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TECHNICAL REPORT:

Improving the Quality of Family Planning Services in Zhezkazgan and Satpaev: A Case-Study on the Improvement Dynamic in Kazakhstan

**April, 2005
Almaty, Kazakhstan**



ЗдравПлюс / ZdravPlus

**ENSURING ACCESS TO
QUALITY HEALTH CARE
IN CENTRAL ASIA**

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The views of the authors expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Table of Contents

I. Acknowledgements	2
II. Abstract.....	3
III. Executive Summary	4
IV. Abbreviations and Acronyms	5
V. Introduction	6
A. Background on Health Sector Reform in Kazakhstan & ZdravPlus	6
B. Issues with quality of family planning services at the start of the project	6
C. How quality of care issues were usually addressed by the system	7
D. Healthcare system in Zhezkazgan and why it was selected.....	7
E. Objectives of this report.....	8
VI. Overall Strategy of the Quality Improvement Project	9
VII. Phase 1: Improving Providers' Performance and Quality of Counseling for Family Planning Services	13
A. Training in Continuous Quality Improvement.....	13
B. The Quality Improvement System.....	14
C. Measuring Quality using the four QIS monitoring tools	15
D. Issues regarding the use of the QIS tools	16
E. Identifying Problems and Implementing Interventions and Changes	19
F. Results of Phase 1	21
G. Discussion of Phase 1	23
VIII. Phase 2: Redesigning and Institutionalizing Family Planning Services	24
A. Interventions and Changes	26
B. Results of Phase 2.....	28
C. Discussion of Phase 2.....	34
IX. Lessons Learned from the QI Project	38
A. The Improvement Dynamic in Karaganda Oblast	38
B. The QI Process for FP Services	39
C. The Impact of QI on Abortion Rates	39
X. Recommendations	40
A. Institutionalization of a Continuous Process for QI of FP services.....	40
B. Replication of Improved Family Planning Services in Karaganda Oblast	41
C. Strengthening of RH Services for Improvement of Health Outcomes.....	41
XI. Conclusion	42
XII. Annexes	43
Annex 1: Quality Improvement System Monitoring Tools	43
Annex 2: The Family Planning Services System - Roles and Responsibilities	50
Annex 3: Contraceptive Use Survey in Users of FGPs (December 03)	52

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II. Abstract

This report describes a quality improvement project in the field of health care undertaken in a joint effort by the Association of Family Physicians and local health administration in Zhezkazgan and Satpaev in Karaganda Oblast, Kazakhstan with the technical assistance of the ZdravPlus project. The documented events in this report show how facility level Continuous Quality Improvement (CQI) projects, in this case with a focus on family planning services, evolved to make changes in the system of care for providing reproductive health services and better meet the needs and expectations of the population.

III. Executive Summary

ZdravPlus has been providing technical assistance to the Zhezkazgan/Satpaev region since 1995; this has resulted in crucial changes in health care provision, financing, and the population's attitude towards health care. Today Zhezkazgan and Satpaev represent the most mature region in Kazakhstan in terms of health care reforms. Family physicians and family nurses in the privately owned practices have a high educational level in all areas of family medicine; the majority of the health professionals were exposed to various training events based on quality standards and evidence-based medicine. This created a favorable background for the introduction of continuous quality improvement (CQI) practices. In 2001, ZdravPlus set up pilot CQI projects, focusing around family planning services, in eight volunteer family practices. In the process of setting up these quality improvement (QI) initiatives, the staff of each facility began to perceive themselves as a component of the holistic system which also needed to be involved in the strive for quality. As a result, a quality team was set up between the different group practices. This team was then able to work for change at the system level.

This document reflects the sequence of events that took place in family practices of Zhezkazgan and Satpaev. It shows how physicians, for the first time, attempted to look at the services they provide through the "eyes of patients" and then improve their performance based on that perspective. Another significant achievement described in the report is that physicians learned how and were able to conduct professional performance self-assessment and monitoring. The report emphasizes that the participants needed some time to learn how to discuss problems in teams and how to think of changes within their level of control. The experience of this project once more shows the importance of leadership and commitment to quality improvement, as well as the significance of individual initiatives along with team decision-making. At the end of the document, the authors put together the lessons learned from the project and some recommendations that may be used when replicating a Quality Improvement approach in the entire oblast and other regions.

IV. Abbreviations and Acronyms

AFPZ	Association of Family Physicians in Zhezkazgan	
AVSC	AVSC International	
COC	Combined Oral Contraceptives	
CQI	Continuous Quality Improvement	A theory of improvement that relies on alternating measurement and interventions
DHS	Demographic and Health Survey	
DMPA	Depot-medroxyprogesterone acetate or Depo-Provera (injectable contraceptive)	
DP	Diagnostic Polyclinic	
FGP	Family Group Practice	
FP	Family Planning	
GC	Genetic Center	
HLS	Healthy Lifestyles	
IC	Information Center	
IEC	Information, Education and Communication	
IMCI	Integrated Management of Childhood Illnesses	
IUD	Intrauterine Device	
JHPIEGO	JHPIEGO Corporation	
LAM	Lactational Amenorrhea Method	
MC	Medical Center	
MOH	Ministry of Health	
QIP	Quality Improvement Project	A structured effort centered around improving quality of care
QIS	Quality Improvement System	A set of specific instruments designed to measure several dimensions of quality of FP services and to plan improvement interventions based on results
QIT	Quality Improvement Team	People involved in a QIP meet on a regular basis to work according to CQI dynamic
RH	Reproductive Health	
SES	Sanitary and Epidemiological Service	
STI	Sexually Transmitted Infections	
TB-DOTS	Tuberculosis – Directly Observed Treatment Short Course	
USAID	United States Agency for International Development	
UNFPA	United Nations Population Fund	
WC	Women’s Consultation	
WHO	World Health Organization	
ZP	ZdravPlus	

V. Introduction

This report describes a pilot quality improvement project (QIP) in Zhezkazgan and Satpaev, two cities in the central Kazakhstan oblast of Karaganda. The project focused around improving the quality of family planning services with modern management approaches in a healthcare system that traditionally does not promote choice in family planning methods. The project evolved from an initial focus on providers' performance to redesigning components of the healthcare system.

Although the work is still in progress, this report draws lessons from two years of effort and describes the impact of the project on the health care providers' performance and attitude, on patient satisfaction with care, and on the healthcare system itself.

This report describes how changes can be introduced in health systems and how they influence both health services and the working habits of the people involved.

A. Background on Health Sector Reform in Kazakhstan & ZdravPlus

The Central Asia Quality Health Project, known as the ZdravPlus Project, funded by the United States Agency for International Development (USAID), is working with the governments of five Central Asian countries to improve the quality and efficiency of their health services. The project works in selected areas of these countries to support health sector reform through technical assistance, training, and limited provision of equipment.

Health reforms in Kazakhstan seek to improve the quality and efficiency of health services, with an emphasis on strengthening primary healthcare. In a shift from the Soviet system, which centered on highly specialized care provided in specialized facilities, new Family Group Practices (FGPs) have been formed that bring together internists, gynecologists, and pediatricians into primary healthcare practices that provide a range of services in a single facility close to where people live. Family physicians working in FGPs are providing a package of basic medical services, which are free for the population and oriented, not only towards treatment, but also towards preventative care. FGPs now have their own budgets based on a capitated¹ rate payment for each person enrolled, forcing them to compete for clients. Because the FGPs' budgets directly depend on the number of people registered with the FGPs, which in turn reflects the level of patient satisfaction with the services they provide, the quality of services is crucial. The FGPs have considerable autonomy in how they manage their facilities and services. No longer are they required to follow detailed instructions from central authorities on how to use their budgets or to formally request every item needed to provide services. However, many challenges remain. The FGPs need to improve the quality of the services they provide, they need to use their newfound autonomy to manage their facilities more effectively, and they need to better respond to clients' needs. Since 1995, the ZdravPlus Project (from 1995-2000 known as ZdravReform) has been supporting such health care reforms in Zhezkazgan and Satpaev in Karaganda Oblast.

The implementation of pilot Quality Improvement (QI) projects is a key strategy that ZdravPlus uses because it triggers changes in the organization and management of health services as well as in the clinical content of care; both are needed in order to improve health outcomes.

B. Issues with quality of family planning services at the start of the project

Year after year, Karaganda Oblast and Zhezkazgan were reporting on the issue of unplanned pregnancies, which is intricately linked to a lack of adequate family planning services, high rates of

¹ A fixed payment to a health facility for each person enrolled with the facility, regardless of number of visits or medical condition.

induced abortion, teenage pregnancies, the growing number of children in orphanages, short spacing between births which undermines maternal and child health, and pregnancies with complications such as tuberculosis, sexually transmitted infections (STIs), or hepatitis. Official health department statistics for several years prior to the QI project, 1996-2000, show that the number of abortions per 100 deliveries decreased from 87 to 66, but it should be kept in mind that abortions are often under reported. (see *Table 1*).

Table 1 Number and Ratio of Abortions and Deliveries in Zhezkazgan

Year	Abortions	Deliveries	Abortion/Delivery Ratio
1996	1385	1591	0.87
1997	1338	1526	0.88
1998	1226	1401	0.88
1999	817	1132	0.72
2000	721	1089	0.66

However, other official statistics, also from the Health Department, give different data, reporting that in 1997 the number of induced abortions exceeded the number of births: the ratio of deliveries and abortions was 1:1.2 (1 delivery per 1.2 abortions). Though a disparity exists between these two official data sources what they both clearly indicate is that abortion was widely used by women to terminate unwanted pregnancies. Induced abortions can contribute significantly to problems with reproductive health and fertility in women of reproductive age; and the high abortion rate can undoubtedly be indirectly linked to the fact that, in the same period of time, 4 or 5 women on average were dying in the region annually due to problems related to pregnancy and delivery.

Before the ZdravPlus Project, family planning services were not included in the basic package of services in FGPs; only gynecologists in maternity house were authorized to provide these services. The scope of work of a gynecologist or family doctor in the FGPs was limited to the treatment of sick women. Also, for a long time, family planning services were limited to one method: the intrauterine device (IUD). There was no counseling, since there was no choice of family planning methods offered to the population. In fact, there was no concept of a “family planning program.” In summary, family planning services, in the sense that the term is understood internationally, were basically non-existent, and because women had no choice, the quality of the services was generally poor and patient satisfaction was low.

C. How quality of care issues were usually addressed by the system

As a holdover from the former Soviet system quality of care issues were addressed in a very punitive way. Through inspections of facilities, variations from the strict norms established at the central level were identified and “culprits” pinpointed and punished. Poor quality of care was always viewed as a consequence of providers’ behavior and no attempts were made to analyze and question the system in which these individuals were working. The system frequently resulted in health workers hiding problems, presenting false results, and developing attitudes of indifference towards clients. It was not unusual to see physicians discouraged after being blamed during an inspection for things they felt were beyond their control. This style of management is far removed from modern theories of human resource management and quality improvement.

D. Healthcare system in Zhezkazgan and why it was selected

At the beginning of this project, primary health care in Zhezkazgan and Satpaev was provided by 16 FGPs (nine in Zhezkazgan and seven in Satpaev) with a total of 112 physicians and 174 nurses and midwives. FGPs are all private, however they are funded from the state budget under the capitated system, which means that the amount of funds depends on the number of patients covered by the

facility; thus, if more patients enroll in a particular facility – that facility will have a higher operating budget.

Specialized outpatient care in Zhezkazgan and Satpaev is provided by a Consultative Polyclinic and five or six privately owned small centers. In Zhezkazgan there are two state-owned hospitals – a general hospital and a children’s hospital, which also have outpatient departments. Both private and governmental outpatient facilities receive money from the state budget to provide some free services to the population.

In-patient care in Zhezkazgan is provided by a 406-bed general hospital. The children’s hospital has 170 beds, the maternity house 105, and the STI hospital 60; the cardiology department “C” has 40 beds, the Copper Corporation Hospital 100, a hospital for the treatment of alcoholism problems 100, and a local sanatorium also has 100 beds.

In Satpaev there is a City Hospital with 180 beds, a psychiatric hospital with 250 beds, a tuberculosis hospital with 200 beds, the Copper Corporation Hospital with 120 beds, and a sanatorium with 50 beds.

The total number of physicians working in the two cities amounts to 546, while the total number of nurses, midwives, and feldshers amounts to 887. There are approximately 3,000 people employed in the health care system in the region, of which the above comprise 48 percent.

The primary health care system in the Zhezkazgan region is focused on the prevention of diseases and practitioners are interested in making innovations and taking on more responsibilities. Since 1996, the health department and physicians in the region were intensively involved in family medicine training funded by the ZdravPlus Project. They were also very keen to know more about the World Health Organization’s (WHO) protocols in different areas of medicine. Step-by-step, all FGP physicians in Zhezkazgan and Satpaev were trained in family medicine, management of STIs, tuberculosis through the directly observed treatment short course (TB-DOTS) strategy, and integrated management of childhood illness (IMCI). In 1998, the health care administration of the Zhezkazgan region, in order to broaden the range of services for the population, asked ZdravPlus to provide some training on family planning. At that stage, three courses conducted by AVSC International and JHPIEGO, each three days long, were arranged and covered a limited number of health workers, mainly gynecologists in FGPs and the maternity house. The trained physicians in FGPs started to provide family planning services, although national policy limited non-ob/gyns to providing counseling and information, barring them from providing clinical services. This education provided a solid foundation when ZdravPlus proposed its technical assistance to improve the quality of family planning services in the region by introducing the continuous quality improvement system.

E. Objectives of this report

This report has three objectives:

1. To report activities and progress to stakeholders in this effort, mainly USAID and the Ministry of Health of Kazakhstan;
2. To draw lessons for extension and replication of efforts to set up and improve the quality of family planning services beyond the pilot area; and
3. To better understand the dynamic of improvement in a specific context and help better design other quality improvement efforts/projects.

VI. Overall Strategy of the Quality Improvement Project

Initially, the project intended to improve the quality of family planning (FP) services at the primary care level, with a special focus on counseling patients regarding the range of contraceptive methods available. (Since the only doctors allowed to provide clinical FP services in FGPs were ob/gyns, this precluded a focus on the actual provision of contraceptive care.) As the project developed, participants put forward a broader goal for improvement at the system level and made suggestions for interventions and changes in the health care system in order to increase the demand for family planning services and improve access to these services in the FGPs.

Historically, the Project can be divided into two phases:

Phase 1 aimed at improving the quality of FP services, especially counseling, through continuous quality improvement (CQI). An international CQI specialist introduced health providers in Zhezkazgan/Satpaev to CQI techniques through the training of those FGPs, which volunteered to participate. After this objective was accomplished, the Project team decided to address health system issues which limit the impact of better services on patients' health and needs.

In **Phase 2**, the quality improvement team (QIT) became larger, involving other levels of the health care system, and the focus shifted from providers' performance to system performance and the (re)organization of reproductive health services. The rationale for this new focus was that aspects/features of the healthcare system influence not only providers' performance but also the extent to which patients benefit from the services they receive. As an example, patients who receive relevant and complete information on different methods of FP might still end up selecting a method that is not their preferred choice due to problems of availability, access, and cost. Providers' efforts would be partially "wasted" if the outputs/outcomes of the care remained what they were before (predominance of one method over the others, i.e. IUD) despite better counseling services, and patients' satisfaction remained unchanged. In other words, the patient might be better equipped to make an "informed" choice, but if there is no (or limited) choice of method in the health system, the quality outcome will remain the same as long as certain aspects of the healthcare system do not change. Therefore, during this phase, three main objectives were set: 1) improving providers' skills; 2) improving population awareness of family planning issues through educational campaigns; and 3) making organizational changes within FGPs by establishing FP rooms to improved access for the healthy population seeking FP information.

The following results were expected from this project:

- Increased performance of providers against counseling standards for four methods of contraception;
- Increased satisfaction of clients with family planning services; and
- Increased demand for (and use of) family planning information provided in FGPs.

Since the beginning of the project, many events contributed to the achievement of results; their chronology is presented in **Table 2**. This table gives an overview of:

- The amount of effort needed to achieve measurable results;
- The time it takes to initiate and sustain a dynamic of improvement; and
- How the Project evolved from simply improving providers' skills in counseling to addressing the system's issues with FP services.

Most events were not initially planned or anticipated by ZdravPlus, but thought of and initiated during the quality improvement project meetings. This flexibility in the evolution of such a project is a key-factor for success and a common feature of a continuous process, which tends to uncover new issues and discover different ways of addressing them, including working around constraints at various levels.

