakers will see that not all the responsibility for supporting the process is being put on their shoulders.

- Generated public opinion in favor of the changes made. The resistance of upper level managers and policymakers to broader, systemic changes will be weaker if we have been able to generate support from different constituencies involved in the initiative such as providers, clients, local managers and community leaders, and consumer rights, professional and other civil society organizations. The support from these constituencies can be expressed in different types of advocacy activities in favor of the proposed changes.

- Clearly defined the changes desired. When pursuing systemic change, it is very important to be as specific as possible, clearly defining the limits of the proposals in order to avoid making managers and policymakers feel overwhelmed and afraid of the consequences of the changes. In this regard, it is useful, whenever possible, to have an approximate idea of the potential costs of the proposals, thereby avoiding unrealistic requests.

Another important aspect of implementing changes at the broader institutional level is that it helps to make the improvements less reversible. At this stage, we want to make the positive changes as permanent as possible.

Table 21. Example of Measuring Progress (table showing the percentage of standards achieved in seven hospitals in Malawi)

AREAS	CHIKWAWA DH			ST. JOHN'S H			LCH			MZUZU CH			QECH			ZOMBA CH			LIKUNI H		
	Base	Int	Ext	Base	Int	Ext	Base	Int	Ext	Base	Int	Ext	Base	Int	Ext	Base	Int	Ext	Base	Int	Ext
CSSD and OR	8.3	59.2	58.3	37.5	83.0	83.3	4.2	73.0	83.3	37.5	39.0	83.3	12.5	64.9	83.3	29.1	54.0	41.6	31.8	62.0	81.8
Operating Theatre			54.5			90.9			68.8			95.8			81.8			22.7			90.9
Isolation Systems	0.0	9.1	10.0	0.0	63.0	90.0	0.0	18.2	10.0	0.0	27.3	60.0	0.0	45.4	40.0	0.0	27.0	20.0	0.0	36.0	80.0
Labor and Delivery	8.0	55.6	77.7	8.3	72.0	83.3	25.0	44.4	50.0	25.0	39.0	83.3	25.0	61.1	83.3	33.3	83.0	33.3	16.6	66.7	88.8
C, S, M Wards	7.6	34.0	12.9	15.4	84.0	90.9	30.7	56.0	31.8	7.14	63.6	86.0	7.1	61.3	86.3	0.0	41.0	44.7	35.7	61.0	80.0
MCH/FP	0.0	54.5	65.2	18.2	63.0	100	16.6	77.3	62.5	58.3	77.3	100	58.3	81.8	87.0	16.6	68.0	60.8	54.5	40.9	85.7
Dental	0.0	78.5	57.1	13.0	78.0	92.7	20.0	93.0	64.2	20.0	57.0	92.7	20.0	71.4	85.7	0.0	87.0	71.4	20.0	50.0	80.0
Laboratory	8.0	58.8	68.2	25.0	58.0	100	16.6	64.7	36.3	8.0	29.4	80.9	8.0	58.8	86.3	25.0	64.0	27.2	25.0	52.9	81.7
Postmortem	0.0	50.0	83.3	0.0	75.0	83.3	0.0	58.3	50.0	0.0	83.3	91.6	0.0	66.6	83.3	0.0	75.0	66.6	N.O.	66.6	83.3
Administrative	0.0	16.7	12.5	0.0	50.0	87.5	25.0	16.7	12.5	0.0	0.0	85.0	0.0	33.3	87.5	0.0	33.0	25.0	0.0	33.0	100
Patient/Client Education	0.0	0.0	0.00	0.0	50.0	100	0.0	50.0	0.0	25.0	0.0	100	25.0	75.0	100	0.0	50.0	50.0	0.0	0.0	75.0
Food Preparation	14.0	14.3	14.2	0.0	71.0	85.7	14.2	71.4	85.7	28.5	85.7	100	28.5	28.5	85.7	14.2	57.1	71.4	42.8	57.0	85.7
Laundry	16.3	83.3	83.3	16.7	50.0	83.3	83.3	100	83.3	33.3	56.7	100	33.3	66.6	83.3	33.3	67.0	66.6	33.3	83.0	100
Waste Disposal	0.0	40.0	20.0	66.7	80.0	100	25.0	0.0	40.0	0.0	60.0	100	0.0	80.0	60.0	0.0	20.0	40.0	75.0	80.0	80.0
Total	6.6	47.2	46.4	21.7	73.0	90.8	19.3	60.6	48.0	19.1	51.7	88.7	19.1	63.1	83.1	16.6	56.0	43.7	30.0	57.7	89.7

