SUCCEED - A KNOWLEDGE-BASED TOOL FOR QUALITY IMPROVEMENT

A BACKGROUND FOR FACILITATORS AND THOSE WHO WANT TO KNOW MORE ABOUT THE TOOL

Quality Action
Improving **HIV** Prevention in Europe

INTRODUCTION

This is a theoretical paper explaining both the research behind and the concepts and methodology of the Succeed tool. The purpose of the document is to provide more background and knowledge for anyone who uses Succeed and would like to understand the methodology better. It is not necessary for people who use Succeed to read this document. It is intended mainly for people who would like more in-depth information, for example those who want to facilitate Succeed workshops or support people or groups in filling in the questionnaire. The document aims to explain the content of the indicators and the questions relating to them. A deeper understanding will help facilitators and users to identify important and relevant information for improving the quality of a project.

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BACKGROUND

Succeed is based on a general tool for Quality Improvement (QI) and Quality Assurance (QA), that was originally developed in Sweden in 1992 to satisfy a long-felt need for methods to follow up and audit health promotion. In the early 1990s, consumer-provider models began to dominate the organisation of health care in Sweden and many other countries. The introduction of purchasing authorities to place contracts for health care highlighted the need to specify work programmes and quality. Total Quality Management (TQM) was the guiding principle for many health care efforts[1].

Health promotion, often run by health care authorities, was increasingly subjected to similar demands to define and assess activities and outcomes. TQM, however, did not seem to be the answer. A group of senior health promotion officials thought that the ideas behind QA and QI were well suited to the long-term and complex conditions of health promotion and prevention and initiated a research project to develop a more suitable methodology under the auspices of the Karolinska Institutet in Stockholm, Sweden. The result was a report highlighting 13 important general success factors in population-based health promotion and prevention. They were operationalised into a questionnaire to be used for the purpose of QA and QI. The questionnaire was then tested and a report published by the local regional health authority[2].

In 1994 the report was awarded first prize at the National Quality Summit of the Association of County Councils (Sweden's health authorities). In the same year, the association sponsored and

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[1] Cullen and Hollingum (1987) *Implementing Total Quality*. IFS Publications Ltd. Springer-Verlag.Köln.

[2] Ader, Berensson, K., Carlsson, P., Enhorn, G., Granath, M., and Urwitz,V. (1992a) Kvalitetssäkring av primärpreventiva program på befolkningsnivå. Rapport Skaraborg County Council.

published the transformation of the research report into an easy-to-use tool, which was subsequently translated into English in 1996[3]. The tool was evaluated by the Swedish Board of Health and Welfare (Sweden's national health authority) in 1999 and was recommended as a good tool for QA and QI on health promotion and prevention. The evaluation also pointed to a number of important factors for successful use of the tool[4]. Increasing use of the tool made it necessary to publish the scientific research behind it, in order for it to be properly peer-reviewed. This was done in 2001[5].

One of the authors of the original tool has been active in HIV prevention and SRHR both in Sweden and internationally during the entire period. This led to a presentation of a project using the original tool at the Conference on Quality in HIV Prevention in Berlin in 2008. The conference marked the beginning of the IQhiv network and the original tool was adapted for HIV prevention by the IQhiv network. This was approved by the owner of the tool (the Swedish Association of County Councils and Municipalities). The owners asked that the new tool be renamed to avoid confusion. The name that was chosen was Succeed.

THE RESEARCH HYPOTHESIS AND THE METHOD BEHIND THE TOOL

QI and QA are generally based on certain key areas (measures or processes) of importance for the quality of a product. These areas or factors are called *indicators*. Ideally, a *standard* should be set for each indicator. The QI exercise demonstrates where the product exceeds or falls short of the standard. Measures can then be taken to make improvements where necessary. Ideally, the people working in production should take part in the exercise since, in many cases, they are a part of the solutions. QI and QA are essential when you cannot test every item produced or when production takes a long time and you need to know that things are going right along the way. The latter is often very true in health promotion and prevention.

The hypothesis was that QA and QI would be a suitable approach for, and would fill a gap in, health promotion and prevention. An indicator is a specially selected measure or attribute that may point to good or poor quality. The idea behind the research was that establishing sets of indicators for health promotion would provide practitioners with tools to systematically conduct the intermediate follow-up that is needed to demonstrate that projects are on the right track towards their often long-term goals.

