SEATS II

Training Curriculum in **CONTINUOUS QUALITY IMPROVEMENT** for Family Planning Programs

Incorporating Expanded Quality Improvement

SEATS

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Family Planning
Service Expansion
and
Technical Support

May 2000

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SEATS II

TRAINING CURRICULUM IN **CONTINUOUS QUALITY IMPROVEMENT** FOR FAMILY PLANNING PROGRAMS

INCORPORATING EXPANDED QUALITY IMPROVEMENT

May 2000

Copies of this curriculum are available from:

Library
John Snow, Inc.
1616 North Fort Myer Drive, 11th floor
Arlington, VA 22209
USA
Tel. (1) (703) 528-7474
http://www.seats.jsi.com

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The goal of the Family Planning Service Expansion and Technical Support (SEATS II) Project is to expand the development of, access to and use of high-quality, sustainable family planning and reproductive health services in currently underserved populations. It built and followed on the SEATS I Project (1990-1995).

John Snow, Inc. (JSI), an international public health management consulting firm, headed a group of organizations implementing the SEATS II Project. These included the American College of Nurse Midwives (ACNM), American Manufacturers' Export Group, AVSC International, Initiatives, Inc., the Program for Appropriate Technology in Health (PATH), Social Sectors Development Strategies (SSDS), World Education, United States Agency for International Development (USAID) Missions and other partner organizations in each country where SEATS was active.

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ACKNOWLEDGMENTS

The SEATS II project placed high priority on improving the quality of care (QOC) in its subprojects. The framework for its work in QOC came from a number of requirements in the USAID contract governing the project. One such requirement was that SEATS II subprojects have plans for continuous quality improvement; another that the project should show measurable improvements in quality. These provisions played an important role in shaping this training curriculum and, accordingly, special acknowledgement is due to USAID both for the financial support that made the curriculum possible and for the curriculum's emphasis on developing Quality Action Plans and showing measurable improvements in the quality of care.

Key people involved in developing the first SEATS II curricula on Continuous Quality Improvement were Nancy Pendarvis Harris, the first SEATS II project director; Linda Ippolito, Senior Technical Advisor for Training and QOC; Don Lauro, Chief of Party, JSI/Morocco; and Elaine Rossi, Senior Technical Advisor. They drew on numerous excellent resources from AVSC International, Family Planning Management Development (Management Sciences for Health), the Institute of Health Care Improvement, the International Planned Parenthood Federation, USAID's Maximizing Access and Quality (MAQ) Initiative, the Quality Assurance Project (University Research Corporation), Oriel Incorporated (formerly Joiner Associates, Inc.) and other sources. JSI expresses its deep gratitude to all these parties for their pioneering work and inspiration.

SEATS II trained hundreds of health care providers and managers in Continuous Quality Improvement (CQI). SEATS II trainers made modifications to the underlying curriculum in light of their own experience, emerging thinking on quality of care and the realities facing service providers in the field. Many suggestions emanating from that experience have been incorporated into this version of the curriculum. The comments of Shalote Chipamaunga, Senior Program Officer in the SEATS II Africa Regional Office; Lisa Hare, Senior Technical Advisor for Sustainability; Mary Lee Mantz, Senior Technical Advisor; Ismael Thioye, Senegal QOC Consultant; Cathy Thompson, Senior Technical Advisor; and Tim Williams, Senior Evaluation Advisor were particularly helpful in that regard. Credit also goes to Asta-Maria Kenney, Senior Technical Advisor for QOC, and Suzanne Plopper, training consultant, who took the lead in compiling the results of field experience and meshing it with the original curriculum to create the version presented here.

THE SEATS II PROJECT

The Family Planning Service Expansion and Technical Support II project (SEATS II) began in 1995 as a continuation of the SEATS I Project (1989-1995) and closed in 2000. The project's purpose was to "expand the development of, access to and use of *quality* family planning and reproductive health services in currently underserved populations" (emphasis added).

The Family Planning Service Expansion and Technical Support II project (SEATS II), was funded by the United States Agency for International Development (USAID) and implemented by John Snow, Inc. (JSI) in collaboration with the following US partners:

- The American College of Nurse-Midwives (ACNM)
- American Manufacturers Export Group
- AVSC International
- Initiatives, Inc.
- Planned Parenthood Federation of America
- Program for Appropriate Technology in Health (PATH)
- Social Sectors Development Strategies
- World Education, Inc.

SEATS II worked with communities, public sector and private sector organizations where there was an expressed need for quality family planning and reproductive health services. By offering innovative perspectives and utilizing well-established approaches, SEATS II sought to increase the efficiency, effectiveness and quality of family planning/reproductive health (FP/RH) programs and helped reach groups of people who would otherwise remain underserved.

Quality of care (QOC) was a major priority of the project, along with increasing access and utilization of services, especially among underserved groups, and improving the sustainability of its subproject partners. Monitoring and evaluation was also an important focus.

The project supported five special initiatives to test new approaches to improving access to services and quality of care in a number of its subprojects:

- The Integration Initiative integrated new family planning and reproductive health components into nongovernmental organizations (NGO)/private voluntary organizations (PVO) programs.

- Midwifery Association Partnerships for Sustainability built the skills of midwives to provide reproductive health services and the capacity of midwifery associations to support them.

- The Youth Initiative increased access to reproductive health information and services for young people.

- The Urban Initiative mobilized urban leaders to address the increasing demand for quality services resulting from rapid urbanization.

- The Women's Literacy Initiative provided models and materials to link women in literacy programs with reproductive health information and services.

Under SEATS II, USAID Missions requested assistance to support their own objectives and programs and the project managed 44 subprojects, initiatives and other activities in Albania, Bangladesh, Cambodia, Eritrea, Guinea, India, Jordan, Kyrgyzstan, Mozambique, Russia, Senegal, Turkey, Uganda, West Bank/Gaza, Zambia and Zimbabwe.

Further information about SEATS II is available through the project's web site at: http://www.seats.jsi.com

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ACRONYMS

COPE	Client-Oriented and Provider-Efficient
CQI	Continuous Quality Improvement
CYP	Couple-years of Protection
EQI	Expanded Quality Improvement
FC	Flipchart
FC/T	Flipchart or Transparency
FGD	Focus Group Discussion
FP	Family Planning
FP/RH	Family Planning/Reproductive Health
HIV	Human Immunodeficiency Virus
HO	Handout
IEC	Information, Education and Communication
IUD	Intrauterine Device
JSI	John Snow, Inc.
MAQ	Maximizing Access and Quality
MOH	Ministry of Health
NGO	Nongovernmental organization
PVO	Private voluntary organization
QOC	Quality of Care
RH	Reproductive Health
SEATS	Family Planning Service Expansion and Technical Support project
STD	Sexually Transmitted Diseases
T	Transparency
TQM	Total Quality Management
USAID	United States Agency for International Development
WHO	World Health Organization

Comments from "Graduates" of SEATS II Training in Continuous Quality Improvement

"The quality meetings that are being held with the support of the project have contributed significantly to our motivation and the improvement and expansion of the quality of services."
—Staff member at a social security hospital in Turkey

"Staff involved in CQI reported that clients had favorable responses to the changes. For example, clients would ask: 'Why is this department more friendly and comfortable than others?'"
—Staff member at a social security hospital in Turkey

"The most interesting part of [Expanded Quality Improvement] was its focus on democratic participation which gives importance to everyone's contribution, from the gardener to the Executive Director. That allowed us to feel confident—that we were part of a solution—and that made us feel we could discuss real problems with our group and our management."
—Staff member at a clinic in Dakar, Senegal

"After quality training, I learned how to identify problems and solve them. Quality is not a static thing; we must keep trying to improve."
—A private midwife in Zimbabwe

"The best way to assure tomorrow's market is to make today's quality absolutely dependable. We offer quality care here in order to be assured of tomorrow's business."
—Sign installed at the Sunridge clinic in Harare, Zimbabwe, after quality training

INTRODUCTION

The SEATS II project trained hundreds of managers and service providers to implement a simple Continuous Quality Improvement (CQI) methodology. As a result, trainees used this approach to identify quality problems in their own agencies or facilities, to develop and implement plans to address those problems and bring about improvements.

This curriculum is a "work in progress" rather than a definitive curriculum. It was developed at the end of the SEATS II project, based on experience with prior unpublished curricula and technical assistance provided in the field. It has never been taught in its current form and users should view it as a curriculum to be further tested and adapted. Only 50 copies are being produced for limited distribution to persons and organizations likely to draw on it and further refine it for use in the field. While recognizing these limitations, the experience of SEATS II to date leads it to believe that the curriculum should prove effective in helping health care providers and managers take the initiative to improve the quality of care in their own agencies or facilities.

This curriculum adopts a simplified CQI approach and incorporates Expanded Quality Improvement (EQI), an innovation that brings community members into the quality improvement process, thus making the process responsive not only to problems identified by health care professionals and clients but also to people in the community *not* using services. Through EQI, facilities are able to broaden their appeal and their client base. The training is built around several widely recognized conceptual frameworks for QOC: the Bruce-Jain Framework, the United States Agency for International Development (USAID)'s Maximizing Access and Quality (MAQ) Initiative checklist, and the International Planned Parenthood Federation's Bill of Rights.

Over the life of the SEATS II project, all subprojects where the CQI process was introduced were successful in implementing it—although they often used only a few of the tools and generally had some difficulty with data collection and analysis. Subprojects that received more intensive technical assistance were able to run through more quality improvement cycles, to resolve more problems and to make better use of data. The SEATS II experience in improving the QOC is described in a companion publication, "Mainstreaming Quality Improvement in Family Planning and Reproductive Health Services Delivery" (see bibliography).

One of the hallmarks of the work of SEATS II work in QOC—and of this curriculum—is a strong emphasis on responding to clients' and communities' perceptions of the QOC. While the curriculum addresses both quality in fact—the technical QOC—and quality in perception—the recognition of clients' needs and expectations—the stress is on the latter. Traditionally, program standards and protocols, training and supervisory systems have sought to ensure that family planning/reproductive health (FP/RH) services meet technical criteria. While recognizing the critical importance of quality in fact, SEATS

saw a need to make services more responsive to clients and communities. This curriculum reflects that orientation.

This training is designed to be extremely practical, giving trainees first-hand experience in using many CQI tools and techniques. It is divided into two parts, allowing participants to return home and implement the skills learned in Part I before returning to the classroom to build on those skills in Part II.

- During Part I, participants learn basic concepts of quality of care in FP/RH, become familiar with the use of CQI tools to help identify quality problems as well as strategies to build and work with Quality Teams. This part of the training lasts four days.

- Afterwards, participants are expected to apply these techniques at their own work sites, setting up Quality Teams and identifying QOC problems using simple tools.

- Part II of the training focuses on the analysis of QOC problems, the development of action plans to resolve them and the measurement of results. Part II is expected to take place six to eight weeks after Part I and lasts two and a half days.

SEATS II obtained the best results from its QOC training when the training was conducted in many short segments—a session (or even part of a session) at a time—at (or close to) the participants' work sites, so that tools and techniques could be put into practice immediately. Recognizing that this is often not possible, this curriculum adopts a two-part approach. Conducting the training all at once—without a break for participants to put their skills into practice—is not recommended.

The training should only be undertaken when certain conditions are in place:

- Senior management in the agencies represented at the training must be supportive of the concept of quality improvement—including a strong client-orientation—and be prepared to give Quality Teams the autonomy to identify problems, propose and implement improvements.

- Participants must come in pairs or teams from their work site. This is because the training is designed to begin the process of teamwork and because a single individual may well encounter difficulty mobilizing a Quality Team at his/her agency or facility and introducing the team to QOC concepts. Ideally, teams from an agency/facility should include both a clinical and a non-clinical perspective.

- Participants in the training should have sufficient stature or seniority that they can initiate quality improvement work in their agency/facility.

- Participants must be committed to come to both Part I and Part II of the training.

The curriculum is designed to be conducted by trainers and/or program/project managers for family planning administrators, clinic managers and service providers with

little or no knowledge of quality improvement methods. Although the curriculum does not assume that the trainers have prior knowledge of quality improvement techniques, it does assume a solid knowledge of family planning and some experience with simple data collection techniques. Some background in quality improvement is also highly desirable.

NOTES TO THE TRAINER

Trainers are advised to read the Introduction to the curriculum with care.

Training Objectives

A list of the general and specific objectives of the training are provided as a handout. See handouts (HO) HO I-I and Ia.

Participants

It is critical that trainers (or organizers of the training) respect the criteria for the selection of participants, as outlined in the Introduction. The training is designed for a *team* from participating agencies. Isolated individuals will not be able to participate effectively—and may have difficulty putting the training to good use when they return to their work sites

It is recommended that, prior to training a team from a particular agency, training organizers ensure that the management of that agency will support use of Continuous Quality Improvement approaches. This may be done through individual contact with the agency manager or—often more effectively—by providing a brief orientation for a group of managers on quality of care and how "graduates" of this training would approach quality improvement.

Training Schedule

As stated in the Introduction, this training is designed to be conducted in two parts. There should be a six-to-eight week interval between these parts to allow participants to set up quality teams at their own work sites and identify some quality problems before returning for Part II.

The proposed schedule (see handouts I-2a and b) is intended as a guideline for the trainer, but actual time will vary, depending on the trainer and the participants. Although Part I can be conducted in four intense days—as proposed here—if time permits, it could be conducted over five days. Part II is less intense and takes two-and-a-half days.

Most days include a revision session for the first 30 minutes of the day. The purpose of this session is to clarify for participants any aspects of the training that are unclear. The suggested approach for the revision sessions is for the trainer to:

- Ask if participants have any questions about topics covered the previous day (or prior days)

- Pose questions to the group based on his/her perception of concepts/issues that remain unclear. Assisting participants to understand the *application* of the material covered to their work situations is a major focus of the revision sessions.

It is often beneficial to conduct a brief, informal evaluation at the end of each day to help trainers determine which aspects of the day were more successful and which were less so in terms of training methodology and content. This can also help trainers use the next day's revision session to address any content areas that may have been unclear and to adapt the training methodology for the rest of the training.

Appropriate Technology

Trainers will need to adapt the materials (handouts, flipcharts and transparencies) used in the curriculum to local conditions. For example, a chalkboard or white board may be used instead of flipchart paper. If electricity is unavailable, transparencies may be presented on flipchart paper.

Discussions

Where the curriculum provides for discussions, it is suggested that key questions be posed by the trainer to trigger the discussion. The key questions are indicated with an arrow and appropriate responses are indicated in *italics* following each question or series of related questions. These questions and responses serve two purposes: I) to ensure that the basic ideas of the session are addressed; and 2) to guide the trainer in preparing and conducting the session.

When participant responses are likely to be variable and more experience-related than training content-related, this is indicated in the modules. In these cases, particular responses to the questions posed are not indicated.

Bibliography and Resource List

The Bibliography and Resource List at the end of the curriculum contain contact information for organizations that have produced valuable materials and resources. The training can be enriched by having these materials available to participants. They provide useful resources that trainers and participants can draw upon during the practical sessions.

SESSION GUIDE I
INTRODUCTION TO WORKSHOP

Objectives:	**By the end of the session, participants will be able to:** ♦ Name at least two skills they would like to improve in planning, implementing and evaluating quality of care (QOC) principles in their workplace. ♦ Reconcile their workshop expectations with the proposed training program objectives. ♦ Name at least four group norms to respect during the workshop. ♦ Explain at least six rules for giving and receiving feedback.
Methods:	Small group work, large and small group discussion
Time:	2.5 hours
Materials:	**Flipchart/transparencies** ♦ Introduction Questions (FC I-1) ♦ General Objectives of the Training (Part I and Part II) (FC/T I-2a and 2b) ♦ Rules for Giving and Receiving Feedback (FC/T I-3) **Handouts** ♦ General Objectives of the Training (HO I-1) ♦ General and Specific Objectives (optional) (HO I-1a) ♦ Workshop Schedule (Parts I and II) (HO I-2a and b) ♦ Rules for Giving and Receiving Feedback (HO I-3) ♦ Pre-test (HO I-4) Flipchart stand, paper, markers and/or Overhead projector, transparencies and markers Masking tape Note pads Pencils and erasers Pens Pencil sharpeners Calculator, if available (for Session IX)

INTRODUCTIONS

Materials Needed:	Flipchart stand, paper, markers **Flipchart/Transparency** ◆ Introduction Questions (FC/T I-1)

Trainer:

Welcome the group to the training.

SMALL GROUP WORK

Ask participants to form groups of two, preferably with someone they do not know well. In each small group, participants introduce themselves (specifying the name they wish to be called during the workshop) and discuss/respond to the following questions:

1. What is your experience in the delivery and/or management of family planning services?
2. What would you like to gain from this workshop?
3. What will help you gain/achieve this?
4. How will you know when you have achieved it?

Group:

Each participant introduces his/her partner to the group (with the name he/she wishes to use and his/her responses to the above questions)

Trainer:

Note on flipchart paper the responses to question 2.

Trainers introduce themselves.

WORKSHOP OBJECTIVES

Materials Needed:	**Flipchart/transparencies** ♦ General Objectives of the Training (Part I and Part II) (FC/T I-2a and 2b) **Handouts** ♦ General Objectives of the Training (HO I-1) ♦ General and Specific Objectives (optional) (HO I-1a) ♦ Workshop Schedule (HO I-2a and b)

LARGE GROUP DISCUSSION

Trainer:

Post the general training objectives for Parts I and II of the training. Distribute the handouts Workshop Schedule, General Objectives of the Training, and General and Specific Objectives (optional). Emphasize what the training is designed to accomplish:

- Part I: To introduce participants to basic concepts of quality of care (QOC) and tools used in the identification of quality of care problems; and

- Part II: The analysis of QOC problems and the development of solutions to address the identified problems.

Explain that the workshop is divided into two parts in order to make it as practical and useful as possible:

- To enable participants to apply problem-identification tools studied during Part I of the training to the identification of QOC problems in their work settings

- To be able to analyze actual problems and develop solutions during Part II of the training.

Lead the group in a discussion of any differences between participants' expectations and proposed workshop objectives and the schedule. Discuss possibilities of integrating participant needs that are not represented in the proposed plan.

ADMINISTRATIVE QUESTIONS AND WORKSHOP NORMS

LARGE GROUP DISCUSSION

Trainer:

Ask the group to discusses the proposed schedule for the training (when to start and end each day, break times, etc.). As a part of adult learning, it is important to allow participants to express their opinions and the reasons for their choices. Explain that Part I of the training is very intense and that there will be a homework assignment on Day 2, but other evenings will be free.

Ask the group:

- What factors interfere with their learning in a workshop and what group norms they want to establish to facilitate their learning?

Appropriate Responses:

- *Establish and respect workshop hours (minimum of six hours training/day)*
- *Active participation*
- *Respect the participation of others and respect individual differences*
- *Respect the principles of feedback (to be discussed)*
- *Allow everyone to participate*
- *Everyone is responsible for his/her own learning*
- *No smoking in class*
- *Turn off cell phones, mobile phones and pagers*

Trainer:

Explain logistical arrangements as necessary (coffee breaks, accommodations, transportation, etc.).

FEEDBACK

Materials Needed:	**Flipchart/Transparencies** ♦ Rules for Giving and Receiving Feedback (FC/T I-3) **Handout** ♦ Rules for Giving and Receiving Feedback (HO I-3)

LARGE GROUP DISCUSSION

Trainer:

Introduce feedback as an important element in facilitating learning. Post the flipchart, Rules for Giving and Receiving Feedback, and ask volunteers to read each item and explain it to the group. Clarify participant explanations and questions as necessary. At the end of the session, distribute the handout Rules for Giving and Receiving Feedback.

Feedback is more effective when:

1. It is *specific* rather than general.
2. It concerns the *attitude or behavior* of the person, rather than the person him/herself
3. It takes into consideration the *needs of the person receiving feedback*
4. It is directed toward an *attitude or behavior the person can change*
5. It is *wanted* and not *imposed*
6. It is an *exchange of ideas and information* rather than advice
7. It is given at the *right* moment
8. It includes the *quantity of information* the receiver can use and not the quantity we want to give
9. It concerns *what was said or done* and not why it was said or done
10. It is *verified* to assure that it was clear and that the person understood the feedback
11. It is *positive and constructive—not negative*
12. The *receiver listens without defending his/her behavior*

PRE-TEST

Materials Needed:	Handout ♦ Pre-test (HO I-4)

Participants take the pre-test.

TRAINER'S KEY TO PRE/POST TEST ANSWERS

I. Put a (T) in front of the statement if it is true, and a (F) in front of the statement if it is false.

1. __**T**__ Family planning clients most often define "quality of care" in terms of the manner in which they are received and treated.

2. __**F**__ In general, the choice of family planning method should not need to change during a woman's reproductive life.

3. __**F**__ Health workers should give family planning clients all the information they have about all available family planning methods in order to ensure an informed choice.

4. __**F**__ Quality improvement efforts are most effective when FP service providers identify all quality of care problems because they are best qualified for the task.

5. __**F**__ Maintaining quality of care in a FP service is the responsibility of supervisors.

6. __**T**__ An understanding of team member behavior helps members identify patterns of interaction in the group.

7. __**T**__ It is important to solicit community participation in quality improvement efforts because the community knows more about certain aspects of quality of care than do service providers.

8. __**T**__ An important outcome of improved quality of care is greater trust and respect between clients and service providers

II. For the following questions, circle the letter next to the best response. (The correct response is printed in **bold** as a key for the trainer.)

1. In the context of quality of care in family planning, choice of method means:

   a. having at least five kinds of methods to choose from
   b. the service provider guides the client to make the best choice based on the client's social and medical history and the service provider's perception of what would be best for the client
   c. the client's voluntary choice of method based on her/his understanding of all essential information about the chosen method as well as about other available methods
   d. reasonable access to all methods (geographically and in terms of cost and lifestyle of the client)

2. Which of the following should the service provider help the client consider in order to help him/her make an informed choice of method?

   a. his/her (and his/her partner's) reproductive intentions
   b. the stage of his/her reproductive life
   c. his/her health status
   d. his/her lifestyle
   e. his/her perception of personal competence in using the method
   f. all of the above

3. Quality of care problems are defined in the context of:

   a. program standards
   b. client expectations
   c. service providers' expectations
   d. all of the above

4. Which of the following is *not* an important source of data for identifying problems in the quality of care?

   a. routine service statistics
   b. client interviews
   c. medical records
   d. studies conducted in other health facilities

5. Which of the following is *not* a principle of quality improvement?

   a. Quality improvement efforts must satisfy the needs of both internal and external clients
   b. Quality improvement focuses on ineffective personnel in the system and on new inputs to improve the system
   c. Program management must provide a firm commitment and support for quality improvement to be effective

d. The collection and analysis of data is essential for the identification of quality of care problems
e. Quality improvement respects the contributions of all staff and their ability to improve service delivery processes

6. Which of the following is *not* a benefit of teamwork in improving the quality of care?

a. Access to greater technical skill and practical experience
b. Short term efficiency in problem solving
c. An appreciation for various roles in carrying out service delivery processes
d. Fewer accusations about who causes the problems

7. Which of the following is *not* a rule for giving feedback in the context of teamwork?

Feedback:
a. is wanted and not imposed
b. is positive and constructive, and not negative
c. takes into consideration the needs of the person receiving the feedback
d. is given at the right moment
e. includes advice so that the person will know how he/she needs to change

8. Which of the following statements on conflict in teamwork is true? (One answer only)

a. Conflict is a normal occurrence and can be useful to stimulate creativity and innovation
b. Conflict is a way in which problems can be discussed and tensions released
c. Conflict can improve the quality of decision-making by allowing different points of view to be considered
d. Conflict can be an obstacle to productive teamwork
e. All of the above

III. In each of the following questions, there is a list of items followed by a corresponding list of elements. In the blank next to each item, write the letter of the element that corresponds the best.

1. Match the following tools/techniques used for problem identification with their primary purpose.

Brainstorming __**c**___
Service statistics __**f**___
Observation of counseling __**b**___

Client exit interviews __d___
Flow chart __e___
Client flow analysis __g___
Focus group discussions __a___

a. Provides qualitative data regarding client/community perceptions of quality of care (or other issues)
b. Assists in assessing information given to clients, certain aspects of technical competence, interpersonal relations, and continuity and follow-up within the context of FP consultations
c. Promotes openness and creativity in people's thinking about an issue and generates maximum input from the group
d. Provides quantitative data regarding clients' perceptions of quality of care
e. Analyzes the sequence of activities occurring in a process
f. Provides broad indications of how a program, or particular service, functions
g. Helps a team assess where there are obstacles to the efficient flow of clients through a health facility

2. Match the following tools/techniques for problem analysis with their primary purpose

Pareto analysis __b___
Pie chart __d___
Cause-and-effect diagram __c___
Bar chart __a___
Decision matrix __e___

a. Provides a graphic comparison between categories of data
b. Helps identify the relatively few factors/causes responsible for most of the problem
c. Helps a team consider the complexity of a problem and all contributing factors
d. Shows relative proportions of various items making up the whole
e. Assists a group to choose one problem to work on, out of a list of two or more possibilities

3. Match the stages of team development with the appropriate description of each stage

Forming __c___
Storming __d___
Norming __b___
Performing __a___

a. Members begin diagnosing and solving problems
b. Members begin to accept the team, team ground rules, their roles on the

team and the individuality of team members

c. Members explore the boundaries of acceptable group behavior

d. Members begin to realize that the task is different and more difficult than they imagined

4. Match the components of an action plan with the purpose of each

Introduction	__e___
Problem statement	__c___
Theory of cause	__i___
Objectives	__a___
Activities	__f___
Time frame	__d___
Person responsible	__h___
Budget	__g___
Indicators	__b___

a. States the result to be obtained from the quality improvement effort
b. Determines whether the objective has been attained and the quality of care problem solved or ameliorated
c. Makes clear the problem to be addressed by the action plan
d. Indicates when each activity should take place
e. Clarifies the context in which the problem in quality of care occurs
f. Sets out what will be done to achieve the objectives and eliminate the causes of the problem
g. Provides an indication of whether planned activities are financially feasible or not
h. Ensures accountability for the accomplishment of each activity
i. Provides the focus for the objectives of the action plan

SESSION GUIDE II
QUALITY OF CARE - GENERAL CONCEPTS

Objectives:	**By the end of the session, participants will be able to:** ♦ Explain the following underlying concepts of quality of care in the delivery of family planning services: the Bruce-Jain Quality of Care framework, quality in fact and quality in perception, and clients' rights. ♦ Identify at least six groups of stakeholders who should be involved in defining and assessing quality of care in FP/RH services. ♦ Define the terms "internal client" and "external client." ♦ Define the concept of quality of FP/RH service delivery from the perspectives of both external and internal clients.
Methods:	Group exercise, story telling, large group discussion, small group work
Time:	4 hours
Materials:	**Flipcharts/transparencies:** ♦ Characteristics of a Good Family Planning Center (FC II-1) ♦ Bruce-Jain Elements of Quality of Care in Family Planning Programs (FC/T II-2) ♦ Effects/Consequences of Improving QOC (FC II-3) ♦ Three Primary Outcomes of Quality FP/RH Programs (FC/T II-4) ♦ Quality in Health Care: Quality in Fact, Quality in Perception (FC/T II-5) **Handouts:** ♦ Bruce-Jain Framework for Quality of Care in Family Planning Programs Description of Elements (HO II-1) ♦ Six Quality of Care Elements and Medical Barriers that Inhibit Them (HO II-2) ♦ Effects of Improved Quality of Care in Family Planning Programs (HO II-3) ♦ Quality in Health Care: Quality in Fact, Quality in Perception (HO II-4) ♦ IPPF Bill of Rights (HO II-5) Three sheets of paper (sizes: full block note, 1/2 block note, 1/4 block note), each with the word "MOTIVATION" written in big bold letters.

CONCEPT OF QUALITY: PERSPECTIVE OF EXTERNAL CLIENTS

Materials Needed:	**Flipchart** ♦ Characteristics of a Good FP Center (FC II-1) with the title covered

LARGE GROUP EXERCISE

Trainer:

Provide a brief introduction to the concept of external clients' perspectives of QOC. Then invite participants to participate in an activity which will help them to come to a common understanding of the concept of QOC.

Post the flipchart, Characteristics of a Good FP Center (COVER the title) on which are written the following words: organized, professional, warm, clean, flexible, informal, helpful, polite, efficient, understanding, educational, discreet, accessible, comfortable, orderly, friendly, competent, knowledgeable.

Ask participants which of these words describe a health facility where they would like to receive FP/RH services. Which represent behaviors or characteristics which say to them that a center provides acceptable services.

Ask participants to name a word representing a characteristic that they would appreciate in a health facility of their choice. Underline the word. (At the end, all words will likely be underlined.)

Ask participants if there are other words or characteristics they would like to add to the list. Give the group two to three minutes to propose other words and add their words to the posted list as they give them.

ALTERNATIVE EXERCISE

Alternatively, small groups can generate their own lists and report in the large group. The trainer, or a volunteer, notes the responses on the board, eliminating repetition as the small groups report. In this alternative, the trainer should watch to see that certain characteristics of quality, such as those above appear on the list. If they don't, the trainer may wish to prompt the group to consider them as well.

OBSTACLES TO THE DELIVERY OF FP/RH SERVICES

Materials Needed:	Three sheets of paper (sizes: full block note, 1/2 block note, 1/4 block note) each with the word "MOTIVATION" written in big bold letters.

STORY

Trainer:

Tell a story of a client who has come to a health center seeking FP/RH services and encounters a series of obstacles. The story that follows is an example of the kind of story to be used for this activity/exercise, but the story should reflect the realities of the field in the local setting. The details should be recognizable/familiar to the workshop participants. (Before the training, the trainer should identify some obstacles that are commonly found in the local area.)

STORY TELLING INSTRUCTIONS

The story should be told in three segments, reflecting three different visits to the FP/health center. This allows for bringing out several obstacles at each visit, including return visits that would not be necessary if quality services were provided.

While introducing (and telling) the story, hold up a large sign with the word "MOTIVATION" written in large bold letters. Suggest that there is a lot of talk about "unmotivated" clients (complete the statements in accord with local stereotypes of low-income clients) and that this story will address some of the issues behind this "lack of motivation" or "inability of clients to use FP correctly."

Tell the first segment of the story (about the client's first attempt to get FP/RH services at the clinic).

Each time the client in the story experiences an obstacle to her seeking/receiving FP services, tear a piece of the MOTIVATION sign, indicating that the client has lost a little of her motivation to practice FP.

One of the obstacles facing the client is the need to make several clinic visits before receiving the services she is seeking.

For each visit to the clinic, change the MOTIVATION sign as follows:

- At the end of the first visit, discard the first and largest sign, which should be mostly torn up by the end of that visit, representing the obstacles the client encountered during this visit.

- For the second visit, hold up the second sign, which is half the size of the first, indicating that the client is less motivated, that she has been discouraged.

  Continue the story with what happens to the client during the second visit.

  Tear a part of the smaller sign each time the client confronts another obstacle.

  When the story reaches the point where the client comes back a third time, discard the second sign and hold up the third, which is approximately half the size of the second sign.

  Continue the story and tear the sign as the obstacles to service tear away the client's motivation to use the services.

To be effective:

- The story should be told in the first person and with the facial expression and tone of voice matching the client's sentiments as she tells her story.

- Tell the story spontaneously—do not read it. It is more important that the story seem real than that every last detail be included.

- HOLD UP AND TEAR THE "MOTIVATION" SIGNS AT THE APPROPRIATE MOMENTS. Start with a large MOTIVATION sign, change to the middle-sized one and then to the small one with subsequent visits to the clinic.

Trainer:

Story: Obstacles to the Delivery of FP Services

(Hold the large sign in front of you so all can see it.)

My name is [use a common local name]. I'm 30 years old. My husband is a farmer. We live 3 km from here. We've had five children in the 12 years we've been married. I'm tired. I'm tired of having babies.

Some time back, a friend of mine mentioned "family planning" . . . or was it "child spacing"? . . . something like that. I guess I'd heard about it before but I never thought much about it. This time, I decided to go to the clinic and see what they could do for me.

I got to the clinic early in the morning (a little after 8 o'clock) because I have a lot of work to do at home and I needed to get back. There were a few other women there and

the staff were just arriving. I sat there for an hour and it seemed like nothing was happening. ***(Tear the sign.)***

Finally, someone came out and gave us all cards with numbers on them. Slowly, they started calling us. When they called my number, I went into the room. I stood there for the longest time; the nurse seemed to be busy with something else and didn't know I was there. ***(Tear the sign.)***

Finally, she looked up and told me to sit down. She asked me what I wanted, and when I said "family planning?", she looked surprised and said, "Don't you know today is prenatal day? We don't do family planning on Mondays! You'll have to come back on Thursday!" It was now after 10 o'clock and I had to go home. ***(Tear the remaining piece of the sign in half and discard it.)***

(Hold the middle size sign in front of you so all can see it.)

The following Thursday, I came back to the clinic. Again, I arrived early, hoping to see the nurse and get my family planning and get home. Again, there were women waiting when I got there but nothing seemed to happen for a long time, maybe an hour and a half. ***(Tear the sign)***

When I finally got in to see the nurse, and she began asking me questions, I was surprised. She asked me about when I menstruated last and how much, about whether my husband knew I was here, about whether he was faithful to me, and other questions. ***(Tear the sign)***

And there was no privacy. People would stop in to visit with her in the middle of her questioning me, and they would talk and then they'd leave the door open when they left. ***(Tear the sign)***

When she asked if I was menstruating, I told her I had just finished menstruating last week. She scolded me, saying "Don't you know you have to come in for family planning when you're menstruating? How else can we know that you're not pregnant?" ***(Tear the sign)***

She sent me home empty-handed once more, to return when I would have my period. ***(Tear the remainder of the sign in half and discard it. Hold the small sign in front of you so all can see it.)***

The three weeks I had to wait to come back to the clinic were long. I really didn't want to get pregnant. At the same time, I was getting a little tired of coming to the clinic for nothing. This time, I arrived later (about 11 o'clock) because it didn't seem to help to get there early. The numbers had been given out earlier and so when the staff saw I didn't have one, they asked when I arrived. When I told them "about 11 o'clock", they

scolded me, saying "We expect patients to get here early so we can organize our services. Next time, come early!" ***(Tear the sign)***

After the nurse asked me all the questions about pregnancies and my health, she asked me what method I wanted. I told her I had only heard about the pill, but in any case, I really didn't think I wanted to have any more babies. She gave me a package of pills and told me to take one a day at the same time of day. She mentioned something she called "side effects" but I wasn't sure what she meant. She told me to come back just before I needed more pills. I left, and I've started taking these pills. It's not easy. Do I have to take these every day until I can't make babies anymore? Does that mean that I have to come back here once a month until I can't make babies any more? I don't know about this "family planning." ***(Tear the remaining sign in half and discard it.)***

LARGE GROUP DISCUSSION

Trainer:

Lead a group discussion based on the following questions:

- What are the obstacles to the motivation of the client, enabling her to obtain the method best suited to her and to use it correctly?
- What was the effect of each obstacle on the motivation of the client?

Note responses on the board as they are reported by the participants.

In FP/RH, we speak often of the lack of motivation of clients or of their lack of education and inability to use FP methods correctly.

- Do we have a positive or a negative influence on the motivation/education of clients?
- Does our interaction change depending upon whether the client is a woman, a man or a couple?
- In what sense does our behavior and the environment of our clinics influence the motivation of clients (women, men and/or couples) and their ability to correctly use a FP method?

Appropriate Responses:

Responses will vary according to the experiences and perceptions of the group. Ensure that both positive and negative influences are acknowledged.

Trainer:

Suggest that we assess carefully the quality of our own services if we want to improve them and make them more acceptable to our clients and therefore more effective. Ask the following questions in order to help participants think about the delivery of FP/RH services in their own work situations.

- What words would you use to describe the delivery of FP/RH services in your health facilities?

Note responses on the board.

- Are there obstacles to the proper functioning of these services? Are there factors which make these services non-acceptable to clients?

- If so, what are these factors? What are their effects on:

  - Client motivation?
  - The effective use of contraceptive methods?

Appropriate Responses:

Responses will vary, depending upon participants' experience with, and perceptions of, the QOC in their clinics

- Are there differences between the characteristics you listed of a health facility where you would like to receive FP/RH services and the facility in which you work? How can we explain these differences?

Appropriate Responses:

Responses will vary, depending upon the QOC of the clinics represented by the participants, as well as their perceptions of the adequacy of QOC for themselves. To the degree that there are significant differences between what is acceptable QOC to participants as opposed to the QOC they offer in their clinics, the trainer should note these differences to be used later in the identification of QOC problems.

NOTE: The acknowledgement of poor QOC, when it exists, may make some participants uncomfortable. If you perceive any discomfort or resistance in the group, acknowledge that this discomfort is normal and suggest that it is only by confronting problems in QOC that we can do anything about them. This activity is not meant to blame but rather to raise awareness about the quality of services in our facilities. When we as service providers begin to put ourselves in the shoes of clients, we often become more sensitive to the kinds of problems that clients encounter.

BRUCE-JAIN QUALITY OF CARE FRAMEWORK

Materials Needed:	**Flipchart:** ♦ Bruce-Jain Elements of Quality of Care in Family Planning Programs (FC/T II-2) **Handouts:** ♦ Six Quality of Care Elements and Medical Barriers that Inhibit Them (HO II-2) ♦ Bruce-Jain Elements of Quality of Care in Family Planning Programs (HO II-1)

LARGE GROUP DISCUSSION

Trainer:

Based on the activity just completed and on their own reflections, ask participants:

➢ How can we define QOC in the context of FP/RH services from the client's perspective?

Note participant responses as they are given. Guide them, as necessary, to the elements of commonly used definitions.

Appropriate Responses:

Clients' satisfaction with services according to selected measures taken at the institutional and service delivery levels (Jain)

Meeting the needs, expectations and requirements of clients, with the rational use of available resources and a minimum of rework and waste (Institute for Health Care Improvement)

Trainer:

Review with the group the elements of quality of care from the point of view of clients. Distribute the handout, Bruce-Jain Framework for Quality of Care in Family Planning Programs, Description of the Elements.

Ask participants to reflect upon the importance of these elements in terms of some of the obstacles to QOC mentioned in the story as well as obstacles to QOC in their own clinics.

Present the flipchart, Bruce-Jain Elements of Quality of Care in Family Planning Programs.

For each of the following six elements of QOC (numbers 1-6), ask the group the following questions:

- What does each element mean to you?
- How and/or why would each element be important to your clients?

1. Choice of Method

- What does choice of method mean to you?
- How and/or why would choice of method be important to your clients?

Appropriate Responses:

The availability of a variety of FP methods, including a range of short term client-dependent methods and long term client-independent methods, is essential to allowing clients a choice of contraceptive method

Clients' contraceptive needs and values change over time. Such changes may be influenced by the various stages of the woman's, man's, couple's reproductive life

Trainer:

Review with the group the different stages of a woman's, or a man's, reproductive life and why it is important to consider these stages in the provision of FP/RH services:

- From the beginning of a woman's menstrual periods (a man's ability to ejaculate) to the first sexual experience
- From the first sexual experience to marriage (in many cultures)
- From marriage to the birth of the first child
- From the birth of the first child to the birth of the last child
- From the birth of the last child to menopause (to the man's desire to cease producing children)

Consider the woman's/man's/couple's reproductive intentions and note that the following factors are closely allied to those above but may not always be synonymous with one or another of the above stages in all cases:

- Seeking to delay: initiating sexual activity but not seeking birth at that time
- Seeking to give birth
- Seeking to space births
- Seeking to limit births
- Ending childbearing

Note that not all women and men pass through all of the above stages nor experience all of these reproductive intentions.

➢ How might a woman's physical profile or an individual or couple's lifestyle impact on the choice of method?

Appropriate Responses:

The woman's physical profile:

- *Lactational status*
- *Health profile (in terms of contraindications of various methods; and what the client is able and willing to tolerate in terms of side effects)*

The individual's/couple's lifestyle and related issues of method preference:

- *Ease of use of the different methods. (Issues include: does the client seek privacy in using the method? Does he/she prefer a method to be used all the time, regardless of sexual activity, or one to be used only at the time of sexual relations? Is he/she seeking a method to be used without the knowledge of his/her partner and/or parents?)*
- *Risk factors for sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) infection*
- *Frequency of sexual activity*
- *Number of sexual partners*
- *Ease of resupply*
- *Change in values, beliefs, habits and the preferences of the partner*

Monetary cost of the method

Trainer:

Point out that it is important to help clients consider all possible influences over their choices in order to best respond to their individual needs and concerns

➢ What are some factors a client might balance when choosing a method?

Appropriate Responses:

Client choice of method is generally a function of balancing:

- *Contraceptive goals (degree of protection desired, purpose of practicing FP)*
- *Sense of personal competence (in using the method)*
- *Evaluation of the contraceptive (in terms of safety etc)*
- *Accessibility of the method*
- *Convenience of use of the method*
- *Acceptability of the technique of administration or use of the method*

Additional concepts regarding choice of method:

The supply system must be adequate to ensure that methods are in stock, since stock-outs compromise the clients' choice. Supplies also need to be properly stored to ensure their effectiveness.

To ensure choice of method, it is important for the FP/RH program to offer a range of choices within reasonable access to all clients (geographical access, cost access, and lifestyle access—not imposing barriers on who can or cannot receive a particular method due to age, marital status, etc.).

Importance of choice of method

Users' satisfaction with their method of contraception improves their ability to practice family planning. If a woman receives the method she asked for (and for which she has no serious contraindications) — she is more likely to continue with FP services compared with women for whom the health worker chooses the method.

Choice of method reflects a commitment of the FP service to respond to client needs (as opposed to promoting given methods). To the client, choice of method means: his/her voluntary selection of the method based on his/her understanding of all essential information about the chosen method as well as about all other available methods.

2. Information Given to Clients

Trainer:

- What kind of information should be covered during the *initial* discussion/counseling with a client?

Appropriate Responses:

- *Asking if the client has a preference for a particular method.*
- *Informing the client that there are other methods and offering to describe any or all of them.*
- *Describing how the methods are used*
- *Explaining the advantages and disadvantages of the methods*
- *Explaining possible side effects*
- *Outlining major contraindications*

Trainer:

➢ What kind of information should be given *following* the choice of method by the client?

Appropriate Responses:

- *Giving instructions for use of the chosen method*
- *Describing/reviewing side effects and what to do if they occur*
- *Explaining when to return*
- *Explaining the service provider's continuing role and availability to assist with advice, re-supply, referral etc.*
- *Leaving time for questions and clarifications*
- *Ensuring that the client understands crucial information about the method chosen.*

Trainer:

➢ Are there any other considerations to keep in mind during counseling?

Appropriate Responses:

- *Ensuring adequate privacy for counseling*
- *Being brief, non-technical and clear, limiting the amount of information to what the client can understand and retain.*
- *Avoiding all bias for/against FP, for/against specific methods*
- *Helping the client consider method effectiveness against other features of the various methods.*
- *Leaving time for questions, clarification and checking for comprehension*

Additional concept concerning information to clients:

The availability of written information in a facility also supports giving clients accurate, understandable information. For providers, this includes checklists (on a wall or on a desk) to remind them of key information to be included when talking with clients. For clients, it includes informational posters on the walls and brochures with more detailed information about contraceptive methods.

Trainer:

- Why is it important to give information to clients?

Appropriate Responses:

- *A client's knowledge of contraceptive methods and his/her confidence in the service provider is crucial to effective contraceptive use and serves to prevent misunderstandings and problems of misuse, fears and rumors and, ultimately, of discontinuation*

- *The client's understanding of contraceptive methods, especially of her/his chosen method, is important in reinforcing her/his confidence in the clinic. The rapport and content of the initial contact are important in establishing this confidence.*

3. Technical Competence of Providers

Trainer:

- What are some key elements of the technical competence of providers?

Appropriate Responses:

These include that include that providers:

- *Have appropriate training and licensure for their jobs*
- *Are familiar with standards and protocols and have access to a copy in the clinic*
- *Follow standards and protocols in the provision of clinical services*
- *Follow infection prevention and control procedures*
- *Can accurately explain the benefits, use, contraindications, side effects and management of side effects associated with methods of contraception*
- *Receive routine supervision*
- *Have the basic items needed to deliver available FP methods*
- *Respond appropriately to key RH services not provided on site, e.g.,*

they can identify/diagnose, counsel and refer for STD treatment, prenatal care, etc.

Trainer:

➢ Why is technical competence important?

Appropriate Responses:

- *Technical competence is critical to achieving the results the client desires*
- *It maximizes the chances of protecting the client's safety and promoting his/her health*
- *The client expects providers to be technically competent*

4. Interpersonal Relations

Trainer:

Explain that "interpersonal relations" refers to the client-provider relationship.

➢ What is involved in good interpersonal relations?

Appropriate Responses:

- *Warm reception of clients by the clinic staff*
- *Understanding*
- *Respect, including respect for privacy, confidentiality and modesty*
- *Honesty*
- *Two-way communication (without condescension), and attention to non-verbal communication*
- *Flexible guidance of clients*
- *Caring attitude*
- *Identification with the client and his/her problems and needs*
- *Empathetic information-giving to help the client obtain services and use his/her chosen method; and to allay fears*
- *Cooperation and coordination among staff*
- *Personal attention given to clients*

Trainer:

➢ Why are good interpersonal relations important?

Appropriate Responses:

- *They increase the clients' confidence and trust in the staff and in their own choice of method and ability to use it properly*
- *They enhance clients' satisfaction with clinic services which, in turn, may influence whether they:*
  - *seek care and where they go for care*
  - *are willing to pay for services*
  - *follow the provider's instructions on the correct use of their method*
  - *continue using their method*
  - *return for follow-up visits*
  - *recommend the services to others*
- *They set the tone of the clinic/facility*
- *They have a large impact on the job satisfaction of clinic personnel*

Trainer:

Note that the quality of interpersonal relations is influenced by management decisions, beginning with standards of service, staff training, job descriptions and expectations, supervision and the availability of adequate resources.

5. Continuity of care and follow-up

Trainer:

- What do we mean by continuity of care and follow-up?

Appropriate Responses:

Factors include:

- *The provider encourages the client to return as needed*
- *The follow-up/return schedule is reasonable (i.e., balancing good medical practice against the creation of medical barriers to contraception)*
- *There is a reliable resupply system for clients, either at the same clinic or through community-based distribution, pharmacies or otherwise*
- *Follow-up is conducted for clients who are overdue for a return visit; clients are contacted and their reasons for non-return are identified; follow-up is undertaken in such a way as to respect clients' concern about confidentiality*
- *Services are available at all times*

Trainer:

➢ What is the importance of continuity and follow-up?

Appropriate Responses:

- *Continuity and follow-up helps ensure that clients use their method effectively and obtain the desired result*
- *Helps detect problems early—before they become serious*
- *Builds clients' confidence because it demonstrates commitment and concern about their health and wellbeing*

Trainer:

Note that an FP/RH program's effort to ensure client follow-up is a measure of its long-term commitment to its clients. It represents an important link between the provider and clients. Point out that a predictable visiting pattern supports on-going clients, picks up on clients whose needs have changed and helps to prevent discontinuation due to concerns with side effects, etc.

6. Appropriateness and Acceptability of Services

Trainer:

➢ What are some examples of appropriate and acceptable services?

Appropriate Responses:

Clients, as well as non-users of the services, perceive that the following are adequate:

- *Privacy/confidentiality for counseling*
- *Privacy/confidentiality with respect to physical exams*
- *The waiting area*
- *The waiting time*
- *Clinic days and hours (opening times)*
- *The amount of time spent with the provider*
- *The staff (language, sex, etc.)*
- *Proper facilities, including a clean examination room, toilet facilities, water, etc.*
- *There is a reasonable constellation of services to meet clients' needs (either on site or by referral).*

Trainer:

Note that there should be a system in place to get feedback from clients on their satisfaction with services.

- Why are appropriate, acceptable services important?

Appropriate Responses:

- *They demonstrate that an agency/facility seeks to provide services in ways that respond to clients' needs*
- *They enhance the likelihood of clients using services*
- *They create a pleasanter work environment for providers because clients are more satisfied*

LARGE GROUP DISCUSSION

Trainer:

Suggest to the group that another term used to address these six elements of QOC is *the client centered approach* to service delivery. This approach calls for:

- Encouraging the client to take responsibility to communicate his/her particular health needs and expectations
- Knowing clients' expectations and working to ensure client satisfaction
- Giving the client information in order for him/her to make decisions about his/her reproductive life and contraceptive choices
- Organizing services to ensure that client needs and expectations are reasonably met and that clients are satisfied with services.

Distribute the handout, Six Quality of Care Elements and Medical Barriers that Inhibit Them.

Ask for volunteers to read each one and for the group to share:

1. Whether they have seen these barriers occur in any form
2. The effects of the barriers on QOC.

EFFECTS/CONSEQUENCES OF IMPROVING QOC

Materials Needed:	**Flipchart/Transparency** ♦ Three Primary Outcomes of Quality FP/RH Programs. **Handout** ♦ Effects of Improved Quality of Care in Family Planning Programs.

SMALL GROUP WORK

Trainer:

Divide the group into three small groups with the following tasks:

Group 1: To identify the effects of improved QOC, and of poor QOC, on *clients*

Group 2: To identify the effects of improved QOC, and of poor QOC, on *service providers*

Group 3: To identify the effects of improved QOC, and of poor QOC, on *the FP program*

Post the following questions and ask the groups to respond to them in relation to their assigned "population" (clients, service providers, or the program in general).

- Why are we concerned about QOC? What does it matter?
- What are the effects/consequences of improving the QOC?
- What are the effects/consequences of poor QOC?

When the three groups report back they should raise the following key points in their responses:

Appropriate Responses:

Clients: The effects of improved QOC:

- *Satisfaction with the clinic visit and the service and/or method received*
- *Resolution of the problem for which the client came (to the degree possible)*
- *Increased self-confidence and independence in future decision-making about FP/RH concerns*
- *Increased skill in decision-making*

- *More informed and better choices*
- *Decision to adopt a FP method*
- *Correct use of a chosen FP method*
- *Continued use of the chosen FP method*
- *Client copes better with minor side effects*
- *Client respects follow-up visits*
- *Client not affected by rumors and myths*
- *Clients more willing to pay fees for services*
- *Client more likely to achieve his/her reproductive goals*
- *Improvements in mother-child health*

Clients: The effects of poor QOC:

- *Dissatisfied clients*
- *RH problems which could/should have been prevented*
- *Clients reluctant to use the service*
- *High client drop out rates*
- *Contraceptive failures due to poor technique (for some methods) and lack of adequate and/or correct information*
- *Extra follow-up visits (due to poor technique, inadequate or incorrect information)*
- *Increased waiting time for services*
- *Clients fail to achieve their reproductive goals*
- *Declining mother-child health*

Service providers: The effects of improved QOC:

- *Greater satisfaction/motivation*
- *Less time spent responding to client complaints and complications with methods*
- *Greater trust and respect between the client and the service provider*

Service providers: The effects of poor QOC:

- *Negative attitudes toward their work and toward clients (reinforced by negative experiences in the delivery of services)*
- *Inability to improve their own skills*
- *Lack of motivation*

The program: The effects of improved QOC:

- *Increased utilization of services and better health outcomes*
- *Positive reputation of the program (satisfied clients promote FP/RH services and the clinics which meet their needs)*
- *More cost-effective service delivery*

- *Better use of staff time (fewer unscheduled visits for time-consuming minor complaints and side effects)*
- *More continuity in method use/higher continuation rates*

The program: The effects of poor QOC:

- *Poor reputation*
- *Low utilization of services*
- *High cost of running a service which is:*
  - *underutilized by clients*
  - *experiences large numbers of repeat visits due to inappropriate care*
  - *experiences high drop-out rates*

Distribute the handout, Effects of Improved Quality of Care in Family Planning Programs.

Summarize by reviewing with the group the transparency/flipchart, Three Primary Outcomes of Quality FP/RH Programs.

STAKEHOLDERS

LARGE GROUP DISCUSSION

Trainer:

Invite the group to consider briefly other perspectives concerning the FP/RH service delivery process, including the perspectives of other stakeholders.

➢ What does the term "stakeholder" means to you?

Appropriate Response:

Individuals or groups who could affect, or be affected by, the health facility's actions

Trainer:

➢ Which stakeholders are involved in the FP/RH service delivery process in your facilities?

Appropriate Responses:

- *Clients*
- *Front line service providers*
- *Clinic/program managers*
- *District and/or regional health services managers*
- *Health aides*
- *Cleaning personnel*
- *Women and men of reproductive age (currently non-users of the service)*
- *Donors*

SMALL GROUP WORK

Trainer:

Divide the group into six small groups. Designate each of the small groups as one of the following groups of stakeholders:

- Clinic managers
- Donors
- Front line service providers
- District health service managers
- Health aides
- Cleaning personnel

Ask the small groups to describe the aspect of the delivery of FP/RH services that they are involved in at their facility in terms of issues of quality of care (adequacy of the functioning of this part of the system):

- What QOC "should be," (i.e., the expectations of this group of stakeholders) vis-a-vis the quality of functioning of this aspect of the system

- What QOC "is," i.e., how the system actually functions

Each small group presents its responses in the large group. Ensure that all responses are clear to everyone.

LARGE GROUP DISCUSSION

Trainer:

Lead a discussion with the large group, of the small groups' responses, based on the following questions:

- What is the significance of dividing participants into small groups on the basis of their roles as stakeholders?

- What makes these groups different or unique in the context of their involvement in the delivery of quality FP/RH services?

- Do clients and other stakeholders have similar or different perspectives when it comes to quality of services? In what ways are they different?

Appropriate Responses:

- *Clients' perspectives of the QOC are based largely on the quality of client provider interaction, accessibility of services (distance, waiting time, etc.), and on the facility itself. They are most aware of how the personnel with whom they come into contact treat them. Much of their perception has to do with reception, respect, waiting time, etc*

- *Other stakeholders within the system see other aspects of the service delivery process that are also important to the quality of FP/RH service*

  - *Service providers' perspectives of the QOC often relate more to the technical quality of service delivery and the availability of necessary equipment, materials and supplies; and to the way they are treated by management*

- *Management perspectives of QOC often relate to the technical quality of service delivery, the achievement of program objectives and cost effectiveness*

- *Health aides and cleaning personnel's perspectives are likely to emphasize how they are treated/supervised*

- *Donors are concerned about the achievement of program objectives, cost-effectiveness, and knowing how their funds are spent.*

While the perspectives of all groups of stakeholders may overlap on some issues, each group of stakeholders sees particular aspects of service delivery from the perspective of how it impacts upon them or how they interact with it and/or contribute to it.

Trainer:

- How might non-users (women and men of reproductive age who are not currently users of the service) view the delivery of FP/RH services?

- Why is it important to consider their point of view?

Appropriate Responses:

- *Non-users' views of the delivery of FP/RH services will likely be based on what they have heard (if anything) about the services; and on their own perceptions of the accessibility of the services.*

- *Non-users represent a population with potential FP/RH needs:*
  - *They may lack awareness of the availability and usefulness of services, which effectively renders the services inaccessible to them*
  - *Services may in fact be inaccessible to them because of distance, social characteristics (e.g., sexually active adolescents), and/or sex (in the case of men).*

EXTERNAL AND INTERNAL CLIENTS

LARGE GROUP DISCUSSION

Trainer:

Ask the group:

- What is the main difference between the various groups of stakeholders?

Appropriate Responses:

Some are "internal" to the health system, that is they work within the FP service delivery system; and others are "external" to the system, that is they are outside of it and seeking services from the system.

Trainer:

We often think of those "internal" to the system as "internal clients" and those outside the system as "external clients."

- How would you further define "external" clients and "internal" clients?
- Why is it important to have the input of both groups when seeking to improve the quality of FP services?

Appropriate Responses:

- ***External clients****: FP/RH clients who come to our facilities for services; and potential clients who do not currently use these services*
- ***Internal clients****: people who work within the service delivery system. Those within the organization who rely on fellow workers for products and services that help them fulfill their roles in providing quality health care to the external client. Internal clients include front-line workers, supervisors, and other health team members.*
- *It is important to get input from external* and *internal clients in the improvement of QOC: to obtain a more complete picture of the system (what works well, what poses problems; causes behind the problems; what needs to be changed; options for change, etc.); and to form a coalition capable of addressing effectively the problems identified.*

Trainer:

Up until now, we have focused mostly on QOC as it concerns external clients.

- What are the needs of internal clients?
- What do personnel within the system need in order to provide QOC?

Appropriate Responses:

- *Guidance from program standards and protocols*
- *Supportive supervision*
- *Encouragement to provide good quality of care*
- *Adequate working conditions (physical facilities and organization)*
- *Appropriate equipment, supplies and materials (contraceptives, other supplies, equipment and educational materials)*
- *Self-expression (participation in planning and problem-solving; consideration for their views when decisions are taken)*
- *Clear, correct information on technical issues, updated regularly*
- *Training in technical and communication skills*
- *Feedback from managers, supervisors, other service providers and clients*
- *Respect and recognition from co-workers, managers, clients and the community*
- *Backup from other providers and levels of care*

Trainer:

- What is the effect of having, or not having, these needs adequately met?

Appropriate Responses:

- *Management cannot assume that personnel will be able or willing to provide QOC without a minimum of their above needs met*
- *This dissatisfaction is often communicated unintentionally to clients*

Note to Trainer: If participants raise serious issues regarding unmet needs of internal clients, it may be appropriate to identify those related to QOC problems that could legitimately be addressed through CQI.

QUALITY IN FACT AND QUALITY IN PERCEPTION

Materials Needed:	**Flipchart/transparencies** ♦ Quality in Health Care - Quality in Fact and Quality in Perception (FC/T II-5) **Handout** ♦ Quality in Health Care: Quality in Fact, Quality in Perception (HO II-4)

LARGE GROUP DISCUSSION

Trainer:

Show the overhead, Quality in Health Care - Quality in Fact and Quality in Perception.

Ask participants:

- How do these concepts of quality relate to the different stakeholders we've just discussed?

