
**QUALITY OF CARE
IN FAMILY PLANNING
SERVICE DELIVERY**

**A SURVEY OF COOPERATING AGENCIES OF
THE FAMILY PLANNING SERVICES DIVISION,
OFFICE OF POPULATION,
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT**

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with

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Population Technical Assistance Project Advisor to FPSD**

April, 1992

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Glossary and Technical Terms

A.I.D.	Agency for International Development
AVSC	Association for Voluntary Surgical Contraception
CA	A.I.D. Cooperating Agencies
CBD	community-based distribution
CDC	Centers for Disease Control
CEDPA	Center for Development and Population Activities
COPE	Client Oriented, Provider Efficient
CSI	Clinical Services Improvement project (Egypt)
CSM	Contraceptive Social Marketing
CYP	Couple-Years of Protection
DHS	Demographic and Health Surveys
FPA	Family Planning Association herein, a member of the International Planned Parenthood Federation (IPPF)
FPLM	Family Planning Logistics Management project
FPSD	Family Planning Services Division
Grantee	Organization with which Pathfinder works
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
IEC	Information, education and communication
INOPAL	Latin American operations research project
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IQC	Indefinite quantity contract
MIS	management information system
Mission	A.I.D. country offices
MOH	Ministry of Health
OC	oral contraceptive
OR	operations research
PAA	Population Association of America
PATH	Program for Appropriate Technology in Health
PCS	Population Communication Services Project of Johns Hopkins University
POPTECH	Population Technical Assistance Project
QOC	quality of care
SDP	service delivery point
SEATS	Family Planning Services Expansion and Technical Support project
SOMARC	Social Marketing for Change project
TA	Technical assistance
VSC	Voluntary surgical contraception
WHR	Western Hemisphere Region

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EXECUTIVE SUMMARY

I. INTRODUCTION

The Family Planning Services Division (FPSD) of the Office of Population, Agency for International Development (A.I.D.), has identified quality of care as one of three areas of emphasis for the 1990s. FPSD's immediate quality of care goal is to develop an agenda to guide their future work in this area. The ultimate goal is to enhance quality of care at service delivery points. This report represents a step in the process of developing a quality of care agenda. It is the result of a series of discussions held with representatives of eight Cooperating Agencies (CAs) and summarizes the quality of care approaches and activities undertaken by these CAs.

II. PURPOSE

The purpose of this report is to provide information to FPSD on approaches to quality of care of eight of its CAs: AVSC, CARE, CEDPA, Enterprise, IPPF/WHR, Pathfinder, SEATS and SOMARC. The report addresses questions in the following areas: CAs' definitions of quality of care; approaches to assuring quality of care; approaches to assessing quality; success stories; constraints to quality of care; resources devoted to quality of care; future activities; and CAs' recommendations regarding quality of care. In addition, the authors present some conclusions and recommendations. For purposes of brevity, this report primarily presents highlights and trends in quality of care.

III. METHODOLOGY

The authors interviewed senior staff of the eight CAs in March and April, 1991 using a questionnaire specifically developed for this purpose. The interviews were supplemented by a review of quality of care materials prepared by the CAs.

IV. MAJOR FINDINGS

High Degree of Interest. There is a high degree of interest in the topic of quality of care and the majority of CAs welcomed the chance to discuss ideas and approaches. Many were eager to learn what other CAs are doing in this area.

Approaches to Assuring Quality. While the CAs are actively involved in a wide range of quality of care activities, their overall approaches to quality assurance generally fall into four categories: grass roots approach (SEATS, CEDPA and AVSC); medical/management monitoring approach (Enterprise and AVSC); information and training approach (SOMARC and AVSC) and method/stage of program approach (IPPF/WHR and Pathfinder).

Approaches to Assessing Quality. The approaches to assessing quality of care being developed by each CA are often complementary, and the CAs have much to learn from each other. Those CAs interested in a grassroots approach that involves all levels of provider staff might look at SEATS and AVSC's work in this area. Those CAs more interested in working with supervisors and managers might look at the management tools that Enterprise, CEDPA and Pathfinder have developed. Those interested in improving training might ask SOMARC and Pathfinder about their experience with their training modules. Those more interested in using multiple methods for assessment might look at the work of IPPF/WHR and CARE. And those interested in developing a feedback/performance improvement system might look at SOMARC's work in this area.

Success Stories. The CAs point out that they have always been concerned with quality of services in their projects. However, six of the eight CA projects are relatively new to family planning service delivery; documentation of success stories is thus somewhat limited. CA successes range from helping to change service delivery guidelines, to sponsoring key conferences, designing state of the art service delivery projects, developing assessment matrices and other tools, and training to ensure a client-oriented focus in services.

Constraints. CAs face a variety of constraints in attempting to implement quality of care activities. Some of the major constraints include lack of understanding of client-oriented services; provider bias; restrictive government policies; myths about contraceptive methods; perceptions of supervision and quality of care as punitive processes; barriers to access; donor guidelines and restrictions; and duplication of effort among CAs.

Resources. CAs provided only rough estimates of the resources devoted to quality of care since quality of care activities are integral to many other activities they undertake. Estimates ranged from five to 30 percent of project funds spent (either directly or indirectly) on quality of care activities. All CAs agreed that they would require additional resources to implement more fully specific quality of care activities.

Future Quality of Care Activities. All CAs would like to increase staff levels and capabilities in the area of quality of care (both medical and non-medical). They are also interested in trying new approaches to the quality of care elements as well as a range of specific activities such as workshops, expansion of counseling initiatives, in-depth quality-of-care impact and process studies, among other initiatives.

Other Approaches to Monitoring and Assessment of Quality of Care. Even a brief review of recent assessments of quality of care by other CAs revealed that there are several innovative methodologies that have been used recently to evaluate quality of care internationally. These may be helpful to service delivery CAs as they develop their plans for monitoring and assessment of quality of care activities and are summarized in Attachment 8. The U.S. literature on quality of care has not been reviewed for this report.

V. MAJOR RECOMMENDATIONS BY COOPERATING AGENCIES

The following represents some of the most important CA recommendations to enhance quality of care. Additional recommendations are presented in Section 9.

Develop general quality of care guidelines. All of the eight CAs stated quite emphatically that it would be very useful to them if FPSD developed consistent guidelines that could be adapted to their work.

Involve local project staff to assure realistic, field-based guidelines. Both The Office of Population and CAs should be diligent in involving local staff in all aspects of quality of care lest it be perceived as a standard imposed by donors.

Develop a resource pool. The Office of Population and CAs should develop and augment the capabilities of staff and consultants to give country-specific technical assistance in quality of care, and make them available perhaps through some sort of IQC mechanism.

Take an historical look. There has not been a sufficient historical look at quality of care issues in the family planning success stories, such as Indonesia and Thailand. The Office of Population should examine the ways in which quality was essential to the success of these programs.

Study the relationship between quality and impact. FPSD should use the new evaluation project and research CAs to examine the hypothesis that investment in quality of care will result in an increase in acceptors and continuing users, among other topics related to quality of care.

Modify evaluation criteria. CAs are currently evaluated on CYPs delivered. The Office of Population should also evaluate CAs' efforts to enhance quality of care.

Use the CA Meeting. The Office of Population should consider using the CA meeting to continue the education process about quality of care. It should solicit papers on quality of care and have the best ones presented at the meeting.

VI. AUTHORS' CONCLUSIONS AND RECOMMENDATIONS

The following are highlights of the authors' major conclusions and recommendations, which are addressed in greater detail in Section 10. Several recommendations might be implemented through the new Office of Population evaluation project.

Conclusion: Quality of Care at the Local Level. Quality of care will enhance impact only if it is an integral element of service provision at the local level. Local program managers and service providers must be convinced that enhancing the quality of services is important. They are the most important link in the process of providing client-oriented, quality services.

While quality of care standards cannot be externally imposed, CAs and donors do have a role to play in assisting local organization to define and adapt quality of care standards, guidelines and activities, and in providing the required quality of care training (through both training and service delivery CAs.)

Recommendation: The Office of Population, and especially FPSD, should encourage CAs to field test and utilize tools and methodologies that they and others have developed, and to work with local organizations to institutionalize their capability to assess, assure and enhance quality of care in service delivery programs.

Conclusion: Training in Quality of Care. Present training efforts by Office of Population CAs, such as in management, counseling, and areas of technical competence, are implicitly but not explicitly related to quality of care. The effects of such training on quality of care outcomes has not been examined. Furthermore, some CAs are beginning to conduct explicit training in quality of care.

Recommendation: Since service delivery and training are so closely linked, the Office of Population should examine, at the field level, the nature and effects of quality of care training provided by CAs. For example, what is the link between training inputs and service delivery outcomes vis a vis quality of care? Until the Office of Population has answers to these questions it will not know whether and to what extent quality of care is integrated at the local level. Collaboration between training and service delivery CAs should be fostered to ensure that all trainees are exposed to the elements of quality of care, and that quality of care is reinforced in the service delivery setting.

Recommendation: Studies of the effects of traditional training on quality of care outcomes, compared to the impact of explicit quality of care training, should be commissioned by the Office of Population.

Conclusion: Documentation of Quality of Care Activities. Information on the strengths, deficiencies, lessons and effects of the various CA approaches to assuring and assessing quality of care is limited. Documentation of quality of care activities is uneven, in part, because many CAs have only recently begun service delivery activities.

Recommendation: The Office of Population and the CAs should collaboratively plan a series of studies of quality of care assurance and assessment at the field level. Such collaboration could be undertaken through partnerships between research and service delivery CAs. Research CAs should work with service delivery CAs to plan operations research activities, assessments and documentation of the process of improving quality of care.

Recommendation: The Office of Population should encourage documentation of quality of care activities by supporting a *Works in Progress* series or a new journal specifically devoted to quality of care. The Office of Population would thus provide a locus for a professional dialogue on quality of care.

Conclusion: Handbook on Quality of Care Assessment and Assurance Tools. Because the formal study of quality of care is relatively new, methodologies and assessment tools to study this topic are under development.

Recommendation: All instruments and methodologies developed to date to assess quality of care should be documented and made available to CAs. The Office of Population should commission a *Handbook of Quality of Care Assessment Tools and Methodologies*.

Conclusion: Usefulness of Other Approaches to Assessment and Assurance. A brief examination of the quality of care literature undertaken as part of the background review for this report indicated that CAs other than the eight CAs whose work is addressed here are developing innovative quality of care interventions and assessment methodologies. This type of information would be very useful to the service delivery CAs.

Recommendation: The Office of Population should commission a review of the family planning quality of care literature. Such a review would enhance the Office of Population's effort to identify useful approaches to quality assurance and assessment.

1. INTRODUCTION

"Quality of care should not be viewed as a gold standard, but as providing the best possible services given the resources available to an organization."

" We have to be careful of (imposing) a Western notion of quality. It can be a trap and family planning may suffer later on."

Staff, Cooperating Agencies

Introduction. The Family Planning Services Division (FPSD) of the Office of Population, U.S. Agency for International Development (A.I.D.), has identified **quality of care** as one of three areas of emphasis for the 1990s. This is not intended as a new initiative, since A.I.D.-supported family planning programs have always aspired to offer quality care, but rather an area of increased attention and focus. FPSD's immediate quality of care objective is to develop an agenda to guide its future work in this area. The ultimate goal is to enhance quality of care at service delivery points in all countries in which it is providing family planning assistance.

This report represents a step in the process of developing a quality of care agenda, and augments the work of the Subcommittee on Quality Indicators in Family Planning Service Delivery ("Report," 1990). It represents an attempt by FPSD to document the scope of activities of its cooperating agencies (CAs) in the area of quality of care. The report is a summary of discussions with eight CAs on topics such as the CA's past and current quality of care activities, its perspective on issues and problems in the area of quality of care, and plans for incorporating quality of care into service programs in the future. The broader purpose of the discussions was to glean CAs' ideas on quality of care from a practical, field standpoint and to highlight particularly useful models of quality assurance.

Purpose and organization of the report. The purpose of this report is to provide information to the Family Planning Services Division, Office of Population, on approaches to quality of care employed by its eight CAs: AVSC, CARE, CEDPA, Enterprise¹, IPPF/WHR, Pathfinder, SEATS, and SOMARC². The report addresses questions in the following areas: CA definitions of quality of care; general approaches to assuring quality of care; assessing quality; success stories; constraints to quality of care; resources devoted to quality of care; and future activities. It further includes CA recommendations for a quality of care agenda, and the authors' conclusions and recommendations.

¹The Enterprise Program ended in August, 1991, therefore its activities are referred to in the report in the past tense.

²Please see glossary for full names of organizations.

Methodology. The authors interviewed senior staff of the eight CAs in March and April, 1991, using a questionnaire that they had developed with FPSD for this purpose (see Attachment 1). The interviews were supplemented by a review of quality of care materials prepared by the CAs.

View of CAs. CAs welcomed the opportunity to discuss their quality of care activities, ideas for future work and coordination with other CAs and the Office of Population, and applauded FPSD for this effort to document their activities. All CAs agreed that quality of care is vital to the success of family planning programs, and stressed that it has been an integral part of their programs since their inception.

CAs do not view the Office of Population as imposing standards for quality of care on them. Rather they recognize that quality of care involves providing clients with services appropriate for their needs and which respect their dignity. CAs are, however, concerned about FPSD's continued reliance in their contracts on measuring success through quantitative couple-years of protection (CYP). They would like to see success measured also in terms of quality of care indicators.

2. DEFINITIONS OF QUALITY OF CARE

"The basic principle is that the definition of quality of care issues must be developed from within the subproject."

"We must be careful not to turn quality of care into expecting the Mayo clinic in countries we work in."

Staff, Cooperating Agencies

CAs were first asked how they defined quality of care for their programs. The eight CAs have generally adopted the Bruce framework (1989) of quality of care. Most have done so with no modifications, but two have added components (CEDPA and Pathfinder), and another relabeled an existing component (IPPF/WHR). Bruce's framework consists of six elements: choice of methods, information to users, technical competence, continuity of care, interpersonal relations, and constellation of services (see Attachment 2). What is different among CAs is the emphasis they place on the various components and the interpretation they have of the components (see Table 1 at the end of this chapter). All of the CAs stressed the importance of providing client-oriented services.

AVSC's priorities are to make medically safe and effective contraceptive methods available to men and women and to ensure that clients are making voluntary and informed choices about contraceptive methods. As long as its focus was solely on voluntary sterilization, AVSC focused on only five of the six elements in the framework; continuity of care has not been an issue in sterilization, a one-time procedure that does not require further interventions. With its expansion into other surgical methods, e.g. IUDs, NORPLANT, and postpartum contraception, however, AVSC is planning to put further emphasis on this sixth element. AVSC takes a client-oriented approach to quality of care activities. Their view of quality of care could be characterized as providing the best services possible in view of the local context, including resources, medical structure, and policies. AVSC does not have a single definition of quality of care; instead, quality is viewed as a dimension of programs, something which projects strive to reach. Medical quality, for example, is viewed in terms of the level of medical care in each country. AVSC hopes to improve medical care through their projects, if such improvement is necessary, and to try to reduce the obstacles to services.

CARE is also emphasizing quality of care in its new family planning project. They have adopted the Bruce framework and are designing projects with a focus on the client perspective.

CEDPA noted that they use an expanded Bruce framework. They have added management infrastructure, effectiveness and impact because they believe that quality of care cannot be considered from a client perspective alone.

Enterprise viewed quality of care as providing accessible, quality-centered family planning services to clients, based on the assumption that patients who receive quality services will be more satisfied and will be long-term users of family planning. Quality of care was integral to all services rather than a series of separate activities.

For IPPF/WHR, "quality is defined as a property which all programs exhibit, rather than a particular standard to be reached. Setting the appropriate level of quality is key" (Helzner, 1991:5). For IPPF/WHR, the six elements (including the variation on the sixth element suggested by the Subcommittee on Quality Indicators: appropriateness and acceptability of services rather than appropriate constellation of services) define quality of care.

Pathfinder believes that the interaction between the client and the provider is the key element in quality of care. It includes all six elements of quality of care in its activities and has added a seventh: the interaction between donors and service providers. Pathfinder notes that donors have a role to play in helping organizations provide better services and that the dynamic relationship between donors and service delivery organizations can affect the quality of service provision. It maintains that the current framework implies that donor organizations (in this case the CAs through A.I.D. or other funding agencies) provide services, and that this is inaccurate.

SEATS conceptualizes quality of care as the package of services that is provided to the client: informed consent; maximum choice; information in a form that the client can understand and that facilitates informed choice; counseling that facilitates the making of an informed choice; and facilities that support provision of safe, clean services in a culturally sensitive way.

SOMARC, which does not provide clinical services, uses all elements of the Bruce framework except "constellation of services." With regard to the latter, however, they do make referrals depending upon who the implementing agency is and which family planning organizations are available to provide information and services.

Table 1. Quality of Care Elements in Cooperating Agency Activities

Elements of Quality of Care	AVSC ¹	CARE ²	CEDPA	ENTER-PRISE	IPPF ³ /WHR	PATH-FINDER	SEATS	SOM-ARC
Choice of methods	X	2	X	X	X	X	X	X
Information to users	X	1	X	X	X	X	X	X
Technical competence	X	2	X	X	X	X	X	X
Continuity of FP care	*	2	X	X	X	X	X	X
Interpersonal relations	X	1	X	X	X	X	X	X
Constellation of services (appropriateness and acceptability)	X	3	X	X	X	X	X	
Inputs provided to service delivery organizations from donors						X		
Management			X					
Infrastructure			X					
Impact			X					

¹ AVSC will start working on continuity of family planning now that they are expanding from sterilization services to IUDs, NORPLANT and postpartum contraception.

² CARE has ranked the emphasis they will give to the components of quality of care in their projects (1 represent the highest priority).

³ IPPF/WHR has relabeled constellation of services "appropriateness and acceptability."

3. ASSURING QUALITY OF CARE

"Ninety percent of quality of care is big brother."

"Without management commitment to quality, a good provider is up a creek."

Staff, Cooperating Agencies

CAs indicated that quality of care activities are not new to their organizations; an important premise of A.I.D.-funded projects over the years has always been to provide high quality services. At present, CAs view quality assurance as a set of activities to address the components of the Bruce framework, which should have an outcome of enhanced quality services for clients and more satisfied clients.

The goal of CA activities in quality of care is to instill in service providers and managers the notion of client-oriented services. The process of quality assurance should involve service providers (including all staff) taking a critical look at their programs and taking measures to correct areas of weakness. The outcome should be enhanced quality services for clients. CAs stress that quality of care activities are best generated from the field, lest they are perceived as being imposed from above.

There are a range of activities common to all or most of the CAs to assure quality of care. At the same time, the CAs are developing different overall approaches to quality assurance and each CA has its own distinctive emphasis. Generally, their approaches to assuring quality of care fall into the following categories: grass roots; management/medical monitoring; method-specific/stage of program; and information and training. These are not exclusive categories and elements of each can be found in the work of all the CAs. Also, since this is not an evaluation, analysis of the strengths and deficiencies of the various approaches is beyond the scope of this report. Thus, the purpose in this section is not to assess the various approaches nor to discuss each and every CA activity related to quality of care, but rather to highlight general characteristics and trends.

Common Activities to Achieve Quality Assurance

Activities common to most of the CAs include:

- Development of guidelines,
- Production of educational materials,
- Provision of materials to users,
- Training, and
- Activities to enhance client orientation.

Guidelines. All of the CAs have been particularly productive with respect to the development of general quality of care and/or medical guidelines. Among them, they have produced at least ten different guidelines, such as those that focus on a particular topic like AVSC's informed consent and voluntary sterilization and Pathfinder's client-responsiveness, those that emphasize the medical aspects of quality of care (Enterprise, IPPF/WHR and Pathfinder), and those that emphasize training and contraceptive safety (SOMARC).

Educational Materials. All of the CAs provide educational materials to be given clients at service sites. Enterprise provided resources and address lists to their projects with contacts in the information, education and communication (IEC) area. It also helped its employment-based projects develop their own materials. AVSC has developed a resource book for prototype materials on all methods to be adapted to local conditions. They reach illiterate clients with counseling and pictorial materials. Pathfinder emphasizes the need for culturally appropriate informational materials and ensures that materials are available in local languages and appropriate for the client level of education.

