

Final Report

**SEMINAR ON  
MAXIMIZING  
ACCESS AND QUALITY  
OF FAMILY PLANNING SERVICES**

Grand Regency Hotel

July 11 - 12, 1994

Nairobi, Kenya

Final Report

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### **Acknowledgements**

The seminar organizers would like to recognize the contributions of the presenters, rapporteurs and assistance of the staff of IPPF and FHI, especially Ms. Laurencia Okoh and Ms. Linda Ochieng, who helped compile the final report.

Funding for the seminar was provided by the United States Agency for International Development through Family Health International's Cooperative Agreement.

# PROCEEDINGS

## Introduction

A two-day seminar on "Maximizing Access and Quality of Care of Family Planning Services" was held July 11-12, 1994 in Nairobi, Kenya. The seminar was organized by Family Health International (FHI), in collaboration with the Nairobi Regional Offices of the International Planned Parenthood Federation (IPPF) and the Program for International Training in Health (INTRAH). Objectives of the seminar included:

1. To sensitize and raise the awareness of IPPF Executive Directors to the importance of maximizing access and quality of family planning services provided by the IPPF affiliates;
2. To review and discuss the results of a needs assessment questionnaire conducted among affiliates on issues related to access and quality of care;
3. To introduce participants to various methods to assess quality of care; and
4. To develop an illustrative action plan for the most important program areas for improved access and quality of care.

Forty-five participants were present at the seminar. Participants included Executive Directors from thirty-two IPPF affiliates, representatives from the IPPF headquarters in London, its Regional Offices in Nairobi and Lomé, the Nairobi and Lomé offices of the Center for African Family Studies (CAFS), as well as representatives from the Association of Voluntary and Safe Contraception (AVSC), FHI, INTRAH and The Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO). For a complete list of participants see Appendix 1.

## Day One

### Opening

Mr. Kodjo Efu, the Administrative Executive of the IPPF Regional Office in Nairobi, opened the seminar. He was pleased that the seminar was the result of a collaborative effort by IPPF, FHI and INTRAH and hoped that this collaboration would be sustained and further developed. Mr. Efu explained that IPPF's strategic plan, *Vision 2000*, highlights quality of care as a priority strategic issue.

In addition to issues regarding maximizing access and quality, Mr. Efu felt that demonstrated efforts to harmonize approaches by the various agencies was another important aspect of the seminar. One expectation of the seminar was that Executive Directors would translate the theoretical discussion of the various topics into practical reality at the various FPA levels. He concluded by thanking Dr. Mariam Barry (IPPF), Ms. Pauline Muhuhu (INTRAH) and Ms. Kathy Jesencky (FHI) for their hard work in bringing the seminar into fruition and to the United States Agency for International Development (USAID) for funding the activity.

### **Summary of Proceedings**

Dr. Barry, Senior Program Officer for Service Delivery, IPPF/Nairobi, reviewed the seminar program and its objectives. The program can be found in Appendix 2 followed by copies of overheads and presentations in order of their presentation during the seminar. Dr. Barry stated that the successful outcome of the seminar will position FPAs to continue playing a leading role in the improvement of reproductive health by examining and addressing the issues of access and quality of care.

The first day of the program was devoted to raising participants' awareness about the importance of maximizing access and quality of care. Guest speakers, Dr. Carlos Huezo, IPPF's Medical Director, and Dr. Roberto Rivera, FHI's Corporate Director for International Medical Affairs, presented the most current thinking on the elements of access, quality of care, and barriers to maximizing access and quality. Dr. Barry presented the Africa Region's experience in improving quality of family planning services.

### **Access and Quality of Care - An Overview**

According to Dr. Huezo, quality of care is one of the basic reasons for the existence of IPPF. Over the last decade IPPF has increasingly emphasized quality of care at the international, regional and FPA levels with their focus on meeting client's needs through the rights of the client. African FPAs have already begun to implement actions aimed at improving access and quality of care, the most important being a workshop organized in 1993 for ten FPAs. To further the process of improving quality of family planning services, Dr. Barry asked that FPAs identify obstacles impeding access and quality and that FP program heads be fully involved in quality improvement activities.

Dr. Rivera stressed the need for collaboration among agencies in the effort to improve access and quality of care. IPPF, USAID Cooperating Agencies, international experts and the World Health Organization (WHO) have met to agree on a standardized set of service delivery guidelines. Dr. Rivera gave examples of the classification of procedures often required for the safe delivery of contraceptives. These procedures range from essential and mandatory in all circumstances for safe use of contraceptive methods to procedures which are not only unnecessary, but irrelevant -

- such as some lab services. Dr. Rivera promised to share these standardized service delivery guidelines with the FPAs once they are finalized.

Ms. Kathy Jesencky presented results of the needs assessment questionnaire sent to the IPPF affiliates (A copy of the questionnaire and results are included in Appendix 3). Twenty-eight out of thirty-two associations responded to the questionnaire. The assessments emphasized what efforts associations are currently undertaking to improve access and quality of care and the obstacles they face in this initiative.

Some highlights of the assessment results follow. Nineteen of the associations have Community-based Distribution (CBD) programs and many had liberalized eligibility criteria such as not requiring that a client be married before being eligible for contraceptive methods. However, certain restrictive factors still exist, such as unnecessary follow-up visits, a required clinic visit before starting oral contraceptives from CBDs, and provision of the first supply of OCs only when a woman has her menses. All of these practices constitute examples of unnecessary barriers to access to family planning methods.

It was noted that quality of care will not be achieved unless an effective logistics supply system is put in place. Seminar participants agreed that the advantages and disadvantages of providing a particular number of cycles of oral contraceptives should be reviewed by each FPA, taking its unique circumstances into consideration. In addition, it was noted that FPAs should be provided with updated information on service delivery practices, especially those that may pose obstacles to access. This information could assist FPAs in their efforts to remove unnecessary barriers.

### Country-Level Case Studies

Having introduced the topic of improving access and quality of care in the morning, Dr. A. Gnoumou, Executive Director of ABBEF (Burkina Faso), and Dr. I. Achwal, Senior Program Officer of FPAK (Kenya), presented their FPA's experiences in this area. These presentations included ideas about how other FPAs might consider addressing access and quality of care issues.

Noted obstacles to access include:

- Method range usually inadequate due to infrequent availability of stock. In certain cases, methods that are available in urban areas are not available in rural areas.
- Information available to clients is usually limited.
- Lack of adequate training for providers.
- Under-utilization of staff skills. However, in some cases, competence of service providers is below the expected level. Some providers are not able to adapt easily to providing new methods.

- Unsatisfactory provider/client relationship, leading to low accessibility of services.
- Long client waiting time.
- Ineffective follow-up mechanisms for clients.
- Lack of equipment, for example, some rural clinics do not have gynecological tables.
- Lack of publicity, information and educational materials.
- Low staff morale.
- Inappropriate use of clinic facilities/staff in certain cases, evidenced by seeing two nurses attending to one client, and/or under-utilized clinic space.

In order to alleviate such constraints, sectoral-wide efforts (including governmental and non-governmental bodies) should be encouraged to view quality of care as a common goal and to elicit their total commitment in order to achieve it. In light of this, a strategy should be designed as a collective task, taking into consideration various aspects such as:

- Progressive training of all individuals involved in providing services. On-site training and Training of Trainers should be encouraged.
- Improvement of the contraceptive logistics system which allows clinics to receive all necessary supplies.
- Clients should be provided with a reasonable level of contraceptive supplies during each visit, in order to avoid making unnecessary visits to the clinics for re-supply purposes only.
- Development of clear job descriptions which have input from the providers.
- Change of organizational climate such that providers' views are respected and they are involved in administrative decisions.
- Implementation of steps to improve quality of care, which initially appears costly, but with time, proves to be economical.

#### Tools to Assess Quality of Care

Ms. Kathy Jesencky gave an overview of ways FPAs could identify problem areas and measure the effectiveness of interventions. She emphasized that improved access and quality would

lead to:

- greater acceptance of family planning
- increased satisfaction of clients
- increased continuation rates
- increased efficiency

The speakers who followed gave more in-depth explanations of some of the more commonly used methodologies to assess quality of care. Ms. Grace Wambwa, AVSC Program Officer, gave an overview of COPE (Client-Oriented, Provider-Efficient), a self-evaluation tool used in service delivery sites. Ms. Pauline Muhuhu, Regional Director for INTRAH, explained how FPAs could assess service provider competence to ensure that providers had the necessary skills to provide quality family planning services. Dr. Mariam Barry, explained the process of client flow analysis to determine the efficiency of providing care. These three methodologies are outlined below.

#### A) COPE

COPE is a practical tool that can be used to assess quality of care and access to family planning services. The goal of COPE is to make services Client-Oriented and Provider-Efficient. COPE is comprised of the following four parts:

1. **Self-assessment** The assessment is conducted with the aid of a checklist divided into ten sections. This checklist covers clients' rights to quality services and their right to assess these services. The assessment also addresses the needs of family planning service providers.
2. **Client interviews** Interviews are conducted by staff and are intended to enable staff members to objectively review their services and thus gain ideas about how their service provision practices could be improved.
3. **Client flow analysis** This is a method of tracking clients through the clinic from the time they enter until the time they leave.
4. **Plan of action** is a summary of results from the Client - Oriented and Provider-Efficient surveys. Plans of action written by staff include descriptions of actions that can be operationalized to improve service delivery.

#### B) Assessing Service Provider Competencies

Provider competence includes:

1. The ability of the provider to perform clinical procedures and techniques at the minimum acceptable level of performance. Acceptable level of performance refers to the levels at which the safety of the client and the efficacy of the method are enhanced;
2. Observance of protocols, standards; and
3. Protection of clients from infections during the performance of procedures.

The key elements in assessing service provider competencies include:

1. Defining Quality of Care
2. Setting performance standards that indicate an acceptable level of performance to meet quality of care and development of instruments for performance assessment.
3. Training in performance evaluation skills for diagnosis of performance problems.
4. Performance assessment through direct observations.
5. Performance diagnosis and determination of interventions to address performance problems.
6. Interventions
7. Post intervention follow-up

### C) Client Flow Analysis

This is an evaluation method that enables the provider to monitor the way a client is treated from the moment s/he arrives at the clinic until s/he leaves.

The analysis is important, in that it:

1. Measures the waiting time of clients before s/he is served. (If the waiting time is too long, a client may be more likely to discontinue his/her FP method.)
2. Gauges the productivity of staff.
3. Assesses the organizational or managerial capability of staff.
4. Develops a plan of action to enable the provider to reduce clients' waiting time and to improve upon service delivery.

Stages in client flow analysis are as follows:

1. Measure waiting time of client at each level, using the client flow form
2. Measure total waiting time the client spent at the clinic
3. Analyze the above
4. Identify the bottleneck
5. Process results and take remedial action

Remedial action can be taken through:

1. Deciding on how to reduce client waiting time
2. Reviewing the number of contacts (visits/revisits) a client makes
3. Training of staff to carry out various functions
4. Introducing a system of having more centers in urban areas

## **Day Two**

### Working Groups

Participants were divided into four working groups (two anglophone, two francophone) during the morning session to examine specific problems identified in the needs assessment questionnaire. Their task was to draft an action plan that addressed the identified problems. Six problems were examined in detail:

- inaccessibility of services
- insufficient resources
- inadequate logistics/supplies
- unmotivated personnel
- lack of competent personnel
- socio-economic constraints/misconceptions about FP

Three problem areas were addressed in one anglophone and one francophone group and the other three by the third and fourth groups (A list of members of each working group is included in Appendix 4). The working groups brainstormed about the different possible causes of identified problems, then analyzed them and then developed an action plan. The results of the working groups can be found in Appendix 4. The proposed actions intended to provide ideas for appropriate actions to be taken for each identified problem.

Presentation and discussion of the action plans took place during the afternoon session. The priority causes and solutions to the problems were often similar for anglophone and francophone working groups.

### Highlights of Discussion

During discussion periods which followed plenary presentations, participants agreed that the following issues need immediate attention and/or action by all concerned parties, including themselves.

- List of client needs should be made available to service providers to enable them to be more conversant with clients.

- There is a need for more accurate and updated information for service providers.
- Education and advocacy are needed to affect a change in provider attitudes in order to curb or limit service provider bias.
- Management skills of providers should be enhanced in view of the fact that they manage clients as well as resources (financial, human and material).
- Too much counseling might create bottlenecks, therefore counseling sessions should focus on client needs - i.e what s/he wants to discuss.
- Counseling is more effective when combined with educational materials (usage of posters, pamphlets, videos, etc...).
- Staff motivation can be accomplished in various ways. A good salary is not the only means to achieve staff motivation. Another way to motivate staff is to give them recognition and respect for their efforts at work. They need to know that their work is worthwhile and that they form an integral part of the system.
- It is necessary to have effective communication links among the different agencies involved in quality of care issues in order to harmonize and enhance these approaches.
- In recent years, the demand for family planning services has increased while available funding has decreased. It is therefore necessary that family planning resources should match the methods most often used or requested. A way of accomplishing this aim is to utilize the COPE method which not only examines available resources, but their optimal utility as well.
- Service providers should take special care to ensure appropriate follow-up mechanisms for clients in order to minimize unnecessary discontinuation rates.
- Lessons learned from Kenya and Burkina Faso's experiences in improving quality of care include:
  - It is important to thoroughly assess the current service provision if progress is desired.
  - An action plan is needed to ensure continuous evaluation and progress of service delivery activities.
  - Training for providers and encouragement of collaboration with other agencies that have similar objectives is necessary to ensure harmonized efforts to improve quality of care.

## Evaluation of Seminar

A short evaluation form for the seminar was completed by participants (See Appendix 5 for evaluation results). Overall, the results were very positive. Executive Directors felt that access and quality of care are important subjects and that they gained new knowledge about these two issues from the seminar. They made the following suggestions for follow-on activities:

- Improved MIS, logistics and supervision systems
- Wider dissemination of information about access and quality of care to national staff
- More in-depth training on the use of need assessment and evaluation tools
- Organize similar seminars on a national level so that as many staff as possible are exposed to quality of care information

## **Conclusion**

Participants agreed that the objectives of the seminar were achieved. There was also consensus that the seminar was only the first stage of a series of necessary steps to be taken. The next stage is for FPA Executive Directors to develop national-level action plans and to implement them. The Executive Directors will also need to disseminate what has been discussed during the two-day seminar and to sensitize service providers about the importance of removing unnecessary barriers and improving access and quality of care.

Mr. Tunde Taylor-Thomas delivered the closing speech. He reminded participants that their work was not finished, but just beginning. Their commitment to the process of improving access and quality of care would be manifested in the implementation of activities by their FPAs. To this end, he encouraged participants to return home and begin the process so that the momentum would not be lost. He closed with a quotation from the late Kwame Nkuruma, "I do not know of any greater satisfaction than an efficient service rendered to the people of my country."

**Appendix 1**  
**PARTICIPANT LIST**

**BENIN**

M. Boniface O. Yehouenou,  
Directeur Exécutif, par Intérim/  
Responsable Adm et Financier,  
ABPF/Benin,  
B. P. 1468,  
Cotonou.

**BOTSWANA**

Mme. Ramelefo Cally,  
Executive Director,  
BOFWA - IPPF,  
Private Bag 00100,  
Gaborone.

**BURKINA FASO**

Dr. A. D. Gnoumou,  
Directeur Exécutif,  
Association Burkinabè pour le Bien-Etre  
Familial (ABBEF)  
O1 BP 535,  
Ouagadougou 01

Tel: 310598

**BURUNDI**

Mme. Ryanguyenabi, M. Claire,  
Directeur Exécutif,  
Association Burundaise pour le Bien-Etre  
Familial (ABUBEF),  
B P 5232,  
Bujumbura.  
Tel: 23 29 36  
Fax: 23 34 35

**CAMEROON**

Mrs. Grace Walla,  
Executive Director,  
CAMNAFAW,  
P. O. Box 11994,  
Yaounde  
Tel: (237) 23 79 84

**CENTRAL AFRICA REPUBLIC**

M. Clement Eregani,  
Directeur Exécutif,  
Association Centrafricaine pour le Bien-  
Etre Familial (ACABEF),  
B. P. 1366,  
Bangui,  
Tel: (236) 61 54 35  
Fax: (236) 61 67 00

**CONGO**

M. Mboundou Florent,  
Directeur Exécutif ACBEF,  
B. P. 945,  
850 Avenue de 3 Martyres,  
Gateau des 15 Ans.  
Brazzaville.  
Tel: (242) 82 63 31  
Fax: (242) 82 63 31

**COTE D'IVOIRE**

M. Paul Agodio,  
Directeur Exécutif/intérim  
01 B. P. 5315  
Abidjan 01.  
Tel: 25 18 11/25 18 12  
Fax: 25 18 68

**ERITREA**

Mr. Kidisty Habte,  
Coordinator,  
Acting Executive Director,  
Planned Parenthood Ass. of Eritrea  
P. O. Box 226,  
Asmara.  
Tel: 12 73 33  
Fax: 291-1-12 01 94

**ETHIOPIA**

Mr. Araya Demissie,  
Acting Executive Director,  
Family Guidance Association of Ethiopia  
(FGAE),  
P. O. Box 5716,  
Addis Ababa.  
Tel: (251)1-51 41 11  
Fax: (251)1-51 21 91

**GAMBIA**

Mr. Tunde Taylor-Thomas,  
Executive Director,  
GFPA,  
P. O. Box 386,  
Banjul.