Baseline assessment (March–July 2002) Internal monitoring (May/July 2003) External assessment (June/July/August 2004)

Expanding the role of clients and communities

Achieving quality that is sustainable requires not only decided action and commitment on the provider side; it is also essential to have the informed and proactive participation of the users of health services. There are several ways in which clients and communities can make key contributions to the reinforcement of the changes that are being promoted through the SBM-R process:

- Providing inputs on their perceptions and their preferences on quality
- Advocating for quality improvement
- Participating in and supporting performance and quality improvement activities
- Acting as a source of control for quality

For more details about the role of clients and communities in SBM-R, see "Strengthening Demand and Participation" on page 58.

Recognizing and disseminating the achievements

Another powerful mechanism to reinforce the changes is recognition of the achievements made during the SBM-R process. As described above, recognition can be shown in the form of feedback, social or material recognition, or a combination of these.

photo by: JHPIEGO/Malawi

Recognition ceremony for the hospital staff in Malawi

Central elements of SBM-R are the recognition activities and ceremony that take place when the facilities achieve the pre-set level of quality standards. This ceremony should include the senior leaders of the institution to which the facility belongs (ministry of health, NGO), representatives of the community and the civil society (including local government representatives when appropriate), and the workers and managers of the facility.

photo by: JHPIEGO/Malawi

Presentation of commemorative plaque

During the ceremony, the institutional leadership or the local government typically confers a symbolic award (e.g., a commemorative plaque, diploma) to the facility representatives for the achievement of the standards. This symbolic award could be linked to some type of material rewards for the facility (cash award, additional budgetary allocations or in-kind support such as equipment, supplies or professional development opportunities).

In addition to recognizing the achievements of the facility, one of the basic purposes of a high-profile recognition ceremony is to raise awareness about the desired levels of quality of care among the general public. Clients and communities that are more aware of the higher levels of quality reached by the facility create a pressure to maintain the improvements made. Likewise, the recognition ceremony facilitates the dissemination of the experience among health workers at other facilities that are not yet participating in the performance and quality improvement process. It is easier to raise awareness using appropriate communication strategies, including mass media/press coverage of the ceremony (newspapers, radio and/or television). For more information on how to design and use communication strategies, see "The Role of Communication" on page 61.

The three phases of the SBM-R process—preparation and initiation, strengthening and reinforcement—constitute different stages of a continual learning process for everybody involved (facility workers, clients, communities, coaches, technical advisors, institutional leaders). This collective learning is the condition and the basis for the sustainability and further development of the performance and quality improvement initiative.

photo by: JHPIEGO/Malawi

Infection prevention drama by Mzuzu Central Hospital drama group during a recognition ceremony in Malawi

STRENGTHENING DEMAND AND PARTICIPATION

The informed and proactive participation of the users of health services will be one the most important features of the health systems of this century. Clients and communities can play a key role in defining, promoting, achieving and sustaining the quality of health services. As mentioned above, they can do it by:

- Providing inputs on their perceptions and preferences regarding quality
- Advocating for quality improvement
- Participating in and supporting performance and quality improvement activities
- Acting as source of control for quality

OBTAINING INPUTS FROM THE CLIENTS AND COMMUNITY

Learning about clients' preferences regarding the health care they receive or want to receive is an extremely valuable input for designing and organizing health services. Customized services are more likely to increase client satisfaction and facilitate expanded access to and utilization of facilities.

There are several ways of knowing more about clients' and communities' perceptions and preferences related to health services. One option is to review and analyze existing information, if available. Usually it is possible to obtain information on utilization of health services from national/regional health surveys (e.g., Demographic and Health Surveys). This information is often disaggregated by type of facility and provider, and sometimes the reasons behind clients' choices are also stated. Other sources of information are specific studies, quantitative or qualitative, on particular types of service provision and utilization, such as studies on acceptance and continuation of contraceptive methods, or on utilization of facilities for childbirth.