Appropriate Response:

Quality in fact is more the direct concern of clinic/program managers and service providers (in that they have more technical knowledge and skill to assess this aspect of quality), whereas quality in perception is, to varying degrees, of concern to both clients and service providers

Trainer:

- To what degree are both of these aspects of quality necessary to ensure high quality service delivery?

Appropriate Response:

It is impossible to have QOC without attention both to quality in fact and to quality in perception.

Trainer:

Distribute the handout, Quality in Health Care - Quality in Fact and Quality in Perception.

CLIENTS' RIGHTS

Materials Needed:	Handout ◆ IPPF Bill of Rights (HO II-5)

LARGE GROUP DISCUSSION

Trainer:

Distribute copies of the handout, IPPF Bill of Rights and ask for volunteers to read each one:

1) **Right to Information**: To receive information about the availability and benefits of FP

2) **Right to Access**: To obtain services regardless of their social status, economic situation, religion, political beliefs, ethnic origin, marital status, geographic location or other characteristics

3) **Right of Choice**: To decide freely whether to use FP and which method to use (provided there aren't any significant contraindications)

4) **Right to Safety**: To be able to practice FP to reduce the risks associated with unwanted pregnancies; and the right to protection against any possible negative effect of a contraceptive method on their health

5) **Right to Privacy**: To have a private environment during counseling and service delivery

6) **Right to Confidentiality**: To be assured that any personal information will remain confidential

7) **Right to Dignity**: To be treated with courtesy, consideration, attentiveness and with full respect for their dignity

8) **Right to Comfort**: To feel comfortable while receiving services (ventilation, lighting, seating, toilet facilities, etc.)

9) **Right of Continuity**: To receive appropriate contraceptive services and supplies as long as needed

10) **Right of Opinion**: To express an opinion on the services being offered, without fear and with confidence that the opinion is considered valuable

Ask the group:

- Is there anything on the list that you disagree with?
- Is there anything missing?
- In your opinion, what are some of the most difficult rights to ensure? Why?

Suggest that the list of client rights will assist participants, along with other tools, in the assessment of the quality of their services.

SESSION GUIDE III: INFORMED CHOICE AND INFORMED CONSENT

Objectives:	**By the end of the session, participants will be able to:** ♦ Define the terms "informed choice" and "informed consent" ♦ Explain the importance of informed choice and informed consent in the delivery of FP/RH services ♦ Describe the five key provisions of the Tiahrt Amendment and their application to USAID-funded FP/RH activities ♦ Define the provider's role in assuring informed choice and informed consent for FP/RH services
Methods:	Discussion and lecturette
Time:	1.5 hours
Materials:	**Handouts:** ♦ Elements of Informed Choice (HO III-1) ♦ Excerpts from the Tiahrt Amendment (HO III-2) Poster: "Do You Know Your Family Planning Choices?"

INFORMED CHOICE AND INFORMED CONSENT: DEFINITIONS

Materials Needed:	Handout ♦ Elements of Informed Choice (HO III-1)

LARGE GROUP DISCUSSION

Trainer:

Informed Choice

Refer to the discussion in the last session on the Bruce-Jain framework's concepts of choice of method and information given to clients; and the discussion of the client's right to choice in the IPPF framework. Suggest that informed choice and informed consent are central to quality of care.

Lead a discussion on the concept of informed choice, based on the following question and note relevant contributions from the responses on the board.

➢ What do you understand by "informed choice"?

Appropriate Responses:

- *The process by which an individual arrives at a decision about his/her health care, based on a knowledge and understanding of all the relevant information from the service provider's and the client's perspectives.*

- *Informed choice includes:*
  - *the decision to use or not to use family planning or other health services*
  - *the decision about which method/service to use, e.g. which method of contraception*
  - *the decision about where to obtain services (by referral, if desired)*
  - *the right to reflection before making a decision about services*

Trainer:

➢ Why is informed choice important?

➢ Why take the time to ensure an informed choice, since it generally does take a bit longer the first few times with clients?

Appropriate Responses:

- *It reinforces the basic human right to self-determination*
- *It contributes to greater client responsibility for, and confidence in, the decision to use contraception or other services*
- *It increases the likelihood of clients using the method/service effectively*
- *It enables clients to better cope with any side effects they might have with their chosen method*

Trainer:

- Will all, or most, clients with the same or similar medical histories, who are given the same information, make similar informed choices?

- If not, why not?

Appropriate Responses:

- *No. Clients are individuals with unique values, experiences, etc. One must never assume that similar medical histories, ages, parity, lifestyles, etc., will lead individual clients to the same FP/RH decisions. Clients will make decisions based on their own unique values, perceptions, experiences, situations, etc.*

Trainer:

Distribute and discuss with the group the handout, Elements of Informed Choice from the International Planned Parenthood Federation. The handout is reprinted below:

ELEMENTS OF INFORMED CHOICE
International Planned Parenthood Federation

1. Counseling on contraception should be focused mainly on the essential information and discussions needed for the client to make an adequate contraceptive choice and for using the method properly and consistently.

2. Counseling should be restricted to the number of issues that can be properly discussed in the available time.

3. The amount of information provided during a counseling session should be in accordance with what the client can understand and retain in his/her memory. Service providers must remember that the process of learning should be a continuous one, and that no one should be expected to learn in one counseling session more than what is reasonably possible.

4. Service providers must remember that every client has different needs and levels of knowledge and understanding of FP. Therefore the focus of counseling, the counseling technique and the time spent with the client should be tailored to the characteristics and needs of the individual client.

Trainer:

➢ What are some of the obstacles that might stand in the way of the client making an informed choice?

Appropriate Responses:

Clients are often not empowered to make decisions in many aspects of their lives or they may simply defer to the provider because of his/her medical knowledge or social status. Other responses include:

- *Pressure from program managers to increase the number of clients using services*
- *The unavailability of methods or services which effectively limits clients' choices*
- *Limited time to serve a large number of clients*
- *Providers are sometimes biased toward or against certain FP methods*
- *Providers are trained in a medical model of service delivery and do not see empowerment of clients as part of their work*
- *Providers sometimes withhold information--and therefore choices-- from certain categories of clients*
- *Government policies in some countries limit family size and pressure individuals to undergo involuntary abortion or sterilization.*

Trainer:

Add that a client's ability to make an informed choice requires a service delivery structure that is committed to informed choice and organizes its services to allow for this. It further requires skilled service providers who are committed to enabling clients to make informed choices and who take the time to work with them to achieve this. Acknowledge that it can be a challenge to implement informed choice with some clients, even in a supportive environment.

Informed Consent

Continue the above discussion, based on the following questions:

➢ What is the difference, and the relationship, between informed choice and informed consent?

4. Service providers must remember that every client has different needs and levels of knowledge and understanding of FP. Therefore the focus of counseling, the counseling technique and the time spent with the client should be tailored to the characteristics and needs of the individual client.

Trainer:

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Add that a client's ability to make an informed choice requires a service delivery structure that is committed to informed choice and organizes its services to allow for this. It further requires skilled service providers who are committed to enabling clients to make informed choices and who take the time to work with them to achieve this. Acknowledge that it can be a challenge to implement informed choice with some clients, even in a supportive environment.

Informed Consent

Continue the above discussion, based on the following questions:

➢ What is the difference, and the relationship, between informed choice and informed consent?

Appropriate Response:

Informed consent is one logical outcome of informed choice: the client requests a service after making a voluntary and informed decision, based on adequate knowledge of the choices.

Trainer:

➢ How do your clinics ensure informed choice and informed consent?

Appropriate Responses:

To confirm that informed consent has truly been obtained, the provider must ensure that:

- *The client has been fully and accurately informed about the available choices. The service provider may ask questions of the client to determine if he/she has sufficient information to make a decision.*
- *The choice of method or procedure has been freely and voluntarily made from a range of options without pressure, inducement or misrepresentation*
- *The client is deemed legally competent to make the decision according to relevant standards of competency and is free of coercion.*

Some national service delivery guidelines and provider policies require informed consent in writing for certain services—usually for voluntary surgical sterilization and sometimes for intrauterine devices (IUDs) or NORPLANT®.

TIAHRT AMENDMENT

Materials Needed:	Handout ♦ Excerpts from the Tiahrt Amendment (HO III-2) Poster - "Do You Know Your Family Planning Choices?"

LECTURETTE AND DISCUSSION

Trainer:

Distribute copies of the handout, Excerpts from the Tiahrt Amendment of 1998 and review with the group the key provisions of this legislation which applies to FP service delivery projects or programs receiving support from USAID. These provisions, which address the voluntary nature of FP service delivery projects supported by USAID, include the following requirements:

1. Service providers or referral agents in the project shall not implement or be subject to quotas or targets for the number of births, family planning users, users of specific FP methods

2. The project shall not include payment of incentives to:
   a) an individual in exchange for becoming a FP acceptor or
   b) program personnel for achieving a numerical target or quota

3. The project shall not deny any individual any right or benefit as a consequence of his/her decision not to accept FP services

4. The project shall provide FP users with comprehensible information on the health benefits and risks of the method chosen, including information about side effects

5. The project shall ensure that experimental contraceptive drugs, devices and medical procedures are provided only in the context of a scientific study in which participants are advised of the potential risks and benefits

Refer the group to the poster, "Do You Know Your Family Planning Choices" prepared by the Johns Hopkins University School of Public Health/Center for Communication Programs, WHO and USAID. This poster complies with the Tiahrt Amendment provisions (enclosed with this curriculum). This poster could be displayed on the wall during the workshop.

SERVICE PROVIDER'S ROLE IN ASSURING COMPLIANCE WITH INFORMED CHOICE AND INFORMED CONSENT

LARGE GROUP DISCUSSION

Trainer:

Ask the group:

- How would you translate all that has been discussed regarding informed choice and informed consent into practice?

- What are the roles of the program and the service provider in assuring that informed choice is respected and that informed consent is obtained in the delivery of FP/RH services?

Appropriate Responses:

Important elements in assuring informed choice and informed consent:

- *Ensure that program policies, which represent the philosophy of the program, stipulate that informed choice and informed consent are essential elements of the standards of care*
- *Ensure that such policies are clearly and routinely communicated to personnel, and determine ways to ensure their application*
- *Service providers, regardless of personal values, must respect the right and the ability of clients to make their own decisions*
- *There must be a commitment at all levels to assist clients to make informed choices and decisions about their FP/RH needs*

SESSION GUIDE IV: STANDARDS, PROTOCOLS AND MEDICAL MONITORING

Objectives:	**By the end of the session, participants will be able to:** ♦ Define the terms standards, protocols and medical monitoring with respect to the delivery of FP/RH services ♦ Explain the importance of standards and protocols ♦ Explain the importance of communication to the implementation of standards in the quality improvement process ♦ Explain five common sources of variation in the FP service delivery system ♦ Explain the role of standards in reducing variation
Methods:	Large group discussion
Time:	1 hour
Materials:	**Flipchart/transparency** ♦ Standards and Protocols (FC/T IV-1)

STANDARDS AND PROTOCOLS

Materials Needed:	Flipchart/Transparency ♦ Standards and Protocols (FC/T IV-1)

LARGE GROUP DISCUSSION

Trainer:

Lead a discussion based on the following questions:

➢ What guides the delivery of FP/RH services in your facilities?

➢ From a clinical point of view, how do personnel decide which exams, tests, other interventions and/or advice clients need?

➢ What is the basis for such decisions?

Appropriate Responses:

- *Professional training*
- *Professional experience*
- *Program/service delivery standards and protocols*

Trainer:

➢ What do we mean by standards and protocols?

➢ What function do they serve?

Present a brief definition of the terms standards and protocols, using the flipchart/transparency, and discuss the purpose of each.

Definition of Standard: A minimal level of acceptability for any input, practice (performance), or output of service delivery.

Explain that the purpose of standards is to:

- Protect the rights of clients
- Ensure that the most up-to-date and safe practices are used
- Create uniformity in the practices of service providers and in service delivery systems
- Indicate the competencies necessary for training of personnel
- Provide a common thread between training, service delivery practices, management systems and program assessment

- Decrease medical barriers to services
- Provide a source of reference for service providers
- Provide a basis for the development of protocols and indicators, and for measurement and assessment

Definition of Protocol: A guide for the step-by-step processes and decision-making steps required to deliver a service.

Explain to the group that the purpose of protocols is to:

- Ensure uniformity in approach/procedure thus ensuring respect for the standards from which they come
- Serve as a reference point for service providers when there are questions about how to proceed in particular situations

Ask the group:

> ➢ Why should we be concerned with standards and protocols as we work to improve the quality of our services?

Appropriate Responses:

Program standards and clinical protocols can help ensure the QOC by ensuring that information and services provided to clients meet established standards for:

- *Client eligibility for available contraceptive methods*
- *Use of contraceptive methods*
- *Provision of up-to-date information*
- *Method provision*
- *Infection prevention practices*
- *Referral*
- *Follow-up*

They help ensure that other support systems offer adequate support to service providers:

- *Logistics and procurement*
- *Service provider training*
- *Supervision*
- *Monitoring*
- *Evaluation*

Standards and protocols provide the foundation for the safe, effective and efficient provision of services and thus serve as a reference point to:

- *Assess quality in the provision of services and identify problems in QOC and*
- *Evaluate the effects of corrective actions taken.*

Trainer:

Refer participants to the *SEATS II Clinical Protocols for Family Planning Programs: A Resource Book* (see bibliography)

Ask the group:

➢ Does your program (organization or Ministry of Health (MOH)) have standards and protocols for the provision of FP/RH services?

Appropriate Responses:

(Variable responses)

Trainer:

➢ Where do these standards come from?

Appropriate Responses:

Usually a combination of several of the following:

- *National consensus*
- *Expert opinion (international and local)*
- *Legal/regulation*
- *International standards*
- *Professional organizations*
- *Teaching institutions*
- *Service providers and managers*
- *Client perspectives*

Trainer:

What provisions are made for:
- Updating them?
- Communicating them to personnel?

Appropriate Responses:

(Variable responses)

Trainer:

Discuss with the group the following points as necessary, based on your perception of the degree to which participants' organizations have developed, updated and communicated standards and protocols effectively to personnel.

- **Updating of standards and protocols**: Standards and protocols should be reviewed and revised periodically to ensure that they reflect current knowledge and practice

- **Communication of standards and protocols**: Standards and protocols are only as useful as their application. Personnel must learn them and be able to refer to them as needed over time.

Inform the group that standards and protocols must be communicated to all levels of the health system, especially to the individuals and teams who will be expected to perform according to those standards. National standards and protocols (set or adopted at the ministry level) need to be communicated effectively at the regional, district and clinic levels.

Note that personnel will be more likely to apply standards and protocols if they understand:

- Why the standard or protocol was developed
- Its importance to the quality of services
- Who it will affect
- What tasks it concerns

Standards and protocols may be communicated to personnel via a combination of the following:

- Pre-service training
- In-service training
- Supervision
- Job aids
- On-the-job training
- Professional seminars and conferences
- Official letters, pronouncements, laws and regulations

They should be communicated by a person who is seen by the intended audience as having credibility (and who understands the information base behind the standard or protocol and is able to explain it clearly and accurately).

VARIATION

LARGE GROUP DISCUSSION

Trainer:

Facilitate a discussion of the phenomenon of variation, and how standards and protocols can help staff control variation in the process of service delivery:

- Can any set of standards or protocols be applied in exactly the same manner all the time? If not, why not?

Appropriate Response:

No. In any process or task that we perform in the delivery of FP/RH services, conditions change. Variation is a natural characteristic and is not always a cause for concern.

Trainer:

- What are some examples of variation you encounter in your clinical practice?

Note participant responses on the board.

Appropriate Responses:

- *The time needed to get lab results back*
- *Expected versus actual time for a client's appointment*
- *Tthe time clients spend waiting*
- *The number of completed medical records*
- *The number of clients receiving a home visit each month*
- *Percentage of IUD clients that develop infections*
- *The number of clients seen in a day*
- *Other*

Trainer:

- What kinds of factors contribute to these variations?

Appropriate Responses:

- *Machines (computers, lab equipment, etc.)*
- *Materials (forms, supplies, clinical instruments, etc.)*
- *Methods (procedures, protocols, techniques, etc.)*

- *Measurement (bias, inaccuracy, etc.)*
- *People (service providers, managers, technicians, clients)*

Trainer:

➢ Can standards help health workers control unnecessary variation in the delivery of services? How?

Appropriate Responses:

Yes. By specifying what the organization expects in terms of inputs, processes and outputs; and by monitoring and improving processes as needed, to make the system responsive to these expectations.

SUPERVISION SYSTEMS

LARGE GROUP DISCUSSION

Trainer:

➢ What systems do you use or are you familiar with in your own agency to monitor compliance with standards and protocols?

Appropriate Responses:

- *Supervision*
- *Licensing*
- *Accreditation*

Trainer:

➢ How well does the supervisory system in your agency work?

Appropriate Responses:

Answers will vary, but some significant problems are likely to be raised.

Trainer:

➢ In what ways can service providers supervise quality in fact (technical quality of care) in situations in which formal supervision does not happen or is inadequate?

Appropriate Responses:

Service providers may individually or collectively monitor their activities, based on standards and guidelines:

- *Service providers may meet periodically to review their activities in terms of their respect for the organization's standards and protocols*

- *Service providers may individually evaluate themselves and/or each other, using supervisory check lists*

Trainer:

➢ Is a good supervisory system, based on standards and guidelines, sufficient to ensure quality of care?

Appropriate Response:

- *No. Usually supervisory systems look only at quality in fact, but do not address quality in perception.*

- *Quality in fact has long been the focus of the formal supervisory system, using checklists based on standards and protocols.*

- *Quality in perception is a relatively more recent focus of concern in the delivery of family planning services. Standards and checklists are being developed and refined to facilitate the monitoring of quality in perception.*

Trainer:

Emphasize that since quality in perception is a newer concept than quality in fact, and receives less attention, it is the major focus of this training curriculum.

➢ Are you familiar with any approaches to improving quality in perception?

Appropriate Response:

If the group mentions Continuous Quality Improvement (CQI), COPE or any other approach, ask them to describe the system.

Trainer:

Explain that this curriculum centers on CQI which focuses on the identification of weaknesses or problems in both quality in fact and quality in perception and addressing those weaknesses or problems. Quality Teams at various levels of the system undertake these improvements in the quality of care.

Trainer:

➢ How can supervisory systems and CQI be linked?

- *Supervisory systems and CQI can complement each other by including supervisors on the Quality Team or addressing issues identified by supervisors. In such cases:*

  - *Supervisors can bring to the attention of the Quality Teams certain problems and/or help clarify the parameters of certain service delivery problems.*

  - *Supervisors can also serve as facilitators within the team, helping members to function as a team and to carry out their problem identification and problem*

solving activities. By creating an environment of teamwork and by coaching individuals and groups, supervisors can greatly increase their own effectiveness. They can strengthen the skills of other personnel and encourage them to take responsibility for the quality of their services, helping improve and maintain the quality of services they provide.

MEDICAL MONITORING

LARGE GROUP DISCUSSION

Trainer:

Before going on to discuss CQI, tell the group that there is one other important aspect of quality in fact that they should be aware of–medical monitoring.

Point out that, in addition to having standards and protocols, health systems need to have a system in place for medical monitoring. Although modern methods of contraception are very safe, complications—and even deaths—can occur. The purpose of a medical monitoring system is to prevent and investigate deaths and serious complications that could be attributed to health services provided at the facility. In family planning, this is particularly important for providers of voluntary surgical sterilization, Norplant® and IUDs.

➢ What types of problems could occur in the provision of family planning services?

Appropriate Responses:

Some of the problems are:

- *Complications from anesthesia*
- *Failed sterilization*
- *Excessive bleeding*
- *Serious infections*
- *Injury to the uterus, bowel or bladder*

Trainer:

➢ What are some of the systems that could be put into place to prevent deaths and complications and investigate them if they occur?

Appropriate Responses:

- *Ensure that clinical procedures (e.g., IUD insertion or surgical procedures) are provided only at appropriate facilities*
- *Ensure that the staff providing such procedures are properly trained*
- *Ensure that standards and protocols are regularly reviewed and updated*
- *Ensure that complications are recorded in the client's record*
- *Ensure that internal monitoring, self-assessment and problem-solving capabilities are in place*
- *Ensure that follow-up medical site visits are conducted*

- *Ensure that any death or serious complication is reported to the appropriate authorities*
- *Ensure that any death or serious complication is investigated so that future problems can be avoided*

Trainer:

Note that although a medical monitoring system is very important to ensure QOC where clinical services are provided, setting up such a system is complex and is beyond the scope of this training. Providers of clinical services, however, need to ensure that such a system is in place.

SESSION GUIDE V
CONTINUOUS QUALITY IMPROVEMENT (CQI) PRINCIPLES AND TOOLS

Objectives:	**By the end of the session, participants will be able to:** ♦ Define Continuous Quality Improvement (CQI) ♦ Differentiate between the CQI process and other quality improvement processes (e.g., Client-Oriented and Provider Efficient (COPE)) process ♦ Explain how the CQI approach is different from the traditional approach to quality assurance ♦ Describe the five basic principles of CQI ♦ Name the five steps of the simplified CQI process to be used in this training ♦ Identify at least four sources of data useful in the CQI problem identification process ♦ Describe six CQI tools useful for identifying possible QOC problems and the purpose of each
Methods:	Lecturette, group exercise, large group discussion, case study and small group work
Time:	12 hours
Materials:	**Flipcharts/Transparencies:** ♦ Traditional Approach to Quality Assurance/Continuous Quality Improvement (FC/T V-1) ♦ SEATS Quality Improvement Cycle (FC/T V-2) ♦ A Quality Problem or Another Kind of Problem? (FC/T V-3) ♦ CQI Tools for Identifying Quality Problems (FC/T V-4) ♦ Presentations on CQI Tools (FC V-5) **Handouts:** ♦ Principles of CQI (HO V-1) ♦ CQI Tools • Brainstorming (HO V-2) • Service Statistics (HO V-3 and 3a) • Client Exit Interviews (HO V-4 and 4a) • Focus Group Discussions (HO V-5 a, b and c) • Facility Audit (HO V-6 and 6a) • Flow Charts (HO V-7 and 7a) • Client Flow Analysis (HO V-8 and 8a) • Observation of Counseling (HO V-9 and 9a) • MAQ Checklist (HO V-10) ♦ Using CQI to Strengthen Family Planning Programs (HO V-11) ♦ Manager's Toolbox for CQI (HO V-12)

APPROACHES TO QUALITY IMPROVEMENT

Materials Needed:	Flipchart/Transparency ♦ Traditional Approach to Quality Assurance/Continuous Quality Improvement (FC/T V-1)

LECTURETTE AND LARGE GROUP WORK

Trainer:

Introduce this session by telling the group that now that they have a good grasp of what quality of care is, it's time to move on to the quality improvement process. Remind them that this is the only session where homework is required, but that the homework will be fun and interesting.

Review with the group some quality improvement approaches widely used in FP/RH programs, referring back to any that may already have been mentioned in the last session:

1. **Quality Assurance (QA)**

   A comprehensive approach to quality management, combining quality design, monitoring and improvement activities into large-scale quality assurance programs. Employs a six-step problem-solving methodology using analytical tools developed in industry.

2. **Client-Oriented and Provider-Efficient (COPE)**

   Uses a set of simple self-assessment tools developed for front-line workers at FP clinics and for regional, district and site supervisors. Focuses on client interviews, analysis of client flow through clinics and questionnaires on all aspects of service delivery. COPE follows the IPPF framework on Clients' Rights and Providers' Needs.

3. **Continuous Quality Improvement (CQI)**

   A step-by-step process, using specific tools to facilitate the identification and analysis of problems in the quality of care; the identification of solutions; and the evaluation of results. CQI is implemented by Quality Teams drawn from all ranks of an organization.

4. **Total Quality Management (TQM)**

   Similar to CQI

While these systems differ slightly in their approaches, all follow the same basic steps to make improvements in the quality of care:

- Identify problem areas
- Analyze the root causes of the problem
- Design and implement solutions
- Evaluate results

This curriculum is based on a simplified version of the CQI approach and CQI tools. It also includes Expanded Quality Improvement (EQI), a SEATS innovation, which expands CQI teams to include representatives of the community and referral sites in addition to service providers. Because of the community dimension, it addresses *access* to services for currently underserved populations at the same time as improving the QOC.

Post the flipchart, Traditional Approach to Quality Assurance/Continuous Quality Improvement, and ask for volunteers to read and explain each contrasting characteristic.

PRINCIPLES OF CQI

Materials Needed:	Handout ♦ Principles of CQI (HO V-1)

LECTURETTE AND LARGE GROUP DISCUSSION

Trainer:

Post and review the five major principles upon which CQI is based and that are necessary for it to be effective:

1. Leadership must provide firm commitment and support for CQI

CQI requires new ways of thinking, a willingness to change and strong mutual support and respect among management and staff. At whatever level CQI is initiated (national, agency, facility, etc.), management at that level must provide the leadership to start the process and support the work of the Quality Team. If management is not prepared to permit the process to work, CQI will fail. Managers must view it as a priority and communicate this to staff by:

- Their pronouncements and their actions
- Permitting staff to devote time to CQI
- The allocation of essential resources
- Their commitment to implement the changes proposed by the Quality Team

2. Satisfy internal and external clients

The purpose of CQI is to improve the quality of services for both external clients (men and women who receive FP services) and internal clients (program staff who contribute to the provision of services to external clients and who are themselves served by organizational operations). To better identify and respond to the needs of both groups of clients, both need to be involved in the process (including all levels of staff and community members representing actual and potential clients).

3. Focus on improving systems and processes, rather than changing the behavior of individuals; and use of existing resources rather than relying on new inputs to solve problems

CQI, as presented here, assumes that problems in QOC/service delivery are the result of ineffective or poorly functioning processes rather than ineffective personnel. It seeks to develop improved systems and processes and not to blame individuals. It also assumes that improvements can be made using existing resources—or modest additional inputs—rather than depending on new resources to solve the problems.

4. Respect the contributions of all staff and the staff's ability to improve processes

The CQI process is based on respect for the staff's ability to identify, analyze and solve problems within their day-to-day activities. It requires managers to empower staff, through a team approach, to participate actively and candidly in all stages of the problem-solving process. This empowerment of staff not only brings about improvements in the quality of care, but it also increases job satisfaction among Quality Team members.

5. Collect and use data to identify deficiencies and improve processes

Decisions throughout the CQI process need to be based on facts that have been verified through the use of data—and not just opinions or suppositions. Quality Teams need to use data at all stages of the CQI process.

Ask the group:

➢ What are some sources of data that could help identify problems in the QOC?

Appropriate Responses:

Data from:

- *Service statistics*
- *Clinic records*
- *Observation of providers during service delivery*
- *Information provided by staff about problems/concerns*
- *Feedback from clients about their perceptions of the adequacy of QOC (via focus groups, exit interviews, suggestion boxes, etc.)*

Trainer:

➢ Are there any questions or comments regarding these principles?

(Adapted from "Using CQI to Strengthen Family Planning Programs," The Family Planning Manager, see bibliography.)

STEPS OF THE CQI CYCLE

Materials Needed:	Flipchart/transparency ♦ SEATS Quality Improvement Cycle (FC/T V-2)

LECTURETTE AND LARGE GROUP DISCUSSION

Trainer:

Explain that a Quality Team is responsible for implementing the quality improvement cycle—and that there will be further discussion of who should be on a Quality Team later in the training course. The team may be working at any level of the service delivery system: it may be a national team in the Ministry of Health (MOH), a district/municipal team, a team for an entire organization (e.g., an NGO), a team at the clinic/facility level—or even a team of individual practitioners or community based workers.

Show the flipchart/transparency, SEATS Quality Improvement Cycle. Review briefly with the group the five steps in the quality improvement cycle, according to the graphic:

Step 1. Identify a Quality Problem

Problems may be identified two ways:

- The Quality Team may *already have evidence/data* pointing to a problem, e.g., from service statistics, a QOC survey, feedback from supervisors, suggestion boxes, client interviews or some other source.
- The Quality Team may *think* there is a problem in the quality of care and *then verify* whether there is really a problem through data collection. If there are several problems, they are prioritized.

The collection of baseline data (i.e., at the beginning of the problem-solving process) is critical because, without it, it is impossible to determine later on whether the problem was really solved. Baseline data can also help define a problem. Often, simple data may suffice.

➢ What are some examples of simple data or routine data that may already be available to you?

Appropriate responses:

Numbers of users, continuing users, dropouts, method mix, etc.

Trainer:

➢ What are some examples of simple data or non-routine data that you may be able to collect?

Appropriate responses:

- *Reasons for client satisfaction or dissatisfaction*
- *Reasons community members don't use services*
- *Percentage of clients with pelvic infections who receive IUDs*
- *Percentage of clients with high blood pressure who receive pills, etc.*

Trainer:

Routine data from service statistics are more readily available and less costly to obtain than non-routine data. They can only illuminate a limited number of problems, however. Non-routine data may be needed to verify and shed light on other problems. For example, problems involving counseling or interpersonal relations between clients and providers can be identified by observing a number of provider-client interactions or by talking with clients and personnel. A variety of simple techniques (focus group discussions, client exit interviews, etc.) to obtain non-routine data on the quality of care will be discussed in this session.

In essence, a quality problem states the *gap between the desired situation and the actual situation* on the ground. For example, providers may not be performing according to national clinical protocols; a facility may lack essential equipment and supplies; administrative staff at a clinic may not be living up to clients' expectations in terms of friendliness or efficiency.

Step 2. Find the Main Cause(s) of the Problem

To solve a problem effectively, it is essential to pinpoint the major cause or causes with precision. For example, changes in service statistics may have a number of possible causes.

➢ What might cause service statistics to show a drop in the numbers of users over a period of several weeks or a few months?

Appropriate responses:

- *A problem that has caused clients to lose confidence in the agency or its services*
- *A stock-out of contraceptives*
- *Fees that are too high for potential clients to pay*
- *Competition from another facility*

Trainer:

- What might cause service statistics to show large numbers of new users, compared with low numbers of continuing users?

Appropriate responses:

- *Clients are not satisfied with the agency or its services, so they don't come back*
- *A major IEC campaign has generated lots of new users*
- *It may be cheaper/more convenient for clients to go to a pharmacy or some other place for resupply*

Trainer:

- What if service statistics indicate that most clients use just one or two contraceptive methods?

Appropriate responses:

- *Clients don't have a broad choice of methods at the facility/agency*
- *Providers' biases for or against certain methods affects the choices made by clients*
- *Knowledge, attitudes and norms in the community favor those methods*

Trainer:

Explain that in Part II of the training, the group will become familiar with cause-and-effect diagrams, which can help them identify underlying causes of quality problems.

Step 3. Develop A Solution

Developing an effective solution is *the* most important part of the quality improvement cycle. It's also the part that is hardest to teach because there is no formula for a good solution. The key to success, however, is to identify and address the main cause(s) of the problem.

In many situations, it may be advisable to implement the solution on a small scale first in order to determine whether it is likely to succeed. Once any problems in implementation have been identified and rectified, the plan can then be implemented on a larger scale—or an alternative plan adopted. Small-scale implementation may be wise, for example, in situations where the solution is costly, where it may be controversial with the staff involved or where the Quality Team was unsure which of several possible solutions to use.

The development of a Quality Action Plan setting out the activities involved in implementing the solution is helpful for many reasons. For example, it helps ensure that all activities necessary to implement the solution are identified; it helps Quality Team members feel accountable for certain activities; and it helps determine whether funding

might be needed for certain activities. Quality Action Plans will be discussed in detail in the last session.

Step 4. Implement the Solution

As the Quality Action Plan is implemented, the Quality Team may want to meet periodically to monitor progress and address any problems that may arise. For longer-term quality improvement plans, the Quality Team may want to collect and review data on an interim basis to get some indication of whether the plan of action is likely to solve the problem.

In any event, the Quality Team should not let its hands be tied by the Quality Action Plan. Plans often need to be changed as implementation of the solution moves forward.

Step 5. Measure the Results

A problem is not considered solved until it has been shown to be solved, using data. That doesn't have to be complicated. Often the simplest way to determine whether a quality problem has been solved is to take the same tools that were used to identify the problem in the first place, or to measure the baseline, and apply them again.

Remind the group to bear in mind, when they are becoming familiar with the tools to identify problems in the quality of care, that these tools can be used again to measure results once the quality cycle is complete.

A problem may be completely solved after going through the five-step cycle once—or it may be only partially solved, in which case further work is called for. CQI is a continuous cycle that isn't undertaken just once. Quality can always be improved. When the Quality Team selects a problem to work on, it may postpone action on another important problem that can be tackled in another round. In the process of measuring the results of quality improvement efforts, yet another problem may come to light. CQI should become standard operating procedure and be continuously repeated, so as to continuously improve the quality of care. This helps the organization maintain improvements and identify and address new areas where quality can be improved.

TOOLS AND TECHNIQUES USED IN PROBLEM IDENTIFICATION

Materials Needed:	**Flipchart/transparency** ♦ A Quality Problem or Another Kind of Problem? (FC/T V-3)

LARGE GROUP EXERCISE

Trainer:

To verify that participants have a good grasp of what is meant by a QOC problem, show the flipchart/transparency, A Quality Problem or Another Kind of Problem?, and discuss with the group which of these are quality problems and which are more general problems:

1) Friends of service providers are seen ahead of other clients
2) Women of reproductive age express interest in FP but do not wish to use their local clinic
3) For the past three months, the clinic has been stocked out of Depo Provera
4) Providers at the clinic refer clients to the hospital for IUDs
5) Personnel begin seeing clients two hours after the clinic is officially open
6) Personnel strongly recommend certain contraceptive methods to certain clients
7) Women of reproductive age do not wish to use FP
8) Women come to the clinic for an initial visit and never return
9) A clinic that is open five days a week provides FP just one day a week
10) Sterile technique is not used during pelvic exams
11) The clinic does not provide services to unmarried adolescents
12) Transportation to the clinic is difficult

Note to the trainer: Questions 1, 2, 3, 5, 6, 8, 9 and 10 present obvious QOC problems; question 7 is not a QOC problem; and numbers 4, 11 and 12 may or may not be quality problems.

If this exercise indicates a need to review some key concepts in QOC from Session II, do so, focusing on:

- The elements of quality discussed in Session II
- External clients' perceptions of care
- The ability of internal clients (agency personnel) to provide adequate services.

BRAINSTORMING AND SUPERVISION

Materials:	Handout ♦ CQI Tools for Identifying QOC Problems (HO V-1, HO V-12)

LARGE GROUP EXERCISE

Trainer:

The session now moves on to some useful tools to identify problems in the QOC, beginning with *brainstorming*.

Do not tell the group that the discussion is moving to problem identification tools. They will find out shortly! This exercise will take them through a brainstorming to identify problems in quality in perception. Based on that exercise, the group will identify the principles of a good brainstorming and will appreciate how brainstorming can serve as a tool in problem identification.

Tell participants that they're going to brainstorm a QOC problem in the delivery of FP, based on their experience in their programs.

Write the topic of the brainstorming on flipchart paper: Identifying a Problem in Quality in Perception. Clarify that everybody understands the topic.

Agree with participants on the rules for brainstorming:
- Every idea is valid
- Every idea is written down in the words of the speaker. If an idea takes a long time to explain, the speaker should list the main ideas for summary on the board
- No one may interrupt or criticize
- Only questions of clarification may be asked.

➢ What are all of the problems that you can think of related to quality in perception?

Record every idea and continue until no more ideas are offered.

Go over the list with the group, one item at a time. Eliminate any items that the group determines are either not relevant or not important. Ask the group which items they think are the most important problems in quality of care. Reword any items that may need to be clarified.

(Adapted from "Achieving Quality Through Problem Solving and Process Improvement," Quality Assurance Project, see bibliography.)

After the group has reached agreement on the major problems in quality in perception, tell them that they have just used an important tool for identifying problems in the QOC: brainstorming. Review with them the process they have just been through, as outlined in the handout on brainstorming.

➢ Imagine that you are part of a Quality Team at your facility — who would you want to include in a brainstorming session to identify problems in the QOC?

Appropriate responses:

- *Doctors, nurses, midwives*
- *The clinic manager/director of the agency*
- *Community-based distribution agents*
- *Supervisors*
- *Administrative and secretarial staff*
- *Janitors, cleaners, gardeners*
- *Members of the agency's board of directors*
- *Clients or community members*

Trainer:

Remind the group that *feedback from supervision* visits is another way in which to identify quality problems.

➢ How would you link input from supervisors with CQI?

Appropriate responses:

- *The Quality Team can review written assessments left behind by supervisors (Note that all information pertaining to the performance of individual staff members must remain confidential.)*
- *The supervisor could be invited to meet with the team and share his/her findings. (Note that a supervisor's observations about weaknesses in one person's performance are not sufficient to warrant a CQI effort. Rather, there needs to be an identified* pattern *of weaknesses within the particular service delivery process(es) in order to justify a CQI effort.)*
- *The supervisor might be invited to be a member of the Quality Team.*

OTHER CQI TOOLS

Materials Needed:	Flipchart/transparencies ♦ CQI Tools (FC/T V-4) ♦ Presentations on CQI Tools (FC V-5) Handout ♦ CQI Tools

LECTURETTE

Trainer:

Show the flipchart/transparency, CQI Tools for Identifying Quality Problems, and briefly outline the other problem identification tools to be discussed in this session. (Refer to the handouts for information about each tool.)

CQI TOOLS

1. Brainstorming
2. Service statistics
3. Client exit interviews
4. Focus group discussions
5. Facility audit
6. Observation of counseling
7. Flow charts
8. Client flow analysis
9. MAQ checklist

Invite participants to examine these tools and techniques to identify QOC problems. Emphasize that this discussion is only an introduction. Developing and using each of these tools *well* is a science and takes time and in-depth study—for which the time-frame for this workshop is too short.

SMALL GROUP WORK

Divide the participants into four small groups to work on the tools and assign two tools (numbers 2–9 above) to each small group. The following distribution of tools to the groups will allow each group to work with two distinctly different tools:

Group 1: Service statistics and the facility audit
Group 2: Client exit interviews and flow charts
Group 3: Focus group discussions and client flow analysis
Group 4: Observation of counseling and the MAQ checklist

Distribute the handouts on all the tools as well as the handout, CQI Tools for Identifying QOC Problems.

Post the flipchart, Presentations on CQI Tools, and ask each group to prepare brief presentations on their assigned tools, using the handouts and any other resources you may have on these tools. (The handouts provide some suggestions for further reading and it is helpful to the group to have these resources available.)

Each small group's presentation should:

- State the purpose of the tool
- Give a brief description and show the group what the tool looks like
- Outline the main steps in using the tool
- Give a brief example of how it could be used in a specific situation

The groups will likely need about 2 ½ hours to study the tools and prepare their presentations, so they will likely need to do some homework in the late afternoon or evening. Circulate to help them as they work or let them know how they can find you after hours.

Each small group presents its assigned tools to the large group. Ensure that the information presented is accurate and complete. (Refer to the handouts for details.)

PRACTICAL EXAMPLE

CASE STUDY

Trainer:

Facilitate a group discussion of the application of the CQI tools to the first step of the CQI process—identifying a QOC problem—using a concrete example. To the extent possible, it is useful to work with actual data from a local site. However, the following case study can also be used, either in its entirety or in part, to supplement the tools used for a locally generated case study.

Part I of the case study, which is presented in this session, corresponds to Step 1 of the CQI process, Identify a Quality Problem.

Parts II and III of the same case study are included in Sessions IX and X of the training and provide practice in using problem analysis tools and in developing a Quality Action Plan.

Case Study for the Application of the CQI Process: Part I, Problem Identification

Mamba district in Paperland has three major towns and 24 smaller villages. Each of the three major towns has a health center and there are an additional eight health posts that are visited regularly by a nurse or midwife from a health center.

The district has a Quality Team composed of:

- The district medical officer
- The manager of one of the health centers
- A nurse and a social worker from the other two health centers
- The receptionist from the largest center
- A supervisor
- A client
- A community distribution worker
- A representative from Mamba district hospital, to which the health centers often make referrals.

The social worker noticed that there didn't seem to be many FP clients at her own health center and suggested the Quality Team investigate the problem district-wide. The team reviewed *service statistics* for the three health centers for the past two years and determined that the social worker was right. Across the three health centers, an average of only 8 percent of clients came for FP in one year and 7 percent the next. They also noticed that most FP clients were new users—only 25 percent of new clients returned for follow-up visits.

To better define the problem, the team decided to take the following approaches to data collection:

- *Focus group discussions* with three different groups of people:
  1. Women of reproductive age not using FP services
  2. Former FP clients
  3. Staff at the health centers
- *Exit interviews* with current clients.

SMALL GROUP WORK

Practical exercise to enable participants to experience, or observe, the implementation of FGDs and client exit interviews.

Divide the group into small groups of no more than three or four people each and ask them to do the following:

- One small group prepares a **FGD guide** to help them understand why women of reproductive age aren't using FP services at the health centers.
- A second group prepares a **FGD guide** to help them understand why former FP clients do not return.
- A third group prepares a **FGD guide** to find out from health center staff why they think there are so few FP clients and even fewer clients for return visits.
- The other small groups prepare **exit interviews** focusing on what clients like and dislike about the health centers, their knowledge of when they should return for a follow-up visit and any suggestions they may have on how to improve services. Ask these groups to be prepared to give an example of how they would analyze the results of the survey, too.

Depending upon the time available, one or more of the FGD groups should practice conducting a short FGD, using the discussion guide they have developed, with the large group serving as "participants" in the focus group(s).

LARGE GROUP DISCUSSION

Trainer:

Lead a discussion of the FGDs just conducted, around the following topics:

- What were the main findings of the focus group? How would you analyze a focus group discussion?

- How well designed was the discussion guide? How could it have been improved?

- How successful was the moderator in guiding the discussion?

Be sure that key points raised in the handout on FGDs are covered.

Depending on the time available, at least one person from one of the exit interview groups should conduct a brief exit interview. Another workshop participant can play the role of a client.

Lead a discussion around the following topics:

- How well designed was the questionnaire? How could it have been improved?
- How well did the interviewer conduct the interview?
- Who should conduct client exit interviews?
- When and how do you "find" clients to interview?

Ask each exit interview group to present its approach to analyzing the results of the exit interviews. Again, be sure key points addressed in the handout on exit interviews are covered during the discussion.

Now that participants are familiar with some important tools to help identify problems in the QOC, ask them:

- What are some examples of the gap between the ***desired*** QOC and ***actual*** quality of care?

Be sure that gaps in quality in fact are addressed as well as gaps in quality in perception.

Appropriate responses:

- *The* **desired** *QOC, as outlined in clinical protocols, might require several procedures for proper disposal of infectious waste (e.g. disposing of all sharps in a puncture-resistant container, pouring liquid waste down a utility drain or flushable toilet, burning or burying contaminated waste, etc.) but providers might only be following 70 percent of those procedures (***actual** *QOC).*
- *The* **desired** *QOC might be that all facilities have at least a one-month supply of contraceptives in stock. The* **actual** *QOC might be that only 80 percent of facilities meet that standard.*
- *The* **desired** *QOC, as articulated by clients, might be to be able to obtain services for both the mother and the baby at the same time and place. The* **actual** *QOC might be that the woman needs to come for services one day and bring her baby for care another day.*
- *The* **desired** *QOC in the Checklist for Counseling Clients for Informed Choice (HO-V 9a) is a score of 53 or higher for an individual provider (including all critical indicators). The* **actual** *QOC may be below that level.*

Trainer:

- What are some examples of CQI tools you have examined that provide ***quantitative*** measurements of the QOC.

Appropriate responses:

- *Client exit interviews*
- *Observation of counseling*
- *Client flow analysis*
- *Service statistics*

Trainer:

Write the quantitative tools on flipchart paper. If the group has difficulty with the concept of quantitative measurement of QOC, go back to the Checklist for Counseling Clients for Informed Choice (part of HO V-9, Observation of Counseling), where the provider's skills are expressed in numbers and the total is then compared with the total possible score. Explain how the gap between the ***desired*** QOC and ***actual*** quality of care is the difference between these two numbers. An analogy to grades in school tests and examinations may also be helpful.

Discuss how other tools provide a basis to verify improvements objectively—even though the results may not be quantified:

- A changed flowchart can show how a process has been changed
- A facility audit can show changes in the facility, its equipment and supplies.

➢ How can you measure change using focus groups?

Appropriate responses:

- *Since focus groups provide qualitative and not quantitative data, they help describe a problem, but do not provide a solid baseline against which change can be measured.*
- *Focus groups can provide an* **indication** *of change if many participants are included and if a significant majority of participants express different opinions from those expressed at the beginning of the quality improvement cycle.*

LECTURETTE

Trainer:

Explain that this is why researchers and program managers prefer *quantitative* data to *qualitative* data when they want to determine the impact of their interventions, e.g., comparing QOC at the beginning of the CQI cycle and at the end. That does not mean, however, that qualitative data are less valuable than quantitative data. Their value is that they paint a much better picture of a situation than quantitative data. They explain what people think and why a problem may be occurring.

Explain why it is often useful to use *two* tools at the beginning of the quality improvement cycle. For example:

- A Quality Team might conduct exit interviews in order to find out about clients' method choice but discover that waiting time is a problem. From the exit interviews, the Quality Team knows the baseline levels on waiting time (e.g., X percent of clients interviewed said that long waits were a problem) but it doesn't know the *causes* of the long waits, making it hard to develop a good solution to the problem. So the team might decide to do a client flow analysis or focus groups to pinpoint the causes of the problem.
- Conversely, a Quality Team might do some focus groups or a client flow analysis which would indicate that waiting time is a problem—and why it's a problem—but the team would still need baseline data (e.g., How long is the average wait? What percentage of clients consider it a problem?)

➢ Thinking ahead to the end of the quality improvement cycle, do you have any suggestions about how you might measure the results of your quality improvement efforts or determine whether the work of the Quality Team has been effective?

Appropriate responses:

Apply the same tools to measure improvements in the QOC at the end of the cycle that were used to identify the quality problem or measure baseline levels at the beginning of the cycle.

(The descriptions of many of the CQI tools and their use presented in this session are adapted from Using CQI to Strengthen Family Planning Programs and Manager's Toolbox for CQI from The Family Planning Manager, and Achieving Quality Through Problem Solving and Process Improvement, from The Quality Assurance Project. Other sources are COPE: A Self-Assessment Technique for Improving Family Planning Services, published by AVSC International and Client Satisfaction Surveys for Improved Family Planning Service, A User's Manual, by IPPF/Western Hemisphere. See bibliography.)

SESSION GUIDE VI
STARTING A CQI TEAM AND INVOLVING THE COMMUNITY (EQI)

Objectives:	**By the end of the session, participants will be able to:** ♦ Name at least two steps they will take to initiate the CQI process within their organizations. ♦ Explain how the participation of the community in the CQI process (known as EQI) can contribute to the improvement of QOC in FP/RH service delivery ♦ Describe at least three approaches appropriate to community participation in the EQI process
Methods:	Large Group Discussion
Time:	1 hour
Materials:	None

INITIATING CQI ACTIVITIES

LARGE GROUP DISCUSSION

Trainer:

Acknowledge with the group that the overview of CQI and the application of the CQI process to a specific example in the last session prepared them for the process of identifying quality problems. Emphasize that they will become increasingly skilled in the CQI process as they apply the tools in their efforts to improve FP/RH programs.

Facilitate a discussion on the initiation of CQI activities for the improvement of FP/RH services, based on the following question:

➢ How do you plan to proceed in applying the process, tools and techniques we've discussed to your own service delivery system?

Appropriate response:

They will need to involve others in their agency/facility in the process

Trainer:

Emphasize that it is essential that CQI efforts begin with senior management—at least at the level of the facility where CQI is to be applied. (This could be management at a national, regional or district level, at the organizational level in an NGO, or at the clinic level.) Management support at the highest levels facilitates the resolution of certain kinds of problems that involve more than one level. For example, if a clinic finds that there are problems with the logistics system (for contraceptives or supplies) or with insufficient equipment, the clinic may not be able to solve those problems itself—it may need to seek assistance from higher up the system.

It is important for senior management to initiate CQI for several reasons:

- Their leadership creates an environment for quality improvement
- They can take the lead with staff under their management
- They can allocate resources within the system

Add that it is assumed that senior managers of organizations sending personnel to this training are at least somewhat familiar with QOC issues, understand how CQI can help to improve management and the delivery of services, and are supportive of the use of CQI to improve QOC in their institutions.

➢ Assuming you have the support of senior management for CQI, what do you need to do to initiate activities?

Appropriate responses:

- *Form Quality Teams, composed of staff who are involved in management, service delivery, administration, housekeeping or other functions, as well as others who can bring a valuable perspective. These might be members of the board of directors (for an NGO), community-based health workers, a representative from an important referral site and/or community groups (women's organization, neighborhood health committee or similar). The team will participate in the identification of areas for improvement and in the problem-solving and monitoring processes. Such teams should be limited to 10 to 12 members representing all departments/services involved in the potential areas for improvement. (Team membership may change, depending upon the need for certain expertise. The team may be permanent or temporary, depending upon whether the organization wishes to focus on one problem area or on multiple problems which will necessitate a more long term effort.)*
- *Train team members in the techniques they will need to use in the CQI process: teamwork, process analysis, measurement and interpretation of data, problem-solving and monitoring activities.*

Trainer:

Point out to the group that management from the agencies represented at this training should be supportive. The trainers oriented them to quality improvement and what that entails prior to the training.

➢ Assuming you *don't* have the support of senior management, what can you do?

Appropriate responses:

- *Brief management on this training and how quality improvement can benefit the agency*
- *Give some examples of how the agency's services could be improved in ways that senior management might find attractive, e.g. reducing the time taken to serve each client, cutting costs by adopting more efficient purchasing practices or increasing client satisfaction. (It is wise to choose ideas that don't entail substantial expenditures.)*
- *Explain that CQI can reduce the number of problems confronting management*
- *Point out that this is a widely-used, modern approach to management*

Trainer:

➢ Once the team is organized and trained, what is the next step?

Appropriate responses:

- *Assist the teams to define the roles and responsibilities of each team member. Essential team roles to be assigned include leader/facilitator and recorder.*
- *Implement the process, following the steps discussed earlier.*

COMMUNITY PARTICIPATION ON CQI TEAMS

LARGE GROUP DISCUSSION

Trainer:

- Do staff working in health service delivery possess adequate information to assess, and respond to, all aspects of the QOC?

- If not, who else should have input into the CQI process?

Appropriate responses:

No. It is unlikely that health personnel have adequate information regarding certain aspects of client expectations of, and reactions to, QOC. It is important to talk with, and ***listen to****, clients and other community members, to involve community people (clients or potential clients, representatives from referral agencies, etc.) who can speak to this perspective.*

Trainer:

- How do you identify community members who would be good candidates for such a task? What criteria could be used to identify community members who could contribute to the CQI process?

Appropriate responses:

Membership on a Quality Team usually changes depending upon the quality issue being addressed. Generally speaking, participation—be it by health personnel or community members—should be based on each individual's possible contribution to the problem identification and/or problem-solving process.

Trainer:

The following questions, adapted from *Achieving Quality Through Problem Solving and Process Improvement (Quality Assurance Project)*, may help determine who may be needed on a quality team:

- Does anyone on the existing team work in the area of the process in which the problem is located?
- Is anyone on the existing team directly affected by the problem? Are others affected?
- Does anyone on the existing team have authority to make decisions related to the problem's cause?

- Does the existing team have the technical expertise to understand the cause and what might rectify it?

  If the answer to any of these questions is "no," the team should consider changing its membership and/or adding new members who meet the above qualifications.

➢ Who might be potential members of a Quality Team from ***outside*** the FP service delivery system?

Appropriate responses:

Potential members might include representatives from the health sector and/or outside it:

- *Former, current and potential clients who are articulate, objective and who would be interested in assisting in such an endeavor. They should not have personal affiliations with health personnel or others that might influence their participation.*
- *Community leaders representing women, anti-poverty groups, community organizing groups, youth groups, etc. Members should be interested in health issues and have time to devote to the Quality Team.*
- *Health workers, midwives, traditional healers, village health committee members, community advisory board members, representatives of NGOs—all of whom have contact with the community and have a focus on community health.*
- *Representatives from referral sites, such as a hospital where the clinic sends clients for certain services not available on site.*

The selection of members must always be based on individuals' potential for contributing to the problem identification and/or problem resolution processes.

Trainer:

➢ Why is community participation not always solicited and, if solicited, not always effective in helping to understand and correct problems affecting communities?

Ask each participant to note at least one reason on a piece of paper. Then ask each participant for one response, noting each on the board and eliminating duplications, until all possible responses are on the board.

Appropriate responses:

- *Health workers have a better knowledge of a community's health needs than the community does*
- *Lack of perceived usefulness of the services by the community; and lack of perceived usefulness of community input by health personnel*

- *Health personnel's resistance to new ideas and/or distrust of outsiders (the community).*
- *Cultural beliefs that prevent collective problem-solving or participation of more than traditional healers*
- *Mistrust of government and its services*
- *Blockages by local leaders who feel threatened by active community participation on behalf of the whole community*

Trainer:

Add that an additional dimension that is likely to be raised by community members participating on Quality Teams is the problem of lack of access to services. Team members from the health delivery system need to be open to hearing and confronting such challenges, and to working creatively to respond to them.

➢ How, in light of the above factors, can one build bridges between the Quality Team and the community?

Appropriate responses:

- *Hold discussions in the community regarding the community's perception of the QOC provided at clinics*
- *Invite one or more community members to participate on a Quality Team when dealing with issues affecting external clients*
- *Hold an "open house" and show community members around the clinic, explaining the purpose of equipment, etc.*
- *Meet with community organizations to get their perspective on quality improvement.*

SESSION GUIDE VII
TEAMWORK

Objectives:	**By the end of the session, participants will be able to:** ♦ Explain at least five benefits of teamwork to the improvement of quality of FP/RH service delivery ♦ Identify at least four characteristics of effective teams ♦ Describe the four stages of team development ♦ Identify at least six positive behaviors in the context of teamwork ♦ Name three general strategies for avoiding, and responding to, common barriers to communication ♦ Explain how feedback can contribute to positive group behavior in the context of teamwork ♦ Describe five ways of responding to team conflict ♦ Explain at least six common team problems and how to deal with them ♦ Name three ways to support effective teams
Methods	Large group discussion, small group work, lecturette and role play
Time:	4 hours
Materials:	**Flipcharts/ transparencies:** ♦ Positive Team Member Behaviors (FC/T VII-1) ♦ Common Team Problems (FC/T VII-2) ♦ Ways to Support Effective Teams (FC/T VII-3) **Handouts:** ♦ Characteristics of Effective Teams (HO VII-1) ♦ Benefits of Team Work (HO VII-2) ♦ Team Growth (HO VII-3) ♦ Positive Behaviors in Group Work (HO VII-4) ♦ When to Use Conflict Strategies (HO VII-5) ♦ Common Team Problems (HO VII-6)

BENEFITS OF TEAMWORK

Materials Needed:	Handouts ♦ Characteristics of Effective Teams (HO VII-1) ♦ Benefits of Teamwork (HO VII-2)

LARGE GROUP DISCUSSION

Trainer:

Refer to the previous session and to the discussion on the need for CQI teams made up of staff involved in different aspects of the program related to the potential areas of improvement. Ask the group:

➢ Why work as a team in the improvement of QOC? What benefits are there to your working as a team as opposed to each person—or each work unit—working individually on aspects of his/her tasks that need improvement?

Appropriate responses:

- *Access to greater technical skill and practical experience*
- *More comprehensive analysis and better understanding of areas of improvement by all involved, leading to:*
  - *better understanding of processes*
  - *better solutions*
  - *greater commitment to implementation of solutions*
  - *greater chance of implementation of solutions*
  - *better results*
- *Solve larger problems than one person acting alone*
- *Democratic decision-making, leading to:*
  - *greater cooperation among different types of staff*
  - *broad ownership of improvements*
- *Members gain new knowledge, insight and skills*
- *Members gain appreciation for various roles in carrying out processes*
- *Limits accusations that others cause the problems*

Trainer:

➢ Can you think of teams of colleagues with whom you currently work or have worked in the past? It doesn't matter whether the teams were productive and effective teams or dysfunctional and non-productive.

SMALL GROUP WORK

Trainer:

Divide the participants into groups of three or four people and ask them to reflect on their experiences of working in a team and to discuss the following questions:

➢ What makes a team effective? How would you define an effective team?

Appropriate responses:

- *Clarity in team goals*
- *Clearly defined roles*
- *Clear communication*
- *Positive and productive team behaviors*
- *Well-defined decision-making procedures*
- *Balanced participation*
- *Established norms*
- *Awareness of group process and stages of development*
- *Use of a scientific approach and data for decision-making*

Following the discussion, distribute the handouts, Benefits of Teamwork and Characteristics of Effective Teams.

STAGES OF TEAM DEVELOPMENT

Materials Needed:	Handout ♦ Team Growth (HO VII-3)

LARGE GROUP DISCUSSION

Trainer:

Introduce the topic by asking the group:

- Based on your experience, are teams inherently effective?
- Does it "just happen" that people work well and productively together to accomplish the task at hand?

Appropriate responses:

No. There are many things that affect the productivity of teams. Among them are problems occurring within any of the above components of effective teams.

LECTURETTE

Trainer:

Suggest that nearly all teams, including those that are very effective, pass through four basic developmental stages before becoming fully functional:

1. **Forming**. When a team is forming, members cautiously explore the boundaries of acceptable group behavior. Like hesitant swimmers, they stand by the pool, dabbling their toes in the water. This is a stage of transition from individual to member status, and of testing the leader's guidance both formally and informally.

2. **Storming**. Storming is likely the most difficult stage for a team. It is as if team members jump in the water, and thinking they are about to drown, start thrashing about. They begin to realize that the task is different and more difficult than they imagined, and become testy, anxious or overzealous.

3. **Norming.** During this stage, members reconcile competing loyalties and responsibilities. They accept the team, team ground rules (or "norms"), their roles in the team and the individuality of fellow members. Emotional conflict is reduced as previously competitive relationships become more cooperative. In other words, as team members realize they are not going to drown, they stop thrashing about and start helping each other stay afloat.