**GHANA**

Mr. Isaac K. Boateng,  
Executive Director,  
Planned Parenthood Association of Ghana  
(PPAG),  
P. O. Box 5756,  
Accra.

**GUINEA-BISSAU**

Dr. Rodrigues, Joao Cosàm,  
Directeur-Exécutif,  
AGUIBEF,  
Apartado 455 1034 Codex Bissau,  
Tel: 22 14 42

**GUINEA CONAKRY**

Dr. Bandian Sidimé,  
Directeur Exécutif,  
Association Guinéenne pour le Bien-Etre  
Familial (AGBEF),  
B. P. 1471,  
Conakry.

**KENYA**

Mr. G. Z. Mzenge,  
Executive Director,  
Family Planning Association of Kenya,  
Harambee Plaza,  
Haile Salassie Avenue,  
P. O. Box 30581,  
Nairobi.

Dr. Isaac Achwal,  
Senior Programme Officer,  
Family Planning Association of Kenya,  
P. O. Box 30581,  
Nairobi.

Dr. David Kihwele,  
Programme Officer,  
Centre for African Family Studies,  
P. O. Box 60054,  
Nairobi,

Ms. Pauline Muhuhu,  
Regional Director,  
INTRAH Program,  
P. O. Box 55699,  
Nairobi.

Ms. Grace Mtawali,  
INTRAH Regional Clinical Program  
Officer for Anglophone Africa,  
INTRAH,  
P. O. Box 55699,  
Nairobi.

Dr. Mariam Barry,  
Programme Officer, S.D.  
IPPF Africa Region,  
P. O. Box 30234,  
Nairobi.

Dr. Timothy H. Gatara,  
PO/RS.  
IPPF Africa Region,  
P. O. Box 30234,  
Nairobi.

Ms. Kathy Jesencky,  
Senior Representative,  
Family Health International,  
P. O. Box 38835,  
Nairobi.

Ms. Nancy J. Toroitich,  
Training Co-ordinator,  
JHPIEGO,  
P. O. Box 47243,  
Nairobi.  
Tel: 56 68 30

**LESOTHO**

Mrs. Leah Mookho Mosaase,  
Executive Director,  
Lesotho Planned Parenthood Association,  
P. O. Box 340,  
Maseru 100,

**LIBERIA**

Mr. Philip S. K. Suakweli,  
Programme Coordinator,  
Family Planning Association of Liberia  
(FPAL),  
P. O. Box 10-0938,  
1000 Monrovia 10,

**MADAGASCAR**

Mr. Manitra Andriamasinoro,  
Directeur Exécutif,  
FISA APF de Madagascar,  
B. P. 703 Antananarivo 101,  
Tel: (261)-2 335 30

**MALI**

M. Lansina Sidibe,  
Directeur Exécutif,  
AMPPF,  
B. P. 105,  
Bamako.  
Tel: (223) 22 44 94  
Fax: (233) 22 26 18  
Telex: 1200 Bamako

**MAURITIUS**

Mrs. Geeta Oodit,  
Executive Director,  
Mauritius Family Planning Association,  
30 SSR Street,  
Port Louis.  
Tel: 240 27 84  
Fax: 208 23 97

**NIGER**

Mr. Bagné Baba Mahaumadou,  
Directeur Exécutif,  
Association Nigérienne pour le Bien-Etre  
Familial,  
B. P. 13174,  
Niamey.

Tel: (227) 72 26 80  
Fax: (227) 72 27 90

**SENEGAL**

M. Belgasime Dramé,  
Directeur Exécutif,  
ASBEF (Association Sénégalaise),  
5, Route du Front de Terre,  
B. P. 6084,  
Dakar.

**SIERRA LEONE**

Dr. Willie E. Taylor,  
Executive Director,  
Planned Parenthood Association of Sierra  
Leone,  
2 Lightfoot Boston Street,  
Freetown.

**SWAZILAND**

Mrs. Khetsiwe Dlamini,  
Executive Director,  
Family Life Association,  
P. O. Box 1051,  
Manzini,

**TANZANIA**

Dr. Naomi B. Katunzi,  
Executive Director,  
UMATI,  
P. O. Box 1372,  
Dar es Salaam,  
Tel: 28424/5/6, 28322  
Fax: 28426  
Telex: 41780

**TCHAD**

M. Benadjel Mbaissour,  
Directeur Exécutif,  
Association Tchadienne pour le Bien Etre  
Familial (ASTBEF),  
ASTBEF, B. P. 4064 N'Djamena,  
Tel: 51 43 37  
Fax: (235) 51 43 37  
Telex: 52 48 KD. TCHAD

**TOGO**

M. Koudaya A. Nyédzy,  
Directeur Exécutif,  
AFTEF,  
Rue Dosseh Tokoin Lyceé,  
B. P. 4056  
Lomé.

Mrs. Laurencia Okoh,  
Acting Head,  
IPPF/CWASRO  
Central and Western Africa Sub Regional  
Office,  
P. O. Box 4101,  
Lomé.

Dr. Sangare Mariam,  
Programme Office SD,  
CAFS,  
Centre d'Etude de la Famille Africaine,  
B. P. 12425,  
Lomé.

**UGANDA**

Mrs. Joyce B. A. S Nima,  
Executive Director,  
Uganda Family Planning Association,  
P. O. Box 10746,  
Kampala.  
Tel: 041-24 49 85  
Fax: 041-25 83 00

**UNITED KINGDOM**

Dr. Carlos Heuzo,  
Medical Director,  
IPPF/London,  
Regent's College, Inner Circle  
Regent's Park,  
London NW1 4NS.  
Tel:44-71-486 0741  
Fax:44-71-487 7950  
Telex:919573 IPEPEE G

**USA**

Dr. Roberto Rivera,  
Corporate Director for International  
Medical Affairs,  
Family Health International,  
P. O. Box 13950,  
Research Triangle Park,  
N.C. 27709.  
Tel: 919-544-7040  
Fax: 919-544-7261

Ms. Vana Prewitt,  
Senior Health Communications and  
Training Coordinator,  
Family Health International,  
P. O. Box 13950,  
Research Triangle Park,  
N.C. 27709.  
Tel: 919-544-7040  
Fax: 919-544-7261

Ms. Rebecca Kohler,  
Health Communications and Training  
Coordinator,  
Family Health International,  
P. O. Box 13950,  
Research Triangle Park,  
N.C. 27709.  
Tel: 919-544-7040  
Fax: 919-544-7261

**ZAMBIA**

Mrs. Veronica Manda,  
Acting Executive Director,  
P.P.A.Z.,  
P. O. Box 32221,  
Lusaka.  
Tel: 22 81 64/65,  
22 81 78, 22 81 98

**ZAIRE**

Mme. Zawadi Mwenge,  
Directeur Exécutif à l'interim,  
AZBEFIND/IPPF,  
Association Zaïroise pour le Bien Etre  
Familial/Naissance Désirables,  
B. P. 15 313,  
Kinshasa I Zaïre.

**ZIMBABWE**

Mrs. Florence T. Chikara,  
Chief of I.E.C.,  
Zimbabwe National Family Planning  
Council,  
P. O. Box St. 220,  
Southerton,  
Harare.

Appendix 2

**SEMINAR ON MAXIMIZING ACCESS TO SERVICES  
AND QUALITY OF CARE**

July 11 - 12 1994

**Monday, July 11th 1994**

**Chairperson:** Dr. A. B. Selaiman, Nigeria  
**Rapporteur:** Mr. I. K. Boateng, Ghana  
Mrs. Khetsiwe Dlamini, Swaziland

8:00 - 9:00	Registration
9:00 - 9:10	Welcome - Mr. Kodjo Efu, IPPF
9:10 - 9:20	Review Seminar Objectives - Dr. Mariam Barry, IPPF
9:20 - 9.55	Maximizing Access and Quality of Care, an International Perspective - Dr. Carlos Huezo, IPPF
9:55 - 10:10	Experience of the Africa Region in Improving the Quality of Family Planning Services - Dr. M. Barry
10:10 - 10:40	Tea
10:40 - 11:15	The Relationship between Contraceptive Delivery Practices and Quality of Care - Dr. Roberto Rivera, FHI <sup>1</sup>
11:15 - 11.45	Discussion and Questions
11:45 - 12:05	Do Service Delivery Practices in FPAs pose obstacles to Access and Quality of Care? Results of Service Delivery Questionnaire - Ms. Kathy Jesencky, FHI
12:05 - 12:30	Discussion and Questions
12:30 - 2:00	Lunch

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<sup>1</sup>Family Health International

**Chairperson:** Mrs. Grace Walla, Cameroon  
**Rapporteur:** M. Bagnebaba Mamadou, Niger

**2:00 - 2:30** Country Level Case Studies:  
Example of action/experiences in improving quality of care -  
Kenya and Burkina Faso representatives -

**2:30 - 3:00** Discussion and Questions

**3:00 - 3:30** Tea

**3:30 - 3:45** Tools to Assess Quality of Care and Improve Family Planning  
Services: An Overview - Ms. Kathy Jesencky

**3:45 - 4:30** Panel Discussion on Means of Assessing Access and  
Quality of Care  
COPE, - Ms. Grace Wambwa, AVSC<sup>2</sup>  
Assessing Service Provider Competence,  
- Ms. Pauline Muhuhu, INTRAH<sup>3</sup>  
Client Flow Analysis, Dr. Mariam Barry

**4:30 - 5:00** Discussion and Questions

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<sup>2</sup>Association for Voluntary Surgical Contraception

<sup>3</sup>Program for International Training in Health

**Tuesday, July 12th 1994**

- 8:45 - 9:00** Define task of Working Groups, Dr. Mariam Barry
- 9:00 - 10:30** Working Group (Part 1)  
Identify causes of certain obstacles to access and/or quality of care  
(Obstacles that were prevalent in needs assessment)
- 10:30 - 11:00** Tea
- 11:00 - 12:30** Working Group (Part 2)  
Identify actions that IPPF affiliates can take to address the  
obstacles.
- 12:30 - 2:00** Lunch
- Chairperson:** Mrs. J. A. B. Nima, Uganda  
**Rapporteur:** Mr. Boniface Yehouenou, Benin
- 2:00 - 3:00** Presentation of results of Working Groups and discussion
- 3:00 - 3:30** Tea
- 3:30 - 4:30** Next Steps - Brainstorming by Participants
- 4:30 - 4:45** Synthesis - Mrs. Laurencia Okoh, IPPF
- 4:45 - 5:00** Closing - Mr. T. Taylor-Thomas, Gambia
- 6:30** Reception

# MAXIMIZING ACCESS AND QUALITY OF CARE: AN INTERNATIONAL PERSPECTIVE

By Dr. Carlos Heuzo

## Strategic Plan/Vision 2000 of IPPF

Six priorities identified under this plan are:

- (a) Family planning unmet needs
- (b) Sexual and reproductive health
- (c) Unsafe abortion
- (d) Empowerment of women
- (e) Youth
- (f) Quality of care

The Contraceptive Prevalence Rate (CPR) in the region currently is about 10% overall. To achieve a CPR above 20% will be difficult because this will involve reaching the less accessible portion of the population i.e the illiterate and rural population. The focus on quality of care in IPPF has been on the perspective of the CLIENT. It should be recognized that there are also the perspectives of service providers and managers.

## IPPF Guidelines

1. Rights of the client - this has been translated into several languages.

- (a) Right to information - without discrimination
- (b) Right to access
- (c) Right to choice - central
- (d) Right to safety
- (e) Right to privacy
- (f) Right to confidentiality
- (g) Right to dignity
- (h) Right to comfort
- (i) Right to continuity
- (j) Right to opinion

2. Needs Providers

- (a) Need for training of service providers with the knowledge and skills required for their task. Responsibility of managers to provide training of service providers in communication skills between themselves and clients. The providers have a great need for information on issues related to their work. Access to information

can assist service providers to talk with authority and act with confidence.

- (b) Need to use information from international medical panel as a resource about specific issues. This information should be channelled to service providers - system has to be organized to ensure this.
- (c) Need for infrastructure - Service providers need the physical facilities and organization necessary to provide services to required quality.
- (d) Need for supplies - Continuous and reliable supplies for providing service at appropriate standards of quality.
- (e) Need for guidance - clear, objective, relevant to reinforce commitment and competence for providing high quality services.

Dimensions of technology assessment which are important for any project.

- Scientifically sound
- Operationally sound
- Socially sound

Guidelines should be realistic to the needs and resources, didactic and easily adaptable.

Use of guidelines for various purposes.

1. Organization of family planning services
  2. Delivery of clinical and non-clinical services
  3. For assessing quality
  4. As training instrument
  5. As guide for supervision
- (f) Back-up: it is essential for service providers to be reassured that all whatever the level of care they are working, (from the community level to the most comprehensive clinical service deliver site) they are members of a larger family in which individuals or units can provide support for each other.
  - (g) Respect: service providers need recognition of their competence and potential as well as respect for their human needs.
  - (h) Encouragement: the need for stimulus in the development of the providers' potential and creativity.

- (i) Feedback: it is necessary for service providers to have feedback concerning their competence and attitudes as they are judged by others.
- (j) Self-expression: service providers need to express their views concerning the quality and efficiency of the programme and to know that their opinion is taken into account in management decision.

### 3. Some Principles of Quality Care

- As a principle we believe that service providers always try to do a good job.
- A system for quality assurance should be integrated into service deliver activities.
- Active involvement of all levels is essential for success of quality of care services.
- Quality of care strategy should be more pro-active than reactive.

### 4. Assessment of Quality of Care

Service guidelines/standards

Indicators/instruments

Procedures: Data collection/analysis

Use of information

Quality of family planning services: (quality, quantity, resources in balance).

## **EXPERIENCE OF IPPF AFRICA REGION IN THE IMPROVEMENT OF THE QUALITY OF FAMILY PLANNING SERVICES**

**By Dr. T. M. Barry**

The need for raising the awareness of FPAs in the region about the importance of the quality of care led to the organization of the workshop for 10 FPAs in July, 1993; 5 Anglophone and 5 Francophone countries were involved.

Anglophone definition of the quality of care refers to "provision of standard, safe, efficient, accessible services that are immediately available, acceptable and reasonably priced and that are offered in a physical and social environment that is conducive to the improvement of the standard of living".

For the Francophone countries the quality of care refers to: "the provision of family planning services that are available, accessible and offered by competent personnel, in appropriate conditions as stipulated by standards defined to meet clients' satisfaction".

These two workshops enabled the participants to become familiar with IPPF Medical Guidelines and Protocols which they discussed and criticized. Each country presented a national action plan. These action plans comprised:

- Training
- Renovation and fitting of clinics
- Strengthening of supervision

The posters on "CLIENTS RIGHTS" developed by IPPF were widely distributed in several languages and have been well received.

The protocol on CBD was adapted and tested in Kenya, Mali and Madagascar.

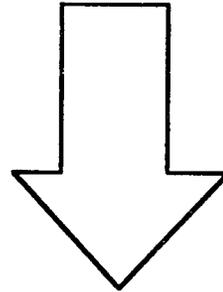
The discussion on the formulation and selection of indicators for quality care adapted to the local conditions of FPAs was initiated during the sub-regional workshops for Anglophone and Francophone countries.

Intervention of agencies other than IPPF in the area of service quality in Africa. There has been collaboration with IPPF by the Population Council, AVSC, CEDPA and Pathfinder, INTRAH and SOMARCH/Future Group, Family Health International.

### **Conclusion**

1. FP program heads to be encouraged to be fully involved in quality improvement activities.
2. FPAs to identify obstacles impeding access to quality services and where possible propose solutions to them.
3. FPAs to be trained in the use of the various quality evaluation tools that are easy to use without requiring additional resources. The actions could contribute to increased contraceptive use in the region (see: NETWORK ON QUALITY OF CARE and AFRICA LINK).

**Maximizing Access and Quality  
(MAQ)**



**Improving Provider Practices**

# Reproductive Health Services Driving Forces

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- Clients' needs
- Community needs
- Program needs
- Providers' needs

# Steps in Reproductive Health Services Design

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Analyze priority community reproductive health needs



Identify reproductive health services



Describe provider's functions



Define educational objectives

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# Access to Family Planning Services

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- The degree to which family planning services and supplies may be obtained at a level of effort and cost that is both acceptable to and within the means of a large majority of a given population.

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# What is Quality in Health Care?

