Why quality improvement?

- Focus on needs (needs analysis)
- Define target groups
- Reach the groups in need, not just the groups easy to reach
- Re-define areas of work that have become habitual
- Plan interventions focusing on impact and sustainability
- Evaluation as part of the process
- Systematise individual and local knowledge

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Learning objectives

• Knowledge of QIP and its performance characteristics
• Ability to use the QIP forms and materials
• Commitment to documentation and self-reflection
• Ability to make assessments
• Ability to interpret feedback
Training content

• Comparing own assessments with those of other reviewers to support the reliability of QIP
• Reflecting on case studies and discussing own experience in relation to the views of other experts to increase objectivity
• Reflecting on own standards and making professional judgements
Training content (continued)

• Applying professional perspectives on project implementation, service delivery and resource allocation
• Raising awareness of inherent bias and balancing making allowances with being overly critical
• Discussing and checking whether criteria, judgments and quality assessments are realistic and relate to the context
What is QIP?

• A scientifically based and validated information system for quality improvement in prevention, health promotion and education.
• Can be used to examine the quality of programmes, projects, campaigns, setting-based interventions as well as health education and training, giving providers feedback and suggestions for improvements.
• Helps to manage and implement prevention and health promotion in a targeted, effective and sustainable manner.
QIP Methodology

- Comprehensive, evidence-based questionnaire
- Validated assessment by external expert reviewers
- Recommendations for quality improvement
The benefits of QIP

• Generates ideas in your team for improving quality
• Delivers practice-oriented reviewer feedback with concrete recommendations for improvement and detailed quality profiles
• Identifies strengths as well as opportunities for improvement and prioritises areas for action
Sources for QIP
(version for prevention in general)

Quality measuring instruments
(EDDRA, WHP, PREFFI, quint-essenz, specific projects of statutory health insurance agencies and German rehabilitation services)

- Evidence-based quality criteria
- Integrating scientific and practical knowledge
- Usability (for planning and all project stages)
- Comprehensive and detailed project portraits
- Best possible data quality (measurements)

Expert experience
(validation interviews, pre-tests, workshops)

Evidence
(numerous reviews)

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Literature review

• 1229 articles found, 53 met inclusion criteria
• 41 reviews reported efficacy factors
• Focus mainly on general population, some on MSM, PWID, adolescents
• Two reviewers extracted and categorised efficacy factors.
• 54 evidence-based efficacy factors identified
Results from field test 2004

• Three or more independent external reviews produce reliable assessments

• Psychometric quality (both increase with training and experience):
  – high consistency: median Gamma 0.8 – 1.00
  – satisfactory concordance: (median Rho 0.6 – 0.7)

• Small differences between groups of reviewers
Results from field test 2004 (continued)

- Relevant and useful output is high
- Experts, reviewers and practitioners confirm the validity of results:
  - QIP provides helpful and realistic comments
  - QIP includes all important aspects of health promotion
  - QIP paints a comprehensive picture of project quality
Adapting QIP to HIV Prevention

2009  QIP presented to the IQ\textsuperscript{hiv} initiative, who asked to adapt QIP to HIV prevention
Reviewed factors of effectiveness in HIV prevention
Selected additional criteria to be included in QIP
Compared QIP with other international quality systems for HIV prevention

2009/10  Adapted documentation and reviewer forms to HIV context, taking into account evidence and input from experts in the field of (community-based) HIV prevention
Adapting QIP to HIV Prevention (cont.)

2010  Translated documentation and reviewer forms into English
QIP reviewer training (IQhiv)

2011  Finalised QIP reviewer training protocol and manual

2012/13  Pilot tests in different European countries (‘Road Show’ and conference workshops)

2013  QIP Description and introduction document for Quality Action
## Efficacy factors I

<table>
<thead>
<tr>
<th>Effective Factors</th>
<th>All</th>
<th>MSM</th>
<th>IDU</th>
<th>Adolescents</th>
<th>General pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Framework</strong></td>
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<tr>
<td>(Fiscal) resources</td>
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<td>Clearly defined intervention</td>
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<td><strong>Theory-based</strong></td>
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<td>Information-Motivation-Behavioural Model</td>
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<td>Theory of Reasoned Action</td>
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<td>Social Learning/Cognitive Theory</td>
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<td>Other</td>
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<td><strong>Intervention method</strong></td>
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<td>Eroticization/entertainment</td>
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<td>Ongoing adaptation and improvement</td>
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<td>3</td>
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</table>
## Efficacy factors II