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[3] Berensson, K., Granath, M. and Urwitz, V. (1996) Succeeding with Health Promotion Projects – Quality Assurance. Landstingsförbundet (The Association of County Councils), Stockholm.

[4] Swedish National Board of Health and Welfare (1999) Uppföljning av kvalitetsmanualen "Att lyckas med folkhälsoprojekt".

[5] Maj Ader, Karin Berensson, Peringe Carlsson, Marianne Granath and Viveca Urwitz (2001) *Quality Indicators for health promotion programmes.* Health Promotion International. Vol 16, No.2. Oxford University Press.

The method chosen to determine the indicators was to conduct a review of evaluations from projects in health promotion and prevention. The review was conducted in 1992 before the era of fast search engines and large scientific databases on the Internet. Literature was hence sought in the large scientific library of the Karolinska Institutet[6] and in some major health promotion and prevention journals. This provided information from project reports, peer-reviewed articles on evaluations, textbooks on health promotion and much more.

In qualitative research you often work with the concept of *saturation*. The texts found were analysed for elements that had proved to be important for success or where the lack of certain measures was found to be responsible for the failure of a project. Certain factors appeared repeatedly in all or at least many cases. When no more new factors came to light saturation was deemed to have occurred and the factors found were considered to be important success factors.

The list of factors can be regarded as providing 'a lowest common denominator' for QA and QI. Based on this list, three sets of indicators were conceptualised:

- Indicators for reviewing the quality of the structure of the project, i.e. how it is organised
- Indicators for reviewing the measures and processes of the project, i.e. how it is carried out
- Indicators of the outcome, intermediate and end results, and other changes

Structure, process and result are three equally important and interdependent aspects of any project. This triangle is often used in QI and QA of medical services.[7]

The review also made it clear that it was not possible to develop any type of more sophisticated measurable standards. There was simply not enough research. For example, how can you tell when an outreach project has reached enough people? Is 40% of the target enough or should it be 80%? If a project works to increase knowledge, what is an adequate standard for knowledge change? The measure of a statistically significant change, i.e. a change that is not a coincidental change, is the only possible reply to this question. There was, and still is, not enough research on these issues. In the future this will probably improve since communications research is expanding and will provide more scientific information to develop standards.

As regards the more qualitative indicators the picture is no different. For example, we know that a formal decision on a project is better than no decision at all – a sign of quality. However, the content of the decision might be hard to review from the point of view of quality.

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[6] The Karolinska Institute is one of the largest medical universities in Europe

[7] Donabedian, A. (1996) Evaluating the quality of medical care. Millbank Memorial Fund Quarterly, 44, 166-206.

This is an important reason why the developers of the tool decided to use the QI approach, which focuses on developing identified gaps in the project, rather than the QA approach, which focuses on a measurable minimum standard.

THE SUCCEED METHODOLOGY. HOW DOES IT WORK?

Based on the research and the list of success factors, indicators were generalised into "sensitising concepts"[8]. The indicators were given specific names. Each indicator stands for a core content that in real life might have slightly different formats in different projects, reflecting the contextual nature of health promotion and prevention.

The content was operationalised into specific questions, reflecting the important success factors that were found in the research.

The questions are constructed in such a manner that a positive answer or, in some cases, a 'Yes', indicates good quality while a negative answer or a 'No' indicates a deficiency or poor quality. This simple division reflects the fact that there is little information on which to base standards. The assumption is that *the more of the indicators (success factors) that are in place in a project, the better the quality.*

Sometimes you might think that measures asked for in the questionnaire do not exist. But after some discussion and thought, and after reading the case examples provided, you might in fact find that things are in place although they were not properly planned for or had been conceptualised differently. For example, there might be a rationale for the choice of target group or there might be a model with a few specific methods being used, although they were not thought of as methods.

Of course, the same goes for things that were thought to exist by actually do not. Often enough, what are thought to be goals are actually activities, for example, 'Our goal is to train staff'. Although you can measure the activities ('We had three training sessions'), this says nothing about results.

The role of the facilitator is to help highlight this by helping people understand how to use the questions and examples. Some additional information on the indicators is provided below, together with the questions relating to them that can be found in the questionnaire.

If improvements are indeed needed, it is advisable to look in the PQD (Participatory Quality Development) toolbox. You will find a number of methods that can help you improve different aspects of your work. Some of the methods are easy to apply as long as you embrace the participatory approach. Others might need some training or supervision before they are used.

