



ENSURING ACCESS TO QUALITY
HEALTH CARE IN CENTRAL ASIA

TRAINING CURRICULUM:

ZdravPlus Quality Improvement System: A Training Course for New Curators

Authors:

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- Family Group Practice Association, Karakol City, Issyk-Kul Oblast, Kyrgyzstan
- Family Medicine Training Center, Karakol City, Issyk-Kul Oblast, Kyrgyzstan
- Family Group Practices numbers 3, 10 and 12 in Karakol City, Issyk-Kul Oblast, Kyrgyzstan
- Family Group Practice Association, Zhezkazgan/Satpaev, Karaganda Oblast, Kazakhstan

The manual would also not have been possible without valuable resource materials from:

“Integrated Supervision for Quality of Care” (draft), Pathfinder International, 2002, and

“SEATS II Training Curriculum in Continuous Quality Improvement for Family Planning Programs,”
John Snow, Inc., May 2000

August 2002



FUNDED BY:
THE U.S. AGENCY FOR
INTERNATIONAL DEVELOPMENT



IMPLEMENTED BY:
ABT ASSOCIATES INC.
CONTRACT NO. 115-C-00-00-00011-00

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I. Proposed Objectives

At the end of this course the participants will:

1. Be able to explain and demonstrate understanding of concepts in Quality of Care, Adult Learning, and Change Management.
2. Be able to competently use checklists in observation of services
3. Be able to competently use the indicators from results of observation of services, facility reviews and client interviews to analyze Quality of Care problems
4. Be able to give feedback
5. Be able to guide a group of providers through a self assessment meeting and an action plan meeting
6. Be able to perform other practical skills used in supervision and training, that are needed in a clinical QIS
7. Be able to implement a pilot in improving and measuring Quality of Care

II. Notes for Trainers

In the light of experiences with this training, for any new curators training a thorough preparation by someone familiar with the program is strongly recommended as follows:

- Organize an introductory meeting for all interested facilities in which the QIS is explained. In this meeting you can explain what the program is about. What are the advantages of the program, what will be needed in terms of commitment
- Attempt to enroll both the clinic head and the practice manager in the training.
- If not at least one of these two shows sufficient interest in QIS to want to participate in the course, do not enroll this facility in the course.

Training needs assessments will take place when trainers visit the participating SVAs to prepare for the training. Handout: Training needs Assessment form.

This same handout will be used at the end of the course to be able to judge the participants confidence in performing the various skills.

Key messages will have to be prepared beforehand on flipcharts. It would be advisable to identify these key messages with a special symbol or color so they stand out from the other flipcharts. After presentation, these flipcharts can be hung up in the training room.

III. Important Source Material:

- “Integrated Supervision for Quality of Care, draft”, Ton van der Velden and Fancine Lanar, Reproductive Health Program Vietnam, Pathfinder, 2002
- “SEATS II Training Curriculum in Continuo

- us Quality Improvement for Family Planning Programs, Incorporating Expanded Quality Improvement,” May 2000

IV. Lesson Plan

Topic Day 1	Time	Training/ Learning Methods (time)	Needs/Notes
1. Organization and Introduction on QIS	1.1: 9:00-9:15 1.2: 9:15-9:45 1.3: 9:45-9:50 1.4: 9:50-10:00 Break 10:00-10:15 1.6: 10:20-11:05 Break 11:05-11:20	1.1 Opening/Welcome Speeches/Introductions (15 min) 1.2 Getting to know each other (game: 30 min) 1.3. Review objectives/agenda (5 min) 1.4 Norms (10 min) The trainer will: - Ask Participant for suggestions for effective participation. - Give Participant additional suggestions. - Ask a Participant to record the suggestions of the Participant. (e.g., smoking, waiting room, etc) 1.5 Present today' s training objectives/agenda (5 min) 1.6 (45 min) a. Presentation on QIS structure, b. Role of curator in the system and c. Presentation on Karakol / Zheskasgan results.	Handout 1.1: Objectives and schedule Also objectives on flipchart Handout 1.2: Suggestions for effective participation Transparency 1: QIS Handout 1.3 QIS Handout 1.4 role of the curator.
2. Defining Quality of Care	2.1 11:20-11:25 2.2: 11:25-12:15	2.1 Participants are to write their definition of QOC on sticky notes. (5 min.). Trainer announces that we will look at these notes again at the end of the course. 2.2 A Hairdresser role play by trainers: (make sure in this role play to have the following elements: - Client is helped very well and is clearly happy with the service. She says to the director that she will tell her friends about the service. She also says she thinks the service is worth more than she is paying now. After the role play ask: how are hairdressers and SVA/FGPs similar? 2.2 b. Motivation story "Aida" (to be adapted with real situation in SVAs) Tell a story of a client who has come to a health center seeking RH services and encounters a series of obstacles. (for the story: see trainers note: AIDA. This story needs to be adapted to a realistic situation in your setting) The story should be told in three segments, reflecting three	See Trainers note: Aida for a suggestion for the

	<p>Lunch 2.4: 14:00-15:00 Break 15:00-15:15</p> <p>Client rights: 15:15-15:35</p>	<p>(Example: organized, professional, warm, clean, flexible, informal, helpful, polite, efficient, understanding, educational, discreet, accessible, comfortable, orderly, friendly, competent, knowledgeable.) Summarize by saying this in itself is a good definition of QOC so you do know what good quality services are like for clients Present flipchart Key message: Everybody knows what good QOC is Ask: how different is your SVA from this ideal service? Present flipchart Key Message Quality is never perfect and should always be improved.</p> <p>2.4 Frameworks for Quality of Care Topic: Bruce/Jain Short lecture on Bruce/Jain framework (20 min)</p> <p>Small Group Work: 3 groups, each takes 2 Bruce /Jain category and answers the question: Why is this category so important? What is included in this category? How does good quality in this category help the client? (30 min) Presentation and lengthy discussion (after lunch) 45 min! Additional information by trainer when needed. For content see handout Bruce Jain framework for Quality of Care in FP programs Give handout after the discussion.</p> <p>Topic: Clients rights: Brief lecture (20') Where does the framework come from? Give Handout, IPPF bill of rights Compare the 2 frameworks Bruce/Jain and IPPF. Show Transparency 3: Theoretical frameworks on Quality of Care. Give Handout 2.3. AVSC/ Engenderhealth's addition of provider 's rights Internal vs. external clients. Why is it important to keep providers/donors etc happy. Concept of Stakeholders.</p> <p>Present flipchart Key message: it is not just the clients who have an interest in how well the facility works. Providers, management and even the health department and donors have an interest.</p> <p>Summary Small group work. (In this small group work they apply previous learning to their</p>	<p>Flipchart with Key messages, Quality 2</p> <p>Transparency 2: Bruce Jain framework</p> <p>Handout 2.1: Bruce/Jain Framework for Quality of Care in Family Planning Programs</p> <p>Handout 2.2 IPPF bill of rights</p> <p>Transparency 3: Theoretical frameworks</p>
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	<p>Small group work: 15:35-16:15</p> <p>Break 16:15-16:30</p>	<p>own situation and learn why good quality is good for everybody): 3 groups. One group describes the effect of good (and bad) quality of care on clients, one group for providers and one group for the clinic as an organization. (40 min)</p> <p>Present flipchart Key message: when quality improves, everybody benefits.</p> <p>Ask Participant to look at their little sticky notes again to see how they would now write their new description now.</p>	<p>on Quality of Care Handout 2.3: Theoretical frameworks on Quality of Care</p> <p>Show Flipchart key messages Quality 3, first message only</p> <p>Handout 2.4: Effects Of Improved Quality Of Care In Family Planning Programs</p> <p>Transparency 4</p> <p>Show Flipchart key messages Quality 3, both messages</p>
		<p>Review of key messages Close</p>	<p>Transparency 5.1: Key messages for quality</p>

Topic Day 2	Tine	Training/ Learning Methods (time)	Needs/Notes
	9-915 9:15-9:25 9:25-9:30	Warm up Game Where are we? Brief review of yesterday. Questions? (10 min) Overview of today's topics/objectives (5 min)	Flipchart with schedule for today
3. Adult learning concepts as applied in CQI	3.1 9:30-9:35 3.2 9:35-10:00 10:00-10:15 Break	<p>3.1 Lecture: Adult Learning (AL) introduction (5')</p> <p>Introduce the topic by saying: Change in quality means a change in how the doctors and nurses do their work. This involves learning new knowledge, skills and attitudes.</p> <p>3.2 Principles of AL</p> <p>Option 1 The trainer will:</p> <ul style="list-style-type: none"> • Ask each participant to write about the best learning experience s/he ever had as an adult. (5 min) • Ask for a few volunteers to relate their experiences aloud. (5 min) • Ask the participant to analyze their best learning experience and write down what made it special. (10 min) <p>Sharing results as before (5 min) Make sure the discussion ends up with the key messages of Adult Learning.</p> <p>Option 2: Present a small lecture if you are not very comfortable with leading group discussions.</p> <p>At the end Present flipchart Key message: 1) Adults have experience and knowledge that should be respected and used 2) Praise and encouragement is very important to help people learn and change behavior so curators should praise and encourage, not punish when they want staff to learn new things and change the way they work 3) Since people are interested in learning about things that can help them with their problems, it follow that they are interested in solving their own problems. To improve Quality we should therefore ask what their problems are. Those are the problems that are most likely to be changed. 4) Active participation of all staff will help us be more effective.</p> <p>3.3 Knowledge, Skills and Attitude</p> <p>Say: Now that we know about learning, let's see if we can take it one step further. What is</p>	<p>Transparencies 6 and 7 (empty vessel theory, experiential learning theory)</p> <p>Show Flipchart key messages adult learning 1</p>

	4.2 11:30-11:40	<p>4.2 Brainstorm: What would make people resent change? Likely outcome: Forced change No involvement Loss of status, money, position,</p>	
	4.3 11:40-12:00	<p>4.3: Small group work, every group with 1 trainer: What would motivate people to change their behavior? Answers on flip chart. Likely outcome: Involvement in change Understand the need for change Increase in money, status, job satisfaction Change lead by friendly person with right authority</p> <p>To process the exercise, do a poster session.</p> <p>Present flipchart Key messages Change management: 1) change is hard for most people 2) people are more likely to change when they have been involved in the discussions about the change 3) people are more likely to change when they understand the need for the change 4) people are more likely to change when they like the person who has introduced the change 5) people are more likely to change if they do not lose much or even gain by the change</p>	<p>Flipchart Key messages Change management</p> <p>Show Transparency 5.3 to summarize</p>

<p>5. ZdravPlus Quality Improvement System</p>	<p>Break 12:00-12:15</p> <p>5.1 12:15-13:00</p> <p>Lunch Game 14:00-14:15</p> <p>5.2 14:15-15:00</p> <p>Break 15:00-15:15</p> <p>Exercise 15:15-16:00</p> <p>Break 16:00-16:15</p>	<p>QIS</p> <p>5.1 Lecture on ZdravPlus QIS. Principles and repeat of structure. (45 min). See handouts 5.1. When explaining the principles, for each principle, refer to the theory in Q, AL or Change management. End with: quality should be measured. (announce lunch, discuss indicators after the lunch)</p> <p>Lunch</p> <p>5.2 Lecture on indicators (see handout 5.2 for content)</p> <p>Exercise in writing indicators. Provide small introductory lecture on how to write indicators (see handout) Make small groups, give each group 1 or 2 problems from first column of the example table in Indicators handout. Ask them to write an indicator for this problem. This exercise is quite difficult. The trainer should circulate actively among the groups, giving advice and correcting mistakes.</p> <p>Give the handout 5.2</p> <p>So we have now seen the structure of the ZdravPlus QIS and we have seen the theory that lies beneath it. Now we will start discussing practical techniques: Review briefly the handout role of the curator from day 1 to refresh their memory.</p>	<p>Refer to Handout 1.3 CQI that was given out on day 1.</p> <p>Handout 5.1 Principles of ZdravPlus</p> <p>Handout 5.2 indicators</p>
<p>6. Self assessment as a Quality Improvement technique (including facilitation skills)</p>	<p>6.1 16:15-16:20</p> <p>16:20-17:00</p>	<p>Self Assessment</p> <p>6.1 Where does this fit in the QIS? Refer to Handout 1.3: structure QIS and show Transparency 1.</p> <p>6.2 Lecture on self assessment (for content see handout, part 1, 2 and 3) Tell the elephant story to explain that everybody should be in the meeting since other people may have another perspective on the problem.</p>	<p>Handout 6.1 Self assessment techniques and meetings</p> <p>Trainers note: elephant story</p> <p>Transparencies 9, 10 and 11</p>
	<p>17:00-18:15</p>	<p>Review of today's key messages</p>	

		Close	
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Topic Day 3	Time	Training/ Learning Methods (time)	Needs/Notes
	9-915 9:15-9:25 9:25-9:30	Warm up Game Where are we? Brief review of yesterday. Questions? (10 min) Overview of today's topics/objectives (5 min)	Flipchart with objectives for today
Topic 6 continued	6.3 9:30-10:00 6.4 9:50-10:30 Break 10:30-10:45 6.5 10:45-11:00 6.6 11:00-11:15 6.7 11:15-12:00	<p>6.3 Meeting preparation. Small groups make checklists for meeting preparation.</p> <p>6.4. Non-verbal Communication skills Exercise in story telling for non-verbal communication. Participants to explain a problem they are having in their work. (20 min) once attentive listeners, once inattentive. Trainer will ask for specific <i>behavior</i> that showed interest (smile, nod, eyebrows lifted, head inclined, lean towards speaker or other body language) Conclusion: These are good skills for curator / facilitator</p> <p>6.5 Praise and encouragement Growing game: Ask a participant to stand next to a wall and reach up as high as she can get. Mark the highest spot on the wall. Now ask her to do it again, but tell the entire group to cheer her on. Lead the cheering. The participant will be now reach higher. Mark the spot. Thank the participant and tell everybody that praise and encouragement can even make people grow!</p> <p>6.6 Verbal communication: large group work: brainstorm on phrases you can use to encourage and praise</p> <p>6.7. Getting people to talk Small group work on questions to use that will help people to speak. Make small groups of 5-7 people each. The small groups are facilitated by one trainee who will receive feedback on facilitation skills from the trainer after the group work ends. Give clear instructions to the group: exact assignment, time available etc. Give one example of a good question. Then give a separate instruction to the facilitators on what skills to use. Assignment to the group: At the end of your small group meeting, have a flipchart with 3 questions a curator could use to open a self-assessment meeting. The questions must make it easy for people to think about problems in their clinic from a client perspective.</p>	Transparency 12

		<p>Instruction to facilitators: Clarify the goal of the short meeting, divide roles, open discussion, use verbal and non verbal encouragement, make sure you have consensus and summarize at the end. After the discussion, the trainer gives feedback to the facilitator about these skills. Make clear to everyone this is not a role play. They are to discuss in the small groups as themselves.</p>	
	6.8 12:00- 13:00	<p>6.8 Drawing them out further Provide a brief lecture on drawing out (see handout, part 6) Do not give the examples of open-ended questions. Small group work with facilitators: Assignment to the group: write at least 2 open-ended questions that you feel will help draw people out. Instruction to facilitators: same as 6.7 After the discussion, give feedback to these skills. Plenary session to compare results</p>	<p>Transparency 13</p> <p>Transparency 14</p>
	14:00-14:15 game	<p>6.9 Summarizing Brief lecture (see handout part 7) - Most important points and - Checking for correctness</p>	<p>Handout 6.2 Facilitation exercises</p>
	6.9 14:15-14:30	<p>6.10 Problem statements Brief introductory lecture: (see handout part 4) Is it a problem or is it an idea about a solution? - Problems beginning with: “we do not have...” are usually ideas about solutions - If you do not know: Ask “what is the problem for the client”</p>	
	6.10 14:30-15:00	<p>Small group work on problem statements. Give each small group a problem statement (from handout 6.2 Facilitation exercises part B) and let them come up with a short role play in which they show how they would come to a good problem statement. No facilitators for this!</p>	<p>Transparency 15</p>
	Break 15:00-15:15	<p>6.11 Re-focusing What to do when the discussion is drifting off the topic. For example the group starts discussing solutions to the problems.</p>	

<p>Small group work: 15:15-15:45</p> <p>6.11 15:45-16:30</p> <p>16:30-16:45 break</p> <p>6.12 16:45-17:00</p> <p>6.13 17:00-17:45</p> <p>6.13 Alternative</p>	<p>Assignment to the group: write at least two good phrases to use to get a group back on topic</p> <p>Instructions to facilitator: same as 6.7, plus drawing out.</p> <p>6.12 Disputes: Lecture: see Handout part 8.</p> <p>6.13 Potential problems: Use handout 6.2 Facilitation exercises, part A. Make small groups with facilitators and give each small group 2-3 problems from section A from handout. Assignment to the group: Let them discuss how they would solve the problem. Instructions to facilitator: same as 6.7 drawing out plus refocusing plus handling disputes if needed.</p> <p>6.13 can also be done in a large group meeting.</p> <p>Review of today's key messages Close</p>		
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Topic Day 4	Time	Training/ Learning Methods (time)	Needs/Notes
	9-915 9:15-9:25 9:25-9:30	Warm up game Where are we? Brief review of yesterday. Questions? (10 min) Overview of today's topics/objectives (5 min)	Flipchart with objectives for today
7. Facility review as a Quality Improvement technique	7.1 9:30-9:40 7.2: 9:40-9:45 7.3: 9:45-10:00 Break 10:00-10:15 7.4: 10:15-10:30 7.5 10:30-11:00 7.6 11:00-11:10 Break 11:10-11:30	Facility Review 7.1 Where does this fit in the QIS? Refer to Handout 1.3: structure QIS and show Transparency 1. 7.2 Review of flipcharts of key messages: Reason we use this tool 7.3 Lecture. For content see handout 7.1. 7.4 Who could you invite to do the facility review? Discussion per facility. 7.5 What instruction would you give the person who is coming to do the facility review for you?: small group work per facility and poster session to process the results. (If desired, the trainer can organize this as small group work with facilitators to further practice facilitation skills. However, this will require more time) 7.6 Go over when to do the facility review and how to deal with the results: make list of problems on flipchart to be used in the first meeting (refer to handout 1.4 "role of the curator")	Transparency 1 Handout 7.1, facility review
8. Observation of services s a Quality Improvement technique	8.1 11:30-11:35 8.2 11:35-11:45 8.3 11:45-12:15	Observation of services 8.1 Where does this fit in the QIS? Refer to Handout 1.3: structure QIS and show Transparency 1. 8.2 review of flipcharts of key messages: Reason we use this tool Explain that observation of services is needed to objectively measure competence. Explain again that the result of the observation is a list of values for the indicators. 8.3 Review of checklists and explain where they come from. Go over when to do the observations and how to deal with the results: make graphs of results on flipchart to be used in the second meeting (refer to handout 1.4 "role of the curator") 8.4 Using checklists Small group discussion with facilitator like in 6.7	Transparency 1 Distribute clinical checklists.