<table>
<thead>
<tr>
<th>Effective Factors</th>
<th>All</th>
<th>MSM</th>
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<th>General pop.</th>
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<tbody>
<tr>
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<td>Small group size</td>
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<td>Face-to-face</td>
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<tr>
<td>Duration</td>
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<td>Peers</td>
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<td>Trained facilitator</td>
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<td>Similarity between facilitator and audience in age, gender, ethnic, behaviour, background characteristics</td>
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<td>-</td>
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<tr>
<td>Two facilitators are better than one</td>
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<td>Credibility, committed, empathetic, gain trust</td>
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<td>-</td>
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<tr>
<td>Non-community members</td>
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## Efficacy factors III

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<th>Intervention content</th>
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<td>278</td>
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<td>18</td>
<td>70</td>
<td>166</td>
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<td>Socio-cultural sensitivity</td>
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<td>Addressing barriers</td>
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<td>Promotion of skills</td>
<td>Risk perception</td>
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<td>Behavioural</td>
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<td>Life skills</td>
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<td>Communication/social skills</td>
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<td>3</td>
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<td>Skills for long-term maintenance of behaviour change</td>
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<tr>
<td>Unspecified</td>
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</table>
# Efficacy factors IV

<table>
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<tr>
<th>Effective Factors</th>
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<th>MSM</th>
<th>IDU</th>
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<th>General pop.</th>
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</thead>
<tbody>
<tr>
<td><strong>all</strong></td>
<td>278</td>
<td>24</td>
<td>18</td>
<td>70</td>
<td>166</td>
</tr>
<tr>
<td>Clearly defined target audience</td>
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<td>-</td>
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<tr>
<td>Homogenous group</td>
<td>9</td>
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<td>2</td>
<td>7</td>
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<tr>
<td>underserved populations</td>
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<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>opinion leaders, high-level political leaders</td>
<td>2</td>
<td>-</td>
<td>-</td>
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<td>1</td>
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<tr>
<td><strong>Tailored to target group</strong></td>
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<tr>
<td>Individualized</td>
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<td>5</td>
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<tr>
<td>Definite specific recommendations</td>
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<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Begin with understanding of target group/research</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>4</td>
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<tr>
<td>General recommendation</td>
<td>15</td>
<td>1</td>
<td>-</td>
<td>5</td>
<td>9</td>
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<td><strong>drug substitution</strong></td>
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<td>3</td>
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<td>confidential counselling and testing</td>
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<td>-</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>empathic, non-stigmatizing, not too demanding counselling by GP</td>
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<td>-</td>
<td>-</td>
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<td>4</td>
</tr>
<tr>
<td>partner notification</td>
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<td>-</td>
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<td>-</td>
<td>1</td>
</tr>
<tr>
<td>contraception</td>
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<td>-</td>
<td>-</td>
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</tbody>
</table>
QIP – the workflow

**Documentation:** Participants describe the structures, concepts, processes and outcomes of their prevention activities in detail.

**Assessment:** External expert reviewers systematically appraise activities along quality dimensions (peer review system).

**Analysis:** QIP pools data to develop benchmarks.

**Quality profiles:** QIP reports scores against benchmarks, reviewer feedback and recommendations.

**to participating institutions/providers**
QIP online
### 7 main dimensions, 22 sub-dimensions

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Sub-dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptual quality</td>
<td><em>relationship to actual need</em> <em>target group selection</em> <em>understanding the target groups</em> <em>goals and objectives</em> <em>prevention approach</em></td>
</tr>
<tr>
<td>Quality of Project Planning</td>
<td><em>coordination with other agencies</em> <em>adaptation of the approach to the operating environment</em></td>
</tr>
<tr>
<td>Contributors and Other Stakeholders</td>
<td><em>personnel and competencies</em> <em>interdisciplinary collaboration and ongoing consultation</em></td>
</tr>
<tr>
<td>Dissemination and Communication</td>
<td><em>dissemination among target groups</em> <em>health education and communication methods</em> <em>media work and information material</em> <em>supporting sustainable change</em></td>
</tr>
<tr>
<td>Process Design and Project Management</td>
<td><em>project management</em> <em>responding to difficulties</em> <em>quality control of external contributions</em></td>
</tr>
<tr>
<td>Measuring Success, Evaluation</td>
<td><em>comprehensive overview</em> <em>documenting reach and acceptability</em> <em>documenting effects</em> <em>evidence of effectiveness</em> <em>collecting service user data</em></td>
</tr>
<tr>
<td>Sustainable Quality Development</td>
<td><em>systematically passing on experience and results for long-term improvement processes</em></td>
</tr>
</tbody>
</table>
1. General information about the project

**Date:**

1.1 Project title (please describe only one project per form and write its name here):

1.2 Responsible organisation:

We need this information to feed the results back to you. We will not share your information with third parties outside GIP. Expert reviewers are committed to professional ethical guidelines (e.g. strict confidentiality of information and documents).

