



Integrated Supervision Skills Manual

**MINISTRY OF HEALTH AND POPULATION
GOVERNMENT OF EGYPT**

MARCH 2005

Ministry of Health & Population
وزارة الصحة والسكان

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MANUAL**

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Acronyms

ANC	Antenatal Care
AVSC	Association for Voluntary Surgical Contraception
CDA	Community Development Association
COC	Combined Oral Contraceptive
CQI	Continuous Quality Improvement
FP	Family Planning
HC	Health Center
HIS	Health Information System
HU	Health Unit
IMCI	Integrated Management of Childhood Illness
IP	Infection Prevention
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
MCH	Maternal and Child Health
MOHP	Ministry of Health and Population
NGO	Non-Governmental Agencies
PHC	Primary Health Care
PICG	Performance Improvement Consultative Group
RH	Reproductive Health
RTI	Reproductive Tract Infection
RHU	Rural Health Unit
SMC	Safe Motherhood Committee
STI	Sexually Transmitted Infections

Introduction

Improving the quality of care in reproductive health (RH) services is an important process. Vital parts of this process include raising the awareness of the population, improving the training of providers, aiding development of national protocols and promoting the upgrading of facilities. A strong supervisory system is one of the most important components because, through such a system, problems can be identified early or even prevented. Once problems are identified, they can be solved rapidly. Good supervision also helps to ensure that the changes that have been introduced can be sustained.

The fields of effective supervision and performance improvement have grown rapidly in recent decades. New insights into adult learning, leadership, change management and issues important to quality of care have contributed significantly to this growth. Beginning in June of 2002, the Ministry of Health and Population (MOHP)/Population Sector has started to bring these insights into play in order to develop and promote a new approach to leading and managing quality of care and performance improvement. This approach, which is termed integrated supervision for quality of care, involves enabling supervisors to adopt supportive coaching and leadership practices, as well as the routine use of performance and client satisfaction indicators to monitor service quality. None of the elements in integrated supervision are “totally new”; rather, it is a combination of existing, proven techniques, skills and attitudes.

During supervisory visits, supervisors teach staff to provide better services as well as providing feedback and support for their technical skills. In addition, both desired results and problems are identified through four sources of data:

- A self-assessment meeting
- Service statistics
- Client interviews
- Integrated supervision checklists

The first data source offers subjective ideas on remaining problems while the last three data sources provide objective measurements of quality of care. A comprehensive list of the problems identified by the clinic team is compiled using these data sources and consequently, an action plan to address these problems is formulated and implemented. The action plan is reviewed during subsequent visits.

Standards of Practice

The Integrated Maternal and Child Health/Reproductive Health (MCH/RH) Package of Essential Services contains a description of each necessary service at the primary health care level in Egypt. This package is an extension of the *Basic Benefits Package*. *The Standards of Practice for Integrated MCH and RH Services* describes how these services are to be delivered. Together, these documents set the standard according to

which everyone involved in client care has been trained. All service providers should receive a copy of the *Standards of Practice for Integrated MCH and RH Services*.

The integrated supervision system monitors whether or not service providers work according to this standard. This system uses a set of indicators to determine if services are performed with high quality of care. Three available documents pertain to integrated supervision:

- Integrated Supervision Skills Manual
- Integrated Supervision Checklist
- Criteria for Scoring

The Purpose of This Document

The purpose of this manual is to provide a set of flexible, adaptable tools and guidelines to facilitate quality clinic supervision. Extensive resources concerned with improving supervisor-supervisee relationships are available, but this manual does not attempt to reiterate these resources. Rather it seeks to provide concrete tools for organizing and carrying out the complex and multi-faceted task of the clinic supervisor. Materials provided here have been drawn from a number of sources, all of which have been field tested to at least some degree. The ultimate aim of the manual is to support supervisors in their role of improving quality of care in clinics.

Summary Overview

The Fundamentals

During recent decades a great deal of knowledge has been gained about effective supervision and performance improvement. New insights into managing and leading change as well as enabling staff to adapt to change are all important to quality of care. The issue of clients' rights, for example, has contributed significantly. In fact, the definition of client has been broadened to include the external client who is served as well as the internal client who provides the service. Combining these and other insights as well as elements from other fields, an approach has been formulated, which has been termed integrated supervision for quality of care. There are no "totally new" elements in this approach; rather it is a combination of existing, proven techniques, skills and attitudes from adult learning, change management, service provision and clients' rights perspectives.

Adult Learning

From adult learning, integrated supervision borrows the ideas that:

- Praise is more effective than punishment
- People learn best and are most effectively when they are themselves involved in the teaching process
- People change their behavior only when they are motivated by real need to do so

Change Management

From change management, integrated supervision takes the following criteria for successful change (see also page 79- 81):

- The clinic staff gets something they want or need
- It has a minimal impact on working relationships
- The change is introduced in phases
- It "fits" the clinic's mission, goals and structure
- It is clearly communicated
- Employees have adequate time to adjust to the change
- Employees understand the rationale for change
- Employees have had a chance to discuss the change
- Change is led by an appropriate level person within the clinic
- The leader of change is liked
- The leader of change has the proper authority

Service Provision

Aspects of service provision affecting quality (see page 41) have been defined as:

- Choice of method
- Information given to clients
- Technical competence of providers
- Interpersonal relations
- Continuity of care and follow-up
- Appropriateness and acceptability of services

Although these criteria are particularly useful in family planning (FP) services, the quality of other services can easily be classified into the same groups. If supervisors and staff consider these aspects of service provision, they can better identify problems.

Clients' Rights

An important insight into quality issues is that clients have rights that should be respected. Respecting clients' rights helps improve the quality of care (see page 47).

When trying to identify problems or their solutions, thinking like a client is important. This "client perspective" is invaluable. Asking the following questions or others like them helps providers and supervisors look at their work with a fresh eye:

- How does this pose a problem for the client?
- How would a client experience this? or even
- What would my mother think of this clinic?

The Integrated Supervision System

The integrated supervision system uses these perspectives and insights to implement a new style of supervision aimed at improving quality of care. This approach to supervision is intended to make continuous improvements to the quality of services delivered to clients by strengthening management at all levels of health care provision. Underlying the concept of integrated supervision is the assumption that when providers work together (through participation and teamwork) and when they are empowered to act and are held accountable for their actions, improved service delivery will result, which will lead to improved organizational change and client satisfaction. Integrated supervision further assumes that if employees have "ownership" of their jobs and of decisions affecting how they perform their jobs, as well as influence upon the outcome of those decisions, they will become more committed to their work and more committed to delivering quality services.

The term "integrated" implies that supervision occurs at all levels, not just from the top down, but across and between hierarchies and departments. In this way, supervision becomes part of the daily, regular functioning of the service delivery site, rather than an isolated event. As such, integrated supervision can only be implemented in health care

delivery sites or networks where there is a management commitment to inaugurating this kind of change and an organizational commitment to the values of personal accountability, employee empowerment and teamwork.

Integrated supervision uses the principles of continuous quality improvement (CQI) (see page 33). CQI is an exciting management approach that is being introduced in FP and MCH programs around the world. It is based on the belief that anybody at any level of an 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. The whole staff shares responsibility for identifying processes or aspects of the work that can be improved. Family planning programs that use CQI can raise staff morale, while they improve productivity, efficiency, and client satisfaction.

In integrated supervision the assumption is made that all members of the staff will try to do a good job if they can and that if they do not perform well, it is often due to a lack of:

- Knowledge
- Skills
- Positive attitude
- Motivation
- Favorable job circumstances

Supervisors should look at these five factors systematically to analyze low performance. On the basis of this analysis, they should provide on the job training to clinic staff. Rather than blame or put the burden of quality on staff performance, the idea is to think together in an innovative way to improve work processes in order to increase service quality (see page 34).

Strategy

Integrated supervision can best be implemented in clinics where all services are delivered in an integrated manner. However, the principles of integrated supervision hold true for any supervisor and the tools can be used in any supervisory situation. If the situation in question is a vertical system, the indicators applicable to that system can be identified for examination. If supervision applies to an integrated service, all indicators can be examined.

Clinic directors along with their teams are responsible for the quality of care offered in their clinic. They are assisted and supervised by the FP and MCH supervisors who provide feedback and support to integrated services in a process of continuous performance improvement; this is the only way quality of care can be achieved. Self-assessment meetings are one of the tools used to increase staff involvement in this process.

The provision of quality service starts with a definition of the standard, which is contained in the national protocols. Everyone involved in client care has been trained in providing services according to the standard and should receive a copy of the protocols. Whether all service providers work according to this standard is ascertained by a monitoring system. The monitoring system uses indicators to determine if services are performed according to the standards. The monitoring system is tied in with a public recognition system: the Gold Star system. This system is consequently used for awarding incentives.

Practice

The MOHP works to improve quality of care in its clinics through the identification and solution of specific problems. Supervision visits are held on a quarterly basis by the FP and MCH supervisors who join forces in a supervision team, which should maintain its composition in order to ensure continuity and follow-up.

Problems in the clinic are identified through regular self-assessment and through monitoring of service statistics. In addition, the supervisor files reviews, checklists, and observations regarding the quality of IUD services, family planning counseling, cleanliness and infection control. The client exit interview is used as a tool to determine areas needing improvement from the client's perspective that should be addressed in the performance improvement plan. Responsibility for collecting the data needed for the indicators is in the hands of the clinic staff with the aim of increasing their ownership of the process. Comparing the actual levels of indicators with the set objectives or desired levels can identify major quality problems. These problems are then discussed with the entire staff of the clinic and their root causes are identified. Later, an action plan is formulated (see page 67). During the subsequent three months, supervisors and staff then implement this action plan in order to address problems in meeting desired levels of indicators.

On-the-Job Training

In addition, supervisors attend client-provider interactions and provide on the job training for the staff, including nurses, physicians and others where needed. Feedback, support and coaching (see page 64) are important tools in on the job training.

Good supervisors know how to manage and lead clinic teams to help them face their challenges and achieve improvement in performance results. They need strong leadership qualities in order to sustain their ability to achieve results. They need to learn competency skills that can help them shift their perspectives to become managers who lead others to improve the quality of services in a context of integrated supervision (see page 73). The performance improvement process and its tools (gap analysis and root causes) are fundamental for the success of integrated supervision (see page 35). Supervisors are encouraged to evaluate themselves regularly.

Principles of Integrated Supervision

The Clinic as a Whole

In integrated supervision, the ultimate goal is to improve quality of care. Quality of care emerges from the combined efforts of all the people and services in a clinic. A clinic's reputation is built upon the totality of its services; clinics do not have a separate reputation for FP, MCH, etc. If one service does not perform well, all other services suffer. The road to improving quality of care within a clinic lies in breaking down the barriers between services. These barriers are obstacles to effective quality improvement and a lack of integration results in waste, errors, delay and unnecessary duplication of effort.

The clinic is seen by its clients as a whole and should function as a one. Therefore no aspect of service provision can be excluded from supervision. Consequently, supervision should include all parts of the clinic work, from FP to MCH, from waiting room to laboratory. Each area of work is important to providing quality of care.

All staff members play a vital role in the provision of services and therefore should be part of supervision activities, up to and including the guard and cleaning staff. All staff members are expected to participate as one team in supervision meetings. When a supervisor works in a vertical system, s/he can still evaluate all the staff and services of that system in an integrated manner, from record keeping to cleaning. By breaking down the barriers between different services, integrated supervision uses or integrates all staff in the supervision process and involves or integrates all activities. The following principles form the core of integrated supervision.

The Client Perspective

The aim of providing good quality services is to make clients healthy and happy. In order to achieve this goal, services must be examined through the eyes of the client so that they can be better organized to suit the client's needs and actively involve the community.

Emphasizing Solutions and Saving Resources

Most people will perform a job well if given the chance. Unfortunately, there are often circumstances that prevent people from doing the best job possible. A good supervisor works with staff to help them do the best job they can. An emphasis upon solutions, not just the finding of problems is vital. The principle of continuous quality improvement concentrates on working towards a solution and avoiding assigning blame. Instead, it acknowledges that most problems are the result of the system, not the individual. Consequently, integrated supervision does not blame individuals; it tries to improve processes and procedures using the CQI approach.

Improved processes lead to increased efficiency and savings. Savings can include human resources, time, supplies, equipment or other financial savings. Integrated supervision saves money in the long run.

Empowering Staff

One of the most important principles in integrated supervision is the shift from identifying the supervisor as the expert to acknowledging the clinic staff as the experts. Typically, the staff know more about what is going on in a clinic than the supervisor. In fact, the staff, not the supervisor, are the experts in a clinic. The supervisor should be a colleague who wants to help, a consultant to use as a resource and someone who can help at a central level. A supervisor can only be these things for the staff if s/he sees him or herself in this light and behaves accordingly. As an additional benefit, the staff will be more motivated to try to work on what they see as the problems and, consequently, these problems are more likely to be solved. Integrated supervision capitalizes on the wisdom and knowledge of the staff. The supervisor helps the staff recognize what can be improved, acts as a resource for technical knowledge and arranges matters at district level. The supervisor focuses his or her efforts on the problems or goals that the staff have set. Integrated supervision supports decentralization and local decision-making.

Introducing Change

Effective supervision is about people changing the way they do things. It is about changing behavior and often about learning new ways to do things. A good supervisor, therefore, understands how and why people change their behavior. A series of realizations from the study of adult learning are used in integrated supervision. Adult learning teaches that praise is more effective than punishment, that people learn best and most effectively when they are themselves involved in the education process and that people change their behavior only when they are motivated by a real need to do so. Since supervision is mostly about encouraging people to change their behavior, these insights are useful for supervisors. A good supervisor will use praise and rewards, not punishment. S/he will tell the staff what is working well in a health unit (HU) or health center (HC), s/he will ask the staff for opinions on what can be improved, rather than dictating his or her opinion, and s/he will make sure that the staff is motivated and convinced before agreeing on changes to be made.

Reinforcement and On-the-Job Training

Training alone is usually not very effective. Supervision visits should be used to reinforce and strengthen training. Improving quality requires a well-trained staff made up of staff members who are aware of the importance of quality improvement and who feel motivated to ensure that clients receive good services. Human resource systems, including training, supervision, logistics and management information systems have considerable impact on staff motivation. Supervision is integrated with training. Both occur at the same time and are mutually supportive.

Measuring Quality

Quality needs to be measured in terms of both the delivered quality through service records and the perceived quality through client interviews. Supervision goes hand in hand with good record keeping.

The Benefits of the Integrated Supervision System

The goal of integrated supervision is to increase quality of care. In the end this benefits all stakeholders. Clients, staff and program management are the most important stakeholders. They each benefit as follows:

Clients

- Are more satisfied with the clinic visit and the service 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/MCH concerns
- Gain increased skill in decision-making
- Make more informed and better choices about their health
- 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

Service Providers

- Experience greater satisfaction/motivation in their work
- Spend less time responding to client complaints
- Gain greater trust and respect from clients
- Earn more money

The Program

- Obtains increased utilization of services and better health outcomes
- Develops a positive reputation (satisfied clients promote FP/RH/MCH 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 lower maternal and childhood morbidity and mortality
- Experiences greater continuity in FP method use/higher continuation rates

Source: Adapted from: Seats II Training Curriculum in Continuous Quality Improvement for Family Planning Programs. *Incorporating Expanded Quality Improvement*. John Snow, Incorporated, 2000.