Training. All the CAs provide considerable training which is guided by the components of quality of care. Enterprise provided training by funding it through JHPIEGO and AVSC. CEDPA intends to use quality of care workshops integrated with other training to train their staff in quality assurance. Pathfinder has a wide range of training activities: long-term training for doctors and nurses, training of trainers, and counseling training in which role-playing is frequently used to develop practical counseling skills.

Client Orientation. All CAs take various steps to enhance the client orientation of their services. For example, counseling is considered vital in AVSC projects, which grew out of its interest in ensuring informed choice for sterilization. AVSC was involved in some of the first

client follow-up surveys to measure informed choice. CEDPA emphasizes the importance of a woman to woman approach in counseling. IPPF/WHR uses client satisfaction studies and counseling skills training. For Pathfinder, the programs run by women's groups tend to be the most client-oriented and they work with grantees to promote privacy and confidentiality especially in Islamic countries like Egypt, Pakistan and Bangladesh. Funds are included in project design for curtains or partitions.

Approaches to Quality Assurance

Despite the commonality of many of the activities the CAs engage in to ensure quality of care, their overall approaches to assuring quality of care are somewhat diverse. Nevertheless, their approaches generally fall into four categories:

- Grass roots;
- Medical/management monitoring;
- Information and training approach; and
- Method/stage of program approach.

These are discussed below.

Grass Roots Approach. A grass roots approach is defined as one in which quality of care plans, indicators, and problem identification is undertaken primarily at the field level by subproject staff.

SEATS staff emphasize that their quality of care approach has been informed by two principles: (1) continuous assessment by providers--to avoid the notion that "every six months there is an inspection;" and (2) grass roots--to avoid a top-down, investigative, punitive conception of quality of care.

Under the SEATS approach, the entire team at the service delivery site--the doctor, nurses, midwives, and fieldworkers--selects one quality of care problem to focus on each month, such as number of post-IUD infections. One person is then assigned to count the times this problem occurs each month and examine the data that the team agreed would be gathered for documentation. The staff person is required to examine the reasons for the occurrence of the infection: bad luck? bad technique? or other? and to report the results of the assessment at a staff meeting. Subsequently, the staff must reach a conclusion about the problem, formulate a recommendation and develop an action plan to address the problem. Once a satisfactory level of achievement is reached in that particular element of quality of care, providers move their focus to the next element on their priority list, beginning the cycle anew.

The key element of the continuous assessment system is that problem identification and resolution are provider-generated. The role of "outsiders," if any, is in providing support materials (e.g., sample patient flow analysis, modules on counseling or MIS etc.) and initial or periodic service training in areas identified by providers.

The difficulty with the approach, as one SEATS staff member pointed out, is that "it involves the one thing not common in developing countries: different cadres of people communicating with each other. The trick will be to get people to understand that assessment and improvement does not have to involve blame and attribution."

One observer commented that the SEATS approach differs fundamentally from most approaches to quality of care. "In the final analysis, most approaches all come down to having an expatriate walk around a clinic with a clip board, fill out a form, write a report, send it off somewhere and then nothing happens." To date, eight service delivery sites in Togo are implementing the grass roots, continuous-assessment-by-provider model.

CEDPA also uses a grass roots approach, but there is considerably more emphasis on an annual monitoring process. CEDPA's basic principle is that the definition of quality of care issues must be developed from within the subproject. It is a key responsibility of management who, in turn, work with their staff to assure quality of services.

CEDPA plans to use a process which is based on subproject self-assessment, and the integration of quality of care objectives into subproject annual implementation plans or the development of Quality of Care workplans. CEDPA subproject staff will use two matrices CEDPA has prepared to develop their own implementation plans or workplans. (The draft matrices are presented as Attachment 3 and discussed in the next section.)

The annual monitoring process will begin with a Workshop on Quality of Care (Month 1). CEDPA-funded subproject managers will attend the workshop to identify quality of care issues and develop workplans. In Month 2, subproject managers will identify specific quality issues with their own staff and develop measurable objectives and action plans to improve problem areas. In Months 3-10, CEDPA will provide assistance (TA, training or additional resources) to help subprojects implement their plans and also conduct a quarterly review. In Month 11, CEDPA will conduct a follow-up assessment to examine progress in implementing the action plans. And in Month 12, the Annual Quality Workshop will be held. Results of the entire quality of care process will be discussed at this workshop and second year action plans will be developed.

AVSC has developed the COPE (Client Oriented, Provider Efficient) system to help local service delivery sites to assess and improve the quality of their services. The COPE system is discussed in Section 4.

Medical/Management Monitoring. A medical/management monitoring approach to quality of care is defined as the setting of medical and other quality standards by management (standards that may or may not be adapted to local conditions) and monitoring the adherence to these standards through project reviews and site visits.

The Enterprise approach to quality of care underwent a pronounced evolution over the life of the project. The process began with a "medical monitoring" orientation, the establishment of a Medical Review Committee and the development of both general quality of care and medical monitoring guidelines (see the bibliography). It culminated in the development of an integrated framework/matrix (discussed in the next section) for assessing and operationalizing improvement in diverse dimensions of service delivery. From the outset, "medical monitoring" included such non-medical perspectives as adequacy of facilities and equipment, efficiency of clinic operations, effectiveness of counseling and communications and degree of client satisfaction.

The matrix, involving more than the medical aspects of service delivery, was not field tested prior to termination of the Enterprise project (Enterprise staff hoped that SEATS might undertake this effort). Thus it is appropriate to describe Enterprise's quality of care approach during project implementation as a medical/management monitoring approach. Enterprise partially implemented a quality of care approach from a clinical perspective; medical advisors were involved in all aspects of subproject development and implementation. During project identification, the Medical Review Committee would undertake a technical medical review if they believed such a review was warranted. During subproject development, they would review all service delivery proposals and conduct site visits and/or proposal review of sterilization and temporary method and IUD subprojects. During subproject implementation, for the type of subprojects just described, there would always be an on-site visit by a member of the Medical Review Committee.

An important element in Enterprise's approach to quality of care involved the belief that **managers** have to understand and be involved in quality of care and be provided with and trained in the use of management tools to ensure quality of care in their clinics. While Enterprise did not promote a top-down, inspection style approach, they believed that "without management commitment to and involvement in quality of care, even a good provider is up a creek."

AVSC also relies on strong medical monitoring to assure quality of care. They provide service delivery guidelines which are to be adapted to local conditions. AVSC staff conduct medical site visits through a decentralized system designed to devolve responsibility by developing medical oversight capabilities in regional offices and within countries. There are periodic visits by project supervisors, AVSC staff, consultants, and reviews of complication reports. AVSC has designed client record forms to highlight variables indicating practices and experiences that could influence quality. They view client record forms as essential for keeping service providers knowledgeable about the client's history, treatment and need for follow-up. Project assessments also examine client flow and the nature of clinic facilities.

Information and Training Approach. An information and training approach is one that gives particular emphasis to the training of providers and staff at the local level in various aspects of quality of care (usually implicitly rather than explicitly) and the provision of accurate information to clients/consumers.

SOMARC's seven years of experience in social marketing strongly reflects this information/training approach. Their quality of care activities are targeted to the retailer and to the consumer. Their goals are as follows.

1. Provide correct information to the retailer. SOMARC staff believe that one of the most important quality of care elements in their program involves influencing the type and quality of information received by consumers when they purchase a contraceptive product from the retailer. Thus, SOMARC trains all retailers involved in the program, primarily pharmacists, pharmacists' assistants and sales assistants. The objective of the training is to ensure that these retailers can provide accurate information and guidance to clients on all types of methods, even methods not included in the Contraceptive Social Marketing (CSM) program such as IUDs and sterilization. Training was initiated in the SOMARC I project. During SOMARC II, given that the project had accumulated substantial training experience and to ensure standardization of training, SOMARC requested PATH to develop a training manual. The manual is entitled *SOMARC FORUM: Contraceptive Safety and Technology, Trainers Guide*. Some of the topics that it covers include: overview of contraceptive technology; contraceptive safety; contraindications, side effects and complications; detailed discussion of all methods except sterilization; interacting with customers; and, referral practice.
2. Provide product information to the consumer. SOMARC provides information both through the mass media and at point of purchase. At point of purchase, SOMARC ensures that brochures and product inserts (instructions) are available for all methods.

AVSC also emphasizes training as an approach to improving quality. AVSC's 1988-1992 Strategic Plan states "training is fundamental for helping local providers and managers expand high quality and sustainable VSC services." AVSC emphasizes training of trainers and has reinstated the position of training coordinator. AVSC provides counseling training and team training to project staff members as well as orientation to all service providers who have contact with clients. They are trying to institutionalize the capability to provide training locally, so as to focus on cultural perspectives of clients. AVSC's counseling training emphasizes the particular characteristics which make counseling VSC requestors different than for other methods and includes screening for requestors who may be at risk of regret. In addition, they train staff members in the COPE system (discussed in the next section). They have also developed several training films in different languages for different regions which show, from the client's perspective, the importance of privacy.

Method Specific/Stage of Program Approach. This approach, as the name implies, emphasizes that the appropriate type of quality of care activity is best determined by the method used in or according to the stage of the family planning program.

In the view of IPPF, taking a method-specific approach is simply common sense: the nature of the program will determine the quality of care activity that is required. In sterilization programs, for example, informed consent is vital. IPPF/WHR recently surveyed FPAs and reviewed copies of their informed consent forms and all FPAs were found to be in compliance with IPPF/WHR's standards. They also stress that different skills and logistics systems are needed for different service delivery mechanisms. Counseling, for example, is stressed in CBD programs. In addition, they have developed VSC and CBD monitoring systems which include screening mechanisms for clients.

Pathfinder emphasizes elements of quality according to the stage of program development and region. In Africa, for example, where most family planning programs are in the "emergent" or "launch" stage, the emphasis is to improve the technical competence of providers and the constellation of services provided. In Latin America, where programs are more developed, Pathfinder emphasizes continuity of care, technical competence and informed choice.

Pathfinder also takes a method-specific approach to quality of care in that the systems designed for monitoring are more complex for clinic-based programs that offer a full range of methods than for CBD programs. Since CBD programs are Pathfinder's primary service delivery mode, referral is an important element in these projects. Through strong referral systems, clients are referred to other service sites for methods not provided through CBD projects. Where possible, project staff establish formal referral agreements with public sector clinics, private practitioners and other providers to ensure access to a range of methods and adequate medical backup. They also take a method-specific approach in counseling, follow-up and client management.

4. ASSESSING QUALITY OF CARE ACTIVITIES

"You can have every item on a checklist checked off and still have a problem."

Staff, Cooperating Agency

Although activities to enhance the quality of services are not new in CA service delivery projects, it is only recently that they have been characterized by the term "quality of care." This recent label has been accompanied by the CAs effort not only to document quality-of-care activities, but also to assess the outcome and impact of these activities. Assessing quality of care is difficult because the quality of care framework lacks specific operational definitions of the six (or more) components. Moreover, the nature of some of the components, such as client provider interaction, makes them hard to observe and thus assess. The Subcommittee on Quality of Indicators did attempt to compile indicators and variables for the elements. The measures developed thus far to assess quality of care are pilot efforts, however, which require extensive field testing for validation.

All CAs include quality of care components in their **project designs** and **regular monitoring**. The language of client-oriented services is built into projects as are the goals of informed choice of methods, technical competence of staff, adequate facilities and appropriate constellation of services. In addition, CAs use and/or are experimenting with **specially developed methodologies** to assess more directly the quality of services. These include special studies, MIS systems, clinic observations, self assessment tools, and patient flow analysis. Table 2 below lists the variety of methods used by CAs to assess quality of care.

While Table 2 presents information on the wide variety of tools CAs use for assessment, the principal assessment approaches fall into four main categories. These are:

- Grass Roots Assessment Approach--AVSC, SEATS;
- Analysis/Feedback/Performance Improvement System--SOMARC;
- Management Tools for Project Monitoring--CEDPA, Enterprise and Pathfinder;
- Multiple Methods--IPPF/WHR and CARE.

While each CA's approach to assessment could be described as involving, to some extent, all or most of the four approaches identified above, it would be impossible, in this brief report, to provide examples of how each CA does this. CA approaches overlap: AVSC, for example, could also be described as using multiple methods, and CEDPA as having a grass roots approach. Instead, this section highlights the **principal approaches** by the CAs and focuses on their **particular contributions** in the area of assessment. These are described briefly below.

Table 2. CA Toolbox to Assess Quality of Care

Quality of care assessment tools	AVSC	CARE	CEDPA	ENTERPRISE	IPPF/WHR	PATH-FINDER	SEATS	SOM-ARC
Regular medical monitoring	X			X	X	X	X	
Regular non-medical monitoring	X	X	X	X	X	X	X	X
Project Design stage	X	X	X	X		X		
MIS (service statistics, method mix)	X			X	X	X	X	
Matrix assessment			X	X		X		
Client records	X			X	X	X	X	
Voluntarism/informed choice	X							
Continuous quality assessment							X	
Minimum Indicators Quality Worksheet						X		
COPE	X							
Patient Flow Analysis	X				X			
Direct observation	X		X	X	X	X	X	X
Clinic monitoring system					X			
Evaluation studies	X	X	X		X	X	X	X
Client satisfaction and acceptability studies	X				X	X	X	
Mystery client (or shopper) studies					X			X
Continuation/discontinuation studies					X		X	
Client intercept studies								X
Panel studies								X

Grass Roots Assessment Approach

AVSC has developed the COPE (Client Oriented, Provider Efficient) approach to help evaluate and improve family planning services. The COPE approach involves all clinic staff, rather than just the manager or doctor. It is locally generated rather than being externally imposed. COPE involves (1) a client flow analysis; (2) a self-assessment for staff to complete; and (3) a follow-up plan (See Attachment 3).

The client flow analysis, an adaptation of the Patient Flow Analysis developed by the Centers for Disease Control (CDC), and modified by other CAs, is a quick and easy way for managers to find out what is happening in their clinics, once they have been trained in its use. It is a time/motion study that describes both client flow and staff utilization. There is considerable emphasis on analyzing the amount of time that clients spend waiting and the amount of time that the staff is involved in direct provision of services. Specific benefits may include reduction of client waiting time and a more equitable distribution of staff workload. Suggested standards are that clients spend no more than 50 percent of their time waiting for services and that staff spend at least 65 percent of their time providing direct services to clients.

In COPE, the self-assessment is a checklist undertaken by the staff which covers such areas as quality of medical and nursing services, counseling, administration, record-keeping, supplies, the physical building and transportation to the clinic. After the assessment, all the staff sit down to discuss what they found, to problem-solve and to propose recommendations. The follow-up process involves writing up any problem areas that have been identified in the course of the self-assessment or flow analysis and developing recommendations. It also calls for identification of staff responsible for follow-up and dates for completion. These are all noted on large sheets of paper which are left at the service delivery site and constitute the plan of action for that site. The COPE assessment process usually takes about three days.

SEATS also uses a grass roots, "problem solving" approach to improving and assessing quality of care, described in greater detail in the preceding section. Their "continuous-assessment-by provider" efforts will be supplemented by: (1) technical monitoring to be undertaken by regional staff--physicians and clinician trainers; (2) MIS monitoring to analyze method mix, number of staff trained, and CYP, among other topics (the MIS is now being field-tested in West Africa, and is expected to be functional in six months); and (3) evaluation studies--short, focused studies of a particular component of quality of care within selected field projects, most probably undertaken in collaboration with The Population Council or Family Health International.

SEATS staff believe that their capabilities to monitor quality of care are quite good because the project has a higher ratio of clinically trained individuals than most family planning projects. The staff give FPSD credit for designing the project in this way, implying that if the Office of Population wants to ensure quality of care, it must budget for requisite staff during design.

Analysis/Feedback/Performance Improvement System

SOMARC's approach emphasizes conducting studies to provide empirical data to managers, both in-country and in Washington, and using the information to improve quality of care and overall project performance.

The principal types of studies that SOMARC uses are the following.

- Tracking Studies are conducted annually to measure changes in attitudes, awareness, and use of clients. Tracking studies tell SOMARC if they are reaching appropriate target groups, if clients are receiving adequate information, and if objectives are being met.
- Mystery Shopper Studies determine if retailers are correctly imparting product usage information to consumers. A trained individual who poses as a customer and asks questions of the retailer to determine the nature and accuracy of the information he or she is providing to clients. SOMARC believes they were the first development organization to use the mystery shopper methodology, an approach frequently used in developed country marketing research.
- Panel Studies consist of a series of interviews with the same individuals over time and are used to measure behavior change.
- Post-evaluation studies are undertaken after termination of a project to determine if objectives have been met.

SOMARC staff are able to document numerous ways in which information from these studies--especially negative findings--have helped them to improve quality of care.

Post-evaluation studies in Ecuador and Ghana showed that the SOMARC training program produced better-informed retailers than those that did not go through the training program. However, it also indicated important areas where training could be improved (e.g., nearly a third of the retailers believed that pills could cause cancer and sterility). The studies also showed that retailers needed to be trained to volunteer information. As a result of these studies, SOMARC has addressed these issues in its training module.

A tracking study in Indonesia showed that advertising of contraceptives in printed media was ineffective. Therefore, SOMARC reoriented their advertising strategy to include significantly greater radio advertising.

One of the important findings of a Brazil post-evaluation study was that Brazilian manufacturers were not effective in training pharmacy retailers. This led SOMARC to ensure

that manufacturers now work with local family planning organizations. The latter will provide the retailers with education and consumer protection information.

The *SOMARC Handbook for SOMARC Marketing Research* provides useful information on methodologies to assess quality of care, especially on ways to combine qualitative and quantitative research, as well as other topics.

Management Tools for Project Monitoring

CEDPA, Enterprise and Pathfinder have all developed specific management tools to assist with project monitoring.

CEDPA staff have developed two matrices (See Attachment 4): one for CBD; the other for clinics. Each matrix uses all six elements of the Bruce framework and assesses each element according to three variables: the management system; the provider level, and the impact level. Since CEDPA emphasizes that quality of care must be defined from within the subproject, the matrices are to be used by subproject staff to develop a quality of care plan for each subproject. The plan may relate to the elements in the matrix but this is not required. The matrix is to be used primarily to give subproject staff ideas for the questions and indicators they might use to develop their own plan.

Given Enterprise's concern that clinic managers (who are frequently physicians) be committed to and understand quality of care, Enterprise developed a five-page draft matrix (see Attachment 5) which can be used by clinic managers for a relatively quick, qualitative assessment of quality of care in the clinic they supervise. The matrix assesses each of five elements across three dimensions (1) facilities/hardware; (2) service delivery; and, (3) client perceptions. Thus for each element, there are 15 specific areas that a manager could quickly obtain information on. This approach has the potential to involve the manager (if the matrix is used, say, every six months) on a regular basis in assessing quality in his or her clinic and shows the manager very quickly where there are problems. While the draft matrix suggests that there will be a "score" for each element, Enterprise staff stress that the final matrix will not use the word "score:" "We just wanted a way of knowing where you stood compared to other options in the same box." While the word "score" may have negative connotations, managers do need to know whether, for each element, their clinic is offering services that would be considered high, low, or of so-so quality compared to their own previous performance, clients' perceptions, or comparable facilities.

Pathfinder has developed a management tool that has three components to assess quality of care and provide feedback (see Attachment 6). The components are: (1) a checklist on indicators of program quality; (2) a checklist on the staff's background (education and training); and (3) a non-VSC clinical site visit checklist. The latter is designed to help a staff member or consultant requested by Pathfinder's Director of Medical Services to assess quality of care in a Pathfinder clinic. The findings for clinics are written up in a matrix form and are discussed with program staff. A follow-up plan is then drafted.

Multiple Methods of Assessment

Multiple methods, as the name implies, involves an organization's using a wide variety of methods and tools for assessment, rather than one or two principal approaches.

While IPPF/WHR does use a matrix (see attachment 7) to determine whether planned strategies are targeting the priority areas of quality of care (Helzner, 1991), IPPF/WHR stresses the importance of using many different methods. According to Helzner (1991:42), "In theory, it might be possible to find one or more indicators of quality that are comprehensive in scope, and easy to gather data for and to calculate, inexpensive to use, comparable across programs, and inclusive of the perspectives of clients, service providers, managers and donors. But it seems more likely that we will need to settle for a range of special studies and other tools to derive indicators of quality." Thus, IPPF/WHR uses a range of approaches that include the following.