*Responsible organisation/institution:*

*Contact person:*

*Address (or e-mail, telephone, fax, website):*

1.3 Project time frame:

- At the planning/preparation stage
- Planning start date (month/year):
- Implementation in progress
- Implementation start date (month/year):
- Completed
- Completion date (month/year):

1.4 Reach and setting: where does the project operate?

- Nationwide
- In the State/Province of:
- At the regional or municipal level in:
- City, suburb, precinct or town:
- Across administrative borders

- Government organisations
- NGO
- Commercial venues (e.g. saunas, bars, clubs, ... which?):
- Drug services (e.g. needle and syringe programme (NSP) ... supervised injecting facility, drop-in centre):
- Sex work premises and locations, which?:
- Ethnic community - geographic origin:
- Youth service, which?:
- Counselling services:
- Hospital:
- School - Which type?:
- Leisure facilities (e.g. cinema, night club):
- Care facility:
- University / College:
5. Planning, preparing and adapting the project

5.1 Integrating the project into wider service provision: What similar activities are underway within your organisation or sector? How do you coordinate your activities to use existing services, recognising opportunities and explore potential synergies?

E.g. mapping local services, collaborating or forming partnerships with other stakeholders

- [ ] No coordination of activities because: 
- [ ] Not necessary because: 
- [ ] Coordination had these results: 

5.2 Are formal agreements with other stakeholders in place?

E.g. on funding, premises, task allocation, personnel

- [ ] Not required because: 

- [ ] Yes, agreement in place with: 
  - [ ] Content: 
  - [ ] 

- [ ] 

- [ ] 

- [ ] 

- [ ] No, agreement yet to be reached with: 
  - [ ] Content: 
  - [ ] 

5.3 Have you examined the conditions in the project's operating environment?

Does the project reflect socio-cultural factors in your field of activity? Is your approach tailored to the prevailing local circumstances?

Please briefly describe your process and its findings:

- [ ] 

5.4 Have you adopted a standardised programme or model?

- [ ] No

- [ ] Yes, which one: 

- [ ] Modified, based on: 

5.5 Is your project implemented according to a written manual or guidelines?

Please attach the manual. The manual can be a list or a loose-leaf collection that has grown over time.

- [ ] No
Requirements for documentation

• Completeness: The form systematically collects what reviewers need for assessment, from the starting environment through planning and implementation to results, documentation and dissemination.

• Accuracy: The form collects practice-oriented quality markers for each QIP quality dimension.

• Economy of effort: Questions focus on core issues. The form mostly uses yes/no or multiple choice and some free text to describe context, basic concepts, adaptations and specific details.
Benefits of documentation

• Often, project teams only manage to read excerpts of studies because they lack the time for comprehensive research and literature review.
• By filling in the documentation form they can quickly absorb the key characteristics of results-oriented prevention and health promotion through the research-based QIP quality dimensions.
Benefits of external assessment

• External points of view are less biased and more objective than self-assessment and lead to new questions, suggestions and ideas.

• External assessment highlights ‘blind spots’, which are easily overlooked internally.
Structure of the assessment

- Uses a detailed assessment guide.
- Contains the 7 main and 22 quality sub-dimensions with guiding questions and assessment criteria.
- For each dimension, the guide leads reviewers to the relevant data in the documentation form submitted by the project.
- Reviewers rate each dimension using a set of clearly defined quality levels.
- The guide offers criteria to assist reviewers in rating each dimension.
Assessment reliability

- Assessment results must comply with scientific standards to be verifiable and reliable.
- The assessments of several reviewers should match as closely as possible.
Assessment validity

QIP ensures statistical validity by:
- guiding reviewers through the assessment process
- condensing each assessment decision into two main steps
- dividing quality into main and sub-dimensions
- providing guiding questions for each step in the assessment
- assisting decision-making with assessment criteria
- suggesting minimum standards for each dimension
- explaining each dimension in the style of a manual
- rating quality according to four clearly structured, self-explanatory levels.
# QIP Quality Levels