Characteristics of an Effective Supervisor

To understand how a supervisor can influence a commitment to quality service at all levels, examine the characteristics and behaviors of effective supervisors.

Some behaviors to look for may include the following:

- Gives praise and encouragement (refer to adult learning) as this is very important in creating a positive learning environment where a participant feels safe to ask and answer questions. Words and non-verbal expressions of praise and encouragement will show the provider that the supervisor approves of the behavior s/he has shown or work s/he has completed and makes s/he more likely to repeat that effective behavior. Praise should be honest and specific.
- Asks for the opinions of the providers as they are the ones responsible for the service and consequently know the advantages and the disadvantages of the process and what works and what doesn't.
- Listens to opinions and criticisms at all levels and allows time for people to explain their opinions and ideas.
- Facilitates and directs when necessary, and not just in an effort to find problems.
- Serves as a role model, because this lends credibility: when a person asks someone else to do something he himself does not do, his words will not be as effective.
- Develops or coaches. This important supervisory role makes others feel that the supervisor is one of the team and consequently gives him or her more influence. Effective coaching to improve a provider's skills relies in part on knowledge, but other issues often affect a supervisor's efforts as well. For example, if the provider is older than the supervisor, it may be difficult or uncomfortable to receive feedback from a younger person. Difficulties such as this can be overcome by using proper adult learning techniques.

Also, at times the supervisor may need to discuss performance problems with a provider. When coaching a provider, the supervisor needs to consider five performance factors:

- Delegates responsibility.
- Gives feedback.
- Uses good non-verbal communication, such as eye contact, nodding, gestures and smiling. This will help ideas to be accepted easily and obeyed pleasantly. When a supervisor is aware of his or her word choice, tone of voice and non-verbal behavior in interactions with providers, s/he is more likely to be

successful in communicating a message to them – and they are more likely to listen to him or her.

- Encourages staff participation.
- Makes appointments for visits and does not come unannounced like an inspector.

Integrated Supervision in Practice

Clinic Level Activities

The MOHP assures the quality of care in its clinics by identifying and solving specific problems in quality of care. Supervision visits are held on a quarterly basis by FP and MCH supervisors. For this purpose, the FP and MCH supervisors join forces in a supervision team, which should retain the same composition throughout in order to ensure continuity and follow-up.

Problems are identified through regular self-assessment and monitoring of selected objective indicators (see page 15) in the clinic using file reviews, observation of clinical services, and review of regular monthly reports in addition to client exit interviews. These tools aid service providers to identify areas needing improvement that should be addressed in their performance improvement plan. The responsibility for collecting the data needed for the indicators is, as much as possible, in the hands of the clinic staff with the aim of increasing their ownership of the process. At the same time, care must be taken not to increase the data collection workload in the clinics. This process will allow major quality problems to be identified. The new set of indicators will reflect FP, RH and MCH quality of care.

Once problems are identified and discussed with the entire clinic staff, root causes are identified (see page 38) and an action plan formulated (see page 67). Over the subsequent three months and prior to the next clinic visit, supervisors and staff implement the agreed upon action plan.

In addition, supervisors should attend client-provider interactions and provide on the job training for the staff including nurses, physicians and others where needed. Feedback (see page 64) and coaching (see page 66) will be important tools in on the job training.

Supervisors are encouraged to evaluate themselves regularly. For this, they can use the guide on page 70.

District and Governorate Level Activities

Many health problems cannot be completely solved at the service delivery point level. Some issues require outside assistance and help may be found from a variety of sources:

- Other areas of the health sector in the form of managers, referral hospitals and universities
- Educational departments in universities or schools
- Women's councils, non-governmental organizations (NGOs) or other civil society institutions

One example of an organization formulated with this purpose in mind is the Safe Motherhood Committees (SMC), which were formed as part of the national maternal

mortality strategy. Currently, all people necessary for discussions of RH topics are represented in SMC, with the exception of some FP supervisory staff.

In the governorates where this supervision approach is used, the governorate and district SMC will expand its scope of work to include all reproductive and child health issues. It will become a platform for discussion and decision-making on all these topics. For this purpose it will include as full members all FP supervision teams. Supervisors will inform SMC members of problems that are prevalent in multiple clinics or that require assistance from other parts of the health sector or other sectors as described above.

Supervision Indicators

Introduction to Indicators

Periodic systematic measurement of a number of indicators helps monitor the quality of work in primary health units. These indicators are chosen on the basis that they are valid, reliable and useful.

What Does “Valid” Imply?

When an indicator is said to be valid, the measurable quality is scientifically proven to be important in achieving a desired outcome. In other words, a valid indicator measures something that has a proven effect on quality. A valid indicator must also refer to a definition of quality. The indicator must be clear, specific and cover multiple aspects of quality. For effective monitoring, each indicator should give information applicable to a broad range of problems.

What is a “Reliable” Indicator?

The biggest dilemma in measuring arises from the fact that no two people see anything exactly the same way and this difference in perception often results in a difference in measurement. Consequently, comparison of results between clinics is problematic, since a different person does the measuring in every clinic. This is termed inter-observer variation. A reliable indicator would be one that gives the same result, no matter who measures it. Practically, this means that after an indicator has been chosen, it must be tested by having people measure the indicator and then compare the results to see how well they agree generally (statistically called concordance) and how well they agree taking chance into consideration (statistically called kappa).

What Does “Useful” Indicate?

Applicability to different levels of the organization can help determine usefulness. Ideally, results from a “useful” indicator can be used to improve the quality of work at the level at which it was measured. For example, at the management level a strategic indicator for all clinics is desirable, while at clinic level, service indicators and client satisfaction indicators would be more important.

Indicator List

Supervisors work with a list of indicators based on the *Integrated MCH/RH Services*. These indicators focus on input, process or output/outcome and can be divided accordingly.

Supervision teams should focus on and work with the *Integrated Supervision Checklist* (see page 15). Quality is scored according to the *Integrated Supervision Checklist* and

affects the amount of incentive payments earned. The scoring of the *Integrated Supervision Checklist* follows an “all or none” rule, meaning that there is no partial credit; for each item; either no points or the full score is awarded. The only exception to this rule is indicator 7.7, which evaluates the extent to which the clinic has met the goals detailed in their quarterly performance improvement plan. This indicator is assigned a total of ten points and points are awarded in accordance with how much progress has been made in meeting each goal.

After all the minimum requirements have been met, clinics can also select their own indicators to be improved in their quarterly action plan.

Integrated Supervision Checklist

Governorate:

District:

Unit:

Indicator	How to Collect The Information/ Criteria for Awarding Points	Max	Clinic Score
1. Provision of Medical Services			
Input			
1.1 <i>Standards of Practice for Integrated MCH and RH Services</i> manual is available	Request to see <i>Standards of Practice for Integrated MCH and RH Services</i> Manual.	2	
Process			
1.2 Quality of IUD insertion skills	Check that procedure is performed properly and observe a procedure (if possible). See Criteria for Scoring (Annex 1)	2	
1.3 Quality of respiratory tract infection and diarrhea case management	Randomly select 4 files of respiratory tract infection and diarrhea cases and check according to the criteria for scoring.	2	
1.4 Referral notes and referral feedback are available and documented in referral record	Check 3 records to verify if referral notes and feedback are available and documented.	2	
Output			
1.5 Percentage of FP clients < 25 years old	Examine FP log book. Number of FP clients below 25 years old divided by total number of FP clients X 100. Criteria: An increase over last quarter is required.	2	
1.6 Percentage of FP clients who have 2 or fewer children	Examine FP log book. Number of FP clients who have 2 or fewer children divided by number of FP clients X 100. Criteria: An increase over last quarter is required.	2	
1.7 Percentage of delivery coverage by trained personnel	Examine MCH log book. Number of deliveries conducted by physician or trained nurse in the previous quarter divided by the total number of recorded deliveries in the same period x 100. Criteria: $\geq 60\%$	1	
1.8 Percentage of deliveries conducted in health facility	Examine MCH log book. Number of deliveries conducted in the health facility in the previous quarter divided by the total number of recorded deliveries in the same period x 100. Criteria: $\geq 60\%$	1	
1.9 Average number of antenatal care visits (aside	Examine New Pregnant log book and Follow-up Pregnancy log book. Number	1	

Indicator	How to Collect The Information/ Criteria for Awarding Points	Max	Clinic Score
from the first visit)	of visits for follow-up antenatal care (ANC) visits divided by the number of new ANC visits. Criteria: ≥ 4		
1.10 Average number of postpartum home visits	Examine MCH log book. Number of postpartum home visits conducted per month divided by total number of deliveries registered in the same month. Criteria: ≥ 2	1	
1.11 Percentage of antenatal coverage for new pregnant women	Examine MCH log book. Number of newly pregnant women per month divided by the average number of births per month x 100. Criteria: $\geq 70\%$	1	
1.12 Percentage of newborns receiving an examination within 15 days of delivery.	Examine MCH log book. Number of children examined within 15 days of delivery per month divided by the monthly average number of births over the previous six months x 100. Criteria: $\geq 95\%$	1	
1.13 Percentage of newborns who are examined for thyroxin level in the blood between 3 and 7 days after delivery	Examine MCH log book. Number of newborns examined in the most recent quarter divided by the total number of births in the same quarter. Criteria: $\geq 95\%$	1	
1.14 Average number of child care visits for each child up to and including the age of 12 months	Examine MCH log books. Number of follow up visits for children at 2, 4, 6, 9, and 12 months of age per month divided by the average number of births per month. Criteria: ≥ 4	1	
1.15 Vaccination coverage by the type of vaccine (for children)	Examine Birth and Session Vaccination log books. Number of children vaccinated with this dose divided by the total number of children X 100. Criteria: $\geq 95\%$	2	
Subtotal		22	
2. Medical Records			
Process			
2.1 Client records and MCH records are stored properly, locked and kept safe	Examine FP and MCH records. Ensure records and order forms are available and in proper storage condition. Criteria: 1 point for FP; 1 point for MCH	2	
Output			
2.2 FP client record is complete, registered and up to date	Examine 3 records. Confirm clients' records, clients' log books and log summaries are correct and complete.	2	

Indicator	How to Collect The Information/ Criteria for Awarding Points	Max	Clinic Score
2.3 Monthly/Quarterly reports are completed and available	Check date the reports were sent and verify that they match the log book for 2 different services. Criteria: See Criteria for Scoring (Annex 1)	2	
Subtotal		6	
3. Health Education and Counseling			
Process			
3.1 Premarital counseling is available	Check availability of the service.	1	
3.2 Clients are counseled on family planning choices in privacy	Observe counseling session and quality of family planning service provision. Verify privacy of the session.	2	
3.3 Client counseling flip chart is available for both services and are used correctly	Check availability of flip chart and verify that they are being used correctly.	2	
3.4 Posters for available services are on display	Confirm that respiratory infection, vaccination schedule for children and family planning posters are displayed in the appropriate rooms.	2	
3.5 Printed IEC material (RH/FP, MCH) is available for clients in appropriate locations and is being distributed in counseling	Confirm that material on contraceptives, postpartum care, premarital counseling, menopause, nutrition for pregnant women, vaccination of pregnant women, and vaccination for children is available in the appropriate locations and is distributed to clients.	2	
3.6 "No smoking" signs are clearly displayed	Confirm signs are displayed.	1	
3.7 Health Education session reports are completed and available	Check availability and completion of the reports	2	
Subtotal		12	
4. Infection Control and Cleaning			
Input			
4.1 Clinic cleaning, infection control materials and tools are available	Confirm availability of buckets, brooms, soap, scrub brush, chlorine Clorox, Betadine and a minimum 10 pairs of HLD gloves.	2	
4.2 Functioning autoclave and drums, and dry heat oven or a boiler are available	Observe and test.	1	
4.3 Hand washing is possible in all examination	Observe and test. Running water, basins, soap and towels are available in	1	

Indicator	How to Collect The Information/ Criteria for Awarding Points	Max	Clinic Score
rooms	all examination rooms.		
4.4 Two wastebaskets are available in all examination rooms	Confirm the presence of two separate wastebaskets for medical and non-medical waste in each examination room, and confirm that they are covered.	1	
4.5 There is appropriate and functioning lighting and ventilation inside the RHU	Observe and verify that there is enough light and that the windows have insect screens and are not broken.	1	
Process			
4.6 Cleaning schedule present and functioning	Confirm that an explicit, written cleaning schedule for different parts of the RHU is available, displayed and being followed.	1	
4.7 Bathrooms are clean	Check cleanliness of bathrooms and usage of chlorine as disinfectant.	2	
4.8 Medical waste is handled with utility gloves and properly disposed	Ask staff how they handle medical waste and examine burning schedule and or verify that waste is transferred to a central burner in a hospital	1	
4.9 Appropriate decontamination procedures for instruments and equipment are followed	Ask staff about decontamination procedures and observe procedures (if possible).	1	
4.10 Appropriate cleaning procedures for instruments are followed	Ask staff about cleaning procedures and observe (if possible). Criteria: See Criteria for Scoring (Annex 1)	1	
4.11 Appropriate high-level disinfection procedures through boiling or chemicals are followed	Ask staff about high-level disinfection procedures and observe (if possible). Confirm that timing starts when rolling boil begins, that the rolling boil is kept for 20 minutes and that items are removed with HLD forceps/pickup.	1	
4.12 Appropriate sterilization procedures (using autoclave and/or dry heat) are followed	Ask staff about sterilization procedures and observe (if possible). Criteria: See Criteria for Scoring (Annex 1)	2	
Output			
4.13 The immediate surroundings of the RHU are clean	Observe and verify that no medical or non-medical waste is present.	1	
4.14 The interior of the RHU is clean	Observe and verify that no medical or non-medical waste is on the ground, that floors are scrubbed and clean, and that furniture and bathrooms are clean and functioning.	2	
4.15 Staff members wear clean uniforms	Observe staff members' uniforms.	1	

Indicator	How to Collect The Information/ Criteria for Awarding Points	Max	Clinic Score
Subtotal		19	
5. Logistics Management			
Process			
5.1 Protocols and procedures for storage and inventory management are available and followed	Observe storage and inventory management procedures, check documents and records	2	
Output			
5.2 Essential drugs are available	Check availability of drugs in pharmacy. Criteria: See Criteria for Scoring (Annex 1)	2	
5.3 Essential contraceptive commodities are available	Check availability of contraceptive commodities in pharmacy. Contraceptives should be available for 2-3 months use, with expiry date at least 3 months from date of supervision visit. Criteria: Check 5 of each to verify	3	
5.4 Essential vaccines are available	Check for presence in vaccination room. Criteria: See Criteria for Scoring (Annex 1)	3	
Subtotal		10	
6. Equipment and Maintenance			
Process			
6.1 Basic laboratory equipment and supplies are available	Observe. Criteria: See Criteria for Scoring (Annex 1)	1	
6.2 A suitable number of IUD insertion sets are in good condition	Check the availability and condition of IUD sets. Number of sets should equal $\frac{1}{3}$ of IUD clients in an overloaded day. Criteria: See Criteria for Scoring (Annex 1)	2	
6.3 Basic clinical equipment is available and functioning	Observe and check against standards. Criteria: See Criteria for Scoring (Annex 1)	2	
6.4 Refrigerator in working condition and maintaining correct temperature	Observe. Criteria: See Criteria for Scoring (Annex 1)	2	
6.5 Basic furniture for the clinic is available and in good condition	Observe. Criteria: See Criteria for Scoring (Annex 1)	1	
Output			
6.6 Records for	Ask for and examine maintenance	2	

Indicator	How to Collect The Information/ Criteria for Awarding Points	Max	Clinic Score
maintenance and maintenance visits are available	records and reports.		
Subtotal		10	
7. Clinic Management			
Process			
7.1 FP/RH and MCH services are available every working day	Ensure that FP, ANC, and child care services are available every working day	2	
7.2 Sufficient seating is available in the waiting areas	Check the availability of at least 6 chairs in the waiting area	2	
7.3 The clinic board meetings minutes and the SIF documents are up to date and accurate	Check for minutes of the most recent clinic board meeting and confirm that all payments and disbursements have been recorded accurately.	2	
7.4 The quarterly performance improvement action plan is easily accessible and communicated to all staff	Request to see the plan and ask staff members about their role in the plan.	2	
7.5 Room signs are displayed properly	Observe room signs.	1	
Output			
7.6 Trained staff is available during all working hours	Check the attendance sheet over the previous month by staff type. Criteria: > 90% average attendance for the entire staff	2	
7.7 The clinic achieved results outlined in the quarterly performance improvement plan	Check results and compare against goals in the plan. Criteria: Each 10% achieved equals 1 point on a scale of 10.	10	
Subtotal		21	
Grand Total		100	

Data Collection and Management

Data for the *Integrated Supervision Checklist* may be collected in the following ways:

- Record books and logbooks
- File review
- Observation of services

The methods used to obtain data are detailed in the *Criteria for Scoring (Annex 1)* and the *Integrated Supervision Checklist*. The *Integrated Supervision Checklist* is used to assure availability of all materials and supplies and assess the service providers, performance of integrated MCH/RH services.

