Quality Action
Improving HIV Prevention in Europe

Quality Action
CASE STUDY

1. Name and country of the organisation

(Please state the name and the country of the organisation that implemented this practical application of a QA/QI tool as part of Quality Action. We do not publish this information unless you agree. You can remain anonymous by adjusting the settings at the end of this form.)

Sensoa, Belgium.

2. Authors of the case study and contact details

(Please provide then name of the author(s) of this case study and any contact names, Email address or websiteswhererеaders can access more information about this practical application of a QA/QI tool.)

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3. External support (facilitators/partners/technical assistance)

(Please list the namesof other organisationsand/or people who were involved in this practical application of a QA/QI tool, e.g. project partners, technical assistance, external stakeholders etc..)

None/ not applicable
For the content of the project:
-Task Force of Health Care Providers (HIV-specialised) : Needs and situational assessment and analysis, advisory and feedback group
-Expert (existing intervision) group of HCP called Zorgoverleg: Feedback group

4. Project/programme

Please briefly describe the project/programme to which you applied the tool.

In 2008, the Flemish government consulted the stakeholders involved on the health crisis among gay men, in particular on HIV prevalence. From these task forces resulted a number of interventions. The task force on psycho-social counseling for HIV positive men who have sex with men underlined the need for support and counseling of these men in adopting safe(r) sex strategies. People living with HIV are facing the challenge of integrating safe(r) sex into their (sexual) lives. Since they attend regular follow up (every 3 to 6 months) in specialised AIDS reference centers, professionals working with people living with HIV were considered the best-placed intermediaries to provide this counseling to people living with HIV. Since most professionals working in AIDS reference centers are medically trained, a need for knowledge, skills and tools for counseling was raised. This formed the main reason for developing a manual consisting of several modules applicable to the counseling of MSM. The manual was disseminated and accompanied by two levels of training.
The manual consisted of 5 parts: Background information on the target group, safe sex, reproductive health; Sexual counseling explained and applied; Developing an integrated approach; Tools; Referrence guide.

5. Goals/aims of applying the QA/QI tool

Please list the goals you wanted to achieve with the practical application of the tool.

The Quality Action project team asked Sensoa to revise a project using the QIP tool as a pilot of the tool itself.

Sensoa chose this project because we were interested in revising this project due to the implemenation difficulties of the manual. We aimed learn some interesting lessons from the application that could be helpful for future projects.

6. Tool and methodology used

(Please indicate which of the five tools you used (Succeed, QIP, PQD, PIQA, Schiff) and briefly sketch out the steps and measures of how you applied it.)

Draft version of the QIP tool:
- The project was completed when the (draft version of) the QIP tool was applied
- In a rather short time frame we applied the (draft version of) the tool
- Two persons filled in the (draft version of) the tool
- Some questions were difficult to apply to this particular project (especially questions concerning who to identify as target group , intermediaries and ultimate beneficiaries)
- In close collaboration, a final application of the QIP tool was send to the Quality Action project team.
- It included our feedback, including our difficulties interpreting some of the questions within the tool.

7. Results and benefits of applying the QA/QI tool

(Please describe what resulted from applying the tool and if and how your project/programme benefitted.)

By reviewing the project step by step, the weaknesses and the strenghts of the project became clear. For instance, although there was an external support group, the intermediaries involved in the project were self-selected based on their own willingness and preparedness to participate. It was not a representative group. Also, interesting questions came up while applying the tool, such as how to involve the support group to maximise the implementation and how to enhance the support group' ownership of the project …

8. Recommendations

(Please describe the lessons learnt from positive or negative experiences during the process of using the tool itself and about the quality of projects/programmes like yours.)

I think one of the main lessons we drew out of applying the QIP tool was to plan it as quickly as possible after the project has been implemented. Otherwise, much useful data is lost or not remembered correctly anymore. Which brings us to that other lesson: register and write down in a central document what choices were made and what supportive material was used throughout the project.

Ii was difficult to fill out the QIP documentation form because the target group definitions were not applicable, or a little bit confusing in our project. In the QIP form they talk about two kinds of target groups: beneficiaries and intermediaries. In our project, our intervention aimed at reaching the HIV professionals, but not to improve their health. So they were the beneficiaries (based on the definitions in the tool). I also tried to fill it out as if the PLWH were the beneficiaries, but that didn't work either. Because we didn't have any actions targeting the PWLH directly.

In retrospect, the Succeed tool might have been a better choice. The outcomes of Succeed harbour the possibility to generalise to other/future projects. QIP is labour intensive and requires a good understanding of public health terminology. Also, our project was already finished and so a lot of the outcomes of QIP were not applicable anymore.

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