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Problem zone</td>
<td>Important prerequisites for the evidence-based implementation of this quality dimension are missing. This results in clear deficiencies, which makes achieving the objectives improbable, unpredictable or uncontrollable.</td>
</tr>
<tr>
<td>1</td>
<td>Needs improvement</td>
<td>The project has created the foundations and basic requirements for successful activities, but is not yet interconnecting or utilising them sufficiently. It at least partially fulfils this quality dimension but should improve it markedly as soon as possible.</td>
</tr>
<tr>
<td>2</td>
<td>Meets Standard</td>
<td>The project has assembled an evidence base, competencies and processes for professional and effective health promotion and integrated them into an overall approach. It therefore complies with the expectations relevant to its field, its operating environment and current research. It operates at a good level of quality and can expect to succeed.</td>
</tr>
<tr>
<td>3</td>
<td>Outstanding</td>
<td>The project exceeds the standard in this quality dimension and can serve as a model because: Either: those responsible continuously and systematically develop quality in prevention and health promotion within this project; they actively extend competencies and knowledge, and implement measures for improvement. Or: the project is developing a new, innovative solution, i.e. a model that meets the requirements of this quality dimension and that can be transferred to other projects. A project shows innovation when it develops, tests and provides evidence for new, potentially effective measures or interventions, or when it applies and adapts a proven approach or accepted method to an existing problem.</td>
</tr>
</tbody>
</table>
Who becomes a QIP reviewer?

- Qualification in a health-related field (medicine, psychology, health sciences, health insurance management, sports and exercise science, public health or similar) or other fields (e.g. management, education, sociology) if they can demonstrate a focus on health.

- Ability to exercise judgment on the appropriate use of prevention and health promotion concepts and methods, based on at least one year’s relevant professional experience (e.g. developing programs, implementing projects, coordinating and organising services, evaluative research, training or quality assurance and improvement).

- Competencies in facilitation and training because people trained in QIP as part of Quality Action will be training and assisting others in using the QIP documentation form.

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Reviewer Code of Conduct

Reviewers commit to carrying out their assignments faithfully and professionally and to act according to ethical guidelines on professional conduct as they exist for health professionals.

1. Confidentiality of assignments: QIP reviewers commit to not passing on any information they received in relation to their assignments. They must not disclose their participation in any assessment to third persons.

2. Copyright: QIP reviewers must not pass on any materials received in relation to an assignment or use them for their own purposes, unless the information is also publicly available and they respect proprietary rights.
3. Independence: QIP reviewers are independent, i.e. they are not bound to any one theory, discipline or method of health promotion and prevention, and agree to apply the evidence-based criteria of the QIP system.

4. Conflict of interest: QIP reviewers do not derive any direct personal or institutional advantage from particular results of their assessments. They declare any possible conflicts of interest openly and decline assignments if necessary.

Reviewers commit to comply with these duties by signing a declaration. They forfeit their right to remain active as QIP reviewers if they breach professional ethics.
## Conceptual quality: Is the project rationale logical and consistent?

<table>
<thead>
<tr>
<th>Quality dimension</th>
<th>Guiding Question</th>
<th>Suggestions for assigning quality levels (assessment criteria)</th>
<th>Reference to documentation form</th>
</tr>
</thead>
</table>
| I. B Target group selection | Has the project established clear, evidence-based criteria for selecting and defining target groups? | - The project defines specific target groups (beneficiaries and/or intermediaries). Choosing ‘everyone’ (the general population) as the target group, e.g. for awareness-raising or antiretroviral drug campaigns, is only rarely useful and must be well supported by evidence. Target groups can be e.g. students of a particular year level at a school, men who have sex with men (MSM) in a city, or people who inject drugs who attend a counselling service or supervised injecting facility (3.1).
- The project should know the size of the target group as accurately as possible (e.g. the number of sex workers in a precinct or local government area). It should at least provide an estimate (3.1).
- The project selects target groups on the basis of exposure to HIV, burden of disease, risk, or the likelihood of their cooperation and provides meaningful information at 3.2. Target groups were not selected based on convenience.
- Where this can increase effectiveness, the project involves intermediaries to support the approach (e.g. teaching personnel or peers, outreach personnel to reach street sex workers etc.) and provides relevant information at 3.3.
- The selected intermediaries are in personal contact with the beneficiaries and can contribute to changes in health knowledge, motivation or behaviour, e.g. by providing health information (3.4).
- The time invested in reaching the beneficiaries and intermediaries is appropriate for the chosen health objectives. As a rule, the project should dedicate the largest proportion of time to the beneficiaries, but invest at least 20–30% when working with intermediaries (3.5). Exceptions are interventions to inform, upskill and empower intermediaries. These will usually focus exclusively on intermediaries (perhaps complemented by public relations activities). | 3.1 to 3.5 |