All indicators are collected every quarter.

Record Books and Logbooks

Record books in clinics are used to calculate statistics about the services provided in the clinic. The *kateb* or the nurse will perform most of these calculations.

File Review

For file reviews, supervisors should use the appropriate logbook or randomly select files. Files to be reviewed for cases handled in the past quarter should be checked to see if each item in the list is recorded. Data in the selected files should match data registered in the logbook.

Observation of Service Delivery

For a properly executed step, such as IUD insertion, the supervisor scores 2 points. Any steps incorrectly performed are awarded 0 points (all or none rule).

Client Interviews

In addition to the *Integrated Supervision Checklist* and the data collected for it, the clinic staff can use a second tool, the client interview, to measure quality of services.

Client satisfaction is the ultimate goal in a client focused organization. An integrated supervision system focuses on offering quality MCH/RH services that satisfy clients in the rural health units. To achieve results, the service provision team will address areas needing improvement from the clients' perspective in their quarterly improvement plan. To gather this data, the client exit interview should be used continuously by service providers to assess improvement in the quality of services from the clients' viewpoint and respond to it in their quarterly plan.

* A record keeper

Client opinions and suggestions can be obtained in many different ways. Each method has its own advantages and disadvantages. Interviews can be done by clinic staff or by outsiders (members of community development associations (CDAs), community members, etc.) or the client can fill in the form herself. Interviews by clinic staff generally encourage the client to give better scores than interviews by outsiders (courtesy bias), however they are easier to arrange. When a client is asked to fill in a form, the number of questions is limited.

All *raedat rifiat* (community outreach workers) are to do three client interviews per week. They should write the answers in a booklet with columns, one row per client. Figure 3 in Annex 2 is an example of how the answers might be recorded. At the end of the quarter, a few days before the supervision team visits, the *raedat rifiat* will hand booklets in to the clinic staff member assigned the data processing task. This staff member will calculate average scores for all questions and plot these on a graph. For details and techniques see Annex 2.

* Rural community health workers

Role of the Supervision Team

The role of supervisory team members is not to try to improve quality on their own but rather to coordinate and motivate the clinic staff to improve the quality of care together.

The Quarterly Supervisory Visit

Before Each Visit the Supervision Team Will:

- Send a letter to remind the clinic of the upcoming visit, include the supervision schedule for the quarter/year and bring up the following:
 - ▶ Propose a date for the visit 
 - ▶ Remind clinic staff to present the findings of the client interviews
 - ▶ Remind clinic staff to collect the data from service statistics (reports and logs) on the *Integrated Supervision Checklist*
- Two weeks after sending the letter the supervision team will follow-up by phone

During the Visit

- Go over the data collected by the clinic staff (see page 29); assure it is ready for presentation in the staff meeting
- Provide coaching in the skills identified by the clinic physician
- Collect the indicators in Table 1 and add them to the *Integrated Supervision Checklist*.

Table 1: Data collected by supervisors

Name of indicator	Technique	Responsible person
1.1 Standards of Integrated MCH/ RH Services manual is available	Checklist	Clinical Supervisor
1.2 Quality of IUD insertion skills	Observation	Clinical supervisor
1.3 Quality of respiratory tract infection and diarrhea case management	File review	MCH Officer and nurse supervisor
1.4 Referral notes and referral feedback are available and documented in referral record	File review	Clinical supervisor
2. Quality of medical record	Checklist, and file review	FP/ MCH nurse supervisors
3. Quality of health education and counseling	Checklist and observation	FP/ MCH nurse and clinical supervisors
4. Quality of infection control and cleaning	Checklist and observation	FP nurse supervisor
5. Quality of logistic management	Checklist	FP/ MCH nurse supervisors
6. Quality of equipment and maintenance	Checklist	FP nurse supervisor
7. Quality of clinic management	Checklist	FP/ MCH Officer

Checklist for Planning a Meeting

Tasks	Completed
Have materials prepared and distributed when necessary.	
Make sure location is accessible and that people are available. Pick a time and place that allows as many people as possible to participate without interruptions to their schedules.	
Inform participants of the time, place and purpose of the meeting and who will attend.	
Identify the desired outcome of the meeting. Clearly define what should be accomplished and make sure that it is possible in the time available.	
Plan some activities that encourage everyone to participate. Include a variety of activities (e.g., writing, listening, discussion, small group work, etc.).	
Make a brief time schedule for the meeting.	
Write the agenda on a flipchart.	

The Staff Meeting

Either the clinic physician or one of the clinic supervisors should facilitate the meeting by mutual agreement. It can be divided into three parts. The first part should be for self-assessment. It is important that as many staff members as possible are present. During this part of the meeting the staff are asked to think of improvements in their work or their clinic that would have a positive effect on the quality of services for clients. Responses are then written on a flipchart as a list of problems, which staff would like to address. For more details see the staff self-assessment on page 53.

The second part of the first meeting is dedicated to the analysis of indicators. A presentation should be made of the following:

- The *Integrated Supervision Checklist* scoring in details, to discuss what works and what needs improvement
- A flipchart with responses to open questions from the client interviews
- Graphs of the indicators currently being closely monitored

The supervisor and staff should decide if there are any obvious problems based on these results. Any such problems are to be added to the flipchart along with the problems identified during the first part of the meeting.

The third part of the meeting should be a review of the last action plan. The supervisor and staff should decide which problems have been solved and which still need work. Those that still need work also go on the problem list flipchart.

The outcome of the meeting is a list of problems. As a conclusion to the meeting, the staff should be encouraged to discuss the problems and think about causes and solutions to them during the course of the subsequent week.

After the Meeting

The supervisor should evaluate the meeting for him or herself in terms of accomplishing the desired objectives, timing and staff participation.

Sample questions for a supervisor to ask him or herself are:

- Did everyone speak?
- Were everyone's ideas heard or did a limited few dominate the discussion?
- Did I dominate the discussion?
- Are the problems the group came up with really theirs or did I guide them towards what I think the problems are?

Follow-up Visit for Action Plan

One to two weeks after the first visit by the supervision team, one supervisor will visit the clinic for a full day in order to make an action plan. Generally, this will be a supervisor who is skilled in leading meetings and letting clinic staff talk. S/he will have a long meeting with the clinic staff in which they formulate an action plan together (see page 67). The supervisor and the physician responsible in the center should discuss who will be responsible for follow-up.

After the Follow-up Visit

The supervisor should support the clinic team to write up the action plan and make a work plan for follow-up to improve accountability. More follow-up visits may be needed. In these visits the supervisor should work with the staff on the implementation of the action plan.

Proposed Schedule and Task List for a Supervision Visit

Ideally all supervisors should be able to supervise all procedures. However, this will require cross-training in clinical items. Before such cross-training can be arranged, the following is a suggested task list for the different supervisors. Supervision teams may discuss the proposed task list and decide on a more appropriate division of tasks if needed.

Tasks for the FP clinical supervisor and the FP nursing supervisor:

- A joint letter should be sent before the visit as described above and below, signed by the FP clinical supervisor and the MCH clinical supervisor
- During the visit, make sure client interviews are done and – if needed – graphed
- During the visit, collect data for the checklist FP indicators

- Provide coaching and other on the job training

Tasks for the MCH clinical supervisor and the MCH nursing supervisor:

- During the visit, collect data for the checklist MCH indicators
- Provide coaching and other on the job training

Role of the Clinic *Kateb and Raeda Rifa*

Before Each Supervision Visit

The clinic *kateb* should collect the following data from the client interviews for discussion with the team and be prepared to present it during the supervision visit and planning meeting.

Table 2: Data obtained from client interviews

Indicator
Client's perception of waiting time (Q 1)
Respectfulness of provider (Q 2)
Client's perception of sufficiency of time spent with provider (Q 3)
Client's perception of privacy (Q 4)
Client's perception of questions answered (Q 5b)
Hand washing (Q 6b)
Client's perception of cleanliness (Q 7)
Free method choice (Q 8b)
Percentage of clients who receive more than one service in a single visit (Q 9)

Role of the Nurses

Table 3: Data from the FP record books

Indicator
1.5 Percentage of FP clients < 25 years old
1.6 Percentage of FP clients who have 2 or fewer children

Table 4: Data from the MCH record books

Indicator
1.7 Percentage of delivery coverage by trained personnel
1.8 Percentage of deliveries conducted in health facility
1.9 Average number of antenatal care visits (aside from the first visit)

1.10 Average number of postpartum home visits
1.11 Percentage of antenatal coverage for new pregnant women
1.12 Percentage of newborns receiving an examination within 15 days of delivery.
1.13 Percentage of newborns who are examined for thyroxin level in the blood between 3 and 7 days after delivery
1.14 Average number of child care visits for each child up to and including the age of 12 months
1.15 Vaccination coverage by the type of vaccine (for children)

A few days before the supervision team arrives, the following should be prepared:

- The main indicators on the previous tables (to be revised by the physician)
- Updated graphs for those indicators that need to be graphed
- The indicators selected by the clinic team as desired results for the quarterly performance improvement plan
- The findings from the client exit interviews

Preparation for the Meeting

- Make sure the room is suitable in terms of size and seating arrangements, taking into consideration group size and activity
- Arrange tea or coffee if possible
- Consider other items to discuss with the supervisor

The Role of the Physician

Before the Visit

- Schedule supervision visits with supervision team and notify staff so they can all be present
- Discuss skills coaching with individual staff members in need of coaching
- Make sure the staff has been notified of the dates and times of the two meetings and that everybody is motivated to come
- To revise and prepare the main indicators for presentation to the team
- To revise the results of the clients interviews with the *kateb* and *raeda rafia*

- During the visit, inform the supervisors of coaching needs. Discuss with them who will lead the problem-finding meeting.

After the Visit

- The supervisor will type up the action plan that was agreed upon during the action plan meeting. S/he will send this to the physician who will distribute it to all staff.
- The physician will follow up the action plan, regularly asking the persons responsible for activities if they are on track, if they have any problems, etc.
- This sort of guidance may be included in the biweekly RHU team meeting to follow up and monitor their plan.

Reporting to the District Level

Supervision teams will provide the data collected to the Health Information Center for data entry to be developed later according to the development phases of the new integrated supervision system. They will send the following the *Integrated Supervision Checklist* form. Data will be entered by data entry staff within two weeks.

District Level Data Processing

The district Health Information System (HIS) center will provide the district team with the *Integrated Supervision Checklist* indicators, by unit calculated from the data collected.

Fundamentals for Supervisors

Continuous Quality Improvement

Continuous quality improvement (CQI) is an exciting management approach that is being introduced in FP and MCH programs around the world. CQI is based on the belief that anybody at any level of an 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, as well as improving productivity, efficiency and client satisfaction.

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 has been used in managing health services, including those offered by FP 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 use the techniques presented by adapting them 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 members 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.

In preparing to introduce CQI, managers must create an environment for quality improvement by obtaining a leadership commitment, focusing on the client's perspective, analyzing the work process, and motivating all levels of staff to participate in a continuous effort to improve FP 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.

1. Identify an area where opportunities for improvement exist.
2. Define a problem within that area and outline the sequence of activities (the process) that occurs in that problem area.
3. Establish the desired outcomes of the process and what is required to achieve them.
4. Select specific steps in the process to study and for each step list the factors that prevent the achievement of the desired outcome.
5. Collect and analyze data on the factors that are preventing achievement of the desired outcomes of the specific step being studied and quantify the outcomes of that step.
6. Take corrective action to improve the process.
7. Monitor the results of the action 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.

Table 5: Traditional management and CQI

Differences Between Traditional Management and CQI		
<i>Aspects</i>	<i>Traditional Management</i>	<i>CQI</i>
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 is done by senior managers and specialists	Problem solving and decision making are 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 members work individually	Staff members work in teams
Performance	Authority is rewarded	Capabilities are rewarded

Differences Between Traditional Management and CQI		
<i>Aspects</i>	<i>Traditional Management</i>	<i>CQI</i>
recognition		
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

Performance Improvement

Performance improvement is a process for enhancing staff performance that employs an explicit set of methods and strategies. Results are achieved through a systematic process that considers the institutional context; describes desired performance; detects gaps between desired and actual performance; identifies root causes; selects, designs and implements interventions to address root causes; and measures changes in performance. Performance improvement is a continuously evolving process that uses the results of monitoring and feedback to determine whether progress has been made and to plan and implement additional appropriate changes.

The Goal of Performance Improvement

The goal of performance improvement is to solve performance problems or realize performance opportunities identified by teams and supervisors, in order to achieve desired results. The overall desired result in the RH/FP field is the provision of high quality, sustainable integrated RH services.

The performance improvement process is most likely to achieve its goal when the following factors are present:

- Managers and staff at all levels actively participate in all stages of the performance improvement methodology and change process
- Managers/supervisors and staff identify and build together on existing performance assets and successes as well as addressing performance problems

The Relationship between Quality Improvement and Performance Improvement

The origins and orientation of quality improvement and performance improvement are somewhat different. Quality improvement has its roots in engineering, statistics and management, while performance improvement has its origins in the behavioral sciences.

While a quality improvement approach starts with the question: What steps can be taken to make sure an appropriate action is taken correctly? Performance improvement asks: What is needed to improve performance?

Ultimately the approaches are complementary since, to provide better client services, the issue of how staff and service providers do their work must be addressed.