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- Performance according to standards. . .
  - *Roemer and Aguilar, 1988 for WHO*
- The extent to which customer needs are met
  - *Berwick, 1991*
- "being treated like a human being"
  - *Chilean woman, 1993*

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# Six Elements of Quality of Care

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*(Bruce framework)*

1. Choice of methods
2. Information
3. Technical competence
4. Interpersonal relations
5. Continuity of care
6. Appropriateness and Acceptability

# Maximizing Access and Quality

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## Choice of methods:

- Removing unnecessary requirements:  
age/parity, contraindications, pelvic exam, laboratory tests, follow-up visits
- who can provide
- where can be obtained
- regulatory

# Maximizing Access and Quality

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## Information given to clients

- More time on counseling
- Accurate updated information:  
requirements for use, disadvantages and advantages,  
contraindications, precautions, side effects
- Provider bias

# Maximizing Access and Quality

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## Technical competence

- Update guidelines
- Update training needs

# Maximizing Access and Quality

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## Interpersonal relations

- More time
- Better time
- More provider options

# Maximizing Access and Quality

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## Mechanisms to encourage continuity

- Unnecessary follow-up visits
- Return whenever necessary
- Optimize services time and resources
- More provider options
- Improve counseling

# Maximizing Access and Quality

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## Appropriate, acceptable services

- No unnecessary procedures
- Resources for expanded or better services
- Improved provider options
- Diverse service delivery points

# Types of Barriers to Family Planning

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Social  
Cultural  
Religious  
Economic

Medical

Regulatory  
Legal

Geographic  
Logistic

Poor Contraceptive Image

Lack of Trained Providers

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# Factors Influencing Family Planning Service Delivery Providers

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## Micro

- Age
- Gender
- Access to current scientific information
- Degree of experience
- Motivation

# Updating Contraceptive Practices

**"Recommendations for updating selected practices in contraceptive use."**

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# **Classification of Procedures for Delivery of Contraceptives**

## **Class I**

**Essential and mandatory in all circumstances for safe use of the contraceptive method**

- **pelvic exam for IUDs**

# **Classification of Procedures for Delivery of Contraceptives**

## **Class II**

**Medically or epidemiologically rational in some circumstances to optimize the safe use of the contraceptive method, but may not be appropriate for all clients in all settings**

- **blood pressure, breast exam for COCs**

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# **Classification of Procedures for Delivery of Contraceptives**

## **Class III**

**May be appropriate for good preventive health care, but not related to safe use of the contraceptive method**

- **pelvic exam for all hormonal methods**
- **cervical cancer screening for all methods**

# **Classification of Procedures for Delivery of Contraceptives**

## **Class IV**

**Not only unnecessary but irrelevant for the safe use of the contraceptive method**

- **routine, mandatory laboratory tests for all methods (cholesterol, glucose)**

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# **Updating Contraceptive Practices**

**"Improving Access to Quality Care in Family Planning: Medical Criteria in Selected Methods of Contraception."**

# Classification of Medical Criteria for Delivery of Contraceptives

<b>Category</b>	<b>Recommendation</b>
<b>1</b>	<b>Used in any circumstance</b>
<b>2</b>	<b>Generally used</b>
<b>3</b>	<b>Generally not used</b>
<b>4</b>	<b>Not to be used</b>

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# **Classification of Medical Criteria for Delivery of Contraceptives**

## **Class I**

**A situation for which there is no restriction for the contraceptive choice**

- **varicose veins, mild headaches for all methods**

# **Classification of Medical Criteria for Delivery of Contraceptives**

## **Class II**

**A situation where the advantage of using the method usually outweighs the theoretical or proven risks (not the method of first choice)**

- **less than 6 weeks postpartum in breastfeeding women for POC**

# **Classification of Medical Criteria for Delivery of Contraceptives**

## **Class III**

**A situation where the theoretical or proven risks usually outweigh the advantages of using the method and alternative methods are not available or acceptable (the method of last choice)**

- **HIV positive women for IUD**

# **Classification of Medical Criteria for Delivery of Contraceptives**

## **Class IV**

**A situation which represents an unacceptable health risk associated with the use of the contraceptive method (method contraindicated)**

- **current and history of VTE for COCs**

# MAQ Assessment I

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- Is what I do, tend to do or advise based on current and up to date scientific knowledge?
- To what extent does my practice or advice positively or negatively affect the quality of service or care that I provide to my clients?

# MAQ Assessment II

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- Do I maintain a flexible, sensitive and responsive attitude to scientific advances, cultural and social needs, as well as a caring attitude toward my clients?
- In pondering the questions above, are there any medical barriers in my practice or advice?
- What can I do to remove these medical barriers? Can I start today?

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# DO FAMILY PLANNING ASSOCIATIONS POSE OBSTACLES TO ACCESS AND QUALITY OF CARE

By Kathy Jesencky

## Introduction

IPPF and its affiliates have been in the forefront of providing family planning services. Often, as non-governmental organizations, they have led the way in innovative initiatives which have made family planning services more accessible to the public. To have a better understanding of FPAs present service delivery practices, a short questionnaire was sent to all the African affiliates to complete. The FPAs were very responsive with 28 associations returning completed questionnaires. The questionnaires were entered and analyzed by Family Health International (FHI). I would like to give a note of thanks to Michelle Villinski, the research analyst of FHI, North Carolina who worked with me to make this presentation possible.

Questionnaires were filled out by a team, program director or a provider. For this analysis only one questionnaire was used from each country. For those countries having more than one questionnaire it would be interesting to compare responses and determine how consistent the responses are from the same country. Service providers should be getting the same information from all sources. We have provided a copy of your country's completed questionnaire or questionnaires in your folders so that you can review it to see how your particular association responded. From these initial responses you might want to look more in detail at certain practices either by holding discussions with a larger group of program staff and providers, or even going out and interviewing or observing during supervisory visits the practices of providers. We recognize that one questionnaire from each country may not be truly representative of all providers and practices in either the FPA, or the country, which includes public clinics and other NGO service facilities, but it was felt that these questionnaires would give us some concrete information on which to discuss quality of care and base out working groups.

To give an overview, respondents were asked open-ended questions as to what their associations were doing to improve access and quality of care, and what obstacles they face in this initiative. There were a variety of answers, but the most prevalent follow. The associations were carrying out several activities to improve access and quality of care. Most notably, they cited:

- providing IEC and counseling for clients
- implementing a CBD program
- increasing the number of service outlets
- improving training and having more frequent updates
- improving supervision and management systems
- creating outreach programs
- improving their reception of clients and reducing waiting time.

What was seen by respondents as obstacles to access and quality of care coincides with the weaknesses found in service provision from the questionnaire. Among others, obstacles to providing quality care were:

- Too few staff; few trained staff; staff turnover
- Financial limitations; high recurrent cost
- Lack of facilities; lack of laboratory
- Unreliable supply of methods; unreliable supply of medical supplies

Some obstacles to access cited were:

- Inaccessibility of services
- Spousal or parent disapproval
- Insufficient staff; untrained staff
- Lack of contraceptive supplies
- Myths and rumours; need for information of FP services

The main obstacles to change:

- Unmotivated staff; resistance to change; provider attitudes
- Too many rumors; religion; uneducated public
- Financial constraints; lack of resources
- Lack of trained staff; overloaded staff members

Topics of interest that were requested to be addressed were:

- Quality of care; continuous quality improvement
- Training, refresher training and motivation personnel
- Cost analysis; creative cost management; sustainability; funding sources for NGOs.

All of these are viable and important topics. Although it would be difficult to cover all in a two-day seminar to the extent that each deserves, through discussions and the small working groups, we hope to touch on a number of them. I would ask you to keep these in mind as we go through the responses to specific questions and start to think about how these affect service delivery and present delivery practices affect the obstacles and how the FPAs can address them.

### **Use of service delivery guidelines**

We discussed a number of important elements in the initiative to maximize access and quality of care. One of the first is correct and up to date service delivery guidelines. To this important question, 20 associations said that their country had national written guidelines. Ten associations said that they used the government's guidelines and twelve used either IPPF's or modified IPPF's medical and service delivery guidelines.

### **Eligibility Criteria**

Besides having guidelines, the content of the guidelines is important. Barriers can be placed on access and quality of care if guidelines are unnecessarily restrictive. Almost all FPAs had the most well-known methods - pills, injectables, IUDs, spermicides, but newer methods (NORPLANT, vasectomy), or those that need specialized facilities (female sterilization) are less available. It is hoped that these effective and long-term methods will become more available in order to offer women the greatest choice.

Eligibility criteria can pose restrictions on the choice of methods. Although not the majority, quite a number of associations still have age and parity criteria for many methods, especially permanent methods. Marital status is taken into consideration for many of the long-term or permanent methods - female sterilization, male sterilization, IUDs. And spousal consent is still required for pills in three associations and for spermicides in two of the associations. What implications do such restrictions have on access, especially for unmarried women who are at risk of unwanted pregnancies and often unsafe abortion must be explored.

The questionnaire did not make the distinction between absolute and relative contraindications. However, current scientific evidence shows that diabetes is not a contraindication to hormonal methods, but women with this condition should be given low-dose pills or preferably progestin-only methods and watched more closely if they choose a hormonal method. There is no problem for the prescription of any contraceptive method in women with sickle cell anemia. Actually, it has been reported that DMPA will reduce the frequency and severity of sickle cell crisis. Pregnancy is probably more harmful to women with these conditions than using hormonal contraception.

Likewise, the notion that a contraceptive method should be stopped or changed after 1-2 years - "to give the body a rest", is not prevalent, but 1-2 associations still carry out that practice.

Presence of STDs/PID is an important consideration if the woman chooses an IUD, but 1-2 of the associations also use this criteria for OCs and spermicides which can provide a protective effect.

### **Who can provide contraceptives**

Access can be facilitated or made more difficult by limiting the type of personnel who can provide services, or having a limited number of trained personnel. We did not ask about the numbers of trained personnel available to provide the services, but rather who is eligible by cadre. Obstetrician/Gynecologists, general practitioners and nurses or nurse midwives were the personnel who most often provided family planning services. Implants, female and male sterilization had fewer trained providers. This may be because these methods require specialized training, or there may be policy restrictions which limit service provision to certain cadre. If the later, increased access to these methods will necessitate policy dialogue and change.

### **Community-based Distribution**

CBD is one of the best ways to increase access to contraceptive methods. Where a CBD program has been initiated, an increase in contraceptive prevalence is notable. Yet, some African countries are still reluctant to initiate this important service delivery mechanism. A review of the questionnaire responses shows that 23 (82%) of the associations have a CBD program; nineteen programs provide oral contraceptives; seventeen (74%) of these programs use a checklist. This is very positive. A CBD pill program greatly increases accessibility to an effective method for those most in need- women in rural areas or those in urban areas who for some reason find clinic access difficult. However, only in half of the CBD programs can CBD workers initiate OCs for their clients. It is understood that often government policies can limit what methods CBD workers can provide, but in these cases, FPAs can take the lead through pilot projects, as they have on other occasions to show governments the importance

of this service delivery mechanism in increasing contraceptive access, while not putting women's lives in danger. This can be done by monitoring the program as well as carrying out operations research projects.

Eight CBD programs (42%) require that women make a clinic visit before initiating pills; in 11 programs CBDs can provide the first supply of pills. When the purpose of the CBD program is to bring services closer to the community, it is ironic that women must go to the clinic before initiating contraception. This appears in direct conflict with the purpose of CBD. Fourteen programs require the women to make a follow-up visit to the clinic. In eight programs (42%), the client must visit a clinic within the first 3 months. Five programs have the woman making a clinic visit within the first 6 months (26%) and one within 12 months (5%).

The vast majority of the programs allow the workers to distribute a 3-month supply of pills, while only 2 give a 6-month supply. What work burden is required to visit clients every 3 months, rather than every 6 should be reviewed by the associations. Likewise, the advantages and disadvantages of providing a greater number of cycles, should be reviewed.

### **Clinic-based Provision**

Oral contraceptives are very labor intensive in terms of return visits. Half of the clinic-based programs prescribe only one cycle of pills at initiation; during follow-up visits the number of cycles distributed increases. Most often 3 cycles or 6 cycles are given. Only 2 programs (8%) provide a year's supply of pills. The number of cycles would have a direct relation on how many clinic visits a woman must make. It should be noted that about half of the women make more than 2 visits the first year. In 8 programs, OC acceptors are asked to make 4 or more visits the first year; six programs require that the woman make 4 visits the second year. Likewise for IUD users, about half on the programs advise women to return 3 or more times the first year. What type of burden this gives to the women and staff should be discussed. Reduction of the burden of routine visits for clinic staff will allow them time to counsel new clients, or be with clients that are having some problem. For clients, reducing the number of visits may mean more savings in terms of time, and money (transport, opportunity costs). With the uptake of family planning, clinics are becoming more and more busy. It is up to management to determine how to use the scarce resources of personnel and supplies optimally. An interesting comparison would be of more and less liberal programs, comparing the implications of each program on use of resources, client satisfaction, continuation rates, etc.

Most of the FPA programs require a full physical, including a pelvic exam before starting a contraceptive method. There have been a number of discussions about the necessity of a physical on the first visit. It has been argued that this may be the only time that a woman comes for services, and that full advantage should be taken to examine a woman and guarantee her physical condition. However, women who are meeting the provider for the first time, especially adolescents, may be put off by a physical, especially a pelvic exam. In the United States, this problem has been faced in some of the family planning clinics by giving the client the choice of whether she wants an exam at the first visit or at a subsequent visit. Another consideration is the logistics of the exam and whether equipment and supplies are available at the time of the visit. Blood and urine tests, or a Pap smear is required by six associations before prescribing a method. This might be off putting because of cost. It is not denied that such services, especially a Pap smear, would be beneficial to the woman's overall

health, but the general consensus of family health specialists is that these exams are not essential and should be the choice of the woman. Contraception should not be denied if, because of cost, time, uncomfotableness or for other reasons, the woman chooses not to undergo these exams. However, if because of age, sexual practices or through history taking, there seems to be a suspicion that such exams or tests are necessary, then this should be explained to the woman. This is all part of making the woman an integral part of her health care, having a say in what happens to her.

Procedures during follow-up visits for OCs differ among the associations. Almost all routinely require weight and blood pressure; less than one quarter (23%) require a physical or pelvic exam. Four associations do not have any routine requirements if the woman doesn't have a problem. It is my firm belief that many times women attribute all sorts of problems to a contraceptive method, even those which are not remotely related. If women do not express a problem or, if after using a checklist the woman does not have a problem, the question should be asked whether there is a need for a routine physical or pelvic exam at each visit.

Traditionally, women did not receive a hormonal method unless she comes to the clinic during menses. This is still true in the vast majority of programs. Here we have excluded those women who have lactational amenorrhea. Twenty-two associations (81%) say that women must have her menses before receiving hormonal contraception and 21 (78)% of women can have an IUD insertion only during menses. This is another obstacle to access. Women who do not come during menses are obliged to make a second visit. How many of the women become pregnant in the meantime or do not return has never been studied. Likewise, additional clinic resources - personnel, time and supplies - are needed for a second visit; client resources (time and money) should also be considered. Good counseling as to when to begin taking the pill is important. Women must be respected and not be treated as children, with providers making the decision that women will not start taking the pill correctly.

### Choice of Methods

Having a choice of methods means that commodities are available. Stock outages not only limit the choice of new acceptors, but also of continuing users. A stock outage forces a woman to change pill brands or change methods. In both cases, this may lower the client's satisfaction with the service and the method. Likewise, in anticipating a stock-out, providers may give less than the routine amount of supplies, necessitating that the client return sooner than usual. Four associations never suffered stock-outs. Nineteen (73%) said that there were occasional stock-outs, and three said that there were frequent stock outs. Quality services cannot be provided if a reliable logistics system is not in place. When asked for which commodities the clinics experience shortages, almost all contraceptives were named. Programs experienced shortages of OCs, injectables, condoms, IUDs and barriers. Some respondents listed up to five commodities that they have run out of.

Oral contraceptives, followed by injectables are the most popular methods among the associations. IUDs are third, with condoms, spermicides and female sterilization following.

When asked what methods are recommended for clients who want to delay a first birth, space births or limit births, it is interesting to note that OCs were named to delay first births, followed by condoms and spermicides. Likewise, OCs and IUDs were preferred to space births. The method preferred by providers to limit births were injectables (50%), followed by female sterilization, IUDs, vasectomy and Norplant. Many providers still have a bias against injectables as a spacing method. They view it more readily to be used by older women who wish to limit their births. Whether female or male sterilization is not readily available, is not

readily accepted, or there is still some apprehension because of its irreversibility, should be examined more closely. In one country a woman has to wait 10-12 months for a tubal ligation. In that time the client gets discouraged or is likely to conceive. Using injectables as a limiting method reinforces the idea that it causes infertility. Also, there is a greater use of resources in the long run to provide women with injectables for the rest of her reproductive life, rather than sterilization (female or male).

Half of the respondents felt that some providers are reluctant to provide certain methods. Most notably, male sterilization was not likely to be prescribed. Female barrier methods, female sterilization, IUDs and condoms followed. Most of the reasons given for this were: categorized as not having trained personnel, cultural and educational reasons and client resistance. It was felt that providers did not have prejudices prescribing injectables and Pills; provider bias was cited only once for the methods of Depo and IUDs.

Respondents from seven associations (25%) felt that there was reluctance to serve certain types of clients. Not surprisingly, reluctance centered on providing contraceptives to adolescents, unmarried and nulliparous women. Most often cited in serving these potential clients were the policy and cultural limitations; fear of post-contraceptive infertility; lack of clear policy guidelines. One association required parental consent for the provision of contraceptives to adolescents. This would definitely pose an obstacle for most adolescents. Providers should understand the importance of responsibly providing contraceptives to these special risk groups and the possible consequences of not using contraceptives. Likewise, it is essential to inquire about sexual behaviors so that appropriate contraceptives are provided, e.g. condoms and spermicides if one is not in a stable and monogamous relation.