	<p>8.4 12:15-13:00</p> <p>Lunch</p> <p>14:00-14:15 game</p> <p>8.5 14:15-14:45</p>	<p>Group assignment: What sort of behavior would you like from a supervisor who observes the way you treat clients?</p> <p>Instructions to facilitator: same as 6.7 plus using the phrases to get people to talk, plus drawing out plus refocusing plus handling disputes if needed.</p> <p>Poster session to present the results.</p> <p>After the poster session the Trainer will summarize on flipchart the sort of behavior curators should use if needed (look for 1:be polite, 2:be unobtrusive 3: try not to influence the measurement)</p> <p>Difference between observations for monitoring vs. training. Different objective, different behavior.</p> <p>8.5 Use of feedback: Intro: sometimes you would like to provide guidance to someone you have seen with a client; help them do a better job next time.</p> <p>Exercise drawing figures (30 min) Divide the participants in pairs. Have the pairs sit back to back</p> <p>Give one person of each pair a drawing figure (See trainers note drawing figures)</p> <p>Let the person with the figure (Talker) describe to the Drawer what is on the page. She cannot see the Drawer's results.</p> <p>The Drawer makes a drawing as best she can. Drawer cannot see the original, or ask questions. Talker cannot see what the Drawer is doing.</p> <p>Start all pairs at the same time and note the time.</p> <p>Wait until all pairs say they are finished. Measure the time it takes.</p> <p>Show results when everybody is finished. (They will not be so good.) Do the exercise again, but now the Talker can see what the drawer is doing (by looking over her shoulder) and can comment. Drawer cannot ask questions or see the original. Again wait until all pairs are finished and measure the time it takes. Show results again.</p> <p>Discuss that the second time the talker could give immediate feedback to the drawer.</p> <p><u>Key message:</u> feedback makes learning go faster and better.</p> <p>8.6 Sequence of feedback, short lecture (15 min). For contents, see handout 8.2 Make sure you refer to adult learning theory to explain why feedback is done in this way. Put the sequence for feedback on a flipchart.</p> <p>8.7 Role plays: feedback.</p>	<p>Handout 8.1 Observation of Services</p> <p>Trainers note: Drawing figures</p> <p>Handout 8.2 Feedback Flipchart with sequence of feedback (for content see in handout 8.2)</p> <p>Trainer notes: role play feedback example, patient-doctor and doctor-curator Handout 8.3cases for feedback role plays</p>
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	<p>8.6 14:45-15:00</p> <p>Break 15:00-15:15</p> <p>8.7 15:15-15:45 Demonstration</p> <p>8.7 15:45-17:45 Participants practice.</p>	<p>Two trainers do role play patient – doctor, then two trainers do a role play doctor – curator to show proper feedback. Then little groups of two participants plus one trainer do role plays on feedback. The trainer will observe the role play and give feedback on how well the participant curator gave feedback to the participant playing the doctor.</p> <p>Exercises for participants in giving feedback. Do role plays in threesomes. One plays provider, one plays curator and one is observer. At the end of the play, the observer gives feedback to the curator on how well she uses her feedback skills (using the same sequence for feedback!)</p>	
	<p>17:45-18:00</p>	<p>Review of today's key messages Close</p>	

Topic Day 5	Time	Training/ Learning Methods (time)	Needs/Notes
	9-915 9:15-9:25 9:25-9:30	Warm up game (15min) Where are we? Brief review of yesterday. Questions? (10 min) Overview of today's topics/objectives (5 min)	Flipchart with objectives for today
9. Interviews as a Quality Improvement technique	9.1 9:30-9:35 9.2 9:35-9:40 9.3 9:40-10:30 Break 10:30-11:00 9.4 11:00-12:00	Client questionnaires: 9.1 Where does this fit in the QIS? Refer to Handout 1.3: structure QIS and show Transparency 1. 9.2 Review of key messages: Reason we use this tool Key message: 1. Interviews done to measure the client's perspective. 2. Interviews done to measure Quality 9.3. Lecture on current interviews (for content see handout 9.1 Interviews) Make sure to include: - Structure of the interview - Which questions to graph, which are only for selection - Importance of graphing and the importance of the cut off point. Show examples of good graphs. 9.4 Do a graphing exercise. Take a dataset from one of the clinics resulting from client interviews and ask all participants to make the graphs. - Discuss when to make the graphs (before first meeting)	Transparency 1 HO 9.1 Interviews Graphing paper Pens etc.
10. Action plans	14:00-14:15 game 10.1 14:15-14:20 10.2 14:20-14:30 10.3: 14:30-15:00 Break 15:00-15:15 10.5: 15:15-16:00	Action plans 10.1 Where does this fit in the QIS? Refer to Handout 1.3: structure QIS and show Transparency 1. 10.2 Review of key messages: Reason we use this tool 10.3 What is an action plan? Brainstorming on components of action plan. 10.5 First column "problems" Brief lecture on prioritization (content handout 10.2 prioritization) Or:	Transparency 1 Flipchart with empty action plan or, if possible, an action pan from one of the clinics already participating in the CQI program Handout 10.1 Action plan meetings

	Break 16:00-16:15	Do small group work with facilitators Assignment: come up with a list of 5 criteria for prioritization Facilitator instruction: see 8.4	Handout 10.2 Prioritization
	10.6 16:15-16:30	10.6 Lecturette: Quick Review on how to formulate problems (see topic discussed in needs assessment training)	
	10.7 16:30-17:00	10.7 Determine causes: Story of locks on doors in Karakol to improve privacy. Key message: without cause analysis you cannot solve the problem.	Handout 10.3 Fishbone Handout 10.4 Brainstorming Transparency 16
	Break 17:00-17:15		
	10.8 17:15-17:45	10.8 Lecture on Fishbone and brainstorming Explanation of fishbone technique and brainstorming	
	17:45-18:00	Key message: 1) Ask the question: what in “clients/staff etc” contributes to the problem. 2) Why, why, why 3) Stop when you find a solution or the cause is out of your reach. Review of key messages	

Topic day 6	Time	Training/ Learning Methods (time)	Needs/Notes
	9-9:15 9:15-9:25 9:25-9:30	Warm up game (15min) Where are we? Brief review of yesterday. Questions? (10 min) Overview of today's topics/objectives (5 min)	Flipchart of today's objectives
10. Action plans continued	10.9 9:30-10:45 Break 10:45-11:00 10.10 11:00-11:20 10.11 11:20-12:00 Break 12:00-12:15	10.9 Quick review of cause analysis. Exercise in 4 small groups, each take one major cause of problems ("bone") for the same problem. Each group will have a facilitator. Instruction for the facilitator is like in 8.4 After small group work, do poster session for 15 minutes and then do large group discussion: which are the important causes everybody found. Select the causes that appear more than once and all other important causes. 10.10 Persons responsible (see handout 10.1) Brief discussion of Key messages: 1) Volunteer 2) Divide the workload 3) Write name, not position 10.11 Time frame (see handout 10.1) Brief lecture: Key messages: 1) Write end date when problem is solved 2) Ask the person responsible how much time she needs. Close.	

Topic day 1 of week 2	Time	Training/ Learning Methods (time)	Needs/Notes
11. Teaching QoC, preparing the ground for effective supervision	All afternoon	Trainers will teach other clinic staff members what QOC means and what the QIS is. It is likely that you can use much of the first day material for this (1.6, and 2.1 to 2.3).	

In week 2 the trainers will assist the new curators in implementing a QIS round in their own facility (SVA/FGP).

Before each activity

The trainer will refer the curators before each activity such as meetings to the appropriate handout. After going over the handout together, the trainer provides a detailed briefing. This should make it very clear to the curator what exactly she is supposed to be doing for this next activity, for example the self assessment meeting etc. Please pay special attention to the things the curator needs to prepare before the meetings, such as flipcharts with problems or graphs.

During the activity

During the activity the trainer will try to let the curator work independently as much as possible. Please only interrupt the curator if there are serious problems.

After the activity

After the activity the trainer will provide feedback to the curator according to the rules the curator has been taught to use herself in this course. Feedback should focus not only on what happened during the activity but also on facilitation and other curator skills (e.g. not only: do we have good problems in the action plan, are they feasible but also: did you summarize, did everybody have a chance to speak, do you have good problem statements, were all people written in the action plan really volunteers etc)

Topic day 6, week 2	Time	Training/ Learning Methods (time)	Needs/Notes
	11. Develop programs for next 6 months 12. Accountability 13. Evaluations 14. Evaluation of course 15. Certificates and Closing	Story time 120 min. Show action plans, tell us difficulties, etc. 11. Participants work in teams to develop programs for QIS activities for 6 months or on how they plan to go from here in their own setting. 12. Accountability. Large group discussion (or small group discussion with facilitators) on the things curators can do to assure that people in the clinics actually implement the action plan. 13. Participants to fill out the same form as they filled out on first day: the self-assessment. After they have done this, the trainer will distribute to each participant the needs assessment form she filled in on the first day of the course. Participants are asked to discuss (in curator pairs if possible) what they feel they are strong and	Filled-in Training Needs Assessment forms from day 1. Blank copies of the participants handout Training Needs Assessment

		<p>weak in. For the weak points they are asked to discuss with their colleague ways to assist each other) (40 min)</p> <p>Participants fill out course evaluation form</p> <p>Certificates.</p>	<p>Course evaluation form</p> <p>Certificates, pomp and circumstance</p>
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V. Trainers Notes

A. Aida

Tell a story of a client who has come to a health center seeking RH services and encounters a series of obstacles. (This story needs to be adapted to a realistic situation in your setting) The story should be told in three segments, reflecting three different visits to the SVA/FGP. This allows for bringing out several obstacles at each visit, including return visits that would not be necessary if quality services were provided.

While introducing (and telling) the story, hold up a large sign with the word "MOTIVATION" written in large bold letters. Each time the client in the story experiences an obstacle to her seeking/receiving RH services, tear a piece of the MOTIVATION sign, indicating that the client has lost a little of her motivation to practice RH. At the end of the first visit, discard the first and largest sign, which should be mostly torn up by the end of that visit, representing the obstacles the client encountered during this visit. Continue the story for the second visit with the second, smaller sign. Etc.

After the story guide a short discussion. Ask: what were the obstacles for Aida? What effect did they have on the motivation of the client? We speak often about our clients' inability to use a method or about their low motivation but often it is our actions and the way we organize our work that makes it hard for clients?

THE STORY:

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

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

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

I got to the clinic early in the morning (a little after 8 o'clock) because I have a lot of work to do at home and I needed to get back. There were a few other women there and the staff were just arriving. I sat there for an hour and it seemed like nothing was happening. *(Tear the sign.)*

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

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

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

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

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

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

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

(Tear the remainder of the sign in half and discard it. Hold the small sign in front of you so all can see it.)

The three weeks I had to wait to come back to the clinic were long. I really didn't want to get pregnant. At the same time, I was getting a little tired of coming to the clinic for nothing. This time, I arrived later (about 11 o'clock) because it didn't seem to help to get there early. The numbers had been given out earlier and so when the staff saw I didn't have one, they asked when I arrived. When I told them "about 11 o'clock", they scolded me, saying "We expect patients to get here early so we can organize our services. Next time, come early!" ***(Tear the sign)***

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

From: SEATS II, Training Curriculum on Continuous Quality Improvement for Family Planning Programs, Incorporating Expanded Quality Improvement, May 2000

B. Trainers Note: Text for Flip Charts of Key Messages

Notes to trainers:

Flipcharts with key messages should be laid-out similar for each flipchart

Please give all flipcharts a common symbol (maybe a key?)

Leave these flipcharts in the training room once you have showed them.

1. Flip Chart Quality 1

Key Messages:

- Providing Quality services is more than having technically competent doctors
- All staff together contribute to the Quality of services, so all staff should help improve the Quality of services.
- Good Quality services are organized so that the client is helped. Looking with the client's eyes at your services may help you to improve them.

2. Flip Chart Quality 2

Key Message:

- Everybody knows what good QOC is
- Quality is never perfect and should always be improved.

3. Flip Chart Quality 3

Key Message:

- Clients, providers , management and even the health department and donors have an interest in providing good quality services.
- When quality improves, everybody benefits.

4. Flip Chart Adult Learning 1

Key Message:

- Adults have experience and knowledge that should be respected and used
- Praise and encouragement is very important to help people learn and change behavior so curators should praise and encourage, not punish when they want staff to learn new things and change the way they work
- Since people are interested in learning about things that can help them with their problems, it follow that they are interested in solving their own problems. To improve Quality we should therefore ask what their problems are. Those are the problems that are most likely to be changed.
- Active participation of all staff will help us be more effective.

5. Flip Chart Adult Learning 2

Key Message:

- Having a different attitude is fine. It makes life interesting. However, some attitudes make it difficult to provide good quality services.

6. Flip Chart Adult Learning 3

Key Message:

- As a curator you can use these 5 factors (knowledge, skills, attitude, circumstances and motivation) to analyze why some service is not provided with good quality.

7. Flip Chart Change Management

Key Message:

- Change is hard for most people
- People are more likely to change when they have been involved in the discussions about the change
- People are more likely to change when they understand the need for the change
- People are more likely to change when they like the person who has introduced the change
- People are more likely to change if they do not lose much or even gain by the change

C. Trainers Note: Elephant Story

Tell the following story and, while you are telling it, act it out.

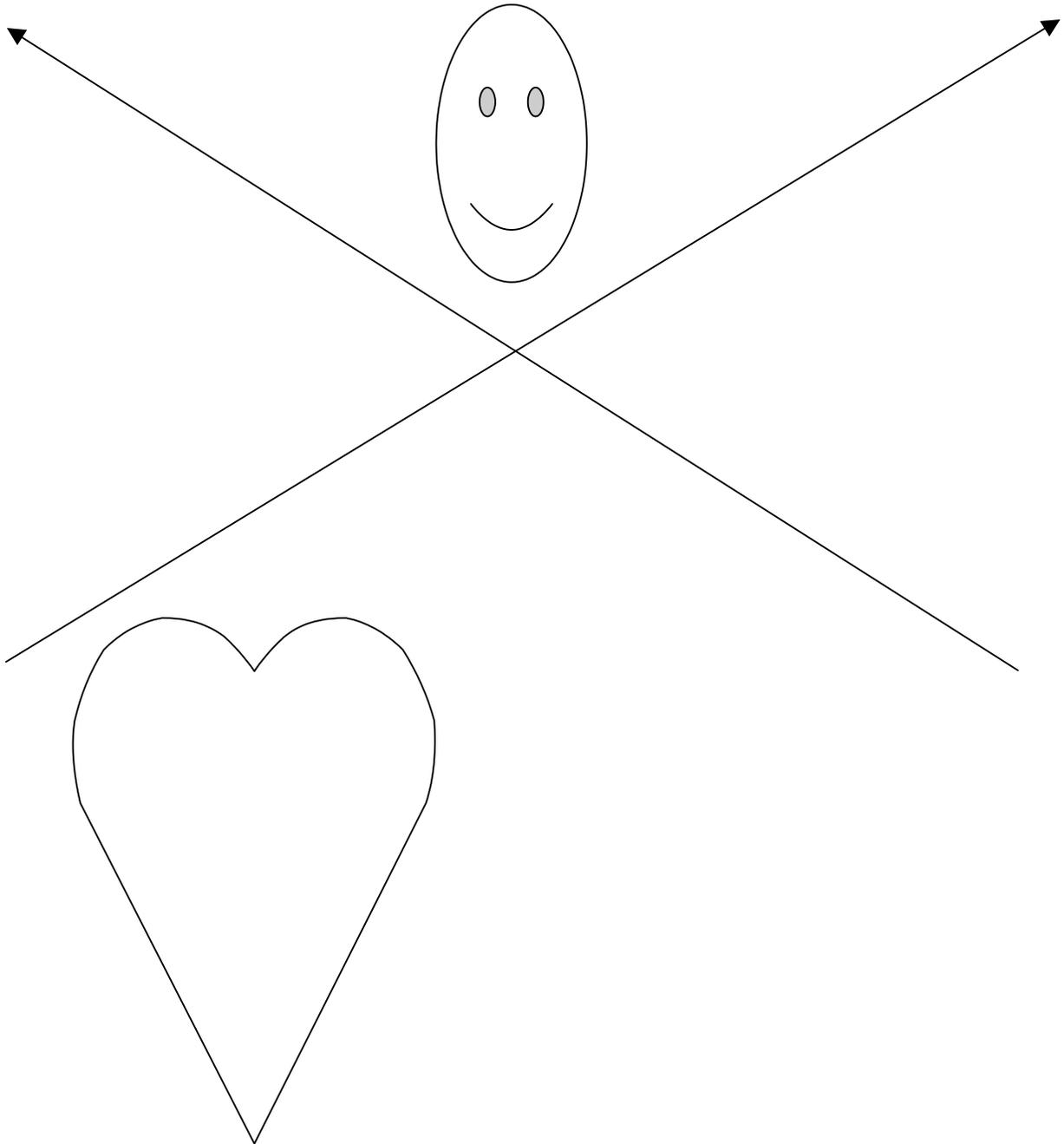
There once was a group of blind men, who were asked to tell what they were standing next to. One of them stepped forward and felt with his hands and said: "It's a wall". Another felt and said: "It's a rope". "No", said the third, "it's a hose". The fourth thought it was a large sheet of paper and the fifth thought it was a thick and pointy wooden stick.

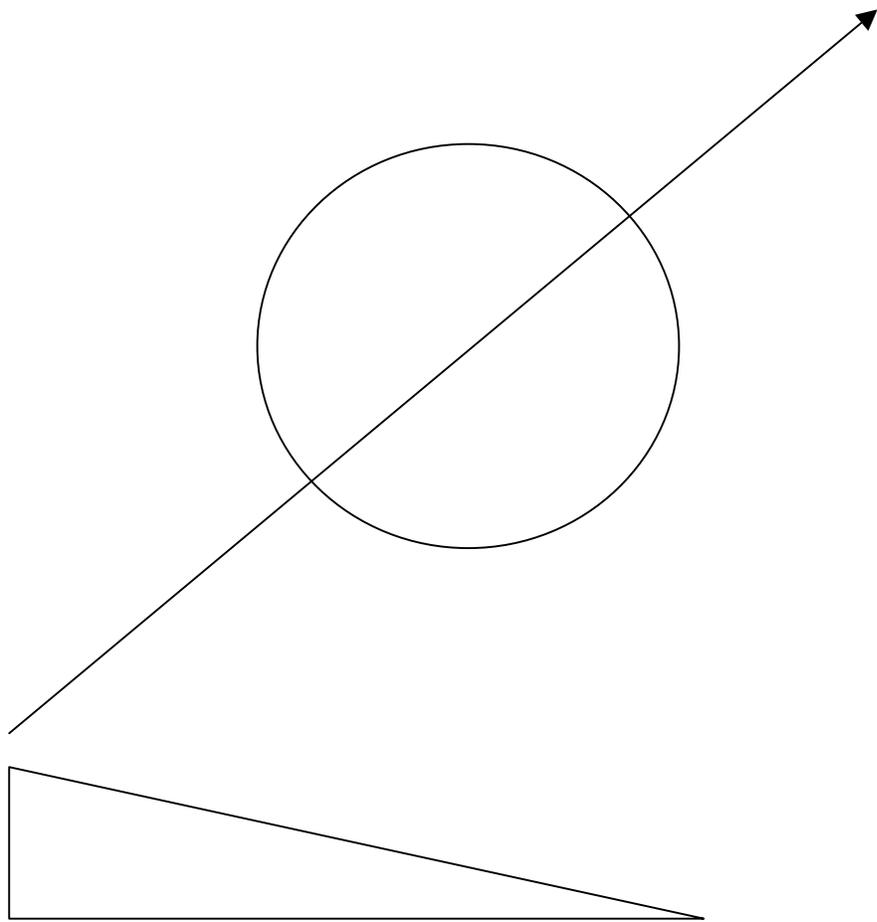
They compared their ideas and came to the conclusion that ?