Table 2 Chronology of main events and results of the QIP for FP services in Zhezkazgan and Satpaev

Events Phases	Date	Main Meetings	Trainings	Measurement	Other	Main Outputs/Results ²
P H A S E 1	January – April 2001		President of Zhezkazgan Family Physicians Association attends CQI workshop and training in Kyrgyzstan ³			2 FGPs in Zhezkazgan started to adapt the QIS tools from Kyrgyzstan to the Kazakhstan situation: check lists for the 4 contraceptive methods, facility review checklist, and client satisfaction questionnaire.
	May – September 2001			2 FGPs tested the QIS tools and looked at the feasibility of this process.		
	July 2001			2 FGPs measured first results using CQI tools		
	September 2001 – December 2001		2 representatives of Zhezkazgan Family Physicians Association attend CQI workshop and training in Kyrgyzstan ⁴			2 specialists became “curators” in their own FGPs to introduce the CQI to their employees and to use it for QI of FP services. They started using the 4 CQI tools. At that point, however, they were not trained to be trainers.
	January 28 – February 1, 2002		2 KZ ZdravPlus office staff and 7 trainers from KR and UZ are trained as trainers of curators in CQI for Zhezkazgan ⁵			A group of 9 trainers were prepared to train curators for FGPs in Zhezkazgan/Satpaev
	February 4 – 16, 2002		Training of 16 curators from in 8 FGPs (5 in Zhezkazgan and 3 in Satpaev)	First round of QIS measurements (baseline)		8 FGPs involved: <ul style="list-style-type: none"> • 5 in Zhezkazgan • 3 in Satpaev QIS tools finalized
	June 2002				Oblast Health Department issues order to allow FGPs to provide clinical FP services	
	August 2002		Follow-up and additional training by international consultant ⁶		ZP assesses QI activities in Kazakhstan and recommends to scale-up best practices from Zhezkazgan and create a multilevel team ⁷	

² Detailed results are presented further in this document.

³ Quality Improvement System: Regional Workshop, January 17 – February 8, 2001. Ton van der Velden; ZdravPlus Trip Report

⁴ Quality Improvement System: Second Regional Workshop. September 3-22, 2001. Ton van der Velden; ZdravPlus Trip Report

⁵ Quality Improvement System: Regional Training of Trainers and Training of Curators, January 23 - February 22, 2002. Ton van der Velden; ZdravPlus Trip Report

⁶ CQI Follow-up and Training in Zhezkazgan, August 20, 2002. Ton van der Velden; ZdravPlus Trip Report

⁷ Review of Quality Improvement Activities in Kazakhstan, August 5-15, 2002. Bruno Bouchet & Irina Stürbu; ZdravPlus Trip Report

Events Phases	Date	Main Meetings	Trainings	Measurement	Other	Main Outputs/Results ²
	August - September 2002			Second round of QIS measurements		3 curators (all three - FGP owners, senior physicians) trained as CQI trainers. As members of the Association of Family Physicians, they expressed their willingness to train new CQI curators.
P H A S E 2	February 2003	ZdravPlus organizes a meeting to setup a multilevel QIT	ZdravPlus starts training family physicians and midwives in FP	Third round of QIS measurements		
	May 2003			New monitoring system in place, looking at demand for and use of RH rooms	Zhezkazgan Health Department issues order to set up a Reproductive Health room in each FGP. ZP sponsors population education campaign "Let's Build a Healthy Family"	
	July -August 2003			Fourth round of QIS measurements		
	July – August 03		ZP completes the training of family physicians and midwives in FP AFPZ, trains 3 more FGPs in CQI		Follow-up of QI activities ⁸	117 providers trained in FP: <ul style="list-style-type: none"> • 88 family physicians • 16 midwives • 13 nurses 11 FGPs involved in QIP <ul style="list-style-type: none"> • 8 in Zhezkazgan • 3 in Satpaev
	August 2003	Multilevel QIT assesses progress and plans next steps		Baseline measurements of # of visits to newly set up family planning rooms and # of visits to FGPs for FP info.		
	December 2003			Fifth round of QIS measurements		

⁸ Follow-up of Quality Improvement Projects and related Activities in Kazakhstan, July 7-18, 2003, Bruno Bouchet & Malika Baiserke; ZdravPlus Trip Report

VII. Phase 1: Improving Providers' Performance and Quality of Counseling for Family Planning Services

A. Training in Continuous Quality Improvement

During this phase, the main intervention was training in CQI and the monitoring of quality of care in the provision of family planning (FP) counseling. This was designed to build on a previous training in FP that took place in 1998.

In September 2001, the two representatives of the Association of Family Physicians of Zhezkazgan (AFPZ) visited Kyrgyzstan, where they were trained in CQI for family planning services at family group practices (FGPs) in Karakol⁹. They brought materials developed in Kyrgyzstan back to Zhezkazgan in order to set up similar quality improvement systems (QIS) at their facilities. The rationale behind this was that the health care (PHC) systems of Kyrgyzstan and Kazakhstan, both coming from the Soviet era, had much in common so it would be easy to adapt the Kyrgyzstan CQI check lists and other tools to the needs of FGPs in Kazakhstan. The staff of two FGPs in Zhezkazgan¹⁰, together with the AFPZ, developed check lists for observation on four contraceptive methods (IUD, pills, DMPA, LAM) along with a facility review check list, and adapted the client satisfaction questionnaire. Before the end of 2001, when the tools were ready, those family group practices in Zhezkazgan used their own tools and independently began CQI projects similar to the ones seen in Karakol.

ZdravPlus supported the initiative of the two FGPs and proposed to replicate the QIS/CQI project in all of Zhezkazgan, with the support of the AFPZ, and starting with CQI training. The AFPZ invited volunteers to the QI project and eight FGPs responded. Each FGP assigned two staff members to be curators. The curators were to take on a leadership role within their FGP in the QIS/CQI process: facilitating the staff meetings, using the four tools of CQI, and collecting data. It was assumed that the best curators could potentially become trainers to train curators from facilities which might choose to join the QI project in the future.

Initially, a gynecologist and a midwife in each FGP were selected to be trained as curators for QI. The reasoning was that family planning issues naturally lay within their professional sphere of activities and it was thought that a gynecologist or a midwife would be the specialists best qualified to perform the observation of FP counseling, as compared to a family doctor.

In January and February 2002, ZdravPlus invited the Quality Improvement consultant Dr. Ton van der Velden to provide a regional training for a team of nine CQI trainers, six from Kyrgyzstan, one from Uzbekistan, and two from Kazakhstan. All trainers from Kazakhstan were then expected to train 16 curators at eight FGPs: five FGPs in Zhezkazgan and three FGPs in Satpaev.

The first step, a one-week training of trainers (TOT) course, took place in Almaty at the end of January 2002. As a second step, in February 2002 the team of trainers went to Zhezkazgan where the newly trained CQI trainers provided a six-day course, which had been specifically tailored to the needs of the pilot with the help of the consultant, for 17 staff members from the eight FGPs under the supervision of Dr. van der Velden. These 17 trainees were selected to be the curators using the criteria mentioned above. During the training, the four CQI tools were developed (see **Annex 1**).

⁹ Improving the Quality of Reproductive Health Services in Issyk-Kul Oblast: Report on a Pilot Project., March 2002. Noorgoul Seitkazieva et al. ZdravPlus Program Document

¹⁰ All names of FGPs have been removed from this document to ensure confidentiality.

As the third step, the newly trained curators started the QI process in their respective facilities starting with exit interviews, facility reviews, and observation of providers using the developed check lists. After collecting information, the staff set up a self-assessment meeting in order to list problems. An action plan meeting was arranged to make decisions on what improvements should be made, who should be responsible and what resources were needed. The CQI trainers provided them with supervision and gave feedback, with assistance from the consultant.

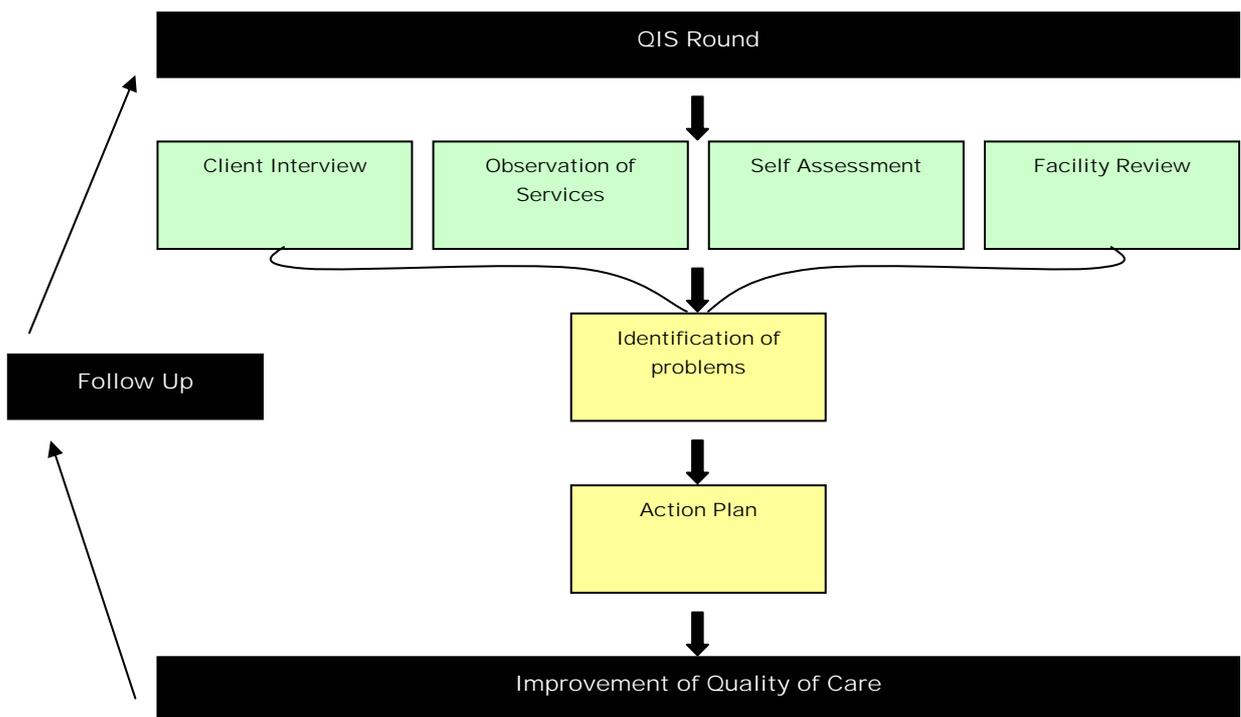
The newly-trained curators started with enthusiasm; however they felt that they lacked skills in meeting facilitation. During the first two rounds, it also became clear that the curator should be a physician and, preferably, a senior physician as it could be extremely difficult for a non-physician curator to exercise leadership over their superiors. Participants also understood that the QI project needs the commitment of every individual involved.

In August 2002, after the first two rounds of measurement and in order to help curators with issues of facilitation, ZdravPlus funded a short training course by Dr. Ton van der Velden aimed specifically at facilitation skills improvement, so curators obtained additional training in adult learning, facilitation techniques, and use of feedback.

B. The Quality Improvement System

The Quality Improvement System (QIS) is a process that aims to continuously measure and improve the quality of care at the facility level by focusing on problems that impair quality but can be solved using locally available resources. It recognizes that staff members are responsible for the quality of care at their own facility and attempts to provide a platform for them to share ideas and operate as a team to improve their work and working environment. It operates in quarterly rounds and uses tools to measure quality from different perspectives and then plan interventions. **Figure 1** illustrates how the QIS works.

Figure 1 QIS Round



C. Measuring Quality using the four QIS monitoring tools

The first tool is an *exit interview*; it objectively measures quality from the clients’ perspective (client satisfaction) and allows for the results to be quantified. Clients are asked to score providers’ actions on a scale of one to five. The questions address clients’ opinions on confidentiality, provider/client relations, waiting time, sanitary conditions, etc. They also solicit clients’ suggestions. The interviews promote a focus on client satisfaction among providers.

The second tool is a *facility walk-through*; the curator goes through the facility with a checklist based on Ministry of Health (MOH) standards. The checklist provides a guide for the evaluation of the “readiness” of the facility to provide services. This tool combines a client’s perspective with a more clinical approach. The checklist used in the Zhezkazgan pilot addresses clinical issues – such as equipment, instruments, drugs and supplies, record keeping, and sanitation – along with more client and community-oriented concerns, such as the availability of information for clients, client comfort, confidentiality, fundraising plans, and community relations.

The third tool is the *observation of providers*; it is made up of four checklists for the direct observation of service provision and counseling regarding the use of IUDs, combined oral contraceptives (COC), Lactational Amenorrhea Method (LAM), and Depo-Provera (DMPA)¹¹. During the observation of providers, the curator observes clinical staff providing services to clients. After observing a clinician providing services, the curator offers him immediate feedback to increase his technical competence – not to criticize or punish. In the pilot project, curators observed contraceptive services. There is a separate checklist for each FP service – one for each family planning method – based on Kazakhstani guidelines for these services. Each item on the checklist is scored: two points are awarded if it is performed correctly and completely; one point if it is performed, but not completely or correctly; and zero points if it is not performed at all. Thus, each observation yields a percentage score for each skill for that provider. Average scores can be calculated for all the providers in an FGP as well as across FGPs.

The fourth tool is a *self-assessment*; the entire staff of the facility meets to identify problems in the quality of care provided. To facilitate discussion, the curators developed a list of questions to trigger discussion when staff members are hesitant to speak out about issues that concern them. In the self-assessment meeting, FGP staff also discusses the results of the client interviews, observation of services, and the facility walk-through.

This step by step process often times takes a number of months to complete.

These tools are presented in *Annex 1*.

Together, these four tools provide both objective and subjective measures of the quality of services provided and offer clients and providers structured ways to express their ideas and opinions (See *Table 3*).

Table 3 Assessing Quality from Clients’ and Providers’ Perspectives

	Objective Measurement of Quality	Subjective Identification of Problems
Clients	Client interviews, closed questions	Facility review Client interview, open questions
Providers	Observation of Services	Self assessment

¹¹ The checklists were developed from the National Reproductive Health in Kazakhstan Guidelines of the National Mother & Child Health Center, approved by the Ministry of Health of Kazakhstan, 1999.

D. Issues regarding the use of the QIS tools

The following describes implementation of the tools and issues regarding their utilization.

(1) Using the exit interview tool

When QIP participants started with the *exit interview* tool, they understood that conducting a client satisfaction survey would be difficult for family physicians who had never previously conducted such a survey. Although the FGP staff was trained, none of the physicians had the time to perform exit interviews. Because of this, the FGPs asked two full-time AFPZ employees, experienced in taking surveys, to conduct the client interviews in FGPs. They visited FGPs as independent interviewers, using random sampling to interview visitors. In every FGP, 30 to 40 visitors were interviewed. The advantage of the AFPZ's involvement in the *exit interview* survey was that it helped to avoid bias, which could have taken place if a provider himself asked his client's opinion on the services provided¹². Interviewees were women of reproductive age. Data obtained through questionnaires were collected and analyzed at the AFPZ. The AFPZ voluntarily provided its technical assistance in conducting client surveys for the first two cycles of the Quality Improvement System. Although this worked at the beginning, the quality improvement teams soon realized that they could not sustain this level of effort and started looking for alternative ways of conducting client surveys (see below).

After the first round of data collection, the three FGPs in Satpaev scored, on average, much lower than FGPs in Zhezkazgan. However, some of the FGPs in Zhezkazgan scored low in specific issues. For instance, in one FGP, clients were not happy with the long *waiting time*. Later, in the third round, when more FGPs joined the QIS project, clients in another FGP also pointed out long waiting times as a problem. In several FGPs the interviewed patients/clients showed a very low level of *contraceptive methods awareness*, especially of *emergency contraception*. Some of the FGPs scored low in terms of *politeness* of physicians to clients and others in terms of *confidentiality*. Curators reported results during staff meetings and discussed what could be done with regard to such problems. Overall, survey results showed a trend towards an increase in patients' satisfaction with the services provided.

In January and February 2003, a client survey for the third QIS cycle coincided with the peak of a flu epidemic in the city and this increase in the number of patients immediately impacted survey results. In some FGPs, waiting time increased; patients complained about lack of comfort in waiting rooms; they didn't like that physicians didn't spend enough time providing FP information; thought that physicians gave inadequate answers; etc. Later, in May - July 2003, many of the findings from client surveys were used to prepare materials for the "Let's Build a Healthy Family" population involvement campaign.