- Patient flow analysis is used extensively to identify bottlenecks and problems in client flow and almost all FPAs in their network have been trained in this approach.
- Direct observation of service sites is employed because this method is easy to use, relatively inexpensive (when conducted by an in-country consultant or supervisor) and can be easily transferred to in-country supervisors.
- Service statistics are used to monitor method mix.
- A computerized clinic monitoring system facilitates the assessment of all six elements of quality of care -- for example, it can facilitate record keeping, statistical reports and analyses of acceptors by method, sociodemographic characteristics of users, and reasons for method switching.
- Client satisfaction and mystery client studies are used to assess the clients' perspectives on a range of indicators.

CARE uses four mechanisms for information flow: daily correspondence; field visits; project implementation reports three times per year; and, evaluations. In addition, CARE intends to choose one country in which to look at quality of care in-depth and to provide information useful for the development of quality of care methodologies.

Other CA Approaches to Assessing Quality of Care

The authors encountered several useful approaches to assessing quality of care undertaken by other CAs during their work on this report, involving the use of innovative methodologies (mystery client studies, contraceptive compliance assessments, and a situation analysis). The findings from these studies, which have important implications for quality of care, are summarized in Attachment 8. The U.S. literature on quality of care was not reviewed.

5. QUALITY OF CARE SUCCESS STORIES?

"The beauty of this approach is that the subproject staff pick the problems, they are involved in measuring, they look at the data and they have to decide what an acceptable level of performance is."

Staff, Cooperating Agency

CAs were asked about their "success stories" in quality of care. Successes included helping to change service delivery guidelines, sponsoring key conferences, designing state-of-the-art service delivery projects, developing assessment matrices and other tools, and training to ensure a client-oriented focus in services. All eight CAs agreed that successful quality of care projects involve a joint effort among project staff, field staff, and headquarters staff.

AVSC cited several examples of successful efforts to improve quality of care. In Bangladesh in the late 1970s, clients were dying during sterilization operations due to over-sedation. CDC diagnosed the problem, and AVSC helped develop new anesthesia guidelines, as well as other service provision guidelines. As a result, Bangladesh now has an excellent anesthesia regimen and is faithful in reporting complications and deaths. The death rates were reduced considerably. In Brazil, AVSC worked to get the system for sterilization of medical equipment and instruments changed from use of ultraviolet light. This success goes beyond family planning since the Ministry of Health produced guidelines regarding appropriate sterilization of equipment and other medical practitioners in Brazil changed practices regarding the use of ultraviolet light for sterilization purposes. In the early 1980s, AVSC was instrumental in showing the importance of good counseling, especially for clinical methods, and introduced the notion of informed choice in family planning. In addition, AVSC has initiated the COPE system for assessing quality and has used it successfully in 17 countries.

CEDPA staff commented that they do not have any success stories yet since they are just beginning their quality of care efforts. Quality of care is most notably linked, in their view, with good training, excellent management, and qualified and motivated staff. They have a number of CBD projects which provide high quality services. Formal assessments of these projects will be undertaken in the future to document their success.

Enterprise staff cite the conferences that they conducted with Egyptian physicians as one of their most important quality of care success stories. Through site visits, Enterprise staff became aware that quality of care in the Egyptian clinics, to which Enterprise was providing technical assistance, was an issue. "We saw a lot of not so great treatment of women in the clinics...not fully answering questions...doctor knows best...not being gentle in a pelvic exam...". Enterprise staff explained that rather than address these issues directly, as explicit quality of care issues,

they addressed them in the context of management for quality (together with management for efficiency).

Thus Enterprise developed a two-day course, "The Family Planning Physician as a Manager," which was taught by a management expert and a medical monitor. An Enterprise staff person observed, "We spent a lot of time on the patient care dimension and the need for full information. We tried to slip these things into management aspects. We know it was well-received because people liked it, remembered it and requested updates."

IPPF/WHR considers the extensive use of Patient Flow Analysis in the region's FPAs to be a success story in quality of care. In addition, the MIS system they have devised should yield useful information for monitoring quality of care. In Uruguay, the FPA's new director recently decided to make quality of care the overriding philosophy defining the goal of the association. The FPA provided training in quality of care; if staff were not comfortable with the new direction of the organization, they were free to leave. Those staff who remain have developed a new team spirit. They have developed a new client history chart including quality of care indicators. With evidence from a patient flow analysis, they have shut down the old clinic and opened a new one, which has been open for one year. It is too soon to say whether the new quality of care philosophy has made a difference.

The quality of care assessment tool used in Jordan and Egypt (discussed in Chapter 4) is an example of a Pathfinder success story. In addition, Pathfinder's work in Egypt with the Clinical Services Improvement Project (CSI) is an example of the work Pathfinder tries to undertake in all their projects. Pathfinder projects seek to improve organizational structure, management systems, job descriptions, clinical and management training, quality assurance, and logistics systems. Most projects, however, do not have the resources that are available to the CSI project in Egypt.

SEATS staff believe that their Togo conference on Quality Assurance in Family Planning Clinics in the Developing World should be considered their first success story. The conference was attended by SEATS staff, representatives of the Togolese Ministry of Health and Family Planning Association (ATBEF), and regional representatives of several collaborating agencies (CARE, INTRAH, AVSC, and Pathfinder).

A major purpose of the conference was to assist participants to develop the tools that they felt would be necessary to develop quality assurance programs in their clinics. The conference facilitator asked participants to: (1) identify those particular elements in family planning programs that ought to be assessed in terms of quality (such as client perspective, complications such as infections, or facilities); (2) identify indicators, meaning the data that they would collect on the elements identified in step one, to show quality of care trends (progress or lack thereof); (3) specify how the data would be collected and how it would be reviewed and analyzed so that the clinic staff could reach conclusions about quality of care in the clinic. The overall purpose of this exercise was to assist participants in using new concepts and tools to construct quality

assurance systems on their own. The most important outcome of the conference was establishing indicator-based, locally-enacted quality of care programs in eight service delivery sites in Togo.

One SEATS staff member commented that in most developing countries there is no understanding of why service data are collected and the data are rarely used for management purposes. "The beauty of this approach [assisting participants to develop their own quality assurance systems]," she commented, "is that subproject staff pick the problems, they are involved in measuring, they look at the data, and they have to decide what an acceptable level of performance is." Despite emphasis on clinic staff deciding upon an acceptable level of performance, all SEATS staff noted that the SEATS approach would be implemented in conjunction with international standards for quality of care.

SOMARC staff cite the following as their success stories. 1) Analyses undertaken in the Dominican Republic, Egypt, Morocco, Ghana and Indonesia demonstrate that quality of care in these programs is very good. The studies contain empirical data that demonstrate high levels of client awareness, and good product information. 2) SOMARC's methodological innovation of the mystery shopper can be used to evaluate quality of care in many different types of programs.

Two examples from Egypt, documenting program success, are summarized briefly below.

Egypt Panel Study: Continuation and Discontinuation. Since it is often assumed that a family planning clinic provides the best setting for counseling clients, SOMARC staff wanted to know if a social marketing program could do as well in providing high-quality service as a clinic-based program. To address this question, SOMARC initiated a panel study which was conducted by the Egyptian social marketing program, Family of the Future. The overall study tracked 1,496 women over a two year period starting in 1985 and analyzed the experiences of 735 women who reported using the pill. Fifty percent of those who obtained their pills from pharmacies were still using this method after two years compared to 36 percent who obtained their pills from clinics. Women who used both clinics and pharmacies had the highest continuation rates--66 percent (possibly because these sources complement each other well, with clinics providing in-depth counseling and pharmacies providing quick and easy supply, or this group of women might be more determined users). The percentage of women who stopped using contraception altogether was about the same for pharmacy and clinic users--8 percent--and somewhat lower--4 percent--for those who used both sources. Thus this study shows that contraceptive social marketing programs can use commercial outlets to provide good quality family planning services.

Egypt Panel Study: CSM Brand Users' Knowledge/Continuation. Another analysis of the Egypt panel study data examined: (1) knowledge of correct use among women who obtained products from pharmacies; and, (2) continuation with the CSM orals brand, Norminest, compared to continuation with other brands. The study found that there were no significant differences in knowledge between Norminest and non-Norminest users. Thus there was no evidence that CSM users are less informed about oral contraceptives than users who obtain their products from other sources. The brand loyalty of Norminest users (for whom the

pharmacy is practically their sole source of supply) was significantly higher compared to users of other brands. Over 67 percent of Norminest users had used the brand the entire two years of the study compared to 47 percent of users of other brands. Thus the concern that women who obtained their products through CSM projects would have higher discontinuation was not supported by the results.

CEDPA staff commented that they do not have many success stories yet since they are just beginning their quality of care efforts. Quality of care is most notably linked, in their view, with good training, excellent management, and qualified, motivated staff. CEDPA has a number of CBD projects that provide high quality services. Formal assessments of these projects will be undertaken in the future to document successes.

6. CONSTRAINTS TO QUALITY OF CARE ACTIVITIES

"Provision of client-focused family planning services is a new philosophy in many countries, and requires a change of attitude of service providers."

"The procurement procedures at A.I.D. have sometimes meant a trade-off between the quality and quantity of commodities."

Staff, Cooperating Agencies

CAs face a variety of constraints in trying to implement quality of care activities. These are discussed below.

Lack of understanding of client-oriented services: Provision of client-oriented family planning services is a new philosophy in many countries, and requires a change of attitude of service providers. Counselors are generally more apt than doctors or other medical personnel to embrace the notion of client-focused services. Moreover, there is often a correlation between the social status differences between providers and clients and the treatment that clients receive. In general, the closer the social status of providers and clients, the better the treatment the clients receive (perhaps paying clients are also treated better). Interventions to change ingrained social attitudes and behaviors are inherently more difficult to do via training than either increasing technical skills or knowledge.

Paternalistic attitudes on the part of the provider, i.e., the notion that the service provider knows what is best for the client, also tend to be a problem. In public sector programs particularly, providers are less willing or able to respond to the needs of clients. Private sector organizations are generally perceived as providing more client-based services. Private voluntary organizations tend to provide better training, better pay, and employ individuals more committed to their cause. Staff turnover tends to be lower in private sector organizations.

Selection of service providers is key to improving interpersonal relations. Generally, the more similar the characteristics of the providers and the clients, the more satisfying the interaction will be. That is why relationships tend to be better in CBD projects.

The main constraint that AVSC faces in assuring quality of care is the traditional medical model of service delivery. It can be difficult to get doctors to speak sensitively with clients and to orient care to their needs and choices rather than medical indications. AVSC observes that it will take time to change the current medical model of service delivery which is physician-oriented rather than client-oriented.

Provider Bias. The constraints faced by AVSC in promoting a choice of methods include vested interests in specific types of country programs, (e.g. a "camp" mentality in the provision of surgical family planning at organized camps) or limitations on other methods, which result in constraints to choice. They observe that methods take on a life of their own, and it takes an active intervention to change the menu of contraceptive choices available in some countries. Providers tend to favor methods they are most familiar with.

Pathfinder also finds that providers are reluctant to offer a range of methods or to facilitate method switching. In addition, doctors generally tend to limit who provides contraceptive services and it is difficult to get them to expand the range of contraceptives that they offer. Pathfinder has worked with doctors in Mexico on a risk analysis to show that pregnancy is a higher risk to women than is the use of any contraceptive. This type of analysis, particularly if it is interactive, can help convince doctors to offer a wider range of family planning methods.

Provider bias could be caused by a lack of knowledge of different family planning methods, possibly due to a lack of training and information or lack of access to commodities. The concept of a client perspective in service delivery under such circumstances is difficult to comprehend.

Restrictive government policies. Import duties and taxes represent one type of restrictive policy. In many countries, agencies and organizations attempting to import contraceptives are required to pay duties and/or taxes. SOMARC cites Uganda as an excellent example of the untiring efforts of the A.I.D. mission director and staff to get this kind of policy changed. After endless discussions, the Ugandan government agreed that contraceptives could be provided tax free through the bilateral project.

Another widespread restriction is limitations on sales of oral contraceptives. Orals cannot be sold as an over the counter product in many countries despite the fact that the risk of dying in childbirth greatly exceeds the risks posed by taking oral contraceptives. SOMARC staff believe that change in this area is possible and cite the example of Ghana (among others). After many discussions, the Ghanaian government finally allowed the country's "chemical sellers" (generally regarded as second class pharmacists because they are only permitted to sell over-the-counter products) to sell oral contraceptives after appropriate training. SOMARC agreed to provide the training and now the "chemical sellers" sell orals as an over-the-counter product.

The range of commodities that Ministries of Health have available can limit the choice of contraceptive methods given to clients. Some Pathfinder projects rely on receiving contraceptive methods from local MOHs.

Overcoming misconceptions and myths. The need to overcome misconceptions and myths about family planning is another constraint, especially for methods which are little known or understood, such as vasectomy. And projects often have to correct misinformation among service providers before clients can be effectively reached.

Each country has certain prejudices and biases about contraceptive methods. Staff have to see what these are and break down myths about certain methods. Mali and Senegal are similar in terms of culture yet have different ideas about the IUD. In Pakistan, methods that cause bleeding are unacceptable. These cultural factors play a key role in how method choice is offered and ultimately accepted. Anti-family planning rumors continue to hamper family planning programs. Studies should be conducted on rumors in countries and materials should be developed to address the rumors.

Supervision There are numerous constraints to good supervision and these too hinder quality of care. Lack of a clear specification of responsibilities of service delivery teams, including staff functions, is a constraint to supervision. To address this, AVSC is developing reference materials on service delivery teams' functions. Also, supervision is often seen as a punitive process, therefore efforts must be made to promote a collegial atmosphere. It is also sometimes difficult to get management interested and involved in supervision, and to get supervisors to put negative comments in writing.

Other constraints to good supervision are lack of training for and transportation of supervisors. Infection control can be a major problem due to lack of training, materials, provider knowledge, and agreed-upon protocols. Adequate supervision can help ensure that infection control measures are followed. Service delivery projects need to do more to impress upon grantees the need for supervision, for example, for commodities. The field needs better methodologies for supervision.

Facilities. While CAs can provide updated equipment and facilities through their projects, it is also important to ensure that staff know how to operate the equipment. Poor use of space or lack of adequate space are constraints faced by many clinics, sometimes due to lack of a clear understanding of how to develop a floor plan. For example, clinic spaces may not have adequate lavatory or private counseling space. In other instances, health managers may want a very highly technical facility which is often not appropriate. In addition, training is often needed to keep clinic facilities clean and the operating space aseptic.

Staff turnover. Turnover of staff in the public sector is generally higher than in the private sector, therefore keeping all staff trained can be difficult. Institutionalizing the training capability locally should help reduce the impact of staff turnover. With staff turnover, the need for training new staff and the need for refresher training for existing staff is constant.

Continuity of Care. AVSC views the need for workable plans for successful follow-up of NORPLANT users and for removal and replacement of implants important to ensure continuity of care.

Perception of Quality of Care as a punitive process. Subproject staff often tend to view quality of care as a punitive process, with the implication that there is something wrong with current methods of service delivery. Quality of care must be presented in a positive light, as a participatory process to improve service provision. If presented this way, funders have a responsibility to ensure that their actions and guidelines reflect this ethic.

Availability of materials and supplies. Many family planning programs suffer from a dearth of materials. The materials that are available tend to include too much text, and are not appropriate for illiterate family planning clients.

In some countries, there is a reluctance to address family planning explicitly in information materials. In many African countries, for example, including Zimbabwe where family planning is relatively advanced, clinics have posters for ORS and nutrition, but none for family planning. Staff are not always trained to introduce clients to written materials. Providers should be trained to make effective use of printed information as well as diagrams and models.

Availability of expendable supplies (e.g. antiseptics, gloves, syringes) is a problem in some countries. Many projects are dependent on Ministry of Health supplies. Many programs need more assistance on commodities from service delivery CAs and their needs may be as simple as shelves on which to store the commodities.

Barriers to Access. SEATS staff observed that in Africa, where most countries are at very low prevalence and infrastructure weaknesses are a major constraint, factors constraining access to services is most often the major barrier to quality services. Efforts to develop appropriate IEC approaches, sensitive counseling skills and good operational service delivery systems are all encompassed within the primary effort of simply making family planning services more widely and readily available to all who wish to use them. Provision of quality care, therefore, is an integral part of the overall thrust to assure that services are available. Emphasis upon quality care at this early stage is clearly well placed, SEATS staff add, for developing service delivery excellence from the outset will probably be easier than attempting to introduce it at a later stage of family planning program development.

Poor Quality Control. Products remain in "storage" for long periods of time. If storage facilities are poor, the product deteriorates. Storage facilities for commodities are not always

good, particularly in small and medium sized projects. Products from storage sometimes get into the market without product inserts and correct usage information. If an old product is in the market, it affects the image of the method.

Quantity or Quality. There is too much attention given to numbers in family planning -- from demographic targets to quantitative methodologies. The field has developed considerably in the areas of macro demographics and micro demographics, but has maintained much of the measurement methodologies from the former. The field needs a better balance between quantitative targets and quality of care.

FPAs, for example, are concerned about emphasizing quality of care in that they worry about being viewed negatively if their "numbers" go down, e.g. their numbers of users and continuers, and their contraceptive use rates.

The cost of providing quality services. In Sub-Saharan Africa particularly, low levels of knowledge among clients require that service providers acquaint clients with all methods of family planning. This process can be time consuming and especially costly if conducted on a one-on-one basis. Since CAs deal with so many different countries (and regions within countries) it is difficult for them to provide written materials in all languages. Projects must depend on personal interaction, which may be more costly. Translation and xerox copying are also very expensive in many countries and represent a constraint to making information available to clients.

Enterprise staff noted that they had 88 subprojects and 11 professional staff to monitor their projects. They found that increasing amounts of technical assistance and monitoring were required to be able to focus on quality of care, but their staff was insufficient for this type of intensive monitoring. Therefore Enterprise focused on developing better monitoring tools to help over-stretched staff address issues of quality.

Donor guidelines and restrictions. A.I.D.-funded CAs must work within well-defined A.I.D. commodities guidelines. Choice of methods is hampered by A.I.D.'s inability to offer certain methods, such as Depo provera, which is popular in many countries.

Also, A.I.D. has to bid for its products every few years. However, there is no guarantee that the same company will win the contract every time. Since each company has its own line of product and formulations, consumers and organizations are forced to switch products when a different company wins the contract. This is what happened when A.I.D. switched from Syntex to Wyeth. This is one reason that SOMARC tries to work with products already in the markets and not depend on A.I.D. supplies. By using commercial products there is a higher degree of continuity.

SOMARC staff noted that they are under pressure to increase CYPs but that they are allowed to work only with pills, IUDs, condoms and vaginal tablets. An important quality of care element--

expanding choice of methods--is hindered by the fact that although injectable are a very popular method and approved locally in many countries, SOMARC, as an A.I.D. CA, is unable to supply this method with A.I.D. funds. SOMARC can work with injectables if they are available in the country but cannot use A.I.D. funds to purchase them or promote them directly. SOMARC (and other CAs) would be able to greatly increase its CYPs if it could offer injectables.

Finally, past experience has emphasized long-lasting methods over more temporary ones; programs thus do not always provide a full range of methods. For this reason, local organizations are skeptical of the idea that they are being encouraged by A.I.D. through CAs to provide a choice of methods.

Cooperation among CAs. AVSC has several subcontracts with PATH to develop materials, and they are sharing their prototype materials with PCS and other CAs. Yet such cooperation among CAs, while useful, is not always consistent. Materials developed by CAs are more likely to be accurate and complete if reviewed by other agencies, particularly those with the needed technical expertise. Information task forces are helping to minimize duplication of efforts, but more work is needed to coordinate efforts by information and service delivery CAs.

Better coordination among the service delivery CAs and the training CAs would help service delivery projects. For example, in the 1980s, some training CAs were ignoring sterilization in their training programs, under the assumption that AVSC was responsible for sterilization training. AVSC is now working with a variety of training CAs to include sterilization in their own training programs.