4. **Performing**. By this stage, the team has settled its relationships and expectations. They can begin performing—diagnosing and solving problems, and choosing and implementing changes. At last, team members have discovered and accepted each other's strengths and weaknesses, and learned what their roles are. Now they can swim as a team.

ROLE PLAY

Stages of Team Development

This role play requires four or five people to represent the members of a Quality Team. Each of the four scenes should be acted out for three to four minutes, with the trainer stepping in between scenes to make the transition.

Trainer:

Divide the remaining participants into four small groups and ask each group to observe one of the four scenes of the role play, focusing on:

- The feelings of the team members
- The behaviors of the team members.

Each small group should prepare to report, after the role play, on their observation of one of the scenes.

SCENE 1
First Meeting of the Quality Team

The team leader explains the problem to be solved: a high rate of Norplant® removals in the first six months of use. She says that after reviewing the data, she decided this would be the team's first quality problem to solve.

The team members are polite and ask a couple of questions.

Team member A expresses enthusiasm and optimism regarding the task.

Team member B expresses fear, shyly, that they will not find a workable solution.

Team members begin to discuss what data to collect.

{End of scene. The trainer announces Scene 2, the next meeting of the Quality Team, one week later.}

SCENE 2
The Same Team Members Meet One Week Later

The team leader indicates that the team has made some progress, but that some data are not available.

Team member A apologizes that she was supposed to help collect data but doesn't have the time. She says she is not sure she can participate because of the time commitment.

Team member B says he doubts they will find a solution to the problem.

Team member C says she is not sure the problem is even an important one.

Team member D whispers loudly to another team member that the problem is that the team leader is not qualified. An argument begins, and team member C storms out of the meeting, saying she does not have time to waste arguing over unimportant problems when she has a clinic full of clients waiting.

{End of scene. The trainer announces Scene 3, at the team meeting two weeks later}

SCENE 3
The Same Team Members Meet Two Weeks Later

Team member A points to two charts, a flow chart and a bar chart with data, reviewing the results of complete data collection. Says that since they met to discuss and redefine the problem to be solved, it allowed them to move more quickly using their quality tools to collect the needed data.

Team member B says how wonderful it is that all their work so far has paid off.

Team member C explains that she first felt encouraged by the team leader and some other members to discuss and find an agreeable resolution to their conflicts. Says now, with the data, she can see where the problem affects her clients and is sure that they will succeed in improving counseling for Norplant® clients.

The team leader praises and thanks the group for their hard work and commitment. Then points out that there are still more steps in the cycle, namely to select and test the improvement they will make. He asks whether the team members have ideas about how to do this. He facilitates a discussion of possible processes to pursue.

{End of scene. The trainer introduces Scene 4, two months later.}

SCENE 4
The Same Team Meeting Two Months Later

Team member A points to a flow chart that shows the changes that were made in establishing a private, quiet place for counseling Norplant® clients. She presents a printed brochure for clients to take home and a follow-up card to remind them when to return.

Team member B points to a bar chart that shows a decrease in Norplant® removals since the changes were made.

Team member C points out that, while this is a good success, they will have to continue to monitor to make sure the results are not lost. Jokes about the initial negative reactions when people said there would be no solution.

The team leader notes that they should think about expanding the adaptation to the whole clinic as soon as they can. The other members agree and begin to work together to plan this broad scale implementation. They agree to meet the following week and consider as a team the next quality improvement issue they want to address.

{End of role play}

As the small groups report their observations to the large group, note the key points on the board. Ensure that the most important points—see the handout on Team Growth—are brought out.

LARGE GROUP DISCUSSION

Trainer:

When all the groups have reported, return to the observations on the board.

- How can a team leader facilitate the group's functioning and progress through this stage in the team growth process?

Refer to the handout, Team Growth.

Summarize the discussion on the stages of team development:

1. When a group of people are first formed into a team, their roles and interactions are not established. Each member reacts to this situation in his/her own unique way.

2. Gradually, the process of team development occurs, as team members understand their roles, find ways to work with one another and learn about team issues. The success of this process is not automatic; it requires leadership which has an understanding and an appreciation of the process, the behaviors at

different stages in the process and how to assist members to participate productively in the process.

3. Teams may cycle through the stages multiple times, depending upon the make-up of the team (stable versus changing membership), team dynamics and the issues that they face.

4. Within teams, there are often hidden agendas or concerns that impact members' focus on the task as well as interpersonal dynamics. If not addressed, these agendas and concerns can inhibit the group's productivity.

5. Three issues common to all team development are:

   - Personal identity in the team (questions of feeling included; being heard, influence and control, etc.; getting along with other team members)
   - relationships among team members (questions of commitment, the effect of hierarchies, cooperation, openness, etc.)
   - identity with the organization (questions of loyalty to one's unit versus to the organization)

5. Initially, teams need to build understanding and support within the team, and to address the above issues as needed so that they do not become obstacles to the team's productivity.

Note to Trainer:

Knowing about the typical stages a team passes through—forming, storming, norming, performing—should relieve much of the fear team members have about the project's success. It is also helpful to be aware of the highs and lows that every team experiences.

A team's mood usually reflects its fortune: with every step forward, the future looks bright and team members are optimistic. But no matter how well a team works together, progress is never smooth. As progress swings from forward to stalled, and then from stalled to backward, the team mood will swing too. These swings are only partly linked to the stages of growth, and they are usually unpredictable.

The team begins with hopefulness and optimism. These positive feelings may last awhile, but usually change to boredom and impatience as the project gets underway. Members begin to feel overwhelmed when they realize just how much they have to learn about making improvements. Somewhere in here the storming starts.

When they finally begin collecting data, team members again feel encouraged—at least they are making progress! Rarely does this elation last: since few people are experts in scientific methods the first time out, team members almost always uncover mistakes in data collection procedures, and realize they must go back and do it again. The mood swings down. Recovery comes as the team learns from experience, makes another attempt, and gathers good reliable data.

The pattern is different for each team. Team members' attitudes depend on both the speed of progress and the resistance or encouragement they receive from their manager or supervisor.

The best way to deal with this process is to understand and accept it with a "this too shall pass" attitude. Changes in attitude, just like growth stages, are normal. The team must cultivate patience. Eventually, everyone will better understand how the work unfolds and will be able to set a more realistic pace.

Teams can also take a more active approach to dealing with the stages they experience by learning when and how to avoid or work through group problems.

Distribute the handout, Team Growth.

POSITIVE BEHAVIORS IN GROUP WORK

Materials Needed:	**Flipchart/transparency** ♦ Positive Team Member Behaviors (FC/T VII-1) **Handout** ♦ Positive Team Member Behaviors (HO VII-4)

LARGE GROUP DISCUSSION

Trainer:

Suggest to the group that as people come together in the context of a team, certain roles and behaviors develop, often as a function of people's personalities and prior experience in similar situations. Some people are very goal-oriented while others are focused on interpersonal issues.

Post the flipchart, Positive Team Member Behaviors.

➢ What do each of these mean? Please explain.

Appropriate responses: (*in italic*)

1. **Suggest methods or procedures**

   Suggest ways of doing things; step in to move the discussion forward; use of methods such as brainstorming, etc.

2. **Seek information or opinions**

   Draw out relevant information, opinions, ideas, suggestions, or concerns from team members. Ask questions to invite others' ideas.

3. **Give information or opinions**

   Share relevant information, opinions, suggestions and concerns.

4. **Encourage others**

   Friendly, warm and responsive; use eye contact and "uh-huhs" to support others' participation.

5. **Reduce tension**

   Reduce tension by using humor appropriately; get the group to laugh; admit errors.

6. **Clarify and elaborate ideas**

Clear up confusion; give examples; point out issues and alternatives; share interpretations of what has been said; build on what others have said.

7. Summarize

Pull together what has been said; organize related ideas; integrate different ideas; offer conclusions for the team to consider.

8. Check decisions

Note when the group is making a decision and state the decision for the group; check to be sure the decision method is acceptable; check to be sure the decision has been well thought through.

9. Resolve disagreements

Work out disagreements; look for ways to address objections and concerns; incorporate others' ideas into proposals.

10. Notice group feelings

Sense and express team feelings and moods; aware of significant shifts in tone and help the team be aware of such shifts.

Trainer:

- How is an appreciation of team members' behavior useful to team members, especially to the leader?

Appropriate responses:

Understanding team members' behavior:

- *Helps members identify patterns of interaction occurring in the group and, therefore, be better able to promote the positive and deal with the negative*
- *Gives team members an awareness of skills which they may be trying to develop themselves*

Trainer:

Distribute the handout, Positive Team Member Behaviors.

TEAM COMMUNICATION

Trainer:

Introduce this brief overview of obstacles to communication within teams by suggesting that:

- The quality of a team's work, to a large extent, depends upon the quality of information they share and their ability to share it effectively

- Often within a team, there are individuals who do not share the positive behaviors discussed above but rather present obstacles to effective communication

Obstacles or barriers to communication within teams

ROLE PLAY

Communication on a Quality Team

Ask for four volunteers to conduct a brief role play with four participants representing members of a Quality Team. The role play can be on any topic, e.g., a brainstorming to identify quality problems. During the brief (five minutes or less) role play, demonstrate as many of the following obstacles as possible.

- Premature evaluation
- One (or more than one) member dominating the discussion
- Interruptions (from within or outside the group)
- Unsolicited advice
- Giving orders
- Not respecting others' opinions or expressing judgments about them
- Moralizing
- Asking unnecessary and/or indiscreet questions
- Expressing psychological explanations about another's input/participation
- Confusing fact with opinion

Ask the group to watch the role play and to make a note of the obstacles they observe.

LARGE GROUP DISCUSSION

Trainer:

➢ What obstacles did you observe during the role play?

Appropriate responses:

Responses will vary, depending upon what the individuals conducting the role play demonstrate

Trainer:

- How can your knowledge of obstacles to communication within teams help you when working with a team?

Appropriate responses:

- *Knowledge of communication obstacles helps individuals to understand the dynamics of working together, why certain people act in certain ways and why others react in other ways*
- *The ability to recognize obstacles to communication enables team members to develop strategies for dealing with them*

Trainer:

- How can you help avoid, and overcome, some of these obstacles?

Appropriate responses:

- *Monitor your own participation and attempt not to contribute to such obstacles*
    - *wait before making a judgment*
    - *pay careful attention to the speaker*
    - *be conscious of the feeling of the speaker and other listeners*
    - *listen and, if appropriate, take notes*
    - *test and confirm whether they have understood the message*
    - *ask questions to clarify points that are not clear*
    - *make helpful suggestions*

- *Be aware of, and indicate, what you are communicating:*
    - *if communicating facts, indicate "The facts are --"*
    - *if communicating feelings, indicate "I feel --"*
    - *if communicating values, indicate "To me -- "*
    - *if communicating options, indicate "In my opinion –"*

- *Assist colleagues in maintaining their objectivity by asking open and objective questions, as appropriate, to clarify points and to redirect discussions as necessary; and by attempting to model the more positive behaviors discussed above in Positive Behaviors in Group Work.*

- *Respect the rules for giving and receiving feedback. In so doing, feedback becomes an important tool for acknowledging positive behaviors and for helping team members to recognize the effects of negative behaviors.*

TEAM CONFLICT

Materials Needed:	Handout ♦ When to Use Conflict Strategies (HO VII-5)

LARGE GROUP DISCUSSION

Trainer:

Suggest that in addition to obstacles to communication, other factors may also create conflict within teams:

> **Personality:** For example, members who are extroverted or introverted; who make decisions based on facts and logic or on intuition and feelings; or who are spontaneous versus methodical in their work.
>
> **Values:** For example, members who value collaboration versus members who value competition.
>
> **Perspective:** Different ways of seeing and experiencing the world.
>
> **Goals:** Personal agendas that may be different from team goals.
>
> **Culture:** Diversity of backgrounds, cultural attitudes, values and beliefs.

➢ How does conflict affect the effectiveness of a team?

Appropriate responses:

- *Conflict is a normal occurrence and at times useful to stimulate creativity and innovation*
- *Conflict is a way in which problems can be discussed and tensions released*
- *Conflict can improve the quality of decision-making by allowing different points of view to be considered*
- *Conflict can be an obstacle to productive team work*

LECTURETTE

Trainer:

Suggest that when conflict becomes an obstacle to productive team work, it requires a strategy for effective resolution. The ability to resolve team conflict is an important skill that team members can develop.

Briefly review the following strategies for responding to conflict, and when they are appropriate:

Avoiding the conflict. Distract attention from issues that are likely to lead to conflict or avoid them completely.

> May be appropriate when: the issue is trivial/ irrelevant, people need to be allowed to cool down and regain perspective, you need more time to gather information, others can resolve the conflict more effectively.

Accommodation. The desire to please others at the expense of one's own needs.

> May be appropriate when: you find that you are wrong; issues are more important to others than to you; you want to build social support for later use; you want to allow other team members to develop by learning from mistakes.

Forcing the conflict. Overpower others and force them to accept your position. Competitive win-lose approach.

> May be appropriate when: quick, decisive action is necessary; the issues are important and unpopular actions need to be implemented; other options are not possible.

Compromising. Try to get others to give up some of what they want in exchange for giving up some of what you want. May be a lose-lose strategy if no one's goal is achieved.

> May be appropriate when: goals are important but not worth disruptions; you need an expedient solution under time pressure; or you need another strategy because other strategies have not worked.

Problem-solving through the conflict. Win-win approach. Find the path that meets everybody's goals and, by doing so, preserve group relationships.

> May be appropriate when: you need to find an integrative solution and both sets of concerns are too important to be compromised; you need to merge insights from people with different perspectives; you want to gain commitment by incorporating concerns into a consensus decision; you want to work through feelings that have interfered with a relationship.

Distribute the handout, When to Use Conflict Strategies, as a reference for participants.

COMMON TEAM PROBLEMS

Materials Needed:	**Flipchart/Transparency** ♦ Common Team Problems (FC/T VII-2) **Handout** ♦ Common Team Problems (HO VII-6)

LECTURETTE AND SMALL GROUP WORK

Trainer:

Review with the group the following common problems in teamwork. Distribute the handout and use the flipchart as a guide.

Following the review, divide the group into five small groups and ask each group to discuss and present to the large group how they would deal with two of the following problems within the context of teamwork:

- Floundering
- Overbearing participants
- Dominating participants
- Reluctant participants
- Unquestioned acceptance of opinions as facts
- Rush to accomplishment
- Attribution of motives
- Discounts others
- Digression and tangents
- Feuding team members

Floundering:

Teams may experience problems starting or ending a task or moving between different steps of a task. At the beginning, they may experience directionless discussions or activities. As the team progresses, some team members may resist moving from one step to the next. At the end, teams may delay unnecessarily, postponing decisions or conclusions.

- At the beginning of a task or project, floundering may suggest that the team is either unclear about or overwhelmed by its task; or that team members are not yet comfortable enough with each other to engage in real discussion or decision making.

- When trying to make decisions, floundering may indicate that the team's work is not really the product of consensus, and that some members are reluctant to say they don't support the team's decisions/conclusions.

- After completing one part of a project or task, floundering may indicate that the team does not have a clear plan and does not know what to do next.

- At the end of a task or project, floundering may indicate that the team members have developed a bond and are reluctant to separate; or that they are reluctant to expose their work to review and possible criticism from others.

Deal with floundering by:

- Reviewing the work plan, or creating a plan if there isn't one.
- Asking the team what they need to do so they can move on; what is holding them up (data, knowledge, support, feelings, previous unfinished business).
- Suggesting that everyone write down, and share, what they think is needed to move to the next stage.

Overbearing Participants:

Overbearing participants exert an unusual amount of influence in a team, often a function of their position of authority or area of expertise. This may be detrimental when the person:

- Discourages or forbids discussion concerning his/her area of authority or expertise

- Signals the "untouchability" of an area/topic by using technical jargon and/or holding up certain standards, regulations or policies as untouchable

- Regularly discounts any proposed activity by declaring that it won't work

Deal with overbearing participants by:

- Reinforcing the agreement that no area is sacred; that team members have a right to any area that concerns the situation they are examining and trying to resolve
- Asking the overbearing person to agree (in advance if possible) to the importance of everyone's participation and access to all relevant information
- Talking to him/her privately and asking for cooperation and patience
- Enforcing the primacy of data and the scientific approach

Dominating Participants:

Dominating participants, with or without authority, consume a disproportionate amount of time talking. This frustrates other team members and prevents the team from building a sense of momentum or accomplishment.

Deal with dominating participants by:

- Structuring members' participation in discussions (by having each one write down and share his/her ideas)
- Raising the "balance of participation" as a concern during the evaluation of meetings
- Practicing gatekeeping: "We've heard from you on this. I'd like to hear what others have to say."
- Asking the team to agree on the value of balanced participation and the need for limits and focus in discussions

Reluctant Participants:

Reluctant participants (those who never speak) generally feel shy or unsure of themselves and must be encouraged to contribute.

Deal with reluctant participants by:

- Structuring discussion to encourage participation by everyone
- When possible, dividing the task into individual or small group assignments and reports
- Practicing gatekeeping: asking if anyone else has ideas about the topic at hand (while looking at the reluctant participant); or more directly asking the individual if he/she has experience or ideas to contribute

Unquestioned Acceptance of Opinions as Facts:

Some team members express personal beliefs and assumptions with such confidence that others assume they are hearing a presentation of facts and may be reluctant to question such self-assured statements. They may feel they need data before challenging such statements.

Deal with unquestioned acceptance of opinions as facts by:

- Asking the presenter if what they said is opinion or fact and if they have supporting data

Rush to Accomplishment:

Often at least one member is impatient for results and unwilling to work through the necessary steps of the process. This may lead the team to hasty and unfounded decisions.

Deal with rush to accomplishment by:

- Reminding the team of the rationale for following the CQI process
- Making sure the team leader is not among those exerting pressure

- Giving constructive feedback to the "rusher," including examples of his/her behavior and its effects on the team's work

Attribution of Motives.

Attribution of motives to people when one doesn't understand, or agree with, their opinion or behavior. This often leads to resentment.

Deal with attribution by:

- Checking it out within the group, asking those to whom the motives were attributed to share their perception of the situation and/or the basis for their opinion or behavior

Discounts Others:

Discounting others, ignoring or ridiculing another's contributions, makes him/her feel discounted or unimportant. This may happen if the contribution was irrelevant to the topic or was not clearly stated, or if others missed the meaning of the statement. Feeling discounted often leads to frustration and/or withdrawal. The contributions of all team members need to be acknowledged and some may need assistance in articulating what is important to them.

Deal with discounting by:

- Helping team members learn to listen actively to what others are saying
- Supporting the discounted person, acknowledging what they have contributed
- Giving constructive feedback to individuals who frequently discount, put down, or ignore others' comments

Digression and Tangents.

Digression and tangents lead to wide-ranging, unfocused conversations. Although there is a natural tendency to stray from a subject, it often occurs when team members lose track of their purpose or want to avoid a sensitive topic.

Deal with digression and tangents by:

- Using a written agenda (individual copies and/or a flipchart) with time estimates for each item; refer to the topic and time when the discussion strays too far
- Directing the conversation back on track
- Acknowledging difficulty in sticking to certain topics and asking what makes the topic so easy to avoid

Feuding team members:

Feuding team members can disrupt an entire team with their disagreements. Such conflicts often existed prior to the formation of the team and will likely outlast it, too.

Deal with feuding team members by:

- Preventing its occurrence by selecting team members so that adversaries are not on the same team if possible
- If confrontations occur during team activities, ask that they deal with their differences outside of the team's work; offer to facilitate the discussion
- Push them to adopt ground rules for managing their differences without disrupting the team

WAYS TO SUPPORT EFFECTIVE TEAMS

Materials Needed:	Flipchart/Transparency ♦ Ways to Support Effective Teams (FC/T VII-3)

LARGE GROUP DISCUSSION

Trainer:

End the session with a brief discussion of ways to support effective teams. Post a flipchart/transparency of the following three strategies and ask the group to explain what each means and how it might apply to their work as team leaders.

1. Focusing attention on a clear set of goals and priorities

2. Leading others by example. Model appropriate behavior (respecting, supporting, listening, communicating, collaborating and being sensitive to the needs of all team members).

3. Balancing the heart and mind. Create a balance between how you think and how you feel in working with teams.

(Much of the material in this section is adapted from Peter R. Scholtes, Brian L. Joiner and Barbara J. Streibel, "The Team Handbook," Second Edition, Madison, Wisconsin, 1996, chapters 6 and 7. © 2000 Oriel Incorporated. All Rights Reserved. Used here with permission.)

SESSION GUIDE VIII
PREPARING TO IDENTIFY QUALITY PROBLEMS AT THE PARTICIPANTS' WORK SITES

Objectives:	By the end of the session, participants will be able to: ♦ Outline their plans to establish a Quality Team in their agency/facility. ♦ Outline their plans to identify a QOC problem in their agency/facility, using simple data collection techniques. ♦ Present their plans to establish a Quality Team and identify a QOC problem
Methods:	Small group work and lecturette
Time:	2 hours
Materials:	None

PLANNING TO IDENTIFY QUALITY PROBLEMS

SMALL GROUP WORK

Trainer:

Ask participants to work in teams with colleagues from the same agency/facility to:

- Outline a plan for establishing a Quality Team at their worksite that includes:
  - Obtaining approval to proceed (if necessary)
  - Identifying potential members of the team
  - Orienting team members to QOC

- Outline a plan to identify a QOC problem in their agency/facility, using simple data collection techniques. For purposes of this exercise, suggest that the groups make a preliminary identification of an aspect of service delivery that needs improvement and organize their plans around that. The plans should:
  - Make a preliminary identification of a QOC problem
  - Identify tools and techniques to be used to make a firm determination about the problem and to measure baseline levels
  - Include strategies for applying these tools/techniques (including who will do the work, when and where, and how any additional resources that might be needed will be mobilized)
  - Plan for analyzing the results
  - Include time-lines and the names of persons responsible for carrying out key activities.

Each team presents to the large group its plan for a Quality Team and to identify a problem in the QOC.

Trainer:

Encourage group members to give feedback as appropriate. Clarify any points as necessary.

Ask if there are any questions about any of the material covered thus far during the training.

WRAP-UP OF PART I

LECTURETTE AND DISCUSSION

Trainer:

Explain to participants that Part II of the training will focus on analyzing the data they collect in the next few weeks.

Ask the participants to bring back to Part II of the training:

- The tools they used to identify quality problems
- The raw data collected, both to verify the problem and to provide baseline levels. This includes questionnaires from client exit interviews, notes from focus group discussions, tables from client flow analyses, etc. Remind the group that they may want to collect both quantitative *and* qualitative data, in order to get good information on the problem. In Part II it will be beneficial if they have collected some *quantitative* data.
- Any analysis of the data they undertake prior to Part II of the training.

Remind the group that the focus of Part I of this training has been on QOC concepts, Step 1 of the CQI process, and on team-building.

Invite participants to apply the knowledge and skills they have gained to:

1. Begin the quality improvement process at their agency/facility

2. Begin the process of making others in their agency/facility aware that quality improvement is a continuous process that involves everybody, from the manager to the janitor.

Suggest that in the second part of the training (to occur six to eight weeks following the initial training), participants will work with the data they will have collected regarding QOC problems in their work sites and begin developing solutions to the problems.

During Part II, participants will also learn how to determine if they have *really* managed to improve the QOC after going through their first quality improvement cycle.

END OF PART I OF THE TRAINING

SESSION GUIDE IX
PROBLEM ANALYSIS

Objectives:	**By the end of the session, participants will be able to:** ♦ Give four reasons why data analysis is important in CQI ♦ Describe six CQI tools/techniques useful for analyzing data regarding QOC problems and the purpose of each tool/technique ♦ Analyze data collected since Part I of the training
Methods:	Lecturette, discussion, group work, small group work and presentations
Time:	8 hours
Materials:	**Flipcharts/transparencies:** ♦ Sample Criteria for the Selection of Quality Problems (FC IX-1) ♦ Mamba District, Findings from Exit Interviews and Focus Groups (FC IX-2a-d) **Handouts:** ♦ Schedule for Part II of the Training (included as handout I-2b for Session 1) ♦ Reasons Given by Clients for Not Returning (table) (HO IX-1) ♦ Bar Charts, Line Graphs and Pie Charts (HO IX-2) ♦ Decision Matrix (includes sample criteria for selection of quality issues and solutions) (HO IX-3a and b) ♦ Pareto Analysis (HO IX-4) ♦ Cause-and-Effect diagrams (HO IX-5 and 5a) Calculator (for the group working on pie charts)

INTRODUCTION

Materials Needed	Handout:
	♦ Schedule for Part II of the training (included as handout I-2b for Session I)

LARGE GROUP DISCUSSION

Trainer:

Welcome the participants back to the training and briefly review with them the schedule for Part II. Ensure that everybody has a copy of the schedule. Remind them of the norms/expectations outlined in Session I.

Lead a general discussion on the participants' experiences since Part I of the training in forming Quality Teams and applying the CQI tools for problem identification.

Start the discussion by asking about their experiences with forming and working with a Quality Team:

- What types of people did they include on the team? Did they include any clients, community members or representatives from community agencies? Did they have any difficulty recruiting people?
- What went well with the team-building process?
- Did any of them get past the Forming stage? Past the Storming stage?
- Did any of the techniques for dealing with teams that were discussed during Part I prove useful?
- What difficulties/problems did they encounter?

Ask about their experiences using the CQI tools:

- Which tools did they use?
- How useful were they?
- What problems did they encounter?
- How did other members of the Quality Team react to the tools?

Before moving on, offer to review any of the material from Part I that participants feel needs further clarification.

PROBLEM ANALYSIS

Materials Needed:	**Flipcharts/Transparencies** ♦ Sample Criteria for Selection of Quality Problems (FC IX-1) ♦ Mamba District, Findings from Exit Interviews and Focus Groups (FC IX-2a-d) **Handouts** ♦ Reasons Given by Clients For Not Returning (table) (HO IX-1) ♦ Bar Charts, Line Graphs and Pie Charts (HO IX-2) ♦ Decision Matrix (H IX-3a and b)

Trainer:

Explain to the group that this session will link Step 1 of the CQI cycle, problem identification, with Step 2, finding the underlying causes of a problem. They will be looking at:

- Ways to present data in a user-friendly way
- Prioritizing problems
- Identifying the underlying causes of a problem.

Presentation of Data: Bar Charts, Line Graphs and Pie Charts

Try to find out before the start of Session IX whether any of the groups have brought back good quantitative data from the field (e.g., from client exit interviews or counseling observation). If so, use that data for this exercise. If not, use the data from the handout on Reasons Given by Clients For Not Returning.

Point out to the group that it is easy to be overwhelmed by data, so that people often miss the important points to emerge from data collection. State that there are ways to present data in a user-friendly format. These include bar charts, line graphs and pie charts—which may already be familiar to many of the participants.

SMALL GROUP WORK

Divide the participants into three groups, giving each one the data brought back from the field by one of the groups (or the handout on Reasons Given by Clients For Not Returning) and the handout on Bar Charts, Line Graphs and Pie Charts.

- One group works on developing a bar chart, using the data
- One group works on developing a line graph, using the data
- One group works on developing a pie chart, using the data

If possible the group working on a pie chart should have a calculator to help calculate percentages.

LARGE GROUP DISCUSSION

The small groups display their charts and graphs to the large group, which examines them to see if they are accurate.

Trainer:

Ask the groups if they would have any difficulty presenting the data they collected back home in one of these formats. If so, help them determine how to present the data. Depending on the time available, this can be done with the whole group as part of the workshop. Alternatively, it can be done (with either the large group or the small group involved) during a break or at the end of the day.

Prioritizing Problems: The Decision Matrix

LARGE GROUP EXERCISE

- When you were back at your work sites in recent weeks, did anyone identify more than one quality problem that they thought should be addressed?

Explain that, in this situation, a decision matrix can be a useful tool.

Take participants through the following exercise to familiarize them with the use of a decision matrix.

- How should the Quality Team should decide which problem to pursue first, in a situation where they have identified more than one important problem?

Appropriate responses:

They may need to develop a list of criteria to guide them in this choice

Trainer:

- What criteria would be useful and valid in selecting priority processes/issues/problems to work on?

Appropriate responses:

- *The issue is important to external clients; improvement in this area can have high external impact*
- *The issue is important to internal clients; improvement in this area can have high internal impact*
- *A problem has existed for some time and is widespread*
- *The benefits from addressing this issue are obvious; the process has high visibility*

- *The issue is within the Quality Team's control and authority*
- *Management and the team are technically capable of making changes in this program area*
- *Support for change exists in this area. Management and those involved in the process recognize the need for change and are committed to it*
- *There are risks associated with not addressing this issue*
- *The problem undermines/affects the achievement of program objectives*
- *The issue can be quickly resolved*
- *Data on this issue are readily available*
- *Resources are available for making changes*

Trainer:

As participants suggest criteria, note them on flipchart paper. If they do not name all of the above criteria, post the flipchart, Sample Criteria for Selection of Quality Problems, and review it with them.

From the list of criteria, help the participants narrow the list to a maximum of four criteria which they consider most important. Suggest that they use numerical values to indicate the most important criteria. Each person individually indicates which four he/she finds most important, using the following scoring values:

- 4 indicates the most important criterion
- 3 indicates the second most important
- 2 indicates the third most important
- 1 indicates the fourth most important

Add up the scores of *all* team members for each criterion to identify the most pertinent criteria. The criterion with the highest score is the one the group views as the most important. If there are tie scores, repeat the prioritization exercise using only the criteria that tied.

Use flipchart paper to construct a decision matrix of problems identified by the group and criteria for selection (see the Decision Matrix handout). Using the matrix, help the group choose a single quality problem that represents the consensus of the group.

Review with the group the process they have just been through and distribute the Decision Matrix handout.

PRACTICAL EXERCISE

Materials Needed:	Handouts ♦ Pareto Analysis (HO IX-4) ♦ Cause-and-Effect Diagrams (HO IX-5, 5a and 5b)

Identifying the Root Cause(s) of a Problem: Cause-and-Effect Diagrams and Pareto Analysis

Trainer:

Present the following tools, including a brief description of each, its purpose, the process for using it and an example of its use in data analysis (see handouts Cause-and-effect Diagrams and Pareto Analysis for details).

Pareto analysis helps to identify the relatively few factors responsible for producing most of the problems in a process, so that quality improvement resources can be concentrated in those areas. The Pareto principle states that 80 percent of the trouble comes from 20 percent of the problems. Pareto analysis helps the Quality Team see the frequency of different causes of a problem, ordering from highest to lowest in terms of the number of occurrences.

Cause-and-effect diagrams are a graphic representation of people's ideas about the causes of a problem. They help the Quality Team consider the complexity of a problem and identify the primary and secondary causes. One application of the diagram could be to analyze why FP clients do not return for follow-up visits.

SMALL GROUP WORK

Trainer:

Divide the group into four workgroups. Ask two groups to read about and report back to the large group on the cause-and-effect diagram and two groups to do the same for Pareto analysis. The groups working on Pareto analysis can work with the same data used for charts and graphs earlier in this session, i.e., either data brought back from the field or data from the handout, Reasons Given by Clients For Not Returning.

The same guidelines used in Session V for the work groups on CQI tools apply for this exercise:

- Distribute the handouts explaining the CQI tools
- Work in small groups to prepare presentations following the four points cited below
- Report back to the large group

When reporting back to the large group, each work group should:

- State the purpose of the tool
- Give a brief description and show the group what the tool looks like
- Outline the main steps in using the tool
- Give a brief example of how it could be used in a specific situation.

Any differences between their descriptions of the tools are discussed and resolved.

Be sure to discuss the difference between a bar chart and Pareto analysis.

(The descriptions of the CQI tools and techniques and their use that are presented in this session are adapted from "Using CQI to Strengthen Family Planning Programs" and "Manager's Toolbox for CQI," The Family Planning Manager and "Achieving Quality Through Problem Solving and Process Improvement," The Quality Assurance Project (see bibliography.)

CASE STUDY (PART II)

Identification of the Main Causes of the Problem

Trainer:

Review with the group the actions and decisions of the Mamba District Quality Team in Part I of the Case Study for the Application of the CQI Process (See Session V).

Part II of the case study will take the group through the problem analysis process and use of the cause-and-effect diagram.

Post the findings of the exit interviews and focus group discussions (see flipcharts) on the wall.

Brainstorm with the group to determine the major quality problems that emerged from the exit interviews and from each set of FGDs, noting appropriate suggestions on flipchart paper.

Add to the list generated by the group the quality problems that were identified by the Mamba District Quality Team (below). That team decided that two quality problems—and a number of causes for those problems—emerged from the exit interviews and FGDs:

1. **Utilization of FP is low**
   - There is a lot of misinformation about FP in the community
   - Clinic hours are inconvenient
   - FP should be available when women come for other services

2. **Many clients fail to return for follow-up visits**
   - Clients lack information about the importance of follow-up visits
   - Clients lack information about when they should come for follow-up visits
   - Health center staff do not have good information about when clients should come back for follow-up visits

- Clinic hours are inconvenient
- The system for follow-up by community health volunteers isn't working
- IEC materials, which include information about follow-up, are out of stock

The Mamba District Team decided that the follow-up system needed to be addressed first, since it was counter-productive to increase utilization of services until an effective system for follow-up was developed.

They also constructed a cause-and-effect diagram to help them determine all the possible causes of the follow-up problem and to identify solutions.

LARGE GROUP EXERCISE

This exercise will allow participants to experience using the Cause-and-Effect Diagram.

Trainer:

Construct a cause-and-effect diagram on a board or on two pieces of flipchart paper (taped together). In the box at the head of the "fishbone," write: many clients fail to return for follow-up visits.

Make four main "bones": clients, providers, materials and systems.

With the entire group, fill in all the possible causes of the follow-up problem in Mamba District, starting with the causes identified by the Mamba District Quality Team above. (See handout IX 5-b Sample Cause-and-Effect Diagram Mamba District) for an example of a completed cause-and-effect diagram addressing clients' failure to return for follow-up visits.)

Other Tools That Can Help Identify Causes of Problems

LARGE GROUP DISCUSSION

Trainer:

Review with the group the tools introduced in Session V, discussing which could be used to identify the causes of a quality problem.

- Client exit interview
- FGDs (point out that these are particularly valuable because they *describe* problems)
- Facility audit
- Flow chart
- Client flow analysis
- Observation of counseling

Analysis of Participants' Own Problems

SMALL GROUP WORK

Participants work in their organizational teams to analyze the data they collected between Parts I and II of the training:

- They analyze the data they collected and prepare charts or graphs with key data. In the case of qualitative data, they prepare a list of the key points
- They prioritize the problems they identified, using a decision matrix or Pareto analysis
- They state the quality problem clearly and concisely
- They identify the major cause(s) of the problem

Trainer:

Circulate and assist the groups as necessary to ensure that their problem analyses are adequate and that their problem statements are clear.

After the teams have completed their analyses and defined their problems, each team presents to the large group, which asks questions/provides feedback as appropriate. The presentations should be arranged around the following topics:

- The problem statement
- Analysis of the quality problem
- The major cause(s) of the problem
- The process and tools used to identify the priority problem and the major cause(s).

SESSION GUIDE X
DEVELOPING SOLUTIONS AND MEASURING RESULTS

Objectives:	**By the end of the session, participants will be able to:** ♦ Describe nine components of a Quality Action Plan ♦ Develop a Quality Action Plan to address the quality problem they identified at their own worksite ♦ Identify indicators to measure quality improvement at their own worksite
Methods:	Lecturette, discussion, case study and group work
Time:	7 hours
Materials:	**Flipchart/transparencies:** ♦ Components of an Action Plan (FC/T X-1) ♦ Mamba District, Findings from Exit Interviews and Focus Groups (FC IX-2a–d from Session IX) ♦ Achieving Results with CQI (FC/T X-2) **Handouts:** ♦ Components of an Action Plan (HO X-1) ♦ Sample Cause-and-Effect Diagram, Mamba District (HO IX-5b from Session IX) ♦ Blank Quality Action Plan (HO X-2) ♦ Mamba District Quality Action Plan (HO X-3) ♦ Achieving Results with CQI (HO X-4) ♦ Post-test (included as handout I-4 in Session I)

DEVELOPING SOLUTIONS

LECTURETTE

Trainer:

Developing an effective solution is *the* most important part of the quality improvement cycle. It's also the part that is hardest to teach because there is no formula for a good solution. The key to success, however, is to identify and address the main cause(s) of the problem.

In many situations, it may be advisable to implement the solution on a small scale first in order to determine whether it is likely to succeed. Once any problems in implementation have been identified and rectified, the plan can be implemented on a larger scale—or an alternative plan can be adopted. Small-scale implementation may be wise, for example, in situations where the solution is costly, where it may be controversial with the staff involved or where the Quality Team is unsure which of several possible solutions to use.

The development of a Quality Action Plan setting out the activities involved in implementing the solution is helpful for many reasons. For example, it helps ensure that all activities necessary to implement the solution are identified; it helps Quality Team members feel accountable for certain activities; and it helps determine whether and where funding might be needed.

As the plan is implemented, the Quality Team may want to meet periodically to monitor progress and address any problems that may arise. For longer-term quality improvement plans, the Quality Team may want to collect and review data on an interim basis to get some indication of whether the plan of action is likely to solve the problem.

The Quality Team should not let its hands be tied by the Quality Action Plan. Plans often need to be changed as implementation of the solution moves forward.

COMPONENTS OF AN ACTION PLAN

Materials Needed:	Flipchart/Transparency ♦ Components of an Action Plan (HO X-1) ♦ Mamba District, Findings from Exit Interviews and Focus Groups (FC IX-2a–d from Session IX) **Handouts:** ♦ Components of an Action Plan (HO X- 1)

LECTURETTE

Trainer:

Distribute the handout, Components of an Action Plan, and show the matching transparency. Review the components with the group, discussing the purpose and content of each component.

1. Introduction:

Describes the setting in which the quality problem occurs

Purpose:

- Clarifies the context of the action plan for anyone reading it

Content:

- The context to which the action plan applies, that is, the local FP service or health center, district FP program or national FP program (depending upon the setting within which the identified problem occurs)
- Characteristics of the setting (service, institution or program) relevant to the identified problem: brief history, policies, resources, services offered, relevant service statistics, etc.

2. Problem Statement

A problem statement is a statement describing precisely how QOC is deficient. It describes the gap between what is happening and what should happen; between actual performance and desired performance as defined by program guidelines and standards, and/or by client expectations. It should relate to the quality of services (quality in fact or quality in perception) or the health of the population being served and should refer to specific processes or activities where improvement is needed, so that the improvement effort is focused and measurable. A problem statement should *not* state the cause of the problem, propose a solution, nor affix blame.

Purpose:

- To make clear for all concerned the problem to be addressed and corrected by the action plan
- To guide the development and implementation of the action plan—to keep it focused
- To assist in the evaluation of the action plan and its implementation

Content:

- States the gap that exists between what is expected to happen (i.e., the program standard, the process as outlined in protocols, the ideal situation articulated by clients, the community, staff or others) and what is actually happening (i.e., the current situation). The formulation of a problem statement assumes a clear definition of the desired process/outcome as well as of each step of the process.

3. Theory of Cause

Purpose:

- Provides the focus for the objective(s) of the action plan

Content:

- Explanation of one or more reasons why the problem exists, based on data the Quality Team has collected and analyzed. There will likely be a primary (direct) cause and secondary (indirect) causes.

4. Objective(s)

Purpose:

- To state the result to be obtained from the quality improvement effort
- To determine the activities to be undertaken

Content:

- The status or result to be achieved at the end of the quality improvement effort
  (*not* the activities that lead to that status/result)
- The opposite of the problem statement
- Must be realistic, given the resources available (or likely to be available)
- Must be measurable

5. Activities

Purpose:

- To set out what will be done to address the causes of the problem and achieve the result laid out in the objective

Content:

- One or more clearly defined activities that will eliminate or reduce the causes of the QOC problem. Generally, a combination of several activities is required to achieve each objective.

6. Time Frame

Purpose:

- Indicates for all concerned when each activity should take place. The time frame allows those concerned to plan for the implementation of quality improvement activities within their existing schedules
- Sequences all activities in a logical order and over a period of time that is realistic, given the resources available
- Facilitates the provision of resources as necessary

Content:

- For each planned activity, the start time and end time is indicated (this may be in weeks, months or quarters of the year)

7. Person(s) responsible

Purpose:

- To assign responsibility and accountability for the accomplishment of each activity (even though activities may actually be implemented by several people)
- To ensure that activities are implemented
- To help management and other personnel know who to address regarding particular activities

Content:

- For each activity, the name or job title of the person responsible for carrying out the activity is indicated.

8. Indicator(s) and Methodology for Measuring Them

Purpose:

- To determine whether, and to what extent, the objective has been attained and the QOC problem solved or ameliorated.

Content:

- A measure (ideally in quantitative terms) of the aspect of QOC that is being improved
- A methodology (i.e., the tool to be used) for measuring whether the objective has been achieved

NOTE: It is important to remember to include *activities to measure the indicators* in the Quality Action Plan, along with timelines, persons responsible and a budget.

9. Budget

Purpose:

- Forces the Quality Team to think through each activity in detail

- Provides an indication of whether planned activities are financially feasible and whether additional funds are needed
- Helps maintain an agency's commitment to make available the funds allocated for planned activities
- Helps managers differentiate between essential and nonessential activities and give essential activities higher priority
- Allows managers to evaluate the actual cost of activities and to consider alternatives if planned activities are too costly

Content:

- Identifies all inputs (personnel time, equipment, supplies, etc.)
- Identifies the cost of each input (consulting those responsible for finance, as necessary, to verify costs, existing financial resources, etc.)

NOTE: In most cases, planned expenses must be met through the existing program budget. Study the budget for the specific program component addressed in the quality action plan to determine where expenses for quality improvement activities can be charged.

CASE STUDY (PART III)

Development of a Quality Action Plan

Trainer:

Display the flipcharts with data from Mamba District and the cause-and-effect diagram developed by the group (or the handout). Work with the group to develop a Quality Action Plan for Mamba District based on the problem and the most important causes of the problem identified by the team in Part II of the case study: many clients fail to return for follow-up visits.

Ask the group to complete the list of activities, along with the timeline, persons responsible and budget.

➢ How will you know whether your efforts have been successful?

Appropriate responses:

- *Follow-up will have improved, as measured by follow-up statistics/continuing users*
- *The measures in the client exit interviews related to clients' knowledge of when to return for routine and non-routine visits should have improved;*
- *FGDs should show improved knowledge among providers and clients of when follow-up visits should happen.*

The group should conclude that the same tools used to identify the quality problem can be applied again to see if the situation has improved.

DEVELOPMENT OF QUALITY ACTION PLANS FOR PROBLEMS IDENTIFIED AT PARTICIPANTS' WORK SITES

Materials Needed:	**Flipchart/Transparencies** ◆ Achieving Results with CQI (FC/T X-2) **Handouts:** ◆ Blank Quality Action Plan (HO X-2) ◆ Mamba District Quality Action Plan (HO X-3) ◆ Sample Cause and Effect Diagram Mamba District (HO IX-5b from Session IX) ◆ Achieving Results with CQI (HO X-4) ◆ Post-test

SMALL GROUP WORK

Participants work in their organizational teams to develop Quality Action Plans based on the problems they identified in their own agencies/sites after Part I and refined in Session IX.

Trainer:

Distribute the blank shells for a Quality Action Plan to guide the groups in the preparation of their plans as well as the sample Quality Action Plan for Mamba District (see handout IX 5-b).

Provide assistance as necessary to ensure that their plans are clear and logical and that they respond appropriately to the identified problems.

When they have finished, each team presents a *sample* of its action plan to the large group:

- *All* the objectives
- All the activities related to *one* objective
- The time frame
- Persons responsible
- Budget
- Indicators (including baseline data, planned endline data and the methodology to be used)

Each plan is discussed after it is presented.

Trainer:

Be sure participants understand that this should not be considered the definitive plan. It will be important to work with Quality Teams at their work sites to go through the processes the group has experienced in Part II of the training.

WHEN THE CQI CYCLE IS COMPLETE...

LARGE GROUP DISCUSSION

Suggest to participants that, in measuring the results of their actions plans, it will be important to determine whether the desired outcome of the entire process has been achieved—but also whether the desired outcome of the steps in the process have been achieved. Present the flipchart/transparency, Achieving Results with CQI, and ask volunteers to present and explain to the group the three possible outcomes of CQI and what to do in each case.

Distribute the handout, Achieving Results with CQI.

Lead a discussion on the actions to be taken in the following situations:

The desired outcome is not achieved:

- Consider the reliability of the data collection methods used. Was the problem adequately analyzed and defined? Consider the indicators used: what was observed and how? what questions were asked and how they were asked? were the CQI tools properly applied, etc. Based on this assessment, consider the validity of the quality problem, as it was originally defined, as well as the validity of the outcome of the CQI process.

- Redefine the process used: add or change steps and/or change the process. Ask: were the planned changes implemented as anticipated? if not, why not? were the anticipated changes realistic, given available resources, staff competencies, etc.? What obstacles were encountered? If staff resistance was a factor, examine the sources of resistance and how to deal with them. Were staff not appropriately involved in the problem identification and resolution process? Has there been staff turnover and has this had an effect? Was there adequate organizational/ administrative support for the changes? Has the external environment in which the program exists changed?

The desired outcomes of each step in the process are achieved but the desired outcome of the whole process is not achieved.

- Reassess the feasibility of the desired outcome of the whole process and the relationship between the steps and whole process. Is it feasible? Have all the necessary aspects of the problem been addressed? Has something been left out?

- Consider whether to continue working on the problem and, if so, how.

All desired outcomes are achieved

- Document the experience, the identified solution and its application. Share the results with people in the agency/facility and community members, as appropriate—particularly with those involved in identifying the problem and implementing the solution. Share the results with others who might benefit from your experience, e.g.,

other providers of health services. Recognize, however, that most situations are unique and that similar problems in different environments may call for somewhat different solutions.

- Move on to the next quality problem. This may be a problem identified in the initial problem-identification process, a problem that emerged in the course of data-collection to examine the results of the CQI cycle just completed, or it may involve a new round of problem-identification.

Emphasize to the group that the CQI process can be applied to any number of problems affecting their programs. Its value grows as staff in an agency develop a "QOC mentality" toward the services provided and the organization's operating procedures. Encourage participants to continue the CQI process with colleagues on a regular basis, making it part of their agency's ongoing operations. Quality services are valued by clients and the community—who are often willing to pay for them. Those involved in improving services are rewarded for their efforts by the sense of empowerment they gain in the process and by the appreciation of internal and external clients for the improvements they have made.

Wish everybody good luck in the implementation of their plans.

POST-TEST AND CLOSING

Materials Needed:	Handout .
	♦ Post-test (HO I-4 from Session I)

Test

Participants take the post-test. Distribute the same test used in Session I.

Closing

Trainers close the course according to local custom. They may invite or suggest follow-up with participants, depending upon resources and needs.

BIBLIOGRAPHY AND RESOURCE LIST

BIBLIOGRAPHY

Aubel, Judi. 1993. *Qualitative Research for Improved Health Program Design.* Available in English, French or Spanish from International Labor Office (see resource list below).

Bruce, Judith. 1990. "Fundamental Elements of the Quality of Care: A Simple Framework," *Studies in Family Planning.* March/April. Vol. 21, Number 2. Available from The Population Council (see resource list below).

Chipamaunga, Shalote R. 1998. *Family Planning/Reproductive Health Trainee Follow Up Tools, A Tool for On-the-Job Performance Assessment.* November. Unpublished document. JSI/SEATS Africa Regional Office.

Debus, Mary. 1988. *The Handbook for Excellence in Focus Group Research.,* HEALTHCOM, Academy for Educational Development. Washington, DC. Available from BASICS Information Center (see resource list below).

Dwyer, Joseph, J. Haws, G. Wambwa, M. Babawale, F. Way and P. Lynam. *COPE: A Self-Assessment Technique for Improving Family Planning Services.* AVSC Working Paper # 1. Available from AVSC International (see resource list below).

"Family Planning Programs: Improving Quality." 1998. *Population Reports.* Series J, Number 47. Population Information Program, Center for Communication Programs, The Johns Hopkins University School of Public Health. Baltimore, MD. Available from Population Information Program, Johns Hopkins School of Public Health, (see resource list below).

Franco, Lynne Miller, J. Newman, G. Murphy and E. Mariani. 1997. *Achieving Quality Through Problem Solving and Process Improvement.* Quality Assurance Methodology Refinement Series, second edition. Quality Assurance Project. Bethesda, MD. Available from Quality Assurance Project (see resource list below).

IPPF Bill of Rights: Medical and Service Delivery Guidelines. Available from International Planned Parenthood Federation (see resource list below).

Ippolito, Linda, N. P. Harris and D. Lauro. 1996. *SEATS II Strategy for Quality of Care in Family Planning and Reproductive Health.* June. JSI/SEATS, Arlington, VA. Available from John Snow, Inc. (see resource list below)

Mainstreaming Quality Improvement in Family Planning and Reproductive Health Services Delivery, Context and Case Studies. 2000. January. JSI/SEATS. Arlington, VA. Available from John Snow, Inc. (see resource list below)

Manager's Toolbox for CQI. 1993. The Family Planning Manager. Supplement to Vol. II, Number 1. January/February. Available from Family Planning Management Development Project (see resource list below).

Maximizing Access and Quality (MAQ), Checklist for Family Planning Service Delivery, with Selected Linkages to Reproductive Health. Available from Population Information Program, Johns Hopkins School of Public Health (see resource list below).

Omachonu, V.K. 1991. *Total Quality Productivity Management in Health Care Organizations.* American Society for Quality Control. Milwaukee, WI.

Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care. Forthcoming. Carolina Population Center. University of North Carolina at Chapel Hill (see resource list below).

Rogers, Marguerite. 1993. "Comparing Quality of Care with Contraceptive Access." *Network.* Vol. 13, Number 3. March. Family Health International. Research Triangle Park, NC. Available from Family Health International (see resource list below).

Scholtes, Peter R., Brian L. Joiner, Barbara J. Streibel. 1996. *The Team Handbook.* Second edition. June. Joiner Associates, Inc.. Available for purchase from Oriel Incorporated, 3800 Regent Street, P.O. Box 5445, Madison, WI 53705-0445, USA

SEATS II Clinical Protocols for Family Planning Programs: A Resource Book. 1995. JSI/SEATS. Arlington, VA. Available from John Snow, Inc. (see resource list below).

Torres, Cresencio and Fairbanks, Deborah. 1996. *Teambuilding: The ASTD Trainer's Sourcebook.* McGraw-Hill. Available from: McGraw-Hill publishers.

Using CQI to Strengthen Family Planning Programs. 1993. The Family Planning Manager. Vol. II, Number 1. January/February. Available from Family Planning Management Development Project (see resource list below).

Williams, Timothy, Yvette Cuca, Jessie Schutt-Ainé. *Client Satisfaction Surveys for Improved Family Planning Service, A User's Manual.* International Planned Parenthood Federation. Western Hemisphere Region, Inc. Available from IPPF (see resource list below).

RESOURCE LIST

AVSC International
440 Ninth Avenue
New York, NY 10001 USA
http://www.avsc.org (see page on Quality)

BASICS Information Center
1600 Wilson Boulevard, Suite 300
Arlington, VA 22209 USA
http://www.basics.org

Carolina Population Center
University of North Carolina at Chapel Hill
CB #8120, University Square
123 West Franklin Street
Chapel Hill, NC 27516 USA
http://www.cpc.unc.edu

Family Health International
P.O. Box 13950
Research Triangle Park, NC 27709 USA
http://www.fhi.org

Family Planning Management Development Project
Management Sciences for Health
891 Centre Street
Boston, MA 02130 USA
http://www.msh.org (see pages on Quality and the Electronic Resource Center)

The Intrah Program
1700 Airport Road, Suite 300
Chapel Hill, NC 27514 USA
http://www.intrah.org

International Labor Office (ILO)
Geneva, Switzerland
Attention: Christine Sutton
Development Policy Department
E-mail: sutton@ilo.org

International Planned Parenthood Federation
Regents College
Inner Circle
Regents Park
London NW1 4NS England
http://www.ippf.org

International Planned Parenthood Federation
Western Hemisphere Region, Inc.
120 Wall Street, 9th floor
New York, NY 10005 USA
http://www.ippfwhr.org

Center for Communication Programs
Johns Hopkins University School of Public Health
111 Market Place, Suite 310
Baltimore, MD 21202 USA
http://www.jhuccp.org

The JHPIEGO Corporation
Brown's Wharf
1615 Thames Street, Suite 200
Baltimore, MD 21231 USA
http://www.jhpiego.org

John Snow, Inc.
1616 N. Fort Myer Drive, 11th Floor,
Arlington, VA 22209 USA
http://www.seats.jsi.com (see page on Quality)

The Population Council
One Dag Hammarskjold Plaza
New York, NY 10017 USA
http://www.popcouncil.org

Population Information Program
Johns Hopkins University School of Public Health
111 Market Place, Suite 310
Baltimore, MD 21202 USA
http://www.jhuccp.org

Quality Assurance Project
Center for Human Services
University Research Corporation
7200 Wisconsin Avenue, Suite 600
Bethesda, MD 20814 USA
http://www.qaproject.org

Reproductive Health Gateway (web site)
USAID Population and Health Materials Working Group
http://www.rhgateway.org

USAID Maximizing Access and Quality (MAQ) Initiative (web site)
http://www.jhuccp.org/maq

HANDOUTS

KEY:

HO	Handout
Roman numerals I–X	Refer to session numbers in the curriculum
Arabic numerals 1–12	Refer to the sequence of handouts in the session (some multi-part handouts have an additional subdivision a-d)
Arabic numerals in parentheses (1)	Refer to page numbers in that handout
e.g., HO IV-2 (3)	Handout for Session IV, as the second item—page 3

GENERAL OBJECTIVES OF THE TRAINING

By the end of Part I of the training, participants will be able to:

- Describe the importance of the improvement of quality of family planing/reproductive health (FP/RH) service delivery to client satisfaction and program performance.
- Explain ways in which their agency/facility ensures that informed choice and informed consent are (or will be) adequately addressed in FP/RH service delivery.
- Apply existing standards and protocols in quality of care (QOC) improvement efforts.
- Apply the principles and tools of continuous quality improvement (CQI) to the identification of FP/RH quality of care problems.
- Describe their planned approach to the identification of problems in the quality of care within their agency/facility.
- Apply the principles of teamwork to the improvement of the quality of FP/RH services.
- Present a plan to establish a Quality Team at their agency/facility and identify a QOC problem, using simple data collection techniques.

By the end of Part II of the training, participants will be able to:

- Apply CQI tools to the analysis of FP/RH quality of care problems.
- Develop Quality Action Plans with clear objectives, appropriate activities, realistic time frames, assigned responsibility for implementation, and indicators to measure quality improvement.

GENERAL AND SPECIFIC OBJECTIVES

TRAINING IN CONTINUOUS QUALITY IMPROVEMENT FOR FAMILY PLANNING PROGRAMS

By the end of Part I of the training, participants will be able to:

Session I

Understand the workshop objectives.

- Name at least two skills they would like to improve in planning, implementing and evaluating quality of care principles in their workplace.
- Reconcile their workshop expectations with the proposed training program objectives.
- Name at least four group norms to respect during the workshop.
- Explain at least six rules for giving and receiving feedback.

Session II

Describe the importance of the improvement of quality of FP/RH service delivery to client satisfaction and program performance.

- Explain the following underlying concepts of quality of care in the delivery of family planning services: the Bruce-Jain quality of care framework, quality in fact and quality in perception, and clients' rights.
- Identify at least six groups of stakeholders who should be involved in defining and assessing quality of care in FP/RH services.
- Define the terms "internal client" and "external client."
- Define the concept of quality of FP/RH service delivery from the perspectives of both external and internal clients.

Session III

Explain ways in which their agency/facility ensures that informed choice and informed consent are (or will be) adequately addressed in FP/RH service delivery.

- Define the terms "informed choice" and "informed consent"
- Explain the importance of informed choice and informed consent in the delivery of FP/RH services.
- Describe the five key provisions of the Tiahrt Amendment and their application to USAID-funded FP/RH activities.
- Define the provider's role in assuring informed choice and informed consent for FP/RH services.

Session IV

Apply existing standards and protocols in QOC improvement efforts

- Define the terms standards, protocols and medical monitoring with respect to the delivery of FP/RH services.
- Explain the importance of standards and protocols.
- Explain the importance of communication to the implementation of standards in the quality improvement process.
- Explain five common sources of variation in the FP service delivery system.
- Explain the role of standards in reducing variation.

Session V

Apply the principles and tools of CQI to the identification of FP/RH quality of care problems.

- Define Continuous Quality Improvement (CQI).
- Differentiate between the CQI process and other quality improvement processes (e.g., COPE).
- Explain how the CQI approach is different from the traditional approach to quality assurance.
- Describe five basic principles of CQI.
- Name the five steps of the simplified CQI process to be used in this training.
- Identify at least four sources of data useful in the CQI problem identification process.

- Describe six CQI tools/techniques useful for identifying possible QOC problems and the purpose of each.

Session VI

Describe their planned approach to the identification of problems in the QOC within their agency/facility

- Name at least two steps they will take to initiate the CQI process within their organizations.
- Explain how the participation of the community in the CQI process (Expanded Quality Improvement (EQI)) can contribute to the improvement of QOC in FP/RH service delivery.
- Describe at least three approaches appropriate to community participation in the EQI process.

Session VII

Apply the principles of teamwork to the improvement of the quality of FP/RH services.

- Explain at least five benefits of teamwork to the improvement of quality of FP/RH service delivery.
- Identify at least four characteristics of effective teams.
- Describe the four stages of team development.
- Identify at least six positive behaviors in the context of teamwork.
- Name three general strategies for avoiding, and responding to, common barriers to communication.
- Explain how feedback can contribute to positive group behavior in the context of teamwork.
- Describe five ways of responding to team conflict.
- Explain at least six common team problems and how to deal with them.
- Name three ways to support effective teams.