Associations are conscientious of their responsibility to provide more complete reproductive health services. All associations provided education about the prevention of STDs and HIV. Likewise, all taught condom use skills and provided condoms. They made referral for STD treatment (93%) and HIV testing (83%) and diagnosed and treated patients with STDs (22 programs) and HIV (3 programs).

It is evident from this brief overview that the FPAs are doing several things which will lead to increased access and quality. For example, implementing CBD programs, requesting the client to return to clinic only once or twice a year for a follow-up visit. However, there are several other practices which may limit access and quality - such as frequent stock outages, limiting access because of eligibility criteria, requiring a clinic visit before initiating pill use with a CBD, not giving a woman pills if she does not have her menses, etc. Each FPA must examine their own particular service delivery practices to determine which should be modified to improve access and quality of care and develop a comprehensive program to address these issues.

**"The Experiences and Initiatives for Improving Quality and Reducting Barriers to Access of Quality Family Planning Services in Burkina Faso".**

Presented By: Dr. André Dedouza Gnoumou  
Executive Director of the ABBEF

OUTLINE

- I. Overview of problems related to service access
- II. Process of identifying problems of service access and actions undertaken
- iii. Lessons learned and perspectives

## I. GENERAL OVERVIEW OF PROBLEMS

Before 1986: Difficulties on technical, institutional and legal levels:

- Pre-eminence of 1920 law
- Lack of technically qualified service providers with adequate training
- Insufficient appropriate equipment

Since 1986: Restrictions:

- Pre-requisite of systematic exams (pills and IUDs)
- Required prescription by health personnel (physicians, midwives)
- Required minimal equipment and supplies
- Methods prescribed only in MCH/PF clinics

## II. PROCESS IN IDENTIFYING PROBLEMS AND ACTIONS UNDERTAKEN

### 1. METHODOLOGY

The aspect of quality expressed only in the MCH/FP program of 1988 - 1992, with 2 essential components.

- Organization of Services
- Strengthening Technical Competencies

The organization of services: Methodologic Schema

- Implementation of a study evaluating services
- Implementation of an operational research project on service integration
- Implementation of a situation analysis of the MCH/FP program on:
  - Operational capacity
  - Quality of services
  - Service performance

Strengthening Technical Competencies

- Since 1992, development and utilization of performance evaluation tools - guidelines, protocols, studies

- Actions to insure a general orientation for the provision of quality services
  - Eliminating prerequisite exams
  - Development of policies and standards and a national FP Strategy
  - Protocols for service delivery

## 2. PROBLEMS IDENTIFIED

- With method choice
- With information given to clients
- With competency of providers
- With interpersonal relations
- Follow-up of clients
- Training of personnel

## 3. ACTION UNDERTAKEN

- Diversification of methods
- Pilot CBD program
- Training health and community agents
- Implication of matrons, indigenous health agents and community agents
- Setting reduced prices
- Greater implication of the private sector (NGOs)
- Dissemination of policies and standards
- Development of an on an appropriate referral system
- Institutional strengthening
- Improvement of the information system
- Defining research directions
- Ongoing studies of FP service delivery protocols

## III. LESSONS LEARNED AND PERSPECTIVES

### -> Lessons Learned

- Quality of care based on common will
- Involvement of all actors
- Effective system of gaining consensus
- United effort in the conception of strategies and initiatives

### -> Perspectives

- Integration of client groups
- Continual training of involved persons
- Follow-up on implementation of pilot programs
- Follow-up research on an appropriate system for client follow-up
- Integration of human rights
- Encouragement for FP program initiatives

**FAMILY PLANNING ASSOCIATION OF KENYA  
EXPERIENCES.**

**PAPER PRESENTED AT IPPFAR REGIONAL  
SEMINAR ON IMPROVING ACCESS TO  
SERVICES AND QUALITY OF CARE**

**BY: DR. ISAAC ACHWAL  
SENIOR PROGRAMME OFFICER**

## **INTRODUCTION**

Family Planning Association of Kenya is the pioneer in the family planning movement in Kenya and one of the oldest FPAs in Africa, having become a member of IPPF in 1962. The Association sees itself as a torch which shows the way to better and healthy family, by playing a leadership role to other agencies. It is in this regard that the Association embarked on giving special attention to improving access to services and quality of care from early 1980s.

Knowledge of family planning has been rated as high in Kenya from successive studies, by women aged 15-49 who have heard of at least one method of family planning. The knowledge was 81 percent in 1984 (Kenya Contraceptive Prevalence Survey), 90 percent in 1989 (Demographic and Health Survey I) and 96 percent in 1993 (Demographic and Health Survey II). Though the contraceptive prevalence has also rose to 17 percent in 1984, 27 percent in 1989 and 33 percent in 1993, there still exists a big gap between knowledge and use. The existing gap between knowledge and use can be greatly reduced by improving quality of care in terms of:

- Choice of methods.
- Information given to clients.
- Technical competence of the personnel.
- Interpersonal relations.
- Mechanism to encourage continuity.
- Appropriate constellation of services/ and reducing medical barriers.

Medical barriers was defined by Shelton and Jacobstein in 1992 as "Dysfunctional practices based at least partly on a medical rationale which results in a scientifically unjustifiable impediment to, or denial of contraception" and include:

- Inappropriate eligibility criteria including age and parity.
- Unwanted contra-indications.
- Inappropriate process hurdles including lab tests.
- Provider bias or misinformation..
- Restrictions on providers.
- Regulatory barriers.

Improving access to services including removal of medical barriers and quality of care is best expressed by IPPF, C. Huezo and S. Diaz in the ten clients rights and ten providers needs as listed below.

**CLIENTS' RIGHTS**

**PROVIDERS' NEEDS**

- |                            |                            |
|----------------------------|----------------------------|
| • Right to information     | • Need for training        |
| • Right to access          | • Need for information     |
| • Right of choice          | • Need for infrastructure  |
| • Right of safety          | • Need for supplies        |
| • Right to privacy         | • Need for guidance        |
| • Right to confidentiality | • Need for respect         |
| • Right to dignity         | • Need for encouragement   |
| • Right to comfort         | • Need for back-up         |
| • Right of continuity      | • Need for feedback        |
| • Right of opinion         | • Need for self-expression |

FPAK provides all methods of family planning and reproductive health care through static clinics, outreach clinics and Community Based Distribution (CBD) which started in 1982.

**OUTLINE OF IDENTIFIED QUALITY OF CARE PROBLEM AREAS IN FPAK  
DURING 1980s**

In the early 1980s the number of new acceptors and total visits peaked and then started declining. Concern over this downturn prompted the Association to evaluate the clinics operations. Some of the problems identified were as follows:

- 1) There was inconsistency in the mix of methods used by the clients. The findings indicated that staff members or clients may be expressing consistent preference for a given method to their clients. Clients also tended to be maintained on specific methods e.g. pills throughout their reproductive life despite the change in their reproductive intentions.
- 2) There was lack of publicity, information and educational materials. There was inadequate information to clients, to other agencies, and personnel. Furthermore, the client medical charts were deficient in that they did not contain all the information desired by the clinic staff, and they were cumbersome to use.
- 3) The policies related to service delivery (e.g. contra-indication to specific methods, eligibility) was not necessarily clear and was not fully understood by the clinic staff, service delivery was therefore inconsistent, and clients did not receive all services that they should. For example, blood pressure was not always recorded in the client's medical chart for clients using orals or injectables. Staff skills was under utilized. There was inadequate clinic equipments and in some instances inadequate clinic personnel.

- 4) There was no proper deployment of personnel since they did not know their job descriptions. Due to inadequate space, there was no proper use of available personnel time. There was a tendency of one nurse relieving while the other rests, instead of the two working together to give clients more time, and shorten the stay in the clinic.
- 5) Appointments seemed to be scheduled without regard to the desire of the client or the needs of the clinic personnel to maintain balanced work loads. Daily client loads varied randomly, heaviest demands during late morning hours and almost no demand existed in late afternoon hours. The records indicated, however, that many clients made an effort to keep their appointments.
- 6) The system for routing clients through the clinic was not as efficient as it could be. The clinic staffing pattern was also not organized according to peak hours resulting in inefficient use of staff time. Most of the above problems arose as a result of inadequate clinic space which can only accommodate one nurse or cannot take extra, update equipment. Many agencies involved in similar activities were not well informed of the services rendered in FPAK clinics, the requirements and how they can refer the clients, hence, minimal networking.

### PROBLEM IDENTIFICATION

Several approaches were used to identify the above mentioned problem as follows:

- 1) In 1982 the Family Planning Evaluation Division (FPED), Programme Evaluation Branch (PEB) of Centre for Disease Control Atlanta (CDC) was requested for assistance in evaluating clinic operation. They carried out "Client Flow Analysis" (CFA) and trained the research and evaluation department to continue with the same on regular basis.

- 2) In 1987 a forum for open review of individual clinic performance by clinic incharges, the regional administrators, headquarters technical personnel and individual clinic sessional doctors was started on annual basis as "Update and Quality Assurance Workshop".
- 3) In 1986 IPPF carried out "Acceptability and use Discontinuation of Contraceptive methods - a six Country Multicentre Study".
- 4) In 1987 a supervision checklist was developed which assists the supervisor to go through client flow, clinic records, cleanliness, technical skills for all methods, infection prevention and contraceptive logistic management.
- 5) In 1987 Client Suggestion Forms with suggestion boxes were introduced in all clinics. This is a kind of client exit interview where a clinic gives out three to five forms on weekly basis to clients to complete after service and clients return the completed forms to the suggestion box.

The forms are reviewed regularly in a clinic meeting by regional administrator and clinic staff.

- 6) In 1989-1993 Client-Oriented and Provider-Efficient (COPE) was introduced in all clinics to assist the clinic personnel identify and solve their problems. Each clinic carries out as many COPE exercises as their requirements demand, with a minimum of one every quarter. COPE is a self-assessment tool for evaluation of quality of care and a tool to help improve that quality. Cope is simple, adaptable to any work site, addresses management issues from the bottom up, and it specifically looks at services from the perspective of client convenience. It gives quantitative and qualitative data on the process of service delivery. It consists of the following:

- **Self-assessment:-**
    - i) Checklist by staff to evaluate quality of medical and nursing services, administration, staffing, community involvement, the physical facility, supplies, record keeping, organization of services, counselling, information and education.
    - ii) Client interview.
  - Client-flow analysis (CFA) - tracking clients through the clinic.
  - Plan of action.
- 7) Three CBD evaluations.
  - 8) Evaluation of model protocol for Community Based Distribution Programme with assistance from IPPF.

### **ACTION TAKEN**

A lot of actions have been taken among which I will single out the following:

- 1) Static clinics have been renovated or constructed and staffed in a manner that addresses clients rights.
- 2) Contraceptive logistics system has been improved. A change was made from the "push" system to the "pull" system with a mandatory requirement for each clinic to maintain minimum stock levels of three months and re-order level of five months.

Clinic incharges and regional managers have been trained by IPPF as trainers in Logistic Management. Their role is to carry out on-site training for all personnel.

- 3) Counselling training was started by FPAK for its personnel which later became a national and regional training.
- 4) Central trainings are still ongoing to improve staff technical skill. However, each clinic is equipped with a library which is regularly updated and all staff carry out on-site training on fortnightly basis or as they deem adequate. If there are areas that they need an outside trainer, then they inform headquarters which organizes for onsite training during facilitatory supervision.
- 5) Computerized Management Information System (MIS) has been developed. It is now due for a review and updating to strengthen it. In quarterly monitoring formats, the graphs for last performance are sent to the regions. They enter the immediate past quarter performance, analyses their data and send their analysis to headquarters. The headquarters in return gives them a feedback.
- 6) In order to reduce medical barriers and create more conducive atmosphere, thus attracting more acceptors, the revisits to the clinic have been reduced. This was done by holding a quality of care workshop in May 1993 for all clinic and regional incharges with assistance from INTRAH. Clients have a thorough examination once in a year. For pills, a new acceptor gets three packets, followed by nine during the next visit, and 13 packets thereafter. A continuing acceptor gets thirteen packets. An IUCD client returns after one month, then six months, and thereafter yearly.

- 7) The evaluation of model protocol for CBD by IPPF, has improved communication between agents and back-up facilities, they have also improved the quality of records, maintained by CBD agents and those sent to the headquarters. However the Association is still looking for funds to print the formats and modify the current computerized MIS.
- 8) Job descriptions are in place and personnel have signed for their jobs.

### LESSONS LEARNT

Improving access to services and quality of care may initially appear to be contradictory goals, since quality of care may be mistaken for addition of more medical barriers. However, they are one and the same exercise.

Initially the implementation may appear to be rather expensive however, once in place, there is substantial savings in terms of personnel time, and expendable supplies. Furthermore, satisfied clients motivate new acceptors and they willingly pay for quality services.

The success of quality of care is fully dependent on the providers accepting the ownership of the tool for evaluation. Without ownership at grassroot level it may almost not be possible to achieve good results.

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## HOW CAN FPAs ASSESS QUALITY OF CARE Presented By: Kathy Jesencky

We have talked about quality of care and the different elements that contribute to providing quality of services. Quality must be taken in the context of the specific environment, its constraints and the resources available. The aim of a quality program should be to provide the best care possible given existing resources. Before, people felt that improved quality meant increased costs. This is not necessarily so. Quality puts an emphasis on the efficient use to resources, thereby reducing operating costs in many cases. Likewise, quality does not mean more medicalization of the service delivery process, but rather appropriate care. That is, utilization of more sophisticated services, when necessary, rather than as a routine. Raising quality can be viewed as one means of expanding coverage and increasing efficiency without substantial additional resources.

Why do we want to improve access and quality? Studies have shown that improved access and quality lead to greater acceptance of family planning, increased satisfaction with the methods and services, thus leading to higher prevalence and increased continuation rates. These in-turn help to meet the reproductive goals of the client, as well as the program goals of the family planning program.

What is needed to improve access and quality? First and foremost, a commitment by top management to create an organizational environment conducive to change is essential. That is the reason for this seminar. You, present here today are decision makers for your FPAs; you help to form policy, set priorities. It is important not only to raise your awareness to the importance of quality, but also to get your commitment, that improved access and quality will play an important role in your program. You will help to create the "enabling" systems (the infrastructure, policies and management) necessary for staff to develop and implement a program for service quality improvement. With this commitment you may rightly ask:

"How can I determine if my FPA provide quality of services?"

An equally important question once you have answered the first is:

"How can I increase the access and quality of services being provided by my association?"

Through the presentations this afternoon we will try to answer these questions.

Service quality improvement is a process, a continuum. We must determine where the clinic falls on the continuum. Service improvement should be incorporated into the day-to-day management of the program, thus becoming an integral part of service provision. On a periodic basis, either through supervisory visits, service statistics, client records or short studies, one can measure and evaluate what progress is being made. Thus, each FPA can be a control for itself in how much progress it has made to improve services.

The process to improve quality should be gone about in a logical way. It can be thought of in the same terms of operations research. However, the main difference is that in operations

research, staff are usually not as intimately involved in the development and implementation of the program. This is an essential element in quality improvement if it is to succeed.

Both quantitative and qualitative methods can be used to assess access and quality of care. Some of the tools which are being used to assess quality are.

- situation analysis
- client flow analysis
- service statistics
- management information systems
- specialized client studies

Qualitative methods such as focus group discussions or observation of providers and their interaction with clients gives the supervisor and program staff a better understanding of the dynamics of the provider-client relation and give a richer understanding of the situation.

The tools used to identify problems can also be used to monitor and/or evaluate the intervention to determine if changes have occurred in improving quality. To measure change indicators must be developed. The Evaluation Project of Tulane University has been developing indicators for the elements of quality of care as described in the Bruce framework. Let us look at one of these elements - provider competence. Presently the Evaluation Project is testing the indicators to see which are valid and the most important. A complete list of indicators can be found on pg. 11 of the Network issue on Quality of Care. If these indicators prove to be a good predictor or improving quality, then FPAs will have a guideline for this initiative. Thus, how to determine if the FPA provides quality service is to develop "quality" indicators.

Implementation of service improvements requires staff and management to not only identify problems, but their causes. Often, people think about the superficial cause, but it is important to think of all the factors that might cause the phenomenon. It will show the complexity of the situation and help staff participants of the process identify what they can and cannot do. Collection of data can help verify the causes of the problem.

Going through this process of problem identification and their related causes is something that we will do in our small working groups tomorrow. It will show that most problems are more complex than thought of at first view, but thinking about them and breaking them down into manageable components will help to determine what can be done.

To improve service quality, there must be a comprehensive effort to improve:

- management practices
- record-keeping systems
- supervision
- logistics
- training
- information and counseling programs

That is, all program components.

Important principles in improving quality of care are:

- Involve the client - Services should be client-oriented. It is important to find out what clients are looking for in improved access and quality services. A hallmark of any undertaking to improve quality is to focus on the needs of the client. The system should be structure to meet those needs and provide providers with the tools to meet the needs of the client.
- Involve the staff - Staff are providing the services and any improvement must naturally involve them. After identifying problems, staff are an important source for suggesting changes and how these changes can be implemented. Staff must feel "ownership" of the process since they will be the implementors of the process.
- Analyze the situation - Use data for decision making. Decisions concerning changes in service practices should be based on collected data - services statistics, observation, client studies, etc. This will allow for sensible decision making, rather than acting on intuition.
- Choose improvements that are "do-able" - That is, choose first improvements that are easy, require few or no additional resources and/or are within our power to make. Success in a small project will give the staff confidence in its skills to make changes. It will give them a feeling of empowerment, and will motivate them to take on more challenging projects. Successful completion of a project should be acknowledged and rewarded - financially or otherwise. At annual meetings one can give an award for the clinic which was the most greatly improved, had the greatest increase in prevalence, had the highest continuation rates, was the most clean, had the best utilization of resources, had lowest staff turnover, etc.