More collaboration is needed between logistics and service delivery CAs. A.I.D. thinks that the FPLM project, which has a mandate to help track commodities, can cover all the logistics needs, but in fact the service delivery CAs should have more logistics staff to provide training and TA in commodity management. Tasks would include 1) monitoring to ensure that the right commodities get where they need to go; 2) monitoring the use of the commodities; and 3) providing TA as deficiencies in commodities and logistics systems are discovered.

Lack of trained CA staff. Constraints are also evident when non-family planning staff are required to monitor quality of care. Enterprise staff, for example, include those with family planning backgrounds and those with business backgrounds, yet every one was required to monitor private sector service delivery subprojects and the project was committed to instilling an emphasis on quality of care among all staff.

7. RESOURCES FOR QUALITY OF CARE ACTIVITIES

CAs provided information estimating the human, fiscal and managerial resources that they allocate to quality of care. It is extremely difficult to disaggregate level of effort and resources currently expended on quality of care because quality of care activities are integral elements of country or program budgets. Estimates may be as low as 3-5 percent of total project expenses if one includes only activities such as patient flow analyses, staff time, and/or in-country activities. On the other hand, estimates may be as high as 30-50 percent if one includes research studies, materials, training, technical assistance, and selected service delivery activities.

AVSC estimates that approximately 28 percent of its program budget is related to quality of care activities. AVSC estimates that an additional 5-10 percent of the program budget would enable it to undertake and evaluate new approaches, and build up capacity to ensure quality of care, particularly at the field level. The additional funds would finance: client surveys, to learn more about client preferences, interests, and perceptions of quality of care in voluntary surgical contraception service sites; surveys of service providers, to learn more about their attitudes, expectations and constraints regarding client-oriented services; professional development for medical staff in the regional offices (some of whom have programmatic responsibilities); and, introduction of the COPE self-assessment approach to regions other than Africa, and dissemination of results. The COPE approach, which is being tested throughout Africa, is currently being funded with AVSC's private funds.

CEDPA is uncertain about the level of resources that they will devote to quality of care since these activities are just getting underway.

Enterprise staff thought that perhaps 10 percent of the entire program budget was spent on quality of care activities.

Approximately 3-5 percent of the IPPF/WHR Matching Grant budget is being spent on identifiable quality of care activities, such as studies, patient flow analysis, staff time, and in-country activities. No estimate was available as to the percentage of IPPF funds from other (non-Matching Grant) sources devoted to quality of care. IPPF/WHR roughly estimated that doubling the amount dedicated in the Matching Grant budget to 10 percent of project expenditures might be sufficient. For IPPF/WHR, additional funds would support: medical staff; grants for evaluation studies; documentation of activities already taking place; meetings on quality (regional, e.g., for medical directors, evaluation officers, etc., and country-specific, for service providers at all levels); and, studies concerning the development of indicators on quality of care.

Of the Pathfinder budget, 60 percent goes to field projects. An estimated 10-20 percent is allocated directly to quality of care activities. Pathfinder estimates that the additional activities (special quality of care activities and assessments) would require an additional 5 percent of project funds. Pathfinder estimates that the additional funds would support special studies on quality of care; more money for general evaluation; mechanisms for longer term follow-up of clients (e.g. 2-3 years); and, staff for logistics improvement.

SOMARC provided information on their overall research budget, since subproject research provides considerable information about quality of care in their subprojects. Staff estimated that research constitutes approximately 30 percent of each country budget. If one adds training, cost of point of purchase materials and product inserts, all of these activities (including the research) might total 50 percent of the country budget. SOMARC would expend additional funds on panel studies, which are very expensive.

SEATS staff estimate that they might spend five percent of the total budget on quality of care activities, although such estimates are difficult to make. SEATS has a special category which collects level of effort and expenditure data on technical activities specifically related to the methodology of developing the continuous quality assurance approach. Specific quality of care inputs or activities at the field level are not disaggregated in this way.

8. FUTURE QUALITY OF CARE ACTIVITIES

CAs were asked what future project activities they plan to undertake to enhance quality of care in service delivery programs.

AVSC will continue to refine and implement new approaches related to quality of care (such as COPE), particularly those related to informing clients, decentralizing and improving medical monitoring and surveillance, training, and delivering client-oriented services. In addition, the element in the quality of care framework which has not been a priority for AVSC but is now is continuity of care (which will be more important for women using NORPLANT and the postpartum IUD than has been the case for sterilization clients). In addition, future activities will be increasingly geared to evaluation. AVSC plans to evaluate what they are already doing regarding quality of care, find out what clients think about and want in VSC services, assess needs, and test new interventions.

In addition, AVSC would like to do more in the area of improving interpersonal relations between service providers and clients. AVSC is expanding its counseling initiative to work with a wider range of clients, including men, people at risk of AIDS, and postpartum women. They also plan to review the medical staff infrastructure at AVSC and continue to decentralize medical monitoring. As AVSC becomes more involved with technical assistance and new technologies, additional technical staff may be needed. In addition, AVSC plans to expand the use of COPE.

CEDPA plans to conduct a Quality of Care Workshop, possibly in Egypt, in the fall of 1991. A major purpose of the workshop will be to assist managers in establishing quality of care plans in their subprojects, using the CEDPA matrices.

IPPF/WHR would like to increase medical staffing and enhance supervision. Currently the office has no medical officer. They would also like to include quality assurance officers in FPAs. They would like additional funding to provide to associations for quality of care studies. In September 1991, IPPF/WHR and the Population Council's INOPAL project hosted a meeting of FPA evaluation officers to provide them with tools to evaluate quality of care. This meeting will be followed by technical assistance visits, where needed, and input from IPPF/WHR staff to FPAs.

Pathfinder plans to select two countries in each region to conduct in-depth studies to measure impact and examine process indicators. These studies will focus on several issues: quality of care, demographic impact on target population, cost of services, and client satisfaction. Pathfinder would also like to increase its commodities staff. Quality of care needs to be viewed within Pathfinder as a measure of performance. Output indicators to measure the impact of

quality initiatives need to be developed, recognized and reported. Financial resources need to be allocated specifically on quality of care activities.

SEATS future activities will involve assessing and refining their approach to quality of care and integrating it into 15 low prevalence country programs.

SOMARC would like to undertake additional panel studies. As one staff member commented, "It would be useful for the system to do more panel studies because they are long-term and they give answers to questions you can't usually get...information on problems accessing the pill, side-effects, switching and stopping." However, these studies are very expensive. One "three-wave" study (three sets of interviews of 2,000 clients over possibly two years) costs approximately \$100,000.

9. RECOMMENDATIONS OF THE COOPERATING AGENCIES

"No group could help or hinder quality of care more than FPSD. People in the field tend to listen to them in terms of what is valued in family planning service delivery."

"I think it would be wonderful if someone said: 'these are the brochures you guys need to send out' ... if someone sifted through and figured it out...the field is always asking for more information."

"There needs to be a place to go for A.I.D.'s bottom line on quality."

Staff, Cooperating Agencies

Some of the major suggestions that CAs had in this area include the following.

Develop general quality of care guidelines. All of the eight CAs stated quite emphatically that it would be very helpful to them if FPSD developed some sort of quality of care guidelines that they could flexibly adapt to their work, and guidance on what is expected of them in the area of quality of care, particularly regarding contractual obligations. There were a variety of suggestions on how this might be approached. One CA noted that the materials on quality of care are scattered, extensive and uneven. It would be extremely helpful if the Office of Population would go through all of these and select the best examples. The Office of Population needs to be sensitive, however, to what CAs can be responsible for in their projects regarding quality of care.

Another CA noted that they don't need standard guidelines but they do need an accepted body of information. Moreover, it would be helpful to have more skills-building orientation sessions at the CA meeting. "There needs to be a place to go for the Office of Population's bottom line on quality." It would be helpful if the Office endorsed certain organization's materials as "the most useful" in particular areas.

One staff member observed that the Bruce framework is a good starting point but, "How are you going to implement and monitor it? What is each person going to do at different levels? This is what we've tried to do in our framework." Quality of care continues to be narrowly defined as client care. The concept should be expanded to include allocation of resources and appropriateness of project design.

Involve local project staff to assure realistic, field-based guidelines. CAs must be careful with use of staff and consultants so as not to impose U.S. standards on other countries. Quality of care must be a participatory process. We need to learn more about what quality means within a given culture, and particularly, to family planning clients. Local staff need to be involved in defining standards for measuring quality of care, lest quality of care be perceived as a standard imposed by donors.

Develop a resource pool. The Office of Population and the CAs should develop and augment the capabilities of staff and consultants to give country-specific technical assistance in quality of care. It would be extremely helpful if specialists in quality of care were available quickly, perhaps through some sort of IQC mechanism. Perhaps POPTECH could develop a quality of care roster and assign one person on their staff to identify quality of care resources, both individuals and institutions. The Office of Population should provide a forum for the exchange of research findings, evaluation tools and ideas through periodic meetings and a data bank.

Take an historical look. One CA suggested that there hasn't been a sufficient historical look. It would be helpful to know which quality of care elements were essential elements in the early, successful programs (e.g., Indonesia and Thailand). How did quality of care contribute to program success or failure? Individuals who worked in these programs are still around and thus the living memory is still there. Interviews and visits could possibly tease out this information which might be helpful to current family planning programs.

Address policy constraints. The Office of Population should seek ways to be more active in addressing policy constraints. CAs believe that while the OPTIONS and other project efforts are useful, the Office of Population could be more proactive in the policy area, for example, by getting mission directors more involved and putting more pressure on governments. It is also important for FPSD CAs to be involved in the policy arena to influence service delivery policies, of Ministries of Health, for example.

Ensure continuity of products. Frequent changes of product disrupts the program. Quality would be enhanced if CAs could be assured that whatever product they are working with would not change during the life of project. The Office of Population needs to pay attention to the decisions made day to day within the Office on the number and variety of methods made available to programs worldwide. There tends to be a lack of long-term planning for commodities, and for phasing-out mature countries such as Mexico and Brazil. Better coordination among donors and better strategic country plans would help ease the commodities bottlenecks and shortages which currently exist.

Modify evaluation criteria. CAs are currently evaluated on CYPs delivered. However, this approach does not provide any information about quality of care. CAs' efforts to enhance provider-client interactions, knowledge, availability and technical competence also are critical elements of their work and they believe they should be evaluated using criteria that reflect these areas. The Office of Population does not always recognize the contribution to CYPs of referral by CBD workers for sterilization (a quality of care activity to ensure choice of methods and

appropriate consellation of services.) Another CA that provides the contraceptive gets the "credit" for the CYP. Quality of care needs its own indicators in addition to CYPs, or CYPs need to be shared among CAs.

Study the relationship between quality and impact. The Office of Population should encourage appropriate CAs to examine the hypothesis that investment in quality of care will result in an increase in acceptors and continuing users. There is a lack of consistency in measuring quality of care. The Office of Population should encourage the study of quality of care indicators, and require recipients of A.I.D. funds to report periodically on quality.

Use the CA meeting. The Office of Population should consider using the CA meeting to continue the education process about quality of care. One CA noted that a recent PAA meeting's approach to quality of care presentations was excellent and the Office of Population might consider a similar approach. A number of first-rate papers on quality of care had been solicited and were presented at the meeting. The panel members had been carefully selected and the discussion was extremely informative.

Put more resources into quality of care. In FPSD's strategy, quality of care should be given affirmative action treatment, and funding should be increased to support quality. CAs are trying to integrate it into their projects but they need to have the funding to do this. In addition, quality of care objectives and indicators should be included in project papers, contracts and cooperative agreements.

Work with Missions. The Office of Population should work with the USAID Missions, in particular with Population Officers, to explain and clarify quality of care concepts and how they can affect both client satisfaction and demographic results, and to explain the role of CAs in quality of care.

10. AUTHORS' CONCLUSIONS AND RECOMMENDATIONS

This section includes the conclusions and recommendations of the authors as a result of their discussions with CAs. These conclusions and recommendations are meant to supplement those of the CAs. We have attempted to synthesize themes which emerged as a result of the discussions. The ideas expressed in this section do not necessarily reflect those of the CAs.

CONCLUSION: Quality of Care at the Local Level. Quality of care will enhance impact only if it is an integral element of service provision at the local level. **Local program managers and service providers must be convinced that enhancing the quality of services is important. They are the most important link in the process of providing client-oriented, quality services.** If they are not convinced of its importance, and do not have the tools and skills necessary to provide quality services and enhance the quality of care they are offering, quality of care is not likely to be a priority.

While quality of care standards cannot be externally imposed, CAs and donors do have a role to play in assisting local organization to define and adapt quality of care standards, guidelines and activities, and in providing the required quality of care training (through both training and service delivery CAs.)

Recommendation: The Office of Population, and especially FPSD, should encourage CAs to field test and utilize tools and methodologies that they and others have developed, and to work with local organizations to institutionalize their capability to assess, assure and enhance quality of care in service delivery programs. Assistance from CAs could include, as appropriate, helping to set quality of care guidelines or standards, designing projects to enhance all components of quality of care, setting up MIS systems emphasizing feedback mechanisms, developing service delivery guidelines to enhance technical competence, develop information and counselling programs to ensure that users are well informed, and train service providers and managers in aspects of quality of care, particularly a client-oriented perspective. FPSD should encourage CAs to document and report on field tests of methodologies and approaches at appropriate fora, such as the CAs meeting.

CONCLUSION: Training in Quality of Care. Present training efforts by Office of Population CAs, such as in management, counseling, and areas of technical competence, are implicitly but not explicitly related to quality of care. The effects of such training on quality of care outcomes have not been examined. Furthermore, some CAs are beginning to conduct explicit training in quality of care (for instance, SEATS and CEDPA are conducting workshops). The outcome of

such training compared to more traditional training to improve quality of care at the service delivery point has not been evaluated.

Recommendation: Since service delivery and training are so closely linked, the Office of Population should examine, at the field level, the nature and effects of quality of care training provided by CAs. How exactly is training in quality of care provided? Have any evaluations been conducted on the outcome of training in quality of care? What is the link between training inputs and service delivery outcomes vis a vis quality of care? Until the Office of Population has answers to these questions it will not know whether and to what extent quality of care is integrated at the local level. Collaboration between training and service delivery CAs should be fostered to ensure that all trainees are exposed to the elements of quality of care, and that quality of care is reinforced in the service delivery setting.

Recommendation: Studies of the effects of traditional training on quality of care outcomes, compared to the impact of explicit quality of care training, should be commissioned by the Office of Population.

CONCLUSION: Constraints to Quality of Care at the Country Level. Constraints to quality of care (host country and A.I.D. policy, regulatory, developmental, manpower, and institutional) vary by country. To address quality of care, the Office of Population and CAs need to understand and identify the specific constraints in each country.

Recommendation: The Office of Population should initiate a series of country-level reviews of constraints to quality of care, perhaps in the BIG countries. One purpose might be to distinguish between constraints which might be addressed through policy dialogue, and those which require additional resources or training to address. To start, the Office of Population should develop two or three country specific action plans to address these constraints, perhaps beginning in demographically important countries.

CONCLUSION: Putting Quality of Care in a Positive Light. CAs agree that quality of care should be couched in positive terms, but assessments sometimes come out with a negative twist. For example, in one assessment tool for quality of care, clinics are rated poor, adequate and good. In the write-up matrix, the final column is titled, "Comments on negative evaluation." The assessment is intended to be a positive experience, but still, it sounds more punitive than positive.

Recommendation: Donors and CAs should be careful to avoid using negative notation when discussing quality of care with local organizations.

CONCLUSION: Documentation of Quality of Care Activities. Information on the strengths, deficiencies, lessons and effects of various approaches to quality assurance and assessment at the field level is limited. Documentation of quality of care activities in family planning is uneven, in part, because many CAs like SEATS, CEDPA and CARE have only recently begun activities in service delivery, and because they do not always have the time and resources to adequately document and assess such activities. Because it is hypothesized that quality of care is a critical element linked to program impact, it is imperative that quality of care activities be documented and systematically assessed.

Recommendation: The Office of Population and the CAs should initiate a series of studies of quality assurance and assessment activities at the field level. Also, the Office of Population should encourage partnerships between research and service delivery CAs to plan operations research activities, assessments, and documentation of the process of improving quality of care.

Recommendation: The Office of Population should encourage the documentation of quality of care activities by initiating and supporting a *Works in Progress* series or a new journal specifically devoted to quality of care. Documentation might include results of studies, descriptions of activities, success stories and failures, discussion of issues and constraints, strategies for problem solving, or presentation of new assessment tools and methodologies. The Office of Population would, in this way, provide a locus for professional dialogue on quality of care.

CONCLUSION: Definition of Quality of Care. Careful thought needs to be given to the differences between quality of care as an **outcome** and as a **process**.

Recommendation: CAs should analyze their working definitions of quality of care and differentiate between the outcomes they expect from their quality of care activities and the process of improving and assuring quality of program elements. Perhaps the Office of Population's new evaluation project could assist CAs in identifying the process and the outcome indicators they find most practical and relevant for subproject quality of care assessment.

CONCLUSION: Handbook on Quality of Care Assessment and Assurance Tools. Because the formal study of quality of care (in international family planning) is relatively new, methodologies and assessment tools to study quality of care are also new. Neither Pathfinder's assessment tools nor AVSC's COPE system are sufficiently documented, for example, and Enterprise's matrix has never been formally released. CAs use client satisfaction surveys, but each CA uses a different methodology, and not necessarily the same questionnaire across countries. Standardization is not required but assessment of the usefulness of the various approaches, tools and methodologies is.

Recommendation: All instruments developed to date to measure or assess quality of care should be documented and referenced and made available to CAs. A working group could evaluate these instruments, perhaps with assistance from research CAs. The Office of Population should commission a Handbook of Quality of Care Assessment and Assurance Tools. The handbook would provide information on diagnostic tools, monitoring approaches, and methodologies, including information on the constraints to using various techniques. The handbook should not be viewed as a one-time effort, but should be updated periodically as new methodologies and tools become available.

CONCLUSION: Usefulness of Other Approaches to Assessment and Assurance. A brief review of other CAs' approaches to quality assurance and assessment undertaken as part of the work for this report indicated that these organizations are developing interventions and methodologies that are innovative and relevant to the work of the service delivery CAs. The CAs should have access to this information.

Recommendation: The Office of Population should commission a review of the family planning quality of care literature. The major purpose of the review would be to identify interventions, methodologies and findings concerning quality of care that would be relevant to the work of the service delivery CAs.

CONCLUSION: Regular Meetings on Quality of Care to Enhance Collaboration.

Office of Population Divisions are all involved in activities that have an impact on quality of care (commodities, information and training, service delivery, research, and policy and evaluation). In particular, service delivery CAs have a lot to share in terms of comprehensive approaches to assessing and assuring quality of care, since their projects tend to include all components of quality of care.

Recommendation: FPSD should convene a working group of service delivery CAs to discuss the results of this quality of care survey, and other future work in quality of care. Also, the Office of Population might consider convening a group of all appropriate CAs to foster a dialogue on quality of care and to enhance Division and CA collaboration. The Office of Population should call for a regular CA meeting on quality of care. The purpose of the meeting would be for the CAs to report on the quality of care activities they have undertaken during the past year and to share ideas for future activities. Or, as recommended by the CAs, this might be done at the CA meeting.

ATTACHMENT 1.

March 1991

Cooperating Agency: _____

Date of Interview: _____

Staff interviewed: _____

QUALITY OF CARE ASSESSMENT SURVEY FOR ST/POP/FPSD

I. General Questions

1. What definition of quality of care does your organization use?
2. How do you operationalize that definition?

II. Quality of Care Elements

1. What elements of quality of care do you emphasize in your programs (e.g. choice of methods, information to users, technical competence, continuity of family planning care, interpersonal relations, constellation of services)?

	Yes	No
A. Choice of methods	_____	_____
B. Information to users	_____	_____
C. Technical competence	_____	_____
D. Continuity of family planning care	_____	_____
E. Interpersonal relations	_____	_____
F. Constellation of services	_____	_____

2. What, specifically, does your organization do in these areas, especially at the field level, to assure quality of care?

A. Choice of methods

1. How does your organization promote choice of methods in your subprojects?
2. What are the constraints your organization faces in promoting a choice of methods? Do the constraints vary by country? By type of program? By program setting (FPSD strategy)?
3. Is choice ever limited by logistical constraints? If so, give examples.
4. Is choice ever limited by policy constraints? If so, give examples.
5. Do your subprojects refer clients to other service delivery sites for procedures they cannot perform or for methods they do not provide? If so, what mechanisms are employed for referral? How do you ensure that referrals take place?