### Additional criteria for quality Level 3:
- The project defines its target groups based on scientific data or current research (e.g. on risk exposure, health need or accessibility) (3.2).
- The chosen intermediaries are socio-culturally similar to the beneficiaries (e.g. age group, behaviour) (3.4).
- The chosen intermediaries possess the necessary competencies (3.4).
- The project involves more than one sub-population from the given social environment, either as beneficiaries or as intermediaries (e.g. staff at a homeless support service, social workers at a counselling service for sex workers who are interested in leaving the industry, outreach workers in a precinct, police, pastoral care workers, personnel at an outreach clinic for sex workers) (3.1, 3.3).
How to proceed with the assessment

• Comprehensive overview: read the entire documentation.

• Proceed from dimension to dimension: start with the sub-dimensions and then assess the main dimension overall.

• Answer the guiding questions and assign a quality level (0 – 3). If this is not possible, assign N (‘not applicable’) or U (‘unclear’).

• Based on your own experience, note ideas and suggestions for improvement, e.g. references to websites, publications or good practice. Make these points brief and specific so that recipients can understand and use them.
If you are unsure...

- Try to get an understanding of the project as a whole. Health targets, target group, context and interventions should match.

- Decide first whether the project needs improvement (level 0 or 1) or not (2 or 3). Then decide whether the project lacks basic prerequisites (level 0) or can serve as a model (level 3). If not, decide on level 1 or 2.
If you are unsure...

- Keep in mind that significant quality deficiencies in one dimension lower the chance of effectiveness and justify a lower overall rating.

- Gaps in the documentation may indicate a lack of quality. QIP helps detect such weaknesses as areas for improvement. Significant gaps therefore usually justify a lower rating.
QIP Database and benchmarks

• Pools assessment results and characteristics of all projects that have applied QIP.
• Calculates the average scores of projects as benchmarks.
• Projects can compare their own scores against the averages and against the highest and lowest scoring projects in their field.

• QIP forms comparison groups according to:
  • Aim or health issue and target group.
  • Type of organisation (e.g. counselling service, NGO)
  • Year and duration (e.g. projects running from 2012-2013)
QIP Structural influences

- The analysis can show structural influences on quality by grouping projects from organisations with similar characteristics. For example, a lack of financial resources may be associated with limited quality in certain areas and a target-group oriented service model may be associated with high quality in certain areas.
What is the feedback for?

• QIP feedback offers participating organisations an overall picture of the current state of the work of the project they submitted for analysis using the QIP documentation form. It is intended to:
  • capture the achievements, quality, results and probable effectiveness of the project
  • indicate starting points for improvement, so that quality and effects can be increased quickly and efficiently by prioritising and working on weaknesses
  • support continuous improvement, so that effectiveness, sustainability and efficiency increase over the long term.
Feedback content

• Brief summary of the QIP data information system
• Explanation of the 7 main and 22 quality sub-dimensions
• Overview of content and significance of the feedback
• Average scores for main and sub-dimensions (calculated from the assessments made on the basis of the documentation form submitted)
In addition, once the database has pooled a sufficient amount of project data:

• Averages of all projects in the same field of activity
• Results of the highest-scoring project (unnamed) in each dimension
• Results of the lowest-scoring project (unnamed) in each dimension
• Information about the number of projects in the group used for comparison and their fields of activity
• Eight graphs illustrating average and comparison scores
• Project-specific advice and suggestions from the expert reviewers.
What can the quality profile tell us?

• The 7 main and 22 quality sub-dimensions present an overall picture of how well the project is designed and where it is already working well (higher and lower-scoring dimensions).
• The results show whether the project is designed according to current professional standards and is likely to have effects.
• The dimensions can be used for process evaluation because they reflect the current quality of activities and the degree to which they achieve their objectives.
What can the quality profile tell us?

• QIP assessments can indicate likely effectiveness for small, innovative, planned or beginning activities as well. To be considered effective, a project must score near or above level 2 (‘Meets Standards’) in all dimensions.

• Benchmarks derived by pooling data from similar projects relate the project’s quality profile to the working conditions present in its field of activity.