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[8] Cohen (1979) What is wrong with social theory? In Filstead, W.J. (ed). Quantitative Methodology. Markham, Chicago, IL.

Structure

Almost all of the reports and studies reviewed pointed to the structure of the project as being the platform for success of any type and much more important than is usually appreciated. Several factors that need attention were found. They correspond to the chosen indicators. The name of the indicator is the heading of each section below.

Goals

This indicator contains questions on problem description goals and sub-goals (which can also be called objectives or targets, depending on the project). A key to success seems to lie in a clear and specific problem description as well as in the conceptualisation of distinct and measurable (SMART) goals[9], both the overall goal and intermediate or sub-goals.. Since the overall goal can be long-term, there is every reason to use intermediate goals or sub-goals for the intermediate effects that are expected.

A common misunderstanding is that goals are set once and for all. Many projects, however, start out with goals that are too wide or goals in areas where there is not enough knowledge. After some time this becomes obvious. Succeed acknowledges that goals can and probably should change during the project as your knowledge deepens. You only have to state a proper rationale for that change. So, if by using Succeed you find that the goals are not optimal, go ahead and make this an area for improvement. It will certainly help the project.

Key populations

In HIV prevention key populations play an important role. They are groups of people who, for different reasons, have a greater vulnerability to HIV infection. There are many groups and they differ both between and within countries.

Knowing why a project is started is a sign of good quality. It might be because of an epidemiological analysis that demonstrates the need. It might because there are people committed to a cause or a group of people who are vulnerable in general.

However, there is considerable evidence that conducting an epidemiological analysis will both help to target a selected group and to provide background knowledge on which groups need prevention the most. The analysis should preferably be based on 'second generation

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[9] SMART means **specific**, **measurable**, **attainable**, **relevant** and **time-bound**. For someone who is not used to developing SMART-goals it can be difficult. One way to think is: What should have changed at the end of the project for the target group?

surveillance'[10] – a combination of many different types of information, both quantitative and qualitative, for example:

- Medical data on infection types and rates
- Knowledge, attitudes and behaviour in the relevant groups
- Important social determinants

This is true not only for HIV but for all work on sexual health and rights as well as in most areas of public health. The capacity to achieve desired changes or to get the message across increases with accurate knowledge based on problem analysis concerning the key populations. Having this type of data will also increase the opportunities for meaningful follow-up.

Sometimes there is no data and other types of information have led to the project. As long as this is clear and transparent, it is a sign of quality. In this case, QI might lead to improvements in surveillance and data collection.

It is sometimes important to make a distinction between the key population that is ultimately intended to benefit from the project and the immediate group targeted by the project. For instance, a project can target staff to make them better equipped to meet the needs of the key population. A project should be able to make this distinction if it is relevant.

Approach

Many studies demonstrate the importance of having a clearly rooted and possibly evidence-based design or model for the project. Having a strategy and clearly delineated activities is a success factor. There should be some kind of project logic or picture describing which actions and measures are expected to produce different types of effects and in what order these actions and measures should be implemented. Research has shown that a project approach based on a theoretical model for health promotion will give better results (for instance, Bandura´s Social Learning Theory). In this context, ethical aspects of the project should also be considered.

Responsibility

An important condition for a successful project seems to be that decisions about the project have been and can be reached at the appropriate level in an organisation, for example, decisions about resource allocation.. Among other things, this has proven to be the most significant success factor for sustainability. Although projects can be started without such decisions, obtaining funding will almost always be a challenge and significant efforts will have to be put into fundraising.

As in all organisational contexts, it is important that there is a clear allocation of responsibility and authority.

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[10] The WHO began to recommend Second Generation Surveillance in 1992. In 2006, UNAIDS coined the phrase 'know your epidemic'.

Resources

Resources can be both material and human. The relationship between level of ambition and available resources must be reasonable. For instance, an extensive study in Australia[11] showed that one of two factors explaining why New South Wales did not have an outbreak of HIV among men who have sex with men (MSM) although the rest of Australia did, was the fact this state spent more resources on their prevention efforts. (The other factor was long-term cooperation between all key stakeholders.)

Many projects are over-ambitious relative to available resources. Funders often think that health promotion and prevention is cheap because it is done using volunteers[12]. Consequently, health promotion and prevention projects are consistently underfunded. This is often the reason for results not being achieved and for burn-out among staff and volunteers. If a project is underfunded, it is a sign of deficient quality.