(2) Problems with the exit interview tool

Feasibility. The Quality Improvement Project participants had to decide who should conduct the interviews – physicians of the FGP, who usually don't have the time and skills to do this and are probably going to receive biased answers? Or an independent interviewer, who in the long run, will charge for this service? During the first two rounds the AFPZ voluntarily helped with interviewing but later the teams saw that this was unsustainable and that they would have to find a more feasible solution. In their QI meeting, teams suggested providing training to registration desk staff, so that this personnel could offer the questionnaire to clients/patients as they exit. The rationale behind this was that by filling in 2-4 questionnaires a day, the FGP registration desk staff could easily interview the needed number of clients (30-35) in two weeks time. Also, the team supported this idea because in this way, interviewing could be conducted at no cost and the answers of clients were less likely to

¹² Known as courtesy bias.

be biased. At this stage, the FGP staff came to the understanding that they would benefit from knowing the clients' opinions on their performance.

Scoring system. The scoring of services provided by physicians at FGPs uses a 5-point scale and this task created some misunderstanding in patient/clients at the beginning. To address this issue, AFPZ interviewers explained to the interviewees that scoring should be performed similar to the 5-point grade system, which is used in schools.

Terminology. Some questions in the questionnaire were difficult to understand or unclear, because of specific terms, such as contraception and confidentiality. In order to improve understanding, the interviewer had to explain the meaning of some questions and terms. The AFPZ started working on the questionnaire in order to avoid difficult terminology and simplify the questions, such as making them shorter by dropping unnecessary words and substituting medical terms with locally accepted equivalents. For example "menstruation" was substituted by a word which is similar to "periods;" and instead of asking about confidentiality, the question was re-designed to ask: "How many times anyone entered the room during your visit to your doctor?"

Language problems. Because the initial questionnaire was developed in Russian, Kazakh speaking respondents had difficulties understanding and answering the questions. Fortunately, the Kazakh speaking interviewers were able to quickly help those respondents and successfully fill in questionnaires. In the course of the project, the QI project participants realized the need to have the satisfaction questionnaire in Kazakh. As the project progressed, the FGPs found ways to solve this problem themselves; some used volunteers among the patients to translate, while in others the questionnaire was translated by Kazakh-speaking staff.

(3) Using the facility review tool:

When the curators conducted the facility reviews, they found out that many of the FGPs had no schedules in the Kazakh language and that in some of them the schedule was inconveniently placed for patients. By round four, all FGPs had solved this issue.

In most FGPs, the facility review revealed that FP materials for clients were lacking. Later, after round three, the situation improved with the help of ZdravPlus, which provided brochures and posters.

The assessment of sanitation in the facility was performed not through the subjective opinions of the reviewers but was based on the records of the regular Sanitary and Epidemiological Service (SES) checks in this facility. For instance, two FGPs had unsatisfactory results of SES checks for instrumentation sterility. By round three, these facilities had solved this problem.

As a result of facility reviews, more attention was given to the staffs' appearance: the need for uniforms was discussed and within one round, almost all FGPs introduced uniforms for their staff.

The general level of basic equipment in all FGPs was assessed as satisfactory. According to the standards each room should have a blood pressure measuring device, a tonometer, and this standard was met in all of the FGPs of the region. In two FGPs, the senior physicians decided to provide every physician with personal tonometers.

In one FGP, the staff decided to increase the convenience of gynecological examinations by setting up a bidet in the toilet so that women would not need to delay the examination if they came to the FGP without having prepared for a pelvic examination.

(4) Problems with the facility review tool:

- **Scoring system.** The facility review is not measured by numerical scoring. In order to quantify progress over time, a score should be developed.
- **Reliability.** The facility review tool used by the facility's own curators tends to give biased results; an external reviewer (in this case from AFPZ) might be able to look at the facilities more objectively.

(5) Using the provider observation tool:

Round 1 results showed that physicians trained in family planning issues in 1998 had not retained these skills because they generally referred clients seeking FP information to gynecologists.

Over the course of the project these counseling skills did improve. This improvement was due in part to the introduction of new clinical protocols on Reproductive Health at the primary health care level, which includes protocols for family planning, developed by the Kazakhstan Mother and Child Health Center in collaboration with the United Nations Population Fund (UNFPA) and ZdravPlus and tested in Zhezkazgan in March 2002. Twenty FGP physicians participated in the testing and received copies of these protocols. These 20 physicians started sharing their knowledge of the protocols with colleagues in their facilities, and eventually this resulted in the gradual improvement of counseling skills. Together with regular use of the CQI checklists, the process of following the clinical protocols helped those physicians who were not trained in FP before 2003 to follow the requirements of the QIS and provide counseling to the clients who came for FP.

In round 1, the trained curators observed patient visits and this caused problems in those FGPs where midwives were observing the counseling provided by physicians. In the FGPs where the midwives-curators were supposed to observe doctors, this proved to be unworkable because the existing hierarchy would not allow midwives to comment on doctors' services. This situation was addressed in two ways; the FGPs decided to invite the AFPZ experts to be the independent observers; while in others senior physicians became involved in the observation of providers and took the lead in this process. This helped significantly in terms of organization of the observation process and reliability of the results.

(6) Problems with the provider observation tool:

- **Time-consuming.** The proper use of this tool requires not less than 30-40 minutes of physicians' time, while the standard consultation time for one patient in a FGP is 15 minutes with the physician seeing four patients per hour. To carry out the observation properly, the curator needs not less than two weeks' time to observe one provider give counseling for all four FP methods (i.e. obviously not all patients have come to their FGP seeking or in need of FP counseling). Although the time varied between FGPs, it took several months for AFPZ to collect data for one round across all FGPs.
- **Sustainability.** The procedure of provider observation is a time-consuming activity, which adds to the curator's or physician's list of job responsibilities.
- **Validity.** This tool is not recognized as valid for quality assessment in the existing health care system. Because of this, presenting the results to the top health management is not seriously considered when routine inspections take place.

(7) Using the self-assessment tool:

Self-assessment meetings in FGPs were arranged at the beginning of every round. To hold a meeting, the attendance of at least 70 percent of the staff was required. The meeting was prepared in advance by the curator, who received the results of exit interviews, the facility review, and provider observations from AFPZ. To be prepared for the meeting, the curator analyzed the information and

drafted a list of problems to be discussed. In some of the FGPs, the self-assessment meeting ended with the action plan development, while in others, staff needed a follow-up meeting in order to generate an action plan.

In practice, the use of this tool showed that if the senior physician is really interested in the staff's opinions, then the meeting can bring about real results. For instance: during the first self-assessment meeting in one FGP, the gynecologist said that the real way to increase the rate of pelvic examinations in women is to equip the gynecological room with a bidet. The senior physician agreed to this idea and provided funds for this innovation; after Round 2, the number of pelvic examinations increased by 10 percent. During the second self-assessment meeting in another FGP, staff discussed the issue of long early morning queues at the laboratory. The lab assistant proposed to instruct two additional nurses on how to collect samples from patients and a second proposal suggested extending the sample collection period by one hour (from 8:00 a.m. to 10:00 a.m. instead of only until 9:00 a.m.); the senior physician agreed to this proposal and included it into the action plan. As a result, the problem of the queue for the laboratory was solved during this round. The way in which these two senior physicians reacted to staff's opinions was encouraging for the personnel and helped them to get rid of the "why make proposals if nobody cares" attitude.

The experience of self-assessment meetings also showed senior physicians that in many cases, they were underestimating the potential of staff in their commitment to improvement. It turned out that those staff members who proposed ideas for improvement were also keen on their implementation, if supported by colleagues. By trusting the staff's abilities and commitment to quality improvement, many facility upgrades were undertaken, such as information stands in the corridors, green plants in the rooms, and creating a more comfortable environment, as well as "interest clubs" for women.

"The QI process can be successful only if the senior physician is interested in results."

Dr. Olga Czhen, Ob-gyn, Curator

In general the physicians found the *self-assessment* tool beneficial because it gave every staff member the chance to speak out. This raised their self-esteem, helped create trust and equal relationships, and revealed internal problems, which may not have been otherwise addressed.

(8) Problems with the self-assessment tool

- **Facilitation.** Many of the curators had difficulties in facilitating meetings due to a lack of facilitation skills. In some of the FGPs, the midwife-curator wasn't a leader in the QI process, so it was even more difficult for her to facilitate the meeting.
- **Fear of speaking.** For the majority of the participants, especially at the beginning of the process, it was difficult for them to speak out and express negative opinions. At the beginning of the QIP, the majority of senior physicians were guided by the traditional mentality of hiding problems instead of openly discussing them, because of the fear of being blamed and punished.

E. Identifying Problems and Implementing Interventions and Changes

The staff of the eight FGPs involved in the Quality Improvement Project began by using the Quality Improvement System tools to monitor quality. Although advised to carry out this exercise quarterly, they did so twice a year. By the end of Phase 1, the eight FGPs had conducted three cycles of the QIS which included the evaluation of counseling, the readiness of their facilities to provide FP services, a measure of client satisfaction with those services, and some interventions to address issues that came to light as a result of the monitoring. The results were discussed during staff meetings, which provided an opportunity to work in teams, receive feedback on providers' performance, and to plan

changes together. This process of looking at one's performance, developing interventions, and repeating this exercise in a cyclical way in order to continually improve performance, is the core of the Continuous Quality Improvement approach.

Once problems were identified using the four tools, the staff of the FGP meets as a team to identify priorities, determine causes of these problems, and develop an action plan to address them¹³. In the action plans, each problem is assigned to an individual who has primary responsibility for implementing the solution. **Table 4** shows that many facilities had the same problems and implemented similar solutions.

In analyzing these results, project participants understood that in some cases even minor organizational changes in routine practices can yield effective solutions (e.g. extending lab hours to reduce queues, etc.), while for others to be solved some expense is unavoidable (e.g. translation and copying of Kazakh language education information, a comfortable environment in the FGP, etc.).

Table 4 Most common problems and solutions

Problem	# of FGPs reporting this problem	Solution	# of FGPs reporting similar solution	% of FGPs who implemented the solution
Long waiting time and long lines	5 FGPs	Set up a system of appointment for a visit. Put the registration desk in charge of appointments and examination room staff in charge of regulating patient flow.	4	80%
Confidentiality issue	8 FGPs	Several solutions were implemented: - Removed patients' charts from the desk of gynecologist; - Started regulating patient flow through coordination between registration desk & examination room staff - Preventing staff from entering the room during a patient visit	6 3 6	75% 37% 75%
Low income clients can't afford such methods as Oral Contraceptive	8 FGPs	Applied to a pharmaceutical company for help; Gedeon Richter company donated COCs and the stock lasted for 6 months	8 FGPs	100%
Patients waiting in line for the laboratory	4 FGPs	- Prolonged the time when lab takes samples for analyses from 8 am to 10 a.m. (instead of 9 a.m.). - Got additional lab assistant in the laboratory.	3 FGPs 1 FGP	75% 25%
FP information is not available for Kazakh speaking population	8 FGPs	Translated brochures from Russian into Kazakh language at the expense of FGP and printed enough for the enrolled Kazakh-speaking population	8 FGPs	100%
Complaints from patients of unpleasant waiting conditions or lack of comfort during waiting	5 FGPs	Bought chairs and arm-chairs. Whitewashed/ painted the waiting hall. Decorated the interior with green plants	4 FGPs	80%

¹³ This plan of action for implementing interventions and changes based on the results of the monitoring can be considered as the fifth tool.

F. Results of Phase 1

By the end of Phase 1, 23 months after the start of the project, 199 staff members in eight FGPs of Zhezkazgan/Satpaev had been trained on the QIS and were using its tools.

As previously stated, using all four of the CQI tools in order to complete a full CQI round, took each FGP a number of months. In the following graphs each CQI cycle is identified by the month in which it started, and it should be assumed that each round took place until the start of the next round.

(1) Providers' Performance

The bar graph below presents the average scores of providers' performance for counseling in eight FGPs per contraceptive method. The counseling skills improved through every round.

At round 1, the highest scores were obtained in the three methods which were the most familiar to providers – IUDs, COC, and LAM (51, 49 and 57 percent respectively). The least known method was DMPA because this method was not widely used in Zhezkazgan or Satpaev. **Figure 2** shows a steady rise in counseling skills across the board for four methods across all FGPs from round to round, and a sharp increase in counseling skills after the third round (phase 2) when the FP training intervention occurred.

Figure 2. Improvements in counseling on four contraceptive methods during five QIS cycles across all FGPs

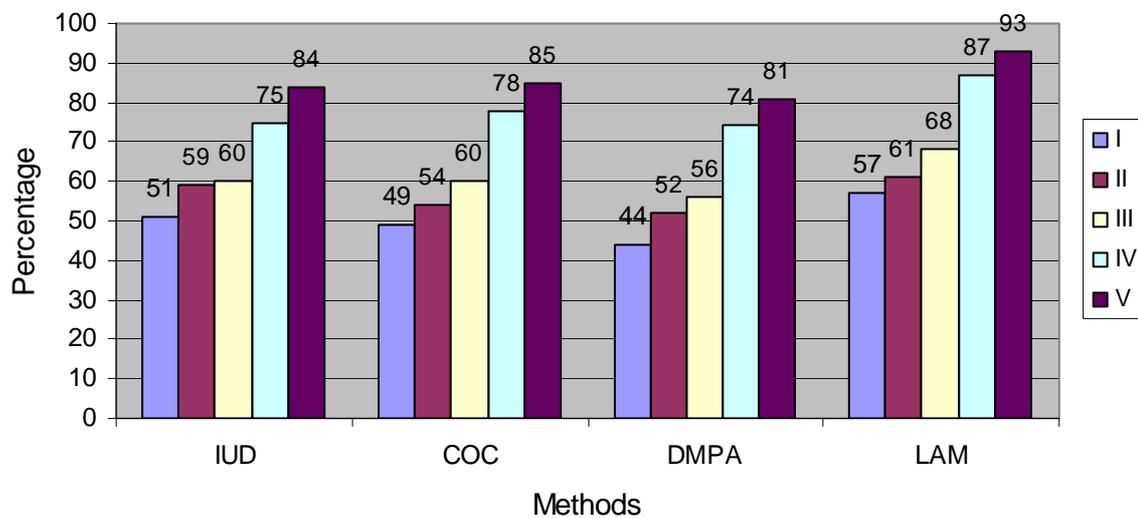
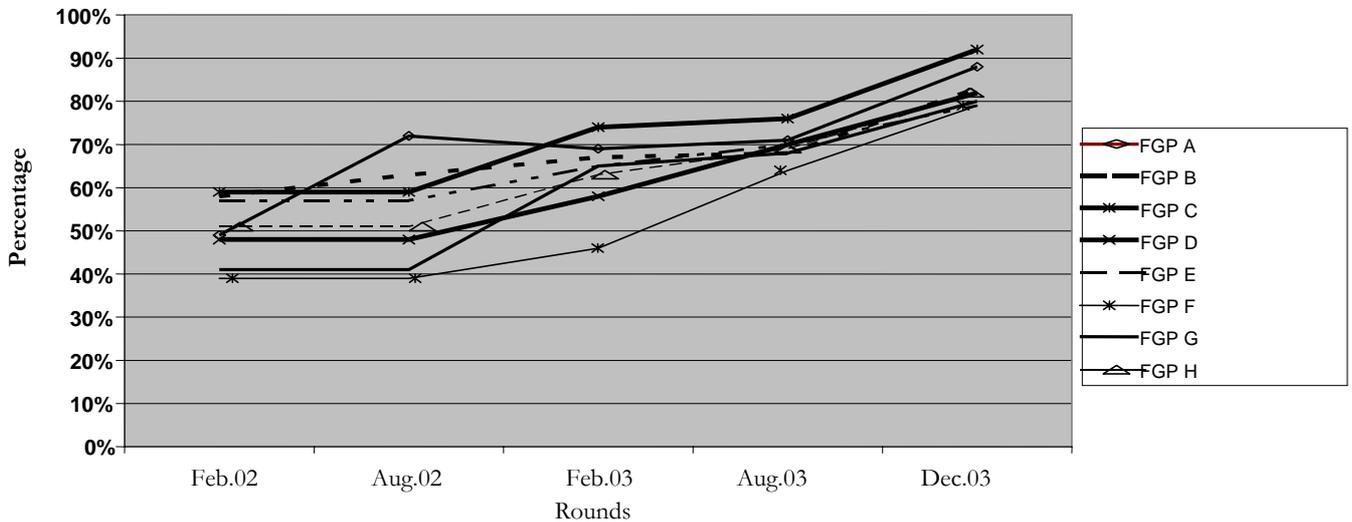


Figure 3 presents the improvement of providers' performance in counseling, all methods combined, in each FGP. It shows that over time, all eight FGPs improved their counseling; also, differences between FGPs decreased overtime, reflecting standardization of care.