Sometimes, there is no information available on the types of services that need to be improved and data must be gathered. For this purpose, it is desirable to use relatively quick and affordable methods such as limited-scope surveys or meetings with clients and community representatives. For example, in Malawi, a local NGO conducted a rapid survey of clients' perceptions and preferences related to infection prevention practices in hospitals to obtain information needed for an SBM-R initiative. Actual and potential clients were interviewed at a sample of hospitals in selected regions of the country using a standard questionnaire. Another example is the PROQUALI initiative in Brazil, where the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs (CCP) collected information on clients' preferences regarding reproductive health services using a focus group methodology applied to actual and potential clients of health clinics. In Guatemala, CCP used a video participatory-meeting methodology to facilitate the dialogue with community members on facility utilization for childbirth and preferences for maternal care.

Whichever method is applied, it must incorporate the client and community inputs into the performance standards. For example, from the Malawi survey mentioned above, it was possible to learn that clients were worried about congested, non-ventilated waiting areas in the hospital because of the risk of acquiring diseases; in the PROQUALI experience in Brazil, clients attending reproductive health clinics cared about clean lavatories; in Guatemala, pregnant women strongly

preferred to be accompanied by a relative or traditional birth attendant during their deliveries in a health facility. Incorporating these points of view will help to make the improved services more user-friendly.

ADVOCATING FOR HIGH-QUALITY SERVICES

Clients can play a very important role advocating for better health services. Public opinion, expressed in different ways (direct meetings, written communications, elections, etc.), is a powerful means of influencing key decision-makers and obtaining more support for health care improvement efforts. These efforts often require the allocation of sufficient resources and the adoption of new health policies or the modification of existing ones. This advocacy role is even more important in the context of decentralization of health care. As district or local level governments begin to play a more prominent role in making decisions about health services, this advocacy role becomes more critical to ensuring that services and resources are in line with the clients' and community's needs and rights.

The advocacy role can be played more effectively when clients and the community are knowledgeable about the meaning and characteristics of high-quality services. SBM-R facilitates this process by setting objective and concrete performance standards for health care delivery. Clients and communities that are familiar with the standards can work in partnership with service providers and managers to promote the achievement of these standards. For example, in some municipalities participating in the PROQUALI initiative in Brazil, community representatives actively participated in the periodic monitoring of the facilities using the performance assessment tool. This process allowed them to be aware of the gaps and needs of the facility and prompted them to contact the local governments to obtain the support required. Similarly, in an SBM-R initiative in maternal and neonatal health in Honduras, community representatives participated in the presentation and analysis of the results of periodic hospital monitoring assessments and then worked with facility providers and managers advocating for resources to solve performance gaps.

PARTICIPATING IN HEALTH SERVICES PERFORMANCE AND QUALITY IMPROVEMENT

In addition to advocating for high-quality services, clients and communities can actively participate in the implementation of improvement activities and in the mobilization of resources. This participation can range from individual collaboration with the improvement efforts to a systematic and organized involvement in overseeing and managing the facility. Health communication and education activities (see next section on the "The Role of Communication") facilitate collaboration from clients by providing information. In several hospitals conducting an SBM-R initiative in infection prevention in Malawi, clients and accompanying relatives (guardians) are helping to keep the hospital grounds clean and enforce traffic flow regulations. In some hospitals, volunteers help with the cleaning of the facility on specified days. Clients and relatives can also work in networks and in partnership with providers to improve compliance with treatment.

In other cases, organized communities systematically participate in committees that oversee the organization and operation of health facilities. In these cases, the performance standards used in the SBM-R process help the community representatives to better understand how a service should work using evidence-based standards.

For the more systematic types of community participation, it is useful to follow well-structured methodologies such as the Community Action Cycle, a well-defined and documented step-by-step

approach to mobilizing communities for health and social change. The Community Action Cycle was pioneered by Save the Children under the Health Communication Project (HCP), and has been used in a number of countries including Brazil, Indonesia and Tanzania, as well as several West African countries. The essential steps of this approach are: a) conduct community analysis; b) adapt existing/develop new tools for implementation; c) train community facilitators; d) invite and orient the community; e) assess and prioritize quality issues; f) design an implementation plan; g) monitor implementation; and h) evaluate the program.

More information on this process is contained in the manual *How to Mobilize Communities for Health and Social Change* (Howard-Grabman and Snetro 2003).

FUNCTIONING AS A SOURCE OF CONTROL FOR QUALITY

One of the most critical roles of clients and communities is to participate in ensuring that health services are provided according to quality standards. In order to enable clients and communities to fulfill this role effectively, certain mechanisms must be in place:

- **Information and education activities.** Clients should be informed about the recommended procedures and steps to follow, and about their rights and responsibilities during the provision of health care. This information should be complemented with educational activities aimed to promote positive behaviors and empower clients to better interact with health service providers. Informed and empowered clients become effective partners of providers in ensuring better outcomes of health activities.