B. Information to users

1. What types of information do your subprojects make available to clients?
2. How is counseling emphasized as an important component in your subprojects?
3. What constraints do your subprojects face in making information available to clients?
4. Are written or other materials made available to clients through your subprojects?
5. Are the materials in local languages?
6. How do you reach illiterate clients?
7. Do your subprojects attempt to reach spouses of clients?
8. What type of training are counselors provided with?
9. What does the training include (knowledge/practical training/the client perspective in service delivery?)

C. Technical competence

How do you promote technical competence in the following areas in your subprojects, and what are the constraints you face in promoting technical competence?

1. Supervision

- a. Actions:
- b. Constraints:
- c. What type of supervisory systems do you have in place in your subprojects?
- d. How do you monitor these supervisory systems?

2. Facilities

- a. Actions:
- b. Constraints:

3. Training

- a. Actions:
- b. Constraints:
- c. What types of training do you provide (or are provided to subproject staff to help them carry out their jobs (e.g. preparatory, in-service or on-the-job training)?

4. Service guidelines

- a. Actions:
- b. Constraints:
- c. Does your organization have standard guidelines or protocols for services in subprojects?
- d. If yes, are they listed in a manual or series of manuals?
- e. What aspects of services do these standards cover?
- f. How do you ensure that these standard guidelines are followed?

D. Continuity of family planning care

1. How do you promote continuity of family planning care in your subprojects?
2. What are the constraints you face in promoting continuity of care?
3. How do your subprojects provide follow-up for clients that have been in their care?
4. How are discontinuers contacted by subproject staff?
5. How are medical records used to help ensure continuity of care in your subprojects?
6. How are MIS systems used to help ensure continuity of care in your subprojects?

E. Interpersonal relations

1. How does your organization try to instill in the staff of your subprojects the importance of understanding the client's perspective in service delivery?
2. What are the constraints your subprojects face in promoting improved interpersonal relations between staff and clients in your subprojects?
3. Do the staff of subprojects consider privacy for and confidentiality of clients important?
4. What steps do you subprojects take to ensure privacy in service delivery?

F. Constellation of services (match of client needs with clients services)

1. What steps does your organization take in your subprojects to match client needs with the services offered?
2. What are the constraints your organization faces in ensuring the proper constellation of services in your subprojects?
3. Do your subprojects survey users to assess their desire for services and their opinion on such things as the hours of operation, days of operation, and location of service points? If so, how is the information used to make changes?

III. Program and Method-Specific Approaches to Quality of Care

1. Do you take type of program (clinic-based, social marketing, etc) into account in your quality of care activities? If so, how?
2. Do you take stage of program (FPSD strategy) into account in your quality of care activities? If so, how?
3. Do you take a method-specific approach to your quality of care work? If so, how?

IV. Approaches to Monitoring and Assessing Quality of Care Activities

1. What approaches does your organization employ to monitor and assess quality of care activities at the field level?
2. What are your procedures for information flow from the field to headquarters and back to the field?
3. Has the information developed through this process changed any part of your organization's approach to quality of care in subprojects? If so, what do you do differently?
4. When deficiencies are discovered, how does your organization help subproject staff with problem solving in this area?

V. Success Stories in Quality of Care

1. What does your staff consider to be the most useful, practical and creative quality of care activity or assessment (e.g. your "success stories")?
2. Who is responsible for these activities?

VI. Constraints to Quality of Care Activities

1. What are the main constraints that your organization faces with respect to improving quality of care (e.g. internal and/or host country specific such as policy, regulatory, infrastructure, logistics, cost)?
2. What should FPSD and the Office of Population do to assist in addressing these constraints?

VII. Future Quality of Care Activities

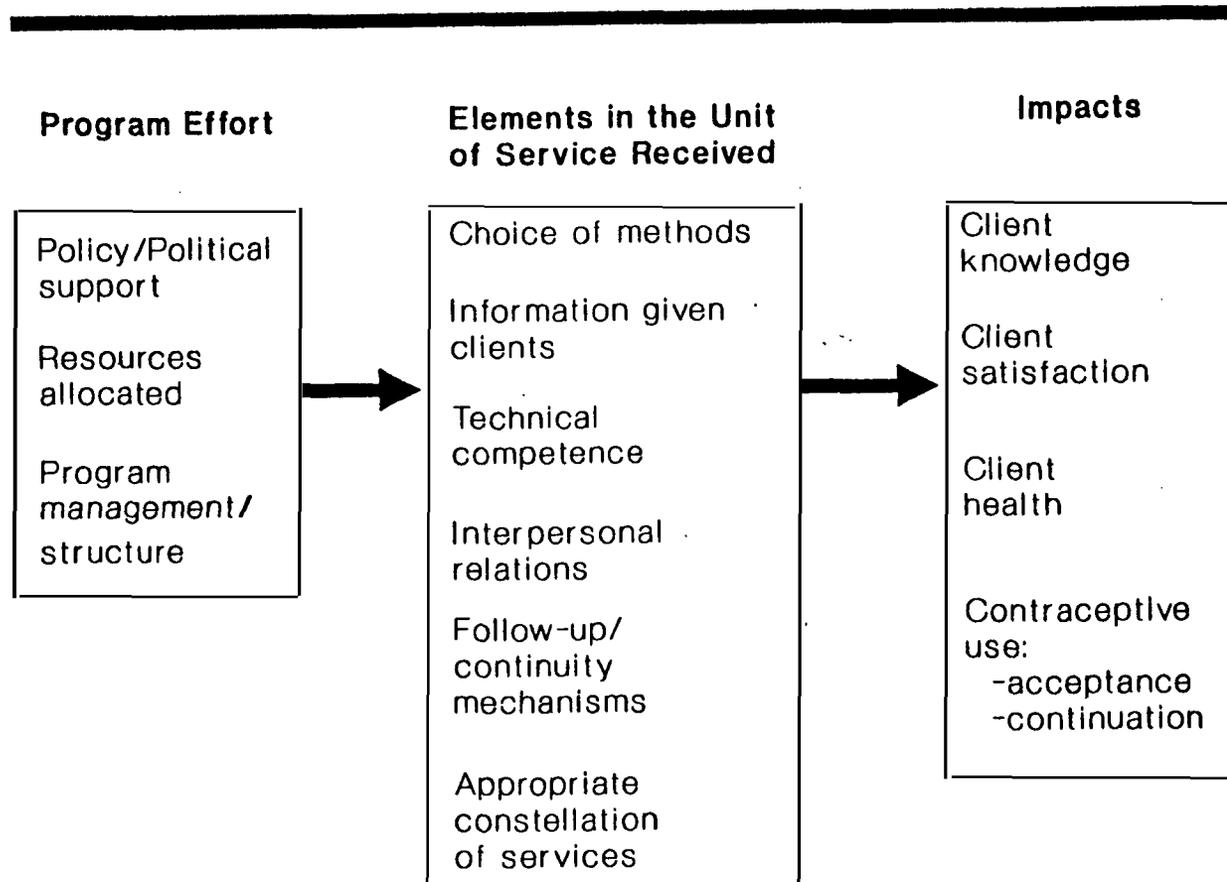
1. In terms of what is practical and feasible, what would you like your organization to be doing in the area of quality of care in the future?
2. If you cannot undertake everything you would like to do, how would you establish priorities among these activities?

VIII. The Costs of Quality of Care Activities

1. What percentage of your program budget do you think you are spending on quality of care activities?
2. Given the priorities you mentioned in question VII.1, what additional funding do think you will need to spend (in percentages)?
3. What would the additional costs entail?
4. Do you foresee a return on the investment in terms of increased numbers of contraceptive acceptors and continued users?

IX. Other comments

Figure 1 The Quality of the Service Experience:
Its Origins and Impacts



ATTACHMENT 2.

Bruce, Judith. "Fundamental Elements of the Quality of Care: A Simple Framework."
Population Council Programs Division *Working Papers*, No. 1, May 1989.

ATTACHMENT 3.

CLIENT ORIENTED, PROVIDER EFFICIENT (COPE) SERVICES S E L F A S S E S S M E N T C H E C K - L I S T

It is suggested that the following components be grouped together for the appropriate staff member to complete:

Administration

- A. Administration
- B. Staff
- C. Community
- D. Evaluation

Other staff

- E. VSC Dedicated Space/Facility
- F. Equipment
- G. Supplies

Records Staff

- H. VSC Records
- I. Communication/reporting
(Attachment A: Client record review checklist)

Counsellors

- J. Organisation of services
- K. Counselling the VSC client
- L. Postpartum services
- M. VSC client follow-up
(Attachment B: VSC client log)

Medical Personnel

- N. Medical screening/pre-op assessment
- O. Pre-op care
- P. Surgical procedure
- Q. Post-op care
- R. Post-op follow-up

Family planning clinic staff

- S. Information and education
- T. FP services
- U. Client Flow Analysis
(Attachment C: client interview form)

PART I: The Self-Assessment Check-list

(Please mark X in the box if there is a problem. If no problem exists, leave the box blank. Comments can be included on the line.)

ISSUES

RESPONSES

A. Administration

Staff Responsible _____

1. Is the administration regularly informed of VSC activities?

2. Is VSC offered with all other family planning methods?

3. Are referrals for VSC coming from other wards/clinics in the hospital?

4. Do you have a VSC committee?

a. if yes, how often do they meet?

b. if yes, who is on the committee?

c. if no, who takes care of VSC details?

5. Who makes decisions on matters pertaining to VSC program?

B. Staff

Staff responsible: _____

1. Who regularly provides the following VSC services?

a. Registration

b. Counselling

c. Pre-operative care

d. Assisting at surgery

e. Surgery

ATTACHMENT A

CLIENT RECORD REVIEW CHECKLIST

SITE: _____

DATE: _____

REVIEWER: _____

SERIAL NO.			
1. Sociodemographic Data completed	_____	_____	_____
2. Medical history completed	_____	_____	_____
3. Physical exam completed	_____	_____	_____
4. Appropriate lab tests done	_____	_____	_____
5. Follow-up on lab tests done	_____	_____	_____
6. Informed consent form signed and attached	_____	_____	_____
7. Pre-op vital signs recorded	_____	_____	_____
8. Pre-op medications recorded	_____	_____	_____
9. Intra-op medications time/name/dose/route recorded	_____	_____	_____
10. Intra-op vital signs recorded	_____	_____	_____
11. Procedure notes recorded*	_____	_____	_____

SERIAL NO.			
12. Post-op vital signs recorded			
13. Post-op medications recorded			
14. Post-op notes completed*			
15. Discharge status completed			
16. First follow-up completed*			
17. Subsequent follow-up completed			
*If a complication occurred			
1. Complication was described			
2. Measures taken were recorded			
3. Medication given recorded			
4. Discharge status recorded			

ATTACHMENT C

CLIENT INTERVIEW FORM

DIRECTIONS:

Introduce yourself to the client and explain that the purpose of the interview is to learn how clients feel about services offered at this family planning clinic, and to get her suggestions on how they might be improved. Stress that the interview is confidential and that her name will not be used. Thank the client for her cooperation.

1. Where did you first hear about family planning?
2. Do you know about sterilisation/tubal ligation/vasectomy?
3. Where did you hear about this?
4. How long have you been coming to this clinic?
5. Have you ever received family planning services somewhere else? If yes, how did the two services compare?
6. What do you like best about this clinic?
7. What do you like least?
8. What suggestions do you have to help us improve our services at this clinic?
9. Do you come from far away? Is transport to this FP clinic expensive for you?
10. Is there anything else you would like to tell us?
11. Interviewers comments:

PART II: CLIENT FLOW ANALYSIS

I. BACKGROUND

WHAT IS CLIENT FLOW ANALYSIS?

Clinic managers often wish for a quick and easy way to examine what's happening in the clinic. Client flow analysis (CFA) was developed to answer this need. It is a simple time/motion study that describes both client flow and staff utilization. Data collected in any one clinic session by regular clinic staff can be charted on graphs and charts to help identify potential clinic improvements. The CFA graph and chart permits rapid evaluation of client flow; they are designed to visually demonstrate the manner in which both patient and staff time are utilized during a clinic session.

WHY DO A CLIENT FLOW ANALYSIS IN YOUR CLINIC?

Specific benefits to be derived from use of the CFA may include reduction of both staff and client waiting time (and frustration) in the clinic, a more equitable distribution of workload for each staff during the workday, and reduction of personnel costs. It may also show how additional clients may be served.

CFA is simple to conduct, simple to interpret, and the results are simple to use. It reveals both strengths and weaknesses in clinic operation. Results of the analysis may be used for self-study, or they may be used to justify needed policy or budgetary changes to a higher authority.

This non-computerized system is an adaptation of the computerized patient flow analysis developed by the Family Planning Evaluation Division of the U.S. Centers for Disease Control.

WHAT TO EXPECT FROM CFA

Although CFA is a powerful tool when used to analyze clinic efficiency, the technique is no substitute for the judgment, expertise, and experience of those who work in the clinic. The technique should always be used in conjunction with what is known about the clinic operation by those who know it best: the staff. CFA can identify shortfalls. You must seek explanations for any unacceptable occurrences identified in the analysis. The CFA output merely acts as a tool to define problems and assist the manager with problem solving.

CFA CAN

Identify bottlenecks.

Identify lapses in client contact time.

Identify missed stops.

CFA CANNOT

Provide the best solution to the bottleneck.

Explain what staff were doing during that time.

Explain why stops were missed.

Identify unscheduled client stops.

Tell you why extra stops were made.

Provide personnel cost estimates.

Judge if personnel costs are reasonable.

Measure client waiting time.

Judge if waits are reasonable.

Measure time clients spend at each stop.

Judge quality of care at each stop.

Demonstrate the effect of client flow of changes in clinic operations.

Judge if the effect is a desirable one.

The study can easily be conducted as frequently as needed in the clinic. However, it is important to note: conducting the CFA only identifies the potential problems. The important part is the address these problems, and initiate improvements in service delivery based on CFA findings.

II. HOW TO CONDUCT A CFA STUDY

The data collection process is relatively simple and requires only a few seconds of clinic personnel time at the beginning and end of their contacts with each client in one clinic session. Basically, each staff member is required to note her/his initial and the beginning and ending time of the contact with each client seen. This process will not disrupt the clinic session. To be of maximum utility, the data must be complete, legible, and accurate.

1. Make appropriate numbers of copies of:
 - a. Attachment D: Client Register Sheet (50 copies for 100 clients)
 - b. Attachment F: Client Flow Chart (4 copies for 100 clients)
 - c. Client Interview Form
2. Synchronize staff watches and clinic clocks.
3. Assign a code to each staff person, e.g., first or second initial.
4. Number the client register sheet (Attachment D as on the log. Enter the visit type code after reason for visit and the code for the family planning method (see Attachment E). Each staff person enters his/her personal code and logs the hour and minutes the contact begins and ends. If a contact is less than a minute, enter a full minute.
5. Instruct the client to carry the form and give it to each person s/he has contact with.
6. If clients attend a group education session, the staff person responsible for conducting the session will enter the beginning and ending time of the session on each client's register form.

7. The client register form can be collected after the last contract and charted immediately if a separate staff person is assigned to oversee the study.

III. HOW TO CHART CLIENT FLOW

1. Using the Client Flow Chart (Attachment H), enter the client number, on the side, beginning with client number "01". Attachment I is a sample of a completed chart.
2. Enter the time the client arrived under "in" and the time the client left (last service completed) under "out."
3. Enter the total number of minutes the client was in the clinic (e.g., client arrived at 9:30 am and last service was completed at 11:05 am - 95 total minutes in the clinic).
4. Total the number of minutes the client spent receiving service from all staff contacts and enter under "contact minutes."
5. Figure the waiting minutes by subtracting "contact" minutes from "total" minutes.
6. Figure the percent of time the client spent waiting for service by dividing the waiting minutes by total minutes. For example:

<u>60 waiting minutes</u>		63% of clients time
95 total minutes	-	was spent waiting

To get an average for the clinic session, total all waiting minutes and divide by total minutes all clients spent in the clinic.

7. If desired, enter visit and method code.
8. Write any pertinent information under comments such as "left before completing visit."
9. To get the percent of staff time spent in direct service to clients, total the number of client contact minutes and divide by the total number of staff minutes available to provide services. For example:

<u>total client minutes</u>		440 46% of staff
four staff x 4 hrs each x 60 minutes	-	960 time spent in client contact

SUGGESTED STANDARDS

- Clients spend no more than 50% of their time in the clinic waiting for service
- Staff involved spend at least 65% of their time providing direct service to clients.

IV. HOW TO GRAPH CLIENT FLOW

1. Using graph paper, enter the time the clinic session began and the time in five minute intervals across the top of the page (see sample, Attachment H).
2. Enter the clients, beginning with number "1" down the side of the page.
3. If possible, use a different color pen or pencil for each staff member. Using the assigned color, draw a line on the paper to represent the time spent with each staff. Waiting time will appear as space between bars.

VIII. HOW TO GRAPH STAFF UTILIZATION

1. Using graph paper, enter the time the clinic session began and continue entering time in five minute intervals across the top of the page (see sample Attachment I).
2. Enter staff initials down the side of the page. Go through each client register form one for each staff member. If the staff initial appears as a "contact," draw a line with that staff member's assigned color to represent the time spent providing service to that client.