While their origins and orientation may be different, there are significant similarities between the quality improvement and performance improvement models. Both are cyclical problem-solving processes. Both advocate the establishment of standards and continual efforts to meet those standards. Both seek to establish the root causes of identified problems. Both identify and select appropriate actions that are intended to address performance problems. Both quality improvement and performance improvement seek the same ends: high quality products or services. Both models draw from the same toolbox, although the use of the tools may vary. The approaches are complementary and the strengths of each should be brought to bear in implementing RH interventions.

Performance Improvement Results

Performance improvement is a process for achieving desired performance results. The goal of performance improvement is the provision of high quality, sustainable health services. Results are achieved through a process that considers the institutional context and creates teams made up of all relevant stakeholders. These teams define desired performance and its indicators, describe gaps between desired and actual performance, identify root causes and select interventions to address the root causes of gaps and measure changes in performance.

The performance improvement process implemented by the Performance Improvement Consultative Group (PICG) is presented in the following framework.

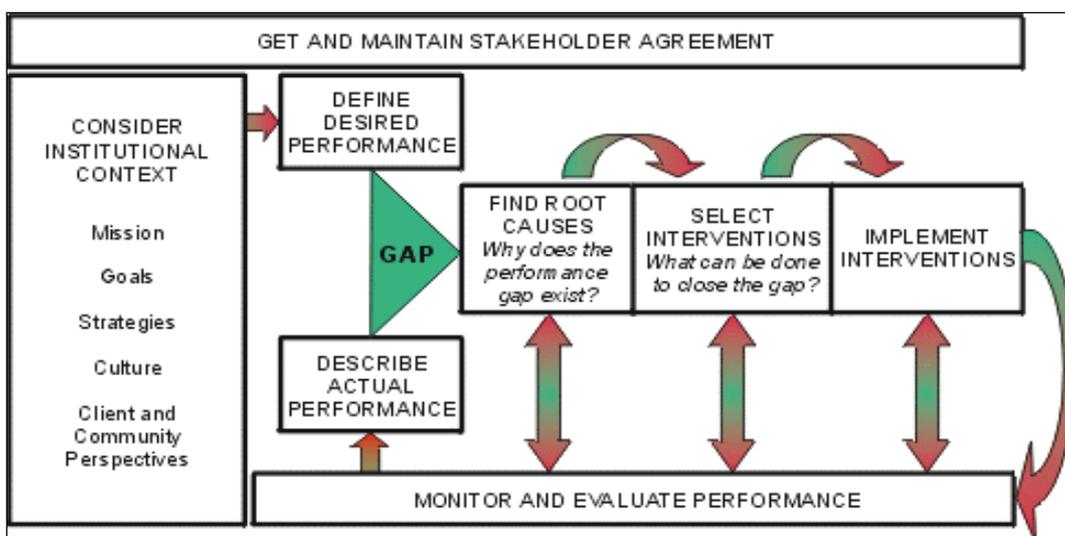


Figure 4: The Performance Improvement Process

Integrated Supervision and Performance

Integrated supervision focuses the efforts of supervisors and clinic teams on making the process of performance improvement an integral part of the system. The quarterly supervision cycle is linked to the performance improvement cycle in order to insure continuous improvement in performance towards high quality standards.

Factors Affecting Performance

Three major factors affect a person's performance:

- Competence to perform a task
- Motivation to perform a task
- Organizational aspects that facilitate or prohibit a provider from performing his or her task or job

Competence

Examine a person's competence to do a task by asking:

- Does s/he have an appropriate level of knowledge about the task (i.e., if you don't know how bacteria is transmitted, you won't understand the importance of gloving)?
- Does s/he have an appropriate level of skill at doing the task (i.e., when you put the gloves on correctly, you maintain sterile conditions)?
- Does s/he have an appropriate attitude toward the task (i.e., if you don't like the feel of gloves or if you think it takes too much time to put gloves on you may not put them on)?

Motivation

Evaluate a person's motivation to do a task in terms of:

- Personal commitment to doing that task well (or at all)
- Confidence in his or her ability to do the task

Organizational Aspects

Address the work environment. In order to do a task correctly, staff need sufficient:

- Equipment
- Facilities
- Drugs
- Supplies
- Organization of the work (regulations, policies, etc.)

Supervisors who are confronted with a staff member who does not perform well should review the five main factors: knowledge, skills, attitude, motivation and organizational aspects.

The Cause-Finding Process

Techniques for Simple Problems

The brainstorming process creates a high volume of ideas, free of criticism and judgment. It encourages “open” thinking when a group is stuck in the “same old way” of thinking. It gets everybody involved and enthusiastic so that a few people do not dominate the group. There are two major methods for brainstorming:

- Structured - in this process each person presents an idea in turn
- Unstructured - in this process people offer ideas as they come to mind

Sessions of both methods can be conducted silently or as a discussion group.

The Structured Brainstorming Process

- The central question is agreed upon and written down
- Each person offers an idea in turn without criticism or discussion. Ideas are written on a flipchart or white board.
- Ideas are generated until everybody passes, indicating all ideas have been exhausted
- Duplicates are discarded

The Unstructured Brainstorming Process

The process is the same without the concept of “taking turns” so everyone offers ideas as they occur to them.

Brainwriting

Brainwriting is essentially the same as brainstorming except that people write down their ideas as they come up with them. Some people find that this method feels safer, especially if ideas are collected anonymously and consequently brainwriting may result in better ideas.

Variation

The 6-3-5 method (proposed by H. Schlicksupp in “Creativity Workshop”) is ideal for groups of a maximum of six. Each person has five minutes to write down three ideas on a sheet of paper. Each person then passes the sheet to the next person who has five more minutes to add three more ideas that build on the first three ideas on the paper. This rotation is repeated until everybody has seen and added to all of the sheets. This method does not have the advantages of anonymity.

Alternatives to Brainstorming

Card Collection

Since some people may be uncomfortable expressing their ideas in front of a group, this alternative allows them to remain anonymous. Each person gets a stack of index cards on which to record ideas. One idea is recorded per card within a specified time period. Afterwards, the cards are collected and read out loud, and can then be sorted into similar themes.

Idea Gallery

Several problem statements are written on separate pieces of flipchart paper, which are posted around the room. The group moves around and writes down their solutions to the problems on the flipcharts. This technique generates creativity and allows “piggybacking” on the ideas of others.

Techniques for Complex Problems

For complex problems, the Ishikawa or fishbone technique works well. This technique was developed by Mr. Ishikawa who theorized that most often the causes of problems fall into major categories. He then designed a diagram in the form of a fishbone into which to plug the causes. Figure 5 is an example of this technique.

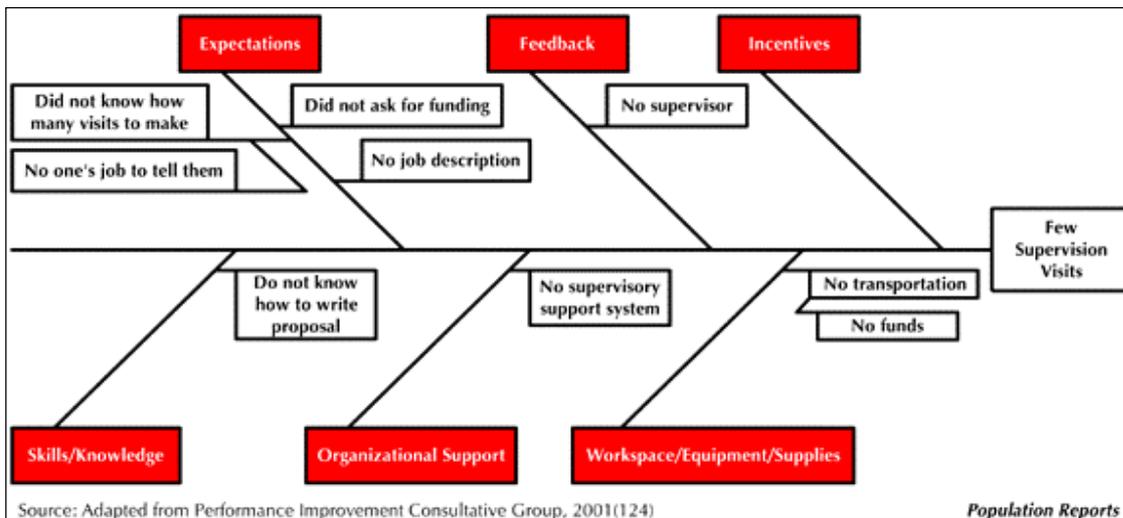


Figure 5: Cause and effect or fishbone diagram

Each category should be examined to find out what factors within the category contribute to the problem. These factors are then written, each on its own line, as smaller bones branching off of the big bone. Each of these factors also have contributing factors, which are added as smaller and smaller bones to the diagram.

The main use for this technique is to allow a team to explore in detail all the possible causes related to a problem. It enables people to focus on the content of the problem, rather than on its history or on different personal interests. It also makes people realize that collectively they have a great deal of knowledge and it enables them to reach a consensus. Lastly, it focuses attention on causes, not symptoms.

Steps in Cause-Finding

Typically it is best to formulate the problem from the clients' perspective by describing its impact on clients. This circumvents the tendency to look for possible causes and focuses attention instead on what is important – the final outcome of the work: improving quality of care to clients. Managers should follow the following steps for cause-finding:

1. Select general categories of possible causes. There is no perfect set of categories. The essential idea is that the categories should be as applicable to the problem as possible; however the below-mentioned five categories will work for most problems. These categories are not mutually exclusive and some causes belong in more than one category. A good start might be:
 - a. Staff
 - b. Policies/rules/standards
 - c. Materials/equipment/facility
 - d. Clients
 - e. Organization of work
2. After choosing categories, the supervisor should then make a flipchart with an appropriate title for each category.
3. Brainstorming or brainwriting all possible causes for each category should be the next step. Possible causes should be placed on the left side of the category flipchart. Some causes fit in more than one category, in which case, they should be placed in both. If the ideas are slow in coming, the major categories can be used as catalysts. For example a supervisor can ask, "What policies/rules might contribute to the problem..." Small groups can work on one category each. To increase participation, people can switch groups after a period so that more people have a chance to work on each category.
4. The reasons underlying each cause should be determined and the answer be written next to it, on the right side of the flipchart. This process will help uncover the underlying or root causes. A supervisor should concentrate on those causes that s/he has control of or are controlled at his or her level or at the level on which his or her direct supervisor works. If people at much higher levels control a cause, it is generally difficult to make an impact upon it (for example salary levels). Trying to analyze the root causes controlled at these high levels is an exercise in futility. The team should keep seeking the reasons behind the cause until one of three things happens:
 - a. A solution to the problem becomes apparent
 - b. The causes under discussion are controlled by factors outside the supervisor's influence
 - c. Discussion has entered a different category of causes

Once all the ideas on the causes of the problem and the underlying root causes have been identified, they should be organized. Root causes are those that appear more than once within or across categories. The most important root causes may be selected through voting. The next step is to seek a solution for these root causes. Root causes should only be included in the action plan if the group can actually influence or solve them.

Bruce/Jain Framework of Quality of Care

The Bruce/Jain framework¹ focuses on using a client perspective in order to improve the quality of care in FP programs and revolves around six elements of quality of care: choice of method, information provided to client, technical competence of providers, interpersonal relations, continuity of care and an appropriate constellation of services.

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. Providing clients a choice is vital because clients' contraceptive needs and values change over time. Such changes may be influenced by the man, woman or couple's:

Stage of Reproductive Life

- Stage 1: From the beginning of a woman's menstrual periods (or a man's ability to ejaculate) to the first sexual experience
- Stage 2: From the first sexual experience to marriage (in many cultures)
- Stage 3: From marriage to the birth of the first child
- Stage 4: From the birth of the first child to the birth of the last child
- Stage 5: From the birth of the last child to menopause (or to the man's desire to cease producing children)

Reproductive Intentions

The following factors are closely allied to those above but may not always be synonymous with one or another of the above stages:

- Seeking to delay: initiating sexual activity but not seeking reproduction at that time
- Seeking to reproduce
- Seeking to space births
- Seeking to limit births

¹ A framework published by Judith Bruce in 1990 combined with measurement and assessment tools developed by Anrudh Jain, which focused attention on the clients' perspective.

- Ending childbearing

Note: Not all women and men pass through all of the above stages or experience all of these reproductive intentions.

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)

Lifestyle and Issues Related to Method Preference

It is important to help clients consider all possible influences over their choices in order to best respond to their individual needs and concerns.

- Ease of use of the different methods: Does the client seek privacy in using the method? Does s/he prefer a method that is used constantly, regardless of sexual activity, or one that is used only when sexual activity occurs? Is s/he seeking a method that can be used without the knowledge of a partner?
- Risk factors for sexually transmitted infections (STIs) and HIV infection
- Frequency of sexual activity
- Number of sexual partners
- Ease of re-supply
- Change in values, beliefs, habits and the preferences of the partner
- Monetary cost of the method
- Client choice of method is generally a function of balancing the following concerns:
 - ▶ 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 Factors

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) without imposing barriers on who can or cannot receive a particular method due to age, marital status, etc.

- The supply system must be adequate to ensure that methods are in stock, since stocking problems compromise the clients' choice

- Supplies need to be properly stored to ensure their effectiveness

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 has asked for (and for which she has no serious contraindications)—she is more likely to continue using it. Providing a choice of method reflects the FP service's commitment to respond to client needs (as opposed to promoting given methods). To the client, choice of method means: s/he has voluntarily selected one of the methods based on his or her understanding of all essential information about the chosen method as well as about all other available methods. Clients who adopt the method of their choice generally keep that method for longer, have fewer problems with side effects and are more content.

Information Given to Clients

Initial Discussion/Counseling

Initial counseling should include the following:

- 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

Follow-up Information

After the client has made a method choice, counseling should include:

- 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 or against FP; for or 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

Giving Additional Information

The availability of written information in a facility also aids in 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 undermine rumors, prevent misunderstandings, misuse, fear and, ultimately, discontinuation.

The client's understanding of contraceptive methods, especially of his or her chosen method, is important in reinforcing his or her confidence in the clinic. The rapport and content of the initial contact are important in establishing this confidence. In addition, clients who have more information are better able to deal with side effects.

Technical Competence of Providers

Technical competence is essential to ensuring quality of care. Key aspects of technical competence include 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 STI 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 or her health.

- The client expects providers to be technically competent.
- Providing technically competent services means clients do not have to come back for treatment of complications, making services cheaper and more popular. It also means fewer complaints from clients, and increased status and well-being for the provider.

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 or her problems and needs
- Empathetic information-giving to help the client obtain services and use his or 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

An emphasis on good interpersonal relations benefits both client and provider in a variety of ways.

- 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
- Clients are more willing to pay for services
- Clients follow the provider's instructions on the correct use of their method
- Clients continue using their method
- Clients return for follow-up visits
- Clients 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 encouraging follow-up include:

- Encouragement from the provider to 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 re-supply system for clients, either at the same clinic or through community-based distribution, pharmacies or otherwise
- Clients who are overdue for a return visit are followed-up: clients are contacted and their reasons for non-return are identified while respecting 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. Encouraging a predictable visiting pattern supports on-going clients, identifies clients whose needs have changed and helps to prevent discontinuation due to concerns about side effects, etc.