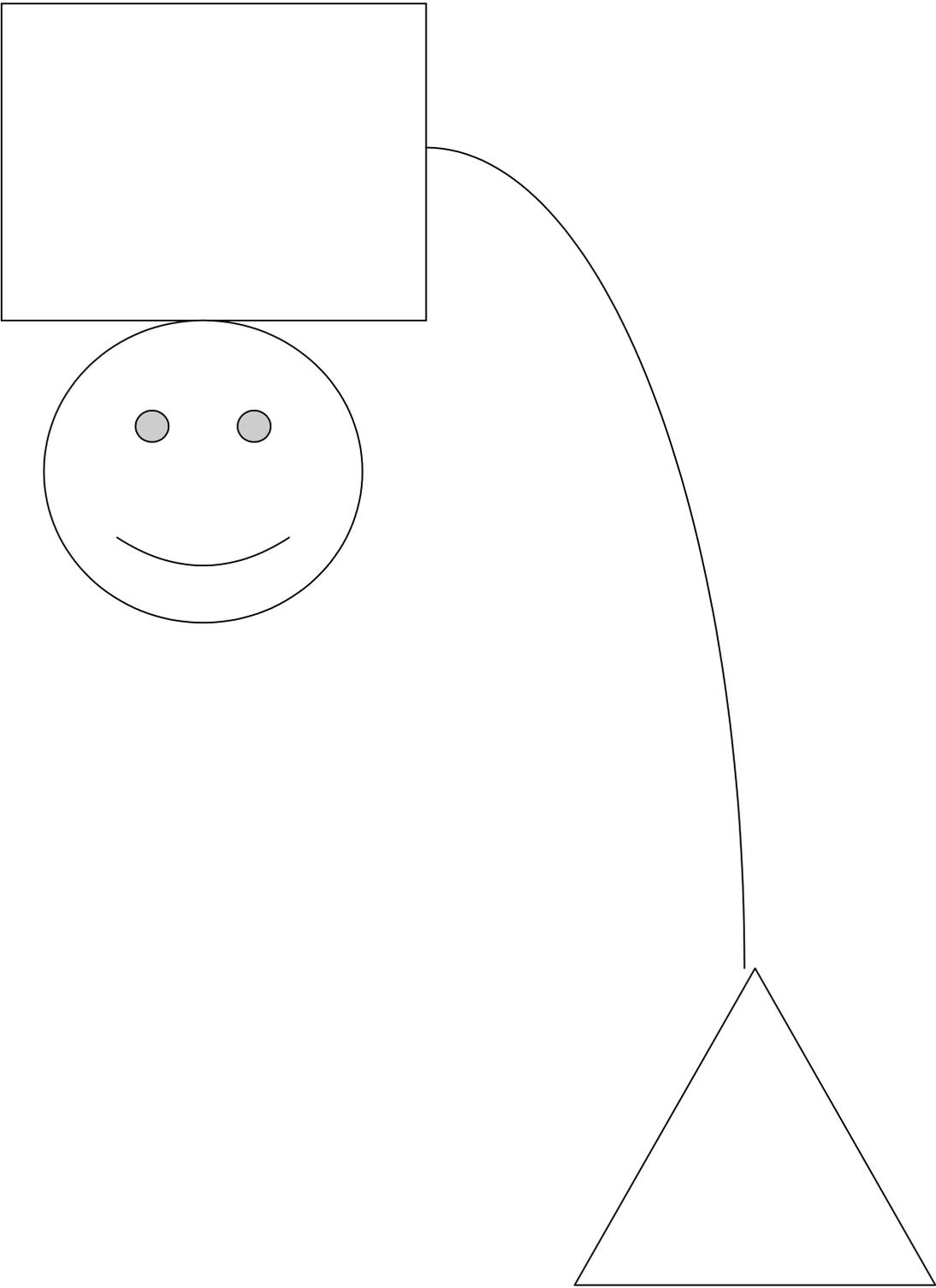
Ask if anyone knows.

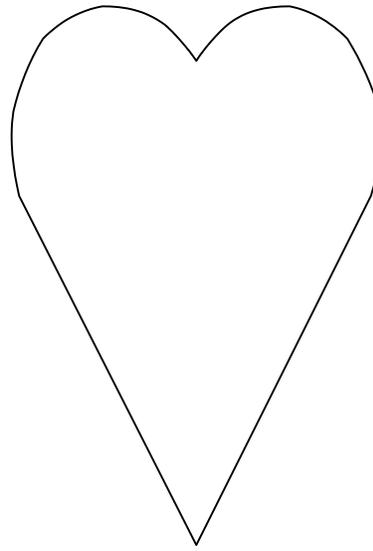
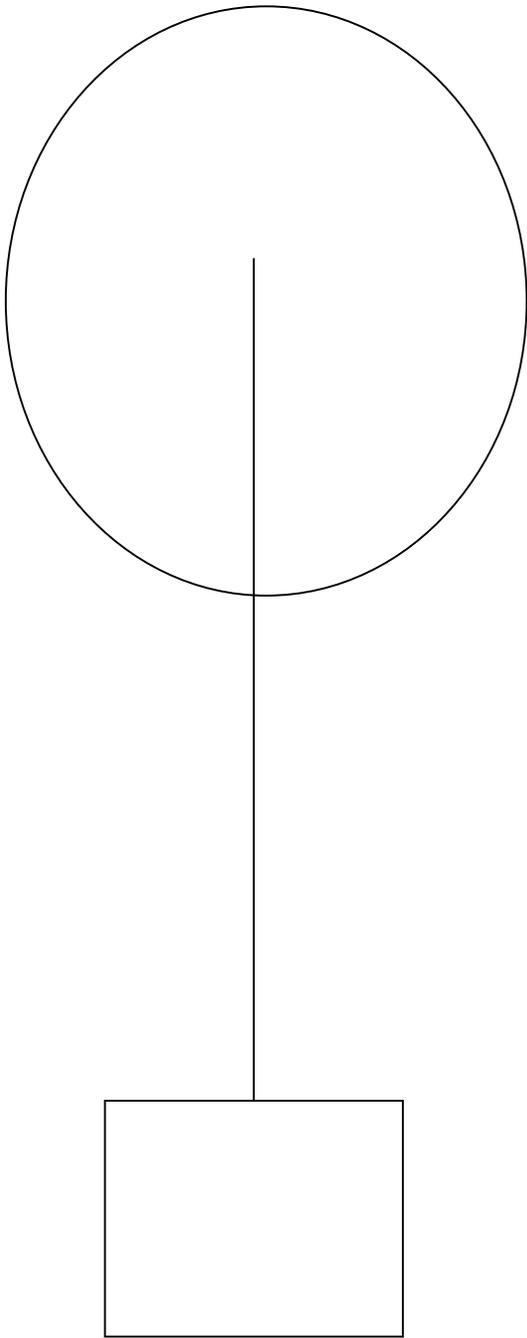
They were standing around an elephant. They concluded that each on his own, they never would have guessed the right answer but since each had a different, and correct, view, together they had a complete picture

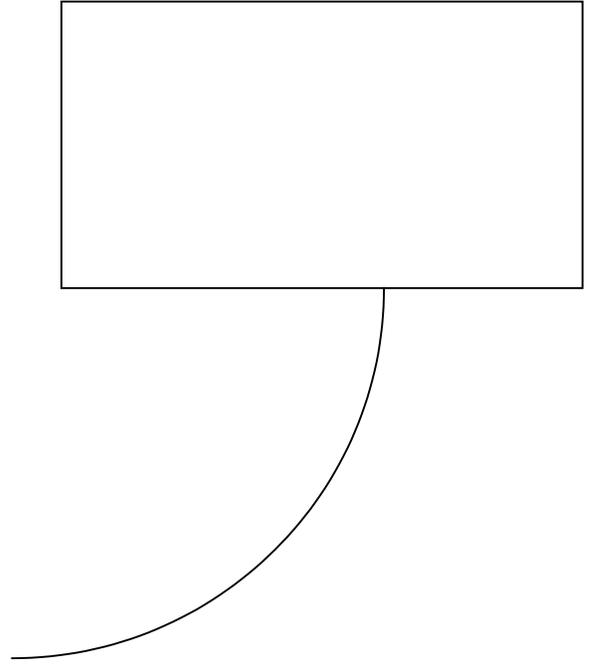
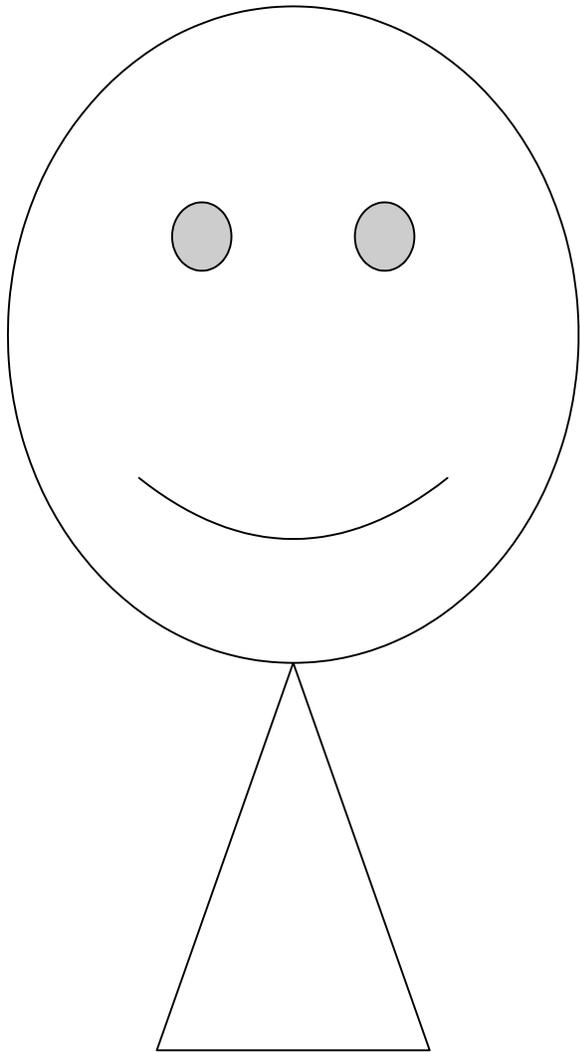
Trainers Note: Drawing Figures

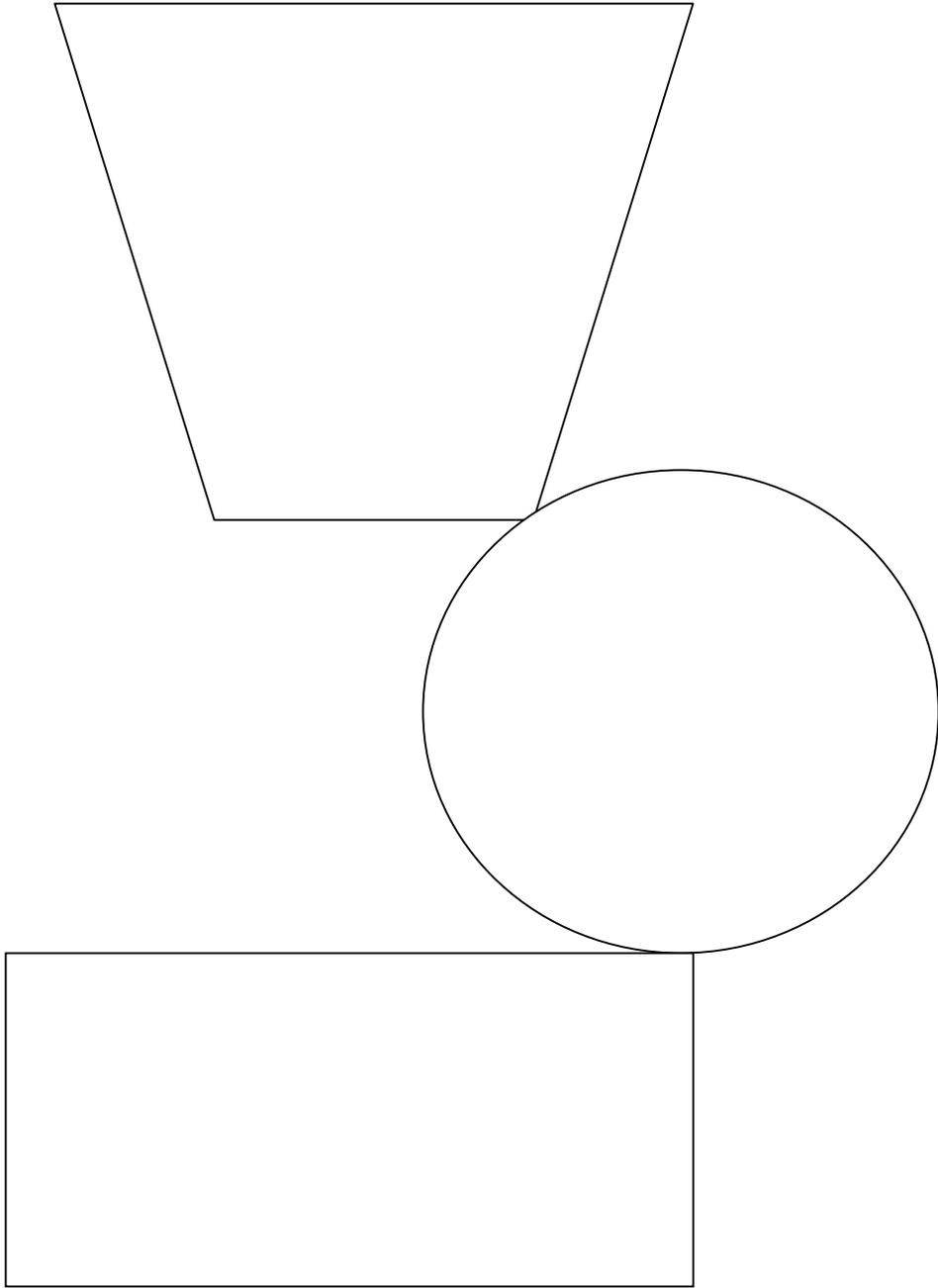


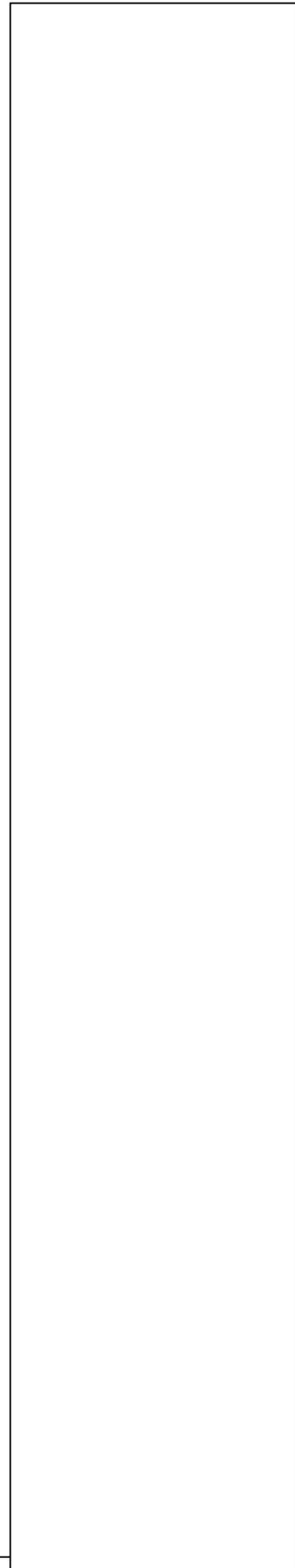
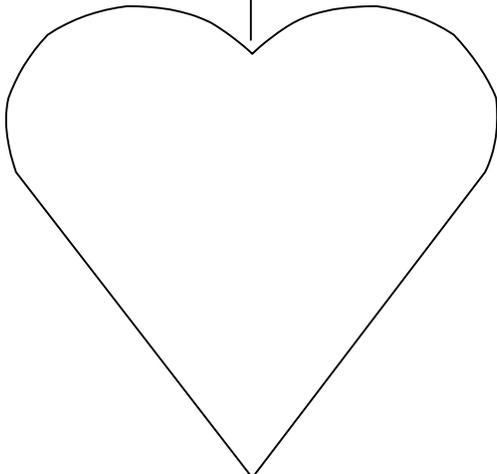
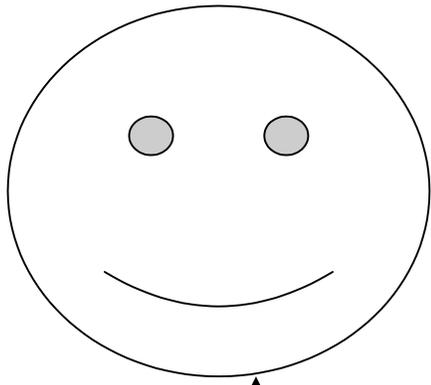












D. Trainers note: "Feedback" Role Play

Nº	Provider	Nº	Patient
1	Hello	1	Hello
2	How can I help you?	2	I came here for advice on contraception.
3	What contraceptive methods do you know?	3	I know about condoms and pills, but I don't want to use them, because my husband doesn't like condoms, and, as for me, I'm afraid I'll forget to take the pills because I'm so busy with the baby.
4	How many kids do you have?	4	I have a boy, two months old
5	How many kids are you planning to have?	5	Three more: two girls and a boy
6	When would you like to have your next baby?	6	In about a year and a half
7	How old are you?	7	23
8	Are you breastfeeding your baby? And how often?	8	Yes, I am. I breastfeed him whenever he wants
9	Has your period started again?	9	No, not yet
10	Are you breastfeeding the baby at night, too?	10	Yes, but not always. Sometimes he sleeps through the night.
11	Have you ever heard about the Lactational Amenorrhea Method (LAM)?	11	Yes, but I'm concerned that it may not be very effective. One of my friends tried it, but she got pregnant and had an abortion.
12	Well, I should tell you that, when properly used, the effectiveness of the method can be up to 98%.	12	Really? As far I know, this method only involves breastfeeding the baby whenever he wants, right?
13	Actually, it's important to breastfeed the baby regularly, at least 6-10 times a day. That's the first rule. The second rule is that your period shouldn't have returned. And the third rule is that this method is only effective for six months after childbirth. That's because at that age the baby should be getting additional food and the frequency of breastfeeding decreases.	13	But I don't understand the link between breastfeeding and pregnancy prevention? What do they have in common?
14	Well, let me explain the mechanism of action for LAM.	14	What do you mean, the mechanism of action?
15	Oh, how breastfeeding prevents pregnancy	15	I see
16	You see, LAM suppresses the process of ovulation. When the baby sucks your breast, that prevents the production of hormones that usually encourage eggs to ripen in your ovaries. Is that clear?	16	Somewhat.... Oh, but it doesn't matter. Please, go on. I think I'm following the three rules of LAM you've mentioned. Also, I think I understand now why my friend got pregnant. She was following only one of the three rules.
17	I'm glad that it's clear to you. Now, you should come to see me here as soon as one of the following occurs: When the baby is 6 months old	17	If I understand correctly, I'm not supposed to give the baby any water or additional food until the age of 6 months? But how can he survive without water?

	If your period returns If you start giving the baby any additional food If you and the baby will be apart for a longer period of time If your baby refuses to suck your breast		
18	You milk contains enough water for the baby—there’s no need for any more. So, if you think that any one of the three rules of LAM no longer holds, then come to see me. Is it clear?	18	Yes!
19	If that’s clear, please repeat for me what is LAM and how it is used?	19	Patient repeats what she understood, and the provider makes additional comments
20	I hope this method will suit you. If you have any questions, please let me know. In four months I’ll expect to see you again, to choose another contraceptive method. At that time ,I’ll tell you more about the method you choose.	20	Thank you. Goodbye!