Session VIII

Present a plan to establish a Quality Team at their agency/facility and identify a QOC problem, using simple data collection techniques.

- Outline their plans to establish a Quality Team in their agency/facility.
- Outline their plans to identify a QOC problem in their agency/facility, using simple data collection techniques.
- Present to the large group their plans to establish a Quality Team and identify a QOC problem.

By the end of Part II of the training, participants will be able to:

Session IX

Apply CQI tools to the analysis of FP/RH quality of care problems.

- Give four reasons why data analysis is important in CQI.
- Describe three CQI tools useful for analyzing data regarding QOC problems and the purpose of each tool.
- Analyze data collected since Part I of the training.

Session X

Develop Quality Action Plans with clear objectives, appropriate activities, realistic time frames, assigned responsibility for implementation, and indicators to measure quality improvement.

- Describe nine components of a Quality Action Plan.
- Develop a Quality Action Plan to address the quality problem they identified at their own work site
- Identify indicators to measure quality improvement at their own work site.

WORKSHOP SCHEDULE: PART I

CONTINUOUS QUALITY IMPROVEMENT IN FAMILY PLANNING PROGRAMS

Day 1	Day 2	Day 3	Day 4
8:30 Opening and Introduction to Workshop 10:30 Break 10:45 Introduction to Workshop: Pretest 11:15 Quality of Care – General Concepts	8:30 Revision 9:00 Informed Choice and Informed Consent 10:30 Break 10:45 Standards, Protocols and Medical Monitoring	8:30 Revision 9:45 Continuous Quality Improvement (continued) 10:30 Break 10:45 Continuous Quality Improvement (continued)	8:30 Starting a CQI Team 9:30 Teamwork 10:30 Break 10:45 Teamwork (continued)
Lunch 12:00 to 13:00			
13:00 Quality of Care – General Concepts (continued) 15:00 Break 15:15 Quality of Care – General Concepts (continued) 16:30 End of day	13:00 Continuous Quality Improvement 15:00 Break 15:15 Continuous Quality Improvement (continued) 16:30 End of day Evening homework	13:00 Continuous Quality Improvement (continued) 15:00 Break 15:15 Continuous Quality Improvement (continued) 16:30 End of day	13:00 Teamwork (continued) 14:45 Preparing to Identify Quality Problems 15:15 Break 15:30 Preparing to Identify Quality Problems (continued) 17:00 End of Part I of the Workshop

WORKSHOP SCHEDULE: PART II

CONTINUOUS QUALITY IMPROVEMENT IN FAMILY PLANNING PROGRAMS

Day 1	**Day 2**	**Day 3**
8:30 Problem Analysis 10:30 Break 10:45 Problem Analysis (continued)	8:30 Revision 9:00 Problem Analysis (continued) 10:00 Break 10.15 Quality Action Plans	8:30 Quality Action Plans (continued) 10:30 Break 10:45 Quality Action Plans (continued) 11:30 End of Training
Lunch 12:00 – 13:00		
13:00 Problem Analysis (continued) 15:00 Break 15:15 Problem Analysis (continued) 16:30 End of Day	13:00 Quality Action Plans (continued) 15:00 Break 15:15 Quality Action Plans (continued) 16:30 End of Day	

RULES FOR GIVING AND RECEIVING FEEDBACK

What is Feedback?

Feedback is communication to a person or group about the effect of their attitude or behavior on another person. It consists of the perceptions, feelings and reactions of the person giving feedback. It is not critical or evaluative but rather descriptive. Feedback provides information that the individual can use to make his/her own evaluation. If an individual does not feel he/she is being evaluated, he/she will feel less need to react defensively.

Feedback is more effective when:

- It is *specific* rather than general. Instead of saying a person is "authoritarian," it would be more useful to say: "When you just made that decision, you didn't listen to what others had to say and I felt as though I was forced to agree with you."

- It concerns the *attitude or behavior of the person* and not the person himself. It is more useful to tell the person that he "talked more than anyone else during the meeting" than to say he is "a loudmouth."

- It takes into consideration the *needs of the person receiving feedback.* Feedback can become destructive when it only serves our own needs and does not consider the needs of the receiver. Feedback is for helping others, not for hurting them.

- It is directed toward an *attitude or behavior the person can change.* Feedback about physical characteristics the person cannot control only hurts and frustrates.

- It is *wanted* and not imposed. Feedback will be more useful if the receiver has asked for it.

- It is an *exchange of ideas and information* rather than advice. In exchanging ideas and information, we leave the receivers the liberty to make their own decisions, according to their goals, needs, etc. When we offer advice, we tell them what they should do which assumes they lack the liberty to decide themselves.

- It is given at the *right moment.* In general, feedback must be given as soon as possible after the action in question (depending upon the receptivity of the receiver). Feedback may provoke several kinds of emotional reactions. The most effective feedback, given at the wrong moment, could do more harm than good.

- It includes the *quantity of information* the receiver can use and not the quantity we want to give. If the person is overwhelmed by feedback, his/her ability to use it will be reduced. When we give more feedback than necessary, it is probably to satisfy our own needs rather than to help the other person.

- It concerns *what was said or done* and not why it was said or done. The "why" takes us from what we observed to assumptions about the motives or intentions of the person. Pretending to understand the motives or intentions of the other usually only serves to alienate him/her and create suspicion and distrust which does not facilitate learning or change. It is presumptuous to assume we know why someone said or did something. If we are uncertain as to a person's motives or intentions, this uncertainty may be our feedback.

- It is *verified* to assure that it was clear, that the receiver understood our feedback. To do this, we can ask the other person to repeat the feedback in his/her own words.

- It is *positive and constructive, and not negative.* Negative feedback hurts while the purpose of feedback is to help the receiver change his/her behavior.

- *Receivers listen without defending their behavior.* When someone is giving feedback, receivers may only listen, except if there is something they don't understand: then they may ask for clarification. When we begin to defend ourselves, usually we stop listening.

PRE- AND POST-TEST

Name:_____

I. Put a (T) in front of the statement if it is true, and an (F) in front of the statement if it is false.

1. ____ Family planning clients most often define "quality of care" in terms of the manner in which they are received and treated.

2. ____ In general, the choice of family planning method should not need to change during a woman's reproductive life.

3. ____ Health workers should give family planning clients all the information they have about all available family planning methods in order to ensure an informed choice.

4. _____ Quality improvement efforts are most effective when FP service providers identify all quality of care problems because they are best qualified for the task.

5. _____ Maintaining quality of care in a FP service is the responsibility of supervisors.

6. _____ An understanding of team member behavior helps members identify patterns of interaction in the group.

7. _____ It is important to solicit community participation in quality improvement efforts because the community knows more about certain aspects of quality of care than do service providers.

8. _____ An important outcome of improved quality of care is greater trust and respect between clients and service providers

II. For the following questions, circle the letter next to the *best* response.

1. In the context of quality of care in family planning, choice of method means:

   a. having at least five kinds of methods to choose from
   b. the service provider guides the client to make the best choice based on

the client's social and medical history and the service provider's perception of what would be best for the client

c. the client's voluntary choice of method based on her/his understanding of all essential information about the chosen method as well as about other available methods

d. reasonable access to all methods (geographically and in terms of cost and lifestyle of the client)

2. Which of the following should the service provider help the client consider in order to help him/her make an informed choice of method?

   a. his/her (and his/her partner's) reproductive intentions
   b. the stage of his/her reproductive life
   c. his/her health status
   d. his/her lifestyle
   e. his/her perception of personal competence in using the method
   f. all of the above

3. Quality of care problems are defined in the context of:

   a. program standards
   b. client expectations
   c. service providers' expectations
   d. all of the above

4. Which of the following is *not* an important source of data for identifying problems in the quality of care?

   a. routine service statistics
   b. client interviews
   c. medical records
   d. studies conducted in other health facilities

5. Which of the following is *not* a principle of quality improvement?

   a. quality improvement efforts must satisfy the needs of both internal and external clients
   b. quality improvement focuses on ineffective personnel in the system and on new inputs to improve the system
   c. program management must provide a firm commitment and support for quality improvement to be effective
   d. the collection and analysis of data is essential for the identification of quality of care problems
   e. quality improvement respects the contributions of all staff and their ability to improve service delivery processes

6. Which of the following is *not* a benefit of teamwork in the context of the improvement of quality of care?

   a. access to greater technical skill and practical experience
   b. short term efficiency in problem solving
   c. an appreciation for various roles in carrying out service delivery processes
   d. fewer accusations about who causes the problems

7. Which of the following is *not* a rule for giving feedback in the context of teamwork?

   Feedback:

   a. is wanted and not imposed
   b. is positive and constructive, and not negative
   c. takes into consideration the needs of the person receiving the feedback
   d. is given at the right moment
   e. includes advice so that the person will know how he/she needs to change

8. Which of the following statements is true regarding conflict in teamwork? (One answer only)

   a. conflict is a normal occurrence and can be useful to stimulate creativity and innovation
   b. conflict is a way in which problems can be discussed and tensions released
   c. conflict can improve the quality of decision-making by allowing different points of view to be considered
   d. conflict can be an obstacle to productive team work
   e. all of the above

III. In each of the following questions, there is a list of items followed by a corresponding list of elements. In the blank next to each item, write the letter of the element that corresponds the best.

1. Match the following tools/techniques used for problem identification with their primary purpose.

   Brainstorming _____
   Service statistics _____
   Observation of counseling _____
   Client exit interviews _____
   Flow chart _____
   Client flow analysis _____
   Focus group discussions _____

a. provides qualitative data regarding client/community perceptions of quality of care (or other issues)
b. assists in assessing information given to clients, certain aspects of technical competence, interpersonal relations, and continuity and follow-up within the context of FP consultations
c. promotes openness and creativity in people's thinking about an issue and generates maximum input from the group
d. provides quantitative data regarding clients' perceptions of quality of care
e. analyzes the sequence of activities occurring in a process
f. provides broad indications of how a program, or particular service, functions
g. helps a team assess where there are obstacles to the efficient flow of clients through a health facility

2. Match the following tools/techniques for problem analysis with their primary purpose

Pareto analysis _____
Pie chart _____
Cause-and-effect diagram _____
Bar chart _____
Decision matrix _____

a. provides a graphic comparison between categories of data
b. helps identify the relatively few factors/causes which are responsible for most of the problem
c. helps a team consider the complexity of the problem and all contributing factors
d. shows relative proportions of various items making up the whole
e. assists a group to choose one problem to work on, out a list of two or more possibilities

3. Match the stages of team development with the appropriate description of each stage

Forming _____
Storming _____
Norming _____
Performing _____

a. members begin diagnosing and solving problems
b. members begin to accept the team, team ground rules, their roles on the team and the individuality of team members
c. members explore the boundaries of acceptable group behavior
d. members begin to realize that the task is different and more difficult than they imagined

4. Match the components of an action plan with the purpose of each

Introduction _____
Problem statement _____
Theory of cause _____
Objectives _____
Activities _____
Time frame _____
Person responsible _____
Budget _____
Indicators _____

a. states the result to be obtained from the quality improvement effort
b. determines whether the objective has been attained and the QOC problem solved or ameliorated
c. makes clear the problem to be addressed by the action plan
d. indicates when each activity should take place
e. clarifies the context in which the QOC problem occurs
f. sets out what will be done to achieve the objectives and eliminate the causes of the problem
g. provides an indication of whether planned activities are financially feasible or not
h. ensures accountability for the accomplishment of each activity
i. provides the focus for the objectives of the action plan

Bruce/Jain Framework for Quality of Care in Family Planning Programs

Choice of Method

The availability of a variety of FP methods, including a range of short term client-dependent methods and long term client-independent methods, *is essential to allowing clients a choice of contraceptive method.*

Clients' contraceptive needs and values change over time. Such changes may be influenced by:

- **The various stages of the woman's, man's, couple's reproductive life:**
  - from the beginning of a woman's menstrual periods (a man's ability to ejaculate) to the first sexual experience
  - from the first sexual experience to marriage (in many cultures)
  - from marriage to the birth of the first child
  - from the birth of the first child to the birth of the last child
  - from the birth of the last child to menopause (to the man's desire to cease producing children)

- **The woman's/man's/couple's reproductive intentions. Note that the following factors are closely allied to those above but may not be synonymous with one or another of the above stages in all cases:**
  - seeking to delay: initiating sexual activity but not seeking birth at that time
  - seeking to give birth
  - seeking to space births
  - seeking to limit births
  - ending childbearing

  Note: Not all women and men pass through all of the above stages nor experience all of these reproductive intentions.

- **The woman's physical profile:**
  - lactational status
  - health profile (in terms of contraindications of various methods; and what the client is able and willing to tolerate in terms of side effects)

- **The individual's/couple's lifestyle and related issues of method preference:**

  - ease of use of the different methods. (Does the client: seek privacy in using the method? does he/she prefer a method that is used constantly, regardless of sexual activity, or one that is used only when sexual activity occurs? is he/she seeking a method that can be used without the knowledge of a partner and/or parents?)
  - risk factors for STDs and HIV infection
  - frequency of sexual activity
  - number of sexual partners
  - ease of resupply
  - change in values, beliefs, habits and the preferences of the partner

- **Monetary cost of the method**

Note: It is important to help clients consider all possible influences over their choices in order to best respond to their individual needs and concerns

Client choice of method is generally a function of balancing:

- contraceptive goals (degree of protection desired, purpose of practicing FP)
- sense of personal competence (in using the method)
- evaluation of the contraceptive (in terms of safety, etc.)
- accessibility of the method
- convenience of use of the method
- acceptability of the technique of administration or use of the method

Additional concepts regarding choice of method:

The supply system must be adequate to ensure that methods are in stock, since stock-outs compromise the clients' choice. Supplies also need to be properly stored to ensure their effectiveness.

To ensure choice of method, it is important for the FP/RH program to offer a range of choices within reasonable access to all clients (geographical access, cost access, and lifestyle access—not imposing barriers on who can or cannot receive a particular method due to age, marital status, etc.).

The importance of choice of method

Users' satisfaction with their method of contraception improves their ability to practice family planning. If a woman receives the method she asked for (and for which she has no serious contraindications)—she is more likely to continue with

FP services compared with women for whom the health worker chooses the method.

Choice of method reflects a commitment of the FP service to respond to client needs (as opposed to promoting given methods). To the client, choice of method means: his/her voluntary selection of the method based on his/her understanding of all essential information about the chosen method as well as about all other available methods.

Information Given to Clients

- **Giving information during the initial discussion/counseling:**

  - asking if the client has a preference for a particular method.
  - informing the client that there are other methods and offering to describe any or all of them
  - describing how the methods are used
  - explaining the advantages and disadvantages of the methods
  - explaining possible side effects
  - outlining major contraindications

- **Giving information following the choice of method by the client:**

  - giving instructions for use of the chosen method
  - describing/reviewing side effects and what to do if they occur
  - explaining when to return
  - explaining the service provider's continuing role and availability to assist with advice, re-supply, referral, etc.
  - leaving time for questions and clarifications
  - ensuring that the client understands crucial information about the method chosen.

- **Other considerations during counseling:**

  - adequate privacy for counseling
  - being brief, non-technical and clear, limiting the amount of information to what the client can understand and retain
  - avoiding all bias for/against FP, for/against specific methods
  - helping the client consider method effectiveness against other features of the various methods
  - leaving time for questions, clarification and checking for comprehension

- **Additional concepts regarding information given to clients:**

  The availability of written information in a facility also supports giving clients accurate, understandable information. For providers, this includes checklists (on a wall or on a desk) to remind them of key information to be included when talking with clients. For clients, it includes informational posters on the walls and brochures with more detailed information about contraceptive methods.

The importance of giving information to clients

A client's knowledge of contraceptive methods and his/her confidence in the service provider is crucial to effective contraceptive use and serves to prevent misunderstandings and problems of misuse, fears and rumors and, ultimately, of discontinuation.

The client's understanding of contraceptive methods, especially of her/his chosen method, is important in reinforcing her/his confidence in the clinic. The rapport and content of the initial contact are important in establishing this confidence.

Technical Competence of Providers

- **Technical competence is essential to ensuring QOC. Key aspects of technical competence include that providers:**

  - have appropriate training and licensure for their jobs
  - are familiar with standards and protocols and have access to a copy in the clinic
  - follow standards and protocols in the provision of clinical services
  - follow infection prevention and control procedures
  - can accurately explain the benefits, use, contraindications, side effects and management of side effects associated with methods of contraception
  - receive routine supervision
  - have the basic items needed to deliver available FP methods.
  - respond appropriately to key RH services not provided on site, e.g., they can identify/diagnose, counsel and refer for STD treatment, prenatal care, etc.

The importance of technical competence

- technical competence is critical to achieving the results the client desires
- it maximizes the chances of protecting the client's safety and promoting his/her health
- the client expects providers to be technically competent

Interpersonal Relations

- **This refers to the client-provider relationship. It involves:**

  - warm reception of clients by the clinic staff
  - understanding
  - respect, including respect for privacy, confidentiality and modesty
  - honesty
  - two-way communication (without condescension), and attention to non-verbal communication
  - flexible guidance of clients
  - caring attitude
  - identification with the client and his/her problems and needs
  - empathetic information-giving to help the client obtain services and use his/her chosen method; and to allay fears
  - cooperation and coordination among staff
  - personal attention given to clients

The quality of interpersonal relations is influenced by management decisions, beginning with standards of service, staff training, job descriptions and expectations, supervision and the availability of adequate resources

The importance of interpersonal relations:

- it increases the client's confidence and trust in the staff and in their own choice of method and ability to use it properly
- it enhances clients' satisfaction with clinic services which, in turn, may influence whether they:
  - seek care and where they go for care
  - are willing to pay for services
  - follow the provider's instructions on the correct use of their method
  - continue using their method
  - return for follow-up visits
  - recommend the services to others
- it sets the tone of the clinic/facility
- it has a large impact on the job satisfaction of clinic personnel

Continuity of Care and Follow-up

- **Factors include:**

- the provider encourages the client to return as needed
- the follow-up/return schedule is reasonable (i.e., balancing good medical practice against the creation of medical barriers to contraception)
- there is a reliable resupply system for clients, either at the same clinic or through community-based distribution, pharmacies or otherwise
- follow-up is conducted for clients who are overdue for a return visit; clients are contacted and their reasons for non-return are identified; follow-up is undertaken in such a way as to respect clients' concern about confidentiality
- services are available at all times

An FP/RH program's effort to ensure client follow-up is a measure of its long-term commitment to its clients. It represents an important link between the provider and clients.

A predictable visiting pattern supports on-going clients, picks up on clients whose needs have changed and helps to prevent discontinuation due to concerns with side effects, etc.

The importance of continuity and follow-up

- helps ensure that the client will use his/her method effectively and obtain the desired result
- help detect problems early—before they become serious
- builds clients' confidence because it demonstrates commitment and concern about their health and wellbeing

Appropriateness and Acceptability of Services

♦ **Clients, as well as non-users of the services, perceive that the following are adequate:**

- privacy/confidentiality for counseling
- privacy/confidentiality with respect to physical exams
- the waiting area
- the waiting time
- clinic days and hours (opening times)
- the amount of time spent with the provider
- the staff (language, sex, etc.)
- proper facilities, including a clean examination room, toilet facilities, water, etc.
- a reasonable constellation of services to meet clients' needs (either on site or by referral).

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There should be a system in place to get feedback from clients on their satisfaction with services.

The importance of appropriate, acceptable services

- demonstrates that an agency/facility seeks to provide services in ways that respond to clients' needs
- enhances the likelihood of clients using services
- creates a pleasanter work environment for providers because clients are more satisfied

SIX QUALITY OF CARE ELEMENTS AND MEDICAL BARRIERS THAT INHIBIT THEM

1. Choice of methods

Medical barriers:

- Age and parity restrictions for oral contraceptives, IUDs, Norplant® and sterilization
- Excessive tests for oral contraceptives
- Limits to numbers of oral contraceptive packs a clinic will provide at a time
- Outdated contraindications for oral contraceptives, IUDs
- Provider bias against hormonal and other methods
- Some methods not approved for use in some countries

2. Information to users

Medical barriers:

- Providers biased against particular methods (IUDs, oral contraceptives, sterilization) don't promote or even tell clients about these methods
- Providers who are not up-to-date cannot keep clients up-to-date
- Providers may withhold information on side effects

3. Competence of providers

Medical barriers:

- Lack of up-to-date service delivery guidelines
- Lack of refresher training
- Client care varies between providers
- Providers require outdated, unnecessary tests
- Limits to who can provide services

4. Client-provider relations

Medical barriers:

- Limits to who can provide services means clients may not be able to work with someone they trust (i.e., a female nurse)

- Clients lack confidence in providers who are not knowledgeable about, and competent to provide, a range of methods

5. Continuity of care

Medical barriers

- Excessive follow-up visits required
- Limits to who can provide services
- Limit to supply of oral contraceptives provided at a time
- Clients not adequately counseled on what to expect with contraceptive use

6. Appropriateness and acceptability of services

Medical barriers

- Excessive and repeated tests and exams required (blood pressure, pelvic, pap smear)
- Age and parity requirements unnecessarily strict
- Start time of method restricted unnecessarily

(Source: Marguerite Rogers, "Comparing Quality of Care with Contraceptive Access," Network, Family Health International, Research Triangle Park, North Carolina, March 1993)

EFFECTS OF IMPROVED QUALITY OF CARE IN FAMILY PLANNING PROGRAMS

Effects or consequences of improving the QOC to clients, service providers and the program

Clients:

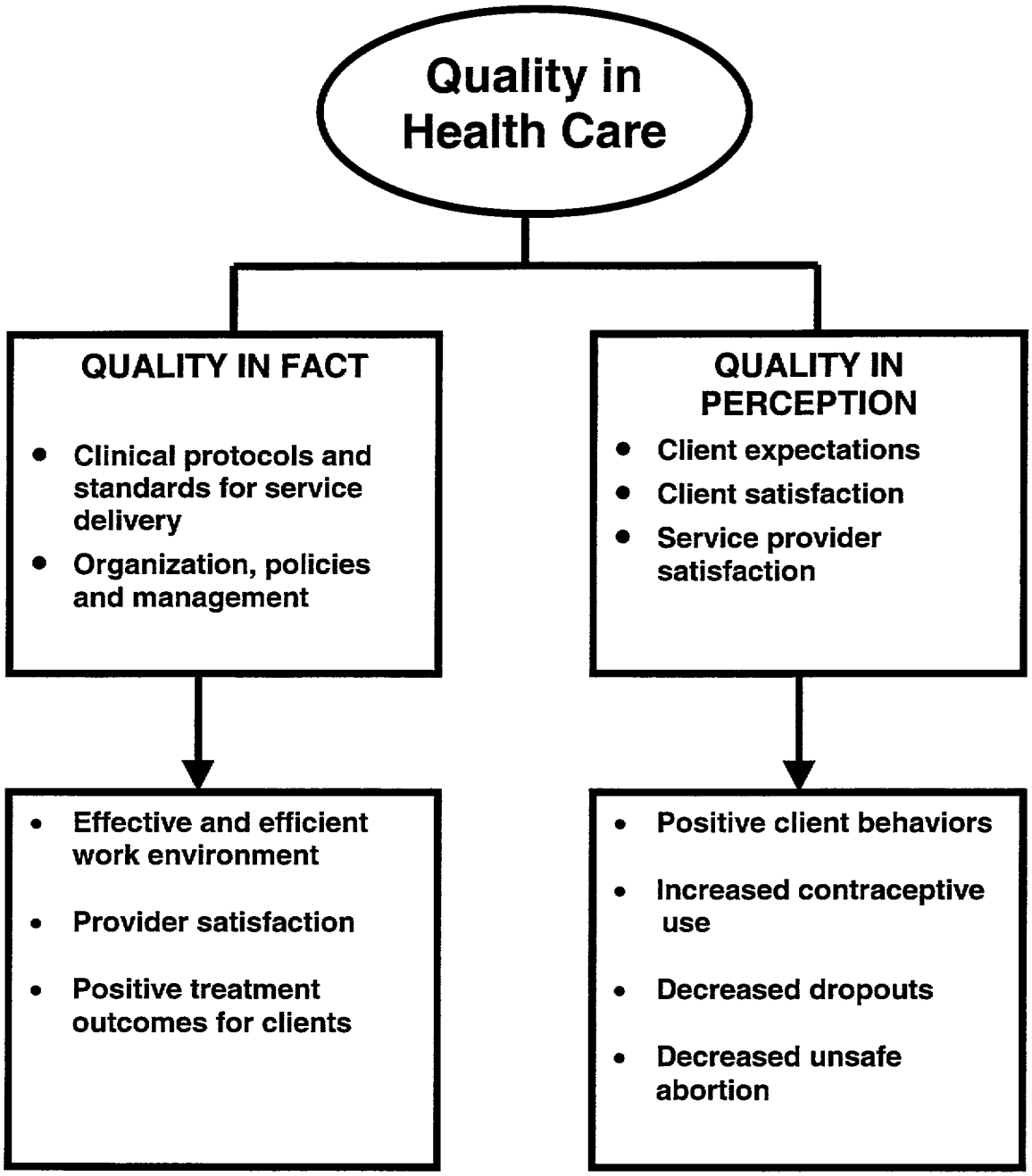
- Are more satisfied with the clinic visit and the service and/or method received
- Are able to resolve the problem for which they came (to the degree possible)
- Gain increased self-confidence and independence in future decision-making about FP/RH concerns
- Gain increased skill in decision-making
- Make more informed and better choices
- Are more likely to make a decision to adopt a FP method
- Are more likely to use correctly their chosen FP method
- Are more likely to continue using their chosen FP method
- Cope better with minor side effects
- Are more likely to respect follow-up visits
- Are less likely to be affected by rumors and myths
- Are more likely to achieve their reproductive goals
- Benefit from improvements in mother-child health

Service Providers:

- Experience greater satisfaction/motivation in their work
- Spend less time responding to client complaints and complications with methods
- Develop greater trust and respect with clients

The Program:

- Obtains increased utilization of services and better health outcomes
- Develops a positive reputation (satisfied clients promote FP/RH services and the clinics which meet their needs)
- Becomes a more cost-effective service delivery system
- Makes better use of staff time (fewer unscheduled visits for time-consuming minor complaints and side effects)
- Experiences greater continuity in method use/higher continuation rates



Adapted from Omachonu

IPPF BILL OF RIGHTS

1. RIGHT TO INFORMATION

All individuals in the community have a right to information on the benefits of family planning for themselves and their families. They also have the right to know where and how to obtain more information and services for planning their families. All family planning programs should be active in disseminating information about family planning. This should be done not only at service delivery sites, but also at the community level.

2. RIGHT TO ACCESS

All individuals in the community have a right to receive services from family planning programs, regardless of their social status, economic situation, religion, political belief, ethnic origin, marital status, geographic location or any other characteristics which may place individuals in certain groups. This right means a right of access through various health care providers as well as service delivery systems. Family planning programs should take the necessary steps to ensure that services will reach all individuals who need them, even those for whom the normal health services are not easily accessible.

3. RIGHT OF CHOICE

Individuals and couples have the right to decide freely whether or not to practice family planning. When seeking contraceptive services clients should be given the freedom to choose which method of contraception to use. Family planning programs should assist people in the practice of informed free choice by providing unbiased information, education and counseling, as well as an adequate range of contraceptive methods. Clients should be able to obtain the method they have decided to use provided there are no significant contraindications to their use of the method.

A client's concept of acceptability and appropriateness changes with circumstances. Therefore, the right of choice also involves clients' decisions concerning discontinuation of a method of contraception and method switching.

There is another aspect of choice that should be considered: as far as is practical, clients have a right to choose where to go for family planning services and the type of service provider with whom they feel most comfortable. Choosing where to go may involve a choice of physical location or a choice of service delivery mode; e.g., community family planning or health worker, pharmacy or over-the-counter service, hospital, health center or family planning clinic.

Governmental, nongovernmental and private sector providers should welcome the establishment of alternative service outlets.

4. RIGHT TO SAFETY

Family planning clients have a right to safety in the practice of family planning. This right to safety implies the following:

- Although it is well recognized that the benefits to health from family planning outweigh the risks, clients have a right to protection against any possible negative effect of a contraceptive method on their physical and mental health.

- Since unwanted pregnancies may represent a risk to health, the right of the client to safety also includes the right to effective contraception.

- When receiving family planning services clients also have a right to protection against other health risks not related to a method of contraception. For example, protection against the possibility of acquiring an infection through the use of contaminated instruments. Safety relates to the quality of service provision, including both the adequacy of the service facility itself, and the technical competence of the service providers. Ensuring the client's right to safety includes assisting the client in making an appropriate choice of contraceptive, screening for contraindications, using the appropriate techniques for providing the method (if applicable), teaching the client about proper use of the method and ensuring proper follow up. The conditions in service delivery sites with the materials and instruments should be adequate for the provision of safe services. Any complications or major side effects should receive appropriate treatment. If this treatment is not available at a particular service site the client should be referred to another facility.

5. RIGHT TO PRIVACY

When discussing his/her needs or concerns the client has the right to do this in an environment in which s/he feels confident. The client should be aware that his/her conversation with the counselor or service provider will not be listened to by any other people.

When a client is undergoing a physical examination it should be carried out in an environment in which his/her right to bodily privacy is respected. The client's right to privacy also involves the following aspects related to quality of services:

- When receiving counseling or undergoing a physical examination, the client has the right to be informed about the role that each individual inside the room, besides those providing services, is playing; e.g., individuals undergoing training, supervisors, instructors, researchers, etc. [Where the presence of individuals undergoing training is necessary the prior permission of the client should be obtained.]

- A client has a right to know in advance the type of physical examination which is going to be undertaken. The client also has the right to refuse any particular type of examination if s/he does not feel comfortable with it or to request this examination be done by another provider.

- Any case-related discussions held in the presence of the clients (particularly in training facilities) should involve and acknowledge the client and not talk over the client. It is, after all, the client's sexual and reproductive organs and functions that are under discussion.

6. RIGHT TO CONFIDENTIALITY

The client should be assured that any information s/he provides or any details of the services received will not be communicated to third parties without his/her consent. The right to confidentiality is protected under the Hippocratic Oath. As such, family planning services should be performed in conformity with the legal requirements and in accordance with ethical values.

A breach of confidentiality could cause the client to be shunned by the community or negatively affect the matrimonial status of the client. It may also lessen a target group's confidence and trust in the staff of a service delivery program. In accordance with the principle of confidentiality service providers should refrain from talking about clients by name or in the presence of other clients. Clients should not be discussed outside service sites. Client records should be kept closed and filed immediately after use. Similarly, access to client records should be controlled.

7. RIGHT TO DIGNITY

Family planning clients have a right to be treated with courtesy, consideration, attentiveness and with full respect for their dignity regardless of their level of education, social status or any other characteristics which would single them out or make them vulnerable to abuse. In recognition of this right of the client, service providers must be able to put aside their personal gender, marital, social and intellectual prejudices and attitudes while providing services.

8. RIGHT TO COMFORT

Clients have the right to feel comfortable when receiving services. This right of the client is intimately related to adequacy of service delivery facilities and quality of services, e.g., service delivery sites should have proper ventilation, lighting, seating and toilet facilities. The client should spend only a reasonable amount of time at the premises to receive the required services. The environment in which the services are provided should be in keeping with the cultural values, characteristics and demands of the community.

9. RIGHT OF CONTINUITY

Clients have a right to receive services and supply of contraceptives for as long as they need them. The services provided to a particular client should not be discontinued unless this is a decision made jointly between the provider and the client. In particular, a client's access to other services should not depend on whether or not s/he continues contraceptive services. The client has a right to request transfer of his/her clinical record to another clinical facility, and in response to that request the clinical record or a copy of it should be sent to that facility or given to the client.

Referral and follow up are two other important aspects of a client's right to continuity of services.

10. RIGHT OF OPINION

Clients have the right to express their views on the service they receive. Clients' opinions on the quality of services, be they in the form of thanks or complaint, together with their suggestions for changes in the service provision, should be viewed positively in a program's ongoing effort to monitor, evaluate and improve its services. Any new program or service delivery facility should ideally involve clients at the planning stage. The aim is to satisfy would-be clients' need and preference in ways that are appropriate and acceptable to them.

(Source: "Bill of Rights, Medical and Service Delivery Guidelines," IPPF Western Hemisphere Region, New York, New York (no date))

ELEMENTS OF INFORMED CHOICE
International Planned Parenthood Federation

The following is a summary of recommendations made by the International Planned Parenthood Federation based on its evaluation of the association between counseling, quality of care and method continuation:

1. Counseling on contraception should be focused mainly on the essential information and discussions needed by the client to make an adequate contraceptive choice and for using the method properly and consistently.

2. Counseling should be restricted to the number of issues that can be properly discussed within the available time.

3. The amount of information provided during a counseling session should be in accordance with what the client can understand and retain in his/her memory. Service providers must remember that the process of learning should be a continuous one, and that no one should be expected to learn in one counseling session more than what is reasonably possible.

4. Service providers must remember that every client has different needs and levels of knowledge and understanding of FP. Therefore the focus of counseling, the counseling technique and the time spent with the client should be tailored according to the characteristics and needs of the individual client.

EXCERPTS FROM THE TIAHRT AMENDMENT

None of the funds made available in this Act nor any unobligated balances from prior appropriations may be made available to any organization or program which, as determined by the President of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization.

None of the funds made available under this heading may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions. In order to reduce reliance on abortion in developing nations, funds shall be available only to voluntary family planning projects that offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services. Any such voluntary family planning project shall meet the following requirements:

1. Service providers or referral agents in the project shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning (this provision shall not be construed to include the use of quantitative estimates or indicators for budgeting and planning purposes),

2. The project shall not include payment of incentives, bribes, gratuities, or financial reward to (A) an individual in exchange for becoming a family planning acceptor, or (B) program personnel for achieving a numerical target or quota of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning,

3. The project shall not deny any right or benefit, including the right of access to participate in any program of general welfare or the right of access to health care, as a consequence of any individual's decision not to accept family planning services,

4. The project shall provide family planning acceptors comprehensible information on the health benefits and risks of the method chosen, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent to the use of the method,

5. The project shall ensure that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits.

(Source: H.R. 4328, "Omnibus Appropriations for FY 1999" enacted by the US Congress)

PRINCIPLES OF CQI

1. Leadership must provide firm commitment and support for CQI

CQI requires new ways of thinking, a willingness to change and strong mutual support and respect among management and staff. Management must provide the leadership to start the process and support the work of the quality team regardless of the level where CQI is initiated (national, agency, facility, etc.). If management is not prepared to permit the process to work, CQI will fail. Managers must view CQI as a priority and communicate this to staff by:

- their pronouncements and their actions
- permitting staff to devote time to CQI
- the allocation of essential resources
- their commitment to implement the changes proposed by the quality team

2. Satisfy internal and external clients

The purpose of CQI is to improve the quality of services for both external clients (men and women who receive FP services) and internal clients (program staff who contribute to the provision of services to external clients and who are themselves served by organizational operations). To better identify and respond to the needs of both groups of clients, both groups need to be involved in the process (including all levels of staff and community members representing actual and potential clients).

3. Focus on improving systems and processes, rather than changing the behavior of individuals; and use of existing resources rather than relying on new inputs to solve problems

CQI assumes that problems in QOC/service delivery are the result of ineffective or poorly functioning *processes* rather than ineffective *personnel*, so it seeks to develop improved systems and processes. It also assumes that improvements can be made using *existing* resources—or modest additional inputs—rather than depending upon *new* resources to solve the problems.

4. Respect the contributions of all staff and the staff's ability to improve processes

The CQI process is based on respect for the staff's ability to identify, analyze and solve problems within their day-to-day activities. It requires managers to empower staff, through a team approach, to participate actively and candidly in all stages of the problem-solving process. This empowerment of staff not only brings about improvements in the quality of care, but it also increases job satisfaction among Quality Team members.

5. Collect and use data to identify deficiencies and improve processes

Decisions throughout the CQI process need to be based on facts that have been verified through the use of data—and not just opinions or suppositions. Quality teams need to use data at all stages of the CQI process.

(Adapted from "Using CQI to Strengthen Family Planning Programs," The Family Planning Manager," January/February 1993)

CQI TOOLS

BRAINSTORMING

Brainstorming is a technique used with groups to generate ideas. It is useful in the CQI process to identify potential problems in the quality of care, possible causes of these problems and to generate ideas about solutions. While it is useful for identifying ideas, it does not provide evidence or data that any of the ideas are valid—even if there is consensus in the group that an idea is valid. Thus, the results of brainstorming need to be verified through data.

To use brainstorming with a Quality Team:

1. Write the topic of the brainstorming on a blackboard or flipchart paper so the whole quality team can see it. (The topic might be: what problems does the group perceive in the quality of care?) Ensure that everyone understands the subject of the brainstorming.

2. Agree on the rules for brainstorming:

   - Every idea is valid.
   - Every idea is written down in the words of the speaker. If an idea takes a long time to explain, the speaker should list the main ideas for summary on the board.
   - No one may interrupt or criticize.
   - Only questions of clarification may be asked.

3. Ask the Quality Team to identify all relevant ideas on the topic (e.g., *all* possible problems in the quality of care). Record every idea and continue until no more ideas are offered.

4. Go over the list on the board or on flipchart paper with the group, one item at a time. Discuss with the team their clarity, relevance, importance, etc. Eliminate any items that the group determines are either not relevant or not important.

(Adapted from Lynne Miller Franco et al., "Achieving Quality Through Problem Solving and Process Improvement," Quality Assurance Project, Bethesda, Maryland, 1997)

CQI TOOLS

SERVICE STATISTICS

Service statistics provide valuable information on how a service is functioning. From service statistics, teams can get broad, preliminary indications of how a program, or a particular clinic, functions.

Type of Data	Examples of Quality Problems Indicated by the Data
Number or percent of service delivery points with personnel trained in FP (or specific FP methods)	• Poor availability of/access to FP services • Poor availability of/access to certain methods
Number or percent of service delivery points with all approved methods for their level available	• Poor availability of/access to certain methods
Number of couple-years of protection (CYP) per month, quarter or year—overall and by method	• Declines in use of services • Declines in use of certain methods
Number or duration of stock-outs for specific commodities/supplies	• Problems with the availability of commodities • Problems with the logistics system
Number of users per month, quarter or year—overall and by method	• Declining public confidence in the agency or certain FP methods • Insufficient staff • Inconvenient clinic hours
Number of *new users* per month, quarter or year—overall and by method	• Declining public confidence in the agency • Misinformation about a specific FP method • Insufficient staff
Number of *continuing users* per month, quarter or year—overall and by method	• New users did not like the agency or its services when they came for their first visit
Number of dropouts per month, quarter or year	• Clients did not like the agency or its services when they came for their first visit • Clients have concerns about side effects of their method • Follow-up systems need to be strengthened
Incidence of complications for specific services	• Providers' clinical skills need improvement
Client-provider ratio	• Clients have long waits • Agency resources are not being used as effectively as possible
Increasing/decreasing income from fees	• High fees can present a barrier to services
Number or percent of the population in the area served by the agency	• The agency is serving a declining segment of the population
Information, Education and Communication (IEC) materials distributed	• Lack of IEC materials • Insufficient IEC conducted
Number or percent of the population in the area exposed to IEC sessions	• The agency is reaching a declining segment of the population

A careful review of statistics such as those above may serve to identify some important quality problems. In all cases, however, after reviewing service statistics and identifying possible problems, additional work will be needed to identify the causes of problems.

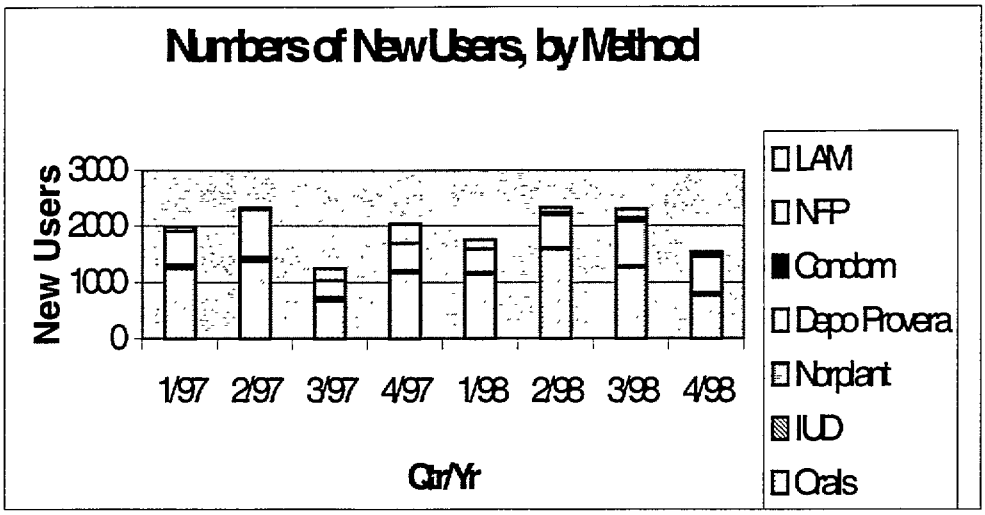
There are other sources of existing data that can also shed light on quality of care issues, e.g., Demographic and Health Surveys, situation analyses and others.

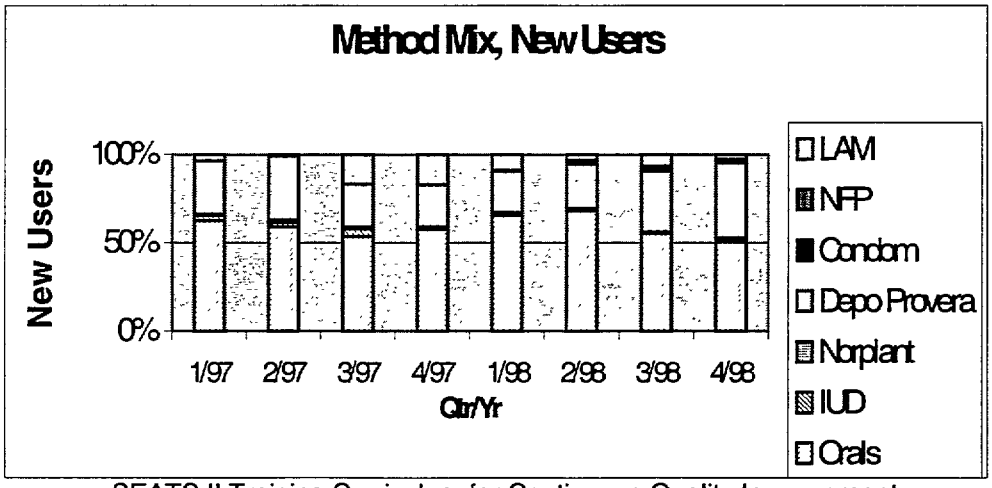
The tables and charts that follow provide some insight into potential problems in the quality of care. A Quality Team looking at these statistics might want to investigate problems such as the following, as they appear.

- Why are there such significant fluctuations in the number of new users by quarter? Specifically, what were the reasons for the drops in the numbers of new users in the 3rd quarter of 1997 and the 4th quarter of 1998?
- Why was there a drop in the number of revisits in the 4th quarter of 1998?
- Why did Norplant insertions stop in the 1st quarter of 1998? And why were there no Norplant revisits at any time in 1997 and 1998?
- Why were there no new condom users in 1997 (even though there were revisits)?
- What were the reasons for the significant drops in numbers of revisits for oral contraceptives in the 3rd quarter of 1997 and the 4th quarter of 1998?
- Why was there such a sharp increase in revisits for Depo Provera in the 3rd quarter of 1998?

New Users

Qtr/Yr	Orals	IUD	Norplant®	Depo Provera	Condom	NFP	LAM	Total
1/97	1240	61	12	601	0	0	72	**1986**
2/97	1371	52	30	846	0	1	20	**2320**
3/97	667	52	13	303	0	1	206	**1242**
4/97	1172	33	1	483	0	0	349	**2038**
1/98	1146	33	0	406	3	6	159	**1753**
2/98	1584	25	0	590	49	0	74	**2322**
3/98	1266	23	0	793	59	9	150	**2300**
4/98	772	34	0	650	11	19	42	**1528**
Total	**9218**	**313**	**56**	**4672**	**122**	**36**	**1072**	**15489**





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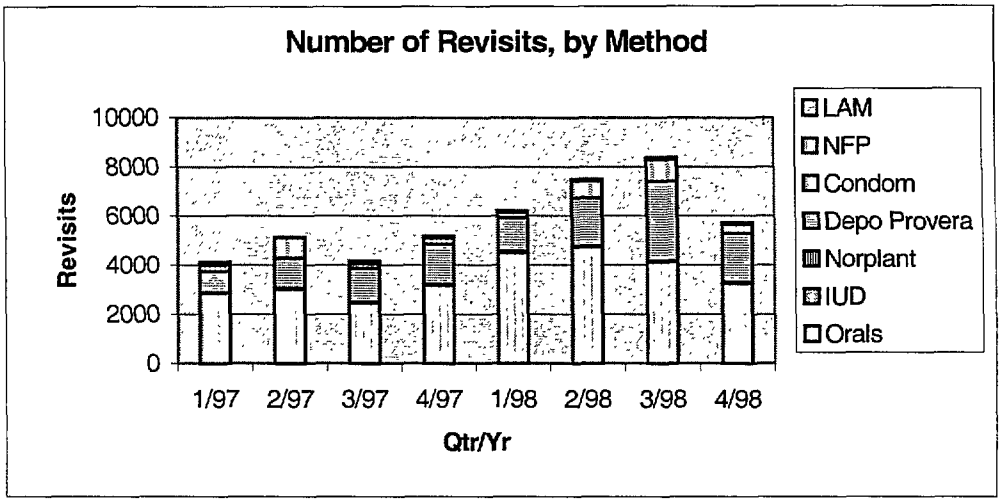
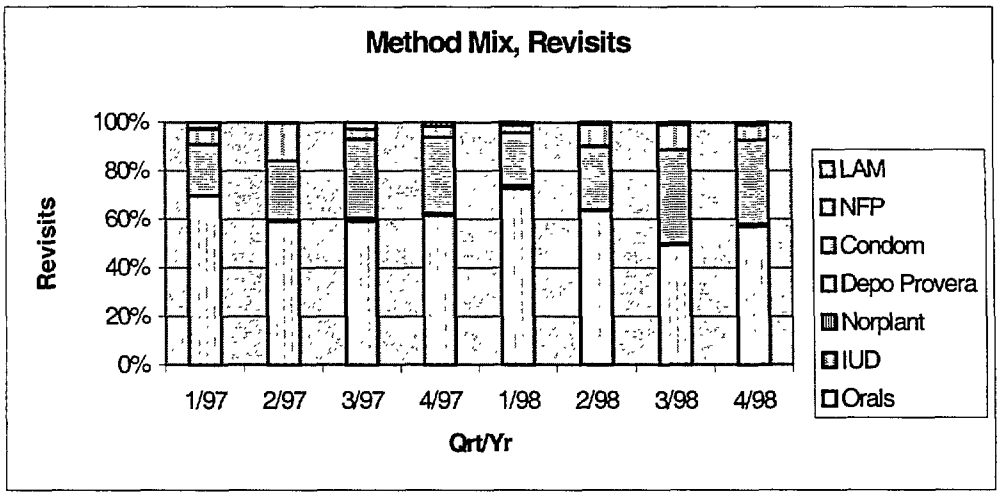
Revisits by Continuing Users

Qtr/Yr	Orals	IUD	Norplant	Depo Provera	Condom	NFP	LAM	Total
1/97	2873	9	0	862	259	17	97	**4117**
2/97	3031	32	0	1249	811	0	5	**5128**
3/97	2468	58	0	1356	173	0	115	**4170**
4/97	3195	45	0	1623	241	0	80	**5184**
1/98	4514	70	0	1351	208	12	58	**6213**
2/98	4757	31	0	1956	672	0	68	**7484**
3/98	4126	50	0	3230	871	17	63	**8357**
4/98	3259	41	0	1994	355	49	16	**5714**
Total	**28223**	**336**	**0**	**13621**	**3590**	**95**	**502**	**46367**





CQI TOOLS

CLIENT EXIT INTERVIEWS

Client exit interviews are an important source of data regarding clients' perceptions of QOC. In exit interviews, clients can provide information about their satisfaction/ dissatisfaction with certain aspects of service delivery. The Quality Team may then need to further identify the causes of any dissatisfaction.

Some examples of client exit interviews are available. A sample is attached. Another good example is available in the publication *Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care, Carolina Population Center, University of North Carolina at Chapel Hill (forthcoming).* These examples can be modified, or additional questions added, to ensure that they address issues of local interest. Alternatively, the Quality Team can design its own interview to explore specific aspects of QOC.

Before conducting client exit interviews, the Quality Team will need to share with clinic staff the reason for doing the interviews and explain how they will be conducted. Clinic staff should concur with the plan. In fact, they may be able to provide useful feedback on how to conduct the interviews successfully or they may suggest important issues that could be explored in the interviews.

Conducting the Interview

Exit interviews are conducted as clients leave the clinic. Individuals conducting the interviews should introduce themselves to the client, explain the purpose of the interview and ask for his/her voluntary assistance to help the team learn more about the QOC provided to clients. Clients who do not wish to participate must not be required to do so and they should not be made to feel guilty about their unwillingness to participate. Clients who participate should be assured that their responses will remain anonymous. Questions should be asked one at a time and the client should be encouraged to respond frankly. At the conclusion of the interview, the interviewer should thank the client for his/her time and assistance.

Number to Interview

The number of clients interviewed is an important consideration. If the sample is too small, there is an increased possibility that a problem will go undetected or a "false" problem will come to light. The larger the sample, the more precise the results, up to a point. In general, 73 interviews is a minimum number to allow for accurate calculations with 90 percent confidence. One strategy that the Quality Team could adopt would be to interview all clients during a one or two week period, depending on client flow.

"Courtesy Bias"

Client exit interviews are an extremely valuable tool for quality improvement efforts. However, it is important to recognize that some clients may not speak entirely openly due to "courtesy bias"—they may hesitate to report negative experiences to persons they think may be affiliated with the clinic—or they may simply wish to please the interviewer. The likelihood of "courtesy bias" can be reduced by using interviewers who will be seen as independent, and/or conducting the interview away from the clinic (e.g., at people's homes).

Analysis

To analyze the results of the exit interviews, go question by question, tabulating how many people answered Yes or No to each question. Then calculate what percentage of *all* the respondents to that particular question answered Yes and what percentage answered No.

If the answers are on a scale (e.g., 1–5), multiple choice or multiple response, tally the number of each response given.

To analyze the results of an open-ended question (i.e., those that do not have Yes/No or numbered answers), write down all the answers to a question and look at the answers most frequently given.

For further information on conducting client exit interviews, see *Timothy Williams, Yvette Cuca, Jessie Schutt-Ainé, "Client Satisfaction Surveys for Improved Family Planning Service, A User's Manual," International Planned Parenthood Federation, Western Hemisphere Region, Inc., New York, New York, April 1998)*

CQI TOOLS
SAMPLE CLIENT EXIT INTERVIEW

1. Is this your first visit to this clinic/service?	Yes	No
2. For what kind of service did you come today? Family Planning? Other? Which?.....	Yes	No
3. Did you receive, or were you prescribed, a contraceptive method today?	Yes ⇨ 5	No
4. Have you received, or were you prescribed, a contraceptive method from our clinic in the last 6 months?	Yes	No ⇨ 11
5. Which method did you receive, or were you prescribed?		
6. Was this the method you wanted when you came here?	Yes ⇨ 8	No
7. If not, why not?		
8. Did you have a consultation with a doctor, nurse, or counselor before obtaining this method?	Yes	No ⇨ 11
INFORMATION AND INTERPERSONAL RELATIONS		
9. Was the use of the method explained clearly to you?	Yes	No
10. Were you informed about other contraceptive methods?	Yes	No
11. Did you feel you had the opportunity to ask questions and clarify doubts?	Yes	No
12. Were you treated in a friendly and respectful way?	Yes	No
ACCESS AND ACCEPTABILITY		
13. Did you have sufficient privacy (during your consultation)?	Yes	No
14. Was it easy to get to the clinic/site?	Yes	No
15. Are the clinic hours convenient?	Yes	No
16. What times are most convenient for you?		
17. Did you find the clinic area to be clean?	Yes	No
18. If not, which areas were not clean?		
19. Was the waiting area comfortable?	Yes	No
20. Were you attended to quickly?	Yes	No
21. How long did you have to wait, approximately?		
22. Was the time spent in consultation sufficient to discuss your needs?	Yes	No
23. Was the cost for your service appropriate?	Yes	No
24. Overall, how satisfied are you with the total service you received during your visit here? Satisfied....._____ More or less satisfied....._____ Not satisfied....._____		
25. Was there anything which displeased you during the visit? (Please explain) _____ _____		
26. What suggestions do you have which could help us offer you better service in the future? _____ _____		

(Source: Adapted, with permission, from Model Client Satisfaction Questionnaire in Timothy Williams, Yvette Cuca, Jessie Schutt-Ainé, "Client Satisfaction Surveys for Improved Family Planning Service, A User's Manual," International Planned Parenthood Federation, Western Hemisphere Region, Inc., New York, New York, April 1998)

CQI TOOLS

FOCUS GROUP DISCUSSIONS

Focus Group Discussions (FGDs) are important sources of information to identify problems in the QOC or reasons for these problems. A focus group is, in essence, a guided discussion, so it does not yield *quantitative* data about a problem, but rather paints a picture of a problem.

A FGD is a discussion, guided by a facilitator, in which a small group (six to 12 people) discusses a subject. Unlike an Information, Education and Communication (IEC) session, the objective is not to inform/educate participants but to *obtain information* from the group. Participants are chosen from specific target populations—for example FP clients, former clients, community members or clinic personnel—whose opinions and ideas are important. Usually, more than one focus group is undertaken in order to ensure that a wide variety of points of view are heard.

The Discussion

The discussion is conducted as an open conversation in which each participant may comment, ask questions of other participants or respond to comments by others, including the facilitator. Interaction among participants is encouraged to stimulate in-depth discussion. The facilitator introduces and directs the discussion of topics and encourages participation in the conversation in an unbiased manner.

Preparation

In preparing to use FGD as a data collection technique, the Quality Team will need to:

- Identify the issues (problems and/or causes of problems) it wishes to learn more about
- Identify the kinds of people who can shed light on these issues and, thus, should be included as FGD participants
- Develop a discussion guide with a series of "open" questions (see below) that will stimulate discussion on the issues
- Identify a good facilitator and organize small groups of six to 12 people to participate in the FGDs.

Discussion Guide

Once the objectives and types of participants in the FGD have been identified, a discussion guide is prepared. The guide should use objective/neutral questions, so as not to bias the answers. Questions should be "open" i.e., questions that will encourage participants to talk, rather than just answer yes or no. The discussion guide is not a formal questionnaire. Although the intended subjects should be covered in the course of the session, the sequence of discussion is not rigidly fixed. Facilitation of the group

interview allows for considerable flexibility. It should be expected that some issues not included in the guide will be raised spontaneously by participants. These issues, if pertinent to the topic, should be followed up since they may represent unexpected findings that contribute to the value of the discussion.

Timing

A FGD should take no more than 1 to 1½ hours. To ensure that all issues are covered, the facilitator should estimate the amount of time to be devoted to each broad topic. If the facilitator is not sensitive to timing, peripheral issues become so time-consuming that insufficient time is left for the main objective of the sessions.

Participants

Potential participants in a FGD should be randomly selected from a neighborhood or population group, such as clients of a clinic or youth in schools. Ideally, it should not be left to a community leader to invite participants, so as to avoid potential bias in the group.

Group sessions should be scheduled for a day and time convenient to participants, at a place that is comfortable and neutral to all. Participants usually appreciate a snack or a beverage in return for their time.

Introduction to the Discussion

The facilitator should welcome participants as they arrive in order to help create a positive rapport and a climate of confidence.

Once participants are seated, the facilitator explains to the group that they have been invited because their opinions on the subject are important. Participants should be encouraged to express their points of view, ideas and experiences freely and spontaneously.

The purpose of the discussion—to improve FP services—should be made known to the group but participants should not be told the specific topic to be discussed (e.g., the hypotheses regarding the various problems and their causes), so they do not become influenced by the thinking of the Quality Team.

Role of the Facilitator

During the FGDs, the facilitator should:

- Introduce the topic very generally so as not to indicate any bias. Explain that the purpose of the discussion is to hear the point of view of *all* participants and encourage the group to speak freely, but also to give others time to speak.

- Ask one question at a time, reformulating it as necessary to ensure clarity; and, as far as time permits, exhaust responses to each topic before moving on to another.
- Encourage the participation of everyone in the group and avoid domination of the discussion by just one or two people.
- Have a colleague/team member take notes or record the conversation on tape in order to obtain a clear record of participants' responses.
- At the end of the discussion:
  - ask the participants if they have any other comments to add
  - thank them for their participation and assistance in helping the Quality Team to better understand the provision of services from their point of view.

Review and Analysis

Immediately following the FGD, the facilitator and the note-taker should review participants' responses to ensure that the notes are complete and clear. Note the differences in responses between the groups interviewed. Analyze the notes/tapes separately for each group, since different findings may emerge from different groups.

Analysis usually looks at:

- What points of view are expressed by *most* people in the group?
- What points of view are expressed by a *minority* of the group?

Focus groups yield valuable information on a topic, but since the results cannot be quantified, they have limitations as a tool to obtain baseline data against which to measure improvements in the quality of care. Thus, if the Quality Team uses FGDs to identify a problem or the possible causes of a problem, it may decide to use a different, quantitative methodology (e.g., exit interviews or client flow analysis) to obtain baseline data.