Several organizations have developed processes to evaluate quality of care and improved programs. For example, the Associations of Voluntary and Safe Contraception (AVSC) has developed a system - COPE (Client Oriented, Provider Efficient) which has been used in many countries in the region and which has become an ongoing self evaluation tool in many clinics. INTRAH has developed a system to help in evaluation the competence of providers, a problem cited by many countries. Both of these will be explained in more detail in a few minutes. Likewise, Mme. Barry will discuss the use of client flow analysis as a tool to assess quality.

These brief presentations are not meant to make you experts in analyzing the quality of care, but to let you understand the variety of methodologies available to you. It is hoped that the different FPAs will take advantage of these in your quest to improve quality.

## **COPE - CLIENT-ORIENTED, PROVIDER-EFFICIENT SERVICES**

**By G. E. Wambwa**

DHSs have documented low FP use due to the many hurdles clients face. Poor quality is a contributing factor.

Approaches health care copied from industry to improve quality are:

1. Quality control
2. Quality assurance

### To Achieve Quality Through These Two Quality Improvement Approaches

Focus is on:

1. An outside supervisor's visits which, due to time factor, are commonly:
  - = Irregular
  - = Far apart
  - = Of low impact on staff performance
  - = Superficial & aim to control people
2. Blame is apportioned for the errors & mistakes identified
3. Problems are solved after errors or mistakes have occurred and have affected customers
4. Solutions made are frequently inappropriate and expensive
5. Customers and providers not adequately consulted

The Association for Voluntary Surgical contraception (AVSC) developed another type of methodology to assess quality - and improve.

**COPE - Client-Oriented, Provider-Efficient Services**

### **Support for cope:**

1. Availability donor and government support
2. The need for quality is well accepted
  - a) It is morally right
  - b) It results in customer satisfaction
  - c) Quality services lead to provider satisfaction

### **What is Cope?**

#### **A Practical Tool**

- \* Simple and ease to understand and use
- \* Cost effective no outside inputs
- \* Integrated in staff routine work
- \* Flexible and transferable
- \* Takes little time
- \* When well understood, it is less threatening to staff
- \* Used by the staff themselves
- \* Empowering for the staff
- \* No blame, focus on systems

#### **Main Purpose or Cope**

or

#### **How Does Cope Help to Improve Supervision?**

It helps all the staff to:

- \* Become more aware of the needs of their customers
- \* Identify available resources
  
- \* Plan how to secure and efficiently use available resources to improve quality of their services
  
- \* Monitor and improve their own performance at the site
  
- \* Supervisors facilitate, not police the work of staff

Cope is not:

- \* Used for punitive measures
  
- \* Conducted by outsiders except when staff themselves refer a matter to an outsider for a specific reason
  
- \* Used by some staff and not other staff

What Cope Does:

- \* Builds teams and
  
- \* Encourages team approach to work and decision making
  
- \* Builds respect and support for other roles
  
- \* Gives staff a forum for:
  - A) Defining quality and how to measure it
  - B) Stopping to look at the quality of their services
  - C) Identifying existing problems
  - D) Recommending solutions which they themselves can implement

- E) Agreeing on who should solve or lead problem solving exercise
- F) Agreeing on date by which the task will be accomplished
- G) Documenting their agreements in a plan of action (work plan)
- H) Agreeing on when they will meet to review action taken

### Factors Which Influence the Success of Cope

- \* Supportive management who
  - A) Permit meetings of representatives of all categories of staff
  - B) Provide the few needed items e.G news print, pens and papers
  - C) Give prompt feedback when a problem is referred to them etc.

Rigid autocratic management can obstruct Cope

How Cope is Done

#### Step 1:

First an agency which wants to use cope needs to identify and train cope facilitators who sell the cope idea to managers so managers can be supporting or staff.

#### Step 2:

The facilitators orient managers to cope at initial meetings at which date for cope is agreed upon.

Managers are given copies of the cope document or avsc working papers to increase their understanding

**Step 3:**

Facilitator writes to remind the management of the:

- A) Need for attendance by all categories of staff at the cope meeting
- B) Date, time and the agreed venue for cope at the institution
- C) Management's agreement to introduce staff to cope

**Step 4:**

1. The facilitator helps staff to work as a team to reach a common understanding about
  - What quality is
  - How to measure it and
  - Who their customers are
2. Identify - Customer needs
  - What do our customers want?
  - Available resources
    - What resources do we have now to meet our customers needs?
  - How to use resources economically and efficiently
    - how can we sue them/share them/secure them/store them/clean them/sterilize them/organize them etc to give our customers quality services?
  - How to measure the level of quality of services
    - How are we doing in meeting our customer's needs?

3. **Facilitator stresses the five important aspects of quality:**
- A) **Freedom from defects or errors**
  - B) **Getting right things done correctly the first time**
  - C) **Promptly solving problems at source**
  - D) **Freedom from blame**
  - E) **Valuing the contribution of every one involved including customers**

**MAXIMIZING ACCESS TO SERVICES  
AND  
QUALITY OF CARE**

**Seminar for Family Planning Executive Directors**

July 11 -12, 1994

**Session: Assessing Service Provider Competences**

**Presenter: Pauline Muhuhu  
INTRAH Program**

# **ASSESSING SERVICE PROVIDER COMPETENCES**

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## **INTRODUCTION**

Provider competence includes;

- The ability of the provider to perform clinical procedures and techniques at the minimum acceptable level of performance. Acceptable level of performance refers to the levels at which the safety of the client and the efficacy of the method are enhanced.
- Observance of protocols, standards and
- Protection of clients from infections during the performance of procedures

It is influenced by quality of training post training use of the skills, availability of the tools to perform the skills and supportive supervision

## **KEY ELEMENTS IN ASSESSMENT OF COMPETENCES**

1. Defining of Quality of Care
2. Setting performance standards that indicate acceptable level of performance to meet quality of care defined and development of instruments for performance assessment.
3. Training in performance evaluation skills for diagnosis of performance problems.
4. Performance assessment through direct observations
5. Performance diagnosis and determination of interventions to address performance problems.
6. Interventions
7. Post intervention follow-up.

# QUALITY INDICATORS FOR ASSESSING PROVIDER COMPETENCE

## A. Provider Skills

- Accurately explains contraception
- Demonstrates skills in clinical procedures
- Demonstrates ability to identify precautions for use of contraceptives
- Avoids unjustified tests, examinations and waiting period

## B. INDICATORS FOR OTHER INFLUENCING FACTORS

### TRAINING:

- Based on institutional and national guidelines
- Is focused on the family planning job to be done
- Provides for refreshers and updates
- Formal Induction training for new clinical service providers.

### WORK ENVIRONMENT

- Written guidelines for family planning practice
- Basic supplies and equipment for service delivery
- Availability of training criteria for service tasks
- Facility has ability to handle STDs or presence of a referral system
- Formal follow-up system for service providers
- Formal clinical induction training for new service providers.

## **PROCESS STEPS**

1. Preparation of supervisor and trainer teams
  - training in performance evaluation skills
  - team building to accomplish common purpose
  - development of team plans for service provider follow-up
2. On-site follow-up that includes;
  - assessment of provider knowledge
  - observation of service provider perform pre-selected procedures that will bring out most of the critical skills for assurance of quality of care.
  - Assessment of environmental factors that affect performance of the service provider
  - Review of clinic records to determine method mix and trends in contraceptive use.
  - Sharing of findings with service provider and technical assistance for improvement.
  - Sharing with immediate management with a view to providing information on strengths and problem solving for environmental conditions that influence performance.
3. Using findings to diagnose any performance problems and plan for training and management interventions

## LESSONS LEARNED FROM THIS APPROACH

- Trainer / Supervisor team strengthens the linkage between in- service training and supervision enabling training to be more focused to the service needs and also for supervisors at higher levels to be proactive in facilitating more desirable conditions for the service provider to offer better services.
- Assessing service provider competence is a labor intense undertaking with rewarding outcomes. Corrective measures that are possible to address on site through on-the-job training are easily separated from those that need workshop type training.
- Focused and specific feedback to management stimulates interest and a commitment to seek resources to address the shortcoming.

## CONSIDERATIONS FOR MANAGEMENT

1. Service provider recruitment and training policies
2. Policies related to management of introduction of new staff to institutional service policies, introduction of new contraceptives to service providers, supplies and equipment to enhance quality of care, technical supervision, service quality monitoring and formal feedback systems.
3. Advocacy for support of quality care and the establishment of mechanisms.
4. Use of internal resources for development, improvement and sustainability of the service provider competences.

## DEFINITIONS OF TERMS

### **Cost-sharing Funds**

In Kenya, funds collected from the token user fees paid by adult patients who seek curative services in Public Health units as out- or in-patients. A specified percentage of fees collected is returned to the institution or district for use in various ways that benefit the community, clients and patients. These funds are managed by the District Health Development Board whose membership includes (among others) the District Medical Officer of Health and community leaders selected by the community served by the institutions.

### **Cut-off Score**

A test measure that expresses the minimum acceptable performance level for competent execution of a job or task.

### **Performance**

Refers to the execution of a task or a series of tasks at the individual level), and their relationship and contribution to the achievement or organizational objectives at different levels of program implementation.

### **Performance Diagnosis**

A term which describes the use of performance evaluation skills for diagnostic purposes. In performance diagnosis the quality and order of execution of a task or a series of tasks is assessed. (In Nakuru district, the performance diagnosis focused on counseling, physical assessment, pelvic exam and IUD insertion skills).

### **Performance Evaluation**

A type of evaluation activity carried out at worksite to determine if the work of personnel reflects training and meets the set standards for service quality and quality of care as well as meeting the service objectives set by the organization.

### **Service Quality**

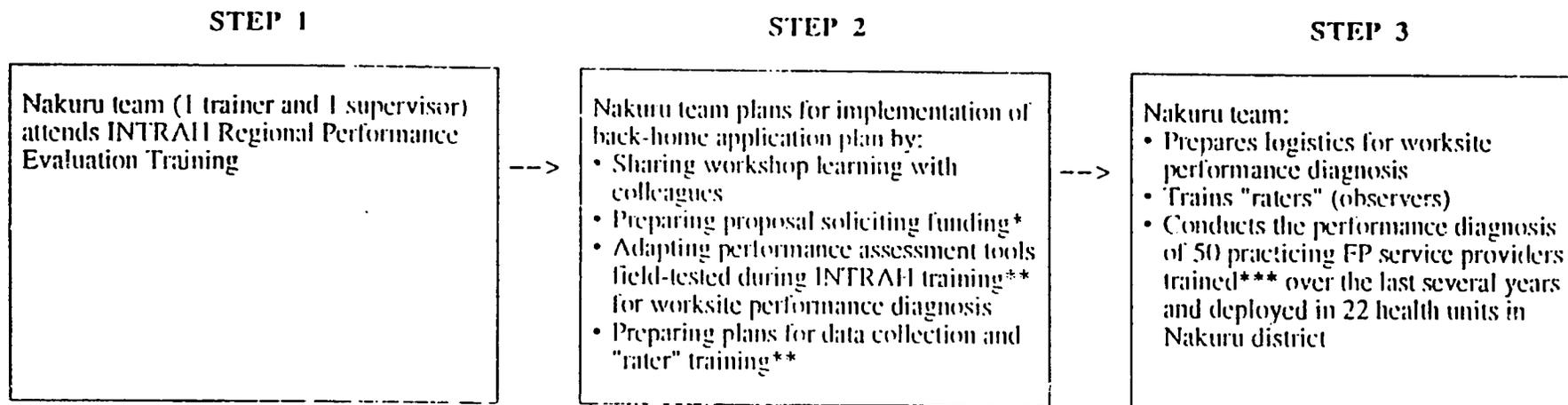
The distinctive character or properties of family planning service delivery. Acceptable quality of care is linked to national service standards and protocols and refers to services delivered to clients which address the following six interrelated quality of care elements (defined by Bruce and Jain):

- Information given to clients
- Technical competence
- Interpersonal relations between provider and client
- Mechanisms to encourage continuity of family planning use
- Choice of contraceptive methods
- Appropriate constellation of services

### **Training**

A sequence of learning activities and processes which are planned on the basis of job descriptions, service policy guidelines and standards. The purposes of training are to establish the foundation for, or to improve skills and knowledge required to perform, various jobs of family planning service personnel.

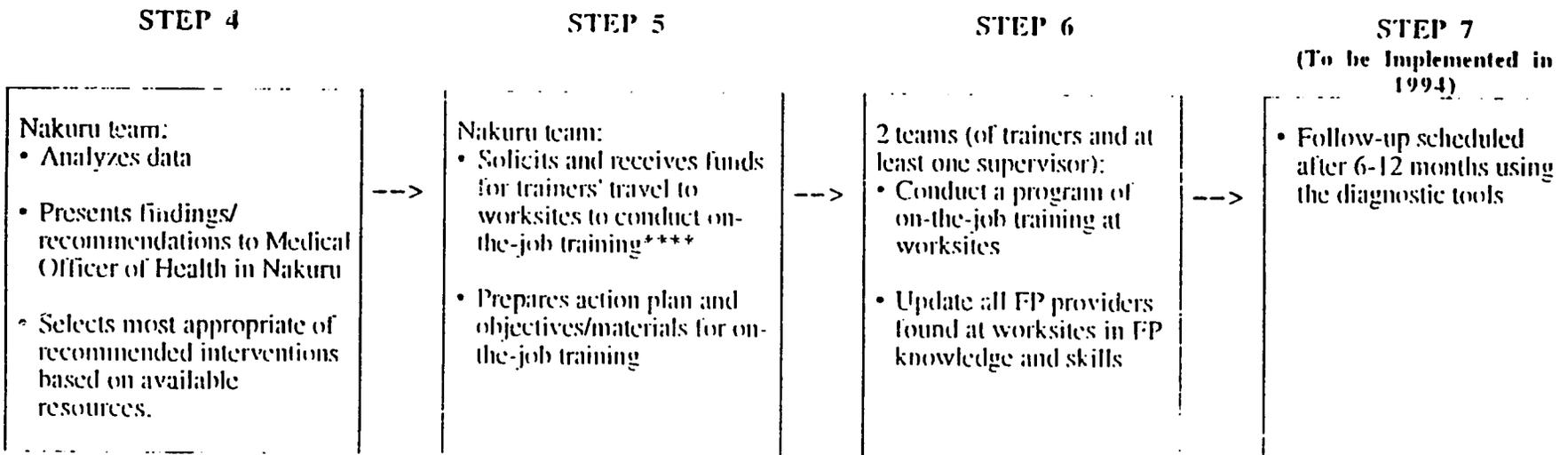
## MULTIPLIER EFFECTS OF THE INTRAHI REGIONAL PERFORMANCE EVALUATION WORKSHOP NAKURU DISTRICT: KENYA



\* Funding/Resources: • INTRAHI • PIIC Division of the Kenyan MOH • District Health Development Board

\*\* INTRAHI reviewed the adapted performance assessment tools, and gave input into the data collection plan and "rater" (observer) training plan

\*\*\* Trained by the Division of Family Health, Kenya Ministry of Health



\*\*\*\* Upon request, INTRAHI provides FP Update of knowledge and skills to 2 Lead Trainers prior to the on-the-job training.