Provider

Nº	Provider
1	Hello
2	How can I help you?
3	What contraceptive methods do you know?
4	How many kids do you have?
5	How many kids are you planning to have?
6	When would you like to have your next baby?
7	How old are you?
8	Are you breastfeeding your baby now? And how often?
9	Has your period started again?
10	Are you breastfeeding the baby at night, too?
11	Have you ever heard about the Lactational Amenorrhea Method (LAM)?
12	Well, I should tell you that, when properly used, the effectiveness of the method can be up to 98%.
13	Actually, it’s important to breastfeed the baby regularly, at least 6-10 times a day. That’s the first rule. The second rule is that your period shouldn’t have returned. And the third rule is that this method is only effective for six months after childbirth. That’s because at that age the baby should be getting additional food and the frequency of breastfeeding decreases.
14	Well, let me explain the mechanism of action for LAM.
15	Oh, how breastfeeding prevents pregnancy
16	You see, LAM suppresses the process of ovulation. When the baby sucks your breast, that prevents the production of hormones that usually encourage eggs to ripen in your

	ovaries. Is that clear?
17	I'm glad that it's clear to you. Now, you should come to see me here as soon as one of the following occurs: <ul style="list-style-type: none"> - When the baby is 6 months old - If your period returns - If you start giving the baby any additional food - If you and the baby will be apart for a longer period of time - If your baby refuses to suck your breast
18	You milk contains enough water for the baby—there's no need for any more. So, if you think that any one of the three rules of LAM no longer holds, then come to see me. Is it clear?
19	If that's clear, please repeat for me what is LAM and how it is used?
20	I hope this method will suit you. If you have any questions, please let me know. In four months I'll expect to see you again, to choose another contraceptive method. At that time ,I'll tell you more about the method you choose.

Patient

Nº	Patient
1	<i>Hello</i>
2	I came here for advice on contraceptive
3	I know about condoms and pills, but I don't want to use them, because my husband doesn't like condoms, and, as for me, I'm afraid I'll forget to take the pills because I'm so busy with the baby
4	I have a boy, two months old
5	Three more: two girls and a boy
6	In about a year and a half
7	23
8	Yes, I am. I breastfeed him whenever he wants
9	No, not yet
10	Yes, but not always. Sometimes he sleeps through the night
11	Yes, but I'm concerned that it may not be very effective. One of my friends tried it, but she became pregnant and had an abortion
12	Really? As far I know, this method only involves breastfeeding the baby whenever he wants, right?
13	But I don't understand the link between breastfeeding and pregnancy prevention? What do they have in common?
14	What do you mean, the mechanism of action?
15	I see.
16	Somewhat.... Oh, but it doesn't matter.

	Please, go on. I think I'm following the three rules of LAM you've mentioned. Also, I think I understand now why my friend got pregnant. She was following only one of the three rules.
17	If I understand correctly, I'm not supposed to give the baby any water or additional food until the age of 6 months? But how can he survive without water?
18	Yes!
19	<i>Patient repeats what she understood, and the provider makes additional comments</i>
20	Thank you. Goodbye!

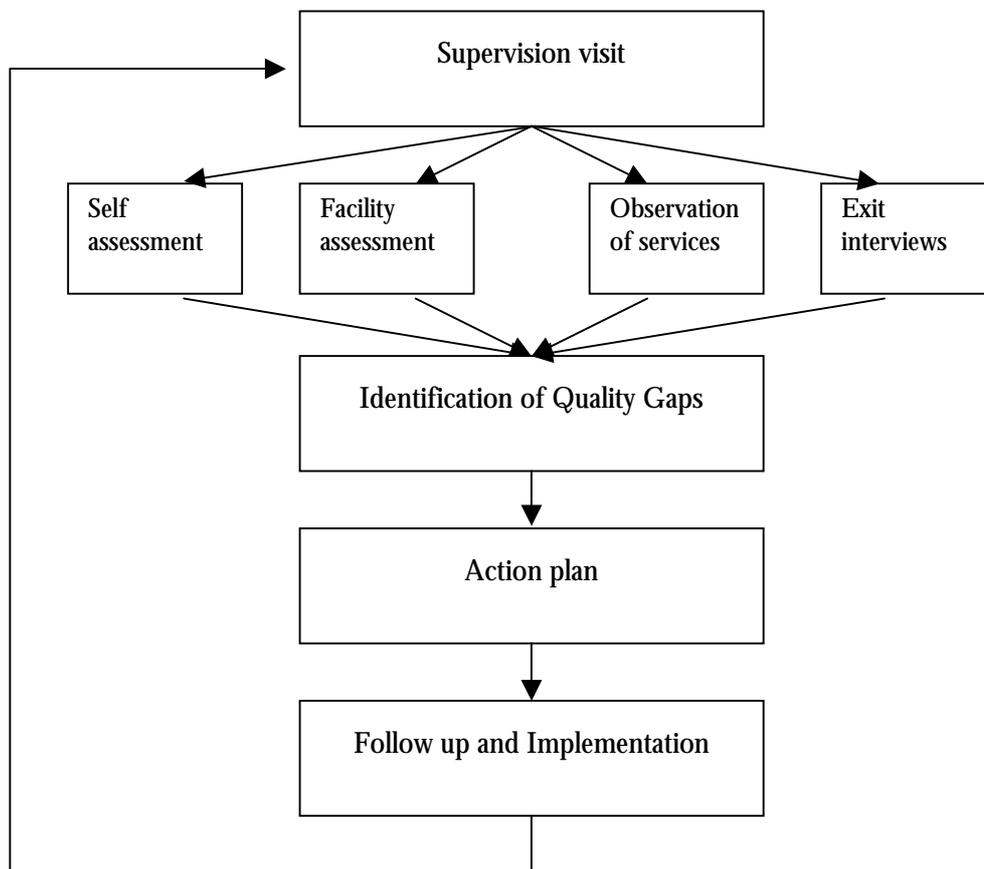
Curator

Nº	Curator	Provider
1	Good job! Very good! Excellent!	Thank you
2	Do you have any more patients?	No
3	Do you have time?	Yes, of course
4	Can we sit together privately and talk?	OK. Let me close the door
5	How do you feel about your counseling?	I think it wasn't bad. Next time I'll do it better.
6	Good! And what did you like best about your counseling?	I managed to get her to speak. Also, I explained to her the details of the three rules for LAM.
7	I agree. Now, let me ask you, what would you do differently next time?	Oh, I forgot to introduce myself. I also forgot to ask if she had been pregnant before, and if so, what happened. Next time, I'll start by explaining how the method works.
8	Fine! And would you mind if I give you some practical advice?	Oh, please do.
9	When you talked to the patient, you used some terms that she didn't understand--medical terms. For instance "mechanism of action" or "ovulation". If you remember, the patient asked what you meant by "mechanism of action." And when you mentioned "ovulation", she didn't understand, but she said it didn't matter. Wouldn't you agree when I say that the more the patient knows about a particular method, the better she uses it?	Yes, I agree.
10	Also, after you finished your explanation of the method, you should have checked to be sure if she really wanted to use it. You should have emphasized at that point that, even if she wants to use it, you can tell her about other methods as well. Otherwise, it might appear that you're encouraging that particular method. What do you think?	I agree. But I thought it was <i>her</i> choice.
11	That's true, but you should have found out for sure.	Actually, yes.
12	Also, after you gave your explanation of the method, you should have given precise instructions. Here, look. According to the check list, instructions should be given to the patient after she decides on the method. What I mean is that you should repeat the points	Yes.

	in more detail. Don't you agree?	
13	You also forgot a very important point, which is to ask if she is giving the baby any additional food. And you should have explained about danger signs.	Yes, I forgot about this.
14	In general, you did a good job of counseling and I'm sure that next time it'll be even better.	Thank you very much. This was really helpful. It's really useful to have an outside opinion.

VI. Continuous Quality Improvement Transparencies

Transparency 1: Structure of a Quality Improvement System



From: "Continuous Quality Improvement (CQI) Operations Manual", Reproductive Health Association of Cambodia, April 1999.

Transparency 2: Bruce Jain Framework

<i>Bruce/Jain Framework</i>
Information and Counseling
Appropriate Constellation of Services
Choice of Method
Technical Competence
Interpersonal Relationships
Continuity of Care

Transparency 3: Theoretical Frameworks on Quality of Care

<i>Clients' Rights</i>	<i>Bruce/Jain Framework</i>
Right to Information	Information and counseling
Right to Access to Services	Appropriate constellation of services
Right to Informed Choice	Choice of Method
Right to Safe Services	Technical Competence
Right to Privacy and Confidentiality	Interpersonal Relationships
Right to Dignity, Comfort, and Expression of Opinion	Interpersonal Relationships
Right to Continuity of Care	Continuity
Staff need for Helpful Supervision and Management	No equivalent
Staff need for Information, Training and Development	No equivalent
Staff Need for Supplies, Equipment, and Infrastructure	No equivalent

Source: Stud Fam Plann, 21(2):61-91 1990 Mar-Apr

Transparency 4: Effects or Consequences of Improving the QOC to Clients, Service Providers and the Program

Clients:

- ◆ Are more satisfied with the clinic visit and the service and/or method received
- ◆ Are able to resolve the problem for which they came (to the degree possible)
- ◆ Gain increased self-confidence and independence in future decision-making about FP/RH concerns
- ◆ Gain increased skill in decision-making
- ◆ Make more informed and better choices
- ◆ Are more likely to make a decision to adopt a FP method
- ◆ Are more likely to use correctly their chosen FP method
- ◆ Are more likely to continue using their chosen FP method
- ◆ Cope better with minor side effects
- ◆ Are more likely to respect follow-up visits
- ◆ Are less likely to be affected by rumors and myths
- ◆ Are more likely to achieve their reproductive goals
- ◆ Benefit from improvements in mother-child health

Service Providers:

- ◆ Experience greater satisfaction/motivation in their work
- ◆ Spend less time responding to client complaints and complications with methods
- ◆ Develop greater trust and respect with clients

The Program:

- ◆ Obtains increased utilization of services and better health outcomes
- ◆ Develops a positive reputation (satisfied clients promote FP/RH services and the clinics which meet their needs)
- ◆ Becomes a more cost-effective service delivery system
- ◆ Makes better use of staff time (fewer unscheduled visits for time-consuming minor complaints and side effects)
- ◆ Experiences greater continuity in method use/higher continuation rates

Adapted from: SEATS II, Training curriculum in Continuous quality improvement for family planning programs, Incorporating expanded quality improvement, May 2000

Transparency 5.1: Key messages on Quality

Quality:

- Providing Quality services is more than having technically competent doctors
- All staff together contribute to the Quality of services, so all staff should help improve the Quality of services.
- Good Quality services are organized so that the client is helped. Looking with the client's eyes at your services may help you to improve them.
- Everybody knows what good QoC is
- Quality is never perfect and should always be improved.
- Clients, providers, management and even the health department and donors have an interest in providing good quality services.
- When quality improves, everybody benefits.

Adapted from: "Integrated Supervision for Quality of Care training module", Ton van der Velden and Fancine Lanar, Pathfinder, 2002

Transparency 5.2: Key messages on Adult Learning

Adult Learning

- Adults have experience and knowledge that should be respected and used
- Curators should praise and encourage
- Since people are interested in learning about things that can help them with their problems, it follows that they are interested in solving their own problems. To improve Quality we should therefore ask what their problems are. Those are the problems that are most likely to be changed.
- Active participation of all staff will help us be more effective.
- Some attitudes make it difficult to provide good quality services.
- Use the 5 factors (knowledge, skills, attitude, circumstances and motivation) to analyze why some service is not provided with good quality.

Adapted from: "Integrated Supervision for Quality of Care training module", Ton van der Velden and Fancine Lanar, Pathfinder, 2002

Transparency 5.3: Key messages on Change Management

Change Management

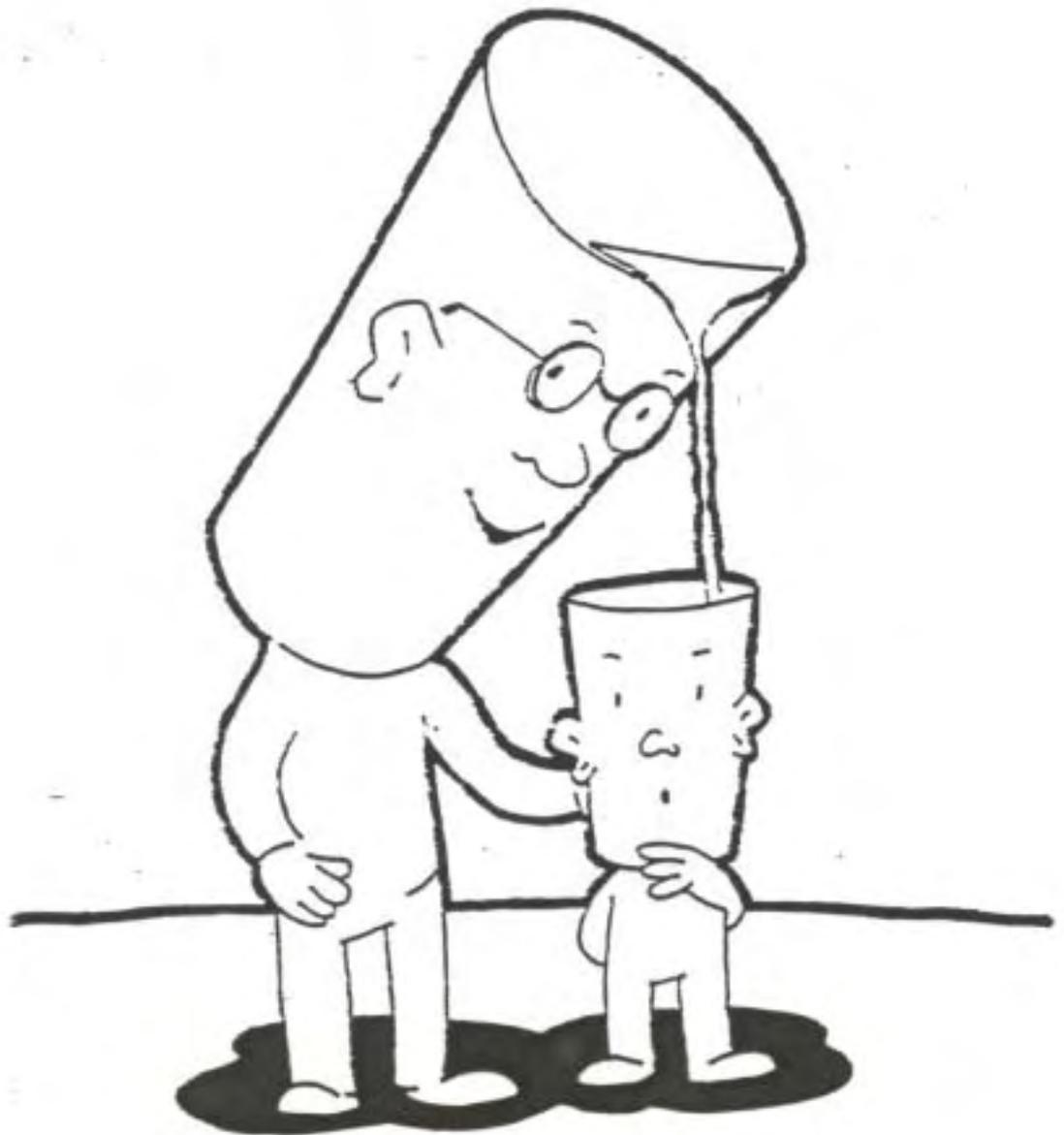
- Change is hard for most people
- People are more likely to change when
 - they have been involved in the discussions about the change
 - they understand the need for the change
 - they like the person who has introduced the change
 - they do not lose much or even gain by the change

Adapted from: "Integrated Supervision for Quality of Care training module", Ton van der Velden and Fancine Lanar, Pathfinder, 2002

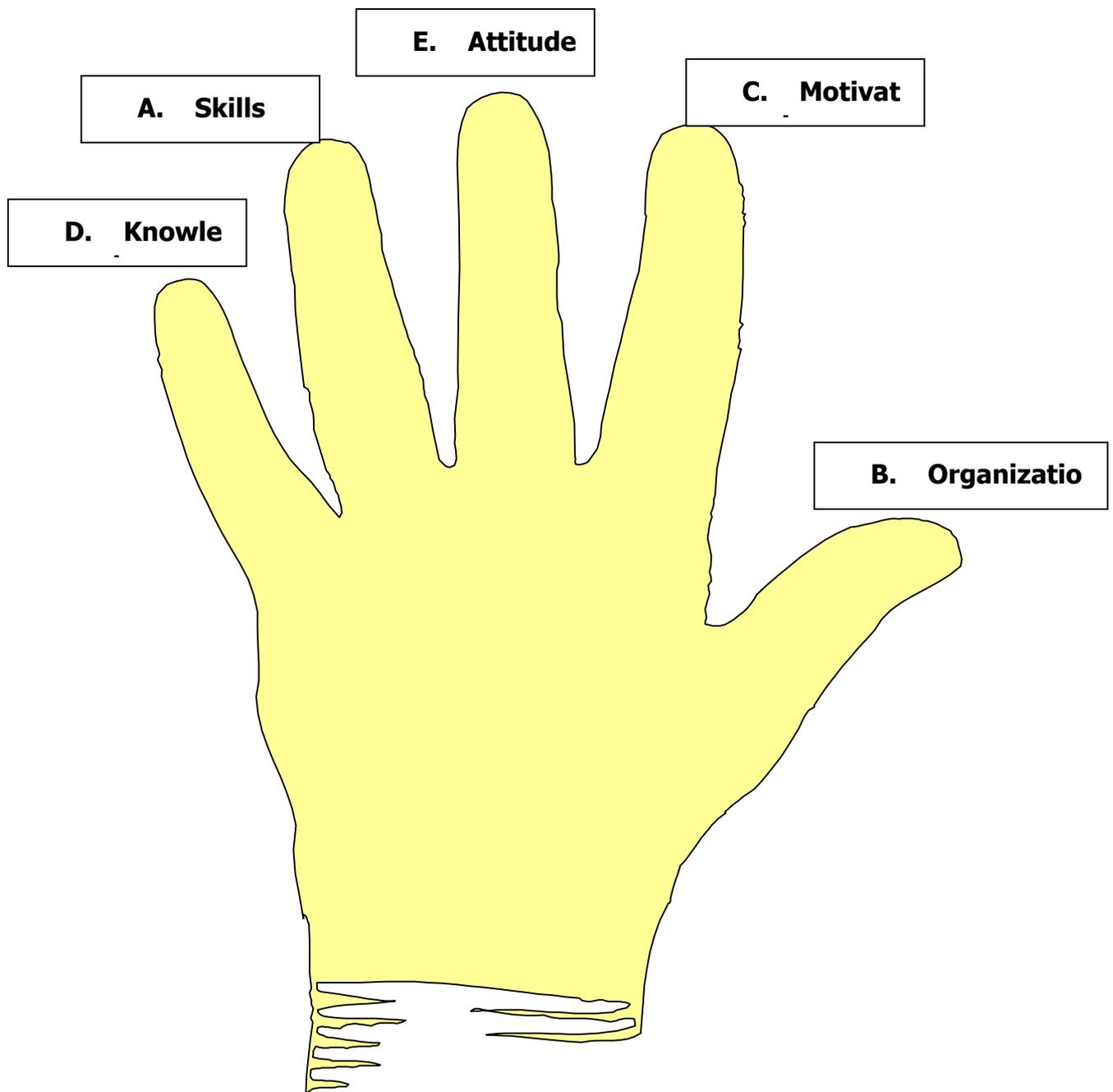
Transparency 6: Experimental Learning



Transparency 7: Empty Vessel Theory



Transparency 8. Five Factors Needed to Perform a Task Well



From: "Integrated Supervision for Quality of Care training module", Ton van der Velden and Fancine Lanar, Pathfinder, 2002.