- **Feedback channels and procedures.** Another key mechanism to be developed is a feedback system that continually lets providers and clients inform one another about how they are fulfilling their roles in the provision of health care. This system can include mechanisms such as suggestion boxes, exit interviews (oral or written), meetings, newsletters, complaint management systems and others.

- **An accountability system for providers and clients.** An effective control system for quality requires the clear establishment of consequences of performance for both providers and clients. It is important to ensure that these consequences will be applied consistently and fairly and that they will correspond with the magnitude of the good or bad performance.

These mechanisms that enable clients and communities to collaborate in controlling the quality of health care are usually incorporated into the SBM-R performance standards, either in a section related to client/community participation or in other sections such as those on client education and management systems.

THE ROLE OF COMMUNICATION

In the context of SBM-R, communication strategies are used not only to raise awareness of the importance of high-quality health service delivery and generate demand, but also to serve as models and motivators of positive provider, client and community behaviors that support the quality improvement process. Thus, SBM-R communication strategies are designed to have an impact on the behavior of both service providers and users.

Communication effects behavior change on the part of service delivery staff by conveying new norms that reflect the standards the SBM-R program seeks to achieve and by publicly recognizing and rewarding those who achieve them. Communication also has an impact on the behavior of those using services, on a number of levels. Messages can be designed to inform clients and community members of their right to quality and raise their expectation of the services they use. Clients come to understand that receiving high-quality services is their right and they begin to demand a higher level of quality. Communication can be used to demonstrate desired behavior and motivate clients to be more proactive and engaged in their own health, particularly when they consult with a provider.

Additionally, the promotional campaigns for services that achieve the required level of compliance with performance standards let the general population know where one can go for high-quality services. A by-product of this kind of promotion is generation of demand for quality at the local level. Communication activities can ignite interest and exert pressure in increasing demand from clients to improve quality.

THREE MAJOR MODES OF COMMUNICATION

Effective communication strategies use a variety of communication modes to ensure that messages and information about the program reach the widest possible audiences and achieve the desired effect. Traditionally, audiences for SBM-R communication programs include clients, providers, clinic/facility managers, community members, district/local level leaders, media professionals and program managers. Use of different modes is necessary based on the profiles of the different audiences as well as the need to reinforce messages through more than one mode. The modes of communication for these audiences include the following:

Mass media. Mass media are television, radio and newspapers that reach a large, often national, audience. A communication strategy should tap into existing media for best coverage. From the start, the media should be considered important partners in the program. In addition to assisting in the launch of the SBM-R program, media representatives should be contacted throughout the process of the SBM-R program to highlight the program's growth, its achievements and outstanding contributors (both clients and facility-based staff). As for generating uniquely branded SBM-R program materials for the media, a program may want to consider designing promotional television and radio spots. Increasingly, information technology is a viable option for other tools like program websites and e-newsletters that can provide continual updates on the program for different stakeholders.

Print/Video. Print and video materials can reinforce broad messages conveyed via the media as well as provide more detailed information on the SBM-R program. Print and video materials can include such things as written directives from the ministry of health on the goals of the SBM-R program;

brochures and/or posters; videos that support facility level SBM-R implementation activities; and newsletters and reference documents describing implementation roles, standards and processes for awarding recognition. Additional print promotional materials may include items that can be given away to service delivery staff and the public such as key chains, hats, buttons and t-shirts.

Interpersonal communication among individuals and groups. Interpersonal communication involves messages provided one-on-one, such as between a supervisor and a provider or a provider and client, but can also include a speaker addressing a larger audience. Previous experience shows that it is important to have strong, visible leaders who serve as champions for the SBM-R program. Ideally, champions and leaders are present at multiple levels—be it a government figure who can have an impact on the national scene or a district-level supervisor who can orient and motivate providers. Use of visual images, along with personal testimony, is especially effective at portraying the behaviors necessary for high-quality service delivery because most people are persuaded about the advantages of an innovation by the experiences of other individuals like themselves.

While it is not absolutely necessary to implement all of the communication activities described above, it is highly recommended that a combination of these three modes of communication be used to ensure that the SBM-R program is well-known and understood by the general public, clients, service delivery personnel and other key stakeholders.