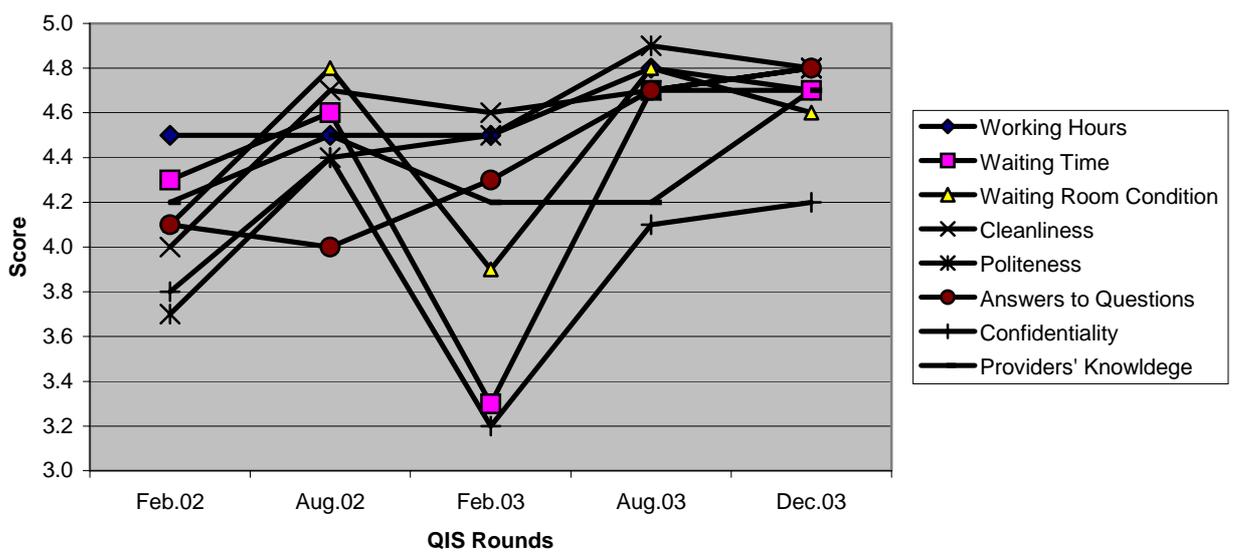
Figure 3 Counseling skills in all methods by FGP



(2) Client Satisfaction and Perceptions

Client satisfaction with services provided and clients' opinions about FGPs was monitored using the *exit interview* tool. **Figure 4** presents average scores over time during five rounds of measurement on different topics, across eight FGPs

Figure 4. Client Satisfaction with FP Services



Overall client satisfaction was high at the beginning of the project, but still improved over time, moving up the range from 3.7 – 4.5 in Feb.2002 to 4.2 – 4.8 in Dec.2003.

The most significant improvement in client satisfaction was made by FGPs on issues of:

- Politeness: from 3.7 score in Round 1 up to 4.8 in Round 5 (a 30% increase);
- Cleanliness of the FGP: from 4.0 in Round 1 to 4.8 in Round 5 (a 20% increase); and
- Answers to questions: from 4.1 in Round 1 to 4.8 in Round 5 (a 17.5% increase).

Client satisfaction decreased for almost every topic in Round 3, which can be explained by the fact that the data collection period coincided with a flu epidemic in the region. The FGPs were crowded with patients, physicians were not able to pay enough attention to FP issues, and this had an impact on the exit interview results.

G. Discussion of Phase 1

(1) On the Results of Phase 1

QIS is feasible and accepted. The important result of Phase 1 was that the QI concept was well accepted by the health care providers at the primary level. With good leadership and enough support, the staff of a primary level facility can be very responsive and active in improving their work environment and the quality of care they provide to patients. By initiating interventions with objectives that were feasible for implementation, achievable, and quickly produced results, FGP staff were encouraged and able to overcome their initial skepticism about the project.

QIS initiated a dynamic of improvement and teamwork. The Continuous Quality Improvement approach, which is a new concept in Kazakhstan, taught the FGP staff techniques of performance monitoring. Health workers learned to measure quality using the QIS tools and present the results in graphs. The FGPs were able to organize teams and appreciate the advantages of working in teams when each staff member was conscientiously contributing to quality improvement.

QIS led to improvements. Performance improved for all the dimensions of quality in providing family planning counseling.

Best practices were identified. Changes are similar among FGPs, which indicates that best practices can be identified for replication.

(2) On participants' perspectives

All participants were driven by the competition for clients; this provided the motivation to perform better and attract more patients to their particular FGP during the next enrollment campaign.

The FGPs were interested in quality improvement. The health care system traditionally urged providers to improve their performance, but without offering training in the area of continuous quality improvement, a systematic method for doing so.

“Due to the QIS/CQI we got rid of the queues, and our senior physician is providing my clients, who are low income, with free contraceptives”

Bagdagul Tagibergenova, gynecologist, curator

The attitudes of participants changed during the project. By the end of Phase 1, when project participants were able to see practical improvement in their own performance and the corresponding improvement in patient opinion, attitudes towards the Continuous Quality Improvement project and the Quality Improvement System became more positive.

“I would be happy to do even better if the results of my performance observation could influence my salary.”

Family Physician in Zhezkazgan

However, the project participants did see the QIS as extra work. Provider observation is not within the formal scope of the curator’s work, so curators have to do this at the expense of their free time.

Participants also wanted rewards for the best performers. Those who were working hard and reaching higher results would like to have been rewarded in some way. Many participants raised this issue at the staff meetings; however, this issue was not solved at the facility level because reserve funds cannot be used to reward staff.

(3) Next Steps

In Phase 1, every FGP involved in the Quality Improvement Project held separate staff meetings, which included self-assessment and action plan development activities. During these staff meetings physicians identified many problems, which they were facing on the way to quality improvement, but were unable to solve at the facility level. This initial experience showed to the primary health care workers that overall quality depends not only on the single worker’s skills and his goodwill or a single facility’s efforts, but also on the PHC system to which they all belong.

The design of the CQI project at the facility level, from the very beginning, assumed an internally managed and confidential process where any negative information about a facility would not be shared with the medical community or with patients. The results collected during the QIS cycles were submitted to the AFPZ for analyzing, but not for broad discussion. This superficial awareness of the Regional Health Care Department about the CQI project did cause some problems. For example, the Oblast Head Specialist expressed resentment for not being introduced from the very beginning to the concept of CQI, which was obviously unfamiliar to the top-level health managers. She blamed international organizations for involving health care workers in a project unfamiliar to oblast top management and for which no official permission had been given at the oblast level. Such “unsanctioned activities”, she said, created additional work for physicians, impeding them from doing their jobs well.

In order to find appropriate solutions to these issues, the CQI project participants and the AFPZ applied to ZdravPlus to support a meeting with oblast and regional health department representatives. At this stage, the FGPs decided to introduce CQI and QIS to top health care management in the oblast and region in order to gain support and understanding. This was the beginning of the Phase 2 of the Project.

VIII. Phase 2: Redesigning and Institutionalizing Family Planning Services

In February 2003, ZdravPlus sponsored a two-day joint meeting in Zhezkazgan which involved the participants of the CQI project, representatives of the local administration, top management at the regional health department, three head specialists from the oblast level in Karaganda, representatives from the Healthy Life Styles Center (HLS), and some AFPZ members. The goal of the meeting was to introduce the Quality Improvement concept to all of those unfamiliar with it and to set up a Multilevel Quality Team, which would move the project to its next phase: institutionalizing the CQI of family planning in the region through the use of the QIS. The meeting was facilitated by Dr. Serik Tleubaev, Chief Obstetrician-Gynecologist in the region. On the first day, the FGPs participating in the QIS introduced the audience to the CQI concept and its tools, how they used these tools, and the results of the first three rounds (the number of QIS rounds completed at that time). From these presentations, a list of priority issues was developed:

- Inadequate FP counseling skills in the majority of providers: physicians decided that 85 percent was the acceptable level of proficiency and saw that an inadequate number of physicians had reached this level;
- Low level of population awareness about FP issues, particularly among teenagers;
- Contraceptives not affordable for low-income population groups;
- FGPs unable to provide free contraception to low-income clients;
- FGPs don't have official indicators, beyond those developed by the QIS, which are approved by decision makers at the system level;
- Lack of male involvement in family planning issues;
- Selection of curators for CQI expansion in the future;
- Pregnancies/abortions in teenagers; and
- Lack of FP materials in the Kazakh language.

The FGP members at the meeting stated that the majority of these issues were beyond the reach of the FGPs. They suggested that these issues needed to be addressed by the health care system as a whole and asked the health care managers for help.

Dr. Serik Tleubaev, Chief Obstetrician-Gynecologist of the Region, presented the situation in the area of reproductive health (RH) in Zhezkazgan/Satpaev. He specifically mentioned as a problem the following: Family Planning services in the region had never been defined as a separate service in the system; PHC physicians were not accustomed to analyzing the results of their work; the poor quality of data collection which often takes place; the high rate of abortions justified by so-called "social indications"; poor continuity of services between FGPs and the maternity house; and the lack of coordination between PHC and the Regional Healthy Lifestyles Center.

Dr. Gul Omarova, Oblast Chief Obstetrician-Gynecologist reported statistics showing that in Karaganda Oblast, and in Zhezkazgan/Satpaev region particularly, the abortion rate is very high and said that this indicates a low level of family planning services in that region. She welcomed the QIS in family planning and was very interested in seeing the results of CQI project activities in the two cities. The participants discussed the provision of family planning services and the current situation regarding reproductive health among the population in the region.

Meeting participants visited FGPs which were a part of the CQI project and used the QIS to observe how family physicians provide FP counseling. The chief ob-gyn from Karaganda highlighted several technical flaws in the counseling. In particular, she said that physicians are under-using the protocols and guidelines, although they have them on their desks, and this reduces the effectiveness of the counseling. She reminded the family physicians that they don't need to learn the algorithms by heart and that it's not an embarrassment for a physician to refer to a guideline in front of a patient. She encouraged family physicians to use the job aids to help improve immediately the quality of counseling and provide for self-education with no need for special training.

In the discussions, family physicians stated that the standard time for seeing a patient (15 minutes, or four patients/per hour, in accordance with regulations) is not enough to provide quality FP counseling. They also pointed out that an average patient who comes for treatment of a disease or injury is not necessarily interested in FP counseling.

The participants of the meeting identified several components of the system responsible for reproductive health in the region: the Women's Consultation located in the maternity house, the Diagnostic Polyclinic, the Copper Corporation Medical Center, the Genetic Center, gynecologists in

FGPs, family physicians in FGPs, the Healthy Life Styles Center, the Information Center, and pharmacies. They agreed that each component of the system can potentially influence family planning services in the region and the overall performance of the RH/FP system. The participants concluded that in order to move forward, they need to understand the roles and assess the capacity of every component in the system. The roles of these institutions are described in *Annex 2*.

Partly as a result of this meeting CQI activities stepped beyond the PHC level by involving more components of the health care system, such as health authorities, the population, HLS, and others.

By the end of the meeting, participants had chosen three priority objectives on which to focus 1) the improvement of FP counseling skills in PHC workers to a minimum level of proficiency, defined as 85 percent or above; 2) population education on the issues of FP; and 3) increasing demand and access to reproductive health information.

A. Interventions and Changes

During this phase the three main interventions were 1) additional training in FP skills; 2) a population education campaign; and 3) the establishment of family planning rooms, which were later named Reproductive Health rooms, in FGPs.

(1) Additional Training of Providers in Family Planning

In June 2002, the health department issued a policy which allowed family practices to provide some services that were previously provided only by gynecologists, such as antenatal care and family planning services. However, family physicians were not able to effectively counsel on FP without additional special training. To address this issue AFPZ applied to ZdravPlus to provide assistance in FP trainings.

From February to June 2003, six FP training courses took place. These trainings were supported and organized by ZdravPlus. Every five-day training course for 19 to 20 trainees was facilitated by four trainers. At the end of each course, the successful trainees received certificates. The main task of these training courses was to train family physicians and midwives in providing counseling in family planning.

The training content was in compliance with the national RH clinical protocols developed by the national Mother and Child Health Center. Every participant was provided with the Russian version of JHPIEGO's *Pocket Guide for Family Planning Service Providers*, P. Blumenthal, 1998, and the National Reproductive Health and Family Planning Guidelines.

The main topics of the course were:

- Family planning principles and women's health;
- Family planning regulations in Kazakhstan;
- Modern contraceptive methods (five main methods) and emergency contraception;
- Counseling steps and "client assessment";
- Sexually transmitted infections (STI) prevention; and
- Clinical sessions: IUD insertion and removal and practical work with a mannequin.

Interactive training techniques and small group work was used and each participant was provided with handouts. The average pre-test scores were high, 80.5 percent, while average post-test scores rose as high as 94.5 percent. It was noteworthy that midwives obtained the highest scores.

In the first three training courses health providers from the eight FGPs involved in CQI project were trained while the rest of the training courses covered other FGPs in the region. The process of training was supervised by AFPZ.

In six months, a total of 117 health providers from Zhezkazgan and Satpaev were trained in family planning counseling; this included 88 physicians and 16 midwives in all 16 FGPs, 10 gynecologists in two maternity houses, and three gynecologists in the Copper Corporation Medical Center. Thus, 104 providers at the primary level who see patients and can provide FP counseling were trained with the support of ZdravPlus -- this constitutes 89 percent of all providers.

(2) Population Education Campaign

A two-month information, education, and communication (IEC) campaign, “Let’s Build a Healthy Family” was conducted from May 15 to July 15 and was sponsored by ZdravPlus in Zhezkazgan. The target audience for this campaign was the population of reproductive age, 15 to 35, and particularly young families. During the campaign, the FGPs distributed materials, including 35,000 copies of family planning brochures and posters donated by ZdravPlus, and the local TV channel aired a video promoting breastfeeding and its advantages for the child and mother, includes information on the lactation amenorrhea method of birth control. Three video spots, each 30 seconds long, were developed with the technical assistance of ZdravPlus on the following topics: 1) ‘family planning means the spacing of pregnancies;’ 2) ‘the four most common contraceptive methods;’ and 3) ‘hormonal contraceptives are safe and effective.’ The FGP physicians scheduled visits to more than 20 schools, three colleges, and the local university and conducted meetings with students focusing on the issues of family planning and health promotion. The physicians invited teenagers to visit FGPs for confidential counseling on contraceptive topics. Each staff member in every FGP was involved in the organization of patient “information corners” and stands with brochures and materials about FP which patients could read and take home.

As a part of the campaign, on June 15, the city administration of Zhezkazgan and the AFPZ conducted a city festival under the same motto “Let’s Build a Healthy Family.” The main messages of this event were devoted to health promotion issues, including family planning. The AFPZ took a lead in this event and, in collaboration with actors in the local drama theatre, facilitated performances in which important issues of family planning were highlighted, such as prevention of unplanned pregnancies, adequate spacing between pregnancies, and families having as many children as they want. This event was supported by the local administration: the Akimat, the health department, local pharmacies, pharmaceutical companies such as Gideon Richter, KRKA (Czech pharmaceutical firm), GladPharma, and Innotex; the Healthy Lifestyles branch was involved in organizational issues and local TV commented on the event in a news program. A special room was organized in each FGP where everyone could receive confidential counseling from FGP gynecologists about any topic related to family planning. More than 50 people applied for a consultation with the specialists on this day. The square in front of the theatre became the stage for a concert, where citizens sang songs and danced. After the concert, AFPZ conducted a question-answer contest for the audience and the winners received prizes. A total of over 2,000 people participated in the festival.

(3) Establishment of Reproductive Health Rooms in FGPs

In May 2003, the Regional Health Department in Zhezkazgan issued an order to create a new unit in PHC settings – a Reproductive Health room – to be set up and staffed to provide family planning information and counseling. Within two months, all nine FGPs of Zhezkazgan had organized RH rooms and started to provide counseling in FP at any time during the working day.

The newly organized units have a staff of two health workers: a physician and a midwife who participated in the ZdravPlus funded FP training course.

The rationale for setting up the family planning rooms were:

- In December 2002, ZdravPlus organized and sponsored a study tour to Lithuania. Dr. Kenzhetai Kabykenov, Head of the Zhezkazgan Regional Health Department, and Dr. Serik Tleubaev were invited on this tour along with other representatives. The officials from Zhezkazgan were very impressed by the RH rooms within PHC settings in Lithuania and they returned with the motivation to create similar rooms in Zhezkazgan's FGPs.
- The data obtained from exit interviews in rounds 1 and 2 showed the low level of the population's awareness of contraceptive methods and clients' desire for more confidentiality in the delivery of FP services.