• The (per dimension) scores of the highest and lowest-scoring project in a field show the quality range achievable in their field: the currently realistic quality potential lies between these two values.
<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Mean</th>
<th>Comparison scores for each dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Your Project</td>
<td>All Projects</td>
</tr>
<tr>
<td>Adressing urgent health problems</td>
<td>2,00</td>
<td>2,25</td>
</tr>
<tr>
<td>Criteria for target-group selection</td>
<td>2,33</td>
<td>2,26</td>
</tr>
<tr>
<td>Understanding of target group</td>
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<td>2,30</td>
</tr>
<tr>
<td>Goals and objectives</td>
<td>2,00</td>
<td>2,04</td>
</tr>
<tr>
<td>Preventive approach</td>
<td>2,00</td>
<td>2,00</td>
</tr>
<tr>
<td>Concept and approach</td>
<td>2,00</td>
<td>2,00</td>
</tr>
<tr>
<td>Integration into the setting</td>
<td>1,33</td>
<td>1,58</td>
</tr>
<tr>
<td>Adaption to local requirements</td>
<td>1,67</td>
<td>1,79</td>
</tr>
<tr>
<td>Planning</td>
<td>1,33</td>
<td>1,66</td>
</tr>
<tr>
<td>Staff and qualifications</td>
<td>2,00</td>
<td>2,17</td>
</tr>
<tr>
<td>Systematic co-operation</td>
<td>2,00</td>
<td>2,07</td>
</tr>
<tr>
<td>Contributors + networking</td>
<td>2,00</td>
<td>2,00</td>
</tr>
<tr>
<td>Dissemination of health information</td>
<td>2,00</td>
<td>1,65</td>
</tr>
<tr>
<td>Intervention methods</td>
<td>2,00</td>
<td>1,89</td>
</tr>
<tr>
<td>Intervention media</td>
<td>-</td>
<td>1,83</td>
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<tr>
<td>Support of sustainable changes</td>
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<td>1,86</td>
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<tr>
<td>Dissemination + intervention methods</td>
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<tr>
<td>Controlling</td>
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<td>1,94</td>
</tr>
<tr>
<td>Strategies for unexpected events/setbacks</td>
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<td>1,59</td>
</tr>
<tr>
<td>Quality control of external contributions</td>
<td>-</td>
<td>1,14</td>
</tr>
<tr>
<td>Project management</td>
<td>-</td>
<td>1,60</td>
</tr>
</tbody>
</table>
Locating the project within its field
QIP expert recommendations and practical suggestions

1. Conceptualization


2. Methodological Framework

The framework is based on a comprehensive review of the existing literature and expert opinions. Key components include:

- **Objective Setting**: Defining clear and achievable goals for the project.
- **Methodological Framework**: A structured approach to implementing the project.
- **Evaluation**: Monitoring and assessing the project's impact.
- **Monitoring and Evaluation**: Regular assessment of project progress.

3. International Examples

Exemplary international projects highlight the importance of community involvement and the need for culturally sensitive approaches. These projects have successfully addressed public health challenges and improved community health outcomes.

4. Implementation Strategies

Effective implementation requires a combination of strategy, resources, and collaboration. Key strategies include:

- **Strategic Planning**: Developing a roadmap for project implementation.
- **Resource Allocation**: Ensuring adequate funding and resources.
- **Collaboration**: Working with local partners and stakeholders.

5. Conclusion

The framework presented in this document provides a comprehensive approach to planning, implementing, and evaluating public health projects. It emphasizes the importance of community involvement, evidence-based practices, and continuous improvement.

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Using QIP feedback to improve practice

• Quality dimensions indicate project components to be redesigned: those below level 2 (‘meets standards’).

• Where the benchmark for the field is significantly higher, look to others for ideas and examples. Reviewers’ comments and suggestions provide direction.

• Several reviewers perceiving significant effects from an activity counts as evidence for effectiveness. This evidence carries weight because it is produced independently, similar to an external evaluation. It can be useful for attracting collaborators, motivating stakeholders and continuing the activity.
Using QIP feedback to improve practice

• Scores under 1.0 in the ‘Evidence of Effectiveness’ dimension call for immediate improvements. Structural barriers are no reason for losing sight of effectiveness.
• If the project cannot improve effectiveness in its current form, it must develop new concepts and approaches to use its resources efficiently.
• As projects are generally managed with professionalism and competence, reviewers are encouraged to use suggestions sparingly. If a project scores low in a dimension, it is often not due to a lack of knowledge but to a difficult environment.