Another factor of importance is that project management should be mandated to allocate funds and to take financing and other day-to-day strategic decisions within the approved budget. When an opportunity arises, there is often no time for a formal decision-making process.

The skill level of the personnel is another key factor. There should be opportunities for staff to develop knowledge within their skills area and to improve their capacity if needed through further education and supervision.

Organisation

A transparent organisation and defined leadership seem to constitute an important factor for successful operations. Any organisational description should ideally specify the mandated tasks and authorities of personnel, including volunteers, involved in the project.

The relationship between the project and any 'parent organisation' running the project must also be reasonable. A project needs a certain amount of independence. For instance, the project management must be sufficiently independent to act in relation to collaborating partners.

Realistic schedules and time plans seem to be another factor indicating quality. An unrealistic schedule will cause stress among staff as well as disappointment. It can also lead to funding being withdrawn if the project does not meet promised targets.

Health promotion and prevention is highly contextual and plans might be affected by uncontrollable events. The fact that the project has a risk management strategy concerning time plans is a sign of quality.

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[11] Christopher K Fairly et al. (2008) Investment in HIV prevention works. Sexual Health. 2008, 5, 207–210.

[12] Yes, it is cheaper than treatment but it still costs money!

Process

The the literature review found few success factors or indicators for health promotion and prevention processes. . Some factors were closely connected to the use of a specific methodology and therefore could not be used as general indicators. One exception was an extensive review of possible researchable processes within health promotion and prevention. In this review, three general measurable or describable areas were identified: *network, exposure and commitment*. Another area that has proved to be possible to measure and describe is *participation*. These four elements form the indicators for the quality of the project process. This does not mean that these indicators give a comprehensive picture of the quality often process. Rather, they are small windows that can provide a sense of the quality.

Support and participation

Support is a concept that attempts to capture how well rooted the goals and approach of the project are among important collaborating partners and those who convey the approach further within the community or among key populations. The fact that the main stakeholders and their roles can be defined and that there are some additional formal commitments such as contracts or agreements is a sign of quality. It is also possible to have feedback on stakeholders' understanding.

The indicator 'support' also includes lack of support and possible obstacles to support.

There may be many obstacles to overcome in a project. They may be at the individual level (uninformed or opposed individuals with some power to obstruct or spread misinformation), the organisational level, or the societal level. It is wise to carry out not only a risk analysis but also an analysis of obstacles, and to assess what you can and cannot do about these obstacles. Awareness of such things is a sign of quality. Many projects spend a lot of time and energy trying to change things that they do nothing about. QI can help them to avoid such counterproductive actions.

Participation means that the partners, key members of the target group or key populations and decision-makers all have opportunities to influence and take part in the development of the project. There are different levels of participation[13]. A distinction can be made between symbolic and active participation. Symbolic participation typically takes place when a collaborating partner agrees to collaborate and sit on a steering committee but sends a powerless junior official to a few meetings and there is little or no activity at the meetings and no action between meetings. Active participation would be the opposite; a person with a mandate sent to the steering group,

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[13] Arnstein S (1971) Eight rungs on the ladder of participation. In Cahn P (ed) Citizens participation: Effecting Community Change. Praeger. London. This paper has been used by PQD to offer methods to develop and describe participation, for instance Power Circles.

a person who is active and contributes to the project, and a collaborating partner undertaking their responsibilities between the meetings.

Network

Network is a term commonly used to refer to any kind of group of people who are important for the implementation. These may be existing groups that meet regularly and have the characteristics of a network. Or they may be groups that meet irregularly and have little or no contact in between concerning the project, but where each member is important and members share certain characteristics from the point of view of the project, for instance a group of experts in different fields. The *Network* concept can also be used metaphorically about people who share characteristics but never meet — only in the view of the project are they a group. The project will therefore communicate with these individuals in a similar way.

In the context of Succeed, these networks may be important for many reasons: for feedback from the community, target group or key population; for relaying information and messages; and for implementing certain actions to reach out on a wider scale. People in these networks are then central to the implementation of the project.

Active networking and information dissemination activities are essential to most projects. The literature shows the importance of skills to develop the understanding and capacity of the people in project networks.

Research also points to the importance of nurturing passionately-committed enthusiasts. Most health promotion and prevention depends on enthusiasts, since very few implementers do the project tasks as a full-time job. Enthusiasts can be volunteers who conduct out-reach in an NGO, a committed nurse or a schoolteacher making extra efforts to help other teachers to do sexuality education. If such people do not obtain recognition for their efforts, their passion can easily abate or, worse, their actions could become hostile and counterproductive.