Thus, the setting up of reproductive health rooms appeared to meet the requirements of several parties. This reorganization in FGPs was aimed at improving the access of a healthy population to preventive services. They were named RH rooms but their use was not limited to FP counseling. This room could also be used for prenatal counseling, parent education in home care for healthy and sick children, breastfeeding promotion and support, and educating child caretakers in child nutrition and early childhood development issues.

This represents a significant change from the way RH services were provided in the past:

- RH services are not only provided by maternity houses, but also at the primary care level;
- RH services are not provided only by physicians, but also by nurses and midwives; and
- RH services are more oriented towards meeting the demands of the population.

The RH room could also be an invaluable resource for confidential counseling of teenagers and youth in STIs and contraceptive issues.

B. Results of Phase 2

From February to August 2003, CQI project participants collected data from rounds three and four of the QIS in eight FGPs. This period was the first round for three additional FGPs that joined the QIS after February 2003.

In accordance with the decisions of the Multilevel Team meeting in February 2003, each FGP continued the CQI process at the facility level through internal monitoring. Since insufficient counseling skills of providers was identified as a problem during the Multilevel Team meeting, AFPZ discussed the issue and proposed to use the CQI *observation of provider* data aggregated across the FGPs as an indicator for the impact of the training.

(1) Objective 1: To improve the quality of family planning counseling in FGPs

The indicator of achievement of this objective was "the percent of health workers in an FGP, providing adequate FP counseling". Counseling is considered adequate when the health worker reaches an 85 percent score in skills proficiency, using the checklist for direct observation. The following indicator was calculated:

$$\frac{\text{number of health workers in FGP trained in FP, who achieved 85 percent score}}{\text{number of health workers in FGP trained in FP}} \times 100 \text{ percent}$$

Figure 5 presents the skills proficiency indicator for the eight FGPs involved in the CQI project from the beginning. These results were obtained from the “observation of provider” checklists; it shows the gradual increase, from round to round, in the number of providers who improved their counseling skills to the required standard of 85 percent.

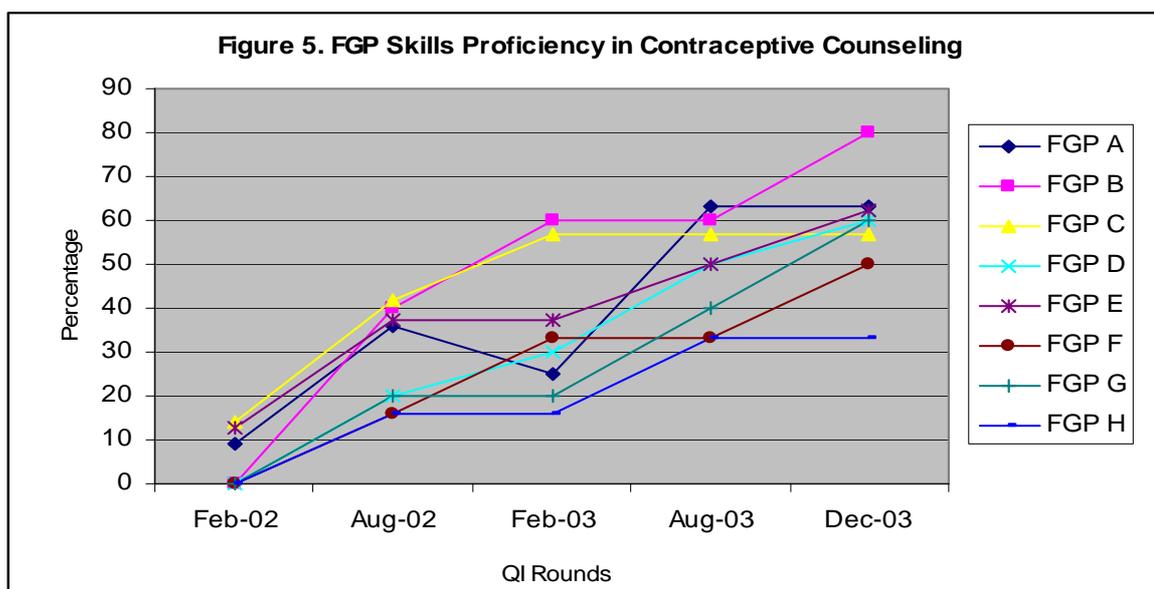


Table 6 below shows that after rounds one and two the counseling skills in family planning issues of FGP gynecologists were much higher than that of family physicians. However, both groups improved over time and the performance gap between gynecologists and family physicians narrowed from 56 percent after round one to 27 percent after round five.

Table 6 Counseling Skills in Gynecologists vs. Family Physicians (percentage)

Specialty	Round 1	Round 2	Round 3	Round 4	Round 5
Family Physicians	22	31	43	44	71
Ob-Gyns in FGPs	78	81	82	86	98
Difference between two specialties	56	50	39	32	27

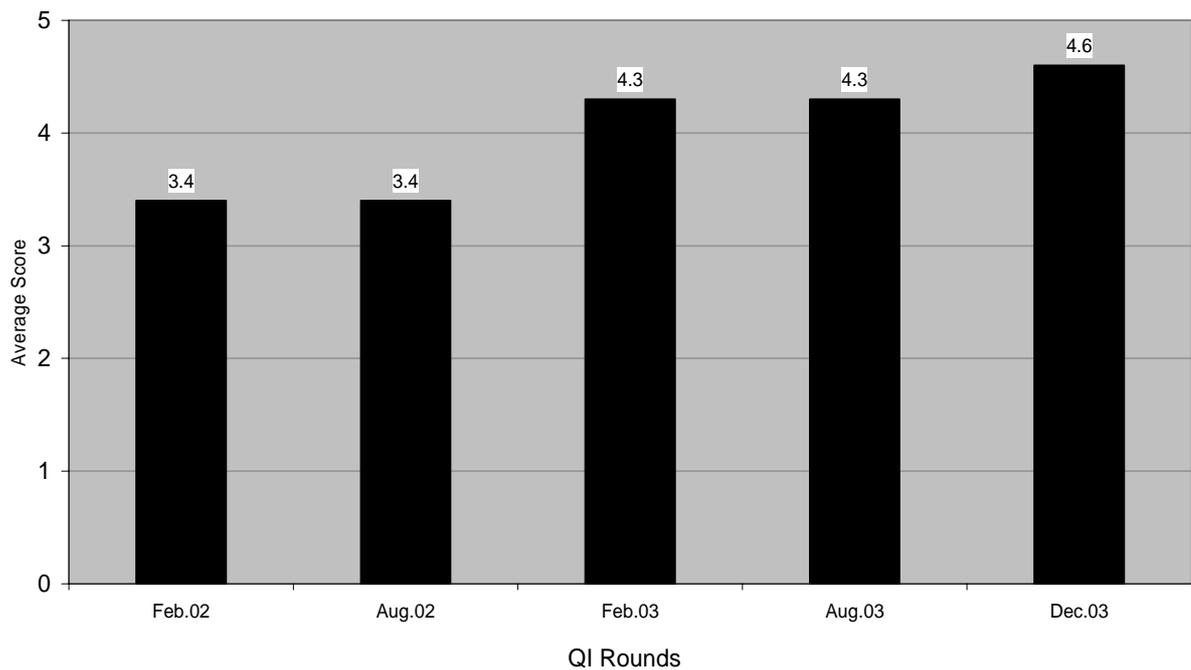
(2) Objective 2: Increasing the Population’s Awareness and Knowledge of Family Planning Methods

In order to evaluate the population’s level of awareness regarding FP issues, the FGPs involved in the Quality Improvement project used the *exit interview* tool. The Multilevel Team decided to use the average score obtained from Question 11 in the *exit interview* questionnaire as the indicator for monitoring the improvement process across FGPs. In this question, the respondent was asked to list the contraceptive methods of which he/she is aware. It was a non-prompted question; each interviewee was expected to mention method(s) familiar to him/her, while the interviewer was ticking the method mentioned on the list of seven methods (IUDs, COCs, DMPA, LAM, calendar, barrier methods, and sterilization). If the respondent wasn’t able to mention even one method, a score of zero was given; if one method was mentioned then the score was one; if two methods mentioned –

then the score was two, and so on. If five methods or more were mentioned then the score was simply five.

Figure 6¹⁴ shows the changes over time in the overall contraceptive knowledge in clients. Contraceptive methods awareness in clients increased from a score of 3.4 (out of a possible 5) in round one to 4.6 by round five. After round two, FGPs actively started patient education activities, such as arranging information stands in corridors and waiting halls with brochures from ZdravPlus. Round three results show a significant increase in awareness; which can probably be attributed to the public education campaign in May - July 2003. The level achieved here stayed high through round five.

Figure 6. Contraceptive Methods Awareness in Clients



In addition, significant progress was seen in the awareness of emergency contraception method by clients, from 24 percent in February 2002 to 74 percent in December 2003.

In December 2003, in addition to the quarterly monitoring of contraceptive awareness in clients, the AFPZ conducted a short **contraceptive prevalence and method satisfaction survey in Zhezkazgan and Satpaev.**

The purpose of the survey was to obtain a picture of contraceptive method prevalence in the population as well as satisfaction with methods used, since the QI project started. An expected and important outcome of all efforts to build family planning services is a client who makes an informed decision about which contraception method is more appropriate and is pleased with his choice. Interviews were conducted as clients exited their FGP following a visit to their doctor. Women of reproductive age were randomly selected and asked to voluntarily fill out a questionnaire. ZdravPlus provided its technical assistance on development of the questionnaire and in analyzing results. A total

¹⁴ Keep in mind that each CQI round is labeled from the start of the round and took place until the beginning of the next round, for example round 1 took place from February 02 – August 02.

of 161 interviews were conducted by AFPZ for 91 respondents in Zhezkazgan and 70 respondents in Satpaev. The Survey questionnaire is in **Annex 3**.

The characteristics of the respondents by age are as follows: teenagers (15 - 19 years old) constituted 20 percent (32 respondents); adults (20 - 39 years old) 61 percent (98 respondents), and adults 40- 49 year olds 19 percent (31 respondents).

The first question was about **use of contraception**: 57 percent (92 respondents) said that they are using a method of contraception, while 43 percent (69 respondents) are not using contraception at all.

Then those 69 respondents were asked **why they are NOT using any contraception**; 35 percent (24 respondents) said that they want to have children; 33 percent (23 respondents) said they are not sexually active; 25 percent (17 respondents) said that they have infertility problems because of diseases. Only 4.3 percent (3 respondents) said that they don't know what methods to use; one respondent reported of being cautious about using any contraception, and one said that her husband doesn't want her to use contraception.

Out of **those who use contraception** (92 respondents) the method mix was as follows: 58 percent (53 respondents) use IUD; 28 percent (26 respondents) use oral contraception; 7 percent (6 respondents) use lactation amenorrhea method; 3 percent (3 respondents) use the calendar method and 2 percent (2 respondents) use DMPA; one respondent reported about a spermicidal method used and another one used the withdrawal method.

When asked **if they were satisfied with the method which they were currently using** 92 percent (85 respondents) said they are quite satisfied, while 8 percent (7 respondents) said NO or NOT SURE.

The latter seven respondents were further asked about the reasons **why they are still using the method which they are not satisfied with** (all of them using IUDs), for which they gave several answers among them “don't know other methods” and “afraid of other methods”, only one answer was that “lack of money” prevents her from using the desired method. When asked **what method they would prefer instead of the one they are using currently**, the preferred choice (57 percent) was oral contraceptives.

In summary: The short survey showed that 57 percent of population surveyed was using contraception; 68 percent of the non-users indicated relevant reasons why they are doing so, such as planning to have children and sexual abstinence. A cause for concern is the fact that 25 percent out of the non-users reported post-abortion infertility or infertility because of diseases. The survey showed that IUDs are still the most popular method of contraception; 58 percent of clients reported using an IUD, while oral contraception was in second place at 28 percent. The survey showed a very high rate of satisfaction with the method used (92 percent). At the same time, the findings in the group of unsatisfied clients show that there is still room for improvement given that ALL unsatisfied clients were using IUDs and said that they don't know other methods or are afraid of other methods.

In conclusion, according to the survey results, the overall level of contraception prevalence and client satisfaction with methods used in the Zhezkazgan/Satpaev region is high. However, it would be misleading to consider these findings to be the direct result of the CQI project implemented in the eleven FGPs of the region, since this was a single survey which took place at the end of the project and there was no base-line survey to compare the data to. The Zhezkazgan Association of Family Physician would like to see questions about contraception prevalence and client satisfaction with their method of contraception on the CQI *exit interview* questionnaire. Regular data collection in this manner will allow for cost effective measurement of the efficacy of the CQI project.

(3) Objective 3: To Increase Demand for Reproductive Health Information

The FGPs understand that preventive services must constitute a significant share of their activities in order to keep the enrolled population healthy. This goal can be achieved only through efficient population education on health issues, carried out both through events such as the “Let’s Build a Healthy Family” campaign and through adequate access to health information in FGPs. The setting up of RH rooms was aimed at assisting health providers in communicating more information to the population. Because the RH rooms represent a new structure in the FGPs, additional efforts were needed to create a demand in population for RH room services. From the very start of the RH rooms in May 2003 the FGPs began collecting data to monitor the change in demand and provide the AFPZ with data for monitoring the process. **Table 7** presents information about visits to RH rooms in the period between May - December 2003.

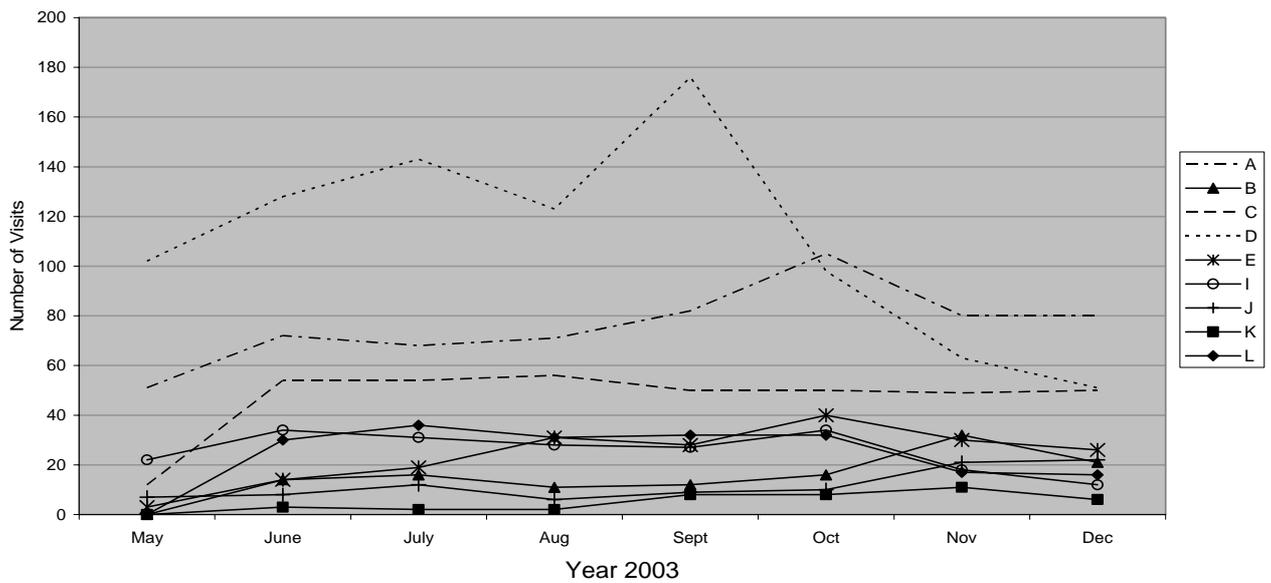
Table 7. Number of Visits to Reproductive Health Rooms in FGPs, May - December 2003

FGP (names are replaced by letters)	Total visits to RH rooms	Adults (18 – 45 years old)		Teenagers (14 – 18 years old)		% Self referrals
		Self referrals	Referred by FP	Self referrals	Referred by FP	
FGP A	2081	652	820	488	121	55
FGP B	1055	412	521	68	54	46
FGP C	778	301	102	328	47	81
FGP D	2496	632	980	403	481	42
FGP E	639	207	241	157	34	57
FGP F	638	102	342	123	71	35
FGP I	1508	560	742	134	72	46
FGP J	1126	599	432	76	19	60
FGP K	445	209	186	35	15	55
Total	10766	3674	4366	1812	914	51

N.B. “Referred by FP” indicates persons referred by a family physician to the RH room for information; “self referrals” indicates a client who decided to visit the room without a doctor’s referral.