BRANDING

A critical role of communication in SBM-R programs is the "branding" of quality, in which a distinctive mark that identifies health facilities that deliver high-quality services is created. This is usually done through the use of a quality logo, or seal of approval, that defines the SBM-R program to the public (see **Figure 12**). This symbol of quality is used in SBM-R promotional communication campaigns.

Figure 12. Examples of Quality Logos

PROQUALI logo for the SBM-R initiative in Family Planning/ Reproductive Health in Brazil

Logo for the SBM-R initiative in Infection Prevention in Malawi

To attract public attention to the facilities that have received awards for their achievements in meeting the set standards for quality services, most SBM-R programs organize public ceremonies and invite the media to recognize those facilities and providers. Recipients of the award are given additional promotional materials (e.g., pins, pens, stickers, etc.) to further promote the quality brand.

In Malawi, public and mission hospitals that met at least 80 percent of the standards set forth for quality in infection prevention were publicly awarded with the Ukhondo Ndi Moyo (Infection Prevention is Life) logo by the Minister of Health or a high level Ministry official. In addition, the local media publicized this accomplishment. This recognition helped to generate demand for the initiative at hospitals in other areas of the country and drew considerable interest from local leaders, providers and community members.

photo by: JHPIEGO/Malawi

Participants wearing t-shirts branded with the logo for the SBM-R infection prevention initiative in Malawi

EVALUATING AN SBM-R INITIATIVE

The purpose of an SBM-R initiative is to improve the performance of health service delivery. Therefore, an evaluation of an SBM-R initiative determines whether the performance of the health facilities has improved or, in other words, whether services are being produced in greater quantity, with better quality and/or more efficiently.

Improvement in performance can be expressed in:

- Volume of services produced
- Quality of services provided
- Efficiency during provision of services

The selection of indicators (objective measurement tools used as a guide to monitor performance) to determine the success of the SBM-R initiative has to be established at the beginning of the process, in accordance with the purpose of the initiative and the characteristics of the services being improved. The indicators can reflect improvements in results or processes of service delivery. The conclusions obtained are more meaningful if these indicators are also assessed in facilities where the SBM-R initiative has not been implemented; this comparison (comparison with control areas) will eliminate other general factors that may potentially have caused the changes observed.

VOLUME OF SERVICES

An increase in the volume of services produced by a health facility can contribute to the expansion of health coverage and/or the provision of uninterrupted services to the population. Performance improvements of this type can be ascertained through the analysis of service production data (related to the services being improved) in a given facility over a period of time. For instance, if the SBM-R initiative focuses on family planning services, it would be important to examine if the quantity of new and continuing users is increasing. If the focus of SBM-R is maternal and neonatal health, we may want to know if the number (and proportion) of deliveries in a health facility is increasing over time. Similarly, if we work with voluntary counseling and testing services for HIV, we would want to know if the number of persons being counseled and tested is increasing. Examination of the increases in services provided serves as an evaluation of the SBM-R initiative at the results level.

It is important to examine data on services delivered over a reasonable period of time to avoid seasonal variations in the provision of services or other short-term effects. In order to obtain valid information, it is also essential to make sure that the mechanisms for collecting, recording and consolidating data in the health facilities are reliable.

Another source of information for assessing improvements in the volume of services produced is population-based surveys that are periodically conducted in many countries, provided that the data are disaggregated at a level that matches the level of the SBM-R intervention (e.g., the district level). These surveys can provide data on utilization of health services by type of facilities, geographical area and the like.

QUALITY OF SERVICES

Measuring changes in quality of services is usually more challenging than measuring volume of services produced. We can try to assess quality at different levels. For instance, we can examine improvements in facility readiness to provide a given set of services. This kind of assessment examines whether the main inputs required for the provision of services are present and available. These inputs include human resources, physical plant, medical supplies including drugs, materials and the like.

We can also determine whether provision of the services being improved is following the right processes, according to recommended evidence-based practices. In this case, it will be necessary to systematically observe how actual services are being provided or to review medical records and other service provision documents. Periodic measurements using the performance assessment tool are usually sufficient to provide this type of information related to facility readiness and processes of care.

Levels of quality can also be assessed at the results level, examining variations in health outcomes. The idea is to determine if, in the end, the services provided have achieved a positive outcome in the health status of the clients served. This is often a challenging task due to the lack of reliable sources of data.

