

Strengthening Situation Analysis Methodology A Coordinated Interregional Approach

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Contents

Abstract	1
I Background to Situation Analysis	3
II Overall Strategy of the Subproject and Recommendations of the Situation Analysis Coordinating Committee	4
III Activities of the Subproject	8
Updating and improving instruments	8
Expanding into other reproductive health services	8
Development of additional instruments	9
Standardizing instruments	10
Exploring and solving methodological issues	11
Investigating reliability and validity	11
Measuring provider technical competence	12
Developing universal indicators and summary scores	13
Developing quality of care and sub-system functioning measures for individual SDPs	14
Measuring impact of quality using Situation Analysis data	15
Exploring DHS linkage	16
Further diffusing the skills required to implement studies	16
Increasing the availability and utilization of data	17
IV Lessons and conclusion	18
Appendix 1 Reproductive Health Issues Addressed by the Situation Analysis Methodology, Number of Indicators, and Examples	21
Appendix 2 Prevention and Treatment of RTIs, STDs, and Other Conditions of the Reproductive Tract	23
Appendix 3 Proposed Revised Observation Module	25
Appendix 4 Pros and Cons of Having a Single Agency Implement a Linked Situation Analysis and DHS	32
Appendix 5 Selected Quality of Care Indicators from Seven African Studies	33
Appendix 6 Participant List and Agenda for Situation Analysis Coordinating Committee Meeting	35
References	37

Abstract

Situation Analysis studies have become a major tool for analyzing program problems, developing policy and programmatic changes, focusing technical assistance programs, and designing OR studies. The methodology has diffused around the world, and has produced a rapidly expanding body of work.

In March 1994, the Population Council developed and U S A I D approved a proposal titled "Strengthening Situation Analysis Methodology: A Coordinated Interregional Approach." This proposal reviewed the experience with Situation Analysis studies and described three problems that required attention: (1) the methodology required strengthening, (2) the existing and forthcoming data needed to be made comparable and accessible, and (3) the skills required for implementing the methodology needed to be institutionalized in other organizations, both in the regions and among U S - based CAs.

The inter-regional subproject proposed to approach these problems through three major activities: (1) creating and coordinating the activities of an interregional Situation Analysis Research Coordinating Committee, (2) hiring and guiding a data manager/analyst to solve existing data problems, develop guidelines and procedures for future data collection and distribution, and create a database of comparable information from past and future Situation Analysis studies, and assist on secondary analysis activities, and (3) training two regional research teams in East and West Africa to assist in conducting Situation Analysis studies requested in Africa.

Because the vast majority of existing and planned Situation Analysis studies were in Africa and Asia and the Near East, the costs of new personnel required for the proposed work were distributed equitably between these two projects (with Africa funding the full cost of the training of African research teams).

In summary, this interregional subproject achieved the following:

- The Advisory Committee was established and held a meeting which established the key activities to be undertaken during the subproject.
- A database has been established that now contains eight of the most recent Situation Analysis studies in Africa.
- Several methodological issues have been explored, such as the reliability of observations or the development of summary indicators of quality of care.
- A number of publications have resulted from secondary analyses.
- New York-based Staff have provided considerable consultation in the field.

specifically providing assistance on (1) the analysis of data in Senegal and the write-up of the first Senegal report, (2) the construction and reporting of indices of quality of care in Senegal, (3) the initial analysis of the Zanzibar data, and (4) the expansion of the data collection instruments in Botswana to cover a broader range of reproductive health issues, and the training of field staff

- Two teams of research consultants have been trained to provide assistance in implementing studies -- one in East and one in West Africa
- The instruments have been greatly expanded to encompass a broader range of reproductive health services
- A Guidebook for implementing Situation Analysis studies was initiated
- Interest in use of the SA methodology has continued to expand worldwide, including developed countries such as Ireland, Chile, and the U S (States of Louisiana and California)

The continuing directions of the subproject include incorporating more reproductive health information in the instruments, standardizing the instruments, developing new questionnaires, measuring change between initial and subsequent studies, and carrying out studies on impact and utilization. A review of some lessons on the collaborative process in this subproject is also included with the conclusion.

I Background to Situation Analysis

Family planning programs have evolved over the last 30 years into complex organizational structures. Consequently, managers now require detailed information on their functioning and on the quality of service delivery. Unfortunately, national family planning programs often lack viable management information systems (MIS) that might be capable of providing some information for guiding managerial decisions. Prior to the development of Situation Analysis methodology, program managers and others relied on service statistics and on population-based KAP surveys as a sources of information to guide program development and evaluation.

A number of research approaches influenced the development of the Situation Analysis methodology, including the systems approach of the PRICOR PHC thesaurus (Center for Human Services, 1988), the rapid appraisal approach, such as Frerichs' Rapid Survey Methodology (Frerichs, 1989, and Frerichs and Khin Tar Tar, 1989), and by the quality of care framework outlined by Bruce and Jain (Bruce, 1990, Jain *et al* 1992). The Situation Analysis approach was first developed in the 1989 Kenyan study and has evolved continuously with subsequent studies. Mensch *et al* (1994a) noted that

"While borrowing from other methodologies, the situation analysis methodology is considered innovative because it integrates a number of approaches to family planning program evaluation. These include (1) a systems perspective for identifying crucial subsystem components of program operation, (2) visits to a large sample of SDPs rather than visits to only a few SDPs or relying on expert opinion, (3) a client oriented focus on quality of care, (4) structured interviews with managers, providers and clients rather than with community informants as is the case with the DHS availability module, (5) recording of clinic facilities, equipment and commodities available on the day of the visit, and (6) non-participant direct observation of all family planning client-provider interactions on the day of the research team's visit."