The Importance of Continuity and Follow-up

- Helps ensure that the client will use his or her method effectively and obtain the desired result
- Helps detect problems early—before they become serious
- Builds clients' confidence because it demonstrates commitment to and concern for their health and well-being

Appropriate Constellation of Services

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

- Privacy/confidentiality for counseling
- Privacy/confidentiality with respect to physical exams
- Waiting area
- Waiting time
- Clinic working days and hours (opening times)
- Amount of time spent with the provider
- Staff (language, sex, etc.)
- Proper facilities, including a clean examination room, toilet facilities, water, etc.

- Reasonable constellation of services to meet clients' needs (either on site or by referral)
- System in place to get feedback from clients on their satisfaction with services

The Importance of Appropriate and 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 satisfied²

ent Bill of Rights³

An alternate way of examining the same basic issue of improving quality of care is the set of basic clients' rights identified by the International Planned Parenthood Federation (IPPF). Whatever the service offered to a patient, these patient rights should be understood and fulfilled. If providers are able to fulfill the patient's rights, then they are half way to success in delivering quality care. A patient's rights are the same whatever the service is.

Patient Rights

Right to Information

All individuals in the community have a right to information on the benefits of health care. They also have the right to know where and how to obtain more information and services for planning their families. All primary health care (PHC) 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.

Right to Access

All individuals in the community have a right to receive health services, regardless of their social status, economic situation, religion, political beliefs, ethnic origin, marital status, geographic location or any other characteristics which may place individuals in certain groups. This means a right of access through various health care providers as well as service delivery systems. PHC programs should take the necessary steps to ensure that services will reach all individuals who need them, even those for whom normal health services are not easily accessible.

Right of Choice

² Source: John Snow, Incorporated. *Incorporating Expanded Quality Improvement*. Seats II Training Curriculum in Continuous Quality Improvement for Family Planning Programs. Boston: May 2000.

³ *Bill of Rights, Medical and Service Delivery Guidelines*. New York: IPPF Western Hemisphere Region, (no date).

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 upon, 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 a client's decisions concerning discontinuation of a method of contraception and method switching.

Another aspect of choice that should be considered, within the limits of practicality, is the client's right to choose where to go for services and the type of service provider with whom s/he feels most comfortable. Choosing where to go may involve a choice of physical location or a choice of service delivery mode; e.g., community health worker, pharmacy or over-the-counter service, hospital, health center, MCH center or FP clinic.

Clients also have the right of choice of provider. Governmental, non-governmental and private sector providers should welcome the establishment of alternative service outlets.

Right to Safety

Clients have a right to safety. This right to safety implies that the providers are well trained and up to date in their knowledge and perform their services with the outlook that all patients are unique and need unique services.

When receiving services, clients also have a right to protection from other health risks. For example, clients should be able to expect proper safeguards 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 appropriate techniques for providing the method (if applicable), teaching the client about proper use of the method and ensuring proper follow-up. For all services, the conditions in service delivery sites in terms of 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.

Since unwanted pregnancies may represent a risk to health, the right of the client to safety also includes the right to effective contraception.

Right to Privacy

When discussing his or her needs or concerns, the client has the right to expect an environment in which s/he feels confident. The client should be confident that his or her conversation with the counselor or service provider will not be overheard by anyone else.

Physical examinations should be carried out in an environment in which the client's right to bodily privacy is respected. The client's right to privacy also involves the following aspects related to quality of service:

- When receiving counseling or undergoing a physical examination, the client has the right to be informed about the role that each individual in the room plays, (aside from those providing services); 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 what type of physical examination will be performed. The client also has the right to refuse any particular type of examination or request it be done by another provider, if s/he does not feel comfortable.
- Any case-related discussions held in the presence of the client (particularly in training facilities) should involve and acknowledge the client rather than ignoring the client. It is, after all, the client's reproductive organs and functions that are under discussion.

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 or her consent. The right to confidentiality is protected under the Hippocratic Oath. Services should conform to legal requirements and be in accordance with ethical values.

A breach of confidentiality can include serious consequences, among them: causing the client to be shunned by the community or negatively affecting the matrimonial status of the client. It can 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.

Right to Dignity

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.

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 only have to spend 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.

Right of Continuity

Clients have a right to receive services and commodities for as long as they need them. The services provided to a particular client should only be discontinued as a result of a joint decision of the provider and the client. The client has a right to request transfer of his or 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 service.

Right of continuity also implies that the same physician will help a client on different visits, and, ideally, conduct all stages of the visit, which would mean having only one physician doing the history, the counseling and the examination rather than having a different person responsible for each task.

Right of Opinion

Clients have the right to express their views on the service they receive. Clients' opinions on the quality of service, whether in the form of compliment or complaint, together with their suggestions for changes in 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' needs and preferences in ways that are appropriate and acceptable to them.

Linking Frameworks

Table 6 demonstrates how the various frameworks applied to quality of care today reinforce each other and cover the same basic issues in slightly different ways.

Table 6: Relationship between frameworks

IPPF Client's Rights	Bruce/Jain Framework	Engender Health additions
Right to information	Information given to clients	Staff need for helpful supervision and management
Right to access to services	Appropriateness and acceptability of services	Staff need for information, training and development
Right to informed choice	Choice of method	Staff need for supplies, equipment, and infrastructure
Right to safe services	Technical competence of providers	
Right to privacy Right to confidentiality Right to dignity Right to comfort Right to expression of opinion	Interpersonal relations	
Right to continuity of care	Continuity of care and follow up	

Source: Adapted from Studies in Family Planning, 21(2):61-91 1990 Mar-Apr.

Tools for Supervisors

Data Collection Tools

File Review

For a typical file review the supervisor should select three to five files and check the quality of medical records and compare it against the relevant log for validity of data.



Staff Self-Assessment

Research has shown that quality of services is more likely to improve if the management utilizes joint problem solving and if the problems that staff members themselves report are addressed. During self-assessment the staff tries to identify problems that hinder quality of care. Even if no problems are identified, the staff will discuss ways to further improve services, since every process has the potential for improvement. The facilitator's role is to guide that process.

Usually when a supervisor comes, staff members try to show themselves in the best possible light and sometimes even try to minimize existing problems. But if a supervisor asks staff members how s/he can help them do their job better or easier, in an open and friendly atmosphere, a visit can be much more productive.

Self-assessment is based on the theories of quality, adult learning and change management. The following insights are useful:

From quality theory:

- All staff members contribute to the quality of services, so all staff members should help improve the quality of services.
- Good quality services are organized with the goal of helping the client. Taking a look at your services from a client's perspective may help improve them.

From adult learning theory:

- People are interested in solving their own problems. Asking them what they perceive as their problems can help improve quality. Problems thus identified are the most likely to be solved.

From change management:

- People are more likely to change when they have been involved in discussions about the change.
- People are more likely to change when they understand the need for the change.
- People are more likely to change when they like the person who has introduced the change.

In a self-assessment, supervisors should:

- Avoid blaming people. It should be stressed that most problems are the result of the system, not the individual.
- Ask the staff to identify quality gaps.
- Use all the staff, not just the senior management.
- Use the wisdom and knowledge of the staff.

In a self-assessment, supervisors:

- Should not tell the staff what the important problems are. The supervisor should not prioritize.
- Should not tell the staff what the solutions are.

Topics for Self-Assessment⁴

Ideally, identification of quality gaps should originate with staff. If ideas are not spontaneously forthcoming, the following series of topics can be used as a springboard for discussion. Staff can discuss these topics in small groups with each group addressing a portion of the topics or staff can take the list home to consider.

Clients' Right to Information and Counseling

1. How do providers within your facility provide information and counseling about reproductive health to clients?
 - a. Do they discuss a range of RH topics with clients?
 - b. Do staff tailor information to clients' needs?
 - c. Are staff available who can communicate with clients of all language groups in your area?
 - d. Do staff explain benefits, risks, contraindications, side effects or other consequences of any treatment, procedure or contraceptive method?
 - e. Do staff ask clients whether they understand the information they have received and whether they have questions?
2. Does your facility conduct education activities about a variety of general and RH matters to engage clients when they are waiting to be served in clinics?
 - a. Health talks
 - b. Posters and pamphlets
 - c. Videos

⁴ Handout by Ton van der Velden SSDS. Questions are adapted from AVSC's Cope for RH Handbook by Dr J. Ahlborg.

3. Do staff provide information on RH issues, including family planning, to the following clients?
 - a. Adolescents and young adults, both female and male
 - b. Women of all ages, regardless of their marital or reproductive status
 - c. Men of all ages, regardless of their marital or reproductive status
 - d. Disabled clients
 - e. Different social and ethnic groups
4. Do staff provide information and counseling or referral about aspects of RH that are either new or frequently neglected (e.g., STIs)?
5. Other issues that you think are important:

Clients' Right to Access and Appropriate Constellation of Services

1. Are clinic location, services offered and hours well posted and known?
2. Are enough staff available when the clinic is the busiest?
3. Do the following clients have access to RH information, counseling, and services?
 - a. Adolescents and young adults, both female and male
 - b. Women of all ages, regardless of their marital or reproductive status
 - c. Men of all ages, regardless of their marital or reproductive status
 - d. Disabled clients
 - e. Different social and ethnic groups
4. Does the facility provide the following STI services to clients and their partners? If not, can it provide referrals for clients who want these services?
 - a. Information
 - b. Prevention counseling
 - c. Counseling for clients who have been diagnosed with an STI or HIV infection
 - d. Screening
 - e. Diagnosis
 - f. Treatment

5. Other issues that you think are important:

Clients' Right to Informed Choice

1. Does the client receive information about available choices (treatments, procedures, contraceptive methods), including both the advantages and disadvantages of each alternative?
2. Do health care staff do each of the following?
 - a. Actively encourage the client to talk and ask questions
 - b. Listen attentively to the client and respond to her or his questions
 - c. Discuss the client's reproductive goals, needs, and service options
 - d. Assist the client to make an informed choice
3. In general, does the client get the choice s/he wants?
4. For options not available at the site, do staff refer appropriately?
5. Other issues that you think are important: _____

Client's Right to Safe Services and Technical Competence

1. Do staff know and follow current, written service delivery guidelines for each of the MCH/RH services provided at the facility?
2. Are technical skills of clinical and other staff assessed and upgraded on a regular basis?
3. What are the major and minor complications that arise from care given at this facility? Do these occur often? Why?
4. Is a qualified clinician always available either at the facility or by referral (24 hours a day) for consultation in case of complications and emergencies?
5. Are clients screened for contraindications to treatments, medical procedures, and contraceptive methods (screening includes where needed a medical, sexual and social history, a physical exam and appropriate lab investigations)?
6. Is aseptic technique used during procedures?
7. Do clients receive written and oral instructions about the following:
 - a. The risks associated with the treatment, procedure or contraceptive method they are receiving

- b. Warning signs
 - c. Where to go for emergency and follow-up care
8. Is there a regular forum for appropriate personnel to analyze and discuss reported complications and service statistics (monthly meetings are the norm in many parts of the world)? Are records kept of these meetings?
 9. Is the facility always clean?
 10. Do staff have access to current, written guidelines on infection prevention? Do they follow the guidelines to protect clients and themselves from infections?
 11. Do staff wash their hands with soap and running water in the following situations?
 - a. Before and after each clinical procedure
 - b. After handling waste
 - c. After using the toilet
 12. Are needles and other sharp objects disposed of in puncture-resistant containers immediately after use?
 13. Are reusable instruments and other items used in clinical procedures decontaminated in a 0.5% chlorine solution for 10 minutes before processing?
 14. Are instruments and other items properly sterilized or high-level disinfected before use?
 15. Are surfaces (such as examination and operating tables) wiped with a disinfectant cleaning solution after each procedure?
 16. Is medical waste handled safely and disposed of by burning or burying?
 17. Do staff assess women considering an intrauterine device (IUD) for risk of reproductive tract infections (RTIs) or STIs by detailed history taking and physical examination? Are those at risk or with indication of infection tested, treated and counseled about other contraceptive options?
 18. Have clients returned with expulsion or infection after IUD insertion? Have such clients been treated appropriately?
 19. Other issues that you think are important:

Clients' Right to Privacy and Confidentiality and Clients' Right to Dignity, Comfort and Expression of Opinion

1. Are all clients who come to your facility welcomed and treated the way you would want to be treated?
2. Do staff respect the client's wishes about whether or not to provide information to family members, including spouses?
3. Does the facility have private space so that counseling sessions cannot be observed or overheard by others?
4. Do staff take measures to ensure that counseling sessions and examinations are not interrupted?
5. Do staff perform physical examinations and other procedures with the clients' dignity, modesty and comfort in mind?
6. Are all services offered in a manner that is respectful, confidential and private?
7. Do staff ask clients if there is another service they need to receive?
8. The list below describes some areas of the facility that clients may use. Do you think these areas are pleasant and comfortable? For example, is there enough space? Is the space well organized, clean, well lit and comfortable?
 - a. Toilet facilities
 - b. Registration, reception, waiting areas
 - c. Counseling areas
 - d. Examination and procedure areas
 - e. Pharmacy
 - f. Labor and delivery rooms (available in some RHUs)
 - g. Maternity wards
 - h. Neonatal wards
 - i. Gynecology wards
 - j. Male wards
 - k. Emergency rooms
 - l. Operating rooms
 - m. Recovery areas
9. Do you think client waiting times are reasonable?
10. Do staff always explain to clients what sort of examination or procedure will be done, what to expect and why the examination or procedure is needed?
11. Do clients have an opportunity to suggest what the facility can do to provide better quality services?

12. Other issues that you think are important

Clients' Right to Continuity of Care

1. For all services provided, are all clients told what to do if they experience problems, including warning signs?
2. Does the facility have sufficient and reliable supplies so that a client can receive medications, contraceptives, laboratory tests, etc., without delay?
3. Are clients' medical and health records completed properly, with information essential for continuity of care?
4. Are client records and the information in them retrievable?
5. Can FP clients get re-supplies without a long wait or other barriers to access?
6. Are there procedures in place to discuss partner notification, when appropriate, with clients diagnosed with STIs?
7. Other issues that you think are important:

Staff Need for Helpful Supervision and Management

1. Does the facility have a system for getting staff ideas on how to improve the quality of services?
2. Do staff feel management motivates them to improve services by doing the following?
 - a. Providing timely and constructive feedback
 - b. Recognizing work well done
3. Are the following records properly filled out and periodically reviewed by supervisors?
 - a. Birth records
 - b. Medical record forms, including client records and informed consent
 - c. Operating room register
 - d. Laboratory records
 - e. Complication reports/records
 - f. Death records and death reporting forms

- g. Reportable disease forms
 - h. Inventory supply forms
4. Does staff know and follow current, written service delivery guidelines for each of the RH services at the facility?
 5. Does a mechanism exist to encourage communication and to improve collaboration between community health workers and staff at the facility?
 6. For all RH services provided at the facility, are staff members assigned responsibility for routinely carrying out the following functions?
 - a. Counseling (for example, a staff member in MCH clinics provide information about available RH services including FP)
 - b. Giving health talks to clients in the clinic or wards (or in the community)
 - c. Coordinating services and referrals with other departments, wards or institutions
 - d. Filing and maintaining records
 - e. Organizing quality improvement activities
 - f. Monitoring and supervising on a regular basis, including the laboratory
 - g. Community relations
 7. Other issues that you think are important:

Staff Need for Information, Training and Development

1. Do staff feel that they have the knowledge and skills they need to provide quality services?
2. Do all staff fully understand infection prevention (IP) practices? (eg, how to make a 0.5% chlorine solution for decontamination, the importance of hand washing, the importance of properly processing instruments and other items, how to properly dispose of waste and sharps?)
3. Do staff know and follow current written service delivery guidelines for each of the MCH/RH services provided at the facility?
4. Do clinical staff know how to perform examinations required for the services they provide (e.g., breast, pelvic, speculum, prenatal and scrotal examinations)?
5. Have clinical staff been trained and do they feel prepared to address RTI/STI
 - a. Prevention strategies

- b. Assessing risk
 - c. Diagnosing
 - d. Treating or referring
6. Other issues that you think are important:

Staff Need for Supplies, Equipment, and Infrastructure

1. Does the facility have adequate lighting in examination, procedure and operating rooms?
2. In the last six months, have shortages or stock-outs of supplies disrupted the provision of any of the services offered at this facility?
3. Are all drugs and contraceptives in stock within the expiration date?
4. Does the facility have a system for procuring, maintaining and repairing equipment? Does it work?
5. Is there a system for ordering client education materials?
6. Are supplies such as gloves, needles and syringes and antiseptic solutions available in necessary quantities?
7. Is the furniture adequate in the following areas of the facility? Is there enough furniture? Is it clean, sturdy, and undamaged?
 - a. Registration, reception, and waiting areas
 - b. Counseling areas
 - c. Examination and procedure rooms
 - d. Pharmacy
 - e. Emergency rooms
 - f. Recovery areas
8. Other issues that you think are important:

Observation of Services

Clients Rights during Monitoring and Observation

The rights of the client to privacy and confidentiality should be considered at all times during a service observation. A client's physical examination should be carried out in an environment in which her or his right to bodily privacy is respected. When receiving counseling, undergoing a physical examination or receiving surgical contraceptive services, the client should be informed about the role of each individual in the room (e.g., service provider, observers, quality consultants, etc.). The clients' permission should be asked every time there are observers present. If the client refuses, it should not affect the service s/he receives in any way.