Transparency 9: Role of Facilitator

Role of the facilitator:

- Organize and prepare meeting
- Run meetings
- Reach consensus

Transparency 10: Consensus

Consensus means that everybody:

- agrees at the end of the meeting
- is motivated and willing to help to implement the decisions

Transparency 11: How to Run Meetings

How to run meetings and reach consensus

1. state goal and structure
2. divide roles if needed
3. make rules if needed
4. guide discussion
 - get people to talk
 - encourage
 - draw out
 - summarize
 - refocus
 - deal with disputes
5. summarize and check for consensus

Transparency 12: Encourage

Encourage

- Verbal:
 - Yes!
 - That's right!
 - Hmm..
- Non-Verbal:
 - Smile
 - Nod
 - Lift eyebrows
 - Lean towards speaker
 - Mimic body position

Transparency 13: Drawing Out

Drawing out

- Use when not clear
- 2 techniques

Paraphrase and ask an open ended question:

- "can you give me an example"
- "can you tell me more?"
- "what do you mean by..."

Transparency 14: Summarizing

Summarize

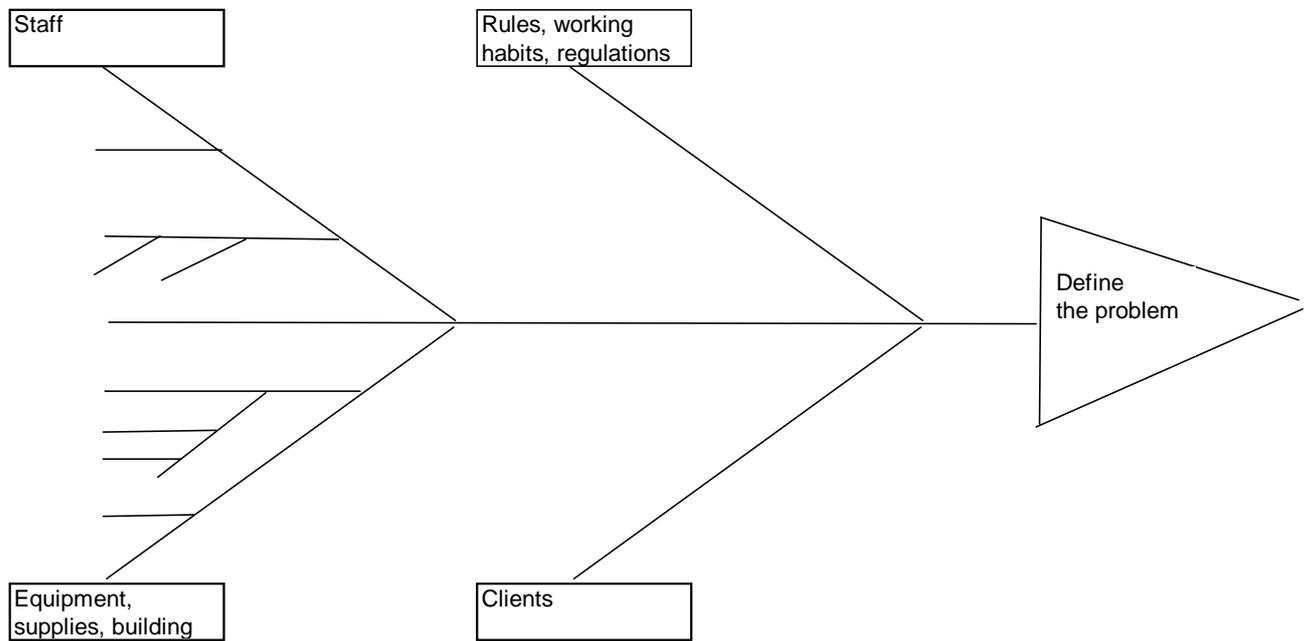
- Use when clear
- To do:
 - Describe the main ideas
 - Check

Transparency 15: Disputes

Disputes

- 3 Techniques
- 1) Find common ground
 - Indicate what you are going to do: summarizing.
 - Summarize the differences
 - Summarize the similarities
 - Check for accuracy
- 2) Not following agreements?
 - Point this out...
- 3) Apply structure

Transparency 16: Fishbone Diagram



VII. Participant Handouts

Participant Handout: Training Needs Assessment

Name: _____

1. Facilitation

Have you ever attended a facilitation course?

Yes No

Where?

When?

2. Quality Improvement

Have you ever worked in a Quality Improvement program?

Yes No

Where?

When?

3 Knowledge, Experience and Competence

Please rate your present level of knowledge, experience or competence by circling the appropriate number using the following rating scale:

1 None at all

5 Excellent

3.1	Knowledge of Theories of Quality of Care	1	2	3	4	5
3.2	Knowledge of Adult Learning Theory	1	2	3	4	5
3.3	Knowledge of change management	1	2	3	4	5
3.4	Skills in giving constructive feedback	1	2	3	4	5
3.5	Knowledge of verbal and non verbal communication	1	2	3	4	5
3.6	Knowledge of facilitation techniques	1	2	3	4	5
3.7	Experience in leading groups through a meeting	1	2	3	4	5
3.8	Competence in leading groups through a meeting	1	2	3	4	5
3.9	Knowledge of indicators and their use	1	2	3	4	5
3.10	Competence in using checklists	1	2	3	4	5

3.11	Experience in using checklists	1	2	3	4	5
3.12	Knowledge of fishbone diagrams/ cause analysis	1	2	3	4	5
3.13	Skills in making action plans	1	2	3	4	5

Participant Handout 1.1: Objectives and Schedule

Training Objectives

At the end of this course the participants will:

1. Be able to explain and demonstrate understanding of concepts in Quality of Care
2. Have created and agreed on standardized checklists and interview forms for QoC supervision activities in selected clinics.
3. Be able to competently use these supervision tools
4. Be able to perform other practical skills used in supervision and training, that are needed in a clinical QIS
5. Be able to teach supervisees what quality of care means.
6. Be able to implement a pilot in improving and measuring QoC

Training Schedule

Week 1

	AM 9:00-13:00	PM 14:00-18:00
Monday	Introduction and theory of Quality of Care	Theory Quality of Care
Tuesday	Adult Learning theory	Change management theory Principles of QIS Self assessment
Wednesday	Self assessment (continued)	Facility Review Observation of services
Thursday	Client interviews Action plans	Action plans (continued)
Friday	Action plans (continued)	no program

Week 2

	AM 9:00-13:00	PM 14:00-18:00
Monday	No program	Teaching of QIS
Tuesday	Implementation of first round, practicing of QIS skills	
Wednesday	Implementation of first round, practicing of QIS skills	
Thursday	Implementation of first round, practicing of QIS skills	
Friday	Implementation of first round, practicing of QIS skills	
Saturday	Discussion of results, evaluation, closing	no program

Participant Handout 1.2: Suggestions for Effective Participation

DO

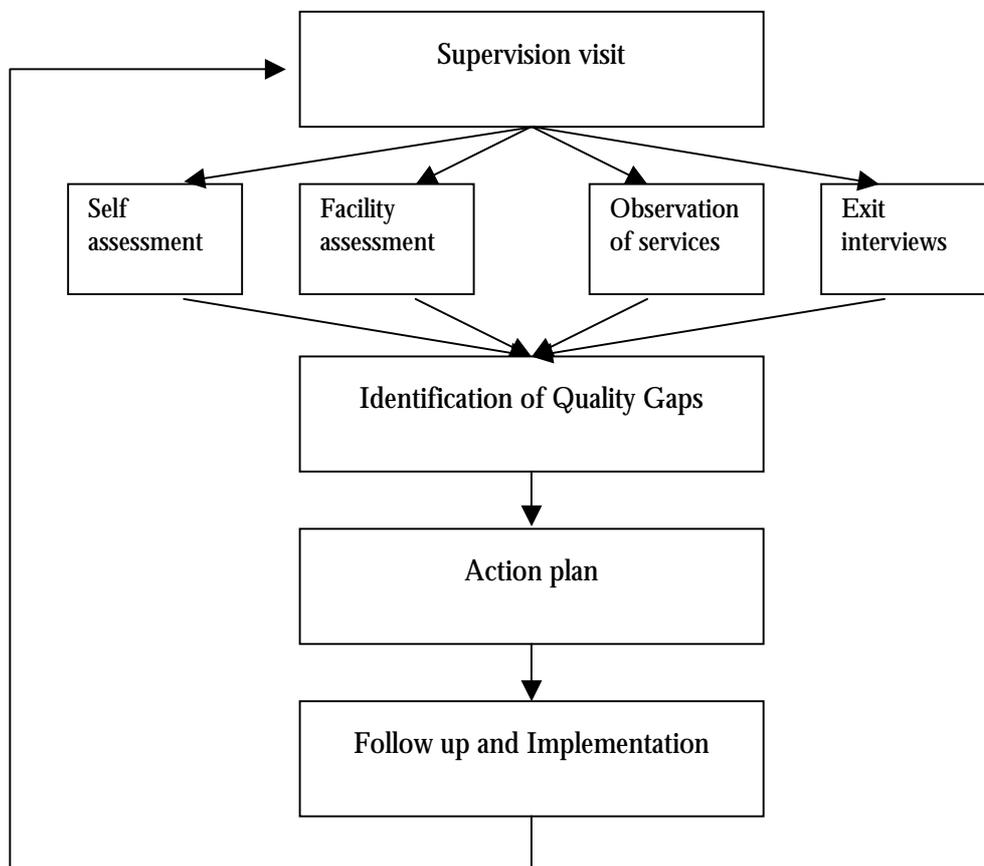
- Do ask a question when you have one.
- Do feel free to share an illustration.
- Do request an example if a point is not clear.
- Do search for ways in which you can apply a general principle or idea to your work.
- Do think of ways you can pass on ideas to your subordinates and co-workers.
- Do be skeptical - don't automatically accept everything you hear.
- Do be on time.
- Do turn cell phones and pagers off

DON'T

- Don't try to develop an extreme problem just to prove the trainer doesn't have all the answers. (The trainer doesn't.)
- Don't close your mind by saying, "This is all fine in theory, but..."
- Don't assume that all topics covered will be equally relevant to your needs.
- Don't take extensive notes; the handouts will satisfy most of your needs.
- Don't smoke in class

From: "Comprehensive Reproductive Health and Family Planning Training Curriculum, module 14: training of trainers", Cathy Solter, Pathfinder International, 1997

Participant Handout 1.3: Structure of a Quality Improvement System



From: "Continuous Quality Improvement (CQI) Operations Manual", Reproductive Health Association of Cambodia, April 1999.

Participant Handout 1.4: Role of the Curator

In the CQI system the curator is a very important person. She does not try to improve the Quality by herself but instead coordinates and motivates the rest of the staff to improve the quality of care together.

In each “round” of the QIS, the coordinator has the following tasks:

1. Organize the client interviews (approximately 80). If there are more clinics using the QIS, it may be useful to coordinate this activity with the other clinics so the interviews can all be done by an independent organization at the same time. Summarize the results for your clinic in graphs and list the answers to the open questions on two flipcharts or handouts, ready to present in the second meeting. See handout “client interview” for details.
2. Do (or organize) observation of services for the existing checklists (family planning and other services) for all doctors in your clinic (FGP/SVA) who provide these services. These observations should be done in a period where there are no client interviews! Summarize the results in a graph for the second meeting. See handout: “Observation of services” for details.
3. Organize a facility review. Summarize the results on a flipchart or handout for the second meeting. See Handout Facility review
4. Then organize a series of meetings to implement the QIS. It usually takes 2 weeks to have all meetings. All meetings need careful preparation.

The **first meeting** is the self assessment. Again it is important that as many staff members are present as possible. This meeting usually takes 3 hours. If it is more convenient, you can break it up into two shorter meetings. In this meeting you ask the staff to think of things they would like to improve in their work or their clinic so that the quality of the services for clients is improved. The result of the meeting is a flipchart with a list of problems they would like to work on. For more detail on this meeting, see the handout: “Self assessment.”

In the **second meeting** you present

- the flipchart with the results of the facility review, and
- the flipchart with the results of the open questions of the client interview, and
- the graphs of the client interviews, and
- the graphs of the observation of services.

Decide together with the staff if there are any problems that are obvious from these results. (for the graphs: are the values over the warning line?) These problems are added to the flipchart with the problems from the first meeting.

You also go over

- the last action plan.

Decide together with the staff which problems have been solved and which still need work. Those that still need work also go on the problem list flipchart.

(NB if the curator is not working at the clinic herself, making this problem list is best done by someone from the clinic for example the clinic director or head doctor. It is important for the QIS that the clinic staff, and especially the head doctor and head nurse, feel responsible for the Quality of Care in their FGP. Therefore, it is good if the staff see their boss bring up problems with Quality of Care since they will feel

it is more “their” problem than when an outsider brings it up. In addition, it increases ownership with the clinic head.)

The **third meeting** is the action plan meeting. In this meeting you work together with the staff to take the list of problems from the first and second meeting and make an action plan for the next period. For more details on this meeting, see handout: “action plan meetings”.

Participant Handout 2.1: Bruce/Jain Framework for Quality of Care in Family Planning Programs

Choice of Method

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

Clients' contraceptive needs and values change over time. Such changes may be influenced by:

- **The various stages of the woman's, man's, couple's reproductive life:**
 - from the beginning of a woman's menstrual periods (a man's ability to ejaculate) to the first sexual experience
 - from the first sexual experience to marriage (in many cultures)
 - from marriage to the birth of the first child
 - from the birth of the first child to the birth of the last child
 - from the birth of the last child to menopause (to the man's desire to cease producing children)
- **The woman's/man's/couple's reproductive intentions. Note that the following factors are closely allied to those above but may not be synonymous with one or another of the above stages in all cases:**
 - seeking to delay: initiating sexual activity but not seeking birth at that time
 - seeking to give birth
 - seeking to space births
 - seeking to limit births
 - ending childbearing

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

- **The woman's physical profile:**
 - lactational status
 - health profile (in terms of contraindications of various methods; and what the client is able and willing to tolerate in terms of side effects)
- **The individual's/couple's lifestyle and related issues of method preference:**
 - ease of use of the different methods. (Does the client: seek privacy in using the method? does he/she prefer a method that is used constantly, regardless of sexual activity, or one that is used only when sexual activity occurs? is he/she seeking a method that can be

- used without the knowledge of a partner and/or parents?)
 - risk factors for STDs and HIV infection
 - frequency of sexual activity
 - number of sexual partners
 - ease of re-supply
 - change in values, beliefs, habits and the preferences of the partner
- **Monetary cost of the method**

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

- **Client choice of method is generally a function of balancing:**
 - contraceptive goals (degree of protection desired, purpose of practicing FP)
 - sense of personal competence (in using the method)
 - evaluation of the contraceptive (in terms of safety, etc.)
 - accessibility of the method
 - convenience of use of the method
 - acceptability of the technique of administration or use of the method
- **Additional concepts regarding choice of method:**

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

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

- **The importance of choice of method**

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

- **FP services compared with women for whom the health worker chooses the method.**

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

Information Given to Clients

- **Giving information during the initial discussion/counseling:**
 - Asking if the client has a preference for a particular method.

- informing the client that there are other methods and offering to describe any or all of them
- describing how the methods are used
- explaining the advantages and disadvantages of the methods
- explaining possible side effects
- outlining major contraindications
- **Giving information following the choice of method by the client:**
 - giving instructions for use of the chosen method
 - describing/reviewing side effects and what to do if they occur
 - explaining when to return
 - explaining the service provider's continuing role and availability to assist with advice, re-supply, referral, etc.
 - leaving time for questions and clarifications
 - ensuring that the client understands crucial information about the method chosen.
- **Other considerations during counseling:**
 - adequate privacy for counseling
 - being brief, non-technical and clear, limiting the amount of information to what the client can understand and retain
 - avoiding all bias for/against FP, for/against specific methods
 - helping the client consider method effectiveness against other features of the various methods
 - leaving time for questions, clarification and checking for comprehension
- **Additional concepts regarding information given to clients:**

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

- **The importance of giving information to clients**

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

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

Technical Competence of Providers

- **Technical competence is essential to ensuring QOC. Key aspects of technical competence include that providers:**
 - have appropriate training and licensure for their jobs
 - are familiar with standards and protocols and have access to a copy in the clinic
 - follow standards and protocols in the provision of clinical services
 - follow infection prevention and control procedures
 - can accurately explain the benefits, use, contraindications, side effects and management of side effects associated with methods of contraception
 - receive routine supervision
 - have the basic items needed to deliver available FP methods.
 - respond appropriately to key RH services not provided on site, e.g., they can identify/diagnose, counsel and refer for STD treatment, prenatal care, etc.
- **The importance of technical competence**
 - technical competence is critical to achieving the results the client desires
 - it maximizes the chances of protecting the client's safety and promoting his/her health
 - the client expects providers to be technically competent

Interpersonal Relations

- **This refers to the client-provider relationship. It involves:**
 - warm reception of clients by the clinic staff
 - understanding
 - respect, including respect for privacy, confidentiality and modesty
 - honesty
 - two-way communication (without condescension), and attention to non-verbal communication
 - flexible guidance of clients
 - caring attitude
 - identification with the client and his/her problems and needs
 - empathetic information-giving to help the client obtain services and use his/her chosen method; and to allay fears
 - cooperation and coordination among staff
 - personal attention given to clients

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

- **The importance of interpersonal relations:**

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

Continuity of Care and Follow-up

- **Factors include:**

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

An FP/RH program's effort to ensure client follow-up is a measure of its long-term commitment to its clients. It represents an important link between the provider and clients.

A predictable visiting pattern supports on-going clients, picks up on clients whose needs have changed and helps to prevent discontinuation due to concerns with side effects, etc.

- **The importance of continuity and follow-up**

- helps ensure that the client will use his/her method effectively and obtain the desired result
- help detect problems early—before they become serious
- builds clients' confidence because it demonstrates commitment and concern about their health and wellbeing

Appropriateness and Acceptability of Services

- **Clients, as well as non-users of the services, perceive that the following are adequate:**
 - privacy/confidentiality for counseling
 - privacy/confidentiality with respect to physical exams
 - the waiting area
 - the waiting time
 - clinic days and hours (opening times)
 - the amount of time spent with the provider
 - the staff (language, sex, etc.)
 - proper facilities, including a clean examination room, toilet facilities, water, etc.
 - a reasonable constellation of services to meet clients' needs (either on site or by referral).

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

- **The importance of appropriate, acceptable services**
 - demonstrates that an agency/facility seeks to provide services in ways that respond to clients' needs
 - enhances the likelihood of clients using services
 - creates a pleasanter work environment for providers because clients are more satisfied

Adapted from: SEATS II, Training curriculum in Continuous quality improvement for family planning programs, Incorporating expanded quality improvement, May 2000

Participant Handout 2.2: IPPF Bill Of Rights

- RIGHT TO INFORMATION

All individuals in the community have a right to information on the benefits of family planning for themselves and their families. They also have the right to know where and how to obtain more information and services for planning their families. All family planning programs should be active in disseminating information about family planning. This should be done not only at service delivery sites, but also at the community level.

- RIGHT TO ACCESS

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

- RIGHT OF CHOICE

Individuals and couples have the right to decide freely whether or not to practice family planning. When seeking contraceptive services clients should be given the freedom to choose which method of contraception to use. Family planning programs should assist people in the practice of informed free choice by providing unbiased information, education and counseling, as well as an adequate range of contraceptive methods. Clients should be able to obtain the method they have decided to use provided there are no significant contraindications to their use of the method.

A client's concept of acceptability and appropriateness changes with circumstances. Therefore, the right of choice also involves clients' decisions concerning discontinuation of a method of contraception and method switching.

There is another aspect of choice that should be considered: as far as is practical, clients have a right to choose where to go for family planning services and the type of service provider with whom they feel most comfortable. Choosing where to go may involve a choice of physical location or a choice of service delivery mode; e.g., community family planning or health worker, pharmacy or over-the-counter service, hospital, health center or family planning clinic.