The data in table 7 show that, although the percent of self-referrals is almost equal to the number of visits under physician’s referral (51 percent vs. 49 percent), the breakdown for adults and teenagers shows a significant difference between these two groups. Thirty-four percent of total visits (10,766) were by adults who visited the RH room on their own, while almost 41 percent of total visits were by adults referred by a family physician. For the teenagers’ group, the situation is quite different – 17 percent of the total visits were from teenagers who came on their own, while less than nine percent of total visits were made by teenagers referred to the RH room by a family physician. Also, as seen from the table, when looking at only the adult group, self-referrals to the RH room constitute about 46 percent of all visits (8,040), while in the teenager’s group the self-referrals share is 66.5 percent of all visits to RH rooms (2,726). This emphasizes the importance of a RH room in FGPs as a means of improving access to FP information for those population groups, such as teenagers, which rarely visit FGPs due to medical problems or are perhaps embarrassed to visit a doctor when seeking such information. **Figure 8 below** shows some trends in visits by teenagers to RH rooms in nine FGPs of Zhezkazgan from May through December 2003. Although the diagram presents absolute numbers, this information is helpful for QI teams in FGPs because it allows for monitoring the impact of any routine intervention; for example, in FGP D the peak of visiting took place in September after a series of lectures were provided for school students.

Figure 8. Teenagers visiting RH rooms in Zhezkazgan



Indicator for monitoring Objective 3:

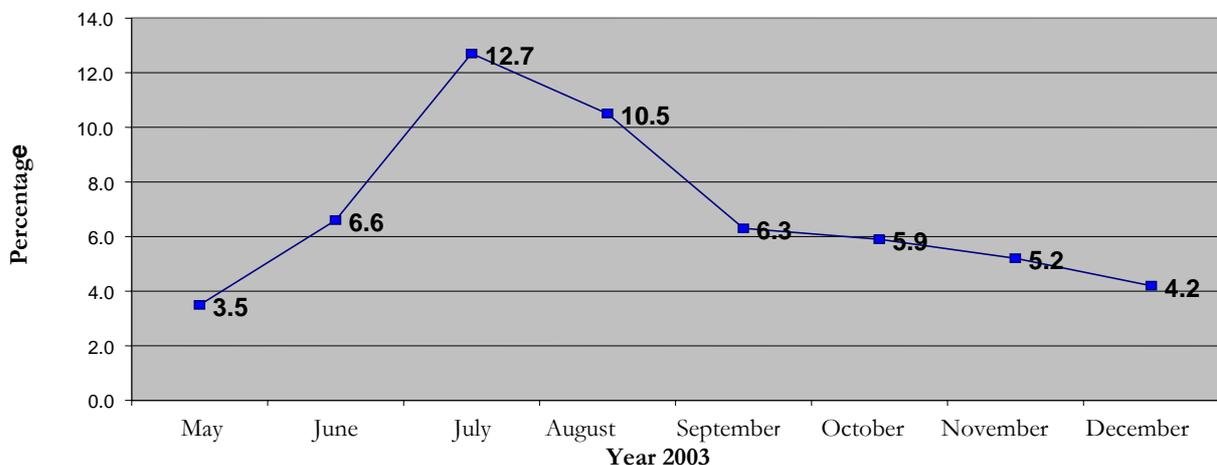
The indicator for monitoring the achievement of objective three was defined as “The percentage of visits to RH rooms among all visits to FGP”. The following indicator was calculated:

$$\frac{\text{number of visits to RH room per month} \times 100 \text{ percent}}{\text{Total number of visits to FGP per month}}$$

Every month the AFPZ collected data on RH room visits and the total number of client visits to FGPs involved in the CQI project. The indicator was calculated as a percent of visits to RH rooms of all visits to the FGP in a month.

Figure 9 shows the overall trend in visiting RH rooms across all FGPs involved in the QIP from May to December 2003. The peak of visits in July can probably be linked with the IEC “Let’s Build a Healthy Family” campaign, which took place in May – July 2003 in Zhezkazgan.

Figure 9 Visits to RH rooms as a Percent of all Visits to 8 FGPs, Zhezkazgan/Satpaev, May - Dec. 2003



C. Discussion of Phase 2

(1) Impact of the Family Planning Services Quality Improvement Project

The first objective during phase two of the project was the improvement of physician's counseling skills. In a period of six months, almost 90 percent of PHC workers in the region were covered by Family Planning training (117 in total) and every trained physician was provided with a copy of clinical protocols and guidelines for family planning, approved by the MOH on the government level. Monitoring of FP counseling skills show an improvement in the quality of counseling provided. Overtime the percentage of workers who improved their counseling skills up to 85 percent (proficiency threshold) increased from 3 percent at the beginning of the project in February, 2002, to 45 percent in December, 2003.

To really see progress towards their second objective; increasing the population's awareness and knowledge of FP methods; the QI team realized that they would need to implement a citywide population involvement campaign. The two-month 'Let's Build a Healthy Family' campaign, which was conducted in collaboration with the Association of Family Physicians in May-June 2003, brought positive attention to the issue of family planning. Overall, contraceptive methods awareness in clients improved from an average knowledge of 3.4 methods in February 2002 to an average knowledge of 4.6 methods in December 2003. In addition, significant progress was seen in the awareness of emergency contraception method by clients; only 24 percent in February 2002, this increased to 74 percent in December 2003.

In reality, family physicians in Zhezkazgan and Satpaev spend most of their time treating sick patients and devote very limited time to healthy people, especially for counseling purposes. The QI team considered this to be a barrier to quality counseling on family planning issues. Thus, fulfilling their third objective, the creation of FP/RH rooms, was a way to overcome this barrier to the adequate provision of FP counseling. In addition the RH rooms would allow for a broad range of health promotion activities, not only providing information about family planning issues, but also children, teenagers, men and women's health issues. Monitoring of RH room visits as a percentage of overall FGP visits show steady use of this service with an increase in visits following the 'Let's Build a Healthy Family' population involvement campaign.

(2) The Effect of the Quality of Family Planning Services on Contraceptive Use

Although a change/increase in contraceptive use was not stated as an objective of the project, it is relevant to look at its trend during the period that the QI project was implemented. Data on trends in contraceptive use and method mix in Kazakhstan and in Karaganda Oblast from four different sources of information; official statistics, the Demographic and Health Survey 1999¹⁵; the ZdravPlus Knowledge, Attitudes, and Practices survey; and an AFPZ survey from 2003, were compared.

- **Official numbers** from Zhezkazgan (see **Table 8**) obtained from regular annual FGP reports show a decline in the absolute numbers of contraceptive users between 2001 and 2002, followed by an increase in 2003—which could be related to the availability of donated contraceptives in the FGPs. Stocks of donated contraceptives have been declining in Zhezkazgan in recent years. Contraceptive users who were purchasing their methods in pharmacies were not necessarily reported by FGPs, which were mostly concerned in keeping records of the donated contraceptives use. Noteworthy is a shift in the method mix, with growing proportions of oral contraceptive users and possibly condom users, along with an apparent slight shift away from IUDs.

¹⁵Demographic and Health Survey, Kazakhstan, 1999; Measure DHS, Macro International Inc.

Table 8. Number of Contraceptive Users (inpatient and outpatient), Zhezkazgan, 2001-2003

	2001	2002	2003
IUDs	1,206 (25 %)	1,042 (26%)	987 (18%)
Oral contraceptives	1,858 (39%)	1,394 (35%)	2,324 (42%)
Injectables	655 (14%)	280 (7%)	383 (7%)
Condoms	633 (13%)	735 (19%)	1,013 (18%)
Spermicides	342 (7%)	305 (8%)	394 (7%)
Other barrier methods	78 (2%)	198 (5%)	436 (8%)
Total	4,772 (100%)	3,954 (100%)	5,537 (100%)

- The latest **Demographic and Health Survey (DHS)** in Kazakhstan, which took place in 1999, presented some data on contraceptive prevalence in the country indicating an increase in contraceptive use in all women of reproductive age, compared to the 1995 DHS: from 43 percent to 48 percent for all methods and from 34 percent to 39 percent for modern methods only (Oral Contraceptives, Injectables, IUDs, Diaphragms, Condoms & Sterilization). In Karaganda oblast, the proportion of married women who were using contraception at the time of the surveys increased from 66 percent to 72 percent between 1995 and 1999¹⁶. Of the methods used the IUD constituted 39 percent in 1995 and 47 percent in 1999, making this the most widely used method in the Karaganda region. In the meantime, oral contraceptives among married women went from 3 percent in 1995 to 4 percent in 1999.
- The **Knowledge, Attitudes, and Practices (KAP) survey conducted by BRIF** Central Asia Social & Marketing Research Agency under contract with ZdravPlus in 2001, 2002, and 2003 presented data on contraceptive use and method mix in Zhezkazgan and Karaganda. It should be noted that unlike the DHS survey, this survey included both men and women from age 15 up to the elderly—although two-thirds of the sample were women and half were aged 20-49. Moreover, the sample was very small, comprised of just 100 persons in each city, compromising comparisons of the results over time *Table 9 and Figure 10* below present data on contraception use and method mix in these two cities.

Table 9. Number (percent) of respondents currently using a contraceptive method

	Zhezkazgan / Satpaev N (%)			Karaganda N (%)		
	2001	2002	2003	2001	2002	2003
Yes	65 (33)	26 (26)	28 (28)	71 (36)	34 (34)	37 (37)
No spouse/partner	46 (23)	33 (33)	28 (28)	47 (24)	39 (39)	27 (27)
Don't know	4 (2)	0	1 (1)	0	0	0
No	85 (43)	41 (41)	43 (43)	82 (41)	27 (27)	36 (36)
Total	200 (100)	100 (100)	100 (100)	200 (100)	100 (100)	100 (100)

From this table, it is clear that the use of contraceptives in the population has not changed and that it has even decreased slightly in Zhezkazgan/Satpaev (no statistical test performed).

¹⁶ Note: The 1995 DHS puts Karaganda Oblast in the North-East region, along with 6 other oblasts, while the 1999 DHS puts Karaganda oblast as the only oblast of the Central Region. Also, Zhezkazgan was a separate oblast in 1995 and became part of the Karaganda oblast in 1999.

Figure 10: Contraceptive Method Mix

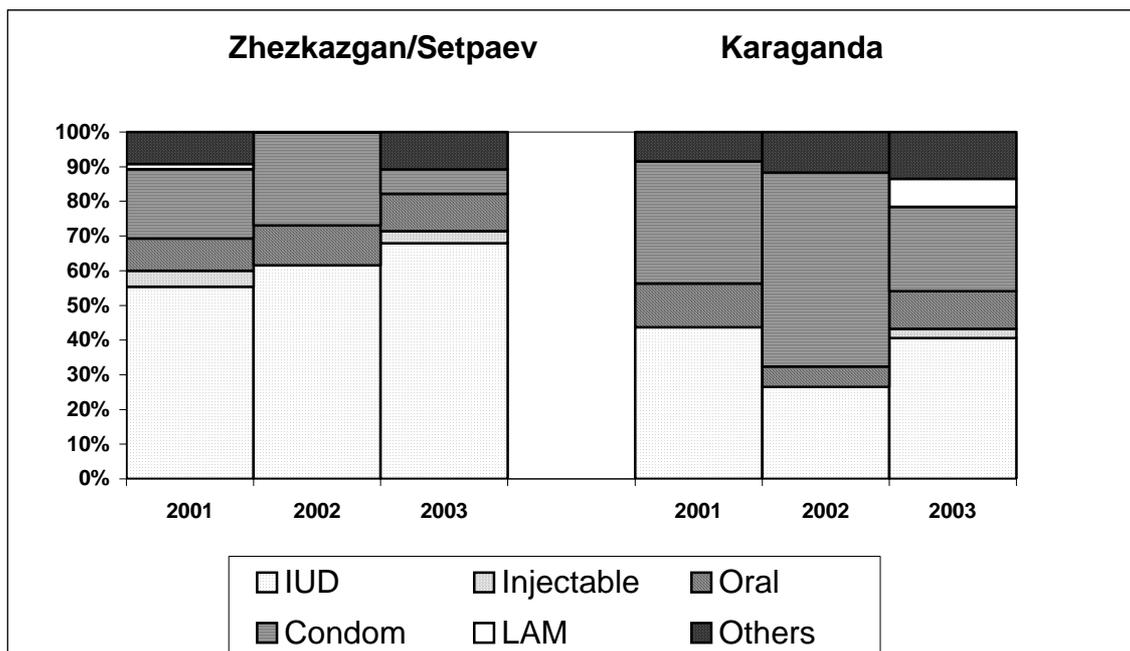


Figure 10 shows that the mix of contraceptive methods among users evolved differently in Karaganda and the cities of Zhezkazgan and Satpaev. The share of IUDs increased in the project area while it did not significantly change in Karaganda. In the project area, oral contraceptives are the second method of choice, while it remains the condoms in Karaganda.

- The short survey conducted by AFPZ/ZdravPlus in Zhezkazgan in December 2003 as a part of the Quality Improvement Project confirmed that contraceptive prevalence in the region is high, constituting 57.8 percent. Traditionally, the IUD has been the predominant method of contraception and this is still the case with 55.9 percent using this method. The December 2003 survey found very different results from the BRIF 2002 survey: specifically a significant increase in the use of COCs accompanied by a decrease in the use of condoms. Because the sampling method for the AFPZ 2003 survey (exit interview of users) was different from the KAP 2002 (household survey), care must be taken in comparing these results. In order to confirm that there is a shift in preferred methods of contraception taking place, repeated surveys should be done, using the same methodology. Table 10 shows the results of the AFPZ 2003 Survey.

Table 10 Distribution of Different Methods of Contraception among Users

Method	AFPZ 2003 Survey, Zhezkazgan, % of users (n=161)
IUD	57.6
Oral contraceptives	28.3
LAM	6.5
Calendar	2.2
DMPA	2.2
Condoms	1.1
Other	2.1
Total	100%

Table 11 compares the findings from various sources on contraceptive use and method mix. Although methods, time periods and population are not the same, the large differences in results are still puzzling and the 3 surveys seem to contradict official statistics. For this reason, it is very difficult to conclude that contraceptive use in the Zhezkazgan population has increased since the beginning of the QIS. The same observation is true for method mix, where IUDs remain the preferred method.