Another way of determining the outcomes of service provision is to assess changes in client satisfaction. There are several methods for obtaining clients' input regarding their levels of satisfaction, including client exit interviews and focus groups. The measurement of changes in client satisfaction is not without challenges. On some occasions, it has been observed that the results, after seemingly successful SBM-R interventions, are paradoxical—a decrease in the levels of client satisfaction is found. This may have occurred because the clients' awareness and expectations about quality can change over time, particularly if educational activities and service improvements are implemented. In any case, obtaining the clients' perspective on the improvement process is essential for a successful SBM-R process.

EFFICIENCY

Efficiency measures the relationship between health outputs produced and resources consumed. Producing more efficiently means obtaining more or better outputs with the same amount of resources, or maintaining the same level of outputs with fewer resources. Improved performance should result in more efficient procedures and mechanisms for the provision of services. During experiences with SBM-R, it is not rare to observe that services improve visibly in terms of quality and volume with relatively marginal increases in expenditures. These improvements and total expenditures can be quantified to give an idea of improved efficiency. In most cases, however, more precise information on costs is needed, in addition to the information on volume and/or quality of services provided. Obtaining this information can be very challenging in many settings due to the lack of good, disaggregated data on costs. Nevertheless, it is possible to conduct a focused analysis of service delivery efficiency without a substantial investment of resources or time. For example, providers at a hospital in Guatemala compared the costs of purchasing oxytocin for management of the third stage of labor with the costs of averted transfusions. After hospital managers saw the potential cost savings, they adopted active management of the third stage of labor with oxytocin as a routine practice at the facility.

The SBM-R approach contributes to improved efficiency of health services and a better utilization of the scarce health resources. This does not imply, however, that significant improvements in

performance and quality of health services can always be achieved without meaningful new investments in health (public and private). In the long run, health care quality improvements are less expensive than doing nothing, but usually require some significant initial investments. This is an extremely important point, particularly if the goal is to improve equity, making high-quality health services accessible to the most disadvantaged sectors of the population.

The measurements made with the assessment tool can provide part of the information needed for evaluating an SBM-R initiative. However, this information should be complemented with the careful tracking of selected indicators of production, quality and/or costs of service delivery.

SCALING UP AND SUSTAINING SBM-R

A common challenge faced in quality and performance improvement initiatives in health care is how to go beyond limited or focused initiatives and achieve a meaningful scale that has a real impact on the delivery of health services in a country.

There are two basic steps for scaling up an SBM-R initiative:

- Create a critical mass of early adopters of the initiative.
- Expand the initiative to a large scale.

CREATING A CRITICAL MASS OF EARLY ADOPTERS

Creating an initial critical mass that shows how the proposed improvements from SBM-R work and what their benefits are is usually a very useful step in scaling up an initiative. Change creates new situations that could generate uncertainty and anxiety for many people. That is why most individuals are more likely to adopt an innovation when they are able to see its results and when they can experiment with it on a limited scale. To create an initial critical mass it is always possible to rely on early adopters of innovations, persons who are able to see first how a new idea or proposal could be beneficial and are willing to take more risk.

The critical mass should be large and visible enough to serve as a model for potential new adopters. It is important to keep in mind that most people are persuaded about the advantages of an innovation by relying on the experiences of other individuals like themselves who have already adopted the innovation.

EXPANDING THE INITIATIVE

Effective strategies are needed to expand the critical mass to a large scale. For instance, rapid and efficient means such as mass media channels should be used to inform a large audience of potential adopters of the SBM-R initiative. This is one reason that recognition ceremonies held when a health facility achieves the pre-set level of standards are widely publicized using mass media.

But knowing about the initiative is not enough for other people to adopt the proposed innovation. At this stage, direct contact among the services that constitute the critical mass and potential new adopters should be actively promoted through visits, demonstrations, presentations, exchanges of information and the like. It is important to keep in mind that simple new ideas are adopted more rapidly than complex ones, and that the new model should be as simple and straightforward as possible. In addition, the "hardware" (tools) and "software" (process) of the model have to be appropriately "packaged" for mass distribution. Self-explanatory manuals and tools and other materials are very important at this stage.

The creation of a support/reinforcement infrastructure also is necessary at this stage. This infrastructure may include the preparation of coaches who are able to work with new adopters, incentive systems that promote the improvements, and institutional systems (such as a system for

external verification of compliance with the standards and recognition procedures) that support the SBM-R initiative on a large scale.