For further information on conducting FGDs, see: *Mary Debus, "Handbook for Excellence in Focus Group Research," Academy for Educational Development, Washington, DC, undated publication* and/or *Judi Aubel, "Qualitative Research for Improved Health Program Design," International Labor Office. Available from BASICS Information Center: http:///www.basics.org.*

CQI TOOLS
SAMPLE FOCUS GROUP DISCUSSION GUIDE
To determine *clients'* perspectives on the quality of care

- This guide suggests some major questions for discussion, with some possible follow-up questions listed below them. The follow-up questions may or may not be appropriate in a given situation.
- This guide includes too many questions for a 1to 1 ½ hour discussion. The Quality Team will want to decide which questions are the most useful and may want to include different questions.

Introduction:

Greet the participants and introduce yourself and the note-taker

Explain that the purpose of the discussion is to find out how to improve the quality of family planning services at _____ clinic.

Give the rules for the discussion:

- The moderator is here to learn—not to express his/her own opinions or to educate participants.
- There are no wrong answers. Everybody's opinion is valuable.
- Participants are asked to respect all opinions.
- Participants are asked to speak one at a time.

Discussion:

- What did you like about this clinic?
- What did you dislike?
- Was it easy for you to get to the clinic?
  - How long did it take, and how did you get here?
  - How could it be made easier for you to get here?
- What do you think of the clinic hours?
  - Are they convenient?
  - What times would be most convenient?

- What did you think of the waiting time? Was it short, reasonable or too long?
  - What do you think is a reasonable time to wait?
  - What do you think of the waiting area?

- What do you think of the facilities at the clinic? Are they adequate?
  - Was the clinic clean? If not, what was not clean?

- Did you get the service you wanted from the clinic? If not, why not?
  - What information were you given about how to use your contraceptive method?
  - What were you told about other methods of contraception?
  - What information were you given about when to come back to the clinic?
  - Was there any discussion of what to do if you have problems with your method of contraception?

- What do you think about the quality of the services provided at the clinic?

- Did you feel that the clinic provided adequate privacy? If not, why not?

- Were you satisfied with the way the staff treated you?
  - What did you like about the way you were treated?
  - What didn't you like about the way you were treated?
  - Did they have the skills to help you?
  - Did they take the time to listen to you?
  - Did you have an opportunity to ask questions?

- Would you recommend to your friends to come to this clinic? Why?

Wrap-up:

- Is there anything else you would like to say about this clinic, its staff and its services—and how they could improve the care they provide?

Thank you very much for participating.

CQI TOOLS
SAMPLE FOCUS GROUP DISCUSSION GUIDE
To determine *community* perspectives on services

This guide suggests some major questions for discussion, with some possible follow-up questions listed below them. The follow-up questions may or may not be appropriate in a given situation.

Introduction:

Greet the participants and introduce yourself and the note-taker

Explain that the purpose of the discussion is to find out about community perspectives on services, particularly family planning services, and how _____ clinic can improve its services.

Give the rules for the discussion:

- The moderator is here to learn—not to express his/her own opinions or to educate
- participants.
- There are no wrong answers. Everybody's opinion is valuable.
- Participants are asked to respect all opinions.
- Participants are asked to speak one at a time.

Discussion:

- What does the term "family planning" mean to you?
  - Is it a good thing? Or bad?
  - What do you hear people saying about family planning?
  - What kinds of people use family planning?
  - Why do people use family planning?
  - What does your family think about family planning?
  - What do your friends think about it?

- Would *you* consider using family planning? Or would you recommend that a friend or relative use it?

- Where would you go for family planning services? Why?

- Let's turn now to a discussion of _____ clinic. Are you aware of _____ clinic?
  - Do you know where it is located? How would you get there?
  - Do you know which services its offers?

- Have you ever used the clinic's services?
  - If not, why not?
  - If yes, were you satisfied with the services? How could they be improved?

- What do you think/what have you heard about the quality of the services provided at the clinic?
  - What have you heard about the cleanliness of the facility?
  - What have you heard about the staff? Are they competent? Are they respectful toward clients?
  - Have you heard anything about the price of services?

- Have you heard anything from people who got a family planning method from _____ clinic? If so, what have you heard?

Wrap-up:

- Is there anything else you would like to say about family planning?

- Is there anything you would like to say about _____ clinic, its staff and its services?

Thank you very much for participating.

CQI TOOLS
SAMPLE FOCUS GROUP DISCUSSION GUIDE
To determine *providers'* perspectives on the quality of care

- This guide suggests some major questions for discussion, with some possible follow-up questions listed below them. The follow-up questions may or may not be appropriate in a given situation.
- This guide includes too many questions for a 1–1½ hour discussion. The Quality Team should to decide which questions are the most useful and may want to include different questions

Introduction:

Greet the participants and introduce yourself and the note-taker

Explain that the purpose of the discussion is to find out how to improve the quality of family planning services at _____ clinic.

Give the rules for the discussion:
- The moderator is here to learn—not to express his/her own opinions or to educate participants.
- There are no wrong answers. Everybody's opinion is valuable.
- Participants are asked to respect all opinions.
- Participants are asked to speak one at a time.

Discussion:

- What do you think about the quality of care provided at this clinic?
  - What are the strong points of the services provided here?
  - What are the weak points?
- Is the clinic as clean and safe as possible? If not, what could be improved?
- Does the clinic have the necessary equipment? If not, what is needed?
- Is the space adequate and well-arranged? If not, how could it be improved?
- Do you feel you have adequate training and support for your job?
  - Are your knowledge and skills up-to-date? If not, where do you think you need help?

- Are there adequate supplies of drugs and commodities, such as contraceptives? If not, where are the problem areas?
- Do clients get the information they need to use the clinic's services effectively?
- What do you think of the referral linkages with other providers for services that aren't provided here? How well do they work?
- Are clients' records properly maintained? Are they kept confidential?
- How well does the clinic handle the job of following up on drop-outs?
- Do you think *clients* are satisfied with the quality of care they receive?
  - What do you hear clients say about services at the clinic?
- Do you feel your time at the clinic is well-used? Or could it be used more efficiently? If so, how could the clinic make better use of your time?
- Do you think the clients' time at the clinic is well-used? Or could it be used more efficiently? If so, how could the clinic make better use of clients' time?
- Would you yourself come to the clinic for services or would you recommend that a friend come to the clinic? If not, why not?

Wrap-up:

- Do you have any other suggestions for how to improve services at the clinic?

Thank you very much for participating.

CQI TOOLS

FACILITY AUDIT

A facility audit is a tool to help assess the adequacy of the physical facility (including its equipment and supplies) where services are provided. Among the things a facility audit examines are:

- The size of the space available to see/examine clients
- Proper accommodations for clients who have to wait
- The availability of a toilet, water and/or electricity
- The cleanliness of the facility
- Adequate equipment, properly maintained
- Adequate supplies and commodities, kept under appropriate conditions
- Properly maintained client records
- A follow-up system
- The availability of IEC materials

To conduct a facility audit, a knowledgeable person walks through a facility looking to see if everything is up to standard. It is important that the walk-through not interfere with the provision of services.

An example of a facility audit used by SEATS' Africa Regional follows. Another (shorter) tool for a facility audit may be obtained from the following publication: *"Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care," Carolina Population Center, University of North Carolina (forthcoming).*

CQI TOOLS
SAMPLE FACILITY AUDIT

DATE: _____ **HEALTH FACILITY/CLINIC:** _____

NAME OF ASSESSOR: _____

INDICATOR	**Yes**	**No**	**N/A**	**COMMENTS**
Method in stock:				**Record stock levels where applicable**
ORAL CONTRACEPTIVES				
Microgynon				
Safeplan				
Microlut				
PC4 (emergency contraception)				
Others (please specify)				
INJECTABLES				
Depo Provera				
Noristerat				
IUD				
Copper T 380A				
CONDOMS				
Female				
Male				
VAGINAL FOAMING TABLETS				
Neosampoon				
Others (specify)				

HO V-6b(2)

INDICATOR	YES	NO	N/A	COMMENTS
IMPLANTS				
Norplant®				
OTHER METHODS OFFERED				
LAM				
SNFP				
VSC				
Space for storage of drugs:				
Adequate				
Not adequate				
Equipment and material in stock:	**Number**	**NO**	**N/A**	**Comments to include functioning/not functioning where applicable**
Sterilizer				
Autoclave				
Gloves				
Disposable syringes and needles				
Jik				
Soap				
Complete IUD insertion kits				
BP machine				
Scale				
Pregnancy test kits				
Stationery				
Couch				
Screens				
Foot stool				

HO V-6b(3)

FP Policy Guidelines and Standards	Yes	No	N/A	If used, indicate purpose
Available				
Not available				
Used				
Not used				
IEC Materials				
Posters				
Flipcharts				
Cue cards				
Space				**If available, comment whether adequate or not adequate**
Counseling				
Health education				
Physical and pelvic examination				
Systems exist for follow-up of clients				
Clients given a review date				
Clients referred				
Follow-up of defaulters				
Records review				**Comments to include the recording of the register**
FP register				
New acceptors				
Continuing/revisits				

Recording				
Every client recorded				
Headings being filled in correctly				
Defaulters noted by review of register				
Referrals followed up to determine if care was given				
Tally sheet filled in completely and accurately				
Monthly activity register filled in accurately				

GENERAL COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Source: Shalote R. Chipamaunga, "FP/RH Trainee Follow-up Tools, A Tool for on-the-job Performance Assessment," JSI/SEATS Africa Regional Office, Harare, Zimbabwe, unpublished document, November 1998)

CQI TOOLS
FLOWCHARTS

A flow chart is a graphic representation of how a process works, showing the sequence of steps involved in the process.

A flow chart is useful to:

- Analyze the sequence of activities occurring in a process
- Establish a common understanding of a process that the Quality Team wishes to examine
- Define the relationship between activities and desired outcomes
- Identify possible causes of problems in the process

Symbols used in flowcharts, their meaning and importance in understanding processes:

OVAL represents the starting point and the end point of the process.

LINES WITH ARROWS indicate the flow of activities and decisions in the process.

RECTANGLE indicates a step or activity in the process. A brief description is given inside the rectangle.

Examine each step/activity in the process to be sure it is accurately represented, and is necessary. Is it cost-effective? Is it important to the quality of the end product?

DIAMOND indicates a decision point. The description of the decision is usually written inside in the form of a question. The responses are paths to be taken, usually "yes" in one direction and "no" in another direction.

Be sure each diamond is necessary and that it is not redundant.

BULLET indicates a wait. Examine each wait (bullet). Why is the wait required? Can it be shortened without reducing quality?

Using flowcharts:

Document the sequence of steps involved in the process to be examined:

- Begin with the first and last steps in the process that will be described. Record the first step at the top of the page and draw an oval around it. Record the last step at the bottom of the page and draw an oval around it.

- Fill in each intermediate step in the process in sequence
  - use rectangles for steps/activities
  - use diamonds for decisions. At decision points, choose one branch and continue to the end. When you reach the last step, repeat the process with each of the other branches.
  - use bullets to indicate points at which clients must wait

- Connect all rectangles, diamonds and bullets, indicating the sequence in the process. If any paths branched off from the main path, connect them as well to represent the process that occurs in such cases.

- Read through the flow chart and check for accuracy and completeness. Pay attention to any symbols you have not specifically examined in the above procedures. Is the flow logical? Are there any areas that are not complete?

When the flowchart is completed and accurate:

- On the left side of the flow chart, note next to each activity the requirements needed for the activity to occur (generally human, financial and material resources—be specific)

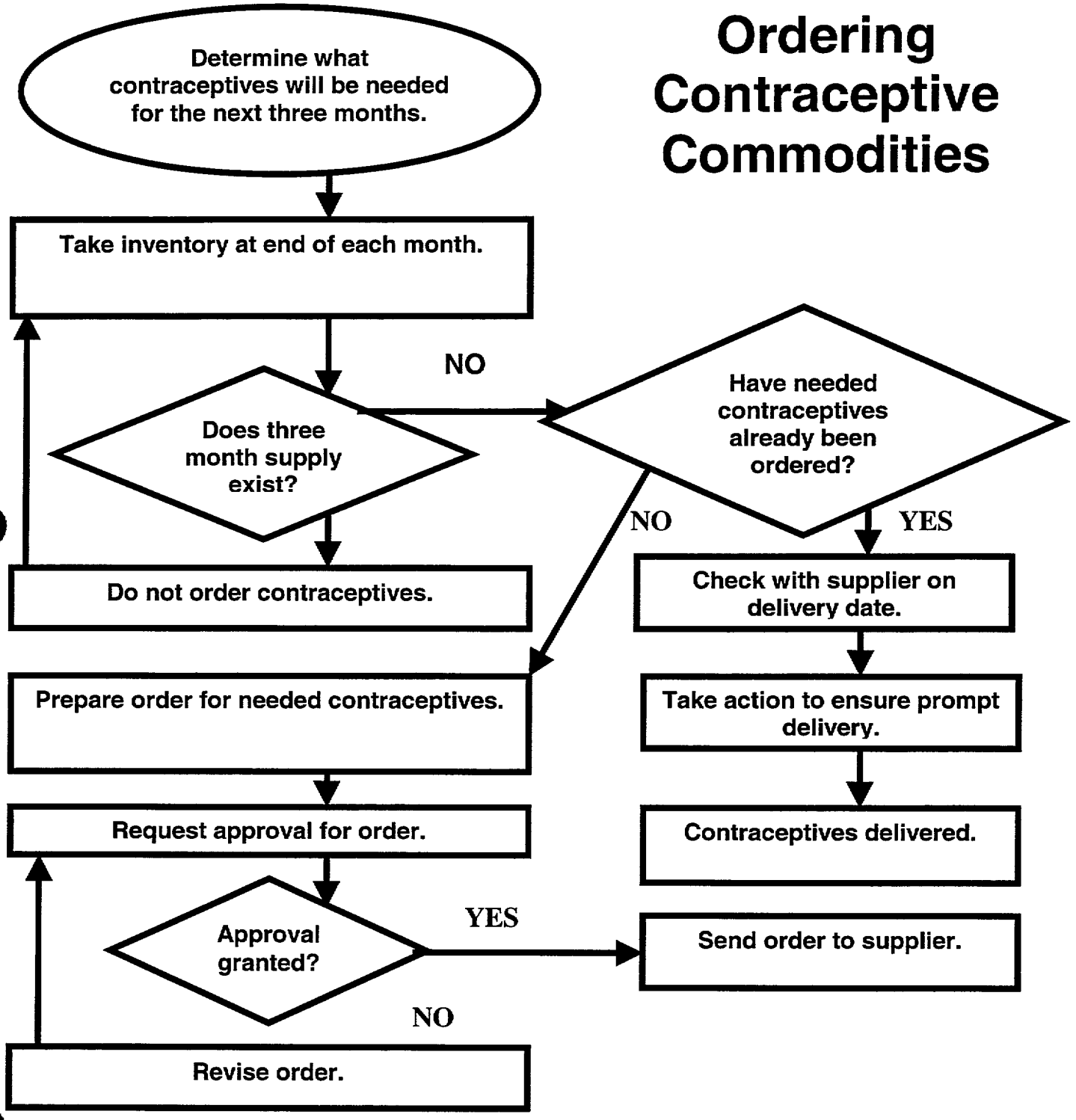
- On the right side of the flow chart, note next to each activity the desired outcomes of the activity. Note the desired outcomes of the entire process at the bottom of the flowchart.

Analyze the chart to identify where there may be problems in the process, that is where there are differences between desired outcomes and actual outcomes.

(Adapted from: Using CQI to Strengthen FP Programs, Family Planning Management Development Project ,and Achieving Quality Through Problem-solving and Process Improvement, Quality Assurance Project.)

CQI TOOLS
SAMPLE FLOW CHART

Ordering Contraceptive Commodities



(Adapted from Using CQI to Strengthen FP Programs, FPMD, and Achieving Quality Through Problem-solving and Process Improvement, QAP)

CQI TOOLS
CLIENT FLOW ANALYSIS

Client flow analysis is the calculation and graphing of the amount of time clients spend in the waiting room and in other service areas of a clinic in the course of a FP consultation. Client flow analysis helps the Quality Team assess where there are obstacles to the efficient provision of services.

To conduct a client flow analysis

1. Construct a Client Register Form, with spaces for:

- Client number
- Type of visit
- FP method
- Time of client's arrival in clinic
- Client service time with places to indicate
  - the initials of responsible staff
  - the time service started
  - the time service was completed
  - total contact time (in minutes) for each contact with clinic personnel as per the different steps of the service delivery process

2. Discuss with clinic personnel the purpose and process of client flow analysis and seek their assistance in analyzing client flow in the clinic. Orient clinic personnel in the use of the Client Register Form.

- All clients should be given a Client Register Form as they come into the clinic. Its purpose should be briefly explained to them. If a client does not wish to participate, he/she must not be required to do so. The client's arrival time should be noted on the form.
- The clients should carry the Client Register Form with them as they proceed through the clinic visit. At each contact with personnel, personnel should record on the Client Register Form:
  - the time their contact with the client started
  - the time their contact with the client ended
  - the total number of minutes they spent with the client
  - their initials

- Personnel should collect the Client Register Form from the client at the client's last point of contact with personnel before the client leaves. All Client Register Forms should be kept for analysis by the Quality Team.

3. For a designated period of time (to be decided by the Quality Team), ask clinic personnel to utilize the Client Register Form with all FP clients coming to the clinic.

4. Construct a Client Flow Chart with nine columns, labeled as follows:

1) Client number
2) Time in and time out (of the clinic)
3) Total minutes (in the clinic)
4) Contact minutes (with all personnel)
5) Waiting minutes
6) Percent waiting (as a percent of total minutes in the clinic)
7) Visit code (first visit or revisit)
8) Method code (FP method)
9) Comments

5. Fill in columns 1 - 8 (and column 9 as appropriate) on the client flow chart, using the Client Register Forms—one line for each form. Add up the totals for columns 3, 4 and 5; and calculate the averages for column 6. Calculate the totals and averages for all users of FP service.

6. The data calculated in step 5 (above) may be graphically displayed in a chart, showing for each client the time of arrival, contact times and waiting times, and method.

7. Similarly, the utilization of time can be graphed for each staff member (based on their having charted the use of their time over a specified period).

The analysis of the above data can assist the Quality Team in assessing the efficiency of the provision of services and utilization of resources.

(Adapted from AVSC Working Paper #1, COPE: A Self-Assessment Technique for Improving Family Planning Services Available from AVSC International)

CQI TOOLS
Sample Client Flow Analysis

Client Register

1. Client Number.....**01**

2. Type of Visit.....**Revisit**

3. Family Planning Method.....**Pill**

4. Time of Client's Arrival in Clinic..... **Hour Min.**

08:00

5. Client Service Time:

Contact	**Initials of Staff Responsible**	**Time Service Started**					**Time Service Completed**				**Total Time-Minutes**
		Hour		Min.			Hour		Min.		
First Contact	NZ	**0**	**8 :**	**1**	**0**		**0**	**8 :**	**5**	**0**	**40**
Second			:					:			
Third			:					:			
Fourth			:					:			
Fifth			:					:			

Client-Flow Analysis:
Sample Client Flow Chart, Partially Completed

Client #	Time In	Out	Total Minutes	Contact Minutes	Wait Minutes	Percent of time Waiting	Visit Code	Meth Code	Comment
01	8:00	8:50	50	40	10	20%	R	P	
02	8:10	9:20	70	11	59	84%	R	I	
03	8:15	9:23	68	14	54	79%	F	I	
04	8:15	11:00	165	57	108	65%	F	A	
05	8:20	11:00	160	17	143	89%	F	L	
06	8:20	10:22	122	8	114	93%	R	A	
07	8:28	12:55	267	193	74	28%	R	P	
08	8:30	9:34	64	8	56	88%	R	C	
09	8:30	9:40	70	7	63	90%	F	L	
10	9:00	10:05	65	6	59	91%	R	N	
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									

Average Time in Clinic: ***110 minutes*** (Total minutes spent in clinic by all clients divided by number of clients.)
Average Contact Time: ***36 minutes*** (Total contact minutes spent by all clients divided by number of clients.)
Average Wait Time: ***74 minutes*** (Total minutes spent waiting by all clients divided by number of clients.)

Method Codes

A Counseling
C Condom
I Injectable
L LAM
N No method, i.e., non-family planning clients, including women who come for prenatal care.
P Pill

Visit Codes

F First Visit
R Revisit

Source: J. Dwyer, J. Haws, G. Wambwa, M. Babawale, F. Way, P. Lynam, "COPE: A Self-Assessment Technique for Improving Family Planning Services," AVSC Working Paper #1, AVSC International, New York, NY, April 1991.

CQI TOOLS

OBSERVATION OF COUNSELING

Observation of FP counseling is an important means of assessing several aspects of QOC, including choice of method, information given to the client, certain aspects of technical competence, interpersonal relations, continuity and follow-up, and certain aspects of the appropriateness and acceptability of services.

Checklist

In order for the observation of counseling to be useful for quality improvement efforts, the Quality Team will need to have a checklist of elements of QOC they wish to focus on. A sample checklist used by the SEATS project in Africa follows. A shorter tool for observation of counseling may be obtained from the following publication: *Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care, Carolina Population Center, University of North Carolina (forthcoming).*

Observation

During the observation of counseling, the team member(s) doing the observation should do it individually and with the consent of the service provider and the client. The observer should sit where he/she can see both the service provider and client, and observe the counseling process, without distracting either individual in the process. He/she should not intervene in the process.

Observation of counseling is the most widely used method of verifying the quality of the interaction between providers and clients. It yields valuable information, but also has some disadvantages. Providers tend to make an effort to perform particularly well when they are being observed; observation may be perceived as intrusive (by the client and/or the provider); it is time-consuming and thus may be relatively costly.

SAMPLE TOOL FOR OBSERVATION OF COUNSELING

CHECKLIST FOR COUSELING CLIENTS FOR INFORMED CHOICE

Name of Service Provider:_____

Qualifications and Title of Service Provider:_____

Date of Observation:_____

Name of Clinic:_____

Name and Title of Observer:_____

INSTRUCTIONS FOR THE OBSERVER:

1. Observe and complete all the appropriate columns as the procedure is being carried out. Intervene **only** if the provider omits or performs a step that compromises method effectiveness, puts the client in danger or inconveniences the clients.

2. Give a full score (2 points) for clinical tasks that are performed correctly according to standard. For tasks that are not performed according to standard, i.e., probed, give 1 point. For tasks not performed according to standard, even after probing, give 0 point. Write specific, nonjudgmental comments in the comments column. Comments will help you give specific feedback and identify which skills need strengthening or which areas need updating.

3. For materials which are not in the clinic, conditions that are not present in the client or are not applicable, give a full score (2) to maintain consistency.

4. Where there is the word OR in the indicator, only one of the alternatives should be given a score.

5. To determine the level of competence, use the cut off score and the score attained on critical indicators. Tasks marked with an asterix (*) are critical (critical indicators). For a satisfactory level of competence:

   a) All critical indicators should attain a full score (2 points). Failure in any one critical indicator means failure on that particular job task.

   b) The score attained should be above cut off. Where there are no critical indicators, use the cut off score only.

A critical indicator is a subtask which, if omitted or not performed according to standard:

- Puts the client in danger
- Compromises method effectiveness
- Leads to non-completion of the task under review

CHECKLIST FOR INFORMED CHOICE COUNSELING	Done according to standard	Done according to standard after prompting	Not done according to standard even after prompting	Comments
Step/Task	**2**	**1**	**0**	
1. Prepares counseling setting and materials:				
Assembles appropriate AV aids				
Assures privacy and confidentiality				
Ensures that both client and counselor are seated facing each other				
TOTAL SCORE = 6 CUT OFF SCORE = 4 SCORE ATTAINED =				
2. Use appropriate counseling skills: (This task to be assessed throughout the procedure)				
Asks open-ended questions				
Probes (as necessary)				
Summarizes/paraphrases				
Reflects feelings				
Assesses client's understanding				
Listens actively				
TOTAL SCORE = 12 CUT OFF SCORE = 8 SCORE ATTAINED =				
3. Establishes client's needs:				
Greets client/creates rapport				
Introduces self and others to the client				
* Asks what client needs				
Obtains/Reviews background data:				
Name				
Age				
Number of children				
Age of youngest child				
Number of more children wanted				

CHECKLIST FOR INFORMED CHOICE COUNSELING	Done according to standard	Done according to standard after prompting	Not done according to standard even after prompting	Comments
Step/Task	**2**	**1**	**0**	
If spacing, when next child is wanted				
TOTAL SCORE = 18 CUT OFF SCORE = 12 SCORE ATTAINED =				
4. Explains methods according to client's needs				
Asks what family planning method client prefers				
If client has a preferred method:				
Asks what s/he knows about the preferred method				
Supplements information that may be omitted and corrects inaccurate information as follows:				
How it prevents pregnancy and its effectiveness.				
Benefits/advantages				
Risks/disadvantages				
* Potential side effects				
* Whether or not method protects from STI/HIV				
* What to do if at risk of STI/HIV				
Routine follow up visits				
If client does not have a preferred method:				
Provides general information about family planning methods available to enable client to select a method of choice as follows:				
What the method is				
How the method works				
Benefits/advantages				

CHECKLIST FOR INFORMED CHOICE COUNSELING	Done according to standard	Done according to standard after prompting	Not done according to standard even after prompting	Comments
Step/Task	**2**	**1**	**0**	
Risks/disadvantages				
* Risk of exposure to STI/HIV				
Routine follow up visit				
TOTAL SCORE = 30	**CUT OFF SCORE = 20**		**SCORE ATTAINED =**	
5. Helps client to select a suitable method				
*Asks client to choose preferred method and explains the method in detail				
*Asks client to select a more appropriate method if preferred method is not suitable				
Allows client to ask questions and answers them correctly				
*Asks client to summarize information in order to check his/her understanding				
Informs client that his/her choice will be confirmed on history taking and/or physical assessment				
Explains the next step related to screening procedures for the method selected by the client				
Proceeds with the next step- which may be Method Specific Counseling (see appropriate checklist)				
TOTAL SCORE = 14	**CUT OFF SCORE = 9**		**SCORE ATTAINED =**	

GRAND TOTAL = 80 OVERALL CUT OFF SCORE = 53 OVERALL SCORE ATTAINED =

Assessment:

1. _____ **Provider competent.** ***(Overall cut off score of 53 or higher and all critical indicators (marked *) scored 2)***

2. _____ **Provider competent but needs strengthening in the performance of critical indicators that were not done according to standard.** ***(Cut-off score of 53 or higher but missed some of the critical indicators)***

3. _____ **Provider not competent. Needs more training/support.** ***(Cut-off score below 53)***

Participant's Signature: _____ **Date:**_____

Observer's Signature:_____ **Date:**_____

(Source: Shalote R. Chipamaunga, "FP/RH Trainee Follow-up Tools, A Tool for On-the-Job Performance Assessment," JSI/SEATS Africa Regional Office, Harare, Zimbabwe, unpublished document, November 1998)

HO V-10 to V-12

HO V-10: MAQ Checklist

HO V-11: Using CQI to Strengthen FP Programs, FPMD

HO V-12: Manager's Toolbox for CQI, FPMD

Copies of these publications follow. See bibliography for ordering information

CHECKLIST FOR FAMILY PLANNING SERVICE DELIVERY, WITH SELECTED LINKAGES TO REPRODUCTIVE HEALTH

MAXIMIZING ACCESS AND QUALITY

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This checklist was prepared by Jim Shelton, Sarah Davis and Jill Mathis (USAID/G/PHN/POP) with assistance from many helpful reviewers. We have incorporated many of their thoughtful comments. We appreciate the time, effort and insight of all those who have offered comments and offer thanks in advance to those whose suggestions will improve the checklist in the future.

INTRODUCTION

What Is MAQ?

MAQ (Maximizing Access and Quality) is an initiative of USAID and collaborating agencies to serve clients and programs by improving both access to and quality of services in a cost-effective manner. MAQ promotes quality services that clients want and need, and works to remove unnecessary barriers that discourage clients from using services. Although quality and access vary with the service delivery setting and resources available, MAQ promotes several universal principles regardless of the setting:

1 - Emphasize access to quality services
2 - Build a client orientation
3 - Support quality and access from the top
4 - Build quality and access from the bottom
5 - Build in approaches to evaluate and improve

What Is the MAQ "Checklist"?

This Checklist is designed to be something of an annotated "memory jogger." The idea is to identify a number of critical areas of access and quality (e.g., client-provider interaction) and then pose a wide number of provocative questions about each. Thus, it is not a formal evaluation tool, nor an encyclopedia. Rather, it simply directs the user to a number of critical issues in each area.

...ho Is the Checklist's Intended User?

The Checklist is meant for design teams, evaluation teams and a wide variety of other users interested in programmatic aspects of FP/RH service delivery quality and access in the specific setting (such as a country program). The Checklist's format generally assumes a certain level of knowledge; however, much of the Checklist is fairly self-explanatory and references are cited throughout. While the Checklist is oriented to clinic-based services, it can be used to promote MAQ in a variety of settings.

How Should I Use the Checklist?

The Checklist is designed to allow sections to be used independently (therefore some overlap occurs among sections). Users may typically find it most useful to pick and choose the most relevant sections. **Since identifying priorities in MAQ is crucial, items considered highest priority are bolded.**

Caveats

The Checklist presents practices in something of an ideal form. Nevertheless, it is not intended to send the daunting message that a program is of poor quality unless all items are perfectly addressed. On the contrary, few if any programs meet the ideal model, and continuous improvement is the best approach. Further, certain aspects of quality and access may vary from place to place and person to person. For example, for some clients, long waiting times may or may not be perceived as a problem.

Sources of Information

Visiting service delivery sites to "eyeball" services and talk to providers and clients is one o the most important steps in assessing access and quality. Additional data sources and references also provide valuable information. Although not available in every setting, the following are particularly useful for assessing access and quality:

1. Situation analysis
2. Personal observation
3. Interviews with providers, clients, managers and policy makers
4. Client follow-up studies
5. Client Oriented Provider Efficient (COPE) surveys
6. Patient flow analysis
7. Mystery client surveys
8. Operations research
9. Previous evaluations and assessments
10. Other specific studies revealing client perspective (e.g., data on clients' perception of the level of quality of care; data on quality of care components most important to clients)
11. Demographic and Health Surveys (DHS)
12. Service statistics (e.g., number of users, return visits, referrals, etc.)
13. Service delivery guidelines

The following documents are useful as references in the areas of access and quality:

1. WHO Medical Eligibility Criteria for Contraceptive Use
2. USAID Technical Working Group's Recommendations for Updating Selected Practices in Contraceptive Use, Volume I and Volume II
3. PocketGuide for Family Planning Service Providers (JHPIEGO)
4. Handbook of Indicators for Family Planning Programs (EVALUATION Project)
5. OPTIONS II Policy Paper Series
6. The Essentials of Contraceptive Technology (JHU/PIP)
7. "New Guidance" Population Reports (JHU/PIP)

CLIENT-PROVIDER INTERACTION

- ☐ **Do FP/RH clients routinely select and receive their chosen method (from among those methods for which they are medically eligible)?**
- ☐ Given that there may be limited time available for client-provider interaction, does the provider focus on giving **priority information that is tailored to the specific client's particular needs?**
  This includes:
  - giving clients information on the various available methods, recognizing that this may require less time for clients who have already chosen a method;
  - conveying **key information on the method chosen** (e.g., effectiveness, **side effects,** how to use, signs to watch for, when to return, noncontraceptive benefits);
  - selecting essential information and phrasing it carefully so as to avoid overwhelming or confusing the client;
  - using language and terms easily understood by clients.
- ☐ Is communication between clients and providers **interactive**? Are clients encouraged to ask questions? Do providers engage in active listening? Do they offer feedback to clients' questions and concerns? Are providers aware of common incorrect rumors about contraceptives?
- ☐ Do personnel attempt to minimize "social distance" (differences in sex, age, social class, economic status, education and cultural backgrounds between themselves and their clients)? Are providers sympathetic, polite, non-hierarchical, respectful, unbiased and attentive?

Which staff counsel clients?

- ☐ Do staff who interact with or counsel clients receive communication training?
- ☐ Is counseling written into their job descriptions?
- ☐ Is the clinic management supportive of their counseling activities?
- ☐ Does the staff have sufficient time to provide key information and cover client concerns?
- ☐ In helping clients choose a method, do providers help clients consider factors of life stage, life situation, sexuality and reproductive health conditions related to choice of contraception?
  Examples of factors that might influence method choice:
  - *client at high risk for STD/HIV,*
  - *client with abusive partner who obstructs her from controlling whether method is used,*
  - *breastfeeding client.*
- ☐ Do providers greet respectfully according to local norms? Do personnel (non-providers as well as providers) respect clients' rights to privacy, confidentiality, dignity and courtesy? **Are providers nice to clients?**
- ☐ Are appropriate IEC **"Job Aids"** (esp. provider-targeted flip charts and wall charts, client brochures, anatomical models, *Essentials of Contraceptive Technology,* etc.) regularly available? Are they used? Are they in a language understood by clients (as appropriate)?
- ☐ Does counseling include STD prevention?

TECHNICAL COMPETENCE

Do clinical providers perform according to good standards in:

- ☐ **Addressing contraceptive side effects (counseling and medical management)?**
- ☐ Properly screening for and providing (as applicable):
  - combined OCs and progestin-only pills?
  - IUDs (including postpartum and postabortion)?
  - voluntary male and female sterilization?
  - injectables?
  - NORPLANT® implants?
  - condoms?
  - female barrier methods (including fitting diaphragms, where applicable)?
  - lactational amenorrhea?
  - natural family planning?
- ☐ Promoting prevention, screening and managing STDs/HIV and reproductive tract infections? (e.g., condom promotion and counseling, diagnosis, referral, prevention counseling, treatment, as appropriate)
- ☐ Counseling? (see client-provider interaction section)
- ☐ Infection prevention? (see section)
- ☐ Helping women in special categories (e.g., breastfeeding) select methods?
- ☐ **Have all service providers received good training relevant to their jobs? Have providers received good refresher training recently? Upon completion of training, are providers competent at performing the clinical procedures and counseling appropriate to their job?**

For guidance on predetermined standards, the following references are useful:

1. Country-adapted standards
2. WHO Medical Eligibility Criteria, 1996
3. *Technical Working Group Recommendations for Updating Selected Practices in Contraceptive Use, Volumes I, 1994, and II, 1997*
4. *PocketGuide for Family Planning Service Providers*, JHPIEGO, 1996
5. *Medical and Service Delivery Guidelines*, IPPF, 1997
6. *The Essentials of Contraceptive Technology*, JHU/PIP, 1997
7. *Safe and Voluntary Surgical Contraception: Guidelines for Service Programs*, AVSC, 1988
8. *Guidelines for Clinical Procedures in Family Planning: A Reference for Trainers*, INTRAH, 1993
9. *Controlling STDs*, Population Reports, June 1993
10. *Natural Family Planning: A Guide to Provision of Services*, WHO, 1988
11. *Guidelines: Breastfeeding, Family Planning and Lactational Amenorrhea-LAM*, Institute for Reproductive Health, 1994
12. *Postpartum IUD Insertion: Clinical and Programmatic Guidelines*, AVSC, 1994
13. *IUD Guidelines for FP Service Programs*, JHPIEGO, 1993
14. *New Guidance*, Population Reports, JHU/PIP, Oct. 1996

INFRASTRUCTURE, PHYSICAL FACILITIES & EQUIPMENT

Are facilities equipped with the basic equipment, supplies and physical structure necessary for providing FP/RH services as appropriate? Do facilities have (where applicable):

- ☐ **adequate utilities** (e.g., running water, accessible sink for handwashing, electricity, access to toilet/latrine for clients as well as staff)? If there is no running water or electricity, are alternatives available which permit providers to hygienically deliver available services?
- ☐ adequate space (e.g., private space for examination and counseling; cool, dry storage space for contraceptives; area for administrative work)?
- ☐ **job aids** and other supplies (e.g., clinical guides such as *Essentials of Contraceptive Technology*, wall posters, flip charts, office supplies, etc.)?
- ☐ adequate furniture?
- ☐ enough specula for pelvic exams?
- ☐ equipment for physical examinations (e.g., working blood pressure equipment)?
- ☐ equipment for insertion and removal of IUDs?
- ☐ equipment for insertion and removal of NORPLANT® implants?
- ☐ equipment for voluntary surgical contraception (male and female)?
- ☐ equipment for sterilizing, cleaning and disinfecting (e.g., sterilizer, soap and clean water for hand washing, gloves)?
- ☐ equipment for performing any simple appropriate laboratory tests?

See: *Guidelines for Clinical Procedures in Family Planning: A Reference for Trainers, Appendix 10*, INTRAH, 1993

METHODS/ COMMODITIES

- ☐ **What commodities are actually available at service delivery points?** (COCs [including COCs for emergency contraception], condoms, POPs, IUDs, NORPLANT® implants, vaginal methods, injectables) Are commodities in sufficient supply?
- ☐ **Do facilities provide the maximum number of methods potentially available (including LAM, barrier methods, hormonal methods, etc.) that their capability will allow?**
- ☐ **Are OCs, IUDs, injectables, condoms, foaming tablets and NORPLANT® implants always available with no disruptions in stock (stockouts)?** Why do stockouts occur? How often do they occur? At what level do they occur?
- ☐ Are methods appropriate?
  Examples:
  - *no high-dose COCs, except for rare instances.*
  - *progestin-only injectable may be limited to one product, to avoid confusion.*
- ☐ Do clinics and warehouses operate according to the FEFO (first expiry, first out) system? Is there an effective, logical system that tracks stock levels and notifies staff when supplies need reordering?
- ☐ Are supplies in good condition (e.g., not expired, no damage to cartons or individual units, labeling intact and correct, etc.)?

- ☐ Are contraceptives, medicines and other supplies kept in manner that ensures good preservation (e.g., away from water, heat and direct sunlight)?
- ☐ Are expired contraceptives destroyed to prevent resale or other inappropriate use? If expiry date is extended, are products relabeled?
- ☐ If injectables are provided, are there adequate supplies of safe needles and syringes and a mechanism to ensure accountability?
- ☐ Are clinical provider guidebooks and job aids available and used (e.g., *Essentials of Contraceptive Technology*)?

PRIVACY & CONFIDENTIALITY

- ☐ **Do counseling and examination rooms/areas have visual and auditory privacy?**
- ☐ Do staff knock or ask permission before entering areas where clients are being examined or counseled?
- ☐ Where examination tables are not in enclosed areas, are they blocked with a curtain or screen?
- ☐ Do providers maintain appropriate confidentiality and privacy with their clients?
- ☐ Do providers ask permission of clients for visitors to be present during consultation?

INFECTION PREVENTION

- ☐ Do providers wash hands:
  - before direct contact with a client?
  - after handling soiled instruments, touching body fluids and mucous membranes?
  - after removing gloves?
- ☐ Do all providers practice appropriate infection prevention techniques? Is the appropriate IP equipment available and used (e.g., sterilizers, chlorine solution)?

See: *PocketGuide for Family Planning Service Providers*, JHPIEGO, 1996
or *Infection Prevention for FP Service Programs*, JHPIEGO, 1992

- ☐ Do facilities have running water? Are they clean? Do facilities have toilets or latrines?
- ☐ Do facilities have proper equipment for decontamination, sterilization or high-level disinfection (an autoclave or "cooker")? Are reusable instruments processed (through decontamination, cleaning and either sterilization or high-level disinfection) before reuse?
- ☐ Are only sterile or high-level disinfected needles used for injecting injectables such as DMPA, Cyclofem and NET-EN?
- ☐ Is appropriate antiseptic solution available for cleaning the cervix prior to IUD insertion and for VSC procedures? Is the solution used properly?
- ☐ Are appropriate gloves available and used for such procedures as pelvic exams, VSC, IUD insertion and removal, NORPLANT® insertion and removal, etc.?
- ☐ In handling infectious waste, do providers practice proper disposal techniques (e.g., dispose of sharp objects in puncture-resistant containers, pour liquid waste down a utility drain or toilet, and bury or burn contaminated waste)?

ACCESS: POTENTIAL BARRIERS TO QUALITY SERVICE

Good access is extremely important but is often limited at many different stages in the process of seeking services. The concept of access is complex — it involves the ease or difficulty of both reaching the service delivery point and receiving services once there. Even seemingly subtle barriers can be daunting to clients.

Access can be assessed from at least three points of view: the client's, the provider's and the third-party observer's. The client's view of appropriate access and respect for his or her autonomy should be used in program guidance whenever possible. However, the client's view must be balanced with providers' needs and appropriate standards. Because of their important role in expanding or hindering access, standards such as national guidelines and norms are crucial. For example, in the area of eligibility criteria, national standards either appropriately or inappropriately can restrict access. Appropriate eligibility criteria protect client safety, while inappropriate criteria constitute needless barriers.

Standards must reflect a sensible, rational approach to balancing the benefits and risks of contraceptive use while maximizing the client's choice.

PHYSICAL & TIME BARRIERS

- ☐ Are service sites easily accessible to clients (e.g., accessible by walking or public transport, readily identified, open convenient hours)?
- ☐ Is a reasonable range of FP/RH services available at service sites at time of visit? Are these services available regularly enough?
- ☐ Does the service delivery system try to address the frequent inability of women to leave their homes to seek services? (For example, CBD approach, sufficient cycles of OCs available, no menstrual requirement.)
- ☐ Is the waiting time reasonable? Is there an "express line" for certain clients?
- ☐ For larger service delivery points is there an efficient system of triage which directs clients to the appropriate provider based on their purpose of visit?
- ☐ Are service sites free from major physical obstacles (e.g., inadequate space, dirty conditions, lack of exam table or light, lack of equipment)?

APPROPRIATE ELIGIBILITY CRITERIA

(Specific illnesses or conditions that determine whether clients can safely use contraceptive methods)[see WHO Eligibility Criteria and national service delivery guidelines]

- ☐ **Age?**
  Example of recommended guideline:
  - *DMPA, OCs (unless woman is a smoker over age 35) and IUDs can be used by clients of any age.*
- ☐ **Parity?**
  Example of recommended guideline:
  - *DMPA, IUDs and OCs can be used by women of any parity.*
- ☐ **Elevated STD risk?**
  Example of recommended guideline:
  - *IUD use is not recommended for women with an elevated STD risk.*

ACCESS: POTENTIAL BARRIERS TO QUALITY SERVICE

☐ Are inappropriate or imprecisely implemented contraindications avoided?
Examples of recommended guidelines:
- *Contraindications for COCs do not necessarily apply to progestin-only pills. For example, women with deep venous thromboembolism can safely use POPs.*
- *Women with varicose veins can use COCs.*

☐ Lactation?
Examples of recommended guidelines:
- *Progestin-only methods can be used by breastfeeding women at least 6 weeks postpartum.*
- *COCs should generally not be used by breastfeeding women in the first 6 months postpartum.*

☐ Marital status?
Example of recommended guideline:
- *Clients have the right to choose freely whether to practice family planning and to select their own method, regardless of marital status.*

☐ Parental or spousal approval?
Example of recommended guideline:
- *Although approval of parents is desirable, adolescents have the right to choose freely whether to practice family planning and to select their own method.*

PROCESS BARRIERS

(Scientifically unjustifiable procedures required for receiving contraception)

☐ No unnecessary or inappropriate initiation barriers?
Example of recommended guideline:
- *IUDs, injectables and NORPLANT® implants can be inserted at any time during the menstrual cycle when you can be reasonably sure the woman is not pregnant.*

☐ "Rest periods" avoided?
Example of recommended guideline:
- *Stopping a method and then resuming several months later is unnecessary for safe use of any method and in fact may compromise safe use (e.g., premature IUD reinsertion increases woman's risk of infection).*

☐ No unnecessary or inappropriate procedures tied to contraceptive delivery?
- From the medical perspective, four classes have been established according to their relevance for contraceptive initiation. (See table below)

Classification and Example

A = essential, mandatory or otherwise important for safe and effective use of the method counseling. *Example: STD risk screening for IUDs.*

B = rational in some circumstances to optimize the safe and effective use of the method, but may not be appropriate for all clients in all settings. *Example: blood pressure for COCs.*

C = may be good preventive health care, but not materially related to safe and effective use of the method. *Example: blood pressure for barrier methods.*

D = not materially related to either good preventive health care or the safe and effective use of the method. *Example: routine, mandatory lab tests such as glucose, cholesterol and liver function tests for use of COCs, injectables, IUDs, NORPLANT® implants and voluntary sterilization.*

- ☐ No inappropriate follow up schedules?
  Examples of recommended guidelines:
  - *IUD user returns once post-insertion (from 4–6 weeks to 3 months), and afterwards any time she has problems.*
  - *Users of all methods should be counseled to recognize warning signs and to return or seek help if they appear.*
- ☐ Inappropriate side effects management avoided?
  Example of recommended guideline:
  - *Women who become amenorrheic while using DMPA can continue to use the method.*
- ☐ Difficult resupply avoided?
  Example of recommended guideline:
  - *If stock permits, as many as 13 OC pill packs at a time can be given to new and returning clients.*

COST BARRIERS

- ☐ Do clients find cost of services and supplies to be affordable (recognizing that costs include both direct fees plus other costs such as transport and opportunity costs)?
- ☐ Are no fees charged for what clients understand to be free service? Are no inappropriate fees charged to clients seeking removal of NORPLANT® implants or IUD?

SOCIAL DISTANCE BARRIERS

(Social differences between client and provider that can hinder effective interaction)

- ☐ **Do providers attempt to overcome differences by making interaction personal and respectful?**
- ☐ If clients and providers have different social, age, economic, religious, ethnic or gender status, do providers put them at ease, so this different status does not intimidate or discourage clients from seeking services or asking questions?
- ☐ Do providers overcome the hierarchy of medical culture, which can be conservative, aloof and highly technical, by treating clients with courtesy and respect, encouraging questions and letting clients make their own choices?

2 ACCESS: POTENTIAL BARRIERS TO QUALITY SERVICE

LEGAL & REGULATORY BARRIERS

- ☐ All contraceptive methods approved?
- ☐ No inappropriate restrictions on types of providers able to provide contraceptives?
  Examples of recommended guidelines:
  - *Properly trained midwives and nurses, etc. as well as physicians can insert NORPLANT®.*
  - *Properly trained CBD agents, midwives and nurses can provide OCs (no physician's prescription needed).*
  - *With proper training, private-sector pharmacists and midwives and others can provide a variety of methods.*
- ☐ Method provision not inappropriately restricted to certain service sites?
  Examples of recommended guidelines:
  - *With proper training, community workers can provide OCs outside of clinics.*
  - *Vasectomy can be done in any facility meeting criteria for infection prevention and trained providers (e.g., vasectomy need not be done only in a hospital).*
- ☐ No regulatory and legal barriers to private-sector growth?
  Example of recommended guideline:
  - *Regulatory and tax policies that act as disincentives to private sector services should be evaluated and reformed.*
- ☐ Import restrictions and customs duties removed?

PROVIDER BIAS

- ☐ **Are clients given their first method choice if they meet medical eligibility criteria and the method is available?**
- ☐ Do providers avoid unduly influencing the client's selection of a method?
- ☐ Are program "targets" avoided, which might detract from optimal choice?
- ☐ No evidence of **"method mix" problems,** whereby unusually high use of a certain method is clustered within clinics, areas or a country?
- ☐ Are providers able to temper their own views about methods and instead facilitate the client's own process of method choice?

TRAINING

- ☐ Is training in maximizing access and quality provided for all FP/RH providers? Priority areas for quality and access training include:
  - client-provider interaction,
  - technical competence in clinical procedures,
  - problem-solving skills,
  - access and barriers,
  - infection prevention.

Does training:

- ☐ follow a competency-based model?
- ☐ address institutional and service delivery site needs?
- ☐ allow providers to practice skills learned?
- ☐ allow for easy transference to actual situations that arise on the job?
- ☐ follow the national service delivery guidelines and serve to reinforce the practice of appropriate national or international norms?
- ☐ link with trainee follow-up and support from supervisors?
- ☐ Do training strategies provide for the inclusion of private-sector providers and managers? For example, do pharmacists and other private providers supplying contraceptives through social marketing receive quality and access training?
- ☐ Is a focus on maximizing access and quality present in both pre- and in-service training?
- ☐ Is in-service training in MAQ regularly available and easily accessible to providers?
- ☐ Does training include a wide variety of modalities (e.g., updates, tutorials, distance learning, "whole site" training, etc.)?
- ☐ Are training methods conducive to quality improvement (i.e., do they involve the participation of all levels of workers to collaboratively seek creative solutions)?

INFORMATION EDUCATION COMMUNICATION (IEC)

- ☐ **Is there adequate provision of good quality provider IEC materials AND ARE THEY USED? (e.g., flip charts, posters, brochures, checklists, etc.)?** Does the information give accurate, balanced, unbiased attention to available methods? Do the IEC materials show how to use methods? Are materials appropriate for the literacy level and language of intended audience?
- ☐ Do materials conform to appropriate national service delivery guidelines?
- ☐ Are materials available for clients to take home?
- ☐ Is there a national IEC strategy? Does it serve the strategy of the overall program?
- ☐ How well does the strategy reflect sound IEC principles such as:
  - following a logical process based on scientific principles and audience research,

- understanding the knowledge, attitudes and practice of the intended audiences,
- pretesting, monitoring and evaluating activities and materials,
- coordinating the dissemination efforts and key messages of various IEC agencies?

☐ Does the strategy encourage clients to discuss FP/RH with partners, health care providers and other members of the community and to promote quality of services?

☐ **Does the strategy identify counseling as a primary way to disseminate information and to promote communication about family planning and reproductive health?**

☐ Is IEC material used to promote choice and to communicate side effects and advantages/disadvantages of contraceptive methods?

☐ Do IEC strategies and messages portray FP/RH providers as competent, caring, client-oriented professionals who are concerned about access and quality (a provider professionalism model)? Do they promote clients' expectations of good quality and access?

☐ Do IEC interventions use appropriate channels to reach women and men (nonliterate, community-based interpersonal communication)? Do materials emphasize responsible reproductive roles and clients' rights to FP/RH?

☐ Do IEC strategies aim to work with community-based groups, professional societies, men's and women's networks and other NGOs to:

- build social norms that support use of FP/RH services?
- seek community input on improving FP/RH service delivery?

☐ Are mass media (press, radio, television, film) used to provide accurate and responsible information on FP/RH in a culturally appropriate manner?

☐ Do IEC strategies or messages provide cues to action that various audiences can use to obtain FP/RH services (such as locations, telephone numbers and suggested actions)?

☐ Do mass media and other IEC appropriately support a variety of worthy RH and other messages mutually supportive of FP (e.g., breastfeeding, individual empowerment, spousal communication, girls' education, status of women, etc.)?

GENDER

☐ **Are gender roles and differences (as they relate to access and use of FP/RH) adequately addressed in counseling and service provision?**
For example:
- *Do service delivery programs make special efforts to reach women who cannot leave the home, do not have access to money, or cannot be seen by male physicians?*

☐ Are program managers and providers sensitive to the power imbalance that women often experience with partners and/or providers in the process of making FP/RH decisions? Is this sensitivity applied to making quality services available to women and men?

- ☐ Is men's responsibility for FP/RH promoted through policy, mass media and service provision? Are men encouraged to play a constructive role in promoting the RH of themselves and their partners?
- ☐ Recognizing the need to provide adequate space for women to comfortably receive services, are select facilities made easily accessible to men?
  For example:
  - *Counseling is available to couples who wish to be consulted together.*
  - *Men can pick up condoms at clinics and/or other channels without feeling stigmatized and without disturbing women clients.*
- ☐ Are providers sensitized to the impact of female genital mutilation and domestic violence on service provision and/or method use? Do they help women cope with these issues?
  For example:
  - *Providers can readily refer women to legal and other services.*
- ☐ Do IEC strategies and messages attend to gender issues in FP/RH? Do they promote supportive messages (i.e., spousal communication, value of girls' education and status of women)?
- ☐ Are training courses structured to maximize women providers' participation? Are providers trained to treat both women and men clients with respect regardless of gender? Do providers receive training in male methods?
- ☐ Do women and men have equal access to employment advancement in FP/RH programs?
- ☐ Where appropriate, is FP/RH linked with other sectors to improve women's lives (education, income generation, women's credit programs) through referrals or programmatic linkages?

SUPERVISION

- ☐ **Do supervisory visits occur frequently enough to adequately monitor and foster service improvement? Do supervisors have the knowledge and practical experience in FP/RH service delivery necessary to provide helpful support?**
- ☐ **Are supervisory visits participatory, helpful and relevant?** Do supervisors routinely ask providers about their clinic-level needs? If so, are they effective at addressing these needs through facilitating providers, through practical problem-solving or by linking with higher levels of administration? Do they promote teamwork?
- ☐ Do supervisory visits include immediate feedback such as constructive suggestions for improvement and recognition of work well done?

MANAGEMENT

- ☐ **Does the program's management style:**
  - **empower all staff to promote quality at the worker level? Does it encourage providers to seek and implement their own creative solutions to problems arising at work?**

- **use data (collected at service delivery points) to make decisions?**
- **use teams (of providers, managers and other staff) for making improvements in systems and processes?**
- **focus on understanding and responding to clients' needs?**
- **foster problem-solving at the clinic level?**

☐ Do program documents specify that the program is to be evaluated on quality and access? Are findings appropriately disseminated and utilized?
Illustrative indicators:
- *range of methods actually available at service delivery sites;*
- *state-of-the-art national guidelines available at service delivery points;*
- *among clients whose choice was not contraindicated, percent who received their method of choice;*
- *percent of clients counseled about side effects;*
- *continuation rates.*

☐ Do managers strive to make their programs cost-effective, even if only based on best judgement? Do they use cost data to maximize cost-effectiveness?

☐ Do flexible job descriptions exist for every staff position, and are they used for evaluations?

☐ Does the management system have mechanisms (i.e., training, rewards, recognition, etc.) to recognize providers who provide high quality and access?

☐ Do managers efficiently and appropriately deploy staff to maximize his/her usefulness? Do managers succeed in using the abilities and skills of providers to promote quality and access?

☐ Is there a management information system? Does it result in better quality service for clients, or does it hinder quality and access by placing undue burden on providers? Does it provide good information for managers to use?

☐ Are staff paid on time?

☐ Do managers apply "systems thinking," including applying all the tools available (training, rewards, modeling, procedures, supervision, job aids, quality improvement, etc.) to advance quality and access?

POLICIES, PROTOCOLS & GUIDELINES

- ☐ **Do FP/RH service protocols and guidelines include: informed choice, privacy and confidentiality, counseling, infection prevention, technical competence, appropriate eligibility criteria, follow-up protocols and removal of inappropriate barriers?**
- ☐ **Do providers use guidelines?**
- ☐ Were protocols and guidelines developed:
  - **in accordance with current accepted international norms for service delivery?**
  - following a needs assessment which identified problems of quality and access?
  - after providers received state-of-the-art FP/RH technology and service delivery updates?
  - through a participatory process involving stakeholders (policy-makers, supervisors, service providers and clients)?
- ☐ Is there a systematic strategy for disseminating and implementing protocols and guidelines? Does the strategy include:
  - ☐ designation of a core group of resource persons trained in the dissemination of guidelines at all levels?
  - ☐ mechanisms for "multiplying" resource persons by familiarizing others with guidelines and training them in dissemination?
  - ☐ **identification of "champions" to advocate guideline use?**
  - ☐ official launching ceremony (with mass media and dignitaries)?
  - ☐ distribution of documents?
  - ☐ distribution of user-friendly tools which help providers and supervisors apply guidelines (i.e., clinical provider handbooks, posters, etc.)?
  - ☐ assurance of resources for equipment, supplies and supervision necessary to put guidelines into practice?
  - ☐ training of providers in health, professional and technical schools?
  - ☐ evaluation of guidelines implementation?
  - ☐ Have policies containing unnecessary regulations and restrictions been identified? Have strategies and solutions been identified to address these restrictions?

    Example:
    - *In Togo outdated national policies contributed to restricted access to hospital family planning services. Eligibility for family planning services was liberalized and providers were trained to practice the new policy. After eligibility criteria were liberalized, adolescent acceptors of DMPA markedly increased in a sample of hospitals.*
- ☐ Are service delivery guidelines developed with the participation of private-sector stakeholders? Is the private sector included in implementation?

CONSTELLATION OF SERVICES

- ☐ **In addition to FP, what other related services (including RH) are provided?**
- ☐ **Given scarce resources, do the services offered reflect good public health priorities? (i.e., do they offer optimal public health benefit for the cost?)**
- ☐ **Do these other health services support family planning and vice versa? Has the program capitalized upon good, practical linkages?**

  Possible examples of supportive linkages:
  - *condom promotion for STD prevention and pregnancy prevention,*
  - *postabortion care and family planning services,*
  - *drama promoting a variety of desirable behaviors such as women's empowerment, pregnancy prevention, STD prevention and responsible parenting,*
  - *appropriate contraception for breastfeeding women,*
  - *appropriate promotion of breastfeeding practice in family planning service delivery sites,*
  - *postpartum services linked with immunization and contraception.*
- ☐ Are there easy links (including referrals and geographic proximity) between related services (e.g., between FP/RH and immunization services) for interested clients?
- ☐ Do priority preventive services such as family planning receive appropriate attention, or are they potentially overwhelmed by curative services? Is there an overload of overall services? Are equipment, facilities, time per client and providers' technical skills adequate to provide the set of services?

PARTICIPATION

- ☐ **Are clients asked about services both informally and through surveys, exit interviews, focus group discussions or suggestion boxes? Is the information used?**
- ☐ **Are client, consumer, provider, women's health advocacy, community and other relevant groups involved in setting the program's activities and practices?**

PROGRAM STRATEGY

- ☐ **Recognizing scarcity of resources, does the program concentrate on priority quality and access components?**
- ☐ **Have "champions" or "change agents" in the area of maximizing access and quality been identified at both national and community levels?** Are they active in the effort to improve services or otherwise empowered to effect change?

  Example at the community level:
  - *Articulate, outspoken midwife motivated to train colleagues in NORPLANT® implants removal.*

  Example at the policy-making level:
  - *Ministry of Health OB/GYN eager to change his or her country's outdated medical protocols.*

- ☐ Has an analysis of existing policies, guidelines and protocols been conducted? What do these documents show regarding:
  - ☐ commitment to maximizing access and quality in a concerted fashion?
  - ☐ quality and access standards? Is there a document defining what quality and access mean in the local context?