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**INTRAH: "Training, Performance Assessment  
and Service Quality"**

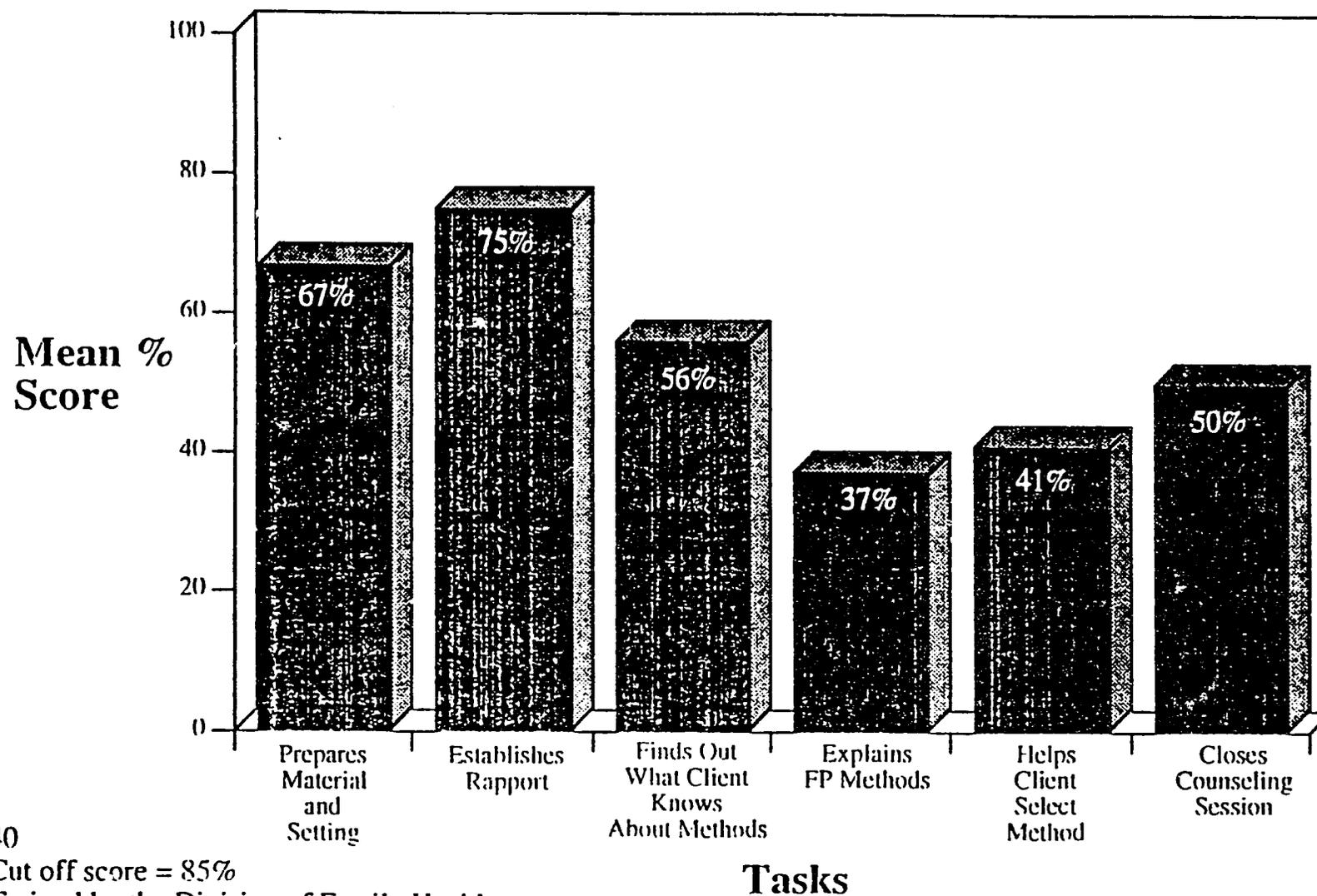
**SUMMARY OF THE NAKURU PERFORMANCE DIAGNOSIS,  
IMPLICATIONS FOR SERVICE QUALITY AND REMEDIAL  
ACTIONS TAKEN**

**WHAT WERE THE RESULTS OF THE NAKURU PERFORMANCE  
DIAGNOSIS?**

- Figure 1 shows that in no task related to counseling did the service providers in the sample reach the cut-off score of 85%
- Figure 2 shows that in no task related to conducting a pelvic exam did the service providers in the sample reach the cut-off score of 88%
- Figure 3 shows that in no task related to IUCD insertion did the service providers in the sample reach the cut-off score of 100%

(Please see "Summary of the Nakuru FP Service Provider Performance Diagnosis, Implications for Service Quality and Remedial Actions Taken." for further discussion of results)

**Figure 1: Mean Performance Scores\* of Nakuru FP Service Providers\*\* on Main FP Counseling Tasks**



N = 40

\* Cut off score = 85%

\*\* Trained by the Division of Family Health, Kenya Ministry of Health

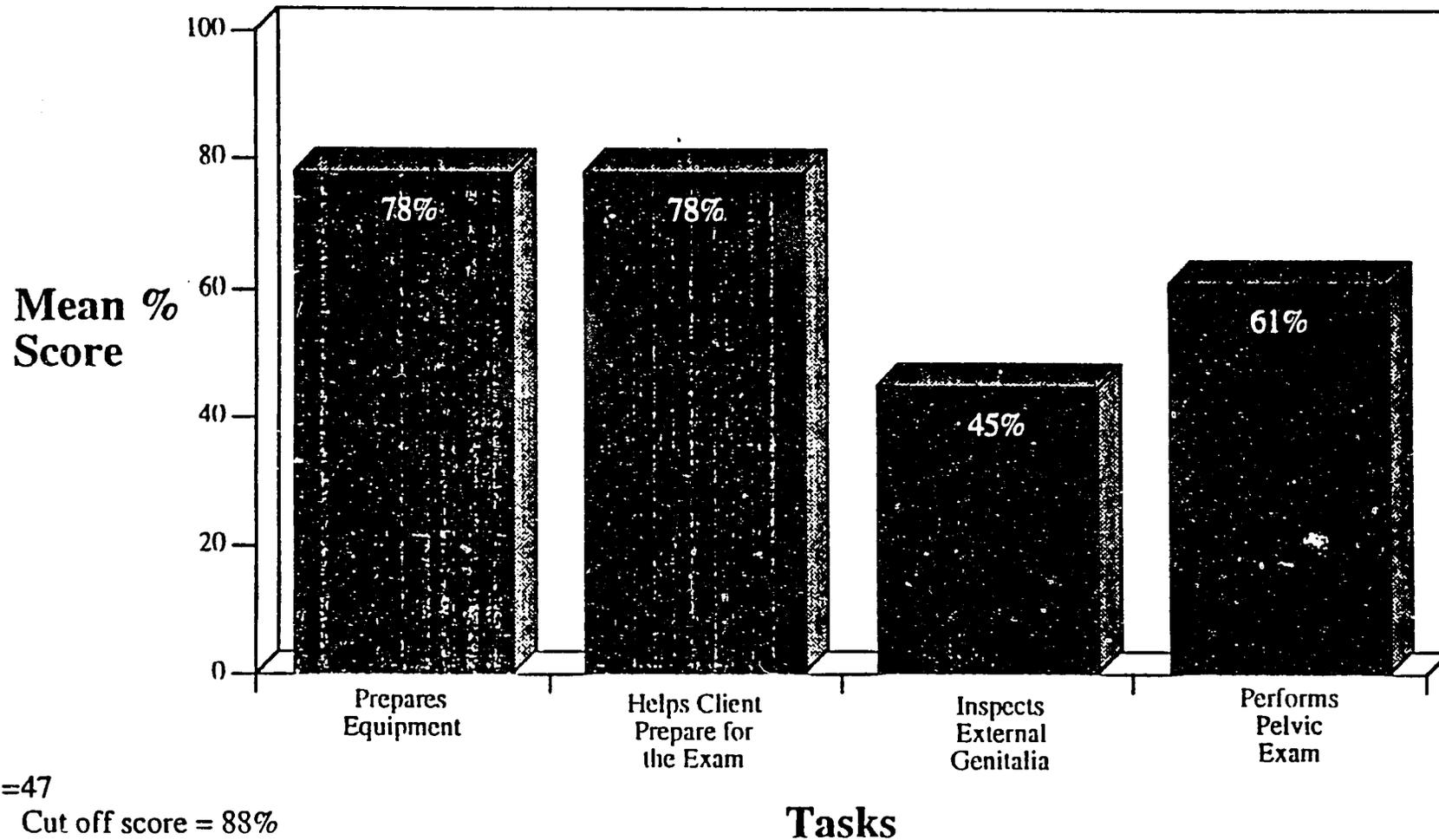
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**SUMMARY OF THE NAKURU FP SERVICE PROVIDER PERFORMANCE DIAGNOSIS,  
IMPLICATIONS FOR SERVICE QUALITY AND REMEDIAL ACTIONS TAKEN**

Summary of Findings/Deficits (see Figure 1)	Implications for Service Quality	Actions Taken
<p align="center"><b><u>Counseling For Informed Choice</u></b></p> <ul style="list-style-type: none"> <li>• The performance scores of service providers were below the cut-off score in all 6 major tasks in counseling for informed choice.</li> <li>• FP methods not provided at the clinic were generally not mentioned even though they were available at other sites in the district (specifically, VSC, Norplant® Implants and NFP).</li> </ul>	<ol style="list-style-type: none"> <li>1. Information given to clients during counseling was not adequate to enable the client to make informed decisions, to exercise the right of choice, or to anticipate and be ready to face/tolerate side effects.</li> <li>2. Lack of accurate and adequate information is likely to jeopardize method effectiveness particularly where the method is client-dependent, which reduces continuity of use.</li> </ol>	<ul style="list-style-type: none"> <li>• A program of on-the-job training of 94 service providers was conducted by trainer/supervisor teams over a period of 5 months (March-July 25 1993) at FP service delivery sites. Focus of training was:             <ul style="list-style-type: none"> <li>- feedback on performance strengths and deficits</li> <li>- demonstration (using role play and real clients) of the correct ways to counsel clients for informed choice and its value</li> <li>- guiding service providers during counseling of clients</li> <li>- updated contraceptive method information</li> </ul> </li> </ul>

**Figure 2: Mean Performance Scores\* of Nakuru FP Service Providers\*\* on Main Tasks for Performing Pelvic Exam**



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94

N = 47

\* Cut off score = 88%

\*\* Trained by the Division of Family Health, Kenya Ministry of Health

**Summary of Findings/Deficits**  
(see Figure 2)

**Performs Pelvic Exam**

In none of the 6 tasks did the service providers performance reach the cut- off score

- Examination/inspection of external genitalia was not performed as per protocols.
- Speculum exam of vagina and cervix was not performed as per protocols.
- The bimanual pelvic exam of the uterus and adnexae was not performed as per protocols
- Clients were not given any feedback on the findings of the exams.
- Instruments and materials used were not decontaminated and disposed of as per protocols.

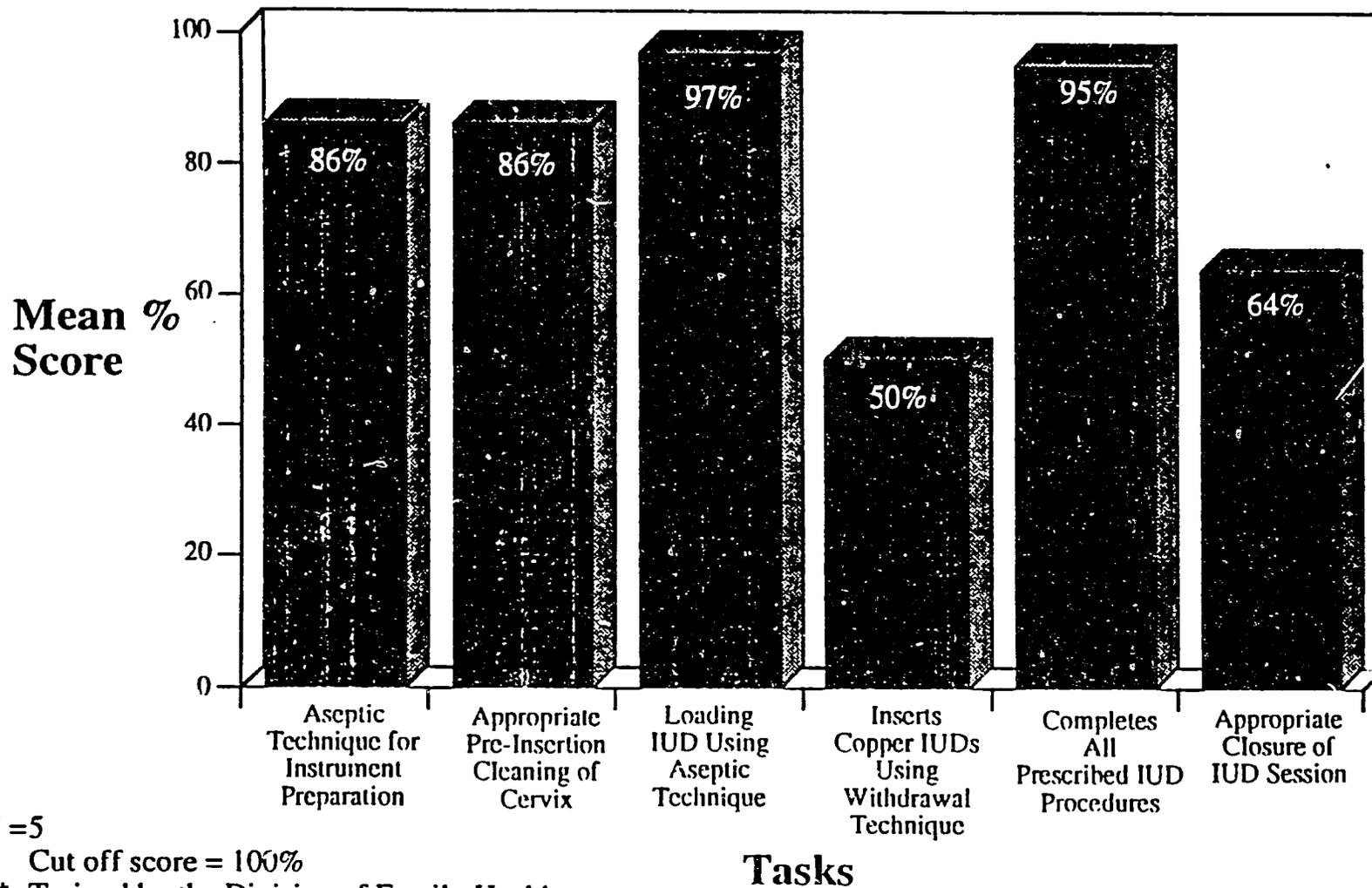
**Implications for Service Quality**

1. Inaccurate and incomplete physical screening procedures may lead the provider to recommend or approve an unsuitable FP method for the client.
2. Withholding significant findings of the pelvic exam indicates a lack of respect for the client, and providers' seeming unwillingness to manage and treat the problem or infection (e.g., STD). Lack of information may lead the client to make an uninformed or inappropriate contraceptive choice.
3. If an STD is missed during the exam, the consequences for the client may be grave: she may select a method, e.g., IUD, that is contraindicated in the presence of an STD, with resultant complications that may jeopardize her reproductive health.

**Actions Taken**

1. On-the-job training of service providers and follow-on training of newly recruited service providers emphasized:
  - technical competence in performing a pelvic exam and techniques related to pelvic exam.
  - aseptic technique
  - service quality

**Figure 3: Mean Performance Scores\* of Nakuru FP Service Providers\*\* on Main Tasks for IUD Insertion**



N = 5

\* Cut off score = 100%

\*\* Trained by the Division of Family Health, Kenya Ministry of Health

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96

**Summary of Findings/Deficits  
(see Figure 3)**

**IUD insertion**

Only 5 service providers were observed providing the IUD method on day(s) of the visit. (Many clients were not opting for IUD).

No service provider's performance reached the cut-off score in any of the 6 major tasks in IUD insertion procedures. In particular:

- Aseptic technique was not observed when loading the IUD. The device was handled with bare hands and thus contaminated.
- The TCu 380A and NOVA T were pushed (the insertion technique for the Lippes Loop) by all service providers instead of using the "withdrawal" technique.
- Inadequate decontamination and sterilization of used equipment/materials was observed with (4 out of 5) service providers.

**Implications for Service Quality**

- Contamination can result in pelvic infection and impaired reproductive health.
- Incorrect insertion technique can result in inappropriate placement of IUD, expulsion or uterine perforation.
- Incorrect decontamination and disposal/re-processing of instruments poses a risk of HIV and other nosocomial infections to other clients and service providers.

**Actions Taken**

1. On-the-job training provided as follows:
  - information was provided about the rationale for and the differences between the insertion techniques for the copper devices and Lippes Loop (now discontinued)
  - demonstrations and return demonstrations were conducted on the withdrawal techniques to be used for inserting copper devices
  - information and demonstrations were given on when and how to disinfect, decontaminate and dispose.
  - supervisors made small amounts of bleach available in all clinics.

**INTRAH: "Training, Performance Assessment  
and Service Quality"**

**LESSONS LEARNED ABOUT IMPROVING THE QUALITY OF  
SERVICE DELIVERY THROUGH PERFORMANCE DIAGNOSIS**

Targeted performance diagnosis--using rating scales and trained observers--helps trainers, supervisors and FP program managers to:

- Focus on and identify quality of care issues and problems that are service provider-driven .

In the case of the Nakuru performance diagnosis, quality of care problems were those associated with service providers' technical competence and the information given to clients.

- Focus (on-the-job) training and service supervision to remedy the performance deficits.
- Identify educational needs (training, retraining and reorientation) when new methods or new brands of contraceptives are introduced.

In the case of Nakuru district, the transition from the Lippes loop to the copper-bearing devices was not accompanied by immediate reorientation or training to address changes in loading and insertion techniques, which resulted in continuation of old, inappropriate practices.

- Justify the use of locally-available funds for service improvements.

In the case of Nakuru district, the use of community-managed cost sharing funds to improve the quality of services through (on-the job) training and service supervision was justified based on results of the performance diagnosis.

IPPF Survey on Service Provision Practices - .

Country: \_\_\_\_\_

Date: \_\_\_\_\_

Position of person or team members completing this questionnaire: \_\_\_\_\_  
\_\_\_\_\_

**I. Guidelines**

1. What guidelines does your FPA follow?

- 1 Government's National Service Delivery Guidelines
- 2 IPPF's Medical and Service Delivery Guidelines
- 3 Modified IPPF's Medical and Service Delivery Guidelines
- 4 Other, specify: \_\_\_\_\_

2. Does your country have written national guidelines which guide clinical personnel in providing family planning services (service delivery guidelines)?