One way to assess quality is, therefore, to find out whether and how a project includes networking in its operations and how consciously it supports enthusiasts.

Reach and response

This indicator is concerned with the extent to which, and with what intensity, target groups come into contact with messages and activities and to what degree the target group and key populations receive and absorb whatever is intended.

Many projects train intermediate 'relayers', such as medical staff, outreach workers from NGOs or schoolteachers. However, it is important to check how they perceive information and messages and, in turn, how they convey them to the intended target audience.. This needs to be done on a regular basis since it will help adapt the project approach and concrete measures to needs of the target groups/ key populations

Ideally, we would also need to have standards, but as long as they do not exist it should be possible to aim for statistically significant changes or substantial changes.[14]

Common methods to measure this are knowledge, attitude and practice (KAP) surveys or focus groups. Such methods are often used to obtain information from the key populations. Many countries have systematised second generation surveillance that includes such questions at a national level. However, such methods can also be used to get information on reach and response from intermediaries or 'relayers'.

Larger projects usually have the financial and human resources to collect feedback on reach and response. The challenge for smaller projects is to develop a feedback system that is feasible to manage with limited resources.[15]

The fact that a project has any measures in place for feedback on reach and response from important groups, including the project target audience, is a sign of quality.

Results

Although the ideal end result of health promotion and prevention is, for example, a decrease in HIV infection, a project will never achieve this on its own; many other factors will contribute to or hinder the achievement of this result. Both research and epidemiological theory tell us that we should look for other endpoints when measuring or describing project results from prevention projects.. The outcome of population-oriented preventive work should preferably be measured based on key determinants of the desired end result, i.e. the specific determinants that the project has been set up to affect.

This is why the formulation of project goals and the logic of the approach are so important.. QI can help to ensure that goals are realistic or to change goals when measurement of results is discussed. The discussion on how to identify useful indicators for measurement is important. We cannot follow the sexual practices of every individual in a key population; it is therefore usual to ask a few strategic questions about issues such as condom use or unprotected anal intercourse. These are indicators of behaviour. Having a plan and methods to monitor progress is a sign of quality. Another sign of quality is the fact that you can answer 'Yes' to the question of whether the project is progressing towards its goals. The quality indicators of project results are therefore as follows:

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[14] We would do well to remember that for commercial interventions and campaigns a small percentage increase in sales is considered a good result. No one expects a 50% change in behaviour from a small investment!

[15] In PQD, both focus groups and the "Rapid Assessment" method are described. However, anyone who undertakes a study using these methods needs some training or supervision to execute them correctly.

Knowledge, attitude and/or behavioural change

In HIV prevention and SRHR, the most relevant determinant to affect is often sexual or drug use behavior. The steps leading to behaviour change are knowledge （of the health risk and protective factors）, attitudes to behaviour change, intention to change behaviour and, ultimately, the behaviour itself. Often project goals, objectives and the approach or model concern these determinants. There are underlying assumptions on how to achieve behaviour change. Looking at ongoing results will provide feedback on these important aspects of the project as well as on how well the needs of the target group or key population are being met. It is important to note that, depending on the goals and objectives, this indicator may relate to the direct target group as well as the key population that is intended to be the ultimate beneficiary.

Is it possible to measure change and what are the measures telling you？ Are you progressing towards the results？ If questions like these cannot be answered, the project will have problems.

Environmental, operational or social changes

Environmental or operational changes indicate changes in the surrounding community such as adapting clinic opening hours, a school principal allowing regular sexuality education by an NGO, more housing for homeless people who inject drugs, or opening a place where people living with HIV can get support. It can also relate to major changes in the operation of the project itself.

Some projects also have an advocacy component and can be instrumental in policy or legal changes, for example changing laws on LGBTQ rights or HIV legislation. Such achievements should be highlighted as important milestones and results.

Sustainability

Some projects have a specific goal. When that goal is achieved the project is completed. Others need more time or to be sustained to achieve the desired effect. Many model projects in the area of health promotion have been shown to have a limited long-term effect if project work is not incorporated into regular organised activities after project completion. If the project is to be effective, this should be considered.

All projects therefore need to consider the issue of sustainability well before the end of the project. If this is done and strategies are devised to ensure this, it is a sign of good quality.