Governmental, nongovernmental and private sector providers should welcome the establishment of alternative service outlets.

- RIGHT TO SAFETY

Family planning clients have a right to safety in the practice of family planning. This right to safety implies the following:

- Although it is well recognized that the benefits to health from family planning outweigh the risks, clients have a right to protection against any possible negative effect of a contraceptive method on their physical and mental health.
- Since unwanted pregnancies may represent a risk to health, the right of the client to safety also includes the right to effective contraception.

- When receiving family planning services clients also have a right to protection against other health risks not related to a method of contraception. For example, protection against the possibility of acquiring an infection through the use of contaminated instruments. Safety relates to the quality of service provision, including both the adequacy of the service facility itself, and the technical competence of the service providers. Ensuring the client's right to safety includes assisting the client in making an appropriate choice of contraceptive, screening for contraindications, using the appropriate techniques for providing the method (if applicable), teaching the client about proper use of the method and ensuring proper follow up. The conditions in service delivery sites with the materials and instruments should be adequate for the provision of safe services. Any complications or major side effects should receive appropriate treatment. If this treatment is not available at a particular service site the client should be referred to another facility.
- RIGHT TO PRIVACY

When discussing his/her needs or concerns the client has the right to do this in an environment in which s/he feels confident. The client should be aware that his/her conversation with the counselor or service provider will not be listened to by any other people.

When a client is undergoing a physical examination it should be carried out in an environment in which his/her right to bodily privacy is respected. The client's right to privacy also involves the following aspects related to quality of services:

- When receiving counseling or undergoing a physical examination, the client has the right to be informed about the role that each individual inside the room, besides those providing services, is playing; e.g., individuals undergoing training, supervisors, instructors, researchers, etc. [Where the presence of individuals undergoing training is necessary the prior permission of the client should be obtained.]
- A Client has a right to know in advance the type of physical examination which is going to be undertaken. The client also has the right to refuse any particular type of examination if s/he does not feel comfortable with it or to request this examination be done by another provider.
- Any case-related discussions held in the presence of the clients (particularly in training facilities) should involve and acknowledge the client and not talk over the client. It is, after all, the client's sexual and reproductive organs and functions that are under discussion.
- RIGHT TO CONFIDENTIALITY

The client should be assured that any information s/he provides or any details of the services received will not be communicated to third parties without his/her consent. The right to confidentiality is protected under the Hippocratic Oath. As such, family planning services should be performed in conformity with the legal requirements and in accordance with ethical values.

A breach of confidentiality could cause the client to be shunned by the community or negatively affect the matrimonial status of the client. It may also lessen a target group's confidence and trust in the staff of a service delivery program. In accordance with the principle of confidentiality service providers should refrain from talking about clients by name or in the presence of other clients. Clients should not be discussed outside service sites. Client records should be kept closed and filed immediately after use. Similarly, access to client records should be controlled.

- RIGHT TO DIGNITY

Family planning clients have a right to be treated with courtesy, consideration, attentiveness and with full respect for their dignity regardless of their level of education, social status or any other characteristics which would single them out or make them vulnerable to abuse. In recognition of this right of the client,

service providers must be able to put aside their personal gender, marital, social and intellectual prejudices and attitudes while providing services.

- RIGHT TO COMFORT

Clients have the right to feel comfortable when receiving services. This right of the client is intimately related to adequacy of service delivery facilities and quality of services, e.g., service delivery sites should have proper ventilation, lighting, seating and toilet facilities. The client should spend only a reasonable amount of time at the premises to receive the required services. The environment in which the services are provided should be in keeping with the cultural values, characteristics and demands of the community.

- RIGHT OF CONTINUITY

Clients have a right to receive services and supply of contraceptives for as long as they need them. The services provided to a particular client should not be discontinued unless this is a decision made jointly between the provider and the client. In particular, a client's access to other services should not depend on whether or not s/he continues contraceptive services. The client has a right to request transfer of his/her clinical record to another clinical facility, and in response to that request the clinical record or a copy of it should be sent to that facility or given to the client.

Referral and follow up are two other important aspects of a client's right to continuity of services.

- RIGHT OF OPINION

Clients have the right to express their views on the service they receive. Clients' opinions on the quality of services, be they in the form of thanks or complaint, together with their suggestions for changes in the service provision, should be viewed positively in a program's ongoing effort to monitor, evaluate and improve its services. Any new program or service delivery facility should ideally involve clients at the planning stage. The aim is to satisfy would-be clients' need and preference in ways that are appropriate and acceptable to them.

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

Participant Handout 2.3: Theoretical frameworks on Quality of Care

Clients' Rights	Bruce/Jain framework
Right to Information	Information and counseling
Right to Access to Services	Appropriate constellation of services
Right to Informed Choice	Choice
Right to Safe Services	Technical Competence
Right to Privacy and Confidentiality	Interpersonal Relationships
Right to Dignity, Comfort, and Expression of Opinion	Interpersonal Relationships
Right to Continuity of Care	Continuity
Staff need for Helpful Supervision and Management	No equivalent
Staff need for Information, Training and Development	No equivalent
Staff Need for Supplies, Equipment, and Infrastructure	No equivalent

Participant Handout 2.4: Effects Of Improved Quality Of Care In Family Planning Programs

Effects or consequences of improving the QOC to clients, service providers and the program

Clients:

- Are more satisfied with the clinic visit and the service and/or method received
- Are able to resolve the problem for which they came (to the degree possible)
- Gain increased self-confidence and independence in future decision-making about FP/RH concerns
- Gain increased skill in decision-making
- Make more informed and better choices
- Are more likely to make a decision to adopt a FP method
- Are more likely to use correctly their chosen FP method
- Are more likely to continue using their chosen FP method
- Cope better with minor side effects
- Are more likely to respect follow-up visits
- Are less likely to be affected by rumors and myths
- Are more likely to achieve their reproductive goals
- Benefit from improvements in mother-child health

Service Providers:

- Experience greater satisfaction/motivation in their work
- Spend less time responding to client complaints and complications with methods
- Develop greater trust and respect with clients

The Program:

- Obtains increased utilization of services and better health outcomes
- Develops a positive reputation (satisfied clients promote FP/RH services and the clinics which meet their needs)
- Becomes a more cost-effective service delivery system
- Makes better use of staff time (fewer unscheduled visits for time-consuming minor complaints and side effects)
- Experiences greater continuity in method use/higher continuation rates

Adapted from: SEATS II, Training curriculum in Continuous quality improvement for family planning programs, Incorporating expanded quality improvement, May 2000. Source: Stud Fam Plann, 21(2):61-91 1990 Mar-Apr

Participant Handout 4.1: Change Management

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

Any way you choose to view change, change creates a series of challenges for every curator and clinic head as well as every employee. Change happens because without it there is no progress, no achievement of goals. Change can come from the “outside” – imposed by forces beyond your control. Or change can come from the inside – initiated by you or areas within your control.

The entire QIS is about change. As a curator, it is helpful to be aware of and sensitive to reactions to change and develop ways to help providers and teams adapt to the change while minimizing the loss in providing quality service.

Resisting Change

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

- their job
- their money
- being needed for their particular skill or competency
- their contacts or interactions with colleagues
- the freedom in their job
- their position of power or authority
- good working conditions
- their status

Other reasons include:

- they do not agree that the change was needed
- they do not like the person responsible for making the change
- they do not like the way the change was announced
- they feel they could have been asked for their opinion
- they feel the change has created more work or effort

Changes, for example actions from an action plan are therefore best accepted when they come from the staff themselves. Another reason to make sure you have their input!

Welcoming Change

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

- better use of their skills

- money
- position of greater power or authority
- more responsibility
- job is easier as a result of the change

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

- have an interest in new challenges
- have a positive attitude toward the person introducing the change
- feel a part of the decision making process to bring about the change
- see new opportunities

What Sort of Changes will Work?

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

Adapted from: “Integrated Supervision for Quality of Care training module”, Ton van der Velden and Fancine Lanar, Pathfinder, 2002

Participant Handout 5.1: Principles of Quality Improvement in ZdravPlus QIS

Client Focus

Quality services are those that meet the needs and expectations of clients or patients, and that treat clients with respect. Therefore, the client is the main focus of quality-improvement efforts.

Staff Involvement and Ownership

Quality improvement is not for managers alone. Every staff member is personally responsible for providing Quality services. Curators and managers promote and sustain staff involvement.

Focus on Systems and Processes

This is based on the belief that people generally want to perform their duties well, but that frequently work processes and systems do not enable people to perform at optimum levels. When organizations remove barriers to good performance, they will see better results. If managers blame staff after mistakes have already been made, staff are likely to resent this. Similarly, honest self-assessment by site staff requires trust and that staff know that identifying problems will not have negative repercussions and result in punishment.

Objective Measurement of Services using Standards

The Quality of services should be measured to find areas where quality of services is low. It should be objectively measured to be able to demonstrate improvements over time.

Staff Development and Capacity Building

Improving quality requires well-trained staff, staff that are aware of the importance of quality improvement, and who feel motivated to ensure that clients receive good services. Human resource systems, including training and supervision, as well as logistics and management information systems have considerable impact on staff motivation.

Cost Consciousness and Efficiency

Improved processes lead to increased efficiency and savings. Savings can include human resources, time, supplies, equipment or other financial savings.

Continuous Quality Improvement

The quality improvement process is ongoing - it never ends.

Rewards, not Fines

People react better to rewards than to fines. Increases in Quality should lead to rewards. Rewards can be as simple as acknowledgement from the clinic head or curator or can be as complex as more earnings. Praise and encouragement are important factors in motivation.

(Adapted from "Using CQI to Strengthen Family Planning Programs," The Family Planning Manager, January/February 1993)

Participants Handout 5.2: Indicators

What is an Indicator?

A quality indicator is a measurement that you follow over time, in a graph, that allows you to understand the quality of your services.

Indicators need to be:

- **Simple:** Easy to measure. The data that you need should be easy to collect.
- **Specific.** What you are measuring must be clearly described. For example: “The percentage of pregnant women who delivered in your enrollment area who receive good quality ANC.” To use this indicator you must be specific about what is good quality care, such as: 3 or more ANC visits plus received iron at months 3, 5 and 8 and received minimum of 2 TT vaccine shots.
- **Measurable.** The result must be a number.
- **Appropriate.** The indicator is selected so that what you measure is proven to be important to the outcome you want to improve. In other words, measure something of which you know it has an effect on quality. Appropriate also means that the indicator must refer to what you think quality is. For example: In trying to improve maternal mortality, it has been found that improving the supply of donor blood in hospitals is lowering the maternal mortality. “The percentage of hospitals with a good blood supply” (all blood tested for HIV and hepatitis and no blood from paid donor) is an appropriate indicator to follow at the national level. Another example: When wanting to show an improvement in the acceptance of family planning methods, a clinic head shows a graph that shows the increasing number of visits to her center. Her reasoning is that more people are coming to the center so more must be accepting family planning. However, there may be quite different reasons for people to come. The indicator she is using (number of visits) is inappropriate for the problem since we are not sure that the number of visits has an effect on the number of contraceptive users.
- **Reliable.** We need to choose the indicator so that no matter who measures it, the result will be the same. A big problem in measuring is that when two people measure the same thing, they get different results. This becomes a problem when we want to compare the results between clinics, since in every clinic there is a different person doing the measuring, or when we want to compare the results over time if a different person does the measuring at different times. An example of an unreliable indicator is: “The examination room is clean: Yes/ No”. Cleanliness is very subjective and different people will have different results even when looking at the same examination room. A good example of a reliable indicator is: “The percentage of clients who accept a contraceptive method per month”. If we give two people the same record book, they will come up with the same percentage.
- **Time limited.** Indicators are values that are measured over a clearly defined time span.

How do you use Indicators?

Indicators are used for the following purposes.

For monitoring. Monitoring is to constantly measure one aspect of your work to make sure the quality is still ok. A good example is measuring the temperature of every patient who is admitted to the hospital every day. In this case you use the temperature as a “monitoring” indicator. Temperature is a very good monitoring indicator: it is specific, appropriate and reliable and measured every day.

For a monitoring indicator there is an additional requirement. It needs to be “sensitive”. Sensitive means that all the possible things that can be wrong must show a change in the indicator. A monitoring indicator should catch a broad range of problems. For example, there are many things that can be wrong with a patient’s health and many of those would show a change in the temperature. When the patient’s

temperature goes up, you still need to investigate the exact problem with this patient. With a monitoring indicator usually comes a cut-off, an action line. That is the value at which you say: “Now we need to investigate. This is not normal”.

A good example is the “immunization quality of management” indicator from BASICS.

For following a specific problem. If you have a quality problem, design an indicator that tells you exactly whether the problem is being solved or not. You use such an indicator until the problem is solved. Sometimes you still measure the indicator after the problem is solved to be sure it *stays* solved. The indicator then becomes more of a monitoring indicator.

Problem following indicators cannot be sensitive. The only way this indicator should improve is there is progress towards solving the problem. So there should be very few other causes that can influence this indicator. When you design an indicator to follow up a problem always ask yourself “What else can influence this indicator that has nothing to do with the problem?” For example, the skills scores that come from the observation of services. (After the skills scores have become good, you need to decide to follow them as a monitoring indicator or to drop them)

For measuring progress towards a goal. For example in some countries there is a National Reproductive Health Care Strategy has a number of objectives for the next 10 years. For each objective they have set targets. These targets are indicators with a desired level in 10 years.

What does an Indicator Look Like?

An indicator can be a number or a percentage.

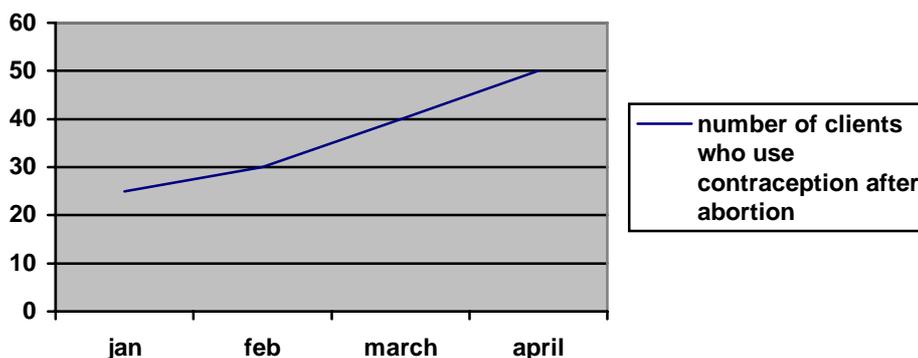
Percentages

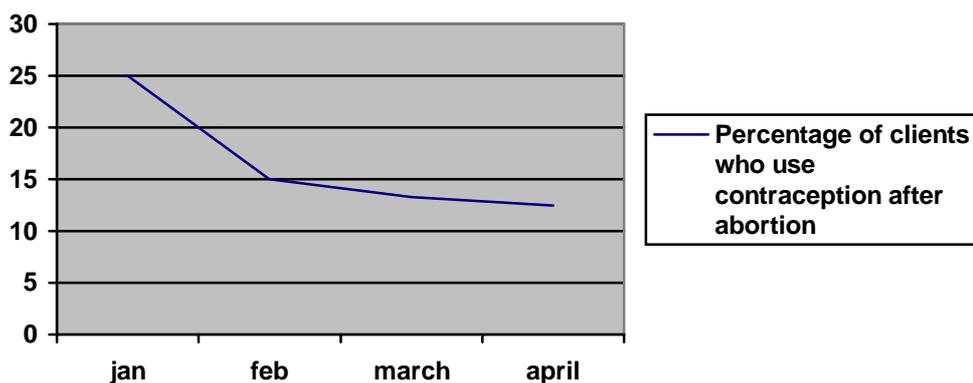
Percentages are used most often. The big advantage of a percentage is that the absolute number of clients that come to the site does not influence it.

For example: If you want to see the quality of abortion counseling, you could measure the post abortion contraception use.

	Jan 2001	Feb 2001	March 2001	April 2001
Total clients for abortion	100	200	300	400
Number of clients that use contraception after abortion	25	30	40	50
Percentage of clients that use contraception after abortion	25%	15%	13.3%	12.5%

Let’s put those numbers in a graph.





Would you say the quality of the counseling has increased or decreased? Everybody would agree that the quality of the counseling has decreased. Using a percentage and not the absolute number allows you to see that much more clearly.

Numbers

Sometimes a number is more appropriate than a percentage. For example when it is important that you know every single event. For example: the number of men who died during vasectomy.

	January 2001	Feb 2001	March 2001	April 2001
Total clients for vasectomy	1000	2000	3000	4000
Number of clients who die after vasectomy	1	2	3	4
Percentage of clients who die after vasectomy	0.1%	0.1%	0.1%	0.1%

Would you say: The percentage is so very low and it stays nicely low, everything is OK? Or would you be concerned by the rising numbers of deaths? Obviously, when there is even one death, that is too much. The absolute number is much more important here than a percentage.

Examples of Possible Monitoring Indicators:

Method Mix

Percentage of pregnant women who receive three ANC visits.

Percentage of children receive DKT3.

Percentage of children fully vaccinated

Percentage of clients who say they are satisfied with services

Percentage of women who can mention at least 3 advantages of their FP method.

Percentage of clients who have to wait more than 15 minutes for services

Average waiting time

Examples of Possible Problems and Indicators

Clients complain about the waiting time	Average waiting time per visit (measured through client interviews, or time studies)
Clients with discharge	Percentage of clients who present with discharge who have a lab test.

complaints who receive no lab test	
Clients complain about lack of privacy	Average number of times someone entered the examination room during examination (measured through client interview) Or Percentage of clients who say they are satisfied with the privacy (measured through client interview)
Providers do not wash their hands after examination	Percentage of examinations in which the provider started by washing her hands (measured through interview. Ask all clients if they were examined. If yes: ask whether the provider washed her hands)
Providers are not competent in inserting IUDs	Percentage of providers who score over 85% in clinical observation. (After a training program, observe all providers in inserting IUDs by using the IUD checklist. Calculate the percentage score for every provider. Then calculate the percentage of providers who score more than 85%)
Providers are biased towards IUDs and influence clients in using them.	Method Mix (After a training session or other activity to try to make providers more aware of the importance of free choice you can follow the method mix of new acceptors over the next 6 months to see if there is a change.)

In general, try to formulate the indicator in the same terms as you used when formulating the problem. Any time you use an indicator that is not stated in those terms, you run the risk of having a less appropriate indicator

A Real Life Example:

After a problem is solved, you may start monitoring it to make sure it stays solved.

For example, in a clinic where abortions are done, it is found that very few women who come for abortion leave with a good reliable family planning method. After some careful cause analysis (fishbone) and a discussion with the staff about the different solutions to the causes, the decision is made to rearrange some tasks to free up staff for counseling. It is also decided that the providers need more training in counseling. You organize a training program. To measure the success of the training, you propose to use as indicator the skills score as measured by observation of services. That is a good indicator to measure the success of the training. However, it is not the best indicator to find out if the problem has been solved. So we need to measure something else as well. How about :“Percentage of MVA clients who say they have been counseled about contraception use after MVA”?

Although that is a decent indicator, having been counseled does not mean clients actually use family planning. It is not the most *appropriate* indicator. You instead decide to use:“The percentage of client who accept a FP method after abortion”. The data can be collected from routine record books. This is better. Even better would be :“the percentage of MVA clients who still use the FP method 3 months after the MVA” or “the percentage of MVA clients who come back for another MVA within 3 years”. Those indicators are much harder to measure though, and a compromise must sometimes be made.

After the training the percentage is much improved. However, you are afraid it will go down again after a while so you decide to keep track of the indicator. The staff decide that whenever the percentage fall below 85%, we need to look at the problem again and do a cause analysis.