    Example:
    - *Egypt's Quality Improvement Program (Gold Star)*
  - ☐ the tone of policy and strategy documents? Recognizing that it may be appropriate to have programmatic goals at the macrolevel, is undue emphasis on targets for staff avoided? Are numerical incentives for "switching" women from one method to another avoided?
  - ☐ Does the method mix suggest that clients make free choices, or is there disproportionate emphasis on one or a few methods?
- ☐ Is leadership (in host-country institutions as well as donors) committed to pursuing strategies and investing resources in maximizing access and quality?
- ☐ Has a mechanism (e.g., an advisor or national quality of care committee) been established to promote quality and access and advocate priority program improvements?
- ☐ Is the program designed so that clients can access services through a variety of service delivery points, modes and sectors? (e.g., clinic and non-clinic services, community- and clinic-based distribution, public and private sector)?
- ☐ Do policy strategies foster private-sector services? For example:
  - reducing government competition with the private sector where it may be counterproductive (e.g., eliminate subsidies to higher income groups who use the public sector, or lower the cost of private services to consumers),
  - encouraging public insurance programs to finance and/or provide more FP/RH services (e.g., greater use of social security for FP/RH services or government-mandated provision of FP/RH services through employers),
  - increasing private-sector awareness of the benefits of FP/RH and improving organizational or technical capacities of private groups to design FP/RH programs.
- ☐ Has an assessment of use of service delivery points (such as a situation analysis) been done? Are service sites in locations that maximize their use and cost-effectiveness? Have service sites serving few clients been reallocated or else improved so that they attract and serve more clients?
- ☐ Is there a strategy for measuring and evaluating programs? Are quality and access prominent among evaluation criteria? Are evaluation findings acted upon?
- ☐ Is there a strategy of quality improvement using "COPE" or other similar approaches?

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MANAGEMENT STRATEGIES FOR IMPROVING FAMILY PLANNING SERVICE DELIVERY

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Manager's Toolbox for CQI

Using CQI to Strengthen Family Planning Programs

Editors' Note

Continuous Quality Improvement (CQI) is an exciting management approach that is being introduced in family planning programs around the world. CQI is based on the belief that *anybody* at *any level* of the organization can make valuable suggestions about ways to improve operations. Unlike traditional management approaches, which focus on improving only the processes that are not functioning well, CQI assumes that any process within an organization can benefit from some improvement. Because CQI emphasizes a process of constant improvement in operations, it requires long-term organizational commitment and teamwork. Family planning programs that use CQI can raise staff morale, and improve productivity, efficiency, and client satisfaction.

This issue offers some practical suggestions for using CQI in your organization. Included with this issue is a supplement called the *Manager's Toolbox for CQI*, which contains important tools and techniques that managers can use to implement CQI.

The Guest Editors for this issue are Ann Buxbaum, Nancy Murray, and Ricardo Vernon. Ann Buxbaum, Director of Management Sciences for Health's work with the Nigeria Family Health Services Project, oversees management training, organizational development, and management information systems for the project. Nancy Murray, FPMD's Regional Director for Latin America and the Caribbean, is collaborating in the Population Council's Operations Research Project (INOPAL II) with the IPPF affiliate in Mexico, MEXFAM. Ricardo Vernon, Deputy Director for INOPAL II in Latin America, is collaborating with MEXFAM and the Guatemala Ministry of Health in implementing INOPAL's CQI initiatives.

The Editors

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Editor-in-Chief
James Wolff

Managing Editor
Claire Bahamon

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Janice Miller
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Catherine Crane Coburn, **Director, FPMD**
Sara Seims, **Director, MSH Population Program**

Family Planning Management Development
Management Sciences for Health
400 Centre Street
Newton, Massachusetts 02158, U.S.A.

Phone: (617) 527-9202
Fax: (617) 965-2208
Telex: 4990154 MSHUI

The CQI Process

The principles and techniques of quality improvement were formulated in the 1950s by W. Edwards Deming, an American management expert, using the ideas of Walter Shewart from the 1930s. These principles and techniques have been applied in corporations all over the world, particularly in Japan, where they have revolutionized corporate thinking and practice. Although quality improvement was first introduced and most widely used in business and manufacturing, its usefulness is not limited to these types of organizations. Recently, the concept of quality improvement been used in managing health services, including those offered by family planning programs.

CQI can be implemented across an entire organization such as a business, hospital, social or health agency, or school. Managers can adapt and use CQI to improve services in individual organizational units, or in several units combined. Clinic managers can adapt the techniques presented in this issue to suit their work setting. Whether CQI is implemented across an entire organization, or within a single unit, strong commitment from management, appropriate resources, and adequate time are all required to make the CQI process successful.

CQI recognizes that many organizational problems result from *systems and processes*, rather than from individuals. CQI encourages staff members at all levels to work as a team, to draw on their collective experience and skills, to analyze systems and processes, to use information to identify the nature and size of each problem, and to design and implement activities to improve services. When staff begin to make improvements, they themselves monitor the impact of their changes. If at first the desired outcomes of the process are not achieved, then the staff can continue to make improvements until these results are achieved.

This issue presents the principles of CQI. It discusses what you need to do to prepare for CQI, how to initiate CQI in your organization, and the steps involved in implementing the CQI cycle.

In **preparing** to introduce CQI, managers must create an environment for quality improvement by obtaining the commitment of leadership, focusing on the client's perspective, analyzing the work process, and motivating all levels of staff to participate in a continuous effort to improve family planning services.

Once the preparation for CQI has been completed, CQI teams must be formed and trained to **initiate** CQI. There are seven steps involved in **implementing** the CQI cycle.

Step 1: **Identify an area** where opportunities for improvement exist.

Step 2: **Define a problem** within that area, and **outline the sequence of activities (the process)** that occurs in that problem area.

Step 3: **Establish the desired outcomes** of the process and the **requirements needed** to achieve them.

Step 4: **Select specific steps** in the process to study and for each step, list the factors that prevent the achievement of the desired outcome.

Step 5: **Collect and analyze data** about the factors that are preventing the achievement of the desired outcomes of the specific step being studied, and quantify the outcomes of that step.

Step 6: **Take corrective action** to improve the process.

Step 7: **Monitor the results** of the actions taken.

It is essential to build CQI into routine organizational procedures by continuously repeating the CQI cycle. This will help to maintain improvements and to identify and address new areas where services can be improved on a regular basis. ■

Differences Between Traditional Management and CQI

Aspects	Traditional Management	CQI
Quality standards	Quality is based on pre-determined program objectives and is monitored periodically.	Quality is based on clients' feedback and needs. Quality is monitored continuously and is built into the work process.
Problem solving	Problem solving and decision making done by senior managers and specialists.	Problem solving and decision making done in collaboration with staff and based on hard data.
Improvement process	Short-term improvements made, often at point of crisis (reactive).	Gradual, continuous improvements made in all functions (proactive).
Program clients	Clients are not usually consulted for their opinions.	Clients are partners and are regularly consulted.
Work environment	Staff work individually.	Staff work in teams.
Performance recognition	Authority is rewarded.	Capabilities are rewarded.
Source of problems	Problems come from people.	Problems come from complex processes and systems.
Style of supervision	Control and direct staff.	Encourage staff to take initiatives.
Financial perspective	Quality costs money.	Quality saves money.

Adapted from Llewelyn Leach and Mayer articles, 1992.

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Understanding the Principles of CQI

Managers who initiate the CQI process must incorporate the five basic principles of CQI into their management style.

Leadership Must Provide Firm Commitment and Support for CQI. CQI requires new ways of thinking, a willingness to change, and mutual support among management and staff. Therefore, the family planning manager, whether a director of a large country program or a manager of a busy clinic, must be willing to initiate CQI and provide ongoing leadership and guidance to the staff at every stage of the process. Managers must consider the improvement of quality to be a top priority, must communicate the importance of quality to their staff, must allocate enough resources to make the CQI process work, and must be prepared to implement changes proposed by their staff.

Satisfy Your Clients. In family planning programs there are two kinds of clients—internal and external clients.

Internal clients are the *program staff* who are served by organizational operations. For example, service providers become satisfied internal clients of a commodities supply system when managers, warehouse staff, and delivery agents have ensured that sufficient levels of contraceptives are always in stock. CQI requires that managers believe in the importance of serving internal clients well. To improve the satisfaction of internal clients, managers need to be ready to involve every level of staff in quality improvement activities, and must create a cooperative work environment.

External clients are the *women and men who receive family planning services.* When external clients are satisfied, a clinic or program not only gains more new acceptors and continuing users, but significantly contributes to the impact of the family planning program on health and fertility. CQI demands that managers believe that meeting clients' needs and expectations will improve services and will better satisfy those clients.

Focus on Process to Solve Problems. A process, or system, is a set of operations or activities that are performed repeatedly to produce services. CQI assumes that problems in service delivery are the result of inefficient, poorly designed, or malfunctioning processes, rather than ineffective staff. If you improve the appropriate part of a process or system where a problem has been identified, you will usually fix the problem. CQI therefore focuses on defining and improving processes to achieve an organization's desired service outcomes.

Respect Your Staff's Ability to Improve Processes. Managers who respect the skills and abilities of their staff can empower them to work together to prevent or solve problems and improve the quality of services. In a busy program or clinic, it is difficult for even the most conscientious manager to be completely aware of every step involved in delivering services. Staff who carry out the day-to-day activities of the clinic know which aspects of their work function well and which don't. They are in an excellent position to use this knowledge to propose practical changes that they themselves will ultimately carry out. Managers who implement CQI need to create an environment in which staff members contribute ideas, make decisions, and do not fear reprisals. This environment empowers staff and increases job satisfaction, which in turn contributes to improved client satisfaction and quality of services.

Collect and Use Data. Decisions about process improvements must be based on facts. Most family planning facilities already generate considerable amounts of service data that can be analyzed to suggest possible solutions. In CQI, managers must use data to determine the nature and size of the problems, and to justify any decisions made to improve processes. ■

CQI's Major Principles

- Secure full commitment and support of leadership.
- Satisfy internal and external clients.
- Focus on processes to solve problems.
- Respect the contributions of all staff.
- Collect and use data to improve processes.

Adapted from Hardee and Gould 1992

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Preparing for CQI

Preparing for CQI involves making senior managers aware that CQI can improve organizational management, and creating a core group that will implement the CQI process.

Raise Awareness and Secure the Commitment of Leadership

A senior manager should be the initiator of the CQI effort. This senior manager should gain the full participation of all managers by helping them to understand the principles of CQI, the improvements it has brought to other organizations, and the risks involved in implementing such an effort. To do this, managers may wish to read about CQI and, if possible, visit other organizations that are using CQI. Local business schools, universities, or schools of management are a resource for finding these materials. For a list of references, see the reference section on page 19 of this issue.

Managers must develop a realistic vision of what they would like CQI to bring to their organization, and be able to communicate that vision to staff at other organizational levels. During this preparation stage, managers can identify and adapt training materials that will be used to introduce and explain CQI to staff. These materials should include information about the steps involved in implementing the CQI process, staff responsibilities for supporting the process, the resources needed, the demands that CQI will place on their staff, and the potential benefits of CQI.

Create a CQI Core Group

In a large organization, the initiating manager will be most effective if he or she organizes a group of senior managers, often called the "CQI core group," who will lead the process. This core group will be responsible for planning the implementation of CQI, getting the process started, and supporting it at all levels of the organization. They will lay out the steps for the ongoing CQI process, develop training materials, organize training for all staff, and provide technical assistance to the teams that will subsequently be formed to carry out CQI. If CQI is being implemented on a small scale, a single unit manager or a designated staff person may perform most of the functions of the core group.

If you are leading the CQI initiative, you will find that even if you form a core group you are the one who will ultimately be in charge. Your job will be to support the entire process. You should make sure that your core group is trained, and that CQI responsibilities are included in the job descriptions of the group members. Their performance should be monitored and rewarded in the same way as their performance in other job functions, and they should be properly trained and helped to grow in the job through feedback and in-service education. You should lead by example and encourage the other core group members to do the same. You must listen to criticism, work closely with your core group, and encourage their full participation in the CQI process. As the CQI teams are formed, and throughout the CQI process, the core group will perform the same support functions for the teams as the CQI initiator has for the core group. ■

Tools and Techniques for CQI

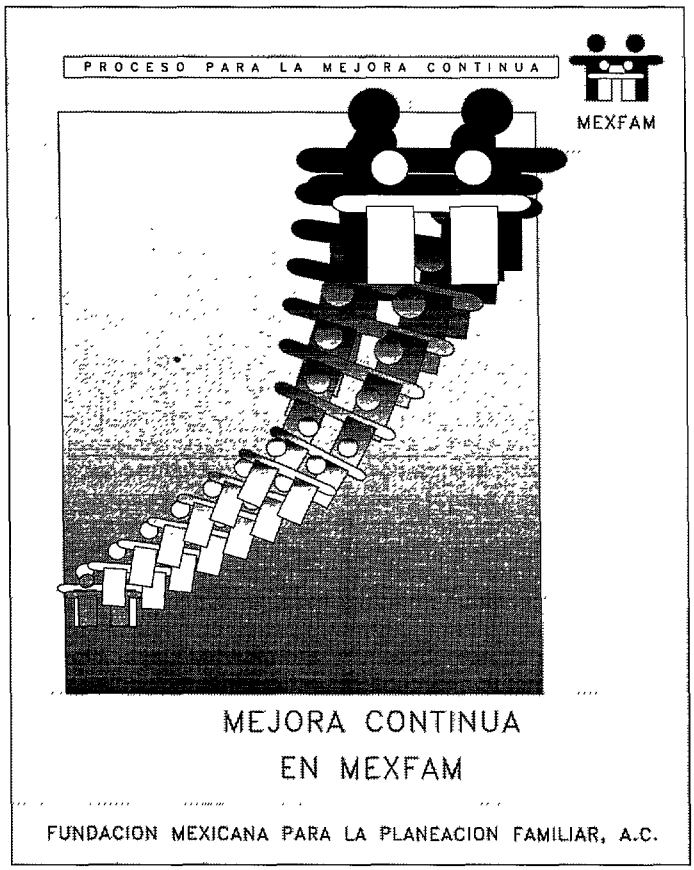
This issue refers to a number of tools and techniques that can be used in implementing the CQI process. The accompanying supplement, *Manager's Toolbox for CQI*, explains when in the CQI process to use these tools and techniques, and how they can be applied in implementing CQI in a family planning program. Please refer to the *Manager's Toolbox for CQI* to learn more about:

- using a matrix for selecting areas for improvement;
- flowcharting;
- brainstorming;
- cause-and-effect diagrams;
- client flow analysis;
- tally sheets;
- bar charts and histograms;
- "Pareto" analysis;
- benchmarking.

The Importance of Preparation: Highlights from MEXFAM's CQI Training Program

In 1991, MEXFAM, the International Planned Parenthood Federation's (IPPF) affiliate in Mexico, initiated a CQI program to improve the quality of the family planning services provided at its headquarters and at six regional service delivery sites. Initially, only some of the departments and regional centers who had been trained, actively embraced the CQI program. As a result of this uneven acceptance, the core group realized that they needed to tailor the general CQI philosophy to MEXFAM's environment, and to develop a uniform conceptual approach that was appropriate to the organization. Consequently, a manual was developed to orient the staff about the principles, purpose, and benefits of using the CQI approach at MEXFAM. The manual was used to train the staff about CQI and provided them with reference material that they could use during the entire implementation process.

The manual stressed the importance of following the key principles of CQI, outlined the implementation schedule of MEXFAM's CQI program, and emphasized the critical elements of the program.



Critical Program Elements:

- CQI is a long-term process.
- CQI results are permanent because they become institutionalized.
- Basic support systems for CQI include knowing the needs of both internal and external clients, producing and managing information, and measuring outcomes.
- Leaders in the process are also responsible for promoting change, facilitating the process, and being active participants who lead by example.
- CQI activities are an investment rather than an expenditure. The positive long-term results of CQI will more than compensate for the effort.
- The CQI process does not necessarily eliminate all of the normal problems and conflicts that always arise.
- CQI provides better tools for identifying and solving problems. Using CQI as a problem-solving technique develops staff's maturity and intellectual skills.

Source: Sistema de Calidad en MEXFAM

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Initiating CQI Activities

To initiate CQI in your organization, you will need to form CQI teams and train the members in CQI methods.

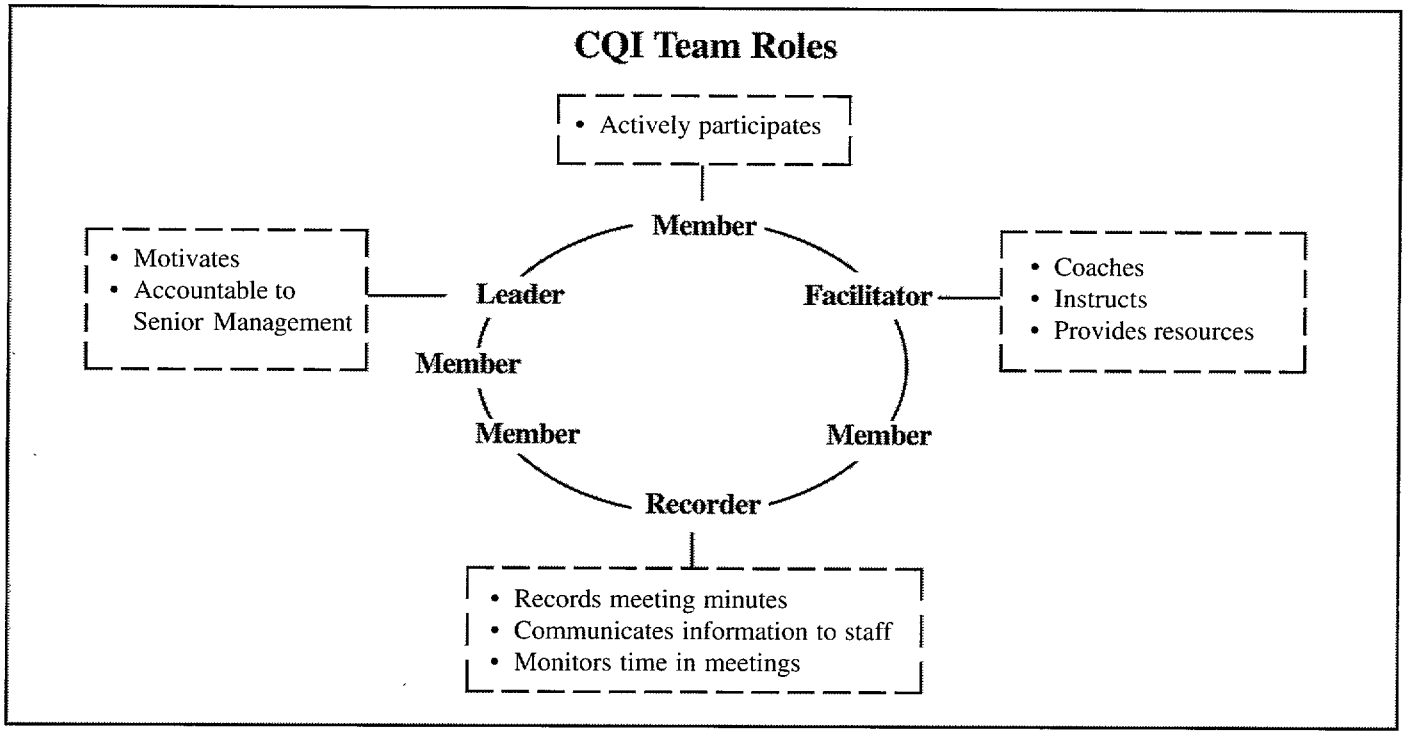
Form CQI Teams

Once you have formed and trained your core group, you are ready to perform the support functions for the CQI initiative. The first task is to form a CQI team made up of staff members who will look at management processes and activities and identify areas for improvement. Members of the CQI team are sometimes made up of staff within a single department of the organization. Another possibility is to form a **cross-functional team** made up of staff members from several departments, such as nursing, laboratory services, and administration. Cross-functional teams have the advantage of being able to look at processes, systems, and problems from different perspectives. The CQI team should include members of the CQI core group, at least in the beginning, to help guide the process. Once the team is formed, the roles and responsibilities of each team member should be determined by the team. At a minimum, each team should have a leader and/or facilitator, and a recorder. If the team is small, the leader and the facilitator may be the same person.

The composition of the CQI team may change once its members have agreed on the first area for improvement. Adding people with expertise in a chosen area can strengthen the team's ability to effectively address the selected problem. On the other hand, members of the CQI team with few skills in that particular problem area may become less active until the team has completed its work on that problem and meets to decide on another area for improvement. CQI teams may be permanent, or they may be formed for a specific quality-improvement activity and then disbanded when the improvement has been instituted. Depending on the situation, either approach can be successful.

Conduct Training

The members of the CQI team must be trained in the techniques that they will use to implement CQI. These include: teamwork, process analysis, the measurement and interpretation of data, problem solving, and the monitoring of activities. Staff may be trained formally, through seminars, or informally, through reading and discussion groups. Any materials used in training should be gathered or prepared well ahead of time so that the training can begin as soon as the CQI teams have been formed. Immediate training of new CQI teams is the most effective way to motivate staff. ■



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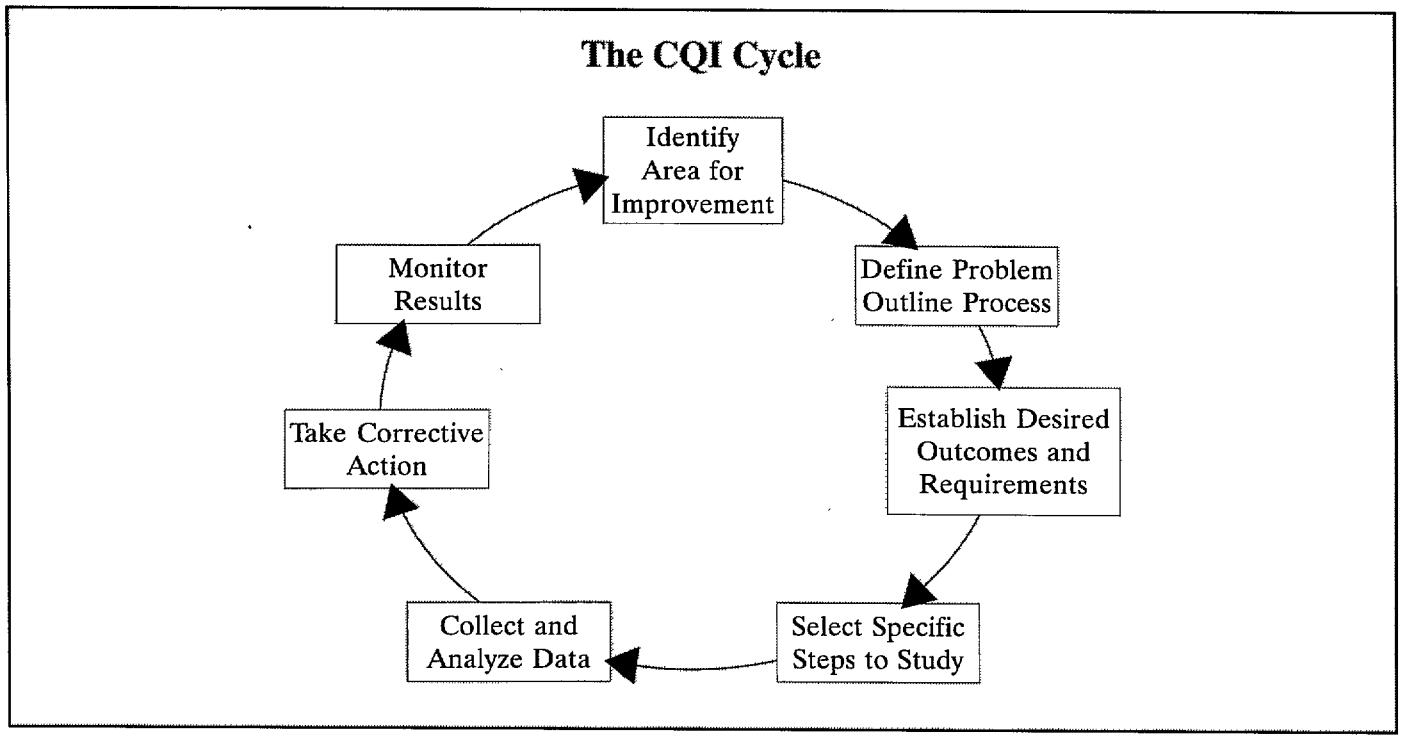
Implementing the CQI Cycle

CQI is a cyclical process. It involves identifying an area where there is an opportunity for improvement, defining a problem within this area and outlining the sequence of activities (the process) that occur in that problem area, establishing the desired outcomes of the process and the requirements needed to achieve them, selecting specific steps in the process to study, collecting and analyzing data about the process, taking corrective action, and finally, monitoring the results of those actions. Once the cycle is completed, the CQI team must determine whether the problem has been solved. If the problem continues, the cycle should be repeated: the process should be restudied and new actions taken until the desired outcome is achieved. If the problem has been solved, the CQI cycle starts again to identify and address a new area for improvement.

The CQI core group supports the CQI team to implement the CQI cycle, and should encourage flexibility in using the CQI process. There is no one right way to do CQI. The contribution of individual ideas and differing work styles will enrich the CQI process and enhance the likelihood of success.



Step 1

Identify an area for improvement. Opportunities for improvement exist in many areas of a family planning program, such as the management of clients, cost recovery, cost reduction, client satisfaction, staff satisfaction, and administrative systems. Ideas for improvement may come from a variety of sources both inside and outside the organization. Organizational assessments, client focus groups, interviews, suggestion boxes, supervisors or managers, staff members themselves, and service statistics are some of the sources the CQI team can use to identify areas for improvement. If a team comes up with a lot of different ideas, the members will want to develop criteria to help them to determine which ones to focus on first. (For an example of selection criteria, see the supplement to this issue, *Manager's Toolbox for CQI.*)

An example of an area for improvement: A clinic nurse brings to the attention of the CQI team recent complaints from clients about how they are treated when they arrive at the clinic.

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Step 2

Define a problem and outline the process. Once the area for improvement has been selected, the CQI team must define a problem within that area and outline the sequence of activities (the process) that occurs within that problem area. This step lies at the heart of CQI success.

> **An example of a problem:** The CQI team discusses and lists the types of complaints clients made about how they are treated when they arrive at the clinic. The CQI team decides to focus on delays in the client registration process, as one important aspect of how clients are treated.

After the CQI team defines the problem, the members must describe the entire process (the sequence of activities) related to that problem. Developing a **flowchart** helps to break up a routine process, or set of activities, into a series of sub-steps that make up that process (see Sample Flowchart of the Client Registration Process, page 10). The team will need to define the beginning and the end of that process, and outline (in sequence) the activities that complete the process. This allows the team to further define and analyze each step in the process.

Step 3

Establish the desired outcomes of the process and the requirements needed to achieve them. The team must establish the desired outcomes of the *entire* process, as well as the desired outcomes of *each step* in the process. These desired outcomes are used to define standards that should be consistently achieved for each step in the process, and for the process as a whole.

> **An example of a desired outcome of the entire process:** Registration process is completed within 30 minutes of client's arrival at the clinic.

> **An example of a desired outcome of one step in the registration process (pulling the client's record):** Registration clerk always locates the client's record within 5 minutes of her arrival at the clinic.

Once the desired outcomes have been determined, the team identifies the conditions or requirements needed in order to achieve each step in the process. Requirements are usually related to resources (human, financial, and material).

> **An example of the requirements needed to achieve one step in the registration process (pulling the client's record):** A filing system exists, and the registration clerk is proficient in using the system.

The desired outcomes and the requirements needed to achieve them are then written next to each step on the flowchart. They should be discussed and fully understood by the team. The completed flowchart should be widely circulated among the staff and referred to frequently in staff meetings and discussions, so that staff will understand what the CQI team is working on and can contribute their ideas.

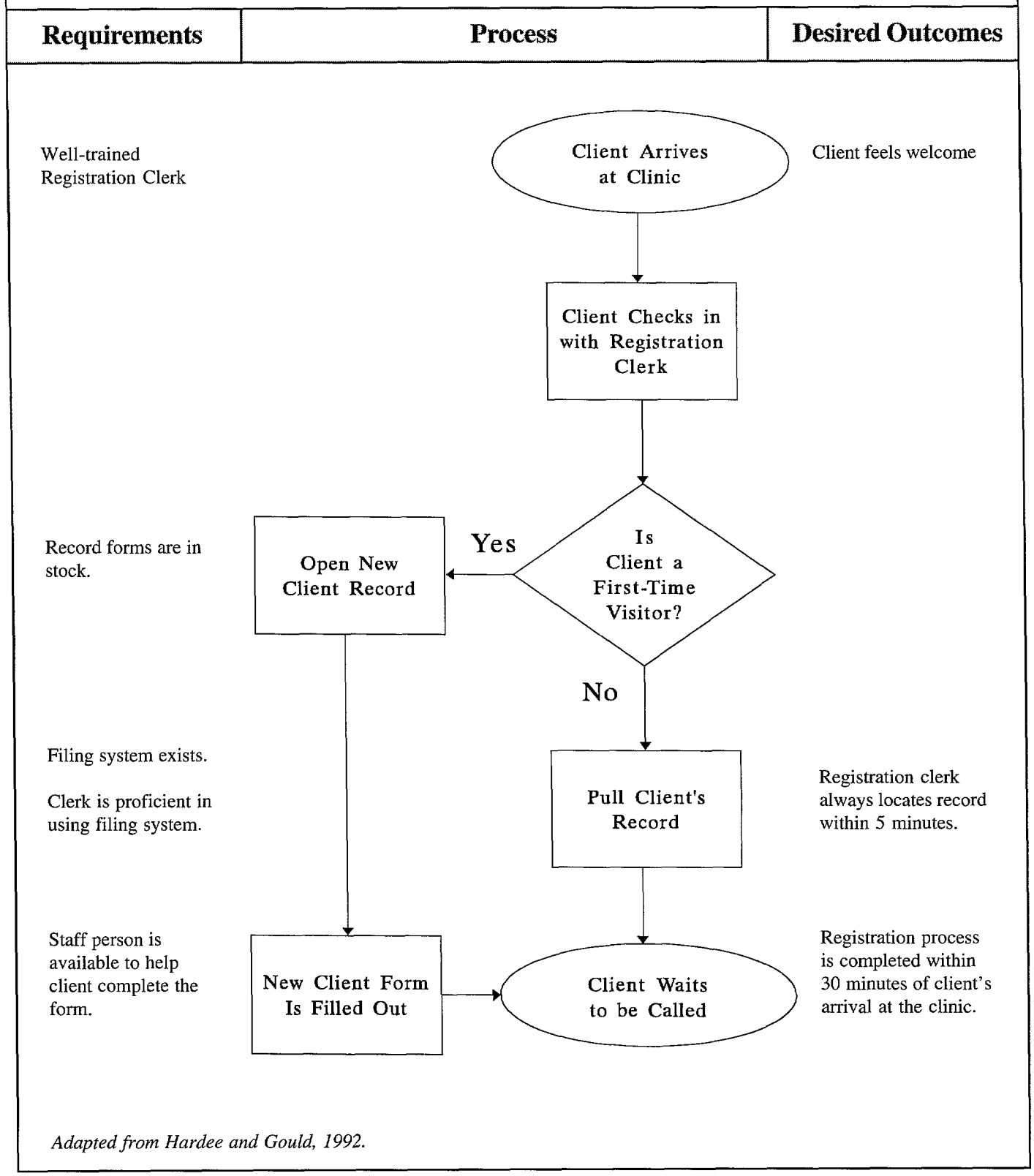
Step 4

Select specific steps in the process to study and, for each step, list the factors that prevent the achievement of the desired outcome. The team will need to identify the specific steps in the process where they believe the desired outcomes are not being achieved. Focusing on these steps will help them to understand the main factors (causes of the problem) that are contributing to an ineffective or inefficient process.

> **An example of a step in the process to study further:** After discussing the steps in the flowchart, the CQI team decides to work on the step labeled "Pull client's record." The CQI team agrees that the client files are not being located quickly. Because the desired outcome of this step is not being achieved—"Registration clerk always locates the client's record within 5 minutes"—the team discusses the factors that are responsible for the desired outcome not being achieved.

There are several techniques that can help the team to identify the possible causes of process failure, including: reviewing the process flowchart; examining the factors that influence the problem; and conducting a brainstorming session where the team can discuss all the possible reasons why the desired outcomes are not being reached. (For more information about these techniques, see the *Manager's Toolbox for CQI.*)

Sample Flowchart of the Client Registration Process



Adapted from Hardee and Gould, 1992.

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An example of several factors that prevent the desired outcome of this step "Pull client's record" from being achieved: The CQI team conducts a brainstorming session to identify the possible factors that are preventing the achievement of the desired outcome of the activity, "Registration clerk always locates the client's record within 5 minutes." The team identifies several possible factors that may be preventing the clerk from achieving the desired outcome. These include: lost records, misfiled records, files are too far away from registration area, inadequate storage space for client records, and illegible records.

The team should consider and list *all* the possible factors so that they are sure not to overlook some of the most significant, but less obvious, causes of the problem. The team can develop a list of possible causes and develop a diagram which arranges and groups the causes of the problem in a way that helps the team to identify the primary and secondary causes of the problem (see Cause-and-Effect Diagram in the *Manager's Toolbox for CQI*).

Step 5

Collect and analyze data. The CQI team initially needs to collect data in order to verify their impressions about the specific problem being studied and the potential causes of the problem, such as those listed in Step 4. Later, the team will collect and analyze data to make sure that the requirements are in place and that they are indeed leading to the desired outcomes.

An example of data that can be collected: The CQI team designs a study to collect data on the factors that delay registration. To do this, they observe the registration process for two days. During the observation, they use a tally sheet to record each factor that causes a delay in finding a client's record and the number of times the record is delayed for each factor listed. Calculating the frequency of each factor that delays registration enables the team to identify the most important causes of delayed registration. These causes should be the focus of the team's efforts to improve the process.

Since collecting data is costly and time-consuming, the CQI team needs to set limits on the amount of data they collect. As data are collected the team should regularly analyze them to determine if they are helpful in verifying the size of the problem, prioritizing its main causes, and suggesting what corrective actions should be taken. Once useful results have been obtained, special studies usually will not have to be repeated. If useful results are not being obtained, the team should re-evaluate this activity and consider collecting other data.

Using Data in the CQI Process

The CQI team may be able to use routine data from service statistics and medical records to verify the existence of problems and to identify causes. Alternatively, they may have to collect non-routine data through different types of surveys or special discussion groups. The CQI team should start with data from routine sources, and, as they need more information, they can introduce non-routine data sources to deepen their study.

- Routine **service statistics** on acceptors, dropouts, or method mix often provide the first indication that a problem exists, and often suggest which processes may be hindering the delivery of high quality services.
- Selected information from **medical records** may further pinpoint the nature and size of the problem as it affects the health and welfare of clients. *For example, calculating the percentage of clients with pelvic infections who receive IUDs, or the percentage of clients with high blood pressure who receive pills, will suggest how well clinical protocols are being followed.*
- Special **assessments** can shed more light on the problem. *For example, using a tally sheet to determine what percentage of providers follow all the steps in a protocol can help indicate the nature and size of a problem, as well as the source of the problem.*
- **Interviews** with clients, either in groups (focus groups), or individually when they leave the clinic (exit interviews), can identify which aspects of the service delivery system cause satisfaction or dissatisfaction, as well as the extent to which various desired outcomes are being achieved.

Analyzing Data in CQI. Analyzing data can help the CQI team to:

- Quantify the difference between the actual and the desired outcomes. These results will indicate how serious the problem is, and whether it may be affecting other aspects of service delivery.
- Determine whether the problem is confined to a specific step or to several steps in the process.
- Determine whether clients are concerned about the problem.
- Determine how long a problem has existed and whether or not the problem is getting worse.
- Indicate whether progress has been made in improving the process.

As the team analyzes the data, they will be able to identify with greater certainty the primary factors that are most responsible for preventing the achievement of the desired outcomes. Analyzing the data will also help them to identify the types of actions that can be taken to correct the problem.

An example of analyzing data: The CQI team prepares a frequency table of the causes of delays in registration. They graph this data and perform a Pareto analysis to show the primary causes of the problem. The sample Pareto analysis indicates that misfiling and inadequate storage space are the two primary causes or reasons why the registration clerk was not able to locate the client records within 5 minutes. Together, these 2 causes account for 70% of the problem.

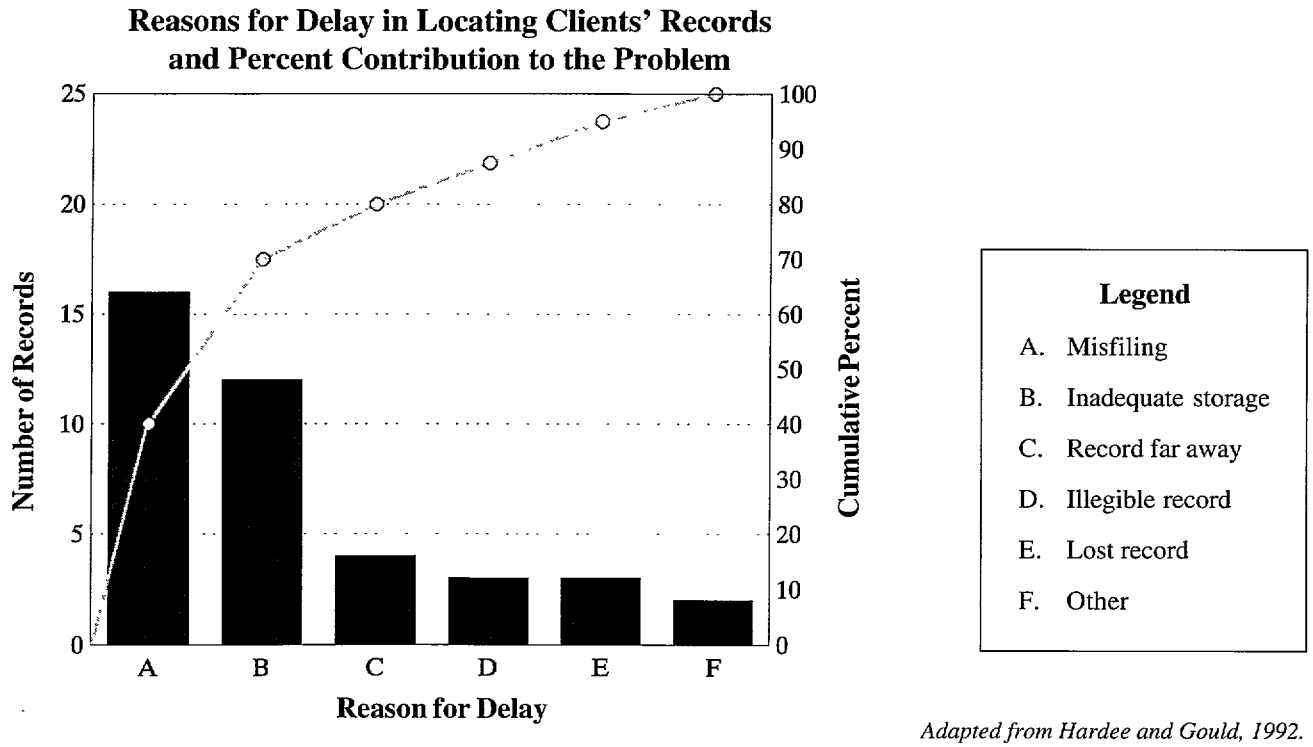
The CQI team can use basic graphing techniques to present the data and to illustrate the magnitude of the problem being studied. It is important to display the data in a way that allows the team to spot trends, so that they can discover the root causes of the problem. Using pie charts, bar charts, and line graphs to display the data will facilitate data analysis and the primary cause of the problem can often be seen more clearly. Performing a "Pareto" analysis helps the team to determine which two or three factors are most responsible for causing the problem. (For information on how to prepare and use pie charts, bar charts, and line graphs, see Issue Number 2 of *The Family Planning Manager*, "Using Service Data: Tools for Taking Action." For data display techniques specific to CQI and how to perform a Pareto analysis, see the *Manager's Toolbox for CQI.*)

Sample Pareto Analysis: Frequency Table

Reasons Identified by CQI Team for Delays in Locating Clients' Records

Reason for Delay (Ordered by frequency of occurrence)	**Frequency**		**Cumulative Percent**
	Number of Records	**% of Total Records**	
A. Misfiling	16	40	40.0
B. Inadequate storage space for client records	12	30	**70.0**
C. Record is far away from registration area	4	10	80.0
D. Illegible record	3	7.5	87.5
E. Lost record	3	7.5	95.0
F. Other	2	5.0	100.0
Total	**40**	**100.0**	**100.0**

Sample Pareto Diagram



Adapted from Hardee and Gould, 1992.

Step 6

Take corrective action. As a next step, the CQI team members will decide on a course of corrective action. The data analysis alone will not determine the specific actions that should be taken, but it will suggest some good alternatives to try. The CQI team can use a technique called "benchmarking" to compare the processes followed in their organization with those of a recognized leading organization in the same field (see *Manager's Toolbox for CQI*). Benchmarking is especially useful when managers wish to redesign a process. Since staff often tend to cling to the procedures that they have always followed, this type of comparison often yields valuable new ideas for improving performance that your staff might not necessarily think of.

Examples of corrective actions that could be taken: Relocating the registration desk to be closer to the files, moving the files closer to the registration area, purchasing a filing cabinet, relabeling the files, creating a less congested work space for the registration clerk, and providing refresher training to the registration clerk in filing procedures. In this example, the corrective actions that the team decides to take are to buy a filing cabinet and to provide refresher training to the registration clerk in filing procedures.

The team should develop an action plan that specifies each action to be taken, the proposed outcomes of these actions, the person who has the primary responsibility for implementing each activity, and a timetable for activities, including the points at which new data will be collected and monitored. The action plan should be integrated with other organizational work plans, to ensure that it is realistic, taking into consideration the staff's other obligations.

It is reasonable to expect that the action plan will change during implementation—dates may have to be adjusted, different staff members may become involved, and intervening events may suggest adding or removing an activity. These changes should be communicated to the staff, agreed upon, and added to the plan, so that the written document always reflects reality and always provides an accurate record of the implementation process.

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Step 7

Monitor the results. Using the same techniques as those used in data collection, a CQI team can determine whether the actions they have taken have, in fact, corrected the problem. There are three likely possibilities:

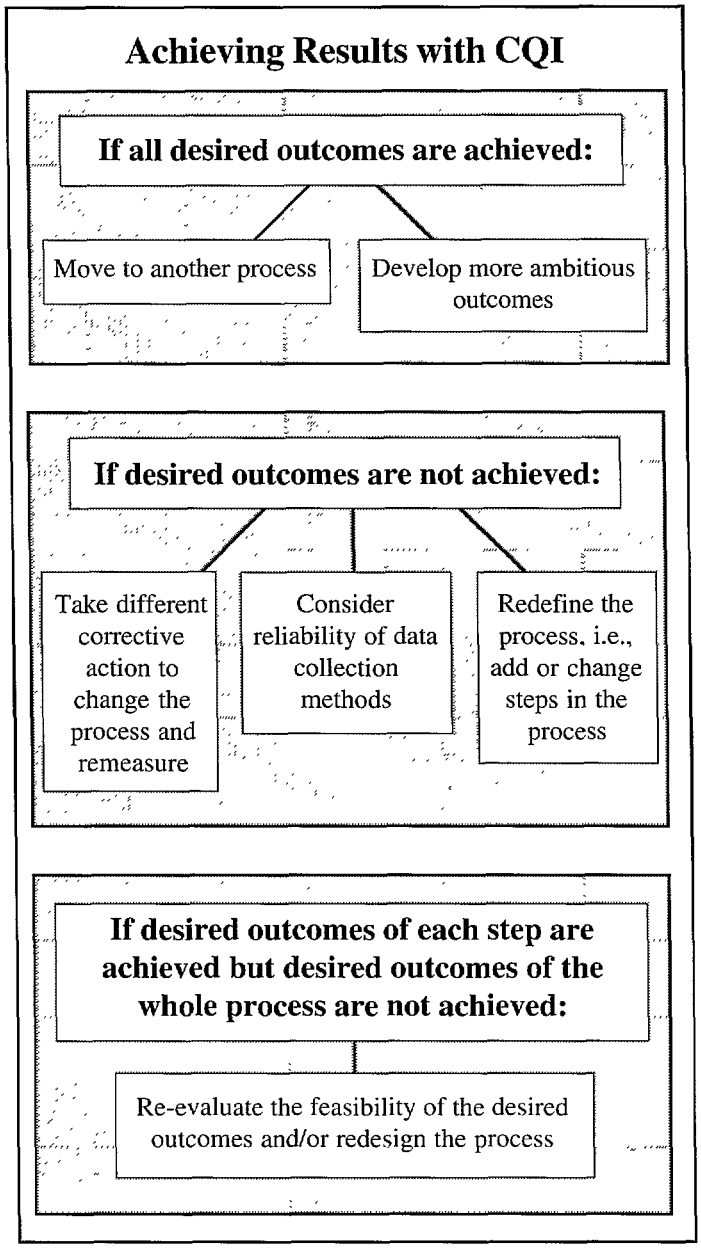
- Desired outcomes of both the process steps and the process as a whole *have* been achieved;
- Desired outcomes of both the process steps and the process as a whole *have not* been achieved;
- Desired outcomes of the process steps *have* been achieved, but the desired outcome of the whole process *has not* been achieved.

Each possibility requires a different kind of response. The ultimate goal of CQI is to develop a process that continuously improves the services that your organization provides.

An example of monitoring results: After the corrective actions have been implemented (purchasing a filing cabinet and retraining the registration clerk in filing procedures), the CQI team has to determine whether these actions have brought about the desired outcome of the specific step in the process being studied and of the overall process. The CQI team repeats the observation for one day to find out whether the registration clerk is locating each client's record within 5 minutes, is using the filing system effectively, and is completing the entire registration process within 30 minutes of each client's arrival. Conducting random interviews with clients as they leave the clinic helps the team to determine whether clients are satisfied with how they are treated when they arrive at the clinic.

Once staff have adopted the new (revised) process, a team member should be assigned to periodically monitor the process, to ensure that the staff continue to follow the modified process. This team member should look out for changes in the data that might indicate a return to the patterns that caused the problem in the first place. ■

Achieving Results with CQI



If the desired outcome of the step is still not being achieved—"Registration clerk always locates the client's record within 5 minutes"—the CQI team should consider implementing some of the other corrective actions that they identified, and monitor the effects of these interventions. If the **desired outcome of the step is being achieved** but the **overall desired outcome is not being achieved**—"Registration process is completed within 30 minutes of client's arrival at the clinic"—the CQI team should re-evaluate the registration process and determine whether the desired outcome is realistic, or redesign the process.

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Implementing the CQI Cycle: The Experience of MEXFAM's Management Information Systems Department

Under MEXFAM's CQI initiative, MEXFAM's Management Information Systems (MIS) Department began meeting regularly to discuss operations that needed improvement. During these discussions, several members of this team expressed concern that they were spending more time providing ad hoc training and technical assistance to staff in the use of computer software than in carrying out their most important task: developing computer systems and software that were necessary for the organization to maintain its level of growth *(Step 1: Identify an area for improvement).*

The MIS Department agreed that the problem was that they had too little time for software and systems development. They determined that the process most related to the problem was how ad hoc training and technical assistance for computer problems was being handled. The team decided to develop a flowchart to illustrate the training and technical assistance process *(Step 2: Define a problem and outline the process).*

The team agreed that the final outcome of the training and technical assistance process should be fewer requests for technical assistance to solve software problems. A requirement should be that all staff have a basic level of computer skills that would allow them to solve most software problems on their own, so that almost all MEXFAM documents could be produced without special assistance *(Step 3: Establish desired outcomes of the process and requirements needed to achieve them).*

Unanimously, the team agreed that the training step was not being satisfactorily carried out, because staff could not solve basic software problems on their own. They did not know how to produce and print documents using all the basic software packages; nor did they know how to interact with the basic computer disk operating system (DOS), on which all the software packages were run *(Step 4: Select specific steps in the process to study and list the factors that prevent the achievement of the desired outcome).*

The team carried out the simple exercise of quantifying the amount of time each MIS Department staff member spent providing basic technical assistance to MEXFAM employees in solving problems related to printing documents, interacting with the DOS-system, using Word Perfect and Lotus, and other computer-related activities. They also quantified the time spent developing computer systems and software *(Step 5: Collect and analyze data).* The unshaded bars in the bar chart show the results of this initial analysis. The analysis verified that the MIS Department staff were spending so much time responding to requests for computer assistance that they had very little time to develop computer systems and software for MEXFAM, which was their primary responsibility.

As a first step towards reducing the amount of time spent providing technical assistance, the MIS Department staff developed an action plan to provide training to groups of MEXFAM employees from different working areas. The training was given for two hours a week over a six-week period *(Step 6: Take corrective action).* When the MIS Department staff remeasured the time they spent on various activities, they found that there had been no change in the number of requests for technical assistance *(Step 7: Monitor the results of the corrective actions).*

They re-examined the training program and discovered that because of absenteeism, many of the employees had not been able to attend the training sessions. They then developed a series of one-week training courses tailored to the needs of staff in each department *(repeat of Step 6: Take corrective action).*

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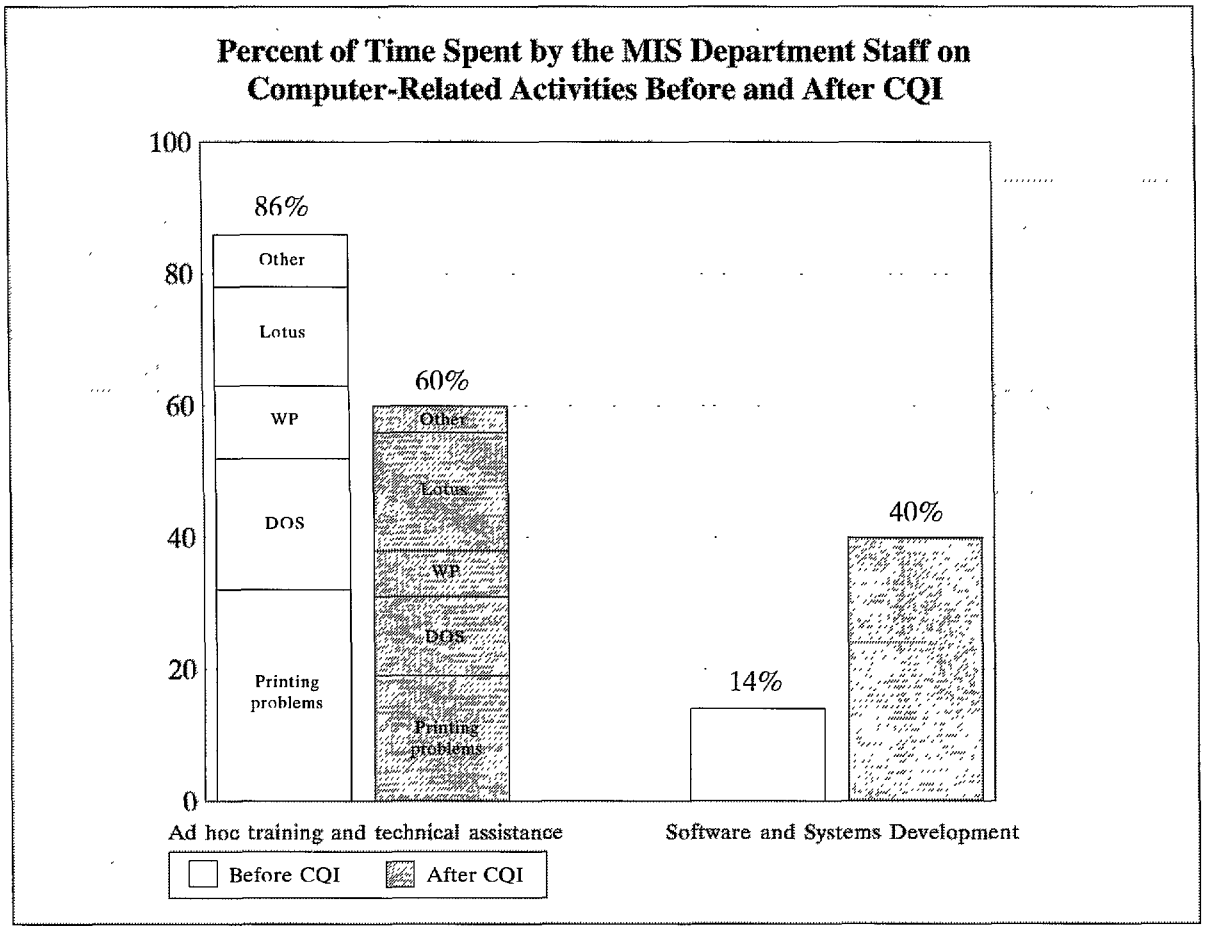
They again measured the proportion of time spent by MIS Department staff on the various activities *(repeat of Step 7: Monitor the results of corrective actions)*. The shaded bars in the bar chart show the results of this second measurement. The proportion of weekly staff time spent providing ad hoc training and technical assistance decreased from over 85% to 60%. The MIS Department had achieved their goal of reducing the amount of time spent providing ad hoc training and assistance, thus increasing the amount of time they could spend developing software and systems packages. As a result of the changes in the training and technical assistance process, the time spent developing software and systems jumped from 14% to 40%. This also resulted in the introduction of 3 new packages in the first 3 months, as compared with the previous year, when only 2 new packages were designed during the entire year.



After the second training program, all MEXFAM employees had learned how to fully utilize the computer software programs, were able to work more independently, and could more often solve computer-related problems on their own. Organizational communications also improved significantly. The CQI initiative had successfully reduced a major source of inefficiency, and had boosted staff morale.

In order to permanently reduce time spent on providing ad hoc training and assistance, MEXFAM's computer training and technical assistance process was modified to include two new steps:

- assess computer skills of all current and new staff;
- provide computer training to staff in each department, tailored to the needs of the department.

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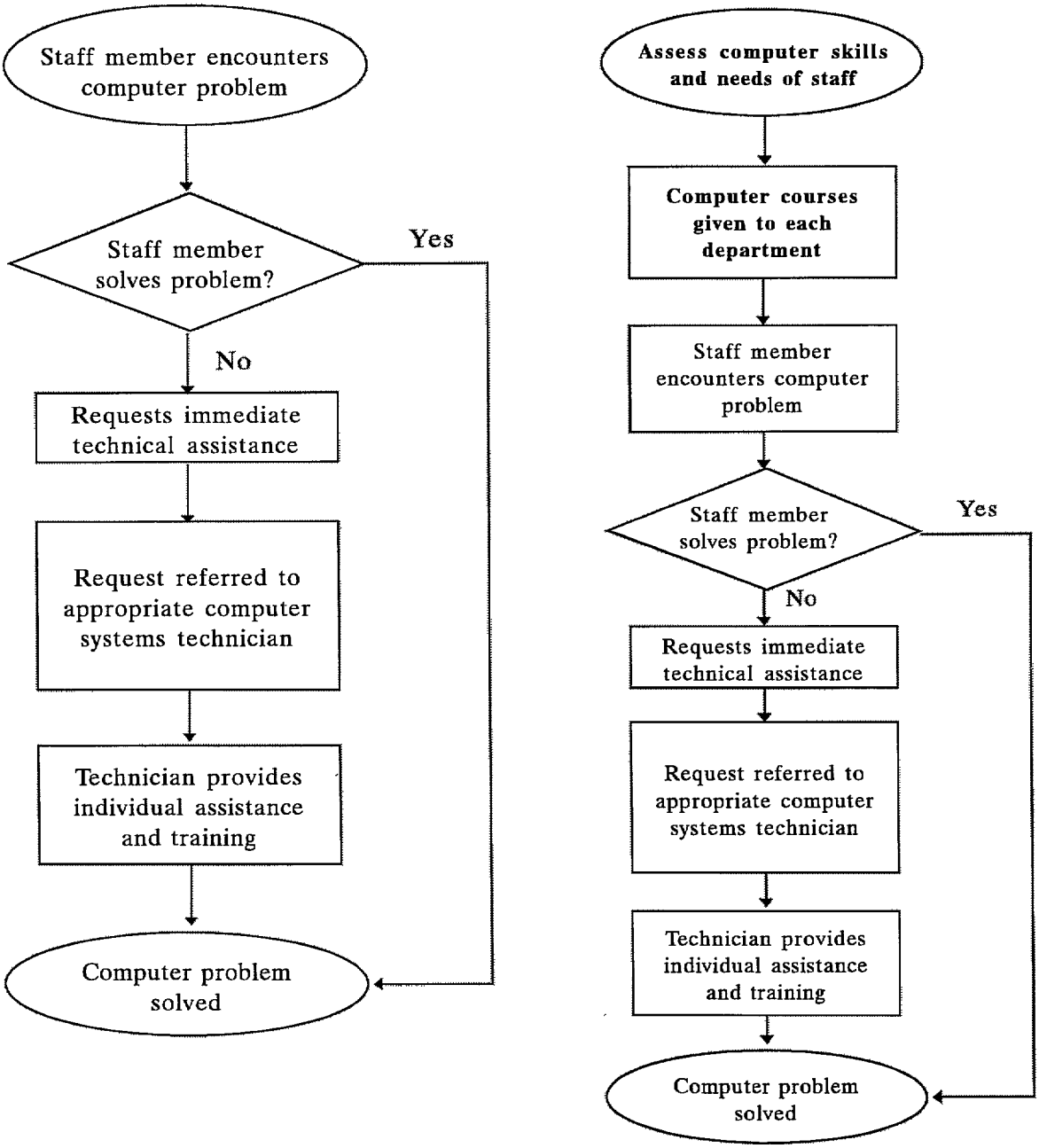
MEXFAM's Computer Training and Technical Assistance Process



Overall Desired Outcome: MIS Department staff spend no more than 60% of their time on ad hoc training and assistance.