SUSTAINING SBM-R

SBM-R has some characteristics that can greatly facilitate its rapid expansion and sustainability:

- SBM-R matches very well with the current **organizational objectives** of most public and private health organizations. The aspects of performance and quality improvement and stronger regulation of service provision are at the center of the attention of health policymakers and managers. SBM-R is also consistent with more systemic quality assurance mechanisms such as standards-based service accreditation/certification schemes and performance-based health care financing models in both the public and private sectors. Consistency with organizational goals facilitates decisions on allocation of resources that are necessary to spearhead and maintain the SBM-R initiative.

- The bottom-up approach of SBM-R increases empowerment of local and facility managers, providers and communities, giving them concrete and practical tools for making informed decisions and better fulfilling their tasks. This characteristic of SBM-R makes it particularly suitable for **decentralization** processes in health. When local policymakers, managers, community leaders and health providers are able to see the benefits of the SBM-R approach, they are usually more willing to support this type of initiatives.

- The SBM-R process has been demonstrated to be a powerful **tool for advocacy and resource mobilization** at different levels. SBM-R helps managers, providers and communities to visualize in concrete terms the types of resources that they need to achieve desired levels of performance and quality. They are thus enabled to make concrete and specific requests for support and more likely to get concrete and specific answers from decision-makers, the community and the civil society. Moreover, the SBM-R focus on results, many of them achieved early in the process with relatively little additional resources, attracts the attention of policymakers and community leaders and facilitates their involvement and support.

- The relatively **easy and streamlined process** for SBM-R implementation makes it more replicable with little external support. Performance and quality improvement efforts can be very complex and sophisticated. Frequently, they are introduced in health services as discrete, specialized and sometimes complicated activities. Thus, they often become an additional burden on health providers and are not "naturally" integrated into their day-to-day service delivery or managerial duties. SBM-R, on the other hand, is conceived to be an "aid" for providers to perform their regular duties in a better way, thereby creating an environment of motivation. This simplicity enhances the likelihood of acceptance by implementers of the initiative.

- SBM-R promotes the constant and systematic involvement in the initiative of different stakeholders at different levels. These stakeholders include individual providers and teams of providers, networks of facilities, clients, organized community groups, national/regional/local governments, the civil society and others, effectively creating a system of **multiples sources of support and control** for the process. That SBM-R does not rely on a single source of support and control (like traditional top-down supervision or provider-centered approaches) increases the likelihood of continuity of activities and the sustainability of their quality.

- SBM-R **does not require a heavy additional infrastructure** for its implementation; it is built upon the normal structures of service delivery organizations, including natural supervisory bodies. Performance and quality improvement is a daily responsibility and task of everyone—providers, managers, clients, etc.—and its achievement is facilitated by the SBM-R tools and processes. This factor also contributes to the sustainability and potential expansion of the SBM-R initiatives.

After a limited initial investment, many SBM-R initiatives have been able to grow, attract additional resources and remain sustainable over a significant period of time. Several of them have also successfully expanded to become large-scale programs.

APPENDIX: SBM-R COUNTRY PROGRAMS

SBM-R DESIGN OPTIONS	COUNTRY						
	Brazil	**Guatemala**	**Malawi**	**Honduras**	**Jamaica**	**Mozambique**	**Afghanistan**
	Program: PROQUALI (In collaboration with the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs and Management Sciences for Health)	**Program**: CaliRed (In collaboration with the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs)	**Program**: Ukhondo Ndi Moyo	**Program**: Maternal and Neonatal Health	**Program**: Voluntary Counseling and Testing	**Program**: Infection Prevention and Control	**Program**: Essential Obstetric Care and Infection Prevention (In collaboration with Management Sciences for Health)
Purpose	To improve the quality, performance and utilization of family planning and selected reproductive health services by actively involving clients and providers in achieving compliance with the standards	To improve the quality, performance and utilization of maternal and neonatal health services provided by skilled providers in a network of facilities	To improve the quality of infection prevention and control practices to protect clients and health care workers from acquiring infections (especially blood-borne and TB)	To improve the quality, performance and utilization of maternal and neonatal health services provided by skilled providers in hospitals	To improve the quality, performance and utilization of voluntary counseling and testing services for HIV by actively involving clients and providers in achieving compliance with the standards	To improve the quality of infection prevention and control practices to protect clients and health care workers from acquiring infections (especially blood-borne and TB)	To improve the quality, performance and utilization of maternal and neonatal health services provided by skilled providers in hospitals To improve infection prevention practices in hospitals
Type/range of services	Initially family planning and selected reproductive health services, later expanded to primary health care	Maternal and neonatal health including normal care and management of complications	Infection prevention practices across the board (direct services to clients/patients and support functions)	Maternal and neonatal health including normal care and management of complications	Voluntary counseling and testing for HIV	Infection prevention practices across the board (direct services to clients/patients and support functions)	Maternal and neonatal health including normal care and management of complications. Infection prevention practices across the board