CLIENT REGISTER

1. CLIENT NUMBER
2. TYPE OF VISIT
3. FAMILY PLANNING METHOD

4. TIME OF CLIENT'S ARRIVAL IN CLINIC

Hour Min

[] [] : [] []

5. CLIENT SERVICE TIME:

	Initial of Staff Responsible	Time Service Started		til	Time Service Completed		Total Contact Time (Mins)
		Hour	Min		Hour	Min	
First contact	[]	[]	[]	til	[]	[]	-----
Second contact	[]	[]	[]	til	[]	[]	-----
Third contact	[]	[]	[]	til	[]	[]	-----
Fourth contact	[]	[]	[]	til	[]	[]	-----
Fifth contact	[]	[]	[]	til	[]	[]	-----

CLIENT REGISTER

1. CLIENT NUMBER
2. TYPE OF VISIT
3. FAMILY PLANNING METHOD

4. TIME OF CLIENT'S ARRIVAL IN CLINIC

Hour Min

[] [] : [] []

5. CLIENT SERVICE TIME:

	Initial of Staff Responsible	Time Service Started		til	Time Service Completed		Total Contact Time (Mins)
		Hour	Min		Hour	Min	
First contact	[]	[]	[]	til	[]	[]	-----
Second contact	[]	[]	[]	til	[]	[]	-----
Third contact	[]	[]	[]	til	[]	[]	-----
Fourth contact	[]	[]	[]	til	[]	[]	-----
Fifth contact	[]	[]	[]	til	[]	[]	-----

ATTACHMENT E

VISIT AND FAMILY PLANNING METHOD CODE SHEET

VISIT TYPE CODES

- F - First visit
- R - Revisit

FAMILY PLANNING METHOD CODES

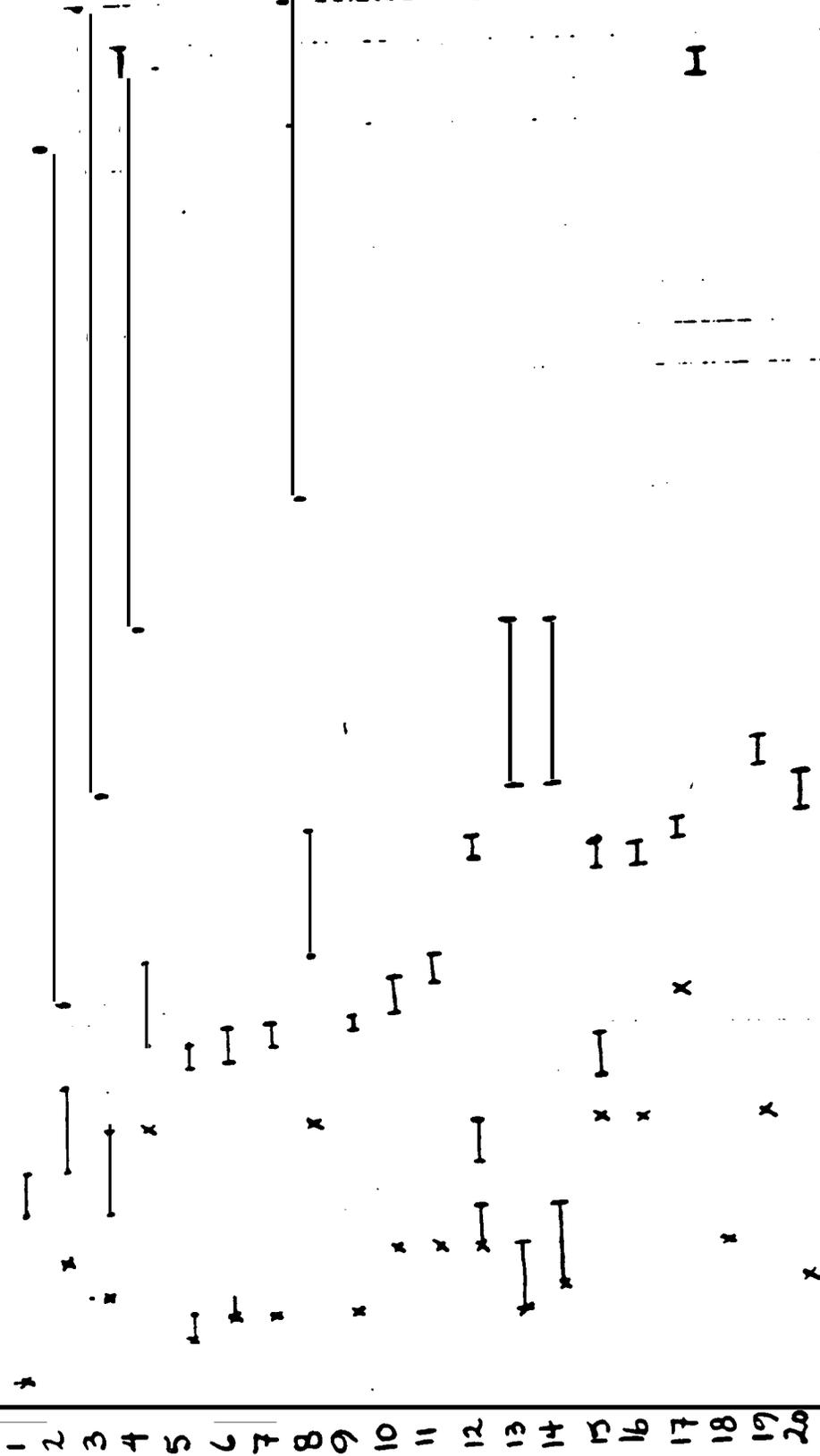
- P - Pill
- I - IUCD
- C - Condom, foaming tablets, jelly, or any combination of these methods
- D - Diaphragm
- J - Injectable (depoprovera, noristerat, etc.)
- V - Vasectomy; use this code whether the client is coming for counselling, surgery, or follow-up.
- T - Tubal ligation; use this code whether the client is coming for counselling, surgery or follow-up.
- O - Other, e.g., natural family planning, withdrawal, folk methods, etc.
- N - No method being used. Also, use this code for all non-family planning (such as antenatal) clients.
- CSL - Counseling

METHOD

PILL

- TUBAL LIG.
- TUBAL LIG.
- TUBAL LIG.
- Injection
- Injection
- "
- Tubal Lig.
- Injection
- "
- "
- "
- counselling
- counselling
- Injection
- No method
- Injection
- "
- "
- "

8 10 20 30 40 50 60 70 80 90 100 110 120 130 140 150 160 170 180 190 200



CONTACT TIME = SOLID LINE
 WAITING TIME = BLANK

CLIENT NO

PART III: FOLLOW-UP PLAN

Staff are provided with large sheets of paper available locally (newsprint, brown paper, etc) and marker pens. If any problem areas have been identified in the course of the self-assessment or client flow analysis, these are written on the large sheets along with recommendations, staff responsible for implementing the recommendations, and dates for completion. (See attachment J for example).

At the final meeting on the last day of the COPE exercise, the staff present their findings in the form of these sheets. Discussion ensues, and some of the recommendations, or the staff responsible, may change. The sheets are left at the site for staff use for follow-up meetings, and comprises their plan of action.

A follow-up visit is arranged for approximately six months after the initial COPE exercise to encourage staff to comply with their own suggestions.

Usually great excitement and enthusiasm is generated, and this is the COPE presenters' opportunity to channel these energies into plans for future improvements. Staff should also be encouraged to talk about the particular strengths and positive aspects of service at their sites.

PROBLEM	RECOMMENDATIONS	STAFF RESPONSIBLE	By WHEN
JSC RECORDS - NOT ENOUGH ROOM	CLEAR OUT OBSOLETE RECORDS	RECORDS CLERK	1 month
NO SIGNS TO FP CLINIC	MAKE SIGNS AND PUT UP FOR PEOPLE TO SEE	ADMINISTRATOR	2 weeks

ATTACHMENT 4.

CEDPA Plans for QOC Management

- A. Proposal development and Project start-up (Project Coordinator)
 - 1. Present and review Guidelines for QOC Assessment
 - 2. Assist project to develop QOC plan
 - 3. Include QOC activities in Annual Workplan and Implementation plan
 - 4. Enclose resume of Project Director and Medical Supervisor.

- B. Project Monitoring (Project Coordinator)
 - 1. Review Guidelines for QOC Assessment and QOC activities on site visits
 - 2. Review training plans and activities
 - 3. Observe provider and client interactions whenever possible
 - 4. Recommendations for technical assistance to CEDPA

- C. Medical QOC (Medical Consultant or specialist)
 - 1. Review of medical guidelines or protocols
 - 2. Medical consultant on-site visit (within year 1 for clinic projects)
 - 3. Technical assistance by medical consultant/specialist as needed

- D. Regional Workshops
 - 1. Regional workshops to assist each subproject in developing QOC plans. May be linked with contraceptive update or other management training.

- F. Mid-term evaluation (Evaluation Specialist or regional consultants)
 - 1. Interviews of Project Manager, field workers, community using QOC-oriented interview guides
 - 2. Focus groups of manager, clients, community members
 - 3. Client verification checklists
 - 4. Medical review as needed or recommended by the Project Coordinator

- E. Final evaluation (Evaluation Specialist, Project Coordinator)
 - 1. Final interviews as in Section F
 - 2. Analysis, documentation of impact of QOC on project success

CEDPA

**INDICATORS FOR
QUALITY OF CARE ASSESSMENT: CBD PROGRAM**

ELEMENTS	MANAGEMENT LEVEL	PROVIDER LEVEL	IMPACT LEVEL
<p align="center">1.</p> <p align="center">CHOICE OF METHODS</p>	<p>1. Methods are available & supply is continuous</p> <p>2. Recordkeeping system tracks commodities distributed</p> <p>3. Supervision system tracks FW goals & activities</p>	<p>1. FW offers choices to clients</p> <p>2. Referrals are made for methods not available through CBD</p> <p>3. Fieldworkers are motivated to recruit clients</p>	<p>1. Clients choose method & can explain why they chose their method</p> <p>2. Clients can describe other methods</p>
<p align="center">2.</p> <p align="center">TECHNICAL COMPETENCE</p>	<p>1. Refresher training for FWs is provided at least annually</p> <p>2. Consultation by medical person to discuss cases</p> <p>3. Written guidelines are provided for screening & distribution of methods</p> <p>4. FW receives training and supervision in record-keeping & follow-up</p> <p>5. FW job descriptions are clear</p>	<p>1. FWs are knowledgeable about methods, proper use, side effects</p> <p>2. FWs follow guidelines in follow-up methods</p> <p>3. FWs complete record-keeping system</p> <p>4. FWs know how to discuss and help clients manage side effects</p>	<p>1. Clients can explain the benefits and risks of their chosen method</p> <p>2. Clients know about common side effects and how to manage them</p> <p>3. Clients know where to go for serious complications</p>
<p align="center">3</p> <p align="center">INFORMING AND COUNSELING CLIENTS</p>	<p>1. Training on edu. & counseling approaches are provided at least annually</p> <p>2. Written material or pamphlets are given to FWs</p>	<p>1. Fieldworker is able to communicate clearly about methods and answer client questions</p> <p>2. Fieldworker uses written materials appropriately</p>	<p>1. Clients feel their questions have been answered</p> <p>2. Clients receive accurate information about methods</p>
<p align="center">4</p> <p align="center">INTERPERSONAL RELATIONS</p>	<p>1. Staff selection is based on good interpersonal skills</p> <p>2. Training includes interpersonal communications skills building</p> <p>3. Supervision is based on periodic observation of client interaction</p>	<p>1. Fieldworker can build trust with clients & gain their respect</p> <p>2. Fieldworker demonstrates good listening skills and sensitivity to clients</p>	<p>1. Clients feel comfortable in discussing FP and other health issues</p> <p>2. Clients are satisfied with service</p>
<p align="center">5</p> <p align="center">MECHANISMS TO ENCOURAGE CONTINUITY</p>	<p>1. Referral linkages and procedures are developed</p> <p>2. Transportation plan is in place</p> <p>3. Follow-up guidelines and system is clear and in writing</p>	<p>1. FW follows system for follow-up visits</p> <p>2. Fieldworker maintains accurate records</p>	<p>1. Clients receive supplies as scheduled</p> <p>2. Clients have opportunity to discuss and change methods</p> <p>3. Good continuation rates</p>
<p align="center">6</p> <p align="center">APPROPRIATENESS AND ACCEPTABILITY OF SERVICES</p>	<p>1. Community leaders and health agencies support CBD program</p> <p>2. Informal and formal IEC plan promotes program</p> <p>3. Increased access to services</p>	<p>1. FW provides services in an appropriate, private setting</p> <p>2. FW understands and works toward goals of program</p> <p>3. FW keeps community informed/involved in program</p>	<p>1. Clients are satisfied with service</p> <p>2. Clients tell others about program</p> <p>3. Community makes referrals to program</p> <p>4. Increase in users</p>

**INDICATORS FOR
QUALITY OF CARE ASSESSMENT: CLINIC PROGRAM**

ELEMENTS	MANAGEMENT LEVEL	PROVIDER LEVEL	CLIENT LEVEL
<p style="text-align: center;">1</p> <p style="text-align: center;">CHOICE OF METHODS</p>	<ol style="list-style-type: none"> 1. Wide range of methods are available including IUD, referrals for sterilization, injectables (if available within country) 2. Adequate and continuous supplies of contraceptives is available 3. Management system projects method mix and tracks utilization data 	<ol style="list-style-type: none"> 1. All personnel, especially clinicians, nurses & counselors offer choices to clients 2. Referrals are made and follow-up provided for methods not offered 3. Providers discuss method preferences with managers if methods are not available. 	<ol style="list-style-type: none"> 1. Clients choose method and can explain why they chose a method 2. Clients can discuss at least one other method 3. Clients understand medical reasons why method may not be suitable
<p style="text-align: center;">2</p> <p style="text-align: center;">TECHNICAL COMPETENCE</p>	<ol style="list-style-type: none"> 1. Clinicians & medical staff receive technical updates once a year minimum 2. Observation of clinician performance done at least once 3. Written guidelines for FP practice are developed and approved 4. Training of clinicians & approval of skills is documented 5. A medical supervisor is designated to overview system 6. A supervision schedule with clinical observation is followed 7. Medical records are reviewed 8. Job descriptions are clear 	<ol style="list-style-type: none"> 1. Clinicians & medical staff demonstrate good knowledge of all meths, use, benefits, side effects 2. Clinicians and medical staff follow guidelines for FP practice 3. Clinicians and medical staff demonstrate good knowledge of infection control procedures 4. Clinicians demonstrate good clinical exam. skills 5. Clinicians perform simple lab tests as appropriate 6. Equipment is properly used and maintained 7. Infections and complications are properly handled 8. Referrals are made as appropriate 9. Proper screening is done for clinical methods 	<ol style="list-style-type: none"> 1. Clients experience minimal physical and emotional discomfort 2. Clients understand about other health problems 3. Clients can explain the benefits & risks of chosen method 4. Clients know about common side effects and how to manage them
<p style="text-align: center;">3</p> <p style="text-align: center;">INFORMING AND COUNSELING CLIENTS</p>	<ol style="list-style-type: none"> 1. Training on counseling is built into clinician training plan 2. Time is provided for clinician to do client counseling 	<ol style="list-style-type: none"> 1. Clinicians and medical staff demonstrate good communication and counseling skills 2. Clinicians and medical staff provide accurate & adequate info. for client decision making 	<ol style="list-style-type: none"> 1. Clients understand their method & how it works 2. Clients receive appropriate materials and instructions about side effects, contraindications
<p style="text-align: center;">4</p> <p style="text-align: center;">INTERPERSONAL RELATIONS</p>	<ol style="list-style-type: none"> 1. Selection of clinician and medical staff includes attention to interpersonal skills 2. Supervision includes review of interpersonal skills 	<ol style="list-style-type: none"> 1. Clinicians and medical staff develop trust and rapport with client 2. Clinician and medical staff listen to client & address their concerns 	<ol style="list-style-type: none"> 1. Client feels comfortable in talking with clinician and medical staff 2. Clients are satisfied with service 3. Good continuation rate
<p style="text-align: center;">5</p> <p style="text-align: center;">MECHANISMS TO ENCOURAGE CONTINUITY</p>	<ol style="list-style-type: none"> 1. Formal follow-up plan is written and clear 2. Referral system is developed and utilized 3. Record keeping system for follow-up visits is developed 4. Supervision system is in place to track follow-up cases 	<ol style="list-style-type: none"> 1. Clinicians follow the same clients if poss. 2. Clinician maintains good record keeping system 3. Manager ensures follow-up between clinic and outreach/CBD 	<ol style="list-style-type: none"> 1. Client continues using method or changes as needed 2. Client returns to clinic for follow-up care as needed
<p style="text-align: center;">6</p> <p style="text-align: center;">APPROPRIATENESS AND ACCEPTABILITY OF SERVICES</p>	<ol style="list-style-type: none"> 1. Clinic is located in accessible, convenient location 2. Clinic is personal, private, clean, attractive 3. Hours are convenient and varied as needed 4. Clinic has adequate exam. & supplies, equipment, running water, etc. 5. Client flow plan is organized and well supervised 6. Outreach, community edu. plan is well defined 7. Increased access to FP services 	<ol style="list-style-type: none"> 1. Clinician and staff have client orientation 2. Clinician and staff are well organized and clients are not made to wait for unusually long periods 3. Staff work in coordination as a team 4. Staff understand & work to achieve clinic goals 	<ol style="list-style-type: none"> 1. Clients are satisfied with services and return as needed 2. Clients tell others about clinic services 3. Community makes referrals to clinic 4. Increase in users

ATTACHMENT 5.

I. CONTRACEPTIVE METHODS CHOICE

<p>A. Facilities/Hardware</p> <p>1. How many contraceptive methods are offered by your program?</p> <p><input type="checkbox"/> Short-term reversibles (pill, barrier methods, injectables, condoms) (1 point)</p> <p><input type="checkbox"/> Long-term reversibles (IUD, Norplant) (1 point)</p> <p><input type="checkbox"/> Irreversible (sterilization) (1 point)</p> <p><input type="checkbox"/> No family planning methods (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>	<p>B. Service/Delivery System</p> <p>1. Which of the categories indicated at the left were distributed by you to your most recent 100 new family planning acceptors?</p> <p><input type="checkbox"/> all methods indicated at the left (3 points)</p> <p><input type="checkbox"/> two methods (2 points)</p> <p><input type="checkbox"/> only one method (1 point)</p> <p><input type="checkbox"/> no methods (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>	<p>C. Client Perceptions</p> <p>1. As far as you know, which methods are available at the facility?</p> <p><input type="checkbox"/> client identifies at least 75 percent of methods available in program (3 points)</p> <p><input type="checkbox"/> client identifies at least half of methods available in program (2 points)</p> <p><input type="checkbox"/> client identifies less than half of methods available in program (1 point)</p> <p><input type="checkbox"/> Client cannot identify any method (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>
<p>2. Which of the following types of pills do you offer at your clinic?</p> <p><input type="checkbox"/> regular dose (1 point)</p> <p><input type="checkbox"/> low dose (1 point)</p> <p><input type="checkbox"/> minipills (1 point)</p> <p><input type="checkbox"/> no pills (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>	<p>2. Of the types of pills indicated at left, which were distributed by you to your most recent 100 pill clients?</p> <p><input type="checkbox"/> all types indicated at left (3 points)</p> <p><input type="checkbox"/> two types (2 points)</p> <p><input type="checkbox"/> one type (1 point)</p> <p><input type="checkbox"/> no pills (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>	<p>2. Have you ever changed a pill due to side effects or other changes in your personal circumstances? (i.e. breastfeeding)</p> <p><input type="checkbox"/> yes, OR no side effects or changes in circumstances have occurred (3 points)</p> <p><input type="checkbox"/> no alternative pill choice was available so method was changed altogether (2 points)</p> <p><input type="checkbox"/> no, no alternative pill/modern method choice was available, but counseling in natural methods was provided (1 point)</p> <p><input type="checkbox"/> no, no alternative method was available or offered so client ceased contracepting (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>
<p>3. Of the contraceptive methods you offer in your clinic, how many do you have at least a 3-month supply of?</p> <p><input type="checkbox"/> all of them (3 points)</p> <p><input type="checkbox"/> more than half of them (2 points)</p> <p><input type="checkbox"/> less than half but at least one method (1 point)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>	<p>3. Does the clinic maintain an inventory record system that</p> <p><input type="checkbox"/> monitors current stock levels (1 point)</p> <p><input type="checkbox"/> ensures first-in, first-out procedures (that monitor exp. date) (1 point)</p> <p><input type="checkbox"/> provides for scheduled re-stocking of contraceptive supplies (1 point)</p> <p><input type="checkbox"/> none of above (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>	<p>3. Is your preferred contraceptive method always available at the clinic?</p> <p><input type="checkbox"/> yes, method is always available (3 points)</p> <p><input type="checkbox"/> usually (with only minor exceptions) available (2 points)</p> <p><input type="checkbox"/> method discontinued (1 point)</p> <p><input type="checkbox"/> availability unpredictable (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>
<p>4. Are any contraceptive methods not offered at your clinic available at other nearby facilities?</p> <p><input type="checkbox"/> more than one method (3 points)</p> <p><input type="checkbox"/> one method (2 points)</p> <p><input type="checkbox"/> none (1 point)</p> <p><input type="checkbox"/> not applicable, full range of methods is available at clinic</p> <p style="text-align: right;"><input type="text" value="Score"/></p>	<p>4. What kind of referral system do you have for methods not offered at your facility?</p> <p><input type="checkbox"/> formal referral system with client follow-up procedures (3 points)</p> <p><input type="checkbox"/> formal referral system with no follow-up procedures (2 points)</p> <p><input type="checkbox"/> informal referrals (1 point)</p> <p><input type="checkbox"/> no referral system exists (0 points)</p> <p><input type="checkbox"/> not applicable, full range of methods available at clinic</p> <p style="text-align: right;"><input type="text" value="Score"/></p>	<p>4. Have you ever been referred to another facility to obtain methods not available at your clinic?</p> <p><input type="checkbox"/> yes OR "no", have always been able to obtain desired method locally (3 points)</p> <p><input type="checkbox"/> no (alternative method choice was not available through existing referral system) (2 points)</p> <p><input type="checkbox"/> yes, but referral center is too difficult to reach or use (1 point)</p> <p><input type="checkbox"/> no (referral option was not mentioned or provided) (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>
<p>5. Do you have at least one service provider trained to provide each method offered by your program?</p> <p><input type="checkbox"/> staff trained to provide all methods (3 points)</p> <p><input type="checkbox"/> one method not covered (2 points)</p> <p><input type="checkbox"/> more than one method not covered (1 point)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>	<p>5. Is staff scheduled so that all reversible methods can be administered at any time the clinic is open?</p> <p><input type="checkbox"/> yes, all methods can be administered at all times (3 points)</p> <p><input type="checkbox"/> no, staff scheduled so that each method can be administered at least once a week (2 points)</p> <p><input type="checkbox"/> no, staff scheduling is not organized to ensure that method will be available at least once a week (1 point)</p> <p><input type="checkbox"/> scheduling of new methods dependent on availability and/or personal schedule of non-staff persons (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>	<p>5. Were you ever unable to obtain a family planning method because the person trained to administer it was absent?</p> <p><input type="checkbox"/> have always been able to obtain method (3 points)</p> <p><input type="checkbox"/> only once was unable to obtain method (2 points)</p> <p><input type="checkbox"/> was unable to obtain method on more than one occasion (1 point)</p> <p><input type="checkbox"/> I am never sure whether I can obtain the method on any given day (0 points)</p> <p><input type="checkbox"/> more than 2 methods not covered (0 points)</p> <p style="text-align: right;"><input type="text" value="Score"/></p>