Information supplied courtesy of Lic. Alfonso Lopez Juarez, Executive Director of MEXFAM, and Dr. Pedro Manuel Acosta and Lic. Jesus Vertiz, of MEXFAM's Evaluation Department.

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Reviewer's Corner

A forum for discussing additional applications of FPM concepts and techniques

On Institutionalizing the CQI process . . . *One reviewer comments,* "Program managers should consider incorporating CQI into routine organizational procedures. The processes described in CQI are similar to those that are typically applied to problem solving. What differentiates normal problem solving from CQI is that CQI is a management philosophy that is designed to be incorporated into routine organizational operations, and can be used to constantly improve operations as the systems evolve. This allows CQI not only to solve existing problems, but also to prevent other problems from developing, by recognizing the potential for a problem before it occurs."

On Organizational Improvement . . . *One reviewer offers,* "CQI creates an opportunity for the staff who carry out the day-to-day routine to work with top management to improve those routine operations. This is very important, because staff who feel that their concerns about clients are not heard or taken into account often become easily discouraged about their work. CQI makes a vertical organization more horizontal, which allows senior staff to exchange ideas and learn from staff who deal with the problems directly."

On the Timing of Implementing CQI . . . *One reviewer advises,* "It is important to initiate the CQI process immediately after training staff in CQI, in order to maintain enthusiasm and to obtain their full and active participation in the process."

On the Risks Involved in Carrying Out a CQI Process . . . *Several reviewers offered advice about the potential risks involved in initiating and implementing the CQI process.*

On Creating False Expectations . . . "CQI teams have to be careful not to create 'false expectations' about whether the changes will completely solve the problem. Raising and then not meeting expectations can discredit the process."

On Overburdening the Staff . . . "It is extremely important not to increase the workload of the staff who carry out the day-to-day routine. CQI often involves additional tasks, particularly in data collection and in time spent in brainstorming, analyzing, and planning solutions. Overburdened staff soon become exhausted, particularly if no immediate improvements are apparent. This can lead to a rejection of the process by the staff because they see it as a waste of time and effort."

On Alienating Clients . . . "Although the goal of CQI is to improve service quality, the process may create disruptions as solutions are tested, or as staff take the time to meet to analyze processes and problem areas. Additional clients may drop out as a result of these inconveniences. Proposed solutions may also create unexpected problems in service delivery in other components of the family planing program, which can have a negative impact on client satisfaction."

On Half-Hearted Leadership . . . "CQI depends on complete, unqualified commitment from the leadership of the organization. Changes in top-level management, or the emergence of pressures from the external environment, can often compromise such commitment or divert the leadership's attention from the process. This can negatively affect the quality of the analysis of the problems and the choice of solutions, and can ultimately worsen the outcomes of the CQI process."

Supporting Your Staff

It is important to remind your staff that the CQI process is cyclical, and that sometimes steps may need to be repeated in order to fully achieve the desired outcomes. Even after corrective actions have been taken, some process outcomes may still not be satisfactory. If a goal has not been reached the first time around, the CQI team can work through the implementation steps again and incorporate the experience gained in the previous efforts. In this way, they can:

- Examine the problem and its process steps from a new perspective (Step 2).
- Review the desired outcomes and requirements (Step 3).
- Review specific steps and factors that inhibit the process (Step 4).
- Collect and analyze other relevant data (Step 5).
- Take corrective action (Step 6).
- Monitor the new results (Step 7).

If staff discover that they need to repeat the CQI cycle again, your enthusiasm as supervisor will help to maintain morale and motivation. Remind your staff that CQI is not a computer program or a scientific formula. It is a skill that harnesses the combined contributions of the entire staff, and, like all skills, it must be built up through experimentation and practice. With consistent effort and commitment, incremental, ongoing improvements will provide a solid foundation for building and sustaining a high-quality program. Whatever the results, be sure to recognize the team's contribution to the CQI process. ■

References

Balm, G. *Benchmarking: A Practitioners Guide for Becoming and Staying Best of the Best.* Schaumburg, IL. QPMA Press, 1992.

Brassard, Michael. *The Memory Jogger: A Pocket Guide of Tools for Continuous Improvement.* Methuen, MA. GOAL/QPC, 1988.

Deming, W. Edwards. *Out of The Crisis.* Cambridge, MA. Massachusetts Institute of Technology Press, 1986.

Hardee, K. and B. Gould. "A Process for Service Quality Improvement in Family Planning." Family Health International, 1992.

Institute for Healthcare Improvement. *Methods and Tools of Quality Improvement.* Brookline, MA. National Demonstration Project on Quality Improvement in Health Care, 1992.

Jain, A. ed. *Managing Quality of Care in Population Programs.* West Hartford, CT, Kumarian Press, 1992.

Juran, J.M. *Juran on Planning for Quality.* New York, N.Y. The Free Press, 1988.

Kaluzny, A., C. McLaughlin, and K. Simpson. "Applying Total Quality Management Concepts to Public Health Organizations." *Public Health Reports.* Vol. 107, No. 3, 1992.

Leebov, W. and C. Ersoz. *The Health Care Manager's Guide to Continuous Quality Improvement.* Chicago IL. American Hospital Publishing, 1991.

Llewelyn Leach, S.C. "US Managers Focus On Boosting Quality." *The Christian Science Monitor.* Vol. 85, No. 4, 1992.

Mayer, Thom, A. "The Transition From Traditional QA to CQI." Paper presented at the American College of Emergency Physicians Symposium, September, 1992.

Nordlund, S. "Implementing Total Quality Management Programs in Health Care Organizations." *Hospital Materiel Management Quarterly* 1991; 12(4):22-26.

Quintanilla, L., L. De La Peza, and R. Vernon. *Calidad En El Servicio: Guia Para Capacitacion* (draft version). INOPAL II Project, The Population Council, 1992.

Shewart, W.A. *Economic Control of Quality Manufactured Products.* Washington, D.C., George Washington University Press, 1986.

Vernon, R. "A Manager's Framework to Guide Family Planning Quality of Care Improvement Efforts." Paper presented at the annual meeting of the American Public Health Association, 1992.

Checklist for Using CQI to Strengthen Family Planning Programs

For Senior-level Managers

- [ ] Raise awareness and secure commitment of leadership for CQI initiative.
- [ ] Become active participants in the CQI process.
- [ ] Create a CQI core group, and provide training and support to the group.
- [ ] Empower staff to carry out the CQI process and provide incentives for successful CQI efforts.
- [ ] Assess CQI results and adopt effective CQI improvements.

For Clinic Managers and Supervisors

- [ ] Establish a CQI team.
- [ ] Empower staff to carry out the CQI process.
- [ ] Become active participants in the CQI process.
- [ ] Monitor the effects of the improvements.
- [ ] Restart the CQI cycle to make more improvements.

For the CQI Team

- [ ] Identify areas where there are opportunities for organizational improvement.
- [ ] Select one area for improvement, and outline the sequence of activities that occur in that problem area (the process).
- [ ] Establish desired outcomes of each step in the process.
- [ ] Select and study the most important steps in the process.
- [ ] Collect and analyze relevant data to quantify the existing outcomes of critical process steps.
- [ ] Develop effective techniques for analyzing and discussing those data within your team.
- [ ] Make improvements in the process to narrow the gap between existing and desired outcomes.

The Family Planning Manager is designed to help managers develop and support the delivery of high-quality family planning services. The editors welcome any comments, queries, or requests for free subscriptions. Please send to:

FAMILY PLANNING MANAGEMENT DEVELOPMENT

The Family Planning Manager
Family Planning Management Development
Management Sciences for Health
400 Centre Street
Newton, Massachusetts 02158, U.S.A.
Phone number: (617) 527-9202
Fax number: (617) 965-2208
Telex: 4990154 MSHUI

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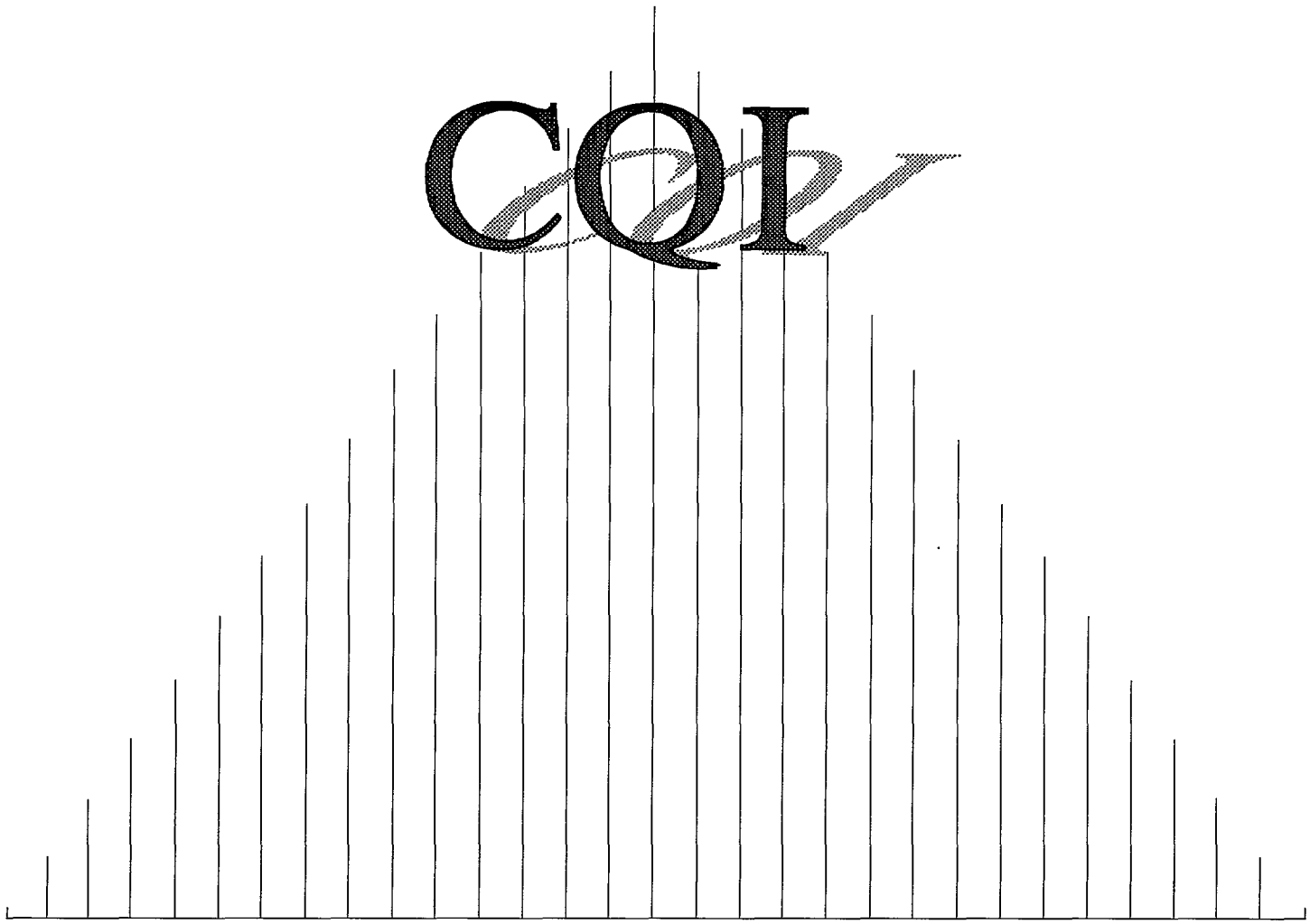
The Family Planning Manager

MANAGER'S TOOLBOX FOR CQI



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FPMD
Management Sciences for Health
400 Centre Street
Newton, Massachusetts 02158
U.S.A.

Phone: (617) 527-9202
Fax: (617) 965-2208
Telex: 4990154 MSHUI

The Guest Editors for this supplement to *The Family Planning Manager* are **Karen Hardee** and **Sharon Kleefield.** Dr. Hardee is Senior Research Associate in the Service Delivery Division of Family Health International in Research Triangle Park, North Carolina. Dr. Kleefield is Senior Associate Director of Quality Improvement at Brigham and Women's Hospital in Boston, Massachusetts.

Manager's Toolbox for CQI

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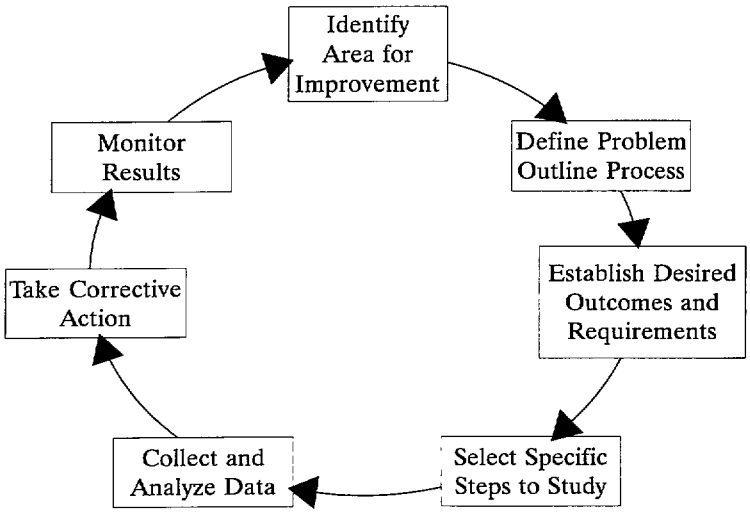
This supplement contains guidelines for using important tools and techniques to enhance the Continuous Quality Improvement (CQI) process in your organization. It describes how each technique can be used, and provides examples that illustrate how the techniques can be applied in a family planning program. This supplement also suggests when, and under what circumstances, each tool or technique can be used in implementing the CQI cycle.

The CQI Cycle



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Using a Matrix to Select Areas for Improvement

The first step in implementing the CQI process requires identifying areas in which improvements are both necessary and feasible. This can be done by selecting areas that the organization has control over changing, and by determining which changes will have the most impact on improving the quality and/or efficiency of services. Often CQI team members will identify many areas where improvements should be made, but will find it difficult to decide which of those areas to study. This step can be made easier by developing a list of criteria that reflect organizational priorities, resources, and constraints, and by assessing each proposed area for improvement in the light of these criteria.

Once the team develops the list of criteria, a comparison table (or matrix) should be prepared that will allow the team to consider each proposed area for improvement against each criterion. By developing and using this matrix, the team can more easily identify which area for improvement will have the most impact on improving quality and/or efficiency. The matrix will also help the CQI team members to decide which problem they should work on first, and to prioritize other areas that they will study next.

Sample Selection Matrix

Area for Improvement	Criteria: Organization Has Control Over Changing	Process Is Important to External Client	Process Is Important to Internal Client	CQI Team Members Agree on Importance of Problem	Process Has High Visibility	Scope of Process is Limited/Changes are Feasible	People Involved in Process will Cooperate	Process Has Short Cycle	Data on Process Are Regularly Collected	Resources Are Available for Making Changes
Client Registration	x	x	Some	Some	x	x	?	x	x	x
Oral Contraceptive Supply System	x	x	x	x	x	x	x		x	x
Follow-up System for Clients who Miss Scheduled Appointment	x	?	x	x	?		?			
Old Records Storage	x		x			x	x	x		x

Adapted from Hardee and Gould, from Institute for Healthcare Improvement, 1992

In this example, the oral contraceptive supply system was determined to be the most important area for improvement, since making sure that the program did not run out of pills fulfilled most of the criteria that were important to the program. Next the team would have to define a problem to study within that area for improvement, such as the ordering process, the inventory control system, the record keeping system, etc. The team would then outline the process for that problem area, using the flowcharting technique (Steps 2 and 3).

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Flowcharting

Flowcharting is a technique used to analyze the sequence of activities that occur in a particular process that you have chosen to study. Developing a flowchart helps you to break up a routine process, or set of activities, into a series of sub-steps that make up that process. A flowchart also helps you to define the relationship between the activities and the desired outcomes of those activities. To develop a flowchart, you need to define the beginning and the end of a particular process or system, and outline (in sequence) the activities that complete the process.

How to . . .

Make a Process Flowchart

1. Determine the first and last steps of the process.
2. Record the first step at the top of the page and draw an **Ellipse** around it.
3. Write down each step in the process in sequence.

   Use **Rectangles** for activities.

   Use **Diamonds** for decisions.

4. Mark the path of the flowchart from the beginning to the end by connecting all the rectangles (activities) and diamonds (decision points).
5. Return to the beginning of the path and repeat Step 4 for any paths that branch off from the main path.
6. Record the last step at the bottom of the page, draw an **Ellipse** around it, and connect the primary path and any branching paths to the last step.
7. Review for accuracy.

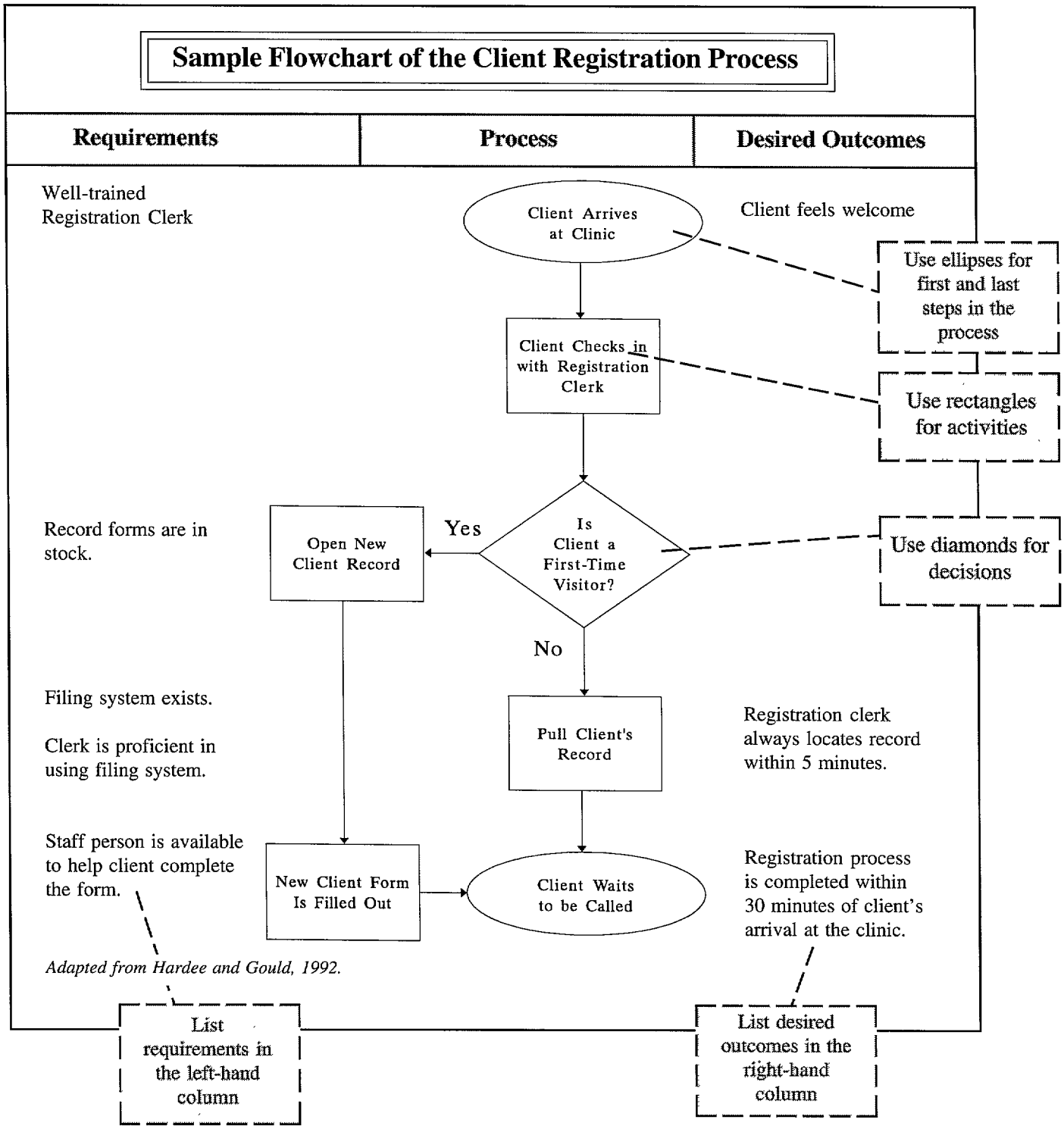
On more complicated flowcharts there may be smaller paths that will branch off from a decision point, since each decision point indicates an alternative process that may take place before it rejoins and completes the process later.

Determine requirements and outcomes

To complete the diagram, write the **requirements** that are needed in order for each activity to occur. Write the requirements in the left-hand column next to each activity. These requirements are often related to resources, such as human, financial, and material resources. Then, in the right-hand column, write the **desired outcomes** of each activity in the process. Write the desired outcomes of the whole process at the bottom of the flowchart. When determining the requirements and desired outcomes of the process, it is also important to consider the time needed to carry out each activity, as well as other constraints.

Once the flowchart is completed and requirements and desired outcomes are noted, the flowchart can be used to compare the differences between the desired and actual outcomes. Often problems are found where the desired outcomes are very different from the actual outcomes. Making this comparison will help you to select the specific steps on which the team should focus its efforts.

Flowcharts are used at Steps 2 and 3 in the CQI process, and should be revised as new recommendations for improvement are made during the CQI process. It would also be helpful to create a flowchart of any new or revised system, which you can then use to present that new system (or process) to other staff in your organization. The flowchart will help staff to see where changes have been made, and how the changes will produce a positive result.



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Brainstorming

Brainstorming is an excellent technique for generating ideas about all the possible causes of a problem. This technique is based on the assumption that all ideas are useful, thus encouraging the team to think creatively. By inviting people to a brainstorming meeting who have very different perspectives (for example, a clinician, a staff member, an administrator, a client, a finance officer, etc.), the meeting is more likely to produce innovative ideas that may not have been considered before. This technique can be used at any step in the CQI process, but can be particularly helpful when the team is discussing the possible causes of a problem, or the factors that are preventing the desired outcomes from being achieved (Step 4).

How to . . .

Brainstorm About the Possible Causes of a Problem

1. Form a group of people to generate a list of possible causes of a problem.
2. Write the problem clearly on a flip chart or blackboard. Check to make sure everyone understands the problem.
3. Agree on rules for the brainstorming session and post the rules:

Rules of brainstorming

Every idea is valid.

Every idea is written down in the words of the speaker. If an idea takes a long time to explain, the speaker should list the major points for summary on the blackboard.

No one may interrupt or criticize.

Only questions of clarification may be asked.

4. Ask the group to identify the possible causes of the problem being studied, and record every idea. (The facilitator can assist this process by asking *why* the desired outcomes are not being achieved.)
5. Continue until no more ideas are offered.

Cause-and-Effect Diagrams

A cause-and-effect diagram is a tool that the CQI team can use to group, in an orderly way, people's ideas about the causes of a problem. A cause-and-effect diagram (also known as a Fishbone diagram) helps the team to determine both the primary and the secondary causes of a problem, and is helpful for organizing the ideas generated from a brainstorming session. The sample "Fishbone" diagram shown here, lists the primary and secondary reasons (causes) why clients may have decided to discontinue using oral contraceptives.

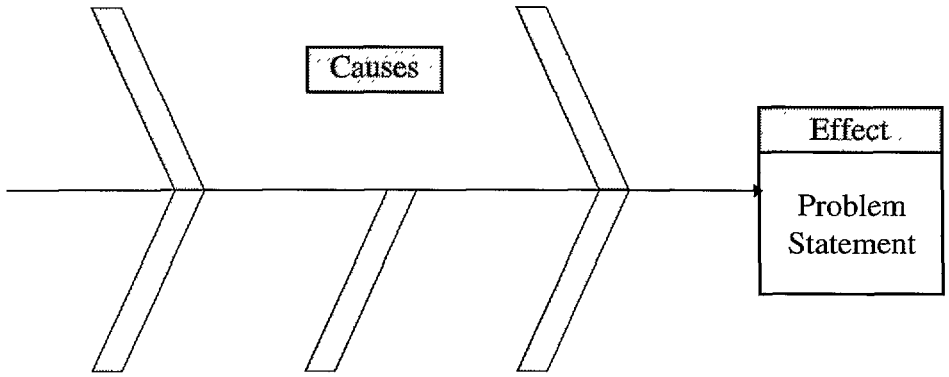
Using a cause-and-effect diagram forces the team to consider the complexity of the problem and to take an objective look at all the contributing factors. Otherwise, the CQI team members may think that one or two causes related to the most recent occurrence of the problem are the most important, when in fact, there may be other more important underlying causes. Constructing a diagram does not solve the problem, but it ensures that the team does not overlook any possible causes of the problem. Data collection tools such as tally sheets, surveys, and clinic registers are some of the sources the team can use to pinpoint the possible causes of a problem. A cause-and-effect diagram should be used when the team is deciding which specific steps in the process to study (Step 4).

By examining a cause-and-effect diagram, team members can more easily choose one or more aspects of the problem that they have some control over changing, and identify those that they believe will significantly improve the situation.

How to . . .

Develop a Cause-and-Effect Diagram

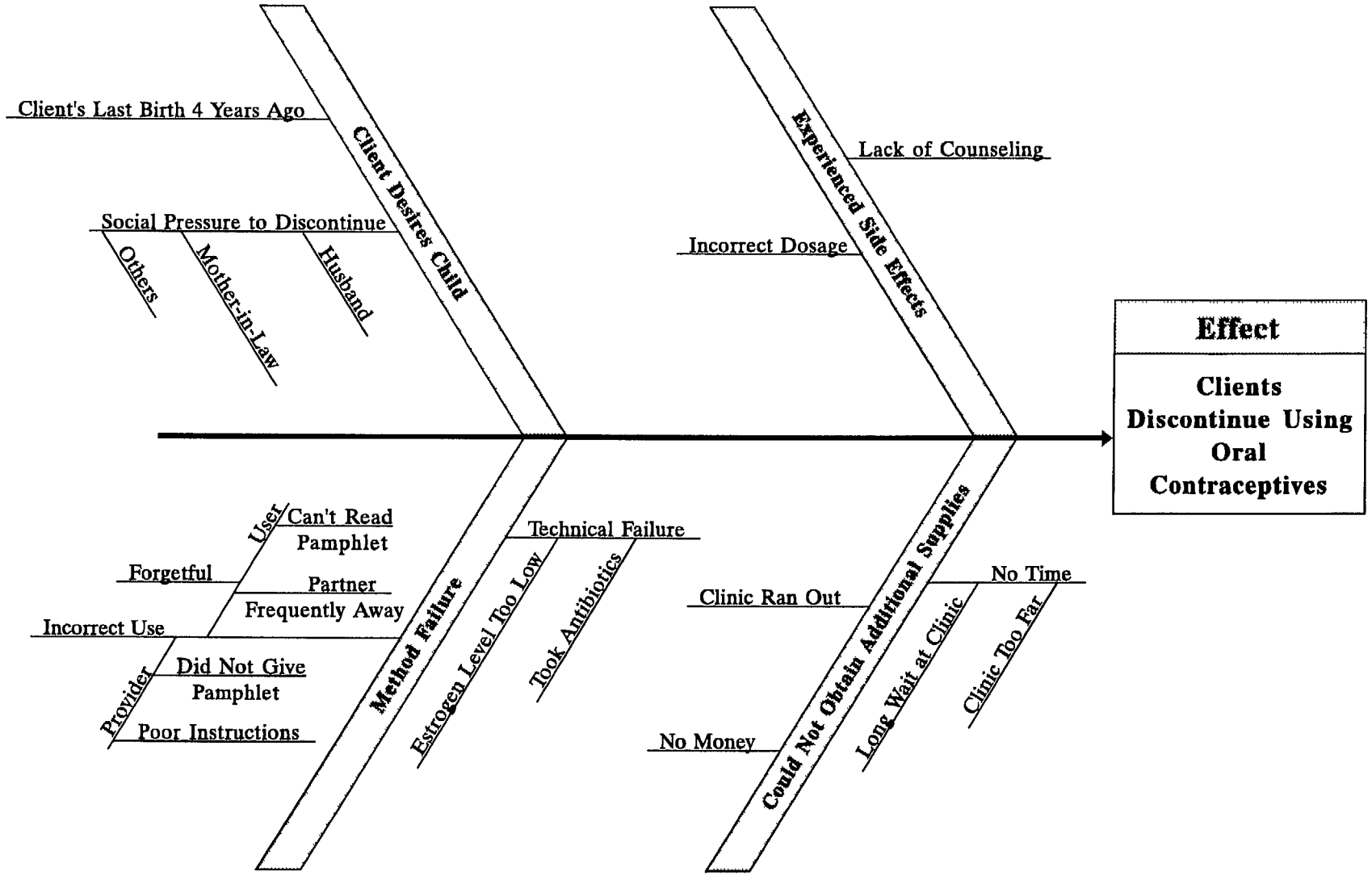
1. Draw a preliminary sketch or outline of a "fishbone" diagram, and fill in the box marked "Effect" with a statement of the problem.



2. Review the process flowchart that you have drawn, and consider the various aspects of the problem you are studying.
3. Brainstorm about the factors (causes) that affect the outcomes of each process step. To help determine the causes of the problem, remember that causes can be related to many aspects of service delivery: the facility itself, material resources, processes of implementation, people, or the system by which performance is measured.
4. Fill in the diagram so that the causes are organized in a logical way, and show both the primary and secondary causes of the problem.
5. Examine the diagram, summarize the primary and secondary causes of the problem, determine which causes the team has control over changing or improving, and collect data to determine which factors contribute most to the problem (Step 5).

Sample Cause-and-Effect Diagram

Problem: Clients Discontinue Using Oral Contraceptives



Adapted from Hardee and Gould, 1992.

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Client Flow Analysis

In many clinics clients often have to spend a long time waiting before being served by a provider. Conducting a client flow analysis is helpful for discovering the primary causes of waiting times (Step 5). It can also help to analyze and understand overall clinic operations, including the route that clients follow as they progress through the clinic, and can indicate changes that will ensure a smooth and efficient process as clients are seen by different clinic staff members.

A client flow analysis consists of keeping track of the time it takes each client to proceed through the various activities involved in a clinic visit. Client flow forms, which can help the CQI team to collect and analyze this type of data, are designed to be used by staff members, and can produce valuable information about clinic procedures. At the end of the day, the information from the client flow analysis can be graphed to show, for example, the amount of time the clients spend waiting, instead of being served by a provider. Other information, such as the amount of time staff spend with clients, or where the client flow becomes particularly congested, can provide the CQI team with suggestions on which factors are impeding the efficient use of staff, time, and materials. For more information about how to conduct a client flow analysis, please see Volume I, Number 1 of *The Family Planning Manager*, "Reducing Client Waiting Time."

For more information on client flow analysis, please refer to the following sources:

- "Reducing Client Waiting Time," Volume I, Number 1, *The Family Planning Manager*. Available from Family Planning Management Development, Management Sciences for Health, 400 Centre Street, Newton, MA 02158, USA.
- "COPE: A Self-Assessment Technique for Improving Family Planning Services." Available from the Association for Voluntary Surgical Contraception, Distribution Unit, 79 Madison Avenue, 7th Floor, New York, NY 10006, USA.
- "Patient Flow Analysis." This is a computerized program available from the Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, Clinic Management Unit, Mail Stop K22, 4770 Buford Highway Northeast, Atlanta, GA 30341-3724, USA.

Tally Sheets

Tally sheets are one way to easily and efficiently collect and organize data (Step 5). Tally sheets do not need to be complicated and can be used to collect data that may already be available in the existing Management Information System. Data collection tools, such as registers, surveys, and logs, are good sources for examining the possible causes of a problem.

Tally sheets should be used to list the types of data that will be collected and to record the number of observations or occurrences that are counted in each category. The sample tally sheet shows how a tally sheet can be used to track client complaints in six different categories. The data collected on the tally sheet can then be used to produce graphs, which can help the CQI team to visualize and pinpoint the factors that have the greatest impact on a problem.

Sample Tally Sheet for Client Complaints

Date: _____

Clinic Name: _____

Staff Member Completing Form: _____

Remarks: _____

_____

_____

Type of Complaint	Tally	Frequency
Lack of privacy	II	2
Clinic not clean	I	1
Method not available	III	3
Waited too long	~~IIII~~ II	7
Staff impolite	IIII	4
Clinic hours inconvenient	~~IIII~~ IIII	9
No bathroom available	III	3
Other	II	2

Adapted from Hardee and Gould, 1992.

Bar Charts and Histograms

Bar charts and histograms can be used to display data graphically, which will help the team to organize and interpret a large number of facts, and to pinpoint the causes of a problem (Step 5). Bar charts and histograms are similar in that they both show the frequency distribution of data, in other words, they provide a graphic representation of the number of occurrences measured in *different categories of data* (bar charts), or in the *variables within a single data category* (histograms).

Examples of different categories of data: Different types and brands of contraceptives, different reasons given for not using contraception, different complaints about the clinic services.

Examples of a continuous variable within a single data category: The age groups (20-24, 25-29, 30-34, 35-39, etc.) of women using the IUD, the number of minutes (less than 5, 5-9, 10-14, 15-19, etc.) spent waiting to been seen by a provider.

continued on page 10

continued from page 9

A simple **bar chart** compares different categories of data, such as *the average lead time promised by the distributor for* ***each method of contraception****; in other words, the average number of weeks it will take to receive delivery of each contraceptive method, after it has been ordered.* The data categories in a bar chart have no natural sequence on the horizontal axis since it doesn't matter in what sequence the data categories (in this case, the methods) are listed.

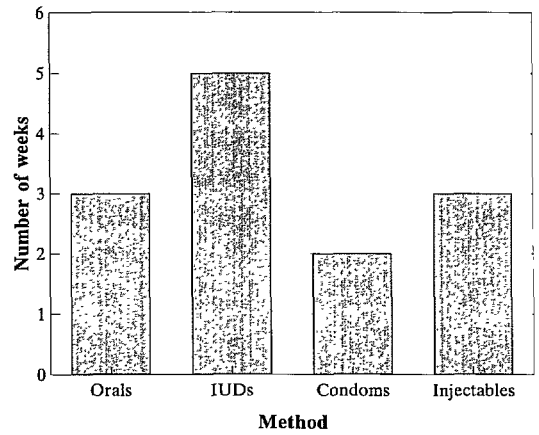
The sample bar chart shows that the distributor has promised a lead time of three weeks for orders of oral contraceptives, five weeks for IUDs, two weeks for condoms, and three weeks for injectables.

A **histogram** is a type of bar chart that compares variables within a single data category, and compares the number of occurrences based on a continuous variable, such as *the actual lead time for orders of oral contraceptives placed in the last two years; in other words, the number of orders of* ***oral contraceptives (single data category)****, graphed in terms of the* ***number of weeks (continuous variable)*** *it took to receive each order.* Since the continuous variable (number of weeks) has a natural sequence (lowest to highest number of weeks), the variable on the horizontal axis of the histogram is ordered sequentially from one to six.

A histogram displays the distribution of data and reveals how much the data vary. There will always be a pattern in the variation, and a histogram allows you to see the pattern. *The sample histogram shows that the number of weeks that it takes for orders to arrive has varied over the last two years, but the pattern reveals that the lead time for oral contraceptives is most likely to be closer to 4 weeks, rather than the 3 weeks promised by the distributor.* Discovering (and displaying) this variation will greatly increase the team's knowledge about a process. In this case, the clinic manager might want to increase the order quantity for pills, to ensure that the clinic doesn't run out of pills while waiting for a new supply to arrive.

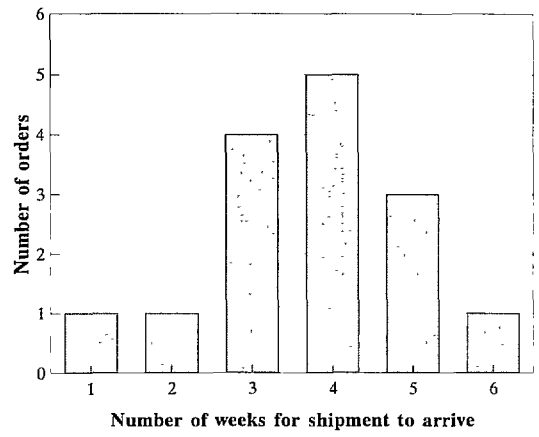
Sample Bar Chart

Lead Time Promised by the Distributor for Each Contraceptive Method Offered by the Clinic



Sample Histogram

Actual Lead Time for Delivery of Oral Contraceptives (1990–1992)



Pareto Analysis

The "Pareto" analysis originates from the work of an Italian economist, Vilfredo Pareto. The Pareto principle states that only a *few* factors are responsible for producing *most* of the result (positive or negative result). This principle was later applied to quality improvement theory by Dr. Joseph Juran, who stated that these "vital few" factors need to be identified so that quality improvement resources can be concentrated in those areas.

The goal of any quality improvement effort is to improve the "vital few" causes of problems in a process, and in so doing, achieve breakthroughs in the overall performance of a process. Focusing on the "vital few" achieves the greatest potential gain from quality improvement efforts. Like a bar chart, the Pareto analysis shows the frequency of responses, or occurrences, of different data categories (or different causes of a problem); except in a Pareto diagram the responses are ordered from the highest to lowest number of responses tallied. In addition, for each response, the Pareto analysis shows the cumulative percentage of the total problem contributed by each additional response. This allows the team not only to see which two or three factors (causes) are responsible for most of the problem, but also to quantify how much of the total these "vital few" factors represent.

How to . . .

Perform a Pareto Analysis

1. Divide the data into categories, *such as each reason given for not using contraception.* Count and record the number of times each reason was cited.
2. Construct a frequency table by ordering the responses from the one most frequently given to the one least often given. Fill in the number of times each reason was given. Then total the number of all the responses at the bottom.
3. For each data category (or reason), calculate the percentage of the total responses it represents, and round to the nearest whole percent. *In this example, a total of 84 responses were counted. Of these 84 total responses, 35 responses (42 percent) referred to a lack of information about family planning (35 divided by 84 = .416 or 42%). The next highest number of responses, 25 (.297 or 30%), indicated a lack of access to family planning services.*
4. Calculate and record the cumulative percentages. Begin by recording the response with the highest percentage *(in this example, 42%)* at the top of the third column. Add to it the percent contribution of the next type of response *(for example 42% plus 30% = 72%)* and record the cumulative percent (72%) in the third column. Continue to record the cumulative percentages for each additional type of response to complete the table.
5. Using the data from the frequency table, construct a bar chart that presents the number of times (frequency) that each response was given, ordered from the most common response (on the left), to the least mentioned response (on the right). The vertical y-axis on the left indicates the number of times (from zero to the maximum) the response was given, and the vertical y-axis on the right marks the cumulative percentages (zero to 100%). Plot the cumulative percentages for each additional type of response, and draw a line to connect the points.

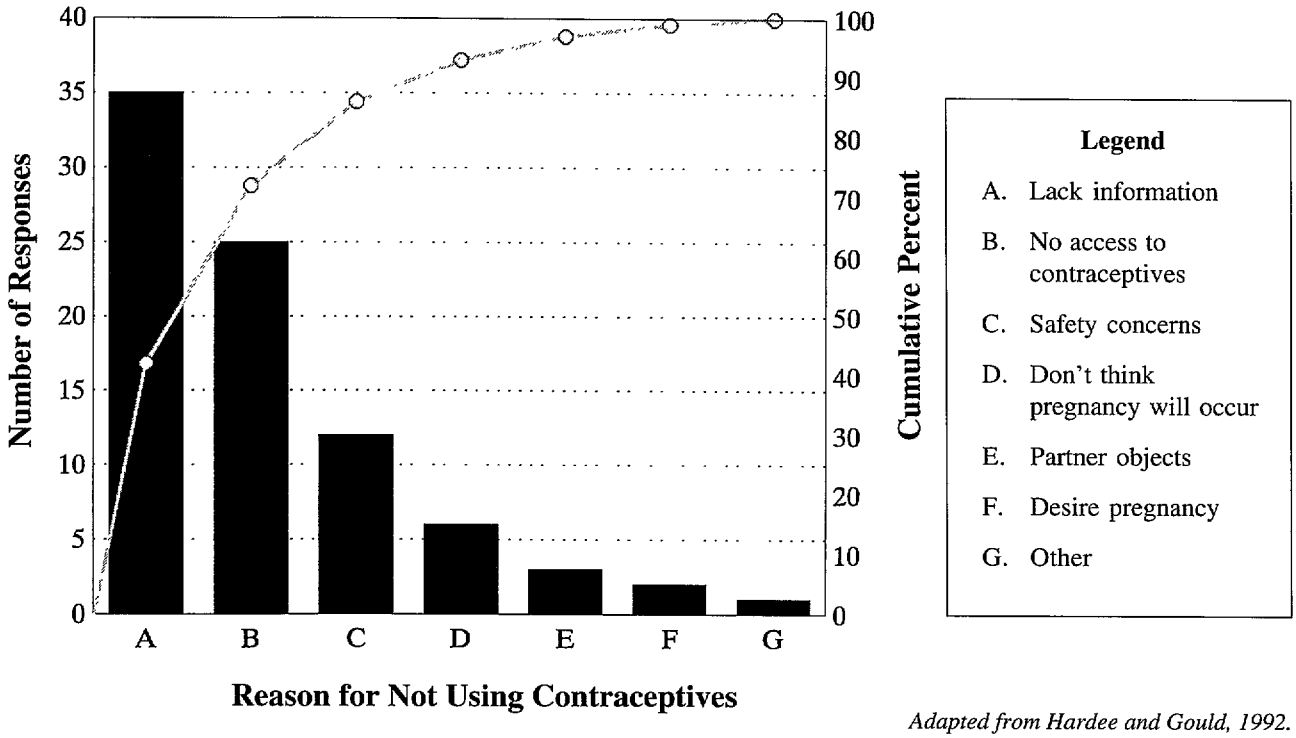
In any CQI effort, the team members should ask themselves, "Which few factors are contributing most to the overall problem?" The Pareto analysis is a technique for finding the answer to this question. *In the sample Pareto analysis, two reasons for not using contraceptives—lack of information and no access to contraceptives—account for 72 percent of the problem. In this example, the CQI team should focus their efforts on those two causes of the problem.* The Pareto analysis is generally used at Step 5 in the CQI process, but it can be used any time during the CQI process when graphing data might help the team to better understand a problem and its causes.

Sample Pareto Analysis

Reasons Given for Not Using Contraceptives By Eligible Couples in the Community

Reason for Nonuse (Ordered by frequency of occurrence)	**Frequency**		**Cumulative Percent**
	Number of Times Cited	**% of Total Responses (rounded)**	
A. Lack information	35	42	42
B. Have no access to contraceptives	25	30	72
C. Concerned about safety of contraceptives	12	14	86
D. Don't think pregnancy will occur	6	7	93
E. Partner objects	3	4	97
F. Desire pregnancy	2	2	99
G. Other	1	1	100
Total	**84**	**100**	**100**

Reasons for Not Using Contraceptives and Percent Contribution to the Problem



Adapted from Hardee and Gould, 1992.

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Benchmarking

By comparing the process followed in your organization with that of another family planning or health services organization, a technique called "benchmarking," you can develop new ideas about how to modify and improve the process that you have selected to study. Not all CQI efforts will require using the benchmarking technique. Whether or not you decide to take the time and resources to conduct a benchmarking exercise will depend, in part, on the size and complexity of the problem you are studying, and how critical that process is to achieving the goals of your organization. This technique can be used during Step 6 in the CQI process, when you are deciding what actions to take to correct a problem.

How to . . .

Use the Benchmarking Technique

To determine whether benchmarking would provide useful ideas for changing the process that you have selected for improvement, you should ask the following questions:

- Does the process produce one of your most important services?
- Are clients dissatisfied with the service they receive as a result of the process?
- Will improvement of the process support the program's overall strategy?
- Can the necessary data be obtained to analyze this process, so that comparisons can be made with other organizations?

Designate a benchmarking travel team. Include in the team someone who has expertise in the process you are trying to improve. Team members could also include: a person who has been designated to implement changes in your organization, a person made responsible for coordinating the benchmarking process and, if appropriate, a program client. Designate one person as the team leader.

Select another organization to use as a "benchmark" for your organization. Identify an organization that provides family planning or health services (ideally, a non-competitor), or a leader in the process you are benchmarking who will be likely to share information with you. For example, to benchmark your contraceptive supply system, choose an acknowledged leader in warehousing and distribution, or choose an organization that has effective methods for storing, tracking, distributing, and ordering contraceptive supplies.

Contact the benchmark organization to explain the purpose of your proposed visit, gain their support for the visit, and set a date for the visit.

Make a site visit to collect data. Determine in advance the kind of information that you want. Send a list of your questions to your benchmark contact, so that he or she can prepare for your visit. Agree on an agenda for the visit. Arrange a meeting, tour the benchmark organization, and obtain answers to your questions. Ask about the organization's future plans for the process you are investigating, and be prepared to share comparable information about your own organization.

Determine any important differences between the process used by your organization and the process used by the benchmark organization.

Present your findings to the team, set new goals, and use the results to propose improvements in the process.

This supplement has described some of the fundamental tools and techniques that can be useful in implementing CQI in your organization. For more detailed information about these and other techniques that can be used in implementing CQI, please refer to the references section on page 19 of this issue of *The Family Planning Manager,* "Using CQI to Strengthen Family Planning Services."

Checklist for Using the Manager's Toolbox for CQI

Tool or Technique	When to Use	Reason for Using
Selection Matrix	Step 1	To help the CQI team select an area for improvement to focus on first, by developing and using a set of selection criteria.
Flowcharting	Steps 2-3	To show the sequence of activities (the process) that occurs in the problem selected for improvement.
Brainstorming	Step 4	To generate ideas about all the possible causes of a problem. This technique encourages creative thinking among team members because all ideas are considered valid.
Cause-and-Effect Diagrams	Step 4	To organize ideas generated from a brainstorming meeting and to define the primary and secondary causes of a problem.
Client Flow Analysis	Step 5	To analyze client waiting time in a clinic and to determine the causes of the long waits.
Tally Sheets	Step 5	To easily and efficiently count, record, and organize data.
Bar Charts and Histograms	Step 5	To display data in graphic format so that trends can be seen and comparisons made.
Pareto Analysis	Step 5	To analyze and identify the "vital few" causes of a problem, so that resources can be focused in those specific areas. (This analysis assumes that there are usually only a few factors that are responsible for causing most of the problem.)
Benchmarking	Step 6	To compare the processes followed in your organization with the processes of an acknowledged leader in the same field.

The Family Planning Manager is designed to help managers develop and support the delivery of high-quality family planning services. The editors welcome any comments, queries, or requests for free subscriptions. Please send to:

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Family Planning Management Development
Management Sciences for Health
400 Centre Street
Newton, Massachusetts 02158, U.S.A.
Phone number: (617) 527-9202
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CHARACTERISTICS OF EFFECTIVE TEAMS

- Clearly defined team goals
- Clearly defined team roles
- Clear communication
- Positive and productive team behaviors
- Well-defined decision-making procedures
- Balanced participation among members
- Established norms for participation
- Awareness of group processes and stages of team development
- Use of a scientific approach and data for decision-making

(Adapted from Peter R. Scholtes, Brian L. Joiner and Barbara J. Streibel, "The Team Handbook," Second Edition, Madison, Wisconsin, 1996, chapter 6. © 2000 Oriel Incorporated. All Rights Reserved. Used here with permission.)

BENEFITS OF TEAMWORK

1. Access to greater technical skill and practical experience

2. More comprehensive analysis of problems and better understanding of areas of improvement by all concerned, leading to:

   - Better understanding of processes
   - Better solutions
   - Greater commitment to implementation of solutions
   - Greater chance of implementation of solutions
   - Better results

3. Solve larger problems than can one person acting alone

4. Democratic decision-making, leading to:

   - Greater cooperation among different types of staff
   - Broad ownership of improvements

5. Members gain new knowledge, insight and skills

   - Members gain appreciation for various roles in carrying out processes
   - Limits accusations that others cause the problems

TEAM GROWTH

STAGES OF TEAM GROWTH

As a team matures, members gradually learn to cope with the emotional and group pressures they face. As a result, the team goes through fairly predictable stages.

Stage 1: FORMING

When a team is forming, members cautiously explore the boundaries of acceptable group behavior. Like hesitant swimmers, they stand by the pool, dabbling their toes in the water. This is a stage of transition from individual to member status, and of testing the leader's guidance both formally and informally.

Forming includes these feelings . . .

- Excitement, anticipation and optimism
- Pride in being chosen for the team
- Initial, tentative attachment to the team
- Suspicion, fear and anxiety about the job ahead

. . . and these behaviors.

- Attempts to define the task and decide how it will be accomplished
- Attempts to determine acceptable team behavior and how to deal with team problems
- Decisions about what information is needed
- Lofty, abstract discussions of concepts and issues; or for some members, impatience with these discussions
- Discussions of symptoms or problems not relevant to the task; difficulty in identifying relevant behaviors
- Complaints about the organization and barriers to the task

Tip: Leading a Team Through Forming

As teams move through stages of growth, team leaders should adapt their behavior to the team's shifting needs.

To build trust and confidence during the forming stage, the leader should:

- Help members get to know each other
- Provide clear direction and purpose

- Involve members in developing plans, clarifying roles and establishing ways of working together
- Provide the information the team needs to get started

Because there is so much going on to distract members' attention in the beginning, progress on work or team goals is slow. This is perfectly normal.

Stage 2: STORMING

Storming is probably the most difficult stage for the team. It is as if team members jump in the water, and thinking they are about to drown, start thrashing about. They begin to realize that the task is different and more difficult than they imagined, and become testy, anxious or overzealous.

Impatient about the lack of progress, but still too inexperienced to know much about decision making or the scientific approach, members argue about just what actions the team should take. They try to rely solely on their personal and professional experience, resisting any need for collaborating with other team members.

Storming includes these feelings . . .

- Resistance to tasks and methods of work different from what each individual is comfortable using
- Sharp fluctuations in attitude about the team's chance of success

. . . and these behaviors.

- Arguing among members even when they agree on the real issue
- Defensiveness and competition; factions and "choosing sides"
- Questioning the wisdom of those who selected this project and appointed the other members of the team
- Establishing unrealistic goals; concern about excessive work
- Creation of a perceived "pecking order," creating disunity, increased tension and jealousy

Tip: Leading a Team Through Storming

At the storming stage, to build self-direction the leader should:

- Resolve issues of power and authority, for example, do not allow one person's power to squash others' contributions
- Develop and implement agreements about how decisions are made and who makes them
- Adapt the leadership role to allow the team to become more independent
- Encourage members to take on more responsibilities

Again, these many pressures mean team members have little energy to spend on progressing toward the team's goal. But they are beginning to understand one another.

Stage 3: NORMING

During this stage, members reconcile competing loyalties and responsibilities. They accept the team, team ground rules (or "norms"), their roles in the team and the individuality of fellow members. Emotional conflict is reduced as previously competitive relationships become more cooperative. In other words, as team members realize they are not going to drown, they stop thrashing about and start helping each other stay afloat.

Norming includes these feelings. . .

- A sense of team cohesion, a common spirit and goals
- Acceptance of membership in the team
- Relief that it seems everything is going to work out

. . . and these behaviors.

- An attempt to achieve harmony by avoiding conflict
- More friendliness, confiding in each other and sharing of personal problems; discussing the team's dynamics
- A new ability to express criticism constructively
- Establishing and maintaining team ground rules and boundaries (the "norms")

As team members begin to work out their differences, they now have more time and energy to spend on their work. Thus they are able to start making significant progress.

Tip: Leading a Team Through Norming

In the norming stage, to build cooperation the leader should:

- Fully utilize team members' skills, knowledge and experience
- Encourage and acknowledge members' respect for each other
- Encourage members to "roll up their sleeves" and work collaboratively

Stage 4: PERFORMING

By this stage, the team has settled its relationships and expectations. They can begin performing—diagnosing and solving problems, and choosing and implementing changes. At last, team members have discovered and accepted each other's strengths and weaknesses, and learned what their roles are. Now they can swim together as a team.

Performing includes these feelings . . .

- Members having insights into personal and group processes, and better understanding of each other's strengths and weaknesses
- Satisfaction at the team's progress
- Close attachment to the team

. . . and these behaviors.

- Constructive self-change
- Ability to prevent or work through group problems

The team is now an effective, cohesive unit. You can tell when your team has reached this stage because you start getting a lot of work done.

The duration and intensity of these stages vary from team to team. Sometimes Stage 4, Performing, is achieved in a meeting or two; other times it may take months. Use the descriptions here to compare your team with the normal pattern for maturing groups. Understanding these stages of growth will keep you from overreacting to normal problems and setting unrealistic expectations that only add to frustration. Do not panic. With patience and effort this assembly of independent individuals will grow into a team.

Tip: Leading a Team Through Performing

In the performing stage, to build openness to change the leader should:

- Update the team's methods and procedures to support cooperation
- Help the team understand how to manage change
- Represent, and advocate for, the team with other groups and individuals
- Monitor work progress and celebrate achievements

(Adapted from Peter R. Scholtes, Brian L. Joiner and Barbara J. Streibel, "The Team Handbook", Second Edition, Madison, Wisconsin, 1996, chapter 6. *© 2000 Oriel Incorporated. All Rights Reserved. Used here with permission.)*

POSITIVE TEAM MEMBER BEHAVIORS

A team works best when members of the group:

- **Suggest methods or procedures**
  Suggest ways of doing things, steps to move the discussion forward; use methods such as brainstorming, etc.

- **Seek information or opinions**
  Draw out relevant information, opinions, ideas, suggestions or concerns from team members. Ask questions to invite others' ideas.

- **Give information or opinions**
  Share relevant information, opinions, suggestions and concerns.

- **Encourage others**
  Are friendly, warm and responsive; use eye contact and "uh-huhs" to support others' participation.

- **Reduce tension**
  Reduce tension by using humor appropriately; get the group to laugh; admit errors.

- **Clarify and elaborate ideas**
  Clear up confusion; give examples; point out issues and alternatives; share interpretations of what's been said; build on what others have said.

- **Summarize**
  Pull together what's been said; organize related ideas; integrate different ideas; offer conclusions for the team to consider.

- **Check decisions**
  Note when the group is making a decision and state the decision for the group; check to be sure the decision method is acceptable; check to be sure the decision has been well thought through.

- **Resolve disagreements**
  Work out disagreements; look for ways to address objections and concerns; incorporate others' ideas into proposals.

- **Notice group feelings**
  Sense and express team feelings and moods; are aware of significant shifts in tone and help the team be aware of shifts.

WHEN TO USE CONFLICT STRATEGIES

Avoiding the conflict. Distract attention from issues that are likely to lead to conflict or avoid them completely.

> May be appropriate when: the issue is trivial/irrelevant, people need to be allowed to cool down and regain perspective, you need more time to gather information, others can resolve the conflict more effectively

Accommodation. The desire to please others at the expense of one's own needs.

> May be appropriate when: you find that you are wrong; issues are more important to others than to you; you want to build social support for later use; you want to allow other team members to develop by learning from mistakes.

Forcing the conflict. Overpower others and force them to accept your position. Competitive win-lose approach.

> May be appropriate when: quick, decisive action is necessary; the issues are important and unpopular actions need to be implemented; other options are not possible.

Compromising. Try to get others to give up some of what they want in exchange for giving up some of what you want. May be a lose-lose strategy if no one's goal is achieved.

> May be appropriate when: goals are important but not worth disruptions; you need an expedient solution under time pressure; or you need another strategy because other strategies have not worked.

Problem-solving through the conflict. Win-win approach. Finds the path that meets everybody's goals and, by doing so, preserves group relationships.

> May be appropriate when: you need to find an integrative solution and both sets of concerns are too important to be compromised; you need to merge insights from people with different perspectives; you want to gain commitment by incorporating concerns into a consensus decision; you want to work through feelings that have interfered with a relationship.

(Adapted from Peter R. Scholtes, Brian L. Joiner and Barbara J. Streibel, "The Team Handbook," Second Edition, Madison, Wisconsin, 1996, chapter 7. *© 2000 Oriel Incorporated. All Rights Reserved. Used here with permission.* *Also adapted from Cresencio Torres and Deborah Fairbanks, "Teambuilding: The ASTD Trainer's Sourcebook," McGraw-Hill, 1996).*

COMMON TEAM PROBLEMS

Floundering: Teams may experience problems starting or ending a task or moving between different steps of a task. At the beginning, they may experience directionless discussions or activities. As the team progresses, some team members may resist moving from one step to the next. At the end, teams may delay unnecessarily, postponing decisions or conclusions.

- At the beginning of a task or project, floundering may suggest that the team is either unclear about or overwhelmed by its task; or that team members are not yet comfortable enough with each other to engage in real discussion or decision making.
- When trying to make decisions, floundering may indicate that the team's work is not really the product of consensus, and that some members are reluctant to say they don't support the team's decisions/conclusions.
- After completing one part of a project or task, floundering may indicate that the team does not have a clear plan and does not know what to do next.
- At the end of a task or project, floundering may indicate that the team members have developed a bond and are reluctant to separate; or that they are reluctant to expose their work to review and possible criticism from others.

Deal with floundering by:

- Reviewing the work plan, or create a plan if there isn't one.
- Asking the team what they need to do so they can move on; what is holding them up (data, knowledge, support, feelings, previous unfinished business)
- Suggesting that everyone write down, and share, what they think is needed to move to the next stage.

Overbearing participants exert an unusual amount of influence in a team, often a function of their position of authority or area of expertise. This may be detrimental when the person:

- Discourages or forbids discussion concerning his/her area of authority or expertise
- Signals the "untouchability" of an area/topic by using technical jargon and/or holding up certain standards, regulations or policies as untouchable
- Regularly discounts any proposed activity by declaring that it won't work

Deal with overbearing participants by:

- Reinforce the agreement that no area is sacred; that team members have a right to any area that concerns the situation they are examining and trying to resolve
- Ask the overbearing person to agree (in advance if possible) to the importance of everyone's participation and access to all relevant information
- Talk to him/her privately and ask for cooperation and patience
- Enforce the primacy of data and the scientific approach

Dominating participants, with or without authority, consume a disproportionate amount of time talking. This frustrates other team members and prevents the team from building a sense of momentum or accomplishment.