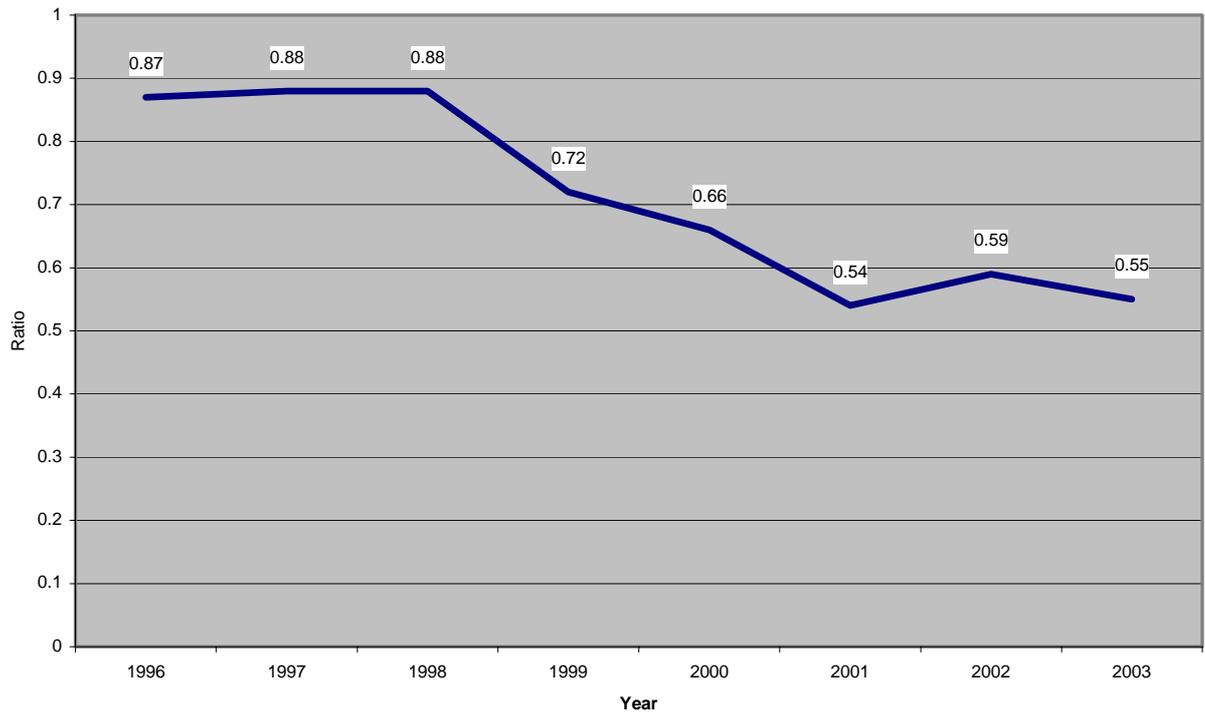
Table 11: Summary table on findings from different survey on contraceptive use and method mix

	Official Statistics 2001-2003 in Zhezkazgan	DHS 1999, in Karaganda	BRIF 2001-2003, in Zhezkazgan	AFPZ 2003, in Zhezkazgan
Population	All reproductive age women using FGPs	Married women 15-49, general population	Men and women 15 and up - concentrated between 15 and 49- general population	Women 15-49 using FGPs
Contraceptive Use (all methods included)	Unknown	72%	28% in 2003	58%
Trend in contraceptive use	16% increase in consumption of donated contraceptives	6% increase between 1995 and 1999	5% decrease between 2001 and 2003	Unknown
Use of IUD (among all users)	18%	47%	68% in 2003	58%
Trend in use of IUD	8% decrease since 2001	8 % increase between 1995 and 1999	13% increase between 2001 and 2003	Unknown

(3) The Effect of the Quality of Family Planning Services on Abortion Rates

Figure 11 presents the data from the Information System database in Zhezkazgan on the ratio of abortions to deliveries, where eight FGPs out of a total of nine had been implementing the CQI quality improvement system since 2002. The reduction in the ratio of abortions to deliveries is not necessarily due only to the strengthening of family planning services through the QIS. However, it is important to keep monitoring this trend in relation to the use of improved RH services and contraceptives.

Figure 11 Trend in the Abortion/Delivery Ratio in Zhezkazgan



IX. Lessons Learned from the QI Project

A. The Improvement Dynamic in Karaganda Oblast

- The QIS is a set of instruments designed only for one type of health service. It proved to be useful in Karaganda Oblast, at least to initiate a dynamic of improvement, but it raises the issue of the teams' capacity to adapt the same approach and instruments to other types of health services. We are not aware that teams applied QIS to another service or health condition.
- The phased approach, moving up from providers' performance to system improvement, makes sense in the KZ environment. This is because the traditional top – down management style assumes that all problems with quality of care come from unsatisfactory or weak providers, but does not see problems with the system of care itself. Once providers' performance improved, as the results show, senior managers are more easily convinced that poor outcomes require addressing system issues, rather than putting more stress on providers.
- The QIS helped staff to separate the problems that are “solvable” at the facility level and the ones that need to be addressed at a higher level and are beyond their control. This evolution was made possible through the establishment of a multilevel team, which involved health care leaders. It helped the management to make decisions about significant changes in the system of care for reproductive health. However, informing and involving managers from the beginning would have facilitated the relationship with the facilities and the AFPZ and would have avoided some miscommunication.

- The AFPZ was a key counterpart in the success of the QIS. It is doubtful that individual FGP would have been able to achieve the same results without the overall umbrella of an association to support them. The CQI project provided an opportunity for the AFPZ to develop its skills and to better define its supporting role to its members. It has grown into a reputable association, with links to international networks, and is recognized as a model among the 32 NGOs registered in Zhezkazgan.

B. The QI Process for FP Services

- Most teams are enthusiastic about the quality improvement process, perceive the value of measuring their performance, and succeeded in improving providers' performance and client satisfaction, through a mix of time-limited interventions and changes in the organization of the facilities.
- The QI process involves three main steps: defining, measuring and improving quality. The QIS provides a method for QI, but its focus is more on measurement than improvement, an approach that experts would call quality assurance rather than QI.
- The Quality Improvement System measures quality of care through the systematic collection of a large amount of data. This allowed the teams to react to the information and address identified gaps with standards, but represented a level of effort that will not be sustainable in the long term. Many issues with the measuring instruments require simplifying the quality monitoring system, in order to succeed in institutionalizing this process.
- Teams experienced some limitation in their capacity to suggest real changes in the system of care, and focused on time-limited interventions such as training and information campaigns. Most interventions or changes are limited to the aspects of FP under the control of one specific facility. This limits the impact of the QIS on the overall system of care for FP services. For example, the issue of availability of –and access to– contraceptives has not been addressed.

C. The Impact of QI on Abortion Rates

- Although the initial goal was limited to improving the quality of FP services, the impact of the project beyond its immediate outputs was also looked at, especially regarding abortion rates.
- Although the data indicate that abortion rates have decreased, it is difficult to draw conclusions about the impact of the QIS on abortion, for three main reasons:
 - The decline of the abortion/delivery ratio started before the project, and what we observed might be the continuation of a natural trend;
 - The expected impact of better FP services on the level of abortions is not known, because abortions are more representative of a social problem beyond the means of the health sector only; and
 - The linear logic that better health services lead to higher use of contraceptives and less abortions is not supported by the data that we reviewed, since contraceptive prevalence has not significantly increased. Future improvement projects on this topic should provide more evidence of the complex links between these factors.

- An improvement project that would aim at achieving health outcomes would probably be designed differently at the beginning, with more explicit objectives, a wider range of targets for changes/interventions and the involvement of more organizations representing the entire system of care for family planning and reproductive health services. Because the QIS was not initially developed to decrease abortion rates, many actors in the system of care were not involved in the project, and many components were not redesigned. A more ambitious goal would require a systemic approach that involves the different organizations and partners discussed earlier in Part 2 and listed in *Annex 2*.

X. Recommendations

A. Institutionalization of a Continuous Process for QI of FP services

- The issue faced by the FGPs involved is to sustain a dynamic of improvement in their facilities. The AFPZ has a key role to play in simplifying the quality monitoring system and reaching the next level of performance. We recommend collecting a minimum number of indicators of performance, but to collect them at least monthly and display them on run charts, with a mix of process and outcome indicators. ZdravPlus can provide technical assistance in the design of a new monitoring system that is not limited to providers' performance, but also includes population-based measures.
- The teams have a good background to be able to address other issues with a QI process. However, this will require additional assistance and training in an overall approach that is more focused on the identification and implementation of changes, and less focused on measurement tools. The trainers recently trained at the School of Public Health¹⁷ would be able to train the health managers of FGPs, the curators and the AFPZ in the QI cycle, and provide them with technical assistance.
- Some of the “small” structural changes (such as setting up RH rooms in FGPs, changes in the schedule of working hours, creating a comfortable environment inside the facilities, etc.) that these facilities have made may seem to be inconsequential outcome of the CQI process, especially if they were the only outcomes. However, these, along with more intangible impacts such as higher staff motivation and better working environments, are common outcomes of QI projects and in fact might have never happened without the dynamic of change created by the CQI process. Although outputs such as increased use of contraceptives or decreased rates of abortion need to remain the central improvement objectives, the value of the less “exciting” results should not be underestimated as an important motivating factor for local teams, hence the institutionalization of CQI.
- The integration of CQI within the daily work of FGPs requires support from the higher levels of the healthcare system, with an appropriate policy that favors a decentralized management, empowers and even requires local staff to participate in improvement efforts. The improvement “system” needs to be structured so as to address complex multi-level and cross-cutting issues (such as the availability of affordable contraceptive methods), which again calls for the early involvement of the oblast health department and the Ministry of Health in the design of an improvement effort.

¹⁷ First Regional Training of Trainers in Quality Improvement in Central Asia. Bruno Bouchet, Jolee Reinke, Lidia Samoshkina, Irina Stirbu and Nilufar Rahkmanova. 8-31 July, 2004. Issyk-Kul, Kyrgyzstan. ZdravPlus Trip Report. Improving the Quality of Family Planning Services in Zhezkazgan and Satpaev: A Case Study on the Quality Improvement Dynamic in Kazakhstan

B. Replication of Improved Family Planning Services in Karaganda Oblast

- Lessons learned during this pilot phase can benefit the extension of the QIS oblast-wide. Two aspects of the project deserve to be replicated: 1) the QI process, after the quality monitoring system is finalized; and 2) the best practices that have been “discovered” by the FGPs and are also relevant to others.
- The QI project has allowed observation of very similar situations across FGPs. Initial performance was low across FGPs and grew roughly at the same pace to reach similar outcomes. Structural problems were almost identical and staff ended-up designing similar interventions and changes. This allows us to be very confident in the results that we can expect from a replication of this approach, both in terms of acceptance of the CQI process and in terms of what best practices could be diffused during the training itself.
- The replication strategy requires careful planning within Karaganda Oblast, and the following features are envisioned: 1) A short “training” event should introduce the standards and measuring tools to a minimum number of staff per FGP, including the head of the FGP; 2) this event should include a performance-based training on the main skills targeted for improvement, so that training in the content that the project will focus on (e.g. family planning) and the QI process happen at the same time; 3) This event should also include the reorganization of services based on the best practices implemented by other FGPs during the pilot-phase; 4) the replication should be led by the AFPZ and involve, as “trainers”, the most pro-active members of the pilot-phase.
- The sustained leadership of the Karaganda Oblast Health Department is a key condition for the successful replication of this model, and requires their full involvement in developing and supporting the replication plan.

C. Strengthening of RH Services for Improvement of Health Outcomes

- In order for better reproductive health services to achieve greater health outcomes, system changes of a wider range might be needed, eventually involving many institutions (such as the ones listed in *Annex 2*) in the reorganization of healthcare services. System changes are more likely to happen if a multilevel team that brings together different organizations is facilitated by a leader trained in advanced QI techniques and tools, such as the ones from the Almaty School of Public Health¹⁸.
- This initial successful experience with the QIS has prepared the Karaganda Oblast Health Department to move from just improving providers’ performance in FP services to addressing system performance issues for a broader range of reproductive health services, more likely to impact health outcomes.
- An important task of the new team will be to define their improvement objective and explicitly describe the reproductive health outcomes that they are trying to achieve. Such outcomes could be: 1) increased spacing between children; 2) decreased complications and side-effects of contraceptives; 3) decreased abortion rates; 4) decreased maternal mortality. The system of care involved, and the composition of the team, will depend entirely on the objective for improvement.

¹⁸ Three trainers from the Almaty School of Public Health were recently trained in advanced Quality Improvement techniques (Issyk-Kul, July 2004).

XI. Conclusion

The Continuous Quality Improvement experience in Zhezkazgan and Satpaev provided a unique opportunity to all involved to learn important lessons about the way the healthcare system “behaves” and the overall dynamic of improvement, i.e. changes, in a Soviet healthcare system in transition. Three main lessons were learned:

1. Providers realized that they have some control over their own practices and the way they organize healthcare services, and that it is their responsibility to address issues under their control through a clear quality improvement objective centered around patients’ needs and expectations;
2. The Oblast leaders became more aware of the complexity and influence of the bigger healthcare system on quality of care, and that it is their responsibility to redesign the components of that system that are beyond the control and authority of one provider or FGP;
3. Finally, the ZdravPlus project learned how to better support such efforts in an environment that is traditionally centralized and where quality management is a new concept that challenges the prevailing authoritarian style.

All partners gained in knowledge and understanding of each other’s perspectives in trying to achieve a common goal. But, most importantly, the big winner is the population of Zhezkazgan and Satpaev, whose reproductive health needs are now better met by more responsive and effective services. When quality improves, everybody wins.

XII. Annexes

Annex 1: Quality Improvement System Monitoring Tools

Family Planning Checklist for Observation of Providers- IUD

		Rounds			
		1	2	3	4
1	Greet – friendly and respectfully – the patient/couple and ask them to take a seat				
2	Introduce yourself				
3	Ask patient about her reproductive plans				
	How many children would she like to have?				
	What spacing would she like to have between deliveries?				
	Ask if she is planning a pregnancy				
	When does she want the next pregnancy?				
4	History				
	Age, marital status				
	Parity				
	Number of deliveries				
	Number of abortions				
	Number of living children				
	Do her children have any hereditary diseases?				
	What method of contraception did she use in the past?				
	How long?				
	Why did she stop using it?				
	What method of contraception is she using currently?				
5	Inform the patient about different methods of contraception				
	Ask if she has any of the conditions requiring caution for IUD use:				
	Confirmed or suspected pregnancy, vaginal bleeding, acute cervical purulent discharge, deformation of uterus, trophoblastic disease, TB of genital organs confirmed, cancer, high risk of STIs, past ectopic pregnancies, uterus less than 6 cm.				
6	Ask if the patient knows about IUDs and be sure that she has chosen IUD as her method of contraception.				
7	Inform her about the IUD: effectiveness 99%, relatively cheap, long-lasting, method use is not related to coitus, no influence on breastfeeding, less side-effects, fertility recovers after removal, no need to visit a physician frequently				
	How it works--prevents sperm and ovum from meeting				
	Disadvantages: requires pelvic exam and STI screening, client cannot stop IUD use, a trained health worker must insert and remove IUD, menstrual changes (heavy and painful menses), does not protect against ectopic pregnancy or STIs.				
	Side effects: menstrual changes (heavy and painful menses), anemia				
	Warning signs that require medical attention: intense pain in lower abdomen, coital pain, STI symptoms, fever, IUD strings cannot be felt in the vagina, no menstruation when expected and signs of pregnancy appear, woman or partner has another partner				
	Ask patient if she has questions or concerns about the IUD				
	Arrange day of IUD insertion: during the first 7 days of menses (if not after birth or abortion), check IUD strings several times during the first month and after menstruation, IUD should be removed no later than assigned date				
	Say a polite good-bye to client and repeat that she can come to the physician at any time				

Family Planning Checklist for Observation of Providers - COC

		Rounds			
		1	2	3	4
1	Greet – friendly and respectfully – the patient/couple and ask them to take a seat				
2	Introduce yourself				
3	Ask patient about her reproductive plans				
	How many children she would like to have?				
	What spacing would she like to have between deliveries?				
	Does she plan for a pregnancy?				
	When does she want to have the next pregnancy?				
4	History				
	Age, marital status				
	Parity				
	Number of deliveries				
	Number of abortions				
	Number of living children				
	Do her children have any hereditary diseases?				
	What method of contraception did she use in the past?				
	How long?				
	Why did she stop using it?				
	What method of contraception is she using currently?				
5	Inform the patient about different methods of contraception				
6	Ask about any of the conditions below that need consideration before using oral contraceptives: Diagnosed or suspected pregnancy, breastfeeding, undiagnosed vaginal bleeding, jaundice or acute liver disease, smoking and older than 35 years, ischemic heart disease or stroke, blood clotting, diabetes, migraines, hypertension, diagnosed or suspected breast cancer or others, liver tumors, taking anti-convulsive or TB drugs				
7	Ask if patient knows about oral contraceptives and be sure that she has chosen COC as her method of contraception.				
8	Inform about COC. Effectiveness 99%, stops ovulation, thickens cervical mucus, making it difficult for sperm to pass through. Intake: 1 tablet a day at the same time without breaks or 7-day break after three weeks. Advantages: very effective, less side effects, does not require pelvic exam, does not interfere with coitus, easy to use, woman can stop use of COC. Disadvantages: must be taken every day, does not protect from STIs, interacts with other drugs (anticonvulsive and TB drugs). Side effects: nausea, breast tenderness, bleeding or bloody discharge between menses, dizziness, headaches, weight gain, acne (during only the first 3 cycles). Warning signs: severe pain in lower abdomen, acute chest pain, cough, shortness of breath, severe migraines, severe pain in lower extremities, absence of menses after intake of pills during a cycle.				
9	Emphasize that patient can stop the method any time she wants				
10	Give her a prescription for COC				
11	Give specific instructions: how to take pills - 1 tablet a day at the same time. Start during the first 5 days of the menstrual cycle. If she has started later, then she should also use condoms. Take all the pills in the pack. Menses should start after the 4th week of using pills or during the week's break. Start the next pack immediately after finishing the previous pack or in a week if 21-pill pack. If patient vomited during 30 min after pills intake, she must take another pill or use a different method for the next 7 days.				
12	Side effects: nausea, breast tenderness, light bleeding, spotting, dizziness, headache, weight gain, acne. All side effects disappear during the first 3 cycles.				
13	Warning signs: severe pain in lower abdomen, acute chest pain, cough, shortness of breath, migraines, severe pain in the legs, absence of menstruation after completing a pack of pills.				
14	What to do if the client missed some pills? If missed 1 pill - take the missed pill at once and the next pill at the regular time. This may mean taking 2 pills on the same day or even 2 at the same time.				
15	Ask patient to repeat instructions to assure correctness of learned information				
16	Ask patient if she has questions and concerns about COC				
17	Explain to patient when to come back for an exam: the first time after 3 months, if there are no problems patient must do preventive visit to physician every 6-12 months				
18	Advise to come back if patient has problems				
19	Say good bye politely to client and repeat that she can come at any time to the physician				