SBM-R DESIGN OPTIONS	COUNTRY						
	Brazil	**Guatemala**	**Malawi**	**Honduras**	**Jamaica**	**Mozambique**	**Afghanistan**
Type of facility	Health centers	Network of services (health posts, health centers, community maternities and district hospitals) linked with a network of communities	Hospitals (mission and public)	Regional and district hospitals	Health centers	General and provincial hospitals	Hospitals
Sectoral coverage	Public sector, 29 health centers	Public sector with participation of international NGOs, local NGOs, municipalities, women's groups and private companies	17 Christian Health Assn. of Malawi and MOH hospitals nationally	Public sector, six hospitals	Health centers, public and private (NGO) sectors	Public sector, six hospitals (initial phase)	Public sector, 15 hospitals
Geographical coverage	Two states in northeast Brazil: Bahia and Ceará Initially pilot in five clinics, later expanded to 29 facilities	Eight health areas of the MOH (included 30 municipalities): 10 hospitals, 44 health centers, 97 health posts and three maternities; Total: 154 facilities and 99 communities Later expanded to 15 hospitals, 66 health centers and 141 health posts; Total: 222 facilities	Initial phase: seven hospitals in the three regions (three in the south, two in the center, and two in the north regions) Expansion: 17 hospitals nation-wide	Two health regions, with three hospitals in each region	Nationwide; initially 15 clinics in the four health regions	Six provinces (initial phase); expansion: 12 hospitals nation-wide	Selected provinces

SBM-R DESIGN OPTIONS	COUNTRY						
	Brazil	**Guatemala**	**Malawi**	**Honduras**	**Jamaica**	**Mozambique**	**Afghanistan**
Consequences of performance/ incentives	A clinic achieves recognition when it meets 90% of the pre-established performance standards Feedback plus social recognition: public recognition ceremony honors facilities with a "quality symbol" plaque T-shirts, certificates, unit pictures for providers	Accreditation when the facility meets 85% of the pre-established performance standards and a recognition when site achieves more than 70% of the criteria Feedback plus public recognition: ceremony honors facilities with a "quality symbol" in a plaque Diplomas, and letters of recognition provided to outstanding staff Cross-visits to other accredited sites as an incentive	Institutional and public recognition when a hospital meets 80% of the pre-established performance standards in total and in each area: public recognition ceremony honors facilities with a "quality symbol" and plaque Internal promotion: T-shirts, certificates for providers for partial achievements	Internal recognition in hospitals	Dissemination of best practices Institutional recognition under consideration	Institutional recognition	Institutional recognition
Recognition body	Combined Multidisciplinary external assessment team (representatives from MOH, university, professional associations, civil society)	Combined Multidisciplinary external assessment team (representatives from MOH, university, professional associations, civil society)	Combined Multidisciplinary external assessment team (representatives from MOH, university, professional associations, civil society)	MOH	MOH	MOH	MOH

SBM-R DESIGN OPTIONS	COUNTRY						
	Brazil	**Guatemala**	**Malawi**	**Honduras**	**Jamaica**	**Mozambique**	**Afghanistan**
Support and facilitation	First phase (pilot): intensively facilitated by facility, district and state teams Expansion: partially facilitated by the same teams	First phase (pilot): facilitated by hospital and district teams Expansion: partially facilitated by same teams	First phase (pilot): intensively facilitated by hospital and central level teams Expansion: partially facilitated by hospital and central level teams	Facilitated by facility teams	Facilitated by regional teams	Facilitated by facility and central level teams	Facilitated by hospital teams
Management	Decentralized: state (regional) and local (municipality) levels	Combined: MOH central level and health areas and districts with strong coordination with municipal governments	Centralized (central MOH)	Combined (central and regional MOH)	Combined (central and regional MOH)	Centralized (central MOH)	Combined (central and provincial MOH)

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