- 1 Yes
- 2 No (Skip to question 4)
- 3 Don't know

3. Would you say that the guidelines your FPA is using and the national guidelines are:

- 1 Almost the same
- 2 Somewhat different
- 3 Significantly different
- 4 Don't know
- 5 No national guidelines

4. Would you say that the FPA guidelines your FPA is using and the IPPF guidelines are:

- 1 Almost the same
- 2 Somewhat different
- 3 Significantly different
- 4 Don't know

**II. Eligibility criteria**

5. Please circle the appropriate response to each question for each method: Y (Yes), N (No), DK (Don't Know).

	Progestin - Only Pill	Combined Pills	Injectables	Implants	IUDs	Female Sterilization	Vasectomy	Sperm
Is this method provided in your program?	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N
<b>Is access to this method restricted based on:</b>								
Age?	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N
Parity?	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N
Marital status?	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N
Spouse's consent?	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N
Smoking status	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N
Diabetes?	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N
Sickle cell disease?	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N
Use of method for more than 1-2 years?	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N
Presence of STDs or PID?	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N
Other, specify _____ _____ _____	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N

160

**III. Regulatory restrictions**

6. Please indicate in the table below which methods each category of health worker is permitted to provide. Circle response Y (Yes), N (No), DK (Don't know).

	Obs-Gyne	General Practitioners	Nurses or Nurse Midwives	Community Workers
Progestin-only pills	Y N DK	Y N DK	Y N DK	Y N DK
Combined pills	Y N DK	Y N DK	Y N DK	Y N DK
Injectables	Y N DK	Y N DK	Y N DK	Y N DK
Spermicides	Y N DK	Y N DK	Y N DK	Y N DK
Implants	Y N DK	Y N DK	Y N DK	Y N DK
IUDs	Y N DK	Y N DK	Y N DK	Y N DK
Female Sterilization	Y N DK	Y N DK	Y N DK	Y N DK

7a. Does your FPA provide community-based distribution (CBD) of contraceptives?

- 1 Yes
- 2 No (Skip to question 8)
- 3 Don't know

7b. If yes, which methods are provided through the CBD program? (Circle all that apply)

- 1 Combined OCs (initial use)
- 2 Combined OCs (resupply)
- 3 Progestin-only Pills (initial use)
- 4 Progestin-only Pills (resupply)
- 5 Condoms
- 6 Spermicides
- 7 Injectables (initial use)
- 8 Injectables (resupply)
- 9 Other, specify: \_\_\_\_\_

7c. Do CBD workers use a checklist for screening clients for hormonal methods?

- 1 Yes
- 2 No
- 3 Don't know

7d. Is a clinic visit required for CBD clients who wish to initiate OCs?

- 1 Yes
- 2 No
- 3 Don't know

7e. Is a clinic follow up required for CBD clients?

- 1 Yes, after \_\_\_\_\_ months
- 2 No
- 3. Don't know

7f. If there are no problems, how many cycles of pills does the CBD give to a client during follow-up visits?

\_\_\_ no. of cycles

**IV. Service Provision Routine**

8. Which of the following examinations or procedures are generally required before clients are allowed to begin using the following methods? Circle the appropriate response: Y (Yes), N (No), DK (Don't Know).

Examination or procedure required	Progestin-only pills	Hormonal Methods	Female Sterilization	Vasectomy	IUDs
a. Full physical exam	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
b. Pelvic exam	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
c. Laboratory blood test	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
d. Laboratory urine test	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
e. Laboratory STD test	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
f. PAP smear	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK

9. Are women normally told to reschedule appointments because of their menstrual status? (i.e to come back during menses)

9a. To receive initial supply of hormonal methods

- 1 Yes
- 2 No
- 3 Don't know

9b. For inserting IUDs

- 1 Yes
- 2 No
- 3 Don't know

9c. If a woman who is more than 6 weeks postpartum and experiencing amenorrhea because she is breastfeeding comes to your clinic requesting family planning services, what do you advise her to do?

- 1 Nothing
- 2 Continue using lactational amenorrhea method
- 3 Consider using a hormonal method
- 4 Consider using a modern, non-hormonal method
- 5 Other (specify) \_\_\_\_\_

10. How many months supply of pills do providers in your FPA clinic routinely provide?

10a. At first visit (no of cycles) \_\_\_\_\_

10b. At follow-up visit (no of cycles) \_\_\_\_\_

11. What are the routine procedures a woman follows for a resupply of OCs at the clinic if she doesn't complain of any problems? (Circle all that apply.)

- 1 Weight
- 2 Blood pressure
- 3 Physical examination
- 4 Pelvic examination
- 5 Other, specify:
- 6 None of the above

12. If no problems arise, when would follow-up visits be scheduled:  
(Please circle the month a woman is expected to return.)

12a. Combined oral contraceptives:

Month

First year 1 2 3 4 5 6 7 8 9 10 11 12

Subsequent years 1 2 3 4 5 6 7 8 9 10 11 12

12b. IUDs:

Month

First year 1 2 3 4 5 6 7 8 9 10 11 12

Subsequent years 1 2 3 4 5 6 7 8 9 10 11 12

13a. How often does your clinic have a shortage of contraceptive commodities?

- 1 Never (skip to question 14)
- 2 Occasionally
- 3 Frequently
- 4 Always

13b. For which contraceptives do you experience shortages?

- 1 Condoms
- 2 Female barrier methods
- 3 Injectables
- 4 IUD
- 5 NORPLANT
- 6 Oral contraceptives (Progestin-only)
- 7 Oral contraceptives (Combined)
- 8 Other (specify) \_\_\_\_\_

**V. Provider Preferences**

14. In general, who determines the most appropriate method for the client?

- 1 Client
- 2 Provider
- 3 Provider and client jointly
- 4 Other (specify) \_\_\_\_\_

15. Please indicate the four most popular methods in your clinic, and the approximate percentage of your clients who use each of these methods.

Method 1	_____	Percent of Users	_____
Method 2	_____	Percent of Users	_____
Method 3	_____	Percent of Users	_____
Method 4	_____	Percent of Users	_____

16. Which methods do providers in your FPA tend to prefer for the following types of clients?

16a. A client who wants to delay the first birth

Method 1 \_\_\_\_\_

Method 2 \_\_\_\_\_

16b. A client who wants to space the next birth

Method 1 \_\_\_\_\_

Method 2 \_\_\_\_\_

16c. A client who wants to stop having children

Method 1 \_\_\_\_\_

Method 2 \_\_\_\_\_

17a. Are there any modern contraceptive methods that many providers in your FPA are less likely to prescribe?

- 1 Yes
- 2 No (Skip to question 18a)
- 3 Don't know

17b.

Less likely to prescribe this method		If so, for what reasons? (specify)
Condoms	Y N DK	
Female barrier methods	Y N DK	
Female Sterilization	Y N DK	
Injectables	Y N DK	
IUD	Y N DK	
Male Sterilization	Y N DK	
Norplant	Y N DK	
OCs (Progestin-only)	Y N DK	
OCs (Combined)	Y N DK	
Other (specify) _____ _____	Y N DK	

18a. Are providers reluctant to serve certain types of clients? (For example, adolescents, unmarried clients, women without children, men)

- 1 Yes
- 2 No (Skip to question 19)
- 3 Don't know

18b.

Reluctant to serve these clients?		If so, for what reasons? (specify)
Adolescents	Y N DK	
Unmarried clients	Y N DK	
Women without children	Y N DK	
Men	Y N DK	
Other (specify) _____ _____	Y N DK	

**VI. STDs/HIV and Family Planning**

19. Please indicate the following STD/HIV services your FPA provides  
 Circle response. (Y = Yes, N = No, DK = Don't Know)

Service	STD	HIV
1 Prevention education	Y N DK	Y N DK
2 Teaching condom use skills to clients	Y N DK	Y N DK
3 Condom distribution	Y N DK	Y N DK
4 Referral	Y N DK	Y N DK
5 Diagnosis and treatment	Y N DK	Y N DK
6 Other (Specify) _____ _____	Y N DK	Y N DK

Quality of Care

**VII. Constraints and Opportunities**

20. Please list the three most important ongoing activities in your FPA to improve access, quality or service practices:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

21. What, in your opinion, are the three main obstacles your FPA faces in providing quality care?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

22. What, in your opinion, are the three main obstacles your clients/potential clients face when seeking access to family planning services?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

23. What, in your opinion, are the three main obstacles to change to increase clients' access to quality family planning services?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

24. What topics regarding quality of care, access and improving service practices would you like to see addressed at a meeting for Executive Directors on Maximizing Access and Quality of Care? (Please list as many as you like.)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

## SERVICE DELIVERY GUIDELINES

N = 28

- 20 Countries have National Service Delivery Guidelines.
- 10 Associations use National Guidelines.
- 5 use IPPF Medical and Service Delivery Guidelines.
- 7 Use Modified IPPF Medical and Service Delivery Guidelines.
- 1 Non-specified other Guidelines.
- 5 Missing response.

### Age and/or Parity Criteria for Use of a Contraceptive Method.

	Method Provided	Have Age Criteria	Have Parity Criteria
Progestin-only Pills	93%	19%	15%
Oral contraceptives	100%	43%	0%
Injectables	93%	46%	50%
Implants	36%	40%	40%
IUD	100%	36%	68%
Female Sterilization	46%	69%	92%
Male Sterilization	32%	67%	100%
Spermicides	100%	7%	0%

**Use of Marital Status and/or Spousal Consent as  
Eligibility Criteria**

	Marital Status Yes	Spouse's Consent
Progestin-only Pills	0%	8%
Oral Contraceptives	0%	11%
Injectables	4%	12%
Implants	0%	10%
IUD	21%	21%
Female Sterilization*	38%	62%
Male Sterilization	33%	56%
Spermicides	0%	7%

\* 62% (8) of the associations do not require a marital status and  
38% (5) of the associations do not require spouse's consent for female  
sterilization.

**Use of Smoking Status, Diabetes and/or Sickle Cell Disease as  
Eligibility Criteria for Contraceptive Methods.**

	Smoking Status	Diabetes	Sickle Cell Disease
Progestin-only Pills (N=26)	27%	54%	23%
Oral contraceptives (N=28)	86%	79%	46%
Injectables (N=26)	23%	54%	27%
Implants (N=10)	20%	60%	10%
IUD (N=28)	0%	21%	31%
Female Sterilization (N=13)	0%	15%	15%
Male Sterilization (N=28)	11%	11%	0%
Spermicides (N=28)	0%	0%	4%

## **Presence of STD/PID used as a Contra-indication for use of Contraceptive Methods.**

	Yes
Progestin-only Pills (N=26)	0%
Oral contraceptives (N=28)	4%
Injectables (N=26)	4%
Implants (N=26)	10%
IUD (N=28)	89%
Female Sterilization (N=13)	31%
Male Sterilization (N=28)	22%
Spermicides (N=28)	7%

### **Community - Based Distribution Programmes**

- 23 FPAs have community-based distribution programs.
- 19 CBD programs provide pills.
- 17 CBD programs use a checklist.
- All CBD programs distribute condoms.
- All CBD programs distribute spermicides.

### **Required Clinic Visits for CBD Clients**

#### Initial Visit

- 42% demand one clinic visit before providing the pill

### Follow-up Visits

- 42% demand one clinic visit in the first 3 months
- 26% demand one clinic visit in the first 6 months
- 5% demand one clinic visit in the first 12 months
- 26% do not demand any clinic visit

### **Number of Pill Cycles Distributed by CBD Workers at Follow-up**

89% distribute 3 - cycles.

11% distribute 6 - cycles.

### **Distribution of Pill Cycles at Clinic Facilities**

#### Initial Visit

- 52% of clinics provide 1 cycle at initiation
- 44% of clinic provide 3 cycles at initiation
- 4% of clinics provide 6 cycles at initiation

### Follow-up Visits

- 52% provide 3 cycles or fewer
- 48% provide 6 cycles or more

### **Routine Procedures or Exams Required Before Method Initiation**

	<u>Combined OCs</u>	<u>IUD</u>
Physical Exam	93%	89%
Pelvic Exam	86%	93%
Blood Test	11%	11%
Urine Test	21%	11%
STD Test	11%	36%
Pap Smear	18%	21%

### **Routine FU Procedures**

#### Check:

Weight	85%
Blood Pressure	85%
Physical Exam	22%
Pelvic Exam	22%
Other	7%
None of the above	15%

### **Distribution of Pill Cycles at Clinic Facilities**

#### Initial Visit

- 52% of clinics provide 1 cycle at initiation
- 44% of clinics provide 3 cycles at initiation
- 4% of clinics provide 6 cycles at initiation

### Follow-up Visits

- 52% provide 3 cycles or fewer
- 48% provide 6 cycles or more

### **Initiation of Contraception During Menses**

- Must have menses to receive:-

the initial supply of pills

81% - Yes

19% - No

an IUD Insertion

78% - Yes

22% - No

### **Frequency of Stock Outages**

73% Occasional stock outages

12% Frequent stock outages

15% no stock-outs

### **Percentage of FPAs that have had Stock-outs of:**

<u>Commodity</u>	<u>%</u>
OCs	39%
Injectables	36%
Condom	29%
IUDs	18%
Spermicides	21%

## **Recommended Methods For:**

### Delaying First Birth

OCs  
Condoms  
Spermicides

### Spacing Births

OCs  
IUDs

### Limit Births

Injectables  
Female Sterilization  
IUDs  
Vasectomy  
Norplant

## **Reluctance to Serve Certain**

### Types of Clients

Yes - 7 Associations 25%

### Reluctance in Providing Contraceptives to

- Adolescents
- Unmarried Clients
- Nulliparous Women

### Reasons -

- Policy and cultural limitations
- Fear of post - contraceptive infertility
- Lack of clear policy guidelines

One association required parental consent for the provision of contraceptives to adolescents.

## **Appendix 4**

### **Working Groups**

**Groups 1 and 2, Obstacles to access and quality of care**

- a. Inaccessibility of Services
- b. Insufficient Resources
- c. Inadequate logistics/supplies

**Groups 3 and 4, Obstacles to access and quality of care**

- d. Unmotivated staff
- e. Inadequate technical competence
- f. Socio-cultural constraints and misconceptions of family planning

Please identify possible causes (e.g. - specific policies, management systems, training, etc.) of the obstacles given to your group evaluate the frequency and severity of the cause; and select the three priority causes.

Draw up a plan of what the FPA could do to address the major causes.

Present your findings in the following format:

**Obstacle - Possible causes - Priority causes - Means of Verification - Plan of Action**

Leave enough time to discuss each aspect of each obstacle and allow 10 minutes for the rapporteur to summarize the group's discussions so that there is a consensus.

## Group 1

Mrs. Cally Ramalefo - Chairperson (Botswana)

- |     |                       |   |           |
|-----|-----------------------|---|-----------|
| 1.  | Mr. I. K. Boateng     | - | Ghana     |
| 2.  | Mrs. L. Mosaase       | - | Lesotho   |
| 3.  | Dr. A. B. Sulaiman    | - | Nigeria   |
| 4.  | Mrs. Khetsiwe Dlamini | - | Swaziland |
| 5.  | Mrs. J. A. B. Nima    | - | Uganda    |
| 6.  | Dr. A. F. Zinanga     | - | Zimbabwe  |
| 7.  | Mr. Araya Demissie    | - | Ethiopia  |
| 8.  | Dr. Carlos Huezo      | - | (IPPF)    |
| 9.  | Dr. Michael Welsh     | - | (FHI)     |
| 10. | Dr. D. Kiwele         | - | (CAFS)    |
| 11. | Mme. Laurencia Okoth  | - | (IPPF)    |

## Group 2

Mr. J. Taylor-Thomas - Chairperson (Gambia)

- |     |                    |   |              |
|-----|--------------------|---|--------------|
| 1.  | Mrs. Grace Walla   | - | Cameroon     |
| 2.  | Mr. G. Mzenge      | - | Kenya        |
| 3.  | Mr. E. Fenita      | - | Mozambique   |
| 4.  | Dr. W. E. Taylor   | - | Sierra Leone |
| 5.  | Dr. Naomi Katunzi  | - | Tanzania     |
| 6.  | Mrs. V. Munda      | - | Zambia       |
| 7.  | Sr. Kidisty Habte  | - | Eritrea      |
| 8.  | Dr. Roberto Rivera | - | (FHI)        |
| 9.  | Ms. Pauline Muhuhu | - | (INTRAH)     |
| 10. | Ms. Susanne Fenn   | - | (JHPIEGO)    |
| 11. | Dr. Magwa          | - | (CAFS)       |

## Group 3

Mrs. Geeta Oodit - Chairperson (Mauritius)

- |    |                                     |   |               |
|----|-------------------------------------|---|---------------|
| 1. | Mr. Boniface Yehouenou              | - | Benin         |
| 2. | Dr. (Mme) Marie-Claire Ryanguyenabi | - | Burundi       |
| 3. | M. Benadjel M'Baissour              | - | Chad          |
| 4. | Dr. Joao C. Rodrigues               | - | Guinea Bissau |
| 5. | Mr. Manitra Andriamosinoro          | - | Madagascar    |
| 6. | Mr. Belgasime Drame                 | - | Senegal       |
| 7. | Mme. Zawadi Mwenge                  | - | Zaire         |
| 8. | Dr. M. Barry                        | - | (IPPF)        |

## Group 4

Mr. A. N. Kaudaya - Chairperson (Togo)

- |    |                       |   |                          |
|----|-----------------------|---|--------------------------|
| 1. | Dr. A. D. Gnoumou     | - | Burkina Faso             |
| 2. | Mr. Clement Eregani   | - | Central African Republic |
| 3. | Mr. Florent Mboundou  | - | Congo                    |
| 4. | Mr. B. Sidime         | - | Guinea Conakry           |
| 5. | Mr. Lansina Sidibe    | - | Mali                     |
| 6. | Mr. Bagnababa Mamadou | - | Niger                    |
| 7. | Ms. Vana Prewitt      | - | (FHI)                    |
| 8. | Ms. Kathy Jesencky    | - | (FHI)                    |
| 9. | Dr. Mariamm Sangare   | - | (CAFS)                   |

## Results of Group 1

### OBSTACLES TO ACCESS AND QUALITY OF CARE

- A) **Inaccessibility of services**
  - B) **Insufficient resources**
  - C) **Inadequate logistics/supplies**
- 

#### A. **Inaccessibility of Services**

■ **Possible Causes:**

1. **Physical Barriers: e.g**
  - **Geographical**
  - **Infrastructure**
2. **Personnel**
  - **Motivation, work overload;**
  - **lack of integration of FP into health personnel curricula**
3. **Policies**
  - **Health policy: restrictive (clinical/health service area)**
  - **Donor policies/competition/coordination**
  - **NGO/NGO competition**
  - **Government/NGO competition**

#### B. **Insufficient Resources**

■ **Possible Causes:**

1. **Financial constraints**
  - **Reduction e.g declining I.P.F. (IPPF)**
  - **Lack of government support**
  - **Structural adjustment programme**
2. **Management of resources**
  - **Mechanisms of prioritising**
  - **Lack of coordination between programme and finance departments**

#### C. **Inadequate Logistics/Supplies**

■ **Possible Causes:**

1. **Training, monitoring and control systems.**
  - **Inadequate training, planning, supervision of providers**
  - **Lack of an effective monitoring system including stores' management**
  - **Lack of control systems**
2. **Taxation policies changed.**

3. Broad selection of brands of contraception.
4. Varying cost recovery policies (Government/NGO) --- program sustainability affected.