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The Enterprise
Program

II. INFORMATION EDUCATION

A. FACILITIES/HARDWARE

1. Which, if any, of the following strategies do you use to inform people about family planning and the services available at your clinic?
- group talks/educational sessions (1 point)
 - family planning promoter working within the community (1 point)
 - family planning promoters/extension agents operating at workplace (1 point)
 - none of the above (1 point)
- Score

2. Which of the following means of communication have been used by your program to promote family planning?
- posters/pamphlets (1 point)
 - gifts (t-shirts, badges, key rings, etc.) (1 point)
 - folk or mass media (T.V., radio, newspaper) (1 point)
 - none of the above (0 points)
- Score

3. Which of the following educational tools does the program use to instruct clients in family planning?
- anatomical models (1 point)
 - charts/pamphlets (1 point)
 - electronic audiovisual equipment (1 point)
 - none of the above (0 points)
- Score

4. Do you budget a certain amount of money each year exclusively for IEC material?
- yes, IEC budgeted separately (3 pts)
 - no, IEC funding sometimes obtained through other budgeted categories (2 points)
 - no, no money set aside or budgeted for IEC (1 point)
 - no IEC carried out by program (0 points)
- Score

B. SERVICE DELIVERY SYSTEM

1. Do you have a system in place to coordinate and schedule the activities of everyone involved in IEC promotion?
- yes, with written plan (3 points)
 - yes, informal system (2 points)
 - no, no system in place (1 point)
- Score

2. Do you maintain a record keeping system to monitor supplies of promotional materials?
- yes, written records (3 points)
 - yes, informal record keeping (2 points)
 - visual inspection only (1 point)
 - no, no system in place (0 points)
- Score

3. At this moment, which of the following items are in working order and available for use by your training personnel?
- anatomical models (1 point)
 - charts/pamphlets (1 point)
 - electronic audiovisual equipment (1 point)
 - none of the above (0 points)
- Score

4. Do you have an individual or group of individuals responsible for developing and coordinating an IEC program?
- yes, IEC specialists are on staff or are recruited locally (3 pts)
 - no, IEC is handled by available (untrained) staff only (2 points)
 - IEC is low priority and is handled by whomever is available (1 point)
 - no, clinic does not engage in any IEC (0 points)
- Score

C. CLIENT PERCEPTIONS

1. Have you ever been in contact with any of the following:
- a group gathering or educational setting regarding FP? (1 point)
 - a family planning promoter working in the neighborhood/community (1 point)
 - at family planning promoter at your place of employment (1 point)
 - none of the above (0 points)
- Score

2. Have you ever seen any of the following materials produced or distributed by the program?
- posters/pamphlets (1 point)
 - gifts (t-shirts, badges, key rings, etc.) (1 point)
 - mass media (T.V., radio, newspaper articles) (1 point)
 - none of the above (0 points)
- Score

3. While you were being instructed in the use of a contraceptive method(s) did program staff use any of the following tools?
- anatomical models (1 point)
 - pictures (1 point)
 - films, videos, etc. (1 point)
 - none of the above (0 points)
- Score

4. When was the last time you heard or saw anything from or about the family planning program?
- within the past month (3 points)
 - within the past 3 months (2 pts)
 - within the past 6 months (1 pt)
 - more than one year ago (0 pts)
- Score

III. TECHNICAL COMPETENCE OF STAFF

<p>A. Facilities/Hardware</p> <p>1. Of those staff who inform clients or administer contraceptive methods, how many have completed an officially recognized training program in family planning?</p> <p><input type="checkbox"/> all (3 points)</p> <p><input type="checkbox"/> more than half (2 points)</p> <p><input type="checkbox"/> less than half (1 point)</p> <p><input type="checkbox"/> none (0 points)</p> <p style="text-align: right;">Score</p>	<p>B. Service Delivery System</p> <p>1. How often do you require staff to undergo refresher training in family planning service delivery?</p> <p><input type="checkbox"/> each year (3 points)</p> <p><input type="checkbox"/> every two years (2 points)</p> <p><input type="checkbox"/> more than every two years (1 point)</p> <p style="text-align: right;">Score</p>	<p>C. Client Perceptions</p> <p>1. Have you ever had an unplanned pregnancy while using a contraceptive method provided by this program?</p> <p><input type="checkbox"/> no (3 points)</p> <p><input type="checkbox"/> once (2 points)</p> <p><input type="checkbox"/> twice (1 point)</p> <p><input type="checkbox"/> more than twice (0 points)</p> <p style="text-align: right;">Score</p>
<p>2. How many of your clinic staff have been trained in counselling?</p> <p><input type="checkbox"/> all (3 points)</p> <p><input type="checkbox"/> more than half (2 points)</p> <p><input type="checkbox"/> less than half (1 point)</p> <p><input type="checkbox"/> none (0 points)</p> <p style="text-align: right;">Score</p>	<p>2. Is there some mechanism in place that would allow clients to express their satisfaction or dissatisfaction with the services they received at the clinic?</p> <p><input type="checkbox"/> formal surveys or regular meetings with clients (3 points)</p> <p><input type="checkbox"/> informal discussions with clients (2 points)</p> <p><input type="checkbox"/> suggestion box (1 point)</p> <p><input type="checkbox"/> no mechanism available (0 points)</p> <p style="text-align: right;">Score</p>	<p>2. In response to your concerns and questions, do you feel the staff</p> <p><input type="checkbox"/> listened, understood, addressed them fully and were respectful of your feelings (3 points)</p> <p><input type="checkbox"/> only partly responded to concerns, were respectful (2 points)</p> <p><input type="checkbox"/> listened sometimes, partly responded, not always respectful (1 point)</p> <p><input type="checkbox"/> inadequately addressed them, were disrespectful and/or unconcerned (0 points)</p> <p style="text-align: right;">Score</p>
<p>3. Your clinic has available written practice guidelines for which of the following areas?</p> <p><input type="checkbox"/> Counselling, screening and administration of methods (1 point)</p> <p><input type="checkbox"/> Management of side effects, complications, and client referral (1 point)</p> <p><input type="checkbox"/> Return visits and follow-up of missed appointments (1 point)</p> <p><input type="checkbox"/> none of the above (0 points)</p> <p style="text-align: right;">Score</p>	<p>3. What mechanisms are used to ensure that the guidelines are adhered to by staff?</p> <p><input type="checkbox"/> routine reviews of family planning medical records (1 point)</p> <p><input type="checkbox"/> regular observation of staff by supervisor (1 point)</p> <p><input type="checkbox"/> staff meetings or other mechanisms (1 point)</p> <p><input type="checkbox"/> none of the above (0 points)</p> <p style="text-align: right;">Score</p>	<p>3. Have you ever been given contradictory advice or information by clinic staff?</p> <p><input type="checkbox"/> never (3 points)</p> <p><input type="checkbox"/> once (2 points)</p> <p><input type="checkbox"/> twice (1 point)</p> <p><input type="checkbox"/> many times (frequently given contradictory advice) (0 points)</p> <p style="text-align: right;">Score</p>
<p>4. Individual family planning records are maintained for:</p> <p><input type="checkbox"/> every family planning client, including referrals (3 points)</p> <p><input type="checkbox"/> every client but not referrals (2 points)</p> <p><input type="checkbox"/> certain categories of clients (i.e. for certain method types) (1 point)</p> <p><input type="checkbox"/> no records kept (0 points)</p> <p style="text-align: right;">Score</p>	<p>4. Which of the following information is included in your client records:</p> <p><input type="checkbox"/> Client profile (history, demographic info.) (1 point)</p> <p><input type="checkbox"/> examinations, lab testing (1 point)</p> <p><input type="checkbox"/> Documentation of services provided (1 point)</p> <p><input type="checkbox"/> Return visit scheduling and follow-up (1 point)</p> <p><input type="checkbox"/> none of the above (0 points)</p> <p style="text-align: right;">Score</p>	<p>4. Have you ever told clinic staff some important information about yourself that you had to repeat at a later date?</p> <p><input type="checkbox"/> never (3 points)</p> <p><input type="checkbox"/> once (2 points)</p> <p><input type="checkbox"/> twice (1 point)</p> <p><input type="checkbox"/> many times (0 points)</p> <p style="text-align: right;">Score</p>

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A. FACILITIES/HARDWARE		B. ACCESSIBILITY OF FACILITIES		C. CLIENT PERCEPTIONS	
1. SERVICE DELIVERY SYSTEM		2. SERVICE DELIVERY SYSTEM		3. SERVICE DELIVERY SYSTEM	
<p>1. What percentage of your target population can reach your facility within 30 minutes?</p> <p><input type="checkbox"/> 75 - 100% (3 points)</p> <p><input type="checkbox"/> 50 - 75% (2 points)</p> <p><input type="checkbox"/> 25 - 50% (1 point)</p> <p><input type="checkbox"/> 0 - 25% (0 points)</p> <p>Score <input type="text"/></p>	<p>1. Do you do anything to make family planning services more accessible to clients who require more than 30 minutes to reach your clinic?</p> <p><input type="checkbox"/> Regular extension service and/or transport is provided for in not necessary since all clients can reach facility within 30 minutes (3 points)</p> <p><input type="checkbox"/> Assistance is planned and arranged if required (2 points)</p> <p><input type="checkbox"/> Assistance provided informally (1 point)</p> <p><input type="checkbox"/> No assistance provided (0 points)</p> <p>Score <input type="text"/></p>	<p>1. How long did it take you to get to the clinic?</p> <p><input type="checkbox"/> less than 30 minutes (3 points)</p> <p><input type="checkbox"/> 30-60 minutes (2 points)</p> <p><input type="checkbox"/> 60 - 75 minutes (1 point)</p> <p><input type="checkbox"/> more than 75 minutes (0 points)</p> <p>Score <input type="text"/></p>			
<p>2. Are family planning services available during these periods?</p> <p><input type="checkbox"/> weekdays, all hours (1 point)</p> <p><input type="checkbox"/> evening, early morning (1 point)</p> <p><input type="checkbox"/> weekends (1 point)</p> <p>Score <input type="text"/></p>	<p>2. How do you ensure that your hours of operation reflect clients' convenience?</p> <p><input type="checkbox"/> clients are regularly surveyed or interviewed (3 points)</p> <p><input type="checkbox"/> hours of operation based on peak utilization of services (2 points)</p> <p><input type="checkbox"/> informal observation of client utilization of services (1 point)</p> <p><input type="checkbox"/> no formal procedure in place (0 points)</p> <p>Score <input type="text"/></p>	<p>2. Which clinic hours of operation are convenient for you?</p> <p><input type="checkbox"/> weekdays, all hours (1 point)</p> <p><input type="checkbox"/> evening, early morning (1 point)</p> <p><input type="checkbox"/> weekends (1 point)</p> <p>Score <input type="text"/></p>			
<p>3. In regard to the purpose of the visit, what is the highest number of stations a client must pass through from the time he/she enters the clinic to the time he/she leaves it?</p> <p><input type="checkbox"/> two stations (3 points)</p> <p><input type="checkbox"/> three stations (2 points)</p> <p><input type="checkbox"/> four stations (1 point)</p> <p><input type="checkbox"/> more than four (0 points)</p> <p>Score <input type="text"/></p>	<p>3. To regulate the flow of clients through your clinic, which of the following procedures do you employ?</p> <p><input type="checkbox"/> separate scheduling for new acceptors (1 point)</p> <p><input type="checkbox"/> make individual appointments (1 point)</p> <p><input type="checkbox"/> initial screening to identify and process client (1 point)</p> <p><input type="checkbox"/> none of the above (0 points)</p> <p>Score <input type="text"/></p>	<p>3. What was the total length of your visit to the clinic?</p> <p><input type="checkbox"/> 45 minutes (3 points)</p> <p><input type="checkbox"/> 45 minutes to 1 hour (2 points)</p> <p><input type="checkbox"/> more than 1 hour (1 point)</p> <p><input type="checkbox"/> 1 - 1 1/2 hours (0 points)</p> <p>Score <input type="text"/></p>			
<p>4. Type of payment available to clients</p> <p><input type="checkbox"/> cash (1 point)</p> <p><input type="checkbox"/> credit (i.e. delayed payment) (1 point)</p> <p><input type="checkbox"/> reimbursement by third party (i.e. employer, government) (1 point)</p> <p>Score <input type="text"/></p>	<p>4. If clients pay for family planning services, what influenced your current pricing scales?</p> <p><input type="checkbox"/> did business plan/budgetary analysis (1 point)</p> <p><input type="checkbox"/> survey of other clinic prices (1 point)</p> <p><input type="checkbox"/> survey of client capacity to pay (1 point)</p> <p>Score <input type="text"/></p>	<p>4. What did you pay for the family planning services you received?</p> <p><input type="checkbox"/> full amount (on service was free) (3 points)</p> <p><input type="checkbox"/> partial amount (2 points)</p> <p><input type="checkbox"/> unable to pay (1 point)</p> <p>Score <input type="text"/></p>			

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A. FACILITIES/HANDWARE	B. PHYSICAL FACILITIES/EQUIPMENT	C. CLIENT PERCEPTIONS
<p>1. Your clinic has available written guidelines for which of the following areas? (1 point)</p> <ul style="list-style-type: none"> <input type="checkbox"/> maintenance and repair of equipment <input type="checkbox"/> cleaning and maintenance of facilities (i.e. clinic staff) (1 point) <p>Score <input type="text"/></p>	<p>1. What mechanisms are used to ensure that guidelines for cleaning and maintaining facilities are practiced by staff?</p> <ul style="list-style-type: none"> <input type="checkbox"/> following procedure manual/gro guideline (3 points) <input type="checkbox"/> routine monitoring by checklist (2 points) <input type="checkbox"/> internal observation (1 point) <input type="checkbox"/> no system in place (0 points) <p>Score <input type="text"/></p>	<p>1. I felt the medical facility was:</p> <ul style="list-style-type: none"> <input type="checkbox"/> very clean (3 points) <input type="checkbox"/> somewhat clean (2 points) <input type="checkbox"/> not clean (0 points) <input type="checkbox"/> exceptionally dirty (0 points) <p>Score <input type="text"/></p>
<p>2. Which of the following do you have to control infection?</p> <ul style="list-style-type: none"> <input type="checkbox"/> antiseptics, disinfectants, sterilizer (1 point) <input type="checkbox"/> supplies (gloves, cleaning equipment, etc.) (1 point) <input type="checkbox"/> trained infection control provider (1 point) <input type="checkbox"/> none of the above (0 points) <p>Score <input type="text"/></p>	<p>2. To prevent spread of infection, which of the following are available and/or are in use?</p> <ul style="list-style-type: none"> <input type="checkbox"/> written guidelines for proper cleaning and sterilization of equipment and disposal of infected material (1 point) <input type="checkbox"/> adequate supplies (1 point) <input type="checkbox"/> periodic supervision by person responsible for infection control (1 point) <input type="checkbox"/> none of the above (0 points) <p>Score <input type="text"/></p>	<p>2. Have you or anyone you have received an infection as a result of services provided at this clinic?</p> <ul style="list-style-type: none"> <input type="checkbox"/> I personally have not received any infections (3 points) <input type="checkbox"/> I have never heard of anyone who has received an infection (2 points) <input type="checkbox"/> I have heard of someone who did receive an infection (1 point) <p>Score <input type="text"/></p>
<p>3. Have you, at any point during the last month, been unable to provide family planning services because of a lack of equipment, instruments, or supplies?</p> <ul style="list-style-type: none"> <input type="checkbox"/> no (3 points) <input type="checkbox"/> once (2 points) <input type="checkbox"/> twice (1 point) <input type="checkbox"/> more than twice (0 points) <p>Score <input type="text"/></p>	<p>3. Which of the following mechanisms are used to ensure a regular, adequate supply of equipment, instruments, and supplies?</p> <ul style="list-style-type: none"> <input type="checkbox"/> visual inspection of supply stocks (1 point) <input type="checkbox"/> separate allocation of funds to replace supplies and equipment (1 point) <input type="checkbox"/> written inventory of clinic equipment and supplies (1 point) <input type="checkbox"/> none of the above (0 points) <p>Score <input type="text"/></p>	<p>3. Have you ever been denied services because of supply shortages or defective equipment?</p> <ul style="list-style-type: none"> <input type="checkbox"/> no (3 points) <input type="checkbox"/> once (2 points) <input type="checkbox"/> twice (1 point) <input type="checkbox"/> more than twice (0 points) <p>Score <input type="text"/></p>
<p>4. Which of the following are present at the clinic?</p> <ul style="list-style-type: none"> <input type="checkbox"/> comfortable waiting area (1 point) <input type="checkbox"/> private examination/consultation room or area (1 point) <input type="checkbox"/> private toilet/waste facility (1 point) <input type="checkbox"/> none of the above (0 points) <p>Score <input type="text"/></p>	<p>4. When are the areas indicated at left open and available to clients?</p> <ul style="list-style-type: none"> <input type="checkbox"/> open at all times when clinic is open (3 points) <input type="checkbox"/> always available upon request when clinic is open (2 points) <input type="checkbox"/> sometimes available upon request when clinic is open (1 point) <input type="checkbox"/> none of the areas at left exist at clinic (0 points) <p>Score <input type="text"/></p>	<p>4. Did you have adequate comfort and privacy during your visit to the clinic?</p> <ul style="list-style-type: none"> <input type="checkbox"/> yes, very comfortable and private (3 points) <input type="checkbox"/> yes, comfortable and somewhat private (2 points) <input type="checkbox"/> no, not comfortable or private (1 point) <p>Score <input type="text"/></p>

ATTACHMENT 6.
ELEMENTS OF QUALITY

1. INPUTS RECEIVED BY SUB-GRANTEE
 - 1.1 Quantity
 - 1.2 Opportunity afforded
 - 1.3 Adapting of money, Technical Assistance & materials received
2. CHOICE OF FAMILY PLANNING METHOD BY CLIENTS
 - 2.1 Range of contraceptives available
 - 2.2 Pattern of distribution (provider and client bias)
3. INFORMATION/COUNSELING TO CLIENTS
 - 3.1 IEC methods used to communicate
 - 3.2 Content of information given to clients
 - 3.3 Condition of clients' records
4. TECHNICAL COMPETENCE OF SERVICE PROVIDERS
 - 4.1 Staff skills
 - 4.2 Staff training received
 - 4.3 Observance of protocols
 - 4.4 Infection control
5. INTERPERSONAL RELATIONS
 - 5.1 Communication between client/provider
 - 5.2 Time use
6. MECHANISMS TO ENCOURAGE CONTINUITY
 - 6.1 Return rates
 - 6.2 Information provided to clients regarding return visits
 - 6.3 Turn-over of provider staff
 - 6.4 Referral network
 - 6.5 Client tracking system
7. ORGANIZATION OF SERVICES
 - 7.1 Type of services offered
 - 7.2 Location of services
 - 7.3 Safety of services for client/provider
 - 7.4 Days and hours of operation
 - 7.5 Staffing patterns
 - 7.6 Client access to service site
 - 7.7 Appearance of the facilities
 - 7.8 Condition of the MIS
 - 7.9 Management factors

INDICATORS OF PROGRAM QUALITY

Name of Clinic: _____

Date: _____

INDICATORS OF PROGRAM QUALITY	GOOD	ADEQUATE	POOR
<p>1. <u>RESOURCES</u></p> <p>Competence of Personnel</p> <p>Availability of Adequate Contraceptive Supplies</p> <p>Adequacy of Equipment</p> <p>Physical Facilities</p>			
<p>2. <u>MANAGEMENT</u></p> <p>Adherence to Standards & Protocols</p> <p>IEC Services</p> <p>Management Information Systems</p>			
<p>3. <u>SUPPORT</u></p> <p>Program Management</p> <p>Availability of Medical Backup</p> <p>Existence of Standards & Protocols</p>			
<p>4. <u>ACCESSIBILITY</u></p> <p>Cost</p> <p>Distance</p> <p>Time</p> <p>Cultural</p>			
<p>5. <u>ADOPTION</u></p> <p>Continuation Rate in FP Programs</p>			
TOTAL			

STAFF BACKGROUND

	MAHATTA	MADABA	ASHRAFIYA	ZARQA	EL-HUSSEIN	AQABA	IRBID	SALT
FP TRAINING BACKGROUND OF:								
Doctor 1	OJT	FPT	FPT	FPT	FPT	OJT	FPT (Yugoslav.)	OJT
Doctor 2	OJT	--	OJT	FPT	FPT	--	OJT(pm)	?(pm)
EDUCATIONAL AND TRAINING BACKGROUND OF:								
Nurse 1	Practical Nurse OJT	Practical Nurse OJT & FPT	Nurse Assistant OJT & FPT	Practical Nurse OJT & FPT	Practical Nurse OJT & FPT	Midwife FPT	High School OJT	High School OJT
Nurse 2			Practical Nurse OJT*	Practical Nurse OJT*	Practical Nurse OJT*	-- --	?(pm)	?(pm)

OJT = On the Job Training
 FPT = Family Planning Training
 * = Joined Service 2 weeks ago

THE PATHFINDER FUND
NON-VSC CLINICAL SITE VISIT CHECKLIST

Introduction

The Non-VSC Clinical Site Visit Checklist is a tool that has been designed to help any Visitor requested by the Director of Medical Services to assess the quality of care provided by a Non-VSC project site of a Pathfinder-funded clinic. The objective of the assessment is to strengthen problem areas in order to attain maximum safety for the clients.