In this example we use the same indicator for problem following and monitoring. We have seen earlier that that is not ideal. However, sometimes it is the best compromise.

Making an indicator:

1. Define problem

2. Define goal
3. Indicator rolls out
4. Check against criteria
5. Check for other factors that can influence the result (e.g. waiting time study: doctors on vacation etc)

Adapted from: "Integrated Supervision for Quality of Care training module", Ton van der Velden and Fancine Lanar, Pathfinder, 2002

Participant Handout 6.1: Self Assessment

1. Theory of Self Assessment

Research has shown that the quality of services is more likely to improve if the management involves joint problem solving and if the problems that the staff report themselves are addressed. However, self-assessment alone is not enough! The curator must also ask clients, review service statistics and observe current practices since staff may not always recognize the need for improvement. That is why this QIS combines self-assessment with observations of the clinic and clinic services and client interviews. The information collected is then discussed in an open and analytical exchange with all staff members of the clinic.

During self-assessment we try to identify ways to improve quality of care even if no real problems exist. Every process can be improved upon.

Usually when a higher-level supervisor comes, staff put on their best face and sometimes even try to minimize the problems there are. But if you ask staff how you can help them do their job better or easier, in an open and friendly atmosphere, a visit can be much more productive.

Self-assessment is based in the theories of Quality, Adult Learning and Change management.

From Quality theory we learn:

- All staff together contribute to the Quality of services , so all staff should help improve the Quality of services.
- Good Quality services are organized so that the client is helped. Look with the client's eyes at your services may help you to improve them.

From Adult Learning Theory we learn:

- Adults have experience and knowledge that should be respected and used
- Since people are interested in learning about things that can help them with their problems, it follow that they are interested in solving their own problems. To improve Quality we should therefore ask what their problems are. Those are the problems that are most likely to be changed.
- Active participation of all staff will help us be more effective.

From Change management we learn:

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

What you do in a self assessment is:

- To avoid blaming people you need to point out that most problems are the result of the system, not the individual.
- You ask the staff what the Quality Gaps are
- You use all the staff, not just the senior management
- You use the wisdom and knowledge of the staff.

What you do not do in a self-assessment is:

- You do not tell the staff what the important problems are, you do not prioritize.
- You do not tell the staff what the solutions are.

2. Before the Meeting

Checklist for planning a meeting

- Have facilities and equipment reserved, set up, and functional.
- Suit room size and seating arrangements to group size and activity.
- Have materials prepared and distributed when necessary.
- Arrange tea or coffee
- Make sure location is accessible and that people are available. Pick a time and place that as many people as possible can participate without interruptions.
- Tell participants what the time, place and purpose of the meeting is and who will attend.
- Establish for yourself what the outcome is for this meeting, what you want to accomplish. Make sure that you can do this in the time available.
- Plan some activities that encourage everyone to participate. Include a variety of activities (e.g., writing, listening, discussing, small group work etc).
- Make a brief time schedule for the meeting
- Write the agenda on a flipchart

3. The Meeting

Your role in the meeting is that of a facilitator. Someone who makes the meeting easier for the participants. Your job is to guide the meeting, and reach consensus .

Consensus means that at the end of the meeting everybody not only agrees with the decisions but is also willing to help implement the decisions. To reach consensus you must make sure everybody has a chance to speak and everybodys opinion is respected.

When you open the meeting, state the goal of the meeting (for example : to think together and come up with things that we would like to improve in our work so that the clients are better served) and its structure

Divide roles if needed: ask for a notetaker and a timekeeper if you feel you need them.

Make rules if needed, for example: please respect each other opinion, one person to talk at a time, decisions will be taken by voting etc.

Guide the discussion. Guiding the discussion means getting people to talk, encourage them, draw them out, summarize their ideas, deal with disputes and at the end, summarize again and check for consensus.

4. Getting People to Talk

It is a good habit to formulate some good opening questions during your meeting preparation. For example: you could open the discussions by asking:

- “Have you ever felt that you could be doing a better job for some clients? What service was that”

- “If your family came here for their health care, what would you like to see improve for them?”

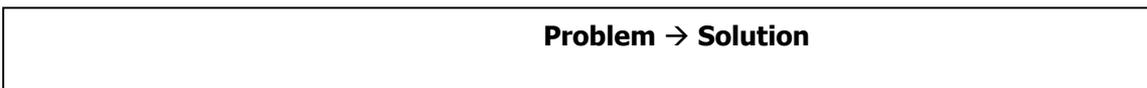
Often when you ask the staff members in a meeting to identify what the problems are in their service, they find it difficult to come up with some suggestions or they may be shy. Possible techniques to get them to talk are:

- Make small groups, with staff mixed in every group. Ask them to come up with well described problems, with as much detail as possible, but not with what may cause them or with solutions. Ask them to write their problems on a flipchart. Ask them to present the flipcharts.
- Alternatively, ask them to write these problems down on small pieces of paper. One problem on one paper. Collect them anonymously and then hang them up for all to see. This way is more anonymous and it may give them more confidence to talk.

Problem statements

Often staff will come up with supplies they lack or equipment they would like. While those are often good ideas, these are not really problems. They are ideas about solutions to problems.

If you accept them, you miss the actual problem, and you might miss the chance to find other possible solutions.



For example: the staff propose :”we lack a colposcope” Having a colposcope is a solution, but to which problem? Likely the problem is something as:”we can not provide colposcopy services to our clients” . If that is the problem, then the cause can indeed be the lack of the colposcope, but also the lack of referral services for colposcopy. With this additional cause identified, other solutions (organizing the referral) are possible.

So: When you accept ideas about solutions, you are prevented from thinking more about the problem and its possible causes. Problems beginning with: “we do not have...” are usually ideas about solutions. This confusion of problems and ideas of solutions is very common. To get around this, ask “**what is the problem for the client?**”

Techniques for if there are dominating people in the group

If one person is very dominating: you can explain that person that she has good ideas but that it is important that others are heard too. Ask her to help you in getting others to talk. Try to get her to accept a “helpers” role.

If you have several dominating persons, put them together in a small group.

5. Encouragement

Encouragement is verbal and non verbal.

Verbal:

- Yes!
- That’s right!
- Humm..

Non-Verbal:

- Smile
- Nod
- Lift eyebrows
- Lean towards speaker
- Mimic body position

6. Drawing Out

One of the jobs of the facilitator is to make sure that once people express their ideas, everybody understands them.

Sometimes people will have difficulty explaining an idea or explain it so vague and confusing that not everybody understands the idea. Drawing them out will help them clarify their thoughts and refine their ideas and help the other people understand them better.

When you draw somebody out correctly, it sends the message: "I would like to hear more about this idea or yours, please tell me more" Together with friendly non verbal communication it is an effective technique.

Drawing people out will also help to make sure the problem is correctly stated.

When to do it:

When you as a facilitator feel you do not quite understand what someone said or if you feel others do not understand it completely. (when you feel everybody does understand, summarize and check for correctness!)

How to do it:

There are two main techniques.

1. Paraphrase the idea and then ask an open ended question:
 - "can you give me an example"
 - "can you tell me more?"
 - "what do you mean by..."
2. paraphrase the idea and then use a "connector"
 - "you are saying we need to do this because?"

[note to translator: if this does not work in the local language, please leave the second technique out]

7. Summarizing

Summarizing is useful to help a discussion along and to clarify the main ideas. To do it, describe the main ideas and then check with the person who brought up the idea to make sure you summarized correctly.

8. Disputes

When two or more people are having an argument, often they become more and more polarized. The differences become greater and they become further and further apart. It becomes harder and harder to reach agreement.

What you might try in this case is point out to them what they have in common. This makes it easier for them to listen to each other again.

How to do it

1. Indicate what you are going to do: summarizing.
2. Summarize the differences
3. Summarize the similarities, the things they have in common.
4. Check for accuracy

For example you can say::

1. "Let me summarize what I am hearing from each of you.
2. I am hearing a lot of differences but also some similarities. It sounds like one group wants to do .. and the other want to do ... Is that right? (or: Vassili, you are saying that we should do.... Is that correct? And Olga, you say that Is that correct?)
3. Even though, you both feel that... (can be as simple as :” you both feel we need to solve this problem/ we need to make sure this doesn’t happen again etc. The more detail you find in the similarities the better.)
4. Am I right?

9. After the Meeting

Evaluate the first meeting for yourself and with the other curator in terms of accomplishing the desired objectives, timing and staff participation (e.g., did everyone speak, did we hear everyone’s ideas or did a limited few dominate the discussion? Did I dominate the discussion? Are the problems and solutions the group came up with really theirs or did I guide them towards what I think the problems and solutions are?).

Adapted from: “Integrated Supervision for Quality of Care, draft”, Ton van der Velden and Fancine Lanar, Reproductive Health Program Vietnam, Pathfinder, 2002

Participant Handout 6.2: Meeting Exercises

Part A

How would you deal with the following problems if you were the facilitator of the meeting?

1. Two people at the far corner of the table have been talking to one another for the past minute or so. You noticed at the start of the meeting that they were frequently exchanging brief comments, but now they seem to have formed their own meeting. . What do you do?
2. The group has been discussing the same issue and repeating the same reasoning over and over. You're all now discussing this for the third time. . What do you do?
3. Vassili has asked an irrelevant question, one that will take four to five minutes to answer. Other members of the group are also expressing strong interest in his question: they too want to know the answer. . What do you do?
4. Every time the discussion becomes interesting, the clinic head-who has not been trained as a curator-stands up and gives a short speech on the problem which always ends with :” So we should try harder and then it will be much better”. After her brief speeches, the staff always is silent. What would you do?
5. The group has been discussing the problem of long waiting times when the staff have their weekly meeting. There are two people very active in the discussion and they are getting louder and louder, just repeating their point of view, without listening to the other. What do you do?
6. When the group is asked to give ideas about improving the quality of care, one doctor stands up and says:” the problem is that nurse Olga does not do good work.” What do you do?

Part B

1. When the group is asked to give ideas about improving the quality of care, one doctor stands up and says:” We need to have a colposcope because we do not have one”. Then she sits down. There is a little silence. What do you do?
2. When the group is asked to give ideas about improving the quality of care, one doctor stands up and says:” We do not have enough money to buy gynecological examination tables for all doctors”. Then she sits down. There is a little silence. What do you do?
3. When the group is asked to give ideas about improving the quality of care, one doctor stands up and says:” The problem is that

Participant Handout 7.1: Facility Review

The facility review is the best opportunity for a curator to look at the facility with the client's perspective. Most providers have a tendency to organize their work and their services in such a way that it is convenient for them. They organize their work in such a way that it is easy for them to do it. It is a normal tendency for providers. However, having the facility organized so the work is easy for the staff is usually **not** the way that is best for the clients.

Also, it is sometimes hard for providers to see their own services with a client's perspective since they are too involved in it. When you work in a building every day, it is hard to imagine that some of your new clients won't be able to find it without some signs on the road. When you have worked a fixed schedule every day, it is hard to imagine that anyone would not know the opening times of the facility.

The facility review is an opportunity to see the services from an outsider's perspective, and from a client's perspective.

Ideally the facility review is done by someone who is not a staff member of the facility.

During a facility review, most supervisors work along a checklist. Although this is useful, checklists give the providers the impression of inspection, of control. This is not the impression you want to give. It may be better just to walk around and ask questions, without a predefined list.

Any problems you find can be mentioned during the meetings. If you do the facility review together with a director, she may be able to mention the problems during the meeting. This probably works better than when the curator comes up with the problems.

Source: "Integrated Supervision workshop", Ton van der Velden, WPF, 2001

Participant Handout 8.1: Observation of Services

Clients Rights during Monitoring and Observation

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

Tips for Conducting a Good Observation

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

- **Before the first consultation:**

Before the first consultation, you must get the provider's permission to sit in and observe the client-provider interaction. Normally this is not a problem.

The providers should also be told that as an observer you cannot participate in providing service during the consultations. The provider should not ask you for your opinions or advice, except in extremely serious situations; the provider should be requested to behave as if you are not present. You will have to be seated fairly close to the client and provider to be able to see and hear exactly what goes on. Make sure you agree on your role and on where you will be sitting.

- **Before every consultation**

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

- **During consultations**

Your presence is definitely going to affect the interaction, probably by making both the client and the provider more self-conscious and aware of what they are saying and doing. Having an observer present will disturb most people in their normal work routine. Some become flustered, some start to forget things they normally do not forget. If this comes up, assure the provider that you understand this. You should do everything possible to make yourself unobtrusive. If possible, you should sit in the background so that you are not directly in eye contact with either the provider or the client.

The observation guide is designed so that you can score boxes that describe what you have seen. Because there is no fixed order for each consultation it is essential that you learn the structure of the observation guide so that whenever you see a particular action or hear a specific issue being discussed you know exactly where to mark the guide. In most cases it should be possible to remember what happened and to mark the guide after the consultation if finished. Once you are skilled with the checklists they can be completed after the consultation, rather than during the consultation. This is less stressful for the provider.

You should wear appropriate clothing (in some cases wearing your uniforms) and have a pleasant smile on your face.

You should keep your paper and pen resting in your lap and be discreet when you note down an observation.

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

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

- **Feedback:**

Observers must be discreet in observing service delivery. In many cases corrective feedback only causes confusion and discomfort for the client and embarrasses the provider. In general feedback should be given *after* each case so that the provider and the observer can talk without the client being present. Corrective feedback during client service should be limited to errors that could harm or cause discomfort to the client.

Participant Handout 8.2: How to Provide Constructive Feedback

The following is a format you can use when you want a provider (or curator if you are a trainer) to change her/his behavior or improve their performance.

Before Giving Feedback Consider the Following:

Choose an appropriate time Make sure that the timing is good to give the feedback. Is the provider in the middle of seeing a client or concentrating on something else? Try to provide feedback as soon as possible.

Choose an appropriate place Privacy when receiving feedback is generally appreciated by the provider. Take special care not to alarm or worry the client by giving feedback in her presence.

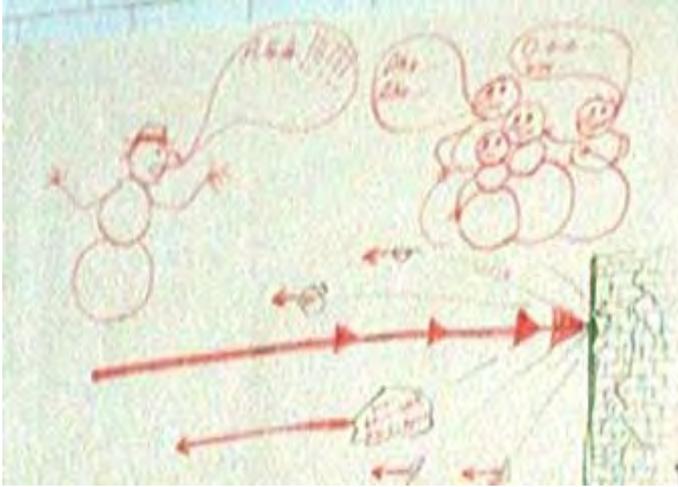
When Giving Feedback Follow these Rules:

1. **Listen.** Let the provider teach herself as much as possible, instead of telling him or her what to do. After all, people learn best when they are active learners! A common technique is to start with “what did you think went well” and then “what do you think you can still improve”. Use paraphrasing, open-ended questions and other effective listening techniques as well.
2. **Prioritize.** Most people find it difficult to absorb more than 3-5 things they need to improve. Try to give feedback about things to improve about only a selected few items. (sometimes it is possible to group several items you noticed into one larger category)
3. **State Facts, not Interpretations.** “You are not comforting this client because you are scared / shy / uncaring” If you do this, you run the risk of being wrong, which does not help the training, coaching or supervision. Only state what you observe and then ask the provider for the interpretation if needed.
4. **Share Your Emotions.** “I get confused as to when these sessions with the client occurred. It also may affect what the other providers do with the client. “ This invites the provider to share her emotions and may help you in your training and supervision.
5. **Indicate Results.** “It is important to have the dates recorded on the form.” Make clear what is expected from the provider. (For example in coaching you also do this before the procedure but in the feedback you can again clarify what it is the provider needs to do or learn)
6. **Negotiate.** This is very similar to the topic mentioned above. “What can you do to make sure that happens?” Let the provider come with the solutions to problems. Active participation in finding solutions will help the provider (or curator) change her behavior.
7. **Discuss Consequences.** (Positive Consequence) “If you do include the dates, it will help everyone to serve the client. (Negative Consequence) “If you continue to leave out the dates, I will have to write this up on your performance chart.” For the most part, use negative consequences after you have used the positive at least once. If the person is just learning a skill, only use the positive. Also, use negative consequences that fit the seriousness of the incident.

A Useful Sequence for Giving Feedback is:

1. Praise the provider with a few general words (good job, that went really well, etc)
2. Ask how the trainee thought the case went. Ask her what she did well / what she was happy with / what she would do exactly the same way next time.
3. Ask her what she would do different next time. (this is a more positive way of asking the question that asking what did you do “wrong”)

4. Discuss the points she brings up and if needed add your own. Prioritize. Ask her how she can do that better next time.
5. Summarize.



“Feedback is not used to “break barriers” and to lower resistance...”

”

Adapted from: “Integrated Supervision for Quality of Care training module”, Ton van der Velden and Fancine Lanar, Pathfinder, 2002

Participant Handout 8.3: Cases for Feedback Role Plays:

1. Valentina is a recently hired midwife who has just completed a training course in IUD insertion and is anxious to try her first case. She is assisted by Dilara, an experienced midwife/doctor from the clinic who encourages her through the case, and has to prompt her at two points where she is unsure of what to do next. The case goes well, though Valentina does not talk to the client at all, not even to introduce herself, and when Dilara checks to make sure the IUD is in the right place, she finds it could be pushed up a little more. After the patient has gone, Dilara gives Valentina some feedback. Valentina is shy and a little scared of her.
2. Gulnara is a new graduate of the medical school. She is starting her career at a FGP. Dr Salima is the clinic head. Gulnara is enthusiastic and would like to practice her skills. She is very proud and confident in her skills but has really little practical experience. Dr Salima first puts her to work as assistant with a more experienced doctor so she can observe some procedures. Salima then allows her to do an IUD insertion without further instructions. She is after all a graduated doctor. Gulnara wants to impress the others with her skills and rushes the procedure, forgetting to sound the uterus and not using the no-touch technique. Salima gives feedback to Gulnara.
3. Salia is a recently hired midwife who has just completed a training course in IUD. She is just married and had her first fight with her husband last night. He wants her to stop work and stay at home full time. She agreed but she cried for a long time last night. Today she is very quiet. Tamila, the clinic head, tells her she will do her first IUD case now. Tamila sits next to her and makes sure all goes well. She has to prompt Salia at two points when she seems unsure of what to do next. The case goes well, though Salia does not talk to the client at all, even to introduce herself. When Tamila checks to make sure the IUD is in the right place, she finds it can be pushed further up in the uterus. After the patient has gone, Tamila gives feedback to Salia.
4. Noorgoul is a new graduate of the medical school. She is starting her career at a FGP. Dr Valentina is the clinic head. Noorgoul is enthusiastic and would like to practice her skills. She is very confident in her skills but has really little practical experience. Dr Valentina first puts her to work as assistant with a more experienced doctor so she can observe some procedures. Valentina then allows her to do an IUD insertion without further instructions. She is after all a graduated doctor. Noorgoul wants to impress the others with her skills and rushes the procedure, forgetting to sound the uterus and not using the no-touch technique. Dr Valentina hears about this from the other staff and tells Noorgoul she made these mistakes a day later when he sees her in the corridor. The curator, some staff and clients are present and Noorgoul is very embarrassed. Valentina just tells her to review her books to find out what her mistakes were. One participant plays Valentina, the other participant plays Farida, the curator. The curator gives feedback to Valentina.
5. Dr Irena is an experienced and capable gynecologist. She is observed doing an IUD insertion by Dr. Risgoul, the FGP curator. Dr Risgoul thinks Dr. Irena has some strange practices. The nurse sits too close by and the instruments are arranged in a different order than normal. After the case Dr Risgoul sits down with Dr Irena and explains clearly and patiently what is wrong. Dr Irena is surprised and seems not to accept the feedback. Why not?