Conducting a Successful Observation

Observation of client-provider interactions provides most of the information regarding how a client is counseled, examined and provided with a method.

Before the First Consultation

Before the first consultation, the provider's permission must be obtained for the supervisor to sit in and observe the client-provider interaction, a request that generally meets with no objection.

The providers should also be told that as an observer the supervisor cannot participate in providing services during the consultation. The provider should not ask for the supervisor's opinions or advice, except in extremely serious situations; the provider should be requested to behave as if the supervisor is not present even though s/he will have to be seated fairly close to the client and provider to be able to see and hear exactly what goes on. It is very important to establish an agreement on the supervisor's role and positioning before the consultation begins.

Before Every Consultation

Before the consultation begins, the provider (not the observer) should ask the client whether it is acceptable for an observer to be present. The client should understand that s/he has the right to refuse. Furthermore, a client's appointment should not be rescheduled or canceled if s/he does not permit an observer to be present.

During Consultations

The supervisor's presence definitely affects the interaction, probably by making both the client and the provider more self-conscious and aware of what they are saying and doing. Having an observer present will disturb most people in their normal work routine. Some become flustered, some forget things they normally do not forget. If incidents such as these occur, the supervisor should assure the provider that s/he understands and do everything possible to make him or herself unobtrusive. If possible, the supervisor should sit in the background to avoid eye contact with either the provider or the client.

Supervisors should wear appropriate clothing (in some cases wearing a uniform) and appear pleasant. Supervisors should keep paper and pen resting in the lap and be discreet when noting an observation.

Very occasionally a provider may do something that is potentially dangerous to the client. For example, the provider may use unsterile equipment when doing an examination, inserting an IUD, or administering an injectable. In these cases, the supervisor should intervene calmly and without embarrassing the provider.

At the end of the consultation, the provider should thank the client for allowing the observation and consequently assisting in improving services.

Feedback

Observers must be discreet in observing service delivery. In many cases corrective feedback only causes confusion and discomfort for the client and embarrasses the provider. In general, feedback should be given after each case so that the provider and the observer can talk without the client being present. Corrective feedback during client service should be limited to errors that could harm or cause discomfort to the client (see the supervisor self-assessment checklist on page 70).

On-the-Job Training

On the job training is the process by which supervisors develop staff through regular coaching and feedback. On the job training is essential for the development of good clinical skills needed to provide quality client services. By directly working with and observing the staff, the supervisor learns which performance needs improvement. The supervisor then needs to know how to work with the staff to develop their skills through on-the-job training.

In order to do this the supervisor will need to build a good relationship and a climate of trust. To do this they must be able to coach effectively.

Coaching

Coaching is an attempt to improve performance through motivation, modeling, practice, constructive feedback and gradual transfer of skills. Coaching can be used in many different situations. This section shows how coaching is used as part of clinical training or supervision. Coaching is usually used for new service providers or for staff who have problems with performance.

Important Issues for Clinical Coaching

Coaching is about learning. Trainees will learn best if:

- They are at ease when they are with the coach. They want to learn something new.
- They understand what is expected of them.
- They are not afraid they will be embarrassed or lose face in front of a patient.

During coaching, supervisors should demonstrate respect for the client's safety, comfort, dignity and privacy at all times.

Steps for a Clinical Coaching Session

Step 1: Briefing

To help a provider learn most effectively, the supervisor and provider should first discuss what s/he needs to learn (learning objectives). The goal is to agree on the nature of a performance problem and to fully understand the need for skill development. Creating a good atmosphere for learning is essential for reaching this understanding.

Additionally, the supervisor should determine his or her role as supervisor/coach and specify whether s/he will act as an assistant or an observer. Sometimes the trainee/provider can determine which role they would feel most comfortable having the supervisor fill. Prearranged hand signals can serve as communication between the supervisor and the provider to indicate agreement or disagreement. The roles of both parties should be clearly defined beforehand, including who will inform the patient about what is happening.

Step 2: Working with the Provider in the Clinical Situation

Working closely with a provider puts special demands on tact and care. The supervisor should avoid saying or doing anything that could make the provider feel inadequate, embarrassed or ashamed in front of a client. People who are unhappy with themselves or with their trainer do not learn anything. Supervisors should be careful not to criticize or correct the provider when the patient is present, instead, saving feedback for the debriefing with the provider. Likewise, attention should be paid to the patient's feelings, as the patient is in a very vulnerable position. His or her privacy should be respected. The number of people in the room should be limited as strictly as possible. The supervisor should avoid giving obvious feedback in the patient's presence or during the procedure as this can be frightening or shake the patient's confidence.

During clinical procedures, supervisors should emphasize other important aspects of care such as respect for the patient and a friendly and caring attitude. These are best taught through good example.

The coach's role depends on the current level of skill of the trainee. In some situations, a supervisor may demonstrate the procedure, in others serve as an assistant, and in still other cases, remain in the background in order to focus on the bigger picture (such as support from nursing staff, organization of supplies and equipment, attention to infection prevention, etc.). The supervisor might want to stand nearby and wear gloves in case s/he needs to step in. Verbal communication and explanations are generally kept to a minimum. Teamwork is important! Key points are:

- To perform the procedure smoothly and efficiently
- To enable the trainee to do as much of the case as independently as possible
- To encourage increasing competence and independence

Step 3: Feedback and Planning for the Future

A large part of on-the-job training takes place during this stage. Motivation is vital. In keeping with this, the supervisor should express his or her confidence in the provider and willingness to provide continued support. Feedback on a session should be given as soon as possible. The supervisor should:

- Ask how the provider thought the case went. Ask him or her what s/he did well and what s/he would do differently the next time.
- Explain clearly what was done well and what needs work, starting with positive comments on tasks well done. To avoid overloading him or her with areas needing work, attention should be focused on three to five items of primary importance. Sometimes several items can be grouped into a general category.
- Discuss the learning objectives stated in the briefing.
- Reinforce correct procedure using models or otherwise demonstrate the areas needing additional practice and attention.
- Make a plan for further learning in keeping with the learning process of introducing a theory, modeling its practice and setting a plan for the next practice. The plan should be realistic and the provider should be capable of accomplishing it.

Providing Constructive Feedback

The following is a tool designed to guide the supervisor in encouraging a provider to change her/his behavior or improve performance.

Before Giving Feedback

Before a supervisor gives feedback s/he should do the following:

- Choose an appropriate time to give feedback. If the provider is in the middle of seeing a client or concentrating on something else, the timing might not be appropriate. Feedback should be given as soon as possible.
- Choose an appropriate place. In general, providers appreciate privacy when receiving feedback. The supervisor should not alarm or worry the client by giving feedback in his or her presence.

During Feedback

When giving feedback the supervisor should follow these rules:

Listen

The supervisor should let the provider teach him or herself as much as possible, instead of telling him or her what to do. People learn best when they are active learners. A common technique is to start with a question such as, “What do you think went well?” and then follow up with: “What do you think you can still improve?” Paraphrasing, open-ended questions and other effective listening techniques are all useful as well.

Prioritize

Most people find it difficult to absorb more than three to five things they need to improve. Feedback on areas for improvement should be limited to a selected few items, although sometimes it is possible to group several items into one larger category.

State Facts, Not Interpretations

An example of an interpretation would be: “You are not comforting this client because you are scared/shy/uncaring.” Interpretations like these are not effective because the supervisor runs the risk of being wrong, which does not help the training, coaching or supervision. Supervisors should state only what they observe and then ask the provider for the interpretation if needed.

Make It Practical

The provider should be allowed to come up with solutions to problems. A supervisor can ask: “What can you do to make sure that happens?” and should not be content with vague assurances like: “I am sure that with your help I can do better next time.” If the provider says this, a good follow-up question would be: “How?”

Discuss Consequences

Consequences can be either positive or negative. An example of a positive consequence might be: “If you include the dates, it will help everyone to serve the client.” A negative consequence might be: “If you continue to leave out the dates, I will have to write this up on your performance chart.” For the most part, negative consequences should only be used after having used the positive ones at least once. If the person is just learning a skill, only the positive should be used. Additionally, negative consequences should fit the seriousness of the incident.

Giving Feedback

Supervisors giving feedback should:

- Praise the provider with a few general words (“good job,” “that went really well,” etc.)
- Ask how the trainee thought the case went. Ask him or her what s/he did well. Ask what s/he was happy with and what s/he would do exactly the same way next time.
- Ask the trainee what s/he would do differently the next time. This is a more positive way of asking what a provider did wrong.
- Discuss the points that the provider brings up and add observations. Prioritize. Ask him or her how s/he can do better the next time. Make it practical.
- Summarize.

Running Action Plan Meetings

Before the Action Plan Meeting

Before the meeting, an action plan should be prepared with the “Problem” column filled in with the results of the first meeting, including self-assessment and review of the *Integrated Supervision Checklist*, the old action plan and client interviews. For an example, see Table 7.

Table 7: Sample Action Plan

	Problem	Cause	Decision or solution	Employee responsible	Date	Expected results
From old action plan, not yet solved	Still not enough antibiotics (less than 2 weeks stock)					
From the Integrated Supervision Checklist	The average number of ANC visits still below 4 visits					
From client interviews	The results on confidentiality were worse: the score was 70% during the second quarter and dropped to 50% during the 3rd quarter.					
From self-assessment	No clear posting of working hours					

During the Action Plan Meeting

Praise the Quality of Services

The supervisor should name specific examples of good service provision, including some examples of good results from the client interviews and clinic tour. Results successfully achieved and service indicators improved should be recognized and acknowledged.

Prioritize

If there are a great number of problems, the supervisor has to decide how to deal with them all. The best option is to spend more time and address them all. In this case, the supervisor should agree with the staff on an appropriate time for a second action plan meeting later in the week to best utilize the useful information collected. The second option is to prioritize. In order to do this the supervisor has to work with the staff to establish criteria for prioritization. Some sample criteria are:

- It is solvable with available resources
- It affects many clients
- It affects the safety of clients
- It affects how clients perceive the clinic
- It is important to the staff
- Staff recognize the need to change it
- It is important to those in charge
- It is in compliance with policies or strategies

The following technique can be used to prioritize. It is called the nominal group technique. It builds commitment to the group's choice through equal participation in the process, allows every group member to rank issues without pressure from others and puts quiet group members in the same position as more vocal members.

Problem Ranking Technique

1. Each problem is assigned a letter (A, B, C, etc.). Numbering might cause confusion with the ranking later on.
2. Each team member records the letters on paper and scores the importance for quality of care according to the criteria. If there are five problems, the most important solvable problem gets a "5," the next important a "4," etc. This method minimizes the effect of team members who leave some statements blank as a zero value would not increase its importance.
3. The scores of all group members are combined. The problem with the highest number of points has the highest priority.

In some situations all problems can be dealt with but this is unlikely in the early stages of using integrated supervision. In the beginning, supervisors should avoid tackling too many problems and avoid the most difficult ones. It is especially important in the beginning that the staff manage to successfully resolve some problems on their own, because it is very motivating. If none of the problems on the first action plan are solved, no one will be interested in doing a second action plan.

Find Causes

Brainstorming can provide the causes for simple problems while a fish bone diagram can be useful for more complex problems (see page 39).

Find Solutions

For each cause a solution or action should be discussed that is feasible in terms of time, money, authority, etc. (e.g., do not try to send someone to the MOHP to argue for more salary for the staff).

Find a Responsible Person

Often responsibility for the necessary actions is clear. Usually responsibility should rest with a person within the clinic. If there is an action that needs to be taken by someone outside the clinic (a supervisor or manager), someone in the clinic should follow-up and maintain contact. A person within the clinic should be responsible for every action and should be specified by name in the action plan. All responsibility should not fall on the shoulders of one or two persons.

Set a Due Date

The responsible person should set a reasonable timeframe within which the action will be taken. The supervisor should accept that timeframe rather than imposing a shorter one. If the timeframe indicated exceeds a reasonable period (e.g., more than two months) the supervisor should consider whether the action is too complex or too large. The possibility that it could be broken up into smaller components and therefore the responsibility divided should be considered.

Determine Indicators of Success

Indicators of success should be determined so that the success of the action can be weighed. When problems from the client interview and observation of services are concerned, this is relatively easy as a desired value for an indicator can be set.

Set a Date for the Next Visit

Agree on Follow-up Procedures (Accountability)⁵

⁵Adapted from a handout developed by Ton van der Velden. SSDS for the “Quality Improvement System Training Course.” Abt Associates, ZDRAV Plus Central Asia Project, 2001.

Evaluating Performance

Supervisors need to complete this self-assessment before starting their new supervisory schedule and monthly after clinic visits to help make decisions about changing/improving their supervisory approach. It will help to keep track of one's progress in enhancing interpersonal relationships with persons in charge of the clinic and other staff.

Do You Need to Change Your Approach?

Take a few minutes to assess how you approach staff and relate to them.