## ACTIONS

### **A. Inaccessibility of Services.**

1. Physical barriers
  - \* Alternative Delivery Systems
    - community based services;
    - social marketing;
    - outreach
 (use multisectoral approach)
  - \* Decentralization (effective)
  - \* Effective back-up systems/clinical referral

### **B. Insufficient resources.**

1. Financial Constraints
  - \* Advocacy
  - \* Diversification of funding sources.
2. Management of resources
  - \* Strengthening/creation of M.I.S
  - \* Training of
    - supervisors
    - program staff
    - finance staff
  - \* Orientation of volunteers and staff on IPPF standards and regulations.

### **C. Inadequate logistics/supplies**

1. Training in supervision, monitoring, control system, and develop cost-recovery policies, limit contraceptive brands.
  - \* Develop MIS
  - \* Develop logistics manual/guidelines
  - \* Train according to MIS and logistics guidelines.
  - \* Monitoring/supervision (MIS and logistics systems)

2. Taxation policies \* Advocacy for exemption

**Major Resources Needed**

In the areas of:

Development of MIS  
Training in financial management  
Strategic planning  
Training in logistics/supply management

HOW COPE IS DONE

1. Hold general meeting.  
All cadres present.
2. Identify customers  
= Internal  
= External
3. Identify customer needs and how to meet them + to measure success.
4. Make action plan.
5. Set review date.
6. Set cope repeat date.

## Results of Group 2

Unmotivated Staff	■ Remuneration package	5	5
	■ Facility/equipment/ supplies	3	3
	■ Human working environment	4	4
	■ Appraisal/staff supervision	4	4
	■ Unclear organizational goal/mission	3	4
Inadequate Technical Competence	■ Lack of training needs assessment and training plans resulting in unfocused training.	4	5
	■ Lack of information updates	5	5
	■ Recruitment practices	3	5
	■ Inadequate supervision and follow-up	4	5
	■ Lack of/inadequate service guidelines and job descriptions	4	5
Socio-Cultural Constraints	■ Myths/Misconceptions	5	5
	■ Low status of women/male domination	5	5
	■ Traditional practices/ Taboos/Religion	5	5
	■ Low level of education	5	5
	■ Donor dependency	5	5
	■ Medicalization of FP services	4	5

<p><b>1. <u>UNMOTIVATED STAFF</u></b></p> <p>a) Remuneration Package</p> <p>b) Human Working Environment</p> <p>c) Supervision of Staff</p>	<p>Review policies, harmonize, update, mobilize resources (Gov, FPAs, Donors)</p> <p>COPE type activity, recognition, periodic meetings/gatherings (get-togethers)</p> <p>Establish supervision guidelines, train in supervision, give feedback, programme supervisory visits</p>
<p><b>2. <u>INADEQUATE TECHNICAL COMPETENCE</u></b></p> <p>a) Lack of training needs assessment/plans</p> <p>b) Information updates</p> <p>c) Guidelines/Job descriptions</p>	<p>Needs assessments, training strategies/plans</p> <p>Policies and mechanisms to be established, effective dissemination of available information</p> <p>Review, update, disseminate and apply guidelines, job descriptions</p>
<p><b>3. <u>SOCIO-CULTURAL CONSTRAINTS AND MISCONCEPTIONS OF FAMILY PLANNING.</u></b></p> <p>a) Low status of women/male domination</p> <p>b) Traditional Practices/Taboos</p> <p>c) Myths/Misconceptions</p>	<p>Establish and operationalise NWAPS, awareness creation and male motivation</p> <p>Targeted awareness programmes. NWAPS to research and develop strategies, agency collaboration</p> <p>Awareness creation, dissemination of <u>truths</u>; Media campaigns, use of opinion leaders, newsletters, studies to document the myths and counter with regular scientific evidence in lay language</p>

### Results from Group 3

1. INACCESSIBILITY OF SERVICES	1. <u>DISTANCE FROM CENTRES</u>	5	5	■ <u>DISTANCE FROM CENTRES</u>	■ <u>CBD</u> ■ <u>MOBILE CLIENTS</u>
	2. <u>COST OF SERVICES</u>	1	1		
	3. <u>RECEPTION OF CLIENTS BY PROVIDERS</u>	4	4	■ <u>RECEPTION OF CLIENTS</u>	■ <u>TRAINING, CONTINUING EDUCATION AND REGULAR SUPERVISION</u>
	4. <u>LIMITED HOURS</u>	1	1		
	5. <u>STOCK OUTAGES</u>	2	2		■ <u>MOTIVATION (VALORIZATION OF THE POST, ENCOURAGEMENT AND PRIZES)</u>
	6. <u>CONSTRAINTS INSTITUTIONAL</u>	3	3		
	7. <u>BARRIERS CULTURAL, MEDICAL, ADMINISTRATIVE</u>	4	4	■ <u>BARRIERS</u>	■ <u>INFORMATION</u> ■ <u>TRAINING/UPDATES</u> ■ <u>O.R TO IDENTIFY BARRIERS</u> ■ <u>ELIMINATE UNNECESSARY REGULATIONS</u>

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2. <u>FINANCIAL</u>	1. <u>INSUFFICIENT RESOURCES</u>	5	5	■ <u>POOR MANAGEMENT</u>	<ul style="list-style-type: none"> <li>■ <u>RESPONSIBILIZE SOMEONE</u></li> <li>■ <u>UPDATING IF NECESSARY</u></li> <li>■ <u>STRENGTHENING OF CONTROL PROCEDURES AND FOLLOW-UP</u></li> <li>■ <u>SANCTIONS IF NECESSARY</u></li> </ul>
	2. <u>POOR MANAGEMENT OF AVAILABLE RESOURCES</u>	2	2	■ <u>INSUFFICIENT RESOURCES</u>	<ul style="list-style-type: none"> <li>■ <u>MOBILIZATION OF RESOURCES AT ALL LEVELS (LOTTERY, DANCES, MONEY -MAKING, PROJECTS, REQUESTS TO NATIONAL INSTITUTIONS, COST RECOVERY)</u></li> </ul>
	3. <u>IMPROPER USE OF AVAILABLE RESOURCES</u>	3	3		

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3. <u>MATERIAL</u>	1. <u>POOR PLANNING AND MANAGEMENT</u>	2	2	<ul style="list-style-type: none"> <li>■ <u>PLANIFICATION AND MANAGEMENT</u></li> </ul>	<ul style="list-style-type: none"> <li>■ <u>RESPONSIBILIZE SOMEONE</u></li> <li>■ <u>UPDATING, IF NECESSARY</u></li> <li>■ <u>STRENGTHENING CONTROL AND FOLLOW-UP PROCEDURES</u></li> <li>■ <u>SANCTIONS</u></li> </ul>
	2. <u>INSUFFICIENT OR OUT-DATED</u>	3	3	<ul style="list-style-type: none"> <li>■ <u>INSUFFICIENT OR OUT-DATED</u></li> </ul>	<ul style="list-style-type: none"> <li>■ <u>CORRECT MAINTENANCE OF AVAILABLE MATERIALS</u></li> </ul>
	3. <u>DEPENDANCE ON OUTSIDE SOURCES (MATERIAL AND FINANCIAL)</u>	5	5	<ul style="list-style-type: none"> <li>■ <u>DEPENDANCE</u></li> </ul>	<ul style="list-style-type: none"> <li>■ <u>DIVERSIFICATION OF SOURCES OF SUPPORT</u></li> <li>■ <u>MOBILIZATION OF INTERNAL RESOURCES (NATIONAL INSTITUTIONS)</u></li> <li>■ <u>ACTIVE INVOLVEMENT OF VOLUNTEERS IN THE MOBILIZATION OF RESOURCES</u></li> </ul>

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## Results of Group 4

### OBSTACLE 1:      **NON-MOTIVATED PERSONNEL**

#### Priority Causes:

1.      Poor working conditions
  - **Insufficient salary**
  - **Condition of Equipment**
  - **Poor working environment**
  
2.      Poor personnel management
  - **Lack of job descriptions**
  - **Lack of supervision**
  - **Lack of career ladder**
  - **Poor interpersonal relations**
  - **Lack of team spirit**
  
3.      Poor information dissemination
  - **Lack of communication**

### OBSTACLE 1      - **Action Plan**

Cause 1:      Poor Working Conditions

Objective:      Improve working conditions

- Revise personnel policies and salary scales
- Evaluate/equip services with appropriate and sufficient materials

Action:      -      Revise policies and salary scales  
                     -      Evaluate conditions of materials  
                     -      Equip services

Cause 2:      Poor personnel management

Objective:      Improve personnel management

Actions:      -      Develop job descriptions  
                     -      Evaluate and train personnel  
                     -      Develop personnel performance objectives  
                     -      Supervision

Cause 3:      Poor information dissemination

Objective:      Improve the information systems

Actions:      -      Evaluate the existing information system  
                     -      Strengthen the system of reports and periodic meetings

**OBSTACLE 2: - INADEQUATE TECHNICAL COMPETENCE**

**Priority Causes:**

1. Inadequate training for job
  - Insufficient up-to-date information
  - Lack of training
  - Lack of continuing education courses
2. Poor job descriptions
3. Lack of supervision and evaluation systems

**OBSTACLE 2 - Action Plan**

**Cause 1:** Inadequate training for job

**Objective:** Bring up to standard training levels for jobs

- Actions:**
- Put into place and effective recruiting system
  - Organization of update courses
  - Transfer of personnel
  - Put into place systems for evaluation and supervision
  - Development of procedures and protocols

**Cause 2:** Poor job descriptions

**Objective:** Assure a better organization of work

- Actions:**
- Evaluate jobs
  - Revise job description
  - Distribute job description
  - Continually evaluate job descriptions

**Cause 3:** Lack of supervision and evaluation systems

- Objectives:**
- Put in place an effective/facilitative system of supervision
  - Put in place an effective evaluation system

- Actions:**
- Develop protocols and norms
  - Develop instruments for supervision
  - Develop instruments for evaluation
  - Train personnel to use protocols, respect standards and use the instruments developed
  - Develop a program of site visits
  - Implement the system of supervision

**OBSTACLE 3: - SOCIO-CULTURAL CONSTRAINTS**

**Priority Causes:**

1. Influence of Traditions
  - Women's status
2. Pronatalist views
  - Subjective interpretation of religious texts
3. Illiteracy
  - Rumours and prejudices about family planning

**Cause 1:** Influence of traditions on women's status

**Objective:** Facilitate the access of women to family planning services

- Actions:**
- Sensitize the parliamentarians and other opinion leaders on women's rights
  - Identify obstacles to access
  - Involve women's groups in family planning activities
  - Involve men in family planning activities
  - Expand family planning services

**Cause 2:** Pronatalist Views

**Objectives:** Increase the knowledge of the public on the benefits of family planning.

- Actions:**
- Put in place strategies and programs to sensitize and inform the public.

**Cause 3:**

**Objective:** Motivate illiterate people to accept family planning

- Actions:**
- Improve local language information programs
  - Develop appropriate teaching methods
  - Develop appropriate messages
  - Put in place a system of follow-up

## Appendix 5

### Seminar Evaluation

Participants were asked to complete a short evaluation form at the end of the seminar. Twenty-seven forms were completed (12 from anglophone participants; 15 from francophone participants). The results are as follows:

#### 1. What were your expectations for the seminar?

Most often, participants said that they expected to learn more about increasing access and quality of care; the principles, analysis techniques and solutions for improved access and quality of care. They also wanted to gain some knowledge about instruments to evaluate quality of care.

Other expectations were:

- Exchange ideas and learn what is happening in other FPAs concerning quality of care
- Identify the obstacles to service access
- Learn how to ensure quality of care
- Gain knowledge on service management
- Analyze the questionnaire results and use these as a basis to improve access and quality of care.

#### 2. Were your expectations met?

The majority of participants (70%) felt that their expectations were met; the other 30% felt that their expectations were partially met.

#### 3. Did you gain any new knowledge?

Only one person felt that s/he did not gain any new knowledge; 96% of the participants felt that they gained new knowledge.

#### 4. If yes, what were the most important points that you learned?

The most important new knowledge for participants was on the ways to evaluate quality of care and the COPE exercise.

Other useful new knowledge was:

- Discussion of client flow analysis
- Eligibility criteria for contraceptive methods
- Experience of other countries
- Definition of access vs. availability
- The part that executive directors can play in improving access and quality of care
- Proposals for action plans
- New scientific knowledge to reduce medical barriers
- Reasons for medical barriers
- New ideas on supervision

**5. Will you have the possibility to use this new knowledge in your work?**

All of the participants (100%) felt that they could use this new knowledge in their work.

**6. If yes, how?**

There were many different answers of how this new knowledge could be incorporated into their work. Among others, responses were:

- When preparing the WP/B, will ensure that some constraints are addressed, i.e. supervision, training, staff motivation;
- Dissemination to other staff and volunteers through workshops, meetings, etc.;
- Identify factors affecting access in the FPA and try to address them;
- Plan COPE exercise for FPA staff;
- Use assessment tools to measure quality;
- Better understanding and appreciation of problems faced in service delivery;
- Discussion with clinic staff about problems in access and quality of care;
- Identify specific problems to maximizing access and quality;
- Review CBD checklist and eliminate unnecessary conditions;
- Implement small research projects which utilize the concepts learned;
- Establish indicators for personnel performance;
- Evaluate services as a beginning to implement procedures to improve quality of care;
- Develop a plan to improve supervision
- Implement the manual on medical directives
- Institute periodic evaluations.

**7. The seminar was evaluated on a scale of 1-10, with 10 being the highest, as to:**

average score

Importance of subject matter -	9.3
Content of presentations -	8.3
Working groups -	8.8
Organization -	8.1

**8. How could the seminar be improved?**

The most common suggestion for improvement was to have had more time. It was felt that a seminar of 3-5 days would have been more appropriate. Participants would have had more time to assimilate and discuss the topic. Likewise, many participants felt that the seminar should have been an independent activity, not added onto the Council Meeting.

Other suggestions included:

- Providing handouts before the presentations
- Participants should respect the time schedule
- Include a visit to service sites
- More in-depth presentations of the FPAs experiences in quality of care
- Discussion of the availability of personnel, equipment and materials to the FPAs
- Fewer presentations
- Resource persons should be offered lunch

**9. For upcoming years, what can you propose as regional activities for improving access and quality of care?**

Here again, there were a variety of activities suggested. Most important -

- Develop systems to address problems in MIS, logistics, training and strategic planning;
- Introduce COPE to all FPAs;
- Renew exercise IPPF undertook last year to renovate and equip clinics to a reasonable standard;
- Provide adequate resources for access and quality of care;
- Training on tools for identification of problems;
- Similar seminars to be organized at the national level so that as many staff as possible can be exposed to quality of care information;
- Improve service providers working conditions and motivation;
- Restructure staffing, define job descriptions, train management and staff;
- Region should organize similar seminars every 2 years as update;
- Follow-up on action plans;
- Provision of information on access and quality of care to all FPAs ;
- Develop standards of quality;
- Training of trainers program in quality of care;
- Update courses for service providers;
- Organize evaluation seminars with strong practical component;
- Organize exchanges of experiences on access and quality of care among FPAs;
- Cost recovery.