Deal with dominating participants by:

- Structuring members' participation in discussions (by having each one write down and share his/her ideas)
- Raising the "balance of participation" as a concern during the evaluation of meetings
- Practicing gatekeeping: "We've heard from you on this. I'd like to hear what others have to say."
- Asking the team to agree on the value of balanced participation and the need for limits and focus in discussions

Reluctant participants (those who never speak) generally feel shy or unsure of themselves and must be encouraged to contribute.

Deal with reluctant participants by:

- Structuring discussion to encourage participation by everyone
- When possible, divide the task into individual or small group assignments and reports
- Practicing gatekeeping: ask if anyone else has ideas about the topic at hand (while looking at the reluctant participant); or more directly ask the individual if he/she has experience or ideas to contribute

Unquestioned acceptance of opinions as facts. Some team members express personal beliefs and assumptions with such confidence that others assume they are hearing a presentation of facts and may be reluctant to question such self-assured statements. They may feel they need data before challenging such statements.

Deal with unquestioned acceptance of opinions as facts by:

- Asking presenters if what they said is opinion or fact and if they have supporting data

Rush to accomplishment. This can happen when at least one member is impatient for results and unwilling to work through the necessary steps of the process. It may lead the team to hasty and unfounded decisions.

Deal with rush to accomplishment by:

- Reminding the team of the rationale for following the CQI process
- Making sure the team leader is not among those exerting pressure
- Giving constructive feedback to the "rusher," including examples of his/her behavior and its effects on the team's work

Attribution of motives to people when one doesn't understand, or agree with, their opinion or behavior. This often leads to resentment.

Deal with attribution by:

- Checking it out within the group by asking those to whom the motives were attributed to share their perception of the situation and/or the basis for their opinion or behavior

Discounts: Ignoring or ridiculing another's contributions, making him/her feel discounted or unimportant. This may happen if the contribution was irrelevant to the topic or was not clearly stated, or if others missed the meaning of the statement. Feeling discounted often leads to frustration and/or withdrawal. The contributions of all team members need to be acknowledged and some may need assistance in articulating what is important to them.

Deal with discounts by:

- Helping team members learn to listen actively to what others are saying
- Supporting those who have been discounted, acknowledging what they have contributed
- Giving constructive feedback to individuals who frequently discount, put down, or ignore others' comments

Digression and tangents. Wide-ranging, unfocused conversations. Although there is a natural tendency to stray from a subject, it often occurs when team members lose track of their purpose or want to avoid a sensitive topic.

Deal with digression and tangents by:

- Using a written agenda (individual copies and/or a flip chart) with time estimates for each item; refer to the topic and time when the discussion strays too far
- Directing the conversation back on track
- Acknowledging difficulty in sticking to certain topics and asking what makes the topic so easy to avoid

Feuding team members can disrupt an entire team with their disagreements. Such conflicts often existed prior to the formation of the team and will likely outlast it, too.

Deal with feuding team members by:

- Preventing feuding by selecting team members so that adversaries are not on the same team if possible

- If confrontations occur during team activities, ask that members deal with their differences outside of the team's work; offer to facilitate the discussion
- Push them to adopt ground rules for managing their differences without disrupting the team

(Adapted from Peter R. Scholtes, Brian L. Joiner and Barbara J. Streibel, "The Team Handbook", Second Edition, Madison, Wisconsin, 1996, chapter 7. *© 2000 Oriel Incorporated. All Rights Reserved. Used here with permission.)*

Reasons Given by Clients for Not Returning	Number
Traveled/away from home at specified time of visit	2
Did not understand purpose of return visit	42
Forgot when to return	26
Did not know when to return	37
Discontinued method due to side effects	3
Desire for pregnancy	2
Ambivalent about use of contraception	4
Clinic too far from client's residence	4
Clinic waiting time is too long	10
Total	**130**

BAR CHARTS, LINE GRAPHS AND PIE CHARTS

BAR CHARTS

Bar charts are graphic representations comparing different categories of data. For example, a bar chart can be used to show the numbers of FP users over time, demonstrating graphically how the numbers went up or down. Because a bar chart depicts a situation more clearly than simple numbers or a table with data, it can help the Quality Team define or select a QOC problem to work on, analyze a problem, verify its causes or assess solutions.

To Construct a Bar Chart:

1. Draw a chart with a vertical and a horizontal axis. The vertical axis represents the variable being studied (numbers, cost, time, etc.); the horizontal axis represents the categories of data being analyzed.

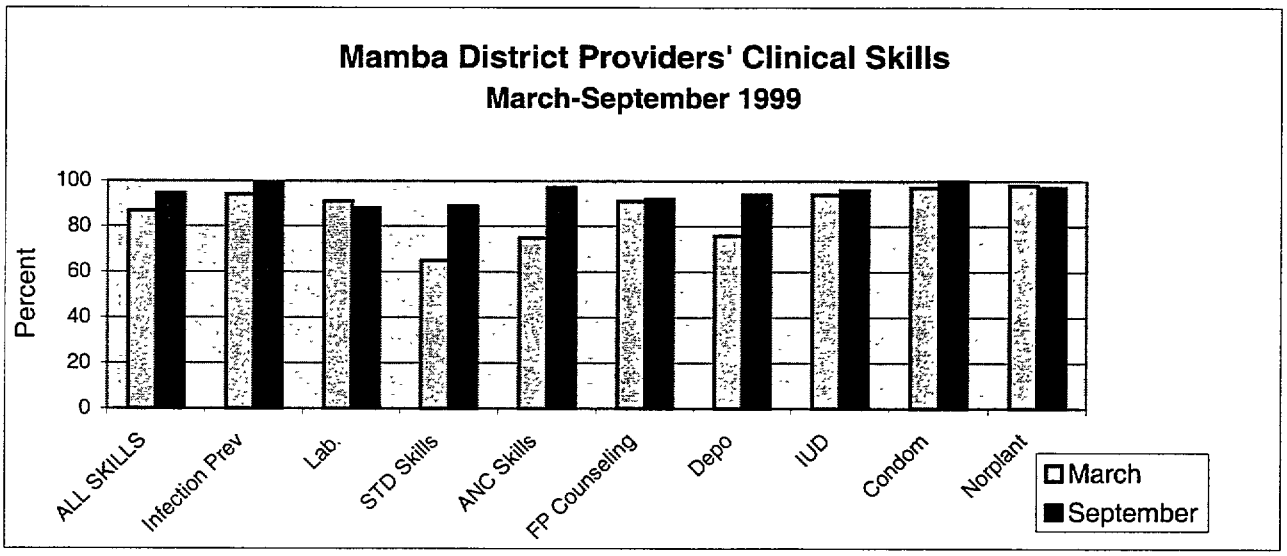
2. Determine the number of bars needed. The number of bars will equal the categories of data being analyzed.

3. Establish the range and scale of the variable on the vertical axis. This will be determined by the lowest and the highest value in the range of variables.

4. Construct the bars, representing the categories of data and the numerical variables. Label the categories of data.

5. Title the chart and indicate the sample and the time period covered by the data.

Sample Bar Chart:



LINE GRAPH

Like a bar chart, a line graph compares different categories of data. Instead of using bars, however, it uses lines, with *each line representing only one type of data.* While a bar chart can have bars showing different *categories* of data (e.g., different contraceptive methods), all the data in a line graph that are linked together with a line must be the *same type of data.* In many cases, either a bar chart *or* a line graph can be used to show the same data, but sometimes one will look better than the other.

Line graphs are particularly useful for depicting data over time. Thus, the numbers of FP users over a certain time period can be depicted in a line graph. Like a bar chart, a line graph can help the Quality Team define or select a QOC problem to work on, analyze a problem, verify its causes or assess solutions.

To Construct a Line Graph:

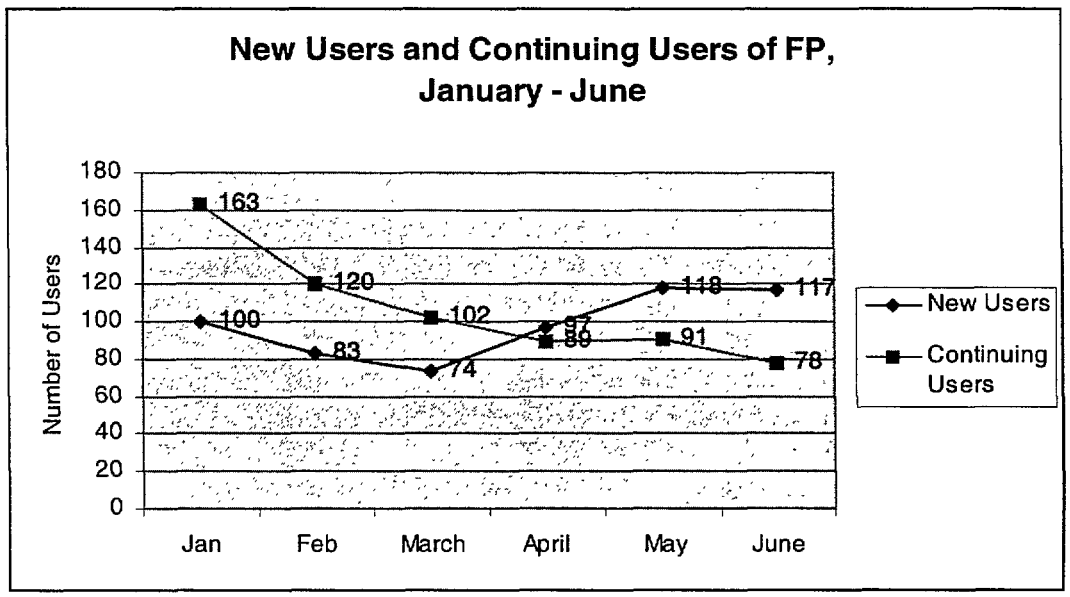
1. Draw a chart with a vertical and a horizontal axis. The vertical axis represents the variable being studied (numbers, cost, time, etc.); the horizontal axis represents the data being analyzed.

2. Establish the range and scale of the variable on the vertical axis. This will be determined by the lowest and the highest value in the range of variables.

3. Plot the data on the graph and link the points with a line.

4. Title the line graph and indicate the sample and the time period covered by the data.

Sample Graph:



PIE CHARTS

Pie charts are graphic representations that show the relative proportions of various items making up the whole. They can be useful to define or select quality problems to work on, to analyze a problem and determine its causes or assess solutions. For example, a pie chart can be used to show method mix, i.e., the percentage of *all* FP clients using the different FP methods.

To Construct a Pie Chart:

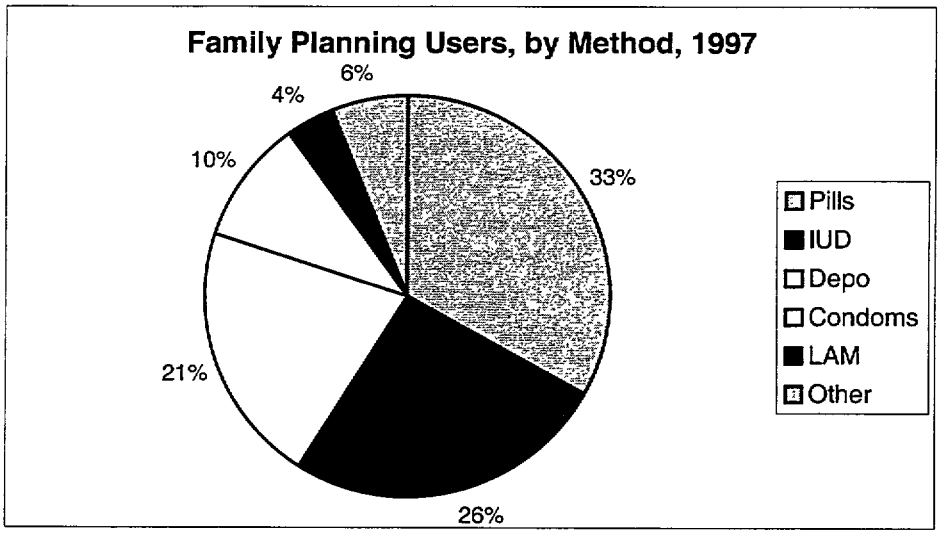
1. From the data collected, calculate the percentage each category contributes to the whole. This is done by dividing the numerical value of each category by the total and multiplying by 100. For example, to determine the percentage of all FP users that are using Depo Provera:

$$\frac{\text{Number Using Depo Provera}}{\text{Total Number of FP Users}} \times 100$$

2. Draw a circle. Using the percentages calculated in step 1, determine what portion of the circle is represented by each category of data. Divide the circle accordingly and fill in each segment of the circle with its corresponding data.

3. Title the Pie Chart.

Sample Pie Chart



(Adapted from Lynne Miller Franco et al., "Achieving Quality Through Problem-Solving and Process Improvement" Quality Assurance Project, 1997)

CQI TOOLS
DECISION MATRIX

A decision matrix is used when the Quality Team wants to choose a problem to work on out of a list of two or more possible problems, or to choose a solution out of a list of two or more possible solutions. It is based on the team evaluating the various choices, using explicit criteria that the group has decided are important for making the decision/choice.

Sample Decision Matrix

ITEMS TO BE PRIORITIZED	CRITERIA				TOTAL SCORE
	C 1	C 2	C 3	C 4	
Item 1					
Item 2					
Item 3					
Item 4					

C = Criterion for selection of problem.

To Use the Decision Matrix:

1. Construct a table like the sample above with a column for the issues to be prioritized—these might be quality problems or possible solutions to problems—three or four columns for the criteria and a column for the total score.

2. In the left-hand column, list the possible problems, or solutions, the group has come up with. Ensure that all team members understand all of the problems/solutions.

3. Select criteria for making the decision, using brainstorming and voting if necessary to determine the most important ones. Common criteria for choosing priority problems to work on, and for choosing solutions, are listed in the accompanying handout, Potential Criteria for Selection of Problems and for Choosing Solutions. Limit the number of criteria to three or four.

4. Decide how to rate each item in the left-hand column (i.e., each problem or solution) in terms of how it meets each criterion. Rating scales could be, for example, 1-5, with 5 representing the "best" match with the criterion and 1 representing a poor match.

5. Each person in the group takes each item in the left-hand column and reviews it according to each criterion, e.g., whether the problem is important to external clients. He/she rates each item individually on a scale of 1 to 5, according to each criterion.

6. Finally, for each item, add up the rankings for all criteria given by the individuals in the group. The item with the highest ranking should be considered by the group as having the highest priority.

(Adapted from Lynne Miller Franco, Jeanne Newman, Gael Murphy and Elizabeth Mariani, "Achieving Quality Through Problem Solving and Process Improvement," Second Edition, Step 9 Develop Solutions and Actions for Quality Improvement, Quality Assurance Project, Center for Human Services, Bethesda, MD , 1997)

SAMPLE CRITERIA FOR THE SELECTION OF QUALITY PROBLEMS

- The issue is important to external clients; improvement in this area can have high external impact.
- The issue is important to internal clients; improvement in this area can have high internal impact.
- A problem has existed for some time and is widespread.
- The benefits from addressing this issue are obvious; the process has high visibility.
- The issue is within the Quality Team's control and authority.
- Management and the team are technically capable of making changes in this program area.
- Support for change exists in this area. Management and those involved in the process recognize the need for change and are committed to it.
- There are risks associated with not addressing this issue.
- This problem undermines/affects the achievement of program objectives.
- This issue can be quickly resolved.
- Data on this issue are readily available.
- Resources are available for making changes.

SAMPLE CRITERIA FOR THE SELECTION OF SOLUTIONS

- The cost of implementing the change is low.
- The opportunity cost is low (the program won't have to give up anything else)
- The solution will be easy to implement.
- Management would support the approach (this may be influenced by the extent to which the management burden is eased or added to).
- There are few/no potential side effects (to the system or clients; impact on other activities).
- There should be little resistance to the change within the organization.
- The change could be implemented quickly.
- The change would have the support of those who will be affected.

CQI TOOLS:
PARETO ANALYSIS

Pareto analysis helps to identify the relatively few factors responsible for producing most of the problems in a process, so that quality improvement resources can be concentrated in those areas. The Pareto principle states that 80 percent of the trouble comes from 20 percent of the problems. Pareto analysis helps the Quality Team see the frequency of different causes of a problem, ordering from highest to lowest in terms of the number of occurrences.

To Conduct a Pareto Analysis:

1. Construct a table with four columns:
   - Category of response
   - Number of times each category of response was given
   - Percentage of the total responses that each category represents (rounded off)
   - Cumulative percent of each additional type of response

2. Divide the data into categories, e.g., the reasons clients do not come back to the clinic for follow-up visits. Note each category of response in Column 1 of the table.

3. Count the number of times each category of response was given. Following the example above, the categories of response are the reasons why clients did not come back for follow-up visits.

   Order all categories of responses in terms of the number of times they were given, from the category *most* frequently given to the category *least* frequently given. Record these numbers in descending order, in Column 2 of the table.

4. For each category of response, calculate the percentage of the total responses it represents, and round it to the nearest whole percent. Record these percentages in Column 3 of the table. Ensure that they add up to 100 percent.

5. Calculate and record the cumulative percentages in column 4 of the table. Begin by recording the category of response with the highest percentage. Add to it the percent contribution of the next highest response (next most frequent category of response) and record the cumulative percent represented by these two categories of response. Continue to record the cumulative percentages for each additional type of response to complete Column 4 of the table.

6. Using data from column 2 of the table, construct a bar chart that presents the number of times (frequency) that each response was given, from the most common response (on the left), to the least mentioned response (on the right).

From both Column 4 of the table, and from the bar chart one can easily analyze the relative contribution of the various causes of the problem under study. In the example below, it can be seen from Column 4 that:

- 73 percent of the problem with follow-up visits can be addressed by solving the first three problems:
  - clients were unsure when to return to the clinic for a follow-up visit
  - clients forgot about the follow-up visit and
  - clients didn't think a follow-up visit was necessary

or

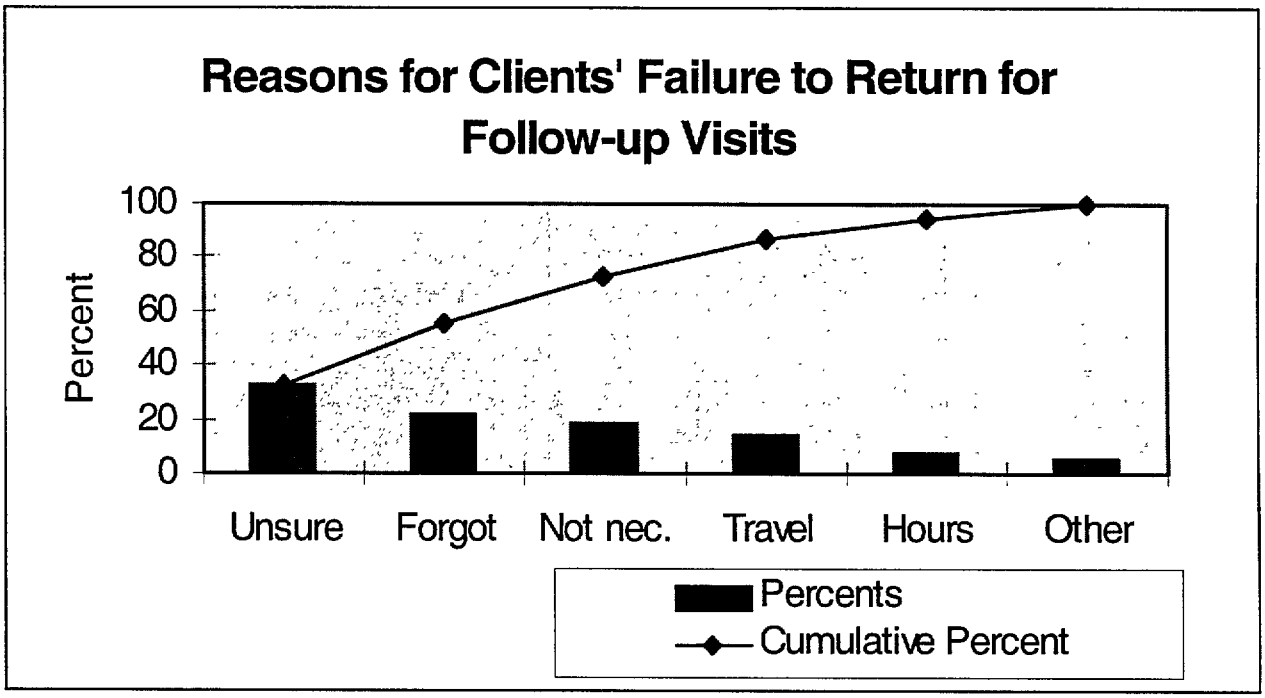
- 55 percent of the problem can be addressed by solving the first two problems:
  - clients were unsure when to return to the clinic for a follow-up visit
  - clients forgot about the follow-up visit.

Sample Table for Pareto Analysis:

Reasons for Clients' Failure to Return for Follow-up Visits

Category of Response	Number of Times Response Given	Percentage of Total Responses	Cumulative Percent
Unsure when to return to clinic	24	33%	33%
Forgot about visit	16	22%	55%
Didn't think visit was necessary	13	18%	73%
Traveled/moved away	10	14%	87%
Hours are inconvenient	6	8%	95%
Other reasons	4	5%	100%
All reasons	**73**	**100%**	**100%**

Sample Pareto Chart:



(Adapted from "Manager's Toolbox for CQI," supplement to The Family Planning Manager, January/February 1993. Available from Management Sciences for Health)

CQI TOOLS

CAUSE-AND-EFFECT DIAGRAM

A cause and effect diagram is a graphic representation of people's ideas about the causes of a problem—both primary and secondary causes. Cause-and-effect diagrams help the Quality Team consider the complexity of a problem and all contributing factors. They may be used to formulate theories of cause of a problem, determine why something did not reach its expectation, examine possible resistance to change, analyze potential solutions and to build support for actions and solutions.

To Construct a Cause-and-Effect Diagram:

1. Draw an outline of a "fishbone" diagram, and fill in the box marked "effect" with a problem statement on the quality of care.

2. Define the categories (branches) of the principle causes of the problem (based on data collected and/or brainstorming). Write them in on the main branches (fish bones) of the diagram. Useful categories include staff, clients, equipment/supplies/materials and systems.

3. Fill in secondary causes (branches off the main branches or fish bones) as indicated by data collected and/or brainstorming about other factors/causes that affect the outcomes of each process step. To uncover additional layers of causes, ask "why?" at each successive response five times. Ensure that the causes are organized in a logical way.

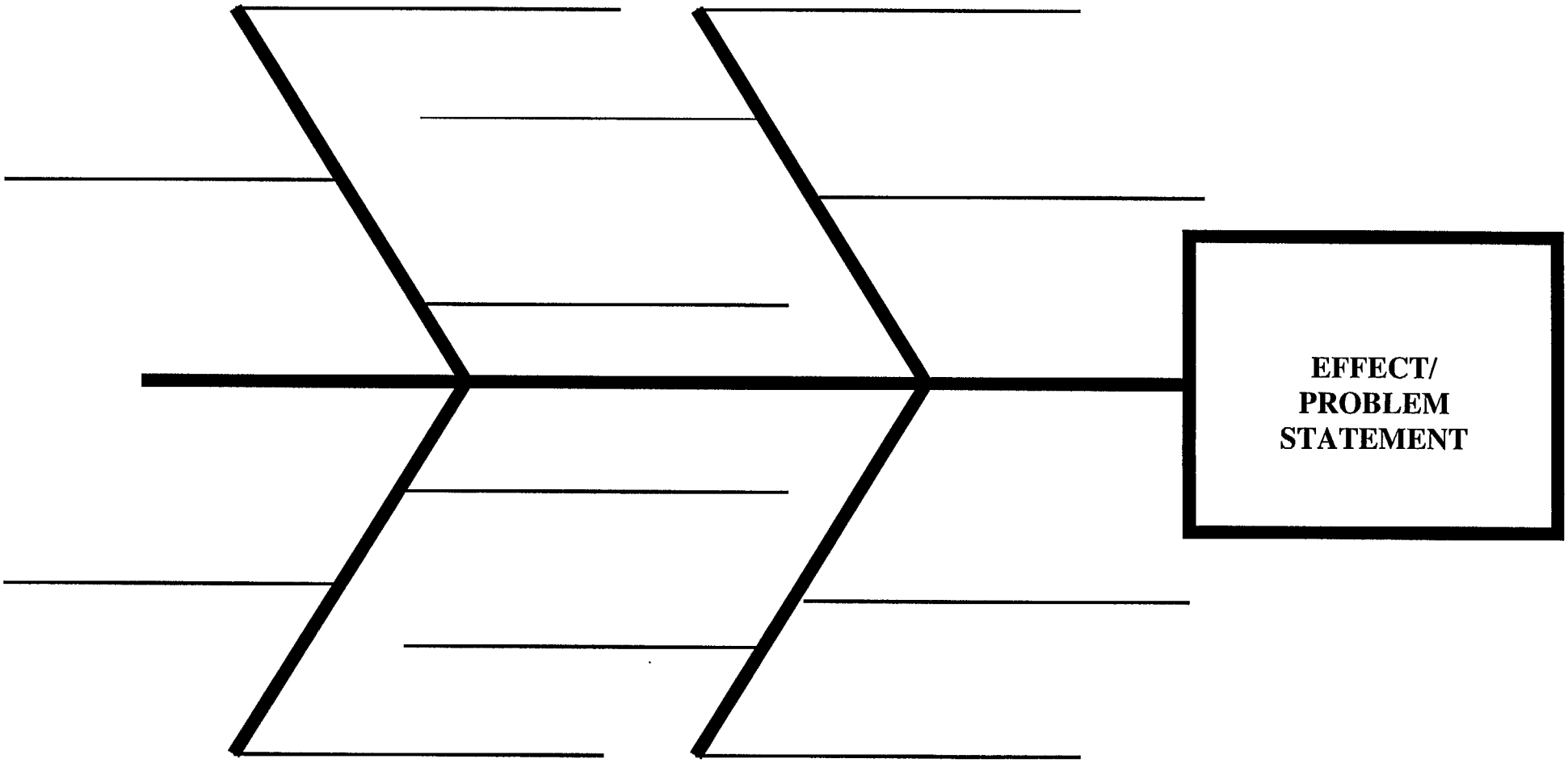
4. Summarize the primary and secondary causes of the problem, and determine which causes the team has control over changing or improving.

5. Remember, the cause-and-effect diagram produces *theories* about the causes, not facts. It gives the Quality Team questions to answer—but not the final answers. It should be followed by:

   - agreement among team members about which supposed root causes to investigate further
   - data collection to determine how frequently each cause occurs.

(Adapted from "Achieving Quality Through Problem Solving and Process Improvement," Quality Assurance Project. Available from University Research Corporation; and from "Manager's Toolbox for CQI," supplement to The Family Planning Manager, Vol. II, No. 1, January/February 1993. Available from Management Sciences for Health.)

CAUSE-AND-EFFECT DIAGRAM



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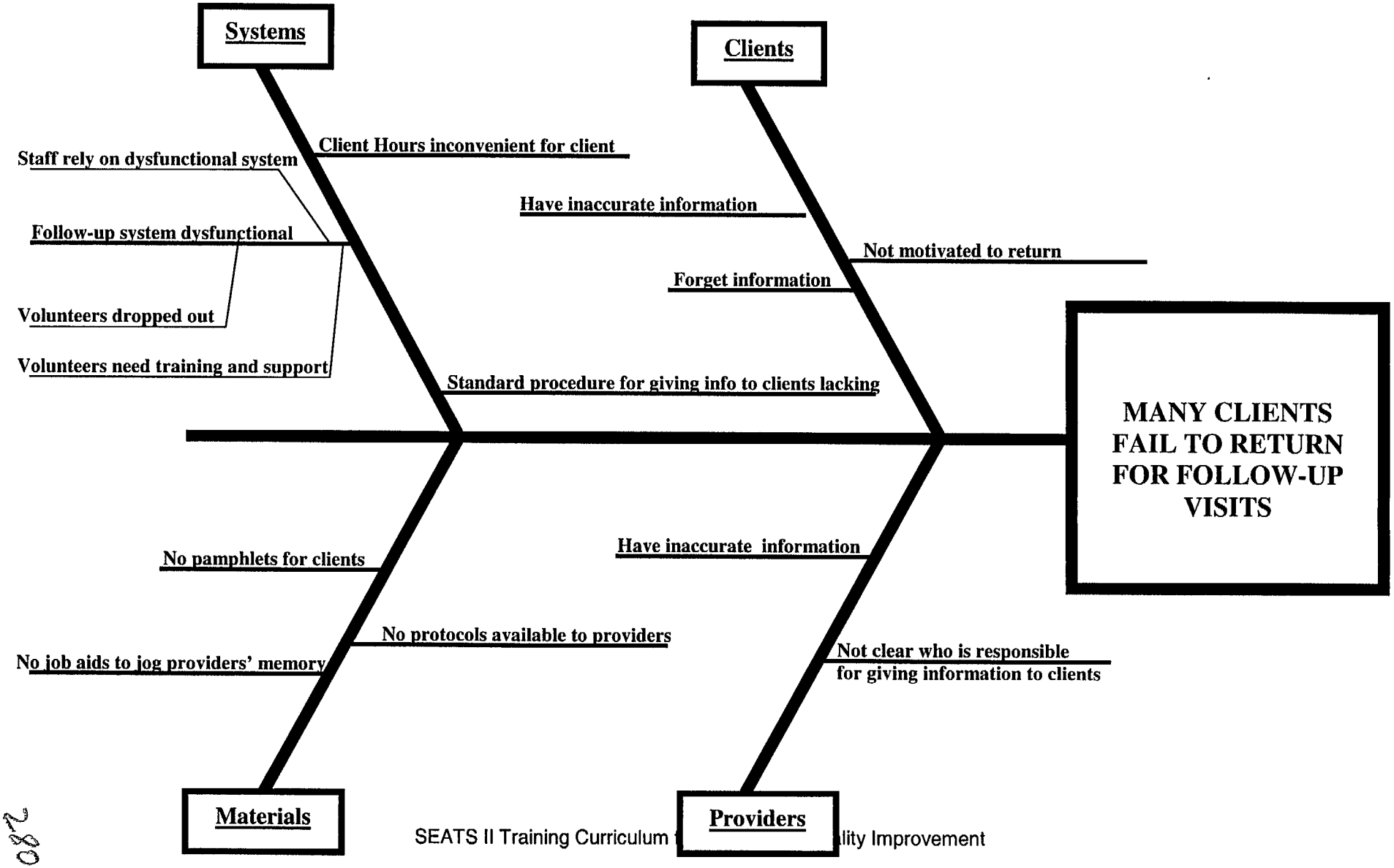
SAMPLE CAUSE AND EFFECT DIAGRAM
MAMBA DISTRICT



COMPONENTS OF AN ACTION PLAN

1. Introduction

Describes the setting in which the quality problem occurs.

Purpose:

- Clarifies the context of the action plan for anyone reading it.

Content:

- The context to which the action plan applies, that is, the local FP service or health center, district FP program or national FP program (depending upon the setting within which the identified problem occurs).
- Characteristics of the setting (service, institution or program) relevant to the identified problem: brief history, policies, resources, services offered, relevant service statistics, etc.

2. Problem Statement

A problem statement is a statement describing precisely how QOC is deficient. It sets out the gap between what is happening and what should happen; between actual performance and desired performance as defined by program guidelines and standards, and/or by client expectations. It should relate to the quality of services (quality in fact or quality in perception) or the health of the population being served and should refer to specific processes or activities where improvement is needed, so that the improvement effort is focused and measurable. A problem statement should *not* state the cause of the problem, propose a solution, nor affix blame.

Purpose:

- To make clear for all concerned the problem to be addressed and corrected by the action plan
- To guide the development and implementation of the action plan—to keep it focused
- To assist in the evaluation of the action plan and its implementation

Content:

- States the gap that exists between what is expected to happen (i.e., the program standard, the process as outlined in protocols, the ideal situation articulated by clients, the community, staff or others) and what is actually happening (i.e., the actual situation). The formulation of a problem statement assumes a clear definition of the desired process/outcome as well as of each step of the process.

3. **Theory of Cause**

Purpose:
- Provides the focus for the objective(s) of the action plan

Content:
- Explanation of one or more reasons why the problem exists, based on data the Quality Team has collected and analyzed. There will likely be a primary (direct) cause and secondary (indirect) causes.

4. **Objective(s)**

Purpose:
- To state the result to be obtained from the quality improvement effort
- To determine the activities to be undertaken

Content:
- The status to be achieved at the end of the quality improvement effort (*not* the activities that lead to that status/result)
- The opposite of the problem statement
- Must be realistic, given the resources available (or likely to be available)
- Must be measurable.

Activities

Purpose:
- To set out what will be done to address the causes of the problem and achieve the result laid out in the objective

Content:
- One or more clearly defined activities that will eliminate or reduce the causes of the QOC problem. Generally, a combination of several activities is required to achieve each objective.

5. **Time Frame**

Purpose:
- Indicates for all concerned when each activity should take place. The time frame allows those concerned to plan for the implementation of quality improvement activities within their existing schedules
- Sequences all activities in a logical order and over a period of time that is realistic, given the resources available
- Facilitates the provision of resources as necessary

Content:

- For each planned activity, the start and end time is indicated (this may be in weeks, months or quarters of the year)

6. **Person(s) Responsible**

Purpose:

- To assign responsibility and accountability for the accomplishment of each activity (even though activities may actually be implemented by several people)
- To ensure that activities are implemented
- To help management and other personnel know who to address regarding particular activities

Content:

- For each activity, the name or job title of the person responsible for carrying out the activity is indicated.

7. **Indicator(s) and Methodology for Measuring Them**

Purpose:

- To determine whether, and to what extent, the objective has been attained and the QOC problem solved or ameliorated.

Content:

- A measure (ideally in quantitative terms) of the aspect of QOC that is being improved
- A methodology (i.e., the tool to be used) for measuring whether the objective has been achieved

NOTE: It is important to remember to include *activities to measure the indicators* in the Quality Action Plan, along with timelines, persons responsible and a budget.

10. **Budget**

Purpose:

- Forces the Quality Team to think through each activity in detail
- Provides an indication of whether planned activities are financially feasible or whether additional funds are needed
- Helps maintain an agency's commitment to make available the funds allocated for planned activities
- Helps managers differentiate between essential and nonessential activities and give essential activities higher priority
- Allows managers to evaluate the actual cost of activities and to consider alternatives if planned activities are too costly

H/O X-1(4)

Content:

- Identifies all inputs (personnel time, equipment, supplies, etc.)
- Identifies the cost of each input (consulting those responsible for finance, as necessary, to verify costs, existing financial resources, etc.)

NOTE: In most cases, planned expenses must be met through the existing program budget. Study the budget for the specific program component addressed in the quality action plan to determine where expenses for quality improvement activities can be charged.

QUALITY ACTION PLAN

Name of Agency: _____

Introduction/Background: _____

_____

_____

_____

Problem Statement: _____

_____

Theory of Cause(s): _____

_____

_____

_____

Objective(s): _____

HO X-2(2)

Activities	Time Frame (Months) J	F	M	A	M	J	J	A	S	O	N	D	Person Responsible	Budget
BUDGET REQUIRED														

285

HO X-2(3)

Activities	Time Frame (Months)												Person Responsible	Budget
	J	F	M	A	M	J	J	A	S	O	N	D		
BUDGET REQUIRED														

Indicators to Measure Improvement:

1. _____

_____

Baseline Data:

_____

_____

Methodology for Measurement:

_____

_____

2. _____

_____

Baseline Data:

_____

_____

Methodology for Measurement:

_____

_____

MAMBA DISTRICT QUALITY ACTION PLAN

Introduction/Background: Mamba District is one of four districts in the Botali Region of Paperland. The district is largely rural and agricultural. There are three major towns and 24 smaller villages. Each of the three major towns has a health center offering basic primary health care services. There are an additional eight health posts in the district that are visited on a regular basis by a nurse or midwife from the closest health center and staffed at other times by community health workers.

The district has the highest maternal mortality rate in the country (790/100,000 live births), a fertility rate of about 7 and a very low contraceptive prevalence rate (7 percent for all methods and 3 percent for modern methods only).

Problem Statement: Only 25 percent of FP clients return to the three large health centers in the district for follow-up visits according to the schedule for follow-up visits in the Paperland FP protocols.

Theory of Cause(s): Client exit interviews and the results of focus groups in the community show that FP clients do not return to the clinics because:

- They lack information about the importance of follow-up visits
- They lack information about when they should come for follow-up visits (74 percent of clients in exit interviews did not have accurate information on when to return for a routine visit; 90 percent did not know under what circumstances to come back for a non-routine visit)
- Health center staff do not have good information about when clients should come back for follow-up visits
- Clinic hours are inconvenient (mentioned by 66 percent of clients in exit interviews)
- The system for follow-up by community health volunteers isn't working
- IEC materials, which include information about follow-up, are out of stock. (None of the clients in exit interviews had received a pamphlet)

Objective: To improve FP clients' compliance with follow-up visits in the three health centers in Mamba District.

Activities	Time Frame (Months) J	F	M	A	M	J	J	A	S	O	N	D	Person Responsible	Budget
Liaison with Mamba District management														
Brief district health director on the problem, the plan of action, the budget required for the Quality Action Plan. Obtain director's approval.		X											Mrs. N, Chair of Q. Team	0
Provide updates on progress for the health director					X			X		X			Mrs. N	0
Many clients fail to return for follow-up visits														
Quality Team discusses the problem, its causes and potential solutions with key staff from the three health centers at the next routine staff meeting and solicits their input		X											Mr. I organizes; Mrs. N chairs	0
Supervisors, health center managers and the Quality Team design a half-day refresher course for nurses, midwives and social workers on protocols for FP follow-up visits			X										Mr. I	50 P
Supervisors and health center managers conduct the refresher course during the supervisors' next visit to each health center				X									Mr. I organizes; helps	200 P
Make signs for health center walls with the follow-up visit schedule (routine and non-routine visits) to remind providers of the schedule			X										Ms. K and Mrs. Y	150 P
Replenish supplies of FP method brochures, so there are sufficient to give to each client			X										Ms. K	500 P
Identify an individual to track supplies of brochures each month and order new stocks on same schedule as contraceptives are ordered			X	X	X	X	X	X	X	X	X	X	Ms. K	
Health center managers and their staffs review procedures for follow-up of past-due clients and plan to reactivate selected volunteers					X								Mrs. N.	0
Implement system to reactivate volunteers for follow-up; train and support them					X	X	X	X	X	X	X	X	Mrs. F	
Social workers conduct weekly education sessions for clients waiting at the health centers, emphasizing the importance of follow-up visits				X	X	X	X						Ms. K	0

Quality Team and supervisors develop counseling observation tool; supervisors observe counseling to verify whether accurate information is being given to clients about follow-up visits; and check on implementation of procedures for follow-up of past-due clients				X			X			X			Dr. X	0
Quality Team contacts Mamba University for assistance in designing, conducting and analyzing exit interviews with clients. (Purpose: to determine if clients' knowledge has increased on when to return for a routine visit and a non-routine visit)							X						Dr. X	0
University presents exit interview questionnaire to Quality Team for review, finalizes tool, conducts the interviews, analyzes them and reports back to Mamba district.								X	X				Dr. X is liaison with University	930 P
Quality Team and health center managers monitor the number of follow-up visits to see if there is a change		X	X	X	X	X	X	X	X				Mrs. Y	0
Report results to district health director, then to key staff from the three health centers at the next routine staff meeting										X			Mrs. N	0
Quality Team meetings to track progress			X	X	X	X	X	X	X	X				0
BUDGET REQUIRED														**2,130 P**

Q Team = Quality Team

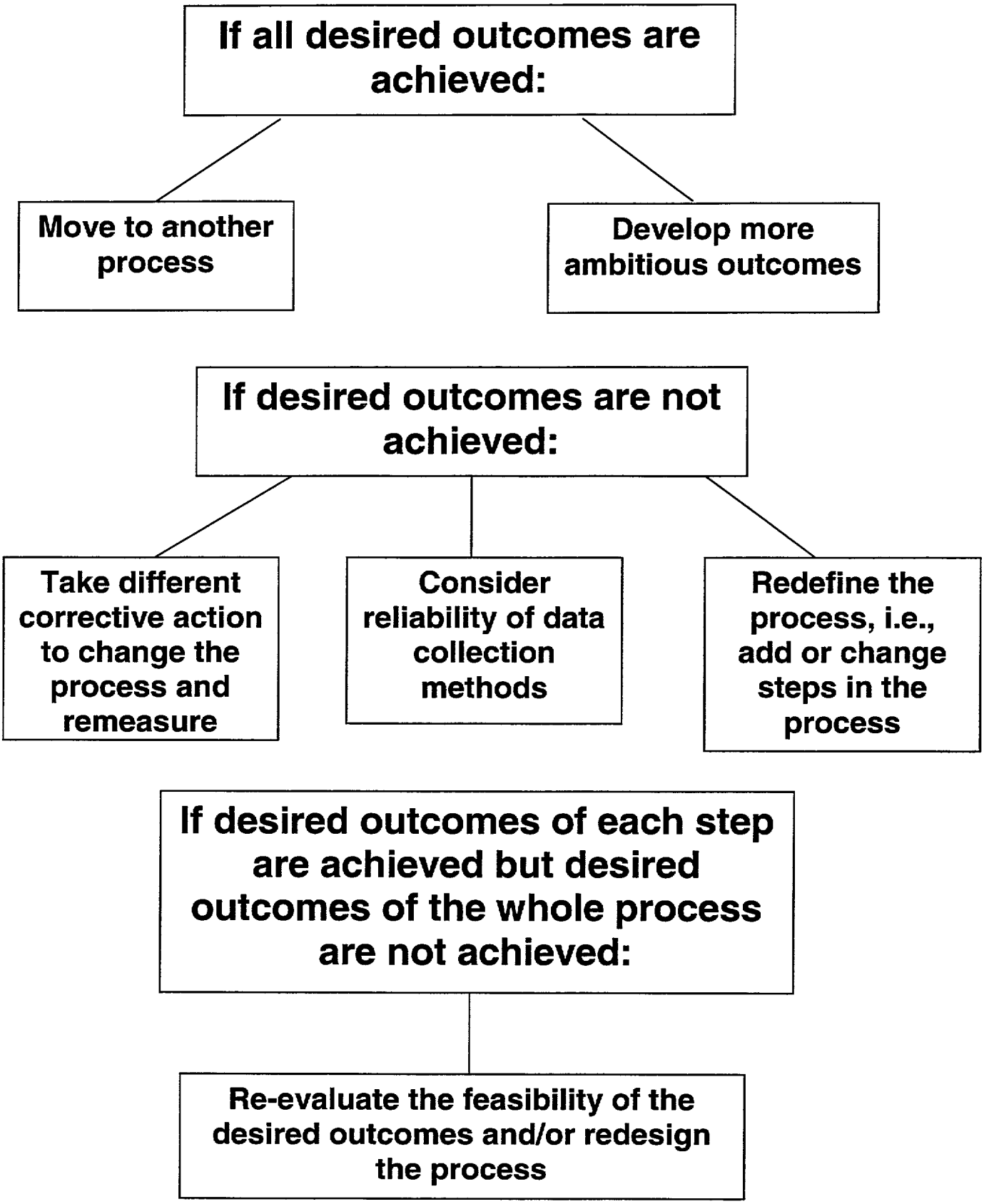
Indicators to Measure Improvement:

Endline: Providers have an average score of 90 percent for the provision of correct information about FP follow-up visits.
Methodology: Observation of counseling (to be conducted at all 3 health centers in April, July and October)
Baseline: No baseline done.

Endline: An increased percentage of clients know when they should return for a routine follow-up visit and can cite the main reasons to return for a non-routine visit.
Methodology: Client exit interviews
Baseline: Only 26 percent of clients knew when to return for a routine follow-up visit; 10 percent knew under what circumstances to return for a non-routine visit (Nov/Dec 1998)

Endline: The number of follow-up visits has increased.
Methodology: Service statistics (follow-up visits)
Baseline: 25 percent of FP clients came for follow-up visits on schedule (1998 total).

ACHIEVING RESULTS WITH CQI



FLIPCHARTS/TRANSPARENCIES

KEY:

FC	For presentation on flipchart paper
FC/T	For presentation on flipchart or transparency
Roman numerals I–X	Refer to session numbers in the curriculum
Arabic numerals 1–5	Refer to the sequence of flipcharts/ transparencies in the session
e.g., FC/T III-3	For presentation on flipchart paper or transparency, in Session III, as the third item

INTRODUCTION QUESTIONS

- **What is your experience in the delivery and/or management of family planning services?**
- **What would you like to gain from this workshop?**
- **What will help you gain/achieve this?**
- **How will you know when you have achieved it?**

GENERAL OBJECTIVES OF THE TRAINING

By the end of Part I of the training, participants will be able to:

- **Describe the importance of the improvement of quality of FP/RH service delivery to client satisfaction and program performance.**
- **Explain ways in which their agency/facility ensures that informed choice and informed consent are (or will be) adequately addressed in FP/RH service delivery.**
- **Apply existing standards and protocols in quality of care improvement efforts.**
- **Apply the principles and tools of CQI to the identification of FP/RH quality of care problems.**
- **Describe their planned approach to the identification of problems in the quality of care within their agency/facility.**
- **Apply the principles of teamwork to the improvement of the quality of FP/RH services.**
- **Present a plan to establish a Quality Team at their agency/facility and identify a QOC problem, using simple data collection techniques.**

GENERAL OBJECTIVES OF THE TRAINING
(continued)

By the end of Part II of the training, participants will be able to:

- **Apply CQI tools to the analysis of FP/RH quality of care problems.**
- **Develop Quality Action Plans with clear objectives, appropriate activities, realistic time frames, assigned responsibility for implementation, and indicators to measure quality improvement.**

RULES FOR GIVING AND RECEIVING FEEDBACK

Feedback is more effective when:

- **It is *specific* rather than general.**
- **It concerns the *attitude or behavior* of the person, and not the person himself or herself.**
- **It takes into consideration the *needs of the person receiving feedback.***
- **It is directed toward an *attitude or behavior the person can change.***
- **It is *wanted* and not imposed.**
- **It is an *exchange of ideas and information* rather than advice.**
- **It is given at the *right moment.***
- **It includes the *quantity of information* the receiver can use and not the quantity we want to give.**
- **It concerns *what was said or done* and not why it was said or done.**
- **It is *verified* to assure that it was clear, that the person understood our feedback.**
- **It is *positive and constructive, and not negative.***
- **The *receiver listens without defending his/her behavior.***

FC II-1

(Characteristics of a Good Family Planning Center)

Organized

Professional

Warm

Clean

Flexible

Informal

Helpful

Polite

Efficient

Understanding

Educational

Discreet

Accessible

Comfortable

Orderly

Friendly

Competent

Knowledgeable

BRUCE-JAIN ELEMENTS OF QUALITY OF CARE IN FAMILY PLANNING PROGRAMS

1. Choice of method
2. Information given to clients
3. Technical competence of providers
4. Interpersonal relations
5. Continuity of care and follow-up
6. Appropriateness and acceptability of services

EFFECTS/CONSEQUENCES OF IMPROVING QOC

Perspectives of Clients, Service Providers and the FP Program:

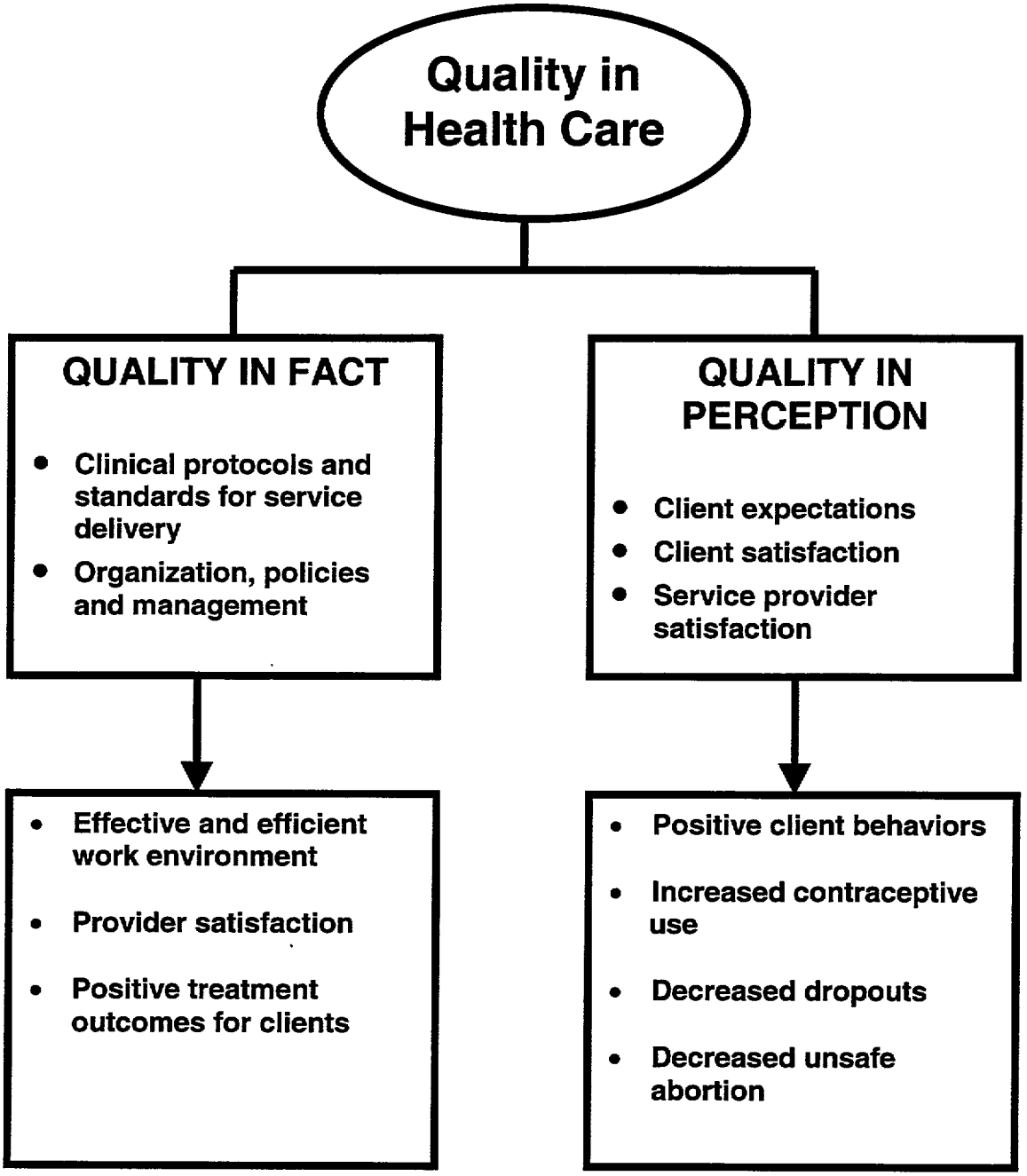
- **Why are we concerned about QOC? What does it matter?**
- **What are the effects/consequences of improving QOC?**
- **What are the effects/consequences of poor QOC?**

THREE PRIMARY OUTCOMES OF QUALITY FAMILY PLANNING AND REPRODUCTIVE HEALTH PROGRAMS

1. **Helping individuals achieve their reproductive goals, thus producing a satisfied clientele of continuing users.**

2. **Meeting unmet demand for family planning services by providing services that are accessible, acceptable, appropriate and provide adequate choice.**

3. **Increasing the contraceptive prevalence rate, leading to improved maternal and child health and reduced fertility.**



Adapted from Omachonu

STANDARDS AND PROTOCOLS

Standard

The minimal level of acceptability for any input, practice (performance), or output within service delivery.

Protocol

A guide for the step-by-step processes and decision-making steps required to deliver a service.

TRADITIONAL APPROACH TO QUALITY ASSURANCE	*CONTINUOUS QUALITY IMPROVEMENT*
External "gold standard" of quality	Quality concepts and processes based on client expectations and input by staff
Identifies deviations from standard in individual performance	Systems and processes as sources of error, stress on continuous improvement in performing an activity
Supervisors responsible for quality assurance	Every employee in charge of quality improvement
Stresses quality in fact and treatment outcomes	Stresses meeting clients' expectations as well as protocols and treatment outcomes
Medical community and policy makers define quality	Participation of customers to define quality according to their needs, wants and expectations
Judges quality during an announced visit by an outside supervisor	All staff involved: receptionists, administrators, clinical providers, medical records clerks, drivers, etc.

SEATS QUALITY IMPROVEMENT CYCLE

A QUALITY PROBLEM OR ANOTHER KIND OF PROBLEM?

1. Friends of service providers are seen ahead of other clients
2. Women of reproductive age express interest in FP but do not wish to use their local clinic
3. For the past three months, the clinic has been stocked out of Depo Provera
4. Providers at the clinic refer clients to the hospital for IUDs
5. Personnel begin seeing clients two hours after the clinic is officially open
6. Personnel strongly recommend certain contraceptive methods to certain clients
7. Women of reproductive age do not wish to use FP
8. Women come to the clinic for an initial visit and never return
9. A clinic that is open five days a week provides FP just one day a week
10. Sterile technique is not used during pelvic exams
11. The clinic does not provide services to unmarried adolescents
12. Transportation to the clinic is difficult

CQI TOOLS FOR IDENTIFYING QUALITY PROBLEMS

Brainstorming

Service Statistics

Client Exit Interviews

Focus Group Discussions

Facility Audit

Flow Charts

Client Flow Analysis

Observation of Counseling

MAQ Checklist

PRESENTATIONS ON CQI TOOLS

- **State the purpose of the tool**
- **Give a brief description and show the group what the tool looks like**
- **Outline the main steps in using the tool**
- **Give an example of how it could be used in a specific situation**

POSITIVE TEAM MEMBER BEHAVIORS

A team works best when members of the group:

- **Suggest methods or procedures**
- **Seek information or opinions**
- **Give information or opinions**
- **Encourage others**
- **Reduce tension**
- **Clarify and elaborate ideas**
- **Summarize**
- **Check decisions**
- **Resolve disagreements**
- **Notice group feelings**

COMMON TEAM PROBLEMS

- Floundering
- Overbearing Participants
- Dominating Participants
- Reluctant Participants
- Unquestioned Acceptance of Opinions as Facts
- Rush to Accomplishment
- Attribution
- Discounts
- Digression and Tangents
- Feuding Team Members

WAYS TO SUPPORT EFFECTIVE TEAMS

- **Focus attention on a clear set of goals and priorities**
- **Lead others by example. Model appropriate behavior by respecting, supporting, listening, communicating, collaborating and being sensitive to the needs of all team members.**
- **Balancing the heart and mind. Create a balance between how you think and how you feel in working with teams.**

SAMPLE CRITERIA FOR SELECTION OF QUALITY PROBLEMS

- The issue is important to external clients; improvement in this area can have high external impact
- The issue is important to internal clients; improvement in this area can have high internal impact
- A problem has existed for some time and is widespread
- The benefits from addressing this issue are obvious; the process has high visibility
- The issue is within the Quality Team's control and authority
- Management and the team are technically capable of making changes in this program area
- Support for change exists in this area. Management and those involved in the process recognize the need for change and are committed to it
- There are risks associated with not addressing this issue
- The problem undermines/affects the achievement of program objectives
- The issue can be quickly resolved
- Data on this issue are readily available
- Resources are available for making changes

MAMBA DISTRICT

Findings from Exit Interviews with 75 Clients:

- **66 percent said that the clinic hours were inconvenient**
- **26 percent complained that there was too little time with the provider**
- **74 percent did not have accurate information on when to return for a routine follow-up visit**
- **90 percent did not know under what circumstances they should come back for a special (non-routine) visit**
- **None received a pamphlet about the chosen method of contraception and how to use it**
- **Other problems were mentioned by less than 20 percent of clients interviewed.**

MAMBA DISTRICT

Findings from Three FGDs with Women of Reproductive Age *Not* Using FP Services:

- **They thought FP was harmful to their health**
- **Some were interested in FP but they were unwilling to make a separate trip to the clinic for FP—which wasn't available the same days as well-baby check-ups**
- **They couldn't come to the clinic at the times it was open**
- **They wanted another baby**
- **A few said their husbands were opposed**

MAMBA DISTRICT

Findings from Two FGDs with *Former Clients* from the Three Health Centers

- They did not know they needed to return for a check-up
- They did not know when to return
- They wanted to have another baby
- They had problems with their FP method and decided to stop using it
- The clinic hours were inconvenient—they needed to work at those times
- Some used to receive a follow-up visit by a community health volunteer to remind them to go back to the clinic. Since they hadn't been visited, they didn't think they needed to go back

MAMBA DISTRICT

Findings from One FGD with *Staff* from the Three Health Centers

- Staff thought there was a lot of misinformation about FP in the community
- They thought clients were uneducated and didn't know how to use FP (or other services) properly
- Staff had conflicting information about when clients should come back for follow-up visits
- The follow-up system at one of the health centers was managed by community health volunteers who hadn't had any training or support for as long as anybody could remember; many had stopped volunteering
- Supplies of pamphlets about the different contraceptive methods and how to use them had run out

COMPONENTS OF A QUALITY ACTION PLAN

1. Introduction
2. Problem Statement
3. Theory of Cause
4. Objective(s)
6. Activities
7. Time Frame
8. Person(s) Responsible
9. Indicator(s) and Methodology for Measuring them
10. Budget

ACHIEVING RESULTS WITH CQI

If all desired outcomes are achieved:

- Move to another process
- Develop more ambitious outcomes

If desired outcomes are not achieved:

- Take different corrective action to change the process and remeasure
- Consider reliability of data collection methods
- Redefine the process, i.e., add or change steps in the process

If desired outcomes of each step are achieved but desired outcomes of the whole process are not achieved:

- Re-evaluate the feasibility of the desired outcomes and/or redesign the process

Source: Using CQI to Strengthen Family Planning Programs