Do You...?	Yes/No	Comments
Approach all clinic staff as important partners of the supervisor and team members in ensuring quality PHC services rather than as mere subordinates		
Knowledge about the clinic and staff being supervised/visited		
Review/study clinic file prior to visit to note agreements/issues raised previously		
Note strengths and limitations regarding clinic performance in delivery of integrated package of PHC services and community participation		
Note staffing complement and technical preparation		
Make yourself aware of important community issues already known/reported		
Note any known recent personal experiences of individual staff members that need supervisor's expression of sympathy, best wishes, or congratulations		
Communication before visit		
Make sure clinic staff are aware of intended supervisory visit and date		
Share written agenda for visit with in charge staff person ahead of visit		

Do You....?	Yes/No	Comments
Approaching and treating clinic staff and their clients well		
Greet staff and announce arrival politely		
Show warmth, respect and patience when handling in charge staff person and others throughout the supervisory visit		
Allow time for staff to complete any consultations underway and for any hand over		
Help to create a calm atmosphere by waiting for an appropriate time before making comments or asking about staff behavior/performance or mistakes e.g., when seated, once there is privacy, when climate is conducive		
Validate that any emergencies have been attended to and in charge staff person is free to attend to the supervisor		
Explain or review agenda for day's visit with in-charge		
Use a team enhancing approach throughout the supervisory activities		
Practice active listening during discussions and throughout the interactions		
Encourage staff to express what they liked about their work in the past month and their wishes for coming weeks		
Give in charge staff person and other staff compliments for jobs done well, new initiative and innovations to improve quality of care		
Take enough time to understand the issues of clinic staff and problems or opportunities at the facility		
Correct errors and incorrect practices gently and constructively rather than by criticizing or scolding		
Assist, involve and encourage in charge clinic staff and other staff to identify problems and in problem-solving		

Do You....?	Yes/No	Comments
Give staff the information they need to do their jobs well (use the relevant sections in the supervisor's manual and standard guidelines)		
Give staff practical, workable suggestions on how they can obtain the supplies, equipment, and other materials they need to do their jobs well		
Maintain open and focused discussions by asking open-ended questions, paraphrasing, and summarizing findings and agreed upon solutions from time to time		
Speak with other levels of staff and not only the in charge staff person		
Concluding the visit		
Summarize with in charge staff person the specific aspects of care that are going well and commend them for it		
Summarize the specific aspects that need change and discuss/review what needs to be done and how		
Share with staff as a group the supervisor's general impressions on what is going well and what needs further improvement based on the supervisor's findings (details to be provided by in charge clinic staff later)		
When ready to leave, thank in charge clinic staff and others where possible		
Bid them goodbye till next time		

Leadership Skills for Supervisors

How to Lead Clinic Teams to Achieve Results

Leading and managing practices, teamwork and management tools help supervisors improve performance results, but they are not enough. Strong leadership values are needed in order to sustain the ability to achieve results. A good supervisor needs skills that can help him or her shift perspective to become a manager who leads others to improve the quality of services within the context of integrated supervision.

Effective and successful supervisors have to:

- Examine personal values
- Build leadership competencies
- Adopt a leadership perspective

Examining Values

Examining a manager's personal values guides him or her during difficult situations and helps him or her to decide how best to serve and support staff (internal clients). A manager who is aware of his or her values can use them both to sustain him or herself during times of setback and to help motivate others. Personal values anchor good leadership. By demonstrating these values as guides to action, a manager can become a role model for his or her staff and other colleagues. In order to lead clinic teams well, it is important to model:

- Integrity
- Mutual trust and respect
- Courage and willingness to take healthy risks
- Continuous learning

Integrity

While people can achieve short-term results without integrity, those who are able to build long-term relationships of mutual trust generally value integrity in themselves and others. People respect leaders for their ethics in all circumstances. Though no one is perfect, a credible leader's actions have to match his or her values. The best leaders also believe in doing things for a greater good, which helps them avoid the temptations that can come with power.

Mutual Trust and Respect

Productive relationships at work are the foundation for creating a climate conducive to work and high staff morale, both of which are key to achieving results. Nurturing existing work relationships, creating new ones to broaden networks, and fixing

relationships that are problematic are all priority tasks. When a supervisor respects staff, colleagues and supervisees, s/he will most likely be respected. Respecting others means respecting their points of view, their values and their needs. Such respect builds trust over time. Trust is easy to break, and once broken, it is difficult to rebuild.

Courage to Take Healthy Calculated Risks

It is a leader's job to set an example for taking "healthy risks"—calculated risks that do not endanger the work, its mission, or individuals. As a supervisor learns about the challenges that the district and clinic teams are facing, s/he will find that some risks are necessary in order to address some of these challenges and make needed changes. Leadership is not for the faint of heart. What makes people effective leaders is not that they never make mistakes, but that they don't give up. When they are beaten down or after they fall, they get up, dust themselves off and find the courage to re-engage. In their persistence, they never lose sight of their challenges and the positive future they are trying to create. Through the networks of trust created, a supervisor can find support and courage for taking necessary chances, making tough decisions, and facing criticism or personal failure. In leading others, supervisors need to recognize that they too need support to muster the courage to take risks as well.

Continuous Learning

Good supervisors are committed to continuous learning and encouraging others to do the same. A supervisor should always be alert for new opportunities and possible obstacles as well as for new knowledge and information that can help in seizing these opportunities. S/he is always looking for ways to learn with his or her team. A commitment to learning new things can help a supervisor stay prepared for whatever may come his or her way.

Building Leadership Competencies

Values can sustain and guide a manager in making choices, but they are not enough. A good supervisor also needs to build leadership competencies. Competencies, as previously mentioned, are the knowledge, attitudes, and skills to do something well. The more competent a supervisor is in the following areas, the easier it will be to apply leadership practices and perform well in complex situations.⁶ The following tables illustrate leadership competencies and practices.⁷

⁶ Management Sciences for Health, *Developing Managers Who Lead*, The Manager, Boston, Ma., 2002

⁷ Management Sciences for Health, *Leading and Managing at All Levels, A Handbook for Improving Health Services*, Boston, Ma., 2005.

Table 8: Competencies and corresponding capabilities

Competencies that Support a Leadership Perspective	
Competency	Capability
Master one's self	Self-reflection and awareness of one's impact on others, manage one's self effectively, use strengths, and work on weaknesses
See the big picture	Capable of looking beyond a narrow focus to take into account conditions outside the immediate sphere
Create shared vision	Can work with others to envision a better future, and use this vision to focus all efforts
Clarify purpose and priorities	Able to choose activities, using agreed-upon criteria for what is most important
Lead change	Can enable a work group to own challenges, enlist stakeholders, and navigate through unstable conditions
Communicate effectively	Can hold conversations focused on outcomes and balance advocacy with inquiry; clarify assumptions, beliefs, and feelings
Negotiate conflict	Able to reach agreements from which both sides can benefit
Motivate committed teams	Can create the clarity, trust, and recognition necessary to enable teams to commit to producing high-quality results

Adopting a Leadership Perspective

To enable groups to face challenges and achieve results over time, a supervisor needs to go through critical shifts in approach. Building leadership competencies will support a shift to a leadership perspective. The primary shift will be from acting as an isolated individual to leading a team. The four shifts in the following table can help put this overall shift into perspective.

Table 9: Leadership perspective shifts

Shifting to a Leadership Perspective	
Shift from...	➔ To...
Individual heroics	Leading teams
Cynicism and despair	Hope and possibility
Activities and busyness	Purposeful results
Blaming others for problems	Owning challenges
Focus on self	Generosity

Leading Change

No problem can be solved from the same level of consciousness that created it.” The quantity of variations on this quote from Albert Einstein indicates that it is a phenomenon many people have observed: People who keep on doing what they have always done, will keep on getting what they have always gotten.

Tools and techniques can only be put to good use if they are accompanied by a shift in mindset, a shift from one psychological state to another. Four essential shifts that accompany effective leadership have been identified and can be termed “leadershifts.”⁸

Leadershifts

1. Leaders have to move from a state of despair or cynicism to a place of hope. They have to dream and see possibilities where others see none.
2. Leaders have to avoid blaming others for problems or failures and instead take ownership of challenges and set to work to do something about them. By doing nothing and only blaming others or whining, things get worse and the leader thus becomes part of the problem.
3. Leaders have to get out of a place of frantic busyness, where activities are done for their own sake, or where performance means just showing up for work, to a place of working purposefully with others to produce results that matter.
4. Leaders have to move out of a place of self-absorption and preoccupation with their own needs to a place in which they can be generous, forgiving and compassionate.

Change is a shift in the way things are currently functioning. Change is happening all the time. Change can be seen as positive, leading to new opportunities and possibilities, but change can also be seen as producing negative and unforeseen pressures.

No matter how change is viewed, it creates a series of challenges for every supervisor and clinic head as well as every employee. Change happens because without it there is no progress, no achievement of goals. Change can come from the “outside” – imposed by forces beyond personal control, or change can come from the inside – initiated by the supervisor or areas within his or her control.

Supervision is about change. Supervisors should be aware of and sensitive to reactions to change and develop ways to help providers and teams adapt to changes while minimizing the loss of quality service.

⁸ Management Sciences for Health, *Leading and Managing at All Levels, A Handbook for Improving Health Services*, Boston, 2005

Resisting Change

The most common reason people might resent or resist change is the fear that they will lose something personal such as:

- Employment
- Money
- Demand for their particular skill or competency
- Contacts or interactions with colleagues
- Freedom in their job
- Position of power or authority
- Good working conditions
- Status

Other reasons include:

- Disagreement with the necessity of the change
- Dislike for the person responsible for making the change
- Dislike or irritation at the way the change was announced
- A feeling that they should have been consulted for their opinion
- A feeling that the change has created more work

Changes are therefore best accepted when they come from the staff themselves, which is another reason to make sure they give their input.

Welcoming Change

There are many reasons why people accept or welcome change. The most common reason is that people see some type of personal gain or benefit. Examples include:

- Better use of their skills
- Money
- Position of greater power or authority
- More responsibility
- Work is easier as a result of the change

In addition to personal gain or benefit, people also accept or welcome change when they:

- Have an interest in new challenges
- Have a positive attitude toward the person introducing the change
- Feel a part of the decision-making process which brings about the change
- See new opportunities

What Kind of Changes Will Work?

The most successful kind of change has the following characteristics:

- The change helps the clinic and its employees get something they want or need
- It has a minimal impact on working relationships
- The change is introduced in phases
- It “fits” the clinic’s mission, goals and structure
- It is clearly communicated
- Employees have adequate time to adjust to the change
- Employees understand the rationale for the change
- Employees have had a chance to discuss the change
- Change is led by an appropriate level person within the clinic
- That person is liked
- That person has the proper authority

Annex 1 Criteria for Scoring the Integrated Supervision Checklist

Criteria for Scoring	
Indicator number	Criteria
1.2 Quality of IUD insertion skills	<ul style="list-style-type: none"> Obtains or reviews brief reproductive health history Asks client if she has emptied her bladder Palpates abdomen and checks for suprapubic or pelvic tenderness and adnexal abnormalities Reassures client and tells her what is going to be done and encourages her to ask questions Puts new examination gloves (disposable) or HLD or sterile (reusable) on both hands Performs bimanual examination and speculum examination
IUD counseling	<ul style="list-style-type: none"> Helps client to make an informed choice Asks if she wants to space or limit births? Explore any attitudes or religious beliefs that may favor or rule out one or more methods Explains contraceptive choices available Explains benefits/advantages of each Explains risks/disadvantages of each Asks client if she has any questions and respond Asks client which method she prefers Helps client to make decision about choice of method
IUD insertion	<ul style="list-style-type: none"> Puts new examination gloves (disposable) or HLD or sterile (reusable) on both hands Swabs cervix and vagina with antiseptic Gently grasps cervix with tenaculum or Volsellum forceps Assesses uterine length and direction using uterine sound Loads TCu 380A inside sterile package(non touch technique) Sets blue depth gauge on the loaded IUD inserter to the depth on the sound Inserts the IUD using the withdrawal technique Cuts strings and gently removes tenaculum
Post-insertion tasks	<ul style="list-style-type: none"> Washes hands with soap and water Completes client record
Post-insertion counseling	<ul style="list-style-type: none"> Teaches client how and when to check for strings

Criteria for Scoring	
Indicator number	Criteria
	<p>Tells client to come back after one month for follow up</p> <p>Tells client she can come back any time if she has any problem</p> <p>Informs the client the IUD should be removed after 10 years</p> <p>Annual examination is encouraged but not strictly necessary</p> <p>Explain in a non-alarming way the two IUD danger signs, stressing the rarity of these:</p> <p>severe bleeding</p> <p>severe abdominal pain</p> <p>Plans for a return visit and give client a definite return date.</p> <p>Documents/records the visit according to local clinic guidelines.</p> <p>Observes client for at least 15 minutes before sending her home</p>
Scoring	Any items missing: no points
1.3 Quality of respiratory tract infection	<p>History:</p> <ul style="list-style-type: none"> • Age • Coughing attacks • Can child drink • Can he swallow • Fever • Convulsion • Middle ear complains • Any other complaints <p>Examination:</p> <ul style="list-style-type: none"> • General condition • Respiratory rate • Abnormal respiration • Temperature <p>Treatment:</p> <ul style="list-style-type: none"> • Correct decision made for treatment • Child is provided with antibiotics if needed, and not if not needed
Quality of diarrhea case management	<p>History:</p> <ul style="list-style-type: none"> • Can the child drink • Can he swallow • Vomiting • Fever

Criteria for Scoring	
Indicator number	Criteria
	<ul style="list-style-type: none"> • Convulsions • Other complaints <p>Examination:</p> <ul style="list-style-type: none"> • Temperature • Weight • Signs of dehydration • General examination • Lab done if needed <p>Treatment:</p> <ul style="list-style-type: none"> • Evaluating dehydration • Correct rehydration method • Starts rehydration if needed • Home treatment given • Correct treatment for continuous diarrhea • Child is provided with antibiotics if needed, and not if not needed
Scoring	<p>1 point = Three files checked must be complete</p> <p>0 points = If one file is not complete</p>
2.3 Monthly/quarterly reports are completed and available	<p>Antenatal (new visits)</p> <p>Antenatal (follow up visits)</p> <p>Delivery & postpartum</p> <p>Child health</p> <p>Vaccination</p> <p>Vaccination session</p> <p>New born and vaccination</p> <p>Iron supplementation</p> <p>Family Planning</p> <p>Thyroid screening</p> <p>Respiratory</p> <p>Dehydration</p> <p>IMCI logs (if available)</p>
Scoring	All logs need to be available for the point to be awarded
4.10 Appropriate cleaning procedures for instruments are followed	<p>Wears utility gloves</p> <p>Completely disassembles instruments and/or opens jaws of jointed items</p> <p>Washes all instrument surfaces and edges with a brush until visibly clean, using soap under running water</p> <p>Dries instruments with clean towel or allows them to dry in air</p>