In order to achieve this objective, the grantee should be familiar with Pathfinder's medical standards and policies. The Visitor should also be thoroughly familiar with Pathfinder site visit requirements (Page Q.1.1-2), medical policies and standards, as well as all the quality assurance indicators to be measured in this checklist. Additional observations not covered in the checklist should be noted in the "other observations" box. The Visitor is encouraged to involve the Project Director of the facility in each step of this quality assessment exercise. The observations and recommendations made should be shared and discussed with the Project Director and staff of the facility.

The Non-VSC Clinical Site Visit Checklist must be used by a Visitor when conducting a site monitoring visit of a Pathfinder-funded project. All items must be assessed and graded for quality. Do not leave any blanks. If you were unable to observe a procedure, please mark "n.o." (not observed) with an explanation as to why this activity was not observed. Monitoring site visits should occur at least once a year.

The Pathfinder Fund
NON-VSC CLINICAL SITE VISIT CHECKLIST

Project PIN: _____
 Name of Clinic: _____
 Date of Visit: _____
 Name of Visitor: _____

When visiting a Pathfinder-funded clinical site which does not provide voluntary surgical contraception (VSC) services, please check the appropriate column after your assessment. Please enter your comments in the "comments" column, especially if "poor" was checked for any category, and make appropriate recommendations to improve the situation. Non-VSC clinic monitoring with this form should occur at least once a year.

Type of Clinic: (Circle one)

Urban Rural Hospital-based Urban Hospital-based Rural

ASSESSMENT OF FACILITY				
AREA OBSERVED	GOOD	ADE- QUATE	POOR	COMMENTS
Client reception area				
Client registration area				
Client interview area privacy				
Client interview area lighting				
Client interview area ventilation				
Client examination area layout				
Client examination area lighting				
Client examination area privacy				
Client examination area access to sink				
Client examination area cleanliness of room				
Ratio of equipment to caseload				
Size of sterilizer/ autoclave to case load				

ASSESSMENT OF PROVIDER SKILLS				
AREA OBSERVED	GOOD	ADE- QUATE	POOR	COMMENTS
Screening				
Counseling				
Practice of Informed Choice				
Practice of Informed Consent				
Post-Procedure Counseling				
Management of Complications				
Instrument sterilization procedures				
Knowledge of CT				
AIDS education of client				
Knowledge of STD				
HEALTH CARE SKILLS				
Physical Exam				
Breast Self Exam				
Pelvic Exam				
PAP Smear Exam				
IUD INSERTION SKILLS				
Aseptic Technique				
Bimanual Exam				
Loading of IUD				
Sounding of uterus				
Insertion Technique				

ASSESSMENT OF CLINIC MANAGEMENT				
AREA OBSERVED	GOOD	ADE- QUATE	POOR	COMMENTS
Staff morale				
Service Provider's attitude toward FP				
Service Provider's attitude toward clients				
Clinic Supervisor's attitude toward clients				
Level of Supervision at Clinic Level				
Level of Supervision from Project Director				
Quality of written Protocols				
Adherence to protocols				
Existing referral system				
Regularity of Commodities Supplies				
Actual availability of all methods to clients				
General attractiveness of clinic				
General cleanliness of clinic				

ASSESSMENT OF CLINIC MANAGEMENT (Continued)	
Average number of cases seen per session	
Number of clinic sessions per week	
Number of hours per session	
Number of FP-trained physicians in attendance at sessions	
Number of FP-trained nurses in attendance at sessions	
Number of FP-trained auxiliaries in attendance at sessions	

INDICATOR OF QUALITY ASSESSED	MAHATTA	MADABA	ASHRAFIYA	ZARQA	EL-HUSSEIN	AQABA	IRBID	SALT	OVERALL ASSESSMENT OF SYSTEM	COMMENTS ON NEGATIVE EVALUATION
I. RESOURCES										
1. Personnel Competence										
a) Safety	Adequate	Good	Poor	Good	Good	Good	Poor	Poor	Good with 3 exceptions	• weak asepsis & infection control
b) Technical Competence	Adequate	Good	Poor	Good	Good	Adequate	Poor	Poor	Adequate with 3 exceptions	• poor client management • wrong IUD technique
2. Availability of Adequate Contraceptive Supplies	Adequate	Good	Adequate	Good	Good	Good	Good	Poor	Good with 1 exception	• only IUD supply is o.k. • non-standard other non C.T. supplies
3. Adequacy of Equipment	Good	Adequate	Poor	Adequate	Poor (1.ad)	Good	Adequate	Adequate	Adequate with 1 exception	• 27% defective in Ashrafiya • inadequate for 2 doctors in El H.
4. Physical Facilities	Good	Adequate	Adequate	Good	Poor (1.ad)	Adequate	Poor	Poor	Adequate with 3 exceptions	• inadequate in El-Hus. as heavy client load and 1 RX & RN • Irbid is dirty & poorly managed • Salt is untidy & dangerous steps
II. MANAGEMENT										
5. Adherence to Standards and Protocols	Adequate	Adequate	Poor	Good	Good	Adequate	Poor	Poor	Adequate with 3 exceptions	• weak infection control protocols • non-compliance to clinical protocols
6. IE&C Services										
a) Outreach	Poor	Poor	Poor	Poor	Adequate	Poor	Adequate	Poor	Poor	• no plan, program nor strategy • no equipment • old materials (mass media)
b) Face to Face	Poor	Poor	Poor	Adequate	Adequate	Adequate	Poor	Poor	Poor	xxxxx
7. Management of Information Systems	Poor	Poor	Poor	Poor	Poor	Poor	Poor	Poor	Poor	• no performance feedback in 1-2 years

INDICATOR OF QUALITY ASSESSED	MAHATTA	MADABA	ASIRAFIYA	ZARQA	EL-HUSSEIN	AQABA	IRBID	SALT	OVERALL ASSESSMENT OF SYSTEM	COMMENTS ON NEGATIVE EVALUATION
III. SUPPORT										
8. Program Management										
a) Management/Administrative Support	Poor	Poor	Poor	Adequate	Poor	Poor	Poor	Poor	Poor	<ul style="list-style-type: none"> • HQ seen by all as unresponsive and un-supportive (except Zarqa) • Irbid is highly supported by their "branch"
b) Supervision (of clinic staff by doctor)	Adequate	Adequate	Adequate	Good	Good	Adequate	Poor	Poor	Adequate with 2 exceptions	<ul style="list-style-type: none"> • clinic run by lower level staff for many reasons
c) Monitoring (of program)	Poor	Poor	Poor	Adequate	Adequate	Poor	Adequate	Adequate	Adequate	<ul style="list-style-type: none"> • no regular monitoring visits by HQ, only infrequent ad hoc • perception of abandonment
9. Availability of Medical Back-up	Poor	Adequate	Adequate	Adequate	Poor	Adequate	Adequate	Adequate	Adequate	<ul style="list-style-type: none"> • adequate informal system • no formal referral system
10. Existence of STDs and Protocols	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Non-existent Poor	Adequate	Adequate with 1 exception	<ul style="list-style-type: none"> • no physical trace of protocols • both doctors unaware
IV. ACCESSIBILITY: FROM CLIENT'S PERSPECTIVE										
11. Cost	Good	Adequate	Good	Adequate	Good	Adequate	Adequate	Adequate	Adequate	
12. Distance	Good	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Poor	Adequate with 1 exception	<ul style="list-style-type: none"> • >50% of clients come from outside Salt
13. Time	Good	Good	Adequate	Adequate	Good	Adequate	Adequate	Good	Adequate	
14. Cultural	Good	Good	Good	Good	Good	Adequate	Adequate	Poor	Adequate with 1 exception	<ul style="list-style-type: none"> • negative attitude to clients
V. ADOPTION										
15. Continuation Rate in F.P. Program	Not Available (N.A)	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A. Poor	

IPPF/WHR INITIATIVES ON QUALITY OF CARE

QUALITY OF CARE ELEMENTS	IPPF/WHR INITIATIVES ON QUALITY OF CARE					
	PATIENT FLOW ANALYSIS	CLIENT SATISFACTION STUDIES	COUNSELING SKILLS TRAINING	AIDS/STD PREVENTION ACTIVITIES	INFECTION CONTROL PROCEDURES	GUIDELINES FOR SERVICE DELIVERY
CHOICE OF METHOD		X	X	X		X
INFORMING AND COUNSELING CLIENTS		X	X	X		
TECHNICAL COMPETENCE			X		X	X
INTER-PERSONAL RELATIONS		X	X			X
MECHANISMS TO ENSURE CONTINUITY		X	X			
APPROPRIATENESS AND ACCEPTABILITY OF SERVICES	X	X		X	X	X

ATTACHMENT 7.

IPPF/WHR INITIATIVES ON QUALITY OF CARE

QUALITY OF CARE ELEMENTS	MONITORING ACCEPTABILITY AND USE CONTINUATION OF CONTRACEPTIVES GUATEMALA & TRINIDAD	MONITORING INFORMED CONSENT FOR VOLUNTARY SURGICAL CONTRACEPTION (VSC)	USE OF DATA COLLECTION AND ANALYSIS			SUPERVISION/DIRECT OBSERVATION
			SERVICE STATISTICS	SPECIALIZED RECORD KEEPING FOR MONITORING VSC & CBD	COMPUTERIZED CLINIC MANAGEMENT SYSTEM (CMS)	
CHOICE OF METHOD	X		X		X	X
INFORMING AND COUNSELING CLIENTS	X	X				X
TECHNICAL COMPETENCE				X	X	X
INTERPERSONAL RELATIONS						X
MECHANISMS TO ENSURE CONTINUITY	X				X	X
APPROPRIATENESS AND ACCEPTABILITY OF SERVICES	X					X

ATTACHMENT 8.

OTHER MONITORING/ASSESSMENT APPROACHES TO QUALITY OF CARE

In the section below, we briefly describe other approaches used by CAs to monitoring and assessing quality of care, as described in several papers the authors came across in their discussions. These approaches might be useful to CAs as they further refine their approaches to quality of care. In addition, the Office of Population might consider using and refining some of these methodologies when evaluating quality of care. For each paper, we briefly describe: (1) purpose; (2) methodology; and (3) major findings.

1. "User's Perspective of Counseling Training in Ghana: The 'Mystery Client' Trial," Dale Huntington, Cheryl Lettenmaier and Isaac Obeng-Quaidoo, Studies in Family Planning, May/June, 1990. (The Population Council).

Purpose. The purpose of the study was to assess the impact of a service provider training program (in counseling) from the user's perspective. While many studies have evaluated counselor training programs from the counselor's perspective, only a few have measured impact from the client's perspective and hence there is a limited research base on which to build a training program's evaluation plan.

Methodology. The study employed the methodology of the simulated or "mystery client." In describing this methodology, the authors noted that quantitative approaches, such KAP surveys, which are widely used in family planning programs, are not well suited to collect data on client satisfaction. In addition, some qualitative approaches (e.g., focus groups) are problematic because there are significant concerns about bias when a third person is present. Less obtrusive methods are needed to provide data from the user's perspective.

Thus, for the purposes of this study, simulated or "mystery clients" were used to evaluate a counseling training program in Ghana. The study compares a small number of encounters in three clinics with trained counselors to encounters in three clinics with untrained counselors. Because the methodology is relatively new, its development is reviewed in detail in the report. Very briefly, the study involved monitors and "mystery clients". The monitors were three female staff members of the Ministry of Health. They recruited and oriented the clients and interviewed them in detail after each client had visited a pair of clinics. Neither the monitors nor the clients knew which clinics had trained family planning counselors. Findings were based on 36 visits by 18 observers.

Major Findings. Some of the major finds were as follows. (1) The "mystery client" study showed that women going to a family planning clinic perceive differences between trained and untrained counselors. The differences are most obvious in the areas on which the training

program specifically focused -- providing accurate information and helping clients make choices. (2) Trained counselors provided a larger variety of contraceptive methods and more information than untrained counselors.

(3) Trained counselors left the choice of contraceptive methods up to the client, whereas untrained providers often chose a method for their clients. (4) Significantly different treatment was reported by clients of different ages. Younger, single women were not treated with the same respect or given the same detailed information as were the older women. Younger clients often were not asked any screening questions.

The report concluded that the value of the findings as a diagnostic tool were immediately recognized (and hence, the counseling training program's curriculum was revised). In addition, the method proved to be an effective tool for program evaluators charged with providing impact evaluation data on counseling training programs.

2. "Oral Contraceptive Compliance and Continuation in Egypt: Complementary Findings of DHS and Focus Group Research," Sarah F. Loza, Hussein Sayed and Linda Potter, March 1991. (Family Health International).

Purpose. In Egypt, oral contraceptive users comprise about 41 percent of those women who are contracepting. The 1984 DHS found several problems with pill use. This was consistent with previous research in Egypt that indicated that women do have difficulties in using oral contraceptives correctly. A one year anthropological study in Imbaba, Egypt, for example, described a "crazy quilt" of pill taking. Thus the purpose of this study was to explain the main factors affecting continuation, discontinuation and correct use of oral contraceptives.

Methodology. The study relied on data from two complementary studies: the 1988 Egypt Demographic Health Survey (DHS) which provided the national quantitative data, and a smaller qualitative study, based on focus groups with oral contraceptive users, conducted in four Egyptian governorates in 1989.

Of the 8,911 married women of reproductive age who were interviewed through the 1988 DHS, 1797 (20 percent) had discontinued OC use in the past five years. Another 1258 were current users. Thus the 1988 DHS asked women in these groups questions about knowledge and actual OC use.

To complement and better understand the findings of the 1988 DHS, a qualitative study was then conducted, using focus groups, with pill users and discontinuers, as well as in-depth interviews with their providers. Ninety-six women participated in 12 focus groups on OC use: six groups with 50 current users and six with 46 discontinuers. They represented four governorates, selected to represent urban and rural areas of Upper and Lower Egypt. In addition, 34 providers -- physicians, nurses, social workers, outreach workers and pharmacists -- were interviewed in each area where the focus groups were held.

Major Findings. 1797 women reported to the DHS that they had discontinued OCs in the past five years. Almost one in five (18 percent) of those discontinuers said they had done so because

they had become pregnant while using the pill. Twice as many (40 percent) had discontinued due to side effects. The types of errors being made included the following.

No Pill Pack. Although interviewed at home, 25 percent of those who said they were current pill users could not show their current pill pack when asked to do so by the interviewer.

Missed Pills. 394 OC users had not taken a pill in two or more days.

Time Between Pill Packets. More than nine out of ten did not know how long to wait between pill packets.

Not Making Up Missed Pills. Once a single pill was missed, almost 40 percent took only the usual dose the next day.

Service System. Eighty-seven percent received their pills from pharmacies. Twenty-four percent said they were not given enough information about the pill by the provider, as reflected in the lack of understanding of correct OC use reported in the survey. From the users' perspective, their providers were not a good source of information. They were uncomfortable and mistrustful of most of the physicians they dealt with.

The study concludes by observing that family planning programs have underestimated the amount of information and assistance women need to take OCs correctly and effectively. Improved training, management and working conditions for service providers, among other interventions, could increase correct and continued use of the pill in Egypt, potentially reducing the number of unintended pregnancies by tens of thousands annually. The study also commented that the methodology employed "can provide invaluable information."

3. "A Situation Analysis of the Family Planning Program of Kenya: The Availability, Functioning and Quality of MOH Services," A Report Prepared By: The Division of Family Health, Ministry of Health, Kenya; The Population Council, Africa OR/TA Project, Kenya, December 1989. (The Population Council).

Purpose. The major purposes of the study were to: (1) evaluate the availability, quality and functioning of the MOH's family planning services in Kenya; (2) develop suggestions for administrative operations and research approaches to strengthen the family planning program; and (3) test a field methodology for evaluating family planning programs at the clinic level. In the discussion below, we will only focus on those aspects of the report that dealt with quality of care.

Methodology. The methodology used was a "quick and clean" approach. The report cites a scholar who defines "quick and clean" as "studies which utilize good sampling procedures, simple observations or questions which can be answered 'yes or no,' report findings in confidence intervals and are completed in very short periods of time, e.g., in a few weeks or less."

For this study, field research teams visited a stratified random sample of 99 of the Ministry of Health's approximately 775 service delivery points (SDPs). Utilizing mostly observation techniques and some interviewing, researchers collected information on a few indicators of each major FP sub-system and on the quality of care provided to 48 new FP clients.

The researchers developed a specific data collection instrument to focus on quality of care provided to new family planning clients. The quality of care measures were based on the framework developed by Bruce and most recently by Jain. The present study attempted to develop and simple indicators for each of the six elements in the Bruce framework in order to reach conclusions about the quality of family planning services in the MOH program and to develop a more detailed quality of care study in the future.

Of the six field research staff, four were staff of the MOH -- one physician, one nurse and two health education officers. Training was provided to the field research staff for six days. A total of five weeks was spent in the field, with periodic visits to Nairobi to discuss research problems and progress.

Major Findings. For quality of care, an overall rating of "moderately high" was given. Some specific findings were:

Appropriate Constellation of Services: Rated High. Kenya has an integrated MCH/FP program, although more attention is necessary for males.

Provider-Client Relations: Rated Moderately High. General satisfaction with FP services was indicated by 93 percent of the 72 clients interviewed. Waiting time was long, with an estimated average from all SDPs of 2.5 hours.

Choice of Methods: Rated Moderately High. Ninety-four percent of new clients observed received information on two or more FP methods -- an average of 3.8 methods were discussed.

Information Given to Clients: Rated Moderate. How to use FP methods is usually discussed (87 percent) but possible complications (60 percent) and management of complications (44 percent) need greater attention.

Provider Competence: Rated High. Clients received appropriate service from providers as defined in this study.

Follow-Up Mechanisms: Rated Low. Few if any mechanisms were observed to facilitate follow-up.

The report included useful comments on the methodology. The authors stated: "the process of observing the quality of care indicators appeared obtrusive and most likely biased the data toward more positive results. One clinic staff member remarked, 'I usually do not have this much time for clients, but in view of your presence, I had better try to do an especially good job.'"

Nevertheless, the methodology was useful in that several areas which require strengthening were documented. The authors also stated that possibly the selection of a larger number of cases at a smaller number of clinics might prove relatively less obtrusive. With more exposure to the researchers, the clinic staff might adjust to the research presence by tending more toward their usual procedures. It may be possible to test this hypothesis by revisiting a sample of the clinics for a longer period of time and observing a larger number of the provider-client interactions.

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