Participant Handout 9.1: Client Interviews

The Structure of the Client Interview

The client interview is a tool that we can use to follow how our clients feel about some important aspects of the Quality of care in our clinic. These aspects are:

1. Convenience of working hours (Question 1)
2. Waiting time (question 2)
3. Waiting area (question 3)
4. Cleanliness (question 4)
5. Politeness of the provider (question 5)
6. Privacy (question 6)
7. Having your questions answered satisfactory (question 7)

There are also further questions about family planning. After you have used this system for a while, you may be content with the results of the family planning questions. At that point you could decide to focus on another aspect of your services (child health care, vaccination ...) Then you can replace the questions about family planning with your own, special topic questions. It is recommended that you do not change the first questions as they are more general about the entire clinic and all services.

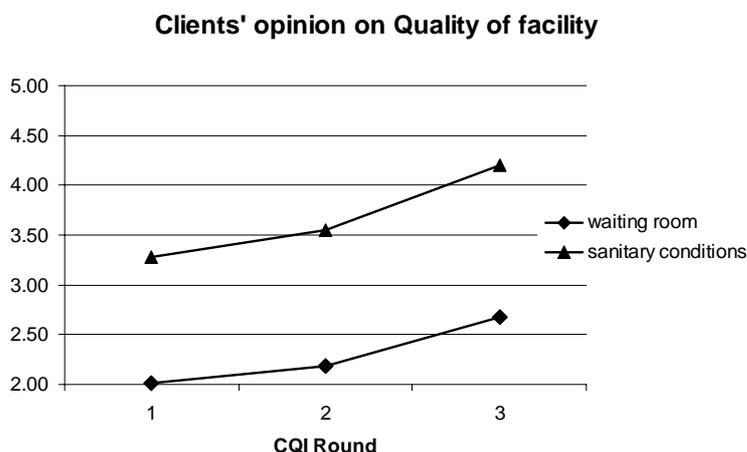
In any case, for statistical reasons you will need approximately 80 questionnaires answered.

Technical Aspects of the Questions

There are some questions that are designed to select only a certain group of respondents. These are: The first part of question 7, question 9 and the first part of question 13.

We have to make the selection to make sure we get the right people to answer our questions. For example if we want to know how the doctors answer client questions (Q7) we need first to make sure that we ask this only of those clients who asked questions to their doctor. If someone did not ask a question to the doctor, they will not know how to answer “were you satisfied..” .

Likewise we are not interested in what people know of family planning when they are 70 years old. It is not a relevant topic for these clients. So for those questions we need to select the clients of reproductive age. (question 9)



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

Analysis

Interview results need to be calculated as an average for all respondents. These results then need to be graphed. See the first picture for an example.

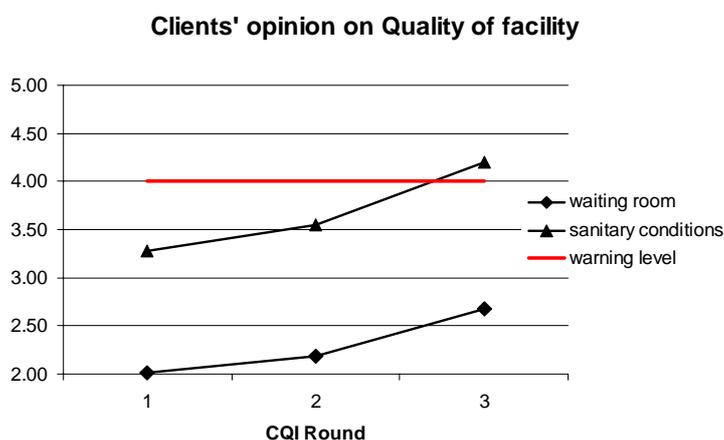
Graphing like this is very useful and makes it much easier to see if there are improvements or not.

However, graphing alone is not enough. We need to ask ourselves: what level is good? What level are we satisfied with? So every indicator needs a cut-off point, a warning level. *This warning level needs to be decided on by the entire staff.* If the indicator goes below that level we automatically know we have a problem and will put the problem on the action plan. In other words, having such a warning level makes the decision much easier and more objective. In the second picture you can see the warning level at 4.0 and therefore the problem with the sanitary conditions is now considered solved in the third round. The waiting room is improving but still needs to be written on the action plan again!

The answers to the open questions should be written on flipcharts, one for question 15, one for question 16. These flipcharts can then be presented in the meeting, just like the graphs. Decide in the meeting with all the staff if there are possible problems that you notice in these answers that you would like to place on the action plan.

Tips for Conducting a Good Interview:

The client interview is designed to be as simple as possible. The text in **Bold** is the text as it should be read to the client. Instructions to the interviewer are in *Italics*.



Always introduce yourself in a pleasant and friendly way

Be sure to emphasize the voluntary and confidential nature of the interview. If the person refuses to be interviewed, politely end the interview and go to another person.

Never change the wording of a question. Ask questions in exactly the way it is written in the questionnaire. Use a neutral voice. Do not try to lead the respondent to one answer or

another. Do not suggest answers to the respondent. Let the respondent answer for him/herself.

If you do not understand the answer to a question, ask the respondent to repeat the answer. But, do not “lead” the respondent in such a way that you suggest an answer. In a neutral way ask the respondent: “can you explain a little more? Take your time, there is no hurry.”

If the respondent does not understand a question, repeat the question slowly and clearly. If the respondent still does not understand the question, you may have to restate the question in different words—but be very careful not to change the meaning of the question.

Do not push the respondent or act as if you are in a hurry. Give the respondent as much time as possible to answer your questions.

If there are difficulties with a particular question or something unusual happens, such as the respondent has to leave suddenly, write what happened in the margin of the questionnaire or on the back. At the end of the day explain to the team leader what happened.

Adapted from: “Integrated Supervision for Quality of Care, draft”, Ton van der Velden and Fancine Lanar, Reproductive Health Program Vietnam, Pathfinder, 2002

Date _____

Time _____

Facility _____

Interviewer _____

Client Interview

Say: Goodmorning /good afternoon, I am from [your organization] and my organization has been asked by this SVA to do a survey on their clients. The SVA is working to improve the quality of their services for their clients and would like to hear the opinion of the clients. I would like to ask you a few questions. The questionnaire is anonymous and will take about 5 minutes. You can stop any time you want. Do you agree?"

If client gives permission:

1. Can you give a mark for the working time of the SVA from 1-5?

1 is very inconvenient for you, 5 is very convenient for you _____

2. Can you tell me what you think about your waiting time this visit? _____

Very short waiting time=5

Short waiting time=4

Normal=4

Long=2

Very long=1

How many minutes did you wait? _____min / Don't know

3. Can you give the waiting area a mark from 1 (very bad) to 5 (very good)? _____

4. Can you give the cleanliness of the whole SVA a mark from 1 (very dirty) to 5 (very clean)? _____

5. Can you give the politeness of the doctor a mark from 1 (from very impolite) to 5 (very polite)? _____

6. Can you tell me how often someone (staff or patient) walked into the room when you were there with the doctor? _____

If she says nobody entered, score= 5 points

If she says someone entered one time , score= 3 points

If she says someone entered more than one time, score=0 point

7. Did you ask the doctor any questions during your visit?

Circle one answer: Yes / No / Don't know

If the client said: "no" or "don't know", go to question 8

If the client said: "yes" please ask:

8. Can you say how satisfied you are with the doctor's answer?

Very satisfied=5

Satisfied=4

Normal=3

Unsatisfied=2

Very unsatisfied=1

score= _____

9. Can you give a mark to the overall quality of health care in this SVA (from 1 (very bad) to 5 (very good))? _____

9. How old are you?

if the client is between 15 and 49 years old, go to question 10

if the client is younger than 15 or older than 49, go to question 14

10. Have you ever used contraception?

Circle one answer: Yes / No / Don't know

11. What kind of contraceptives have you heard of?

16. What would you like to see improved in this SVA?

Write down the client's answer in her own words.

Say: Thank you very much for your help.

Participant Handout 10.1: Action Plan Meetings

Before the Action Plan Meeting

1. Decide which problems from the combined problem list that you made in the first meeting are complex and need cause analysis.
2. Before the meeting, please prepare an action plan with the first column (problem) filled in with the result of the first meeting (self assessment) and second meeting (review indicators from client interviews and observation of services, facility review and old action plan).

For example:

	Problem	Cause	Decision or Solution	Employee Responsible	Date	Expected Results
From old action plan, not yet solved	Still no contraceptive supplies					
From observation of services:	Observation of RH services showed insufficient results in COC (56% and warning level is 85%)					
From client interviews	The issue with confidentiality became worse: the score was 3,17 during the second round and became 2,6 during the 3 rd round. (warning level is 4.0)					
	Clients feel the waiting room is not nice (score is 3.5, warning level is 4.0)					
From Facility review	Facility is so cold in winter that mothers do not want to undress their sick babies for examination					
	Lab only open for receiving samples from 8:00- to 9:00, which is not convenient for clients					
From Self assessment	Not all physicians have access to gynecological table					

During the Action Plan Meeting

1. Praise the quality of services as they currently exist. Name specific examples of good service provision, including some examples of good results from the client interviews and clinic tour. Show again the graphs of indicators that have good results.
2. If you have many problems you have to decide how to deal with them all. The first preference is to spend more time and do them all. Decide with the staff on a good time to have a second action plan meeting later in the week. Since you have collected so much useful information it is a waste not to use it. The alternative is to prioritize. For this you first need to discuss with the group members what

makes a problem an important problem. Some ideas for this are given in Handout 10.2. After reaching consensus on those criteria, the following technique can be used to prioritize. It is called the multi voting. It builds commitment to the group's choice by equal participation in the process, allows every group member to rank issues without pressure from others, and puts quiet group members in the same position as more vocal members.

- Give each group member 3 votes. Tell them they are to give their votes to the problems they find most important, using the criteria that were discussed before. They can give all votes to one problem or two to one problem and one vote to nother or one vote to three problems each.
- Count the votes of all group members. The problem with the highest number of votes has the highest priority.

Sometimes all problems can be dealt with but this is unlikely in the beginning of a QIS. Do not tackle too many problems and do not tackle the very very hard problems. Especially in the beginning of a QIS it is important that the staff manage to resolve some problems on their own, successfully. This is very motivating! If none of the problems on the first action plan are solved, no one will be interested in doing a second action plan.

3. For complex problems, brainstorm causes. (Handout 10.4 brainstorming) Use a fishbone diagram to determine all causes. (handout 10.3 on fishbone) Try to deal with the most important / relevant ones but keep in mind that it needs to be possible.
4. For each *cause* discuss a solution or action that is feasible in terms of time, money, authority etc. (e.g. do not try to send someone of to the Ministry of Health to argue for more salary for the staff.)
5. Often when you discuss actions that need to be taken, it is clear who is going to be responsible. Usually this is someone in the clinic. If there is an action that needs to be taken by someone outside the clinic (a supervisor/ manager/boss type) make sure that there is someone *in* the clinic who will follow up/ keep contact etc. For every action one person within the clinic needs to be responsible. That person is to be written by name, not function, in the action plan. Make sure that not all responsibility falls on the shoulders of only one or two persons.
6. Ask that person what a reasonable timeframe is for the action to be taken. Stick to that timeframe. Do not impose a shorter time. If the timeframe he indicates is very far away (e.g. more than 2 months) consider if the action is not too complex or too large. Can it be broken up in smaller pieces and can the responsibility be divided?
7. Determine how you are going to know that the action was successful. What indicator will we use to measure success? For the problems from the client interview and observation of services this is easiest. You simply decide what value you would like the indicator to have next time.
8. Set a date for the meeting. Agree on what you will do to follow up in the mean time. (accountability)

Adapted from: "Integrated Supervision for Quality of Care, draft", Ton van der Velden and Fancine Lanar, Reproductive Health Program Vietnam, Pathfinder, 2002

Participant Handout 10.2 Sample Criteria For Selection Of Quality Problems

- The issue is important to external clients; improvement in this area can have high external impact
- The issue is important to internal clients; improvement in this area can have high internal impact
- A problem has existed for some time and is widespread
- The benefits from addressing this issue are obvious; the process has high visibility
- The issue is within the Quality Team's control and authority
- Management and the team are technically capable of making changes in this program area
- Support for change exists in this area. Management and those involved in the process recognize the need for change and are committed to it
- There are risks associated with not addressing this issue
- The problem undermines/affects the achievement of program objectives
- The issue can be quickly resolved
- Data on this issue are readily available
- Resources are available for making changes

From: SEATS II, Training curriculum in Continuous quality improvement for family planning programs, Incorporating expanded quality improvement, May 2000

Participant Handout 10.3 Fishbone Diagrams

The main use of a cause and effect or “fishbone” diagram is to allow a team to explore in detail all the possible causes related to a problem.

It enables people to focus on the content of the problem, rather than on its history or on different personal interests. It also makes people realize they collectively have much knowledge and it enables them to reach a consensus. Lastly it focuses them on causes, not symptoms.

How Do I Do It?

Make sure everyone agrees on the problem statement. Include as much information on the “what” “where”, “how much” “when” of the problem. Use concrete data if you have it. Write down the problem in a box (the fishhead) on a large flipchart.

Draw the major cause categories for the main bones. In the industry managers often use People (Man), Machines, Methods and Materials. This is where the picture in the example comes from. For us, a good start would be Staff, Policies/Rules/Standards, Materials/Equipment, Clients. There is no perfect set of root causes or number of categories. You should make them fit the problem.

Now first brainstorm (or brain write or put Post-it notes) all causes and then place them in the right category. Some causes fit in more than one category. In that case, place them in both. If the ideas are slow in coming, use the major categories as catalysts. For example ask: “What rules/ procedures might contribute to the problem that....”

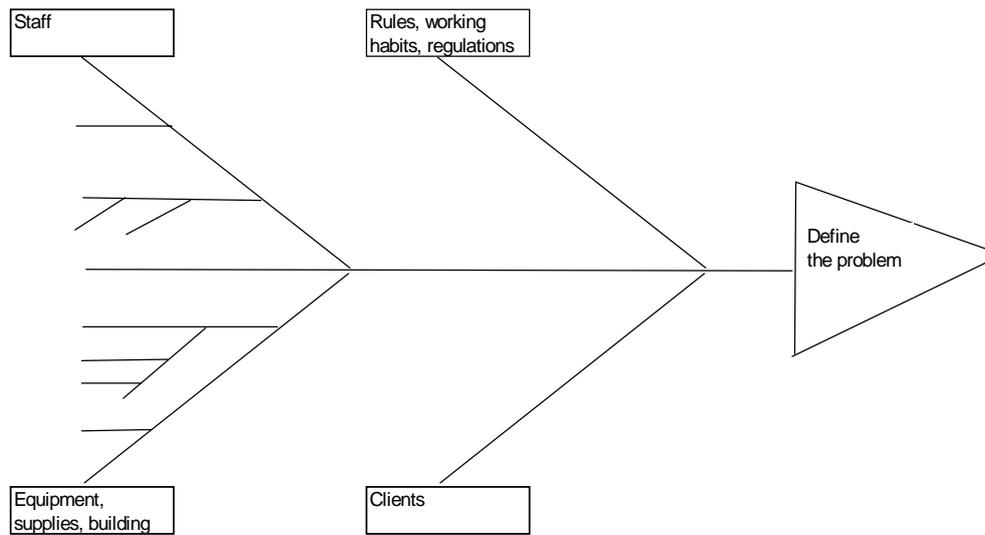
You can also make 4 small working groups, each of which analyzes one category.

For each cause you find ask: “why...”. Sometimes you need to ask Why 3 or more times to find a natural stopping point. This way you will find root causes. A rule of thumb is to stop when

- A cause is controlled by more than one level of management removed from the group. Otherwise the process becomes an exercise in frustration.
- You find an idea about a solution

Try to find root causes by looking for causes than appear more than once within or across categories.. Only select root causes to include in the action plan if the group can actually influence/solve them.

Example



Participant Handout 10.4 Brainstorming/Brainwriting

Brainstorming is used for creating a high volume of ideas, free of criticism and judgment.

It gets everybody involved and enthusiastic so that a few people do not dominate the group

There are two major methods for brainstorming.

- Structured. In this process each person gives an idea in turn
- Unstructured. In this process people give ideas as they come to mind.

Either method can be done silently or aloud.

Structured Brainstorming

The central question is written down and agreed on

Each person gives an idea in turn. No ideas are criticized or discussed. Ideas are written down on a flipchart or white board.

Ideas are generated until everybody passes, which means that all ideas are exhausted

Discard duplicates.

Unstructured Brainstorming

The process is the same except there is no “turn” and everyone can give ideas when they want.

Brainwriting

Brainwriting is the same as brainstorming except people write down the ideas themselves as they come up. The advantage is that it may feel safer for some people to do it this way, especially if you collect ideas anonymously. This may result in better ideas.

Variation:

The 6-3-5 method (proposed by H. Schlicksupp in “Creativity Workshop”). Each person has 5 minutes to write down 3 ideas on a sheet of paper. Each person then passes the sheet to the next person who has 5 more minutes to add 3 more ideas that build on the first 3 ideas on the paper. This rotation is repeated until everybody has seen and added to all sheets (a maximum of 6 persons per group is recommended).

This method is very hard to do anonymously.

Adapted from: “The Memory Jogger” Brassard and Ritter, 1994

Course Evaluation

Rate each of the following statements as to whether or not you agree with them, using the following key:

1 Strongly disagree

5 Strongly agree

Objectives

I feel that the objectives of the workshop were clearly defined.	5 4 3 2 1
I feel I am now able to explain concepts in Quality of Care	5 4 3 2 1
I am now able to competently guide a group of providers and other staff through a QIS round	5 4 3 2 1
I am now able to implement a pilot program in improving and measuring QoC	5 4 3 2 1

Technical Information

I learned new things on Quality of care in this course	5 4 3 2 1
I learned new things on Adult Learning in this course	5 4 3 2 1
I learned new things on using indicators	5 4 3 2 1
I learned new things on group processes	5 4 3 2 1
I learned new things on using checklists	5 4 3 2 1
I learned new things on interviewing	5 4 3 2 1
I learned new things on feedback	5 4 3 2 1
I learned new things on facilitation skills	5 4 3 2 1
I learned new things on brainstorming	5 4 3 2 1
I learned new things on fishbone diagrams	5 4 3 2 1
I learned new things on prioritization	5 4 3 2 1

Training Methodology

The trainers' presentations were clear and organized.	5 4 3 2 1
The material was presented clearly and in an organized fashion.	5 4 3 2 1
The pre-/post- assessment accurately assessed my in-course learning.	5 4 3 2 1
Class discussion contributed to my learning.	5 4 3 2 1
I learned practical skills in the exercises and case studies.	5 4 3 2 1
I learned practical skills during the implementation of the first round	5 4 3 2 1
The handouts were informative.	5 4 3 2 1
The trainer encouraged my questions and input.	5 4 3 2 1

Training Location & Schedule

The training site and schedule were convenient. 5 4 3 2 1

The necessary materials were available. 5 4 3 2 1

Suggestions

What was the most useful part of this training?

What was the least useful part of this training?

What suggestions do you have to improve this workshop?

What suggestions do you have to improve this Quality Improvement System as we are now going to implement it?