Criteria for Scoring	
Indicator number	Criteria
	Removes utility gloves and allows them to dry in air
Scoring	All items need to be performed for the point to be awarded
4.12 Appropriate sterilization procedures (using autoclave and/or dry heat) are followed	<p>Sterilizes for 30 minutes for wrapped items, 20 minutes for unwrapped items (times with clock) at 121oC (250 F) and 106 kpa (15 lbs/in2)</p> <p>Waits 20-30 minutes (or until pressure gauge reads zero) to open lid to allow steam to escape</p> <p>Allows packs to dry completely before removal</p>
Scoring	All items need to be performed for the point to be awarded
5.2 Essential drugs are available	<p>Iron and folic acid</p> <p>Long acting penicillin</p> <p>Amoxicillin syrup</p> <p>Vitamin A children and mothers</p> <p>Vitamin B complex</p> <p>Bronchodilator</p> <p>Antipyretic (paracetamol)</p> <p>Oral rehydration salts</p> <p>Antibiotic eye drops</p>
Scoring	<p>All drugs should be available for 2-3 months use, with expiry date at least 3 months from date checked. Check 2 of each to verify. If one item is missing or not available for 2-3 months use or expired: deduct one point.</p> <p>If two items are missing or not available for 2-3 months use or expired, deduct both points</p>
5.4 Essential vaccines are available	<p>BCG vaccine</p> <p>Oral polio vaccine</p> <p>Quadruple vaccine/ Hepatitis vaccine</p> <p>Triple vaccine</p> <p>Measles vaccine, Tetanus vaccine</p> <p>Salk vaccine</p> <p>M.M.R. vaccine should be available for 1 session</p>
Scoring	All drugs should be available for 2-3 months use, with expiry date at least 3 months from date checked. Check 2 of each to verify. If one item is missing or not available for 2-3 months use or expired deduct both points.
6.1 Basic laboratory equipment and supplies are available	<p>Microscope</p> <p>Centrifuge</p> <p>Sahli, Cups with covers (disposable)</p> <p>Glass tubes (minimum 10)</p> <p>Tube rack</p>

Criteria for Scoring	
Indicator number	Criteria
	Glass probe Slides Slide covers Albumin sticks , (minimum 1 month stock) Glucose sticks (minimum 1 month stock) Pregnancy tests kits Saline Hydrochloric acid
Scoring	All items need to be present for the point to be awarded
6.2 A suitable number of IUD insertion sets are in good condition	A minimum of 3 sets, each containing Iodine cup Artery forceps Uterine tenaculum Sponge forceps Crocodile forceps Scissors Sound 2 speculums Hook for IUD removal
6.3 Basic clinical equipment is available and functioning	Bunzen burner Microscope Centrifuge Sahli, Cups with covers (disposable) Glass tubes (minimum 10) Tube rack Glass probe Slides Slide covers Albumin sticks , (minimum 1 month stock) Glucose sticks (minimum 1 month stock) Pregnancy tests kits Saline Hydrochloric acid
Scoring	All items need to be present for the point to be awarded

Criteria for Scoring	
Indicator number	Criteria
6.4 Refrigerator in working condition and maintaining correct temperature	Appropriate temperature is measured three times per day and recorded each time Ice in freezer does not exceed 0.5 cm of thickness Temperature always stays between 2° C and 8° C.
Scoring	If all these criteria are fulfilled the points are awarded

Annex 2 Conducting Client Interviews

Client Interviews

Client opinions and suggestions can be obtained in many different ways, each of which has its own advantages and disadvantages. Interviews can be taken by clinic staff or by outsiders (community members, members of CDAs, etc.) or the client can fill in the form on his or her own. Interviews by clinic staff generally encourage the client to give better scores than interviews by outsiders, a factor termed courtesy bias. However, they are easier to arrange and allow a greater range of questions since when a client is asked to fill in a form, only a few questions can be asked. For the client interview form, please see page 90.

As mentioned earlier, all *raedat rifiat* will do three client interviews per week which will be recorded in a notebook. At the end of the quarter, a few days before the supervision team visits, they will hand their notebook to the *kateb* who is assigned the data processing task. S/he will calculate scores for all questions and plot these on a graph.

The Structure of the Client Interview

The client interview is a tool to be used to discover how clients feel about some important aspects of the quality of care in the clinic.

Additional questions about FP are included. After a supervisor has used integrated supervision for a while, s/he may be satisfied with the results of the FP questions. At that point s/he can decide to focus on another aspect of his or her services, such as child health care or vaccination. The questions about FP can be replaced with special topic questions. It is recommended that the first questions remain unchanged as they are more general and address the entire clinic and all services.

Technical Aspects of the Questions

Selection Questions

There are some questions that are designed to select a certain group of respondents to make sure the right people are selected to answer the questions. For example if the question is how the physicians answer client questions, the pool must first be narrowed down to those clients who asked their physicians questions. Likewise, since family planning is not a relevant topic for 70 year old clients, only the clients of reproductive age should be selected for questions related to knowledge of family planning.

Selecting the right group of respondents makes the questionnaire go faster and limits confusion for respondents. It also makes the data that is collected more reliable.

Analysis

Interview results need to be calculated as an average for all respondents. These results then need to be graphed. See the graph below for an example of question 2 on the client interview form (see page 90): “Respectfulness of the Provider” for which the minimum level is 90%.

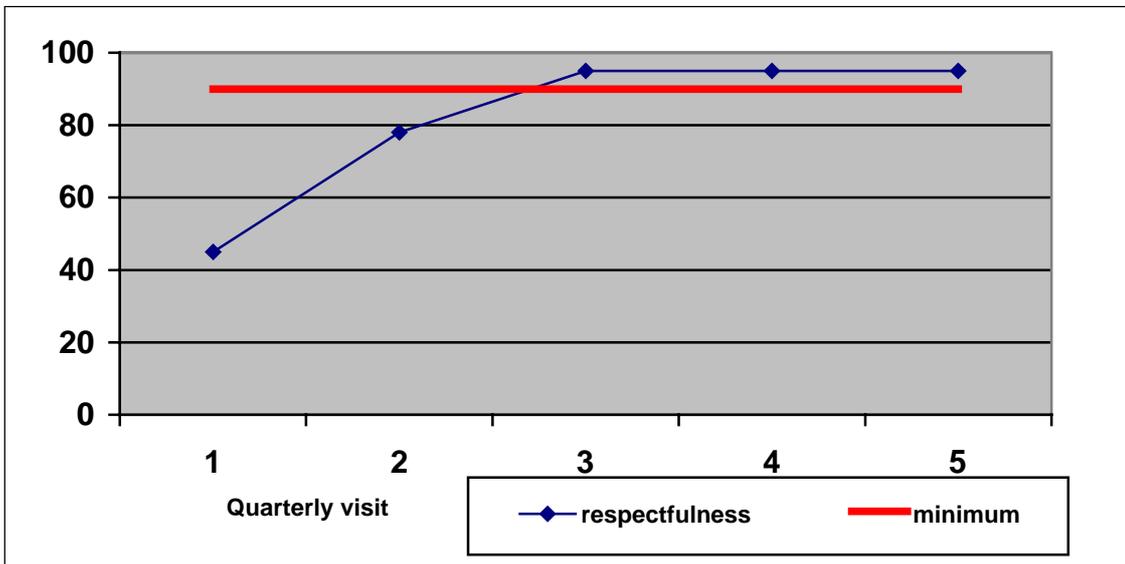


Figure 6: Sample indicator graph

Graphing is a very useful method, which makes it easier to see whether or not there have been improvements. However, graphing alone is not enough. In order to analyze results, the question must be answered: What level is sufficient? For each indicator a minimum needs to be set to act as a warning level. If the indicator goes below that level it serves as an alert to a problem that needs to be put on the action plan. Having such a warning level makes the decision much easier and more objective. In the graph the warning level was set at 90% and therefore the problem with indicator 9 was considered solved after the third measurement.

Answers to the open questions should be written on flipcharts. These flipcharts can then be presented in the first meeting, at the same time as the graphs. The supervisor and staff should make a decision in the first meeting if any possible problems have been raised that should be placed on the action plan.

Who Should Do the Interview?

In principle there are three options for interviewers: 1) an outside, independent agency can do the interviews. The advantages are objectivity and potentially good quality. The disadvantage is cost. 2) A staff member can do the interviews, which is inexpensive and easy to organize, however, clients will tend to be nicer in their answers. Choosing a staff member who is not directly involved in clinical services may make this less of a factor. 3) Clients can be asked to fill out the forms themselves. The advantage is that it is quick and cheap. The disadvantage is that few clients will fill out the form. The best option seems to be to have a staff member do the interviews. To make the data collection as standardized as possible:

- Three interviews should be done every week. The first three clients who leave the building after 10 am should be interviewed. Maintaining fixed methodology is important in comparing the data from one quarter to the next. The person responsible should be someone who recognizes the importance of the interviews and who has the time and motivation to do a good job, every day.
- Ideally she should be dressed in street clothes, not a white coat.
- Interviews can best be done just outside the building and in private.

Conducting a Good Interview

The client interview is designed to be as simple as possible. The following are tips for interviewers:

- Always introduce yourself in a pleasant and friendly way
- Be sure to emphasize the voluntary and confidential nature of the interview. If the person refuses to be interviewed, politely end the interview and go on to the next person.
- Never change the wording of a question. Ask questions in exactly the way they appear in the questionnaire. Use a neutral voice. Do not try to lead the respondent to one answer or another. Do not suggest answers to the respondent. Let the respondent answer for him/herself.
- If you do not understand the answer to an open question, ask the respondent to repeat the answer. But, do not “lead” the respondent in such a way that you suggest an answer. In a neutral way, ask the respondent: “Can you explain a little more? Take your time, there is no hurry.”
- If the respondent does not understand a question, repeat the question slowly and clearly. If the respondent still does not understand the question, you may have to restate the question in different words—but be very careful not to change the meaning of the question.
- Do not push the respondent or act as if you are in a hurry. Give the respondent as much time as needed to answer your questions.

Technique: Client Interview

During the three client interviews per week, *raedat rifiat* will use the questionnaire below. In this questionnaire, the bold text is what the interviewer is to say, instructions to the interviewer are in italics and instructions for scoring answers are on the right half of the questionnaire. Answers are to be recorded in a notebook with columns with one row per client (see figure 2 and 3 below). *Raedat rifiat* should read from a questionnaire stapled in the notebook.

Questionnaire-Client Interview Form

<p>Say: Good morning /good afternoon. I am [your name]. This clinic is working to improve the quality of the services for our clients and we would like to hear the opinion of the clients. I would like to ask you a few questions. The questionnaire is anonymous and will take about 10 minutes. You can stop anytime you want. Do you agree to participate?</p>	
<p>If the client gives permission, continue:</p>	
<p>1. How was your waiting time this visit? Would you describe it as short, normal or long? Please pick one of these answers.</p>	<p>Write the answer: "short" or "normal" or "long" in the box in the notebook.</p>
<p>2. Can you tell me about the respectfulness of the doctor? Was the doctor respectful, normal or disrespectful? Please pick one of these answers.</p>	<p>Write the answer: "respectful" or "normal" or "disrespectful" in the box in the notebook.</p>
<p>3 Can you describe the time you spent with the provider today? Was this more than enough, normal or too short?</p>	<p>Write the answer: "more than enough" or "normal" or "too short" in the box in the notebook.</p>
<p>4. Can you tell me how often someone (staff or patient) walked into the room when you were with the doctor?</p>	<p>Write the answer (the number of times) in the box in the notebook. If she says "don't know" write "don't know."</p>
<p>5. Did the doctor give you a chance to ask any questions during your visit?</p> <p>If the client says: "no" or "don't know," go to question 6.</p> <p>If the client says: "yes" go to 5b.</p>	<p>Write the answer: "yes," "no" or "don't know" in the box in the notebook.</p>
<p>5b. Can you say how satisfied you were with the doctor's answer? Satisfied, normal or not satisfied? Please pick one of these answers.</p>	<p>Write the answer: "satisfied," "normal" or "not satisfied" in the box in the notebook.</p>
<p>6. Were you examined today by the doctor or nurse?</p> <p>If the client says: "no" or "don't know," go to question 7.</p> <p>If the client says: "yes" go to 6b.</p>	<p>Write the answer: "yes," "no" or "don't know" in the box in the notebook.</p>
<p>6b. Did you see him or her wash his /her hands before or after the examination?</p>	<p>Write the answer: "yes," "no" or "don't know" in the box in the notebook</p>
<p>7. Can you tell me what you think of the cleanliness of this clinic? Is it clean, normal or dirty?</p>	<p>Write the answer: "clean," "normal" or "dirty" in the box in the notebook</p>
<p>8. Did you receive a contraceptive method in this clinic during this visit?</p> <p>If the answer is "no" or "don't know," go to Question 9.</p> <p>If the answer was "yes," go to 8b.</p>	
<p>8b. Is this the method that you wanted when you came in?</p>	<p>Write the answer: "yes," "no" or "don't know" in the box in the notebook.</p>
<p>9. What service did you receive today?</p> <p>Cross out all services she mentions</p>	<p>Write the number of crosses in the box in the notebook.</p>

<p>spontaneously. Then ask her: “Did you speak about any other health topics today in the clinic with the staff?” Cross out all other services she mentions.</p> <table border="1"> <tr><td><input type="checkbox"/></td><td>FP</td></tr> <tr><td><input type="checkbox"/></td><td>ANC</td></tr> <tr><td><input type="checkbox"/></td><td>Sick child care</td></tr> <tr><td><input type="checkbox"/></td><td>STI or general gynecology</td></tr> <tr><td><input type="checkbox"/></td><td>Vaccination</td></tr> <tr><td><input type="checkbox"/></td><td>Healthy child monitoring</td></tr> <tr><td><input type="checkbox"/></td><td>Others</td></tr> </table>	<input type="checkbox"/>	FP	<input type="checkbox"/>	ANC	<input type="checkbox"/>	Sick child care	<input type="checkbox"/>	STI or general gynecology	<input type="checkbox"/>	Vaccination	<input type="checkbox"/>	Healthy child monitoring	<input type="checkbox"/>	Others	
<input type="checkbox"/>	FP														
<input type="checkbox"/>	ANC														
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<input type="checkbox"/>	STI or general gynecology														
<input type="checkbox"/>	Vaccination														
<input type="checkbox"/>	Healthy child monitoring														
<input type="checkbox"/>	Others														
<p>10. What do you particularly like in this clinic? Write down the client’s answer in her own words.</p>															
<p>11. What would you like to see improved in this clinic? Write down the client’s answer in her own words.</p>															

Say: Thank you very much for your help

Date	Q1. Wait time	Q2. Respect	Q3. Time spent	Q4. Privacy	Q5b. Satisfied with answers (leave blank if Q5= no)	Q6b Wash hands? (leave blank if Q6 =no)	Q7 Cleanliness	Q9b Method choice Yes/no	Q10 Number of services

Figure 2: Client interview notebook

Date	Q1. Wait time	Q2. Respect	Q3. Time spent	Q4. Privacy	Q5b. Satisfied with answers (leave blank if Q5= no)	Q6b Wash hands? (leave blank if Q6 =no)	Q7 Cleanliness	Q9b Method choice Yes/no	Q10 Number of services
8/8	Short	Respectful	Normal	3	Satisfied	Yes	Normal	Yes	3
8/9	Normal	Normal	More than enough	Don't know	Not satisfied	No	Clean	No	5

Figure 3: Sample page of a client interview notebook

Data Processing

At the end of the quarter, a few days before the supervision team visits, *raedat rifiat* will hand their booklet to the clinic staff member who was assigned the data processing task. This staff member will calculate scores for all questions and plot these on a graph.

Data Analysis

Reviewing data can give an indication as to whether progress has been made in improving the problem over time. Making a graph is the easiest way to do this. An analysis of data can be as simple as looking at the graph and comparing values with the cut-off point. This can give an idea of both how serious the problem is and how long the problem has existed.

The findings need to be discussed with the entire staff to identify challenges that the team will work on the following quarter. The team will use the challenge model to find the root causes of the problems that decrease client satisfaction. Priority actions to be addressed in the quarterly performance improvement plan are intended to improve the client satisfaction regarding identified areas.

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