Family Planning Checklist for Observation of Providers - DMPA

		Rounds			
		1	2	3	4
1	Greet – friendly and respectfully – the patient/couple and ask them to take a seat				
2	Introduce yourself				
3	Ask patient about her reproductive plans				
	How many children would she like to have?				
	What spacing would she like to have between deliveries?				
	Does she want to get pregnant?				
	When does she want to have the next pregnancy?				
4	History				
	Age, marital status				
	Parity				
	Number of deliveries				
	Number of abortions				
	Number of living children				
	Do her children have any hereditary diseases?				
	What method of contraception did she use in the past?				
	How long?				
	Why did she stop using it?				
	What method of contraception is she using currently?				
5	Inform the patient about different methods of contraception				
6	Be sure that she's chosen DMPA as her method of contraception				
7	Ask patient if she is taking any TB drugs (Rifampicin) or anti-spasmodic drugs				
8	Explain about DMPA				
	Effectiveness is more than 99%				
	How it works: thickens cervical mucus, stops ovulation, changes endometrium				
	How to use DMPA: injection every 3 months; use another method if an injection was 2 weeks late				
	Advantages: very effective, prevents pregnancy for at least 3 months, not visible for partner, no estrogen side effects, reversible				
	Disadvantages: does not protect against STIs, changes in menstrual cycle, repeated injections every 3 months, causes weight gain, delayed return of fertility				
	Side effects: changes in menstrual cycle, headaches, weight gain, breast tenderness, moodiness				
	Describe the injection procedure				
9	Ask the patient if she has any concerns				
10	Counseling after injection				
	Make an appointment for the next injection (definite date)				
	Explain possible side effects: changes in menstrual cycle, headaches, weight gain, breast tenderness, moodiness.				
	Give specific instructions on warning signs that require medical attention: late menstruation after a long period of normal menses, severe pain in the lower abdomen, heavy bleeding, infection or bleeding at the injection site, headaches, migraines or blurred vision				
	Advise her to come back if she has problems				

Family Planning Checklist for Observation of Providers - LAM

		Rounds			
		1	2	3	4
1	Greet – friendly and respectfully – the patient/couple and ask them to take a seat				
2	Introduce yourself				
3	Ask patient about her reproductive plans				
	How many children would she like to have?				
	What spacing would she like to have between deliveries?				
	Does she want to get pregnant?				
	When does she plan to have the next pregnancy?				
4	History				
	Age, marital status				
	Parity				
	Number of deliveries				
	Number of abortions				
	Number of live children				
	Do her children have any hereditary diseases?				
	What method of contraception did she use in the past?				
	How long?				
	Why did she stop using it?				
	What method of contraception is she using currently?				
5	Inform the patient about different methods of contraception				
	Ask if she has any of the conditions that need to be considered before using LAM: the woman has already started menstruation after delivery, mother and baby are separated, the baby is given formula, the baby is not breastfed at night, mother breastfeeds less than 6-10 times a day, baby is older than 6 months				
6	Ask what the client knows about LAM and correct her misconceptions				
7	Talk about LAM: effectiveness 98% during the first 6 months after delivery, stops ovulation because breastfeeding interrupts production of the pregnancy hormone. Advantages: prevents pregnancy after delivery, no interference with coitus, no side effects, easy to use. Disadvantages: depends on a woman's behavior (breastfeeding schedule), effective only during the first 6 months, does not protect from STIs, difficult for women who work outside the home. Warning signs: baby is 6 months old, menstruation has started, the baby gets complementary foods, the baby is not breastfed 6-10 times a day, baby is not breastfed at night				
8	Emphasize that patient can use another method at any time				
9	Instruct patient: How frequently to breastfeed baby? 6-10 times a day upon baby's request, feed at least once at night and the break between breast feedings should not exceed 6 hours. When to start complementary feeding? Should not give during the first 6 months (if normal development). Menses? Restart of menses means return of fertility and woman should choose another method. Patient should visit a physician when the baby is 6 months, menstruation starts, or the baby begins to get complementary foods.				
	Ask patient to repeat instructions.				
10	Ask patient if she has questions and concerns and answer her.				
11	Explain when the patient should visit the physician again and advise her to buy spermicides and condoms				
12	Advise to come back if she has problems				
13	Say goodbye politely to client and repeat that she can come in any time to see a physician				

Facility Review Checklist

#		Yes	No	Comments
1	Is there a schedule of work?			
2	Are there informational materials?			
	Booklets			
	Stands			
	Brochures			
	Sign for rooms			
	Suggestion box			
3	Hygiene			
	Use of disinfectants			
	Sterility of instruments			
	Availability of disposable syringes			
	Appearance and uniform of medical staff			
4	Comfort for patients			
	Availability of waiting room			
	Availability of ramp			
	Availability of toilet			
	Warmth			
	Light			
	Are there enough rooms?			
5	Confidentiality			
	Examination room			
6	Availability of equipment in FGP			
	Contraceptives			
	Antonometer			
	Phonendoscope			
	Thermometer			
	Spatula			
	Scale for children and adults			
	Height measure			
	Timer			
	Otoscope			
	Ophthalmoscope			
	Stethoscope			
	Couch			
	Ruler			
	Tape			
	Colposcope			
	Fridge bag			
	Set for anaphylactic shock			
	Set for emergency aid			

Exit Interview Questionnaire

Date

Time

FGP name

Interviewer

Say: "Good day, my name is and I work with AFPZ. In order to improve the quality of services provided to the population, the FGPs in our city would like to know their clients' opinions. It's an anonymous survey and it'll take five minutes of your time to answer these questions. Are you willing to answer some questions?"

If the client agrees:

1. Please assess the FGP's work schedule from 1 (very inconvenient) to 5 (very convenient)

2. What do you think about the waiting time before seeing your physician?

Very short waiting time - 5 short waiting time - 4 Normal -3 Long - 2 Very long - 1

How long did you wait before you saw your physician?

____ min Don't know

3. Assess the waiting room conditions using scores from 1 (very bad) to 5 (very good)

4. Assess cleanliness of the FGP using scores from 1 (very bad) to 5 (very good)

5. Assess politeness of physician using scores from 1 (very impolite) to 5 (very polite)

6. How often did somebody (staff or patient) enter the room and interrupt your conversation with the physician?

If the answer is: nobody interrupted - score 5

Somebody interrupted once - score 3

If the respondent says that there were more than one interruptions - score 0

7. Did you ask questions during your visit?

Yes No Don't know

If client says "No" or "Don't know" - go to question #8

If client says "Yes" - ask: **"How satisfied were you with the physician's answers?"**

Very satisfied - 5. satisfied - 4. more or less - 3. unsatisfied - 2. very unsatisfied - 1

8. Assess the general quality of services in the FGP using scores from 1 (very bad) to 5 (very good)

Total score: _____

9. How old are you? _____

If the client is 15 - 45 years old. go to #10

If the client is younger than 15 or older than 45. then go to #14

10. Have you ever used a contraceptive method?

Circle one of the answers: Yes/ No/ Don't know

11. What contraceptive methods do you know?

Circle every method that the respondent mentions. Don't prompt!

IUD

Oral pills

Injectable method (DMPA)

LAM

Physiological method

Barrier methods

Sterilization

If the respondent mentioned 5 or more names score 5

If the respondent mentioned 4 names score 4
If the respondent mentioned 3 names score 3
If the respondent mentioned 2 names score 2
If the respondent mentioned 1 name score 1
If the respondent mentioned 0 names score 0

12. Did you know that certain people are entitled to get contraceptives in FGPs free of charge?

Circle the answer: Yes/No

13. Have you ever been counseled on use of contraceptive methods in this FGP?

Circle the answer: Yes/No

If the answer is YES, then ask:

Please evaluate how clearly your physician explained the method to you using the 5 score scale. If not clear at all - score 1. if very clear - score 5

14. Have you ever heard about emergency contraception?

Circle the answer: Yes/No

15. What do you like in this FGP?

Write down the answer

16. What would you like to improve in this FGP?

Write down the answer using the respondent's own words

Say: **Thank you very much for your help**

Annex 2: The Family Planning Services System - Roles and Responsibilities

1. i. Population

According to the information database in the Information Center as of January 1, 2003, the population of Zhezkazgan was 109,015, including 33,725 women of reproductive age. In Satpaev, the population was 72,610 of which 21,180 are women of reproductive age.

The total population of the region is 181,625 of which there are 54,905 women of reproductive.

ii. Political background regarding Family Planning: Policies and Regulations

- In the Constitution of the Republic of Kazakhstan (RK) it is stated: "Family, motherhood, fatherhood and childhood are protected by the society and the government."
- In the Address of the President of the Republic of Kazakhstan to the Nation "Kazakhstan 2030" it is stated: "Kazakhstan will follow the civilized path of family planning which excludes any of the risks for women's lives and health."
- Clinical guidelines for practicing physicians "Reproductive Health and Family Planning." editor in chief – Prof. Nina Kayupova, Almaty, 2001.
- Clinical Protocols in Reproductive Health for PHC

At the moment, all PHC workers trained on FP have copies of these guidelines and protocols.

iii. Family Group Practices (FGPs)

FGPs were established in Zhezkazgan and Satpaev in 1995 and in 1996 they became private. The staff of the FGPs are all members of the AFPZ. After the establishment of FGPs ZdravReform, and later the ZdravPlus project, provided technical assistance to train the family physicians on various relevant health topics. All physicians in FGPs had a basic two-month training course in family medicine. They also had at least 25 additional 1-2 week training courses. In 1999, the physicians in FGPs started seeing a mixed patient load, i.e. both adults and children.

The population of Zhezkazgan was positive toward family medicine, emphasizing the proximity of FGPs to their homes, the cordial attitudes of doctors to them as clients, and the possibility of choosing their own provider.

At the moment, each FGP has a staff of family doctors (from 5 to 10) and one or two ob-gyns; in total, the 16 FGPs in the region now have 18 obstetricians-gynecologists.

In 2000, the MOH of RK issued official permission to provide prenatal care in PHC facilities. Before this, pregnant women were assigned only to specialized women's consultations.

iv. Women's Consultation (WC)

Before family medicine was introduced in Zhezkazgan FGPs there was a women's consultation (WC) in the maternity house with 12 physicians on staff. All of these physicians were catchment area ob-gyns assisted by midwives. These 12 physicians provided prenatal care for pregnant women. At that time the population was not accustomed to seeking family planning services; women were generally advised to use IUDs when they came to see a gynecologist for treatment of some problem.

After the establishment of FGPs and the rearrangement of functions prenatal services were left in the WC but the staff was reduced from 12 to two gynecologists. This led to a significant overload for the two physicians, leaving them no time for family planning services. The remaining 10 ob-gyns were allocated among FGPs and their scope of work was now focused on treatment of gynecological problems. Thus, gradually promotion of RH to the healthy population including family planning in WC, shifted to the back burner and responsibilities became vague.

v. Genetic Center (GC)

The GC was established in 1997. The center was designed to provide highly qualified physicians and specialized diagnostics of risks of genetic disorders in fetuses, diagnostics of infections which cause fetal problems, and to provide family planning services. On average, 500 to 600 couples receive services in the GC.

Currently, the GC has two physicians with a pediatric background who are supposed to provide FP counseling if patients ask for it. but none of the GC physicians have ever been trained in FP or counseling techniques.

vi. Diagnostic Polyclinic (DP)

The DP has existed since 1996 and serves adults and children. The DP has so called “narrow specialists” who provide highly qualified specialized care. After the establishment of family medicine and the improvement of professional skills in FGPs. the number of patients going to the DP significantly decreased. For instance, in the late 1990s the number of visits to the narrow specialists in the DP was twice as high as those to family physicians in FGPs. By the end of 2001, the numbers were close. but by 2002 the ratio had changed in favor of family physicians. In 2002, the number of visits to narrow specialists was 192.238 a year. while the number of visits to FGPs amounted to 354.726 –almost twice as many visits compared to the DP.

Such a drastic decrease in the workload led to a reduction of the need for “narrow specialists.” So. at the moment the DP has only one ob-gyn on staff. This specialist provides gynecologic care on a fee-for-service basis. This physician has no incentive to provide FP and wasn’t trained on the topic. so family planning services are not provided in the DP.

vii. Copper Corporation Medical Center (MC)

The MC is funded by the copper mining corporation “Kazakh-Mys.” The MC has advanced medical equipment and a very well-trained, carefully selected staff. The MC has operated a polyclinic since 1999 and a hospital since 2002.

The MC provides free services for its employees while other members of the population are charged fees. In the MC polyclinic, there are “narrow specialists” including three ob-gyns. These specialists provide gynecological and prenatal services for female employees. They are also supposed to provide FP counseling; however. the three specialists didn’t participate in the ZdravPlus FP training Courses.

viii. Pharmacy Network

Zhezkazgan and Satpaev have a network of pharmacies, all of them private. The pharmacies are supervised by a special drug supply department in the local administration.

The Association of Family Physicians in Zhezkazgan (AFPZ) conducted a survey in five pharmacies in Zhezkazgan. The vendors interviewed said that clients do not ask questions about family planning methods. They assumed that the population knows about the issue and said that many clients are shy to ask about this topic. Some vendors said they were ready to talk to clients about contraceptive methods, explaining side effects, indications, etc. The vendors said that teenagers are a very attentive audience, listening carefully to every word. The survey also showed that the majority of pharmacy workers didn’t know who could provide good counseling and most of them referred the client to the ob-gyn in the maternity house.

The AFPZ believes that the pharmacy workers need more information – perhaps a training seminar on interpersonal communication so they could better help teenagers.

ix. Healthy Lifestyles branch (HLS)

The HLS center is a branch of the national structure designed for health promotion among general population. The local HLS has a director and three physicians. They don’t work directly with population. but they are supposed to guide and control the family physicians in their health promotion activities. Thus, the HLS checks the number of lectures that family physicians are required to provide to the enrolled population, which is two hours per month per physician. The FGP is supposed to submit a list of lectures provided monthly.

Also, HLS joins the FGPs and AFPZ for occasional IEC events, such as campaigns, health festivals, sports competitions, etc.

x. Information Center (IC)

The IC has been collecting and analyzing data on hospital cases since 1996. The out-patient data collection started in 2002. but there is insufficient information for analysis at this time. The available database can provide information on the number of cases treated in FGPs per month, the number of births, abortions, births by caesarian section, births to teenagers, complications before and after delivery, etc. The IC can be an invaluable source of information for monitoring of the QI project.

Annex 3: Contraceptive Use Survey in Users of FGPs (December 03)

1. To what age group do you belong?

15-19 years old	1
20-39 years old	2
40-49 years old	3

2. Do you use any method to prevent pregnancy?

Yes. I do	1
No. I don't	2

→ skip to 4

→ go to 3

3. Why don't you use methods to prevent pregnancy?

Don't prompt. Several answers can be circled

Don't know any method	1
I'm afraid to use any method	2
No money to buy them	3
Don't know where to go for advice	4
I want to have a child	5
My husband forbids me to. my religion forbids me to. etc.	6
I don't have sexual relations	7
Other (specify)	8

→ Survey finished

4. What method are you using to prevent pregnancy?

Show the list. Only one answer

IUD	01
Injections	02
Oral pills	03
Condoms	04
Spermicidal	05
Withdrawal	06
Breastfeeding (LAM)	07
Calendar method	08
Female sterilization	09
Male sterilization	10
Other (specify):	88

5. Are you satisfied with the method you are using?

Yes	1
No	2
Don't know	3

→ Finish survey

→ Go to # 6

→ Go to # 6

6. Why aren't you using any other method to prevent pregnancy?

Don't prompt. Several answers are possible

Don't know any other methods	1
I'm afraid to use other methods	2
No money to use other methods	3
Don't know where to go for advice on other methods	4
Other (specify)	8

7. What method would you like to use instead of the one you are currently using?

Several answers are possible

Pills	1
Injections	2
IUDs	3
Condoms	4
Other (specify):	8
Don't know	9