To date the approach has been used primarily for undertaking descriptions and assessments of the availability and functioning of family planning subsystems at a representative sample or all service delivery points (SDPs) in a geographic area, 2) the readiness of these subsystems to deliver quality of care to clients, and 3) the actual quality of care received by clients at these SDPs.

A number of data collection instruments are needed in order to obtain information on these three primary areas of interest (service availability, functioning, and quality). The basic minimum data collection instruments are

- Inventory for Facilities Available and Services Provided at the Service Delivery Point
- Observation Guide for Interaction Between Consenting Family Planning Client (New or Continuing) and Service Provider
- Exit Questionnaire for Family Planning Clients Attending the Service Delivery Point
- Interview Schedule for Staff Providing Family Planning at the Service Delivery Point

II Overall Strategy of the Subproject and Recommendations of the Situation Analysis Coordinating Committee

In the five year period between 1989 and 1994, the Situation Analysis methodology diffused throughout all regions of the world. Studies were carried out in approximately 20 countries. However, despite this widespread utilization of the methodology, Population Council staff were concerned about a number of continuing issues with the methodology. The Africa OR/TA Project II, and the Asia and Near East SA/TA Project developed a joint subproject to deal with these continuing issues. The goal of this subproject was to strengthen the Situation Analysis methodology by resolving methodological, technical, and implementation problems that interfere with the full and effective utilization of the data for improving family planning programs. More specifically the subproject had the following objectives

- updating and improving instruments,
- exploring, and where possible, solving methodological problems,
- further diffusing the actual skills required to implement studies among national and regional institutions,
- increasing the availability and appropriate utilization of Situation Analysis data in comparable formats

These objectives were addressed through three major activities

- (1) creating an interregional Situation Analysis Research Coordinating Committee to give direction to the subproject's activities,
- (2) hiring and guiding a full-time data manager/analyst to solve existing data problems, develop guidelines and procedures for future data collection and

distribution, create a database of comparable information from past and future Situation Analysis studies, and assist on secondary analysis activities, and supporting ten percent of Barbara Mensch's time to work on methodological issues and secondary analysis,

- (3) training two regional research teams in East and West Africa to conduct the many Situation Analysis studies on request in Africa

In the course of implementing the subproject, seven Situation Analyses studies were initiated or completed by the Africa and Asia OR/TA Projects (funded separately as individual subprojects), most of which included at least one innovative methodological or substantive issue. In addition, substantial technical assistance was provided to Situation Analysis studies undertaken in Mali and the Mbeya region of Tanzania. Table 1 describes these studies. The subproject activities served to strengthen the implementation of these individual studies, as well as using these studies as opportunities to explore the methodological and substantive issues identified by the Coordinating Committee and others, including USAID.

Table 1 Situation Analysis Studies conducted simultaneously with the subproject						
Country	Year	Number of SDPs	Observations	Client Exit Interviews	Staff Interviews	Executing Agency
Senegal	1994	180	1123	985	361	MOH
Zanzibar	1995	100	141	141	191	Zanzibar MOH
Kenya	1995	264	1029	997	588	MOH
Botswana	1995	184	406	386	456	MOH
Burkina Faso	1995	309	502	502	662	MOH
Indonesia	1994	180	1123	985	361	BKKBN
Turkey	1994	181	1006	975	232	MOH

As reflected in table 1, the activities of the subproject were weighted more toward Sub-Saharan Africa than ANE, which was due to several factors. First, more studies and more analyses were requested in Africa generally. That is, the subproject's activities reflect regional differences in demand for the methodology. Second, many of the ANE sites possess greater local resources than in Africa, thereby requiring less outside TA. Lastly, the health care service delivery systems in Africa are generally more homogeneous than in the ANE region, which facilitates cross-country standardization of instruments and procedures.

One of the first activities of the subproject was the creation and convening of the Coordinating Committee. Although only one meeting of this Committee was held, the direction for much of what was subsequently accomplished was set in motion during this meeting. The agenda included those methodological topics that were being critically and extensively discussed within and outside the Council.

Fourteen participants, representing several CAs, USAID, and the Population Council attended the meeting, which was held on 6th July 1994. Unfortunately, the meeting did not include any representatives from the field, but further discussion and implementation of the Committee's recommendations were carried out between Council staff in New York and the field. (Appendix 6 gives a full list of participants and an agenda for this meeting.)

While much of the guidance this group provided has proven to be useful, not every recommendation has been fully acted upon. The following are the group's recommendations:

Standardization of instruments

The Coordinating Committee recognized the competing values of both adaptation to local circumstances and comparability with other study data, and agreed that it was valuable to have a group of standardized core instruments covering elements that are usually used. This will facilitate the development and use of a package that should include both standardized instruments and analytic plans. However, the group recommended that we still leave room for adjustment to local circumstances.

Reliability of provider-client observations

The Committee agreed that additional attention is needed on the question of observer reliability. The group supported the ideas of improving observer reliability through training, and of systematically testing inter-observer reliability during the Turkey study.

Summary indicators of program functioning and quality

The Coordinating Committee agreed that the issues of data summary and scoring are related to questions of who is using the data and for what purposes. Program managers planning programmatic improvements are generally interested in individual items that provide insight into particular components of program functioning, while those interested in program evaluation frequently wish to undertake comparisons over time and/or cross-nationally, which are more efficiently carried out with summary scores. The desire of both program managers and evaluators to use the SA methodology to evaluate intervention efforts (with before and after measures of the same programs) suggests that scoring issues are increasing in importance.

Technical competence of providers

The Coordinating Committee recommended that the technical competence dimension of quality of care may need to be considered in a method-specific context, requiring separate indicators for what a technically competent provider would do in the provision of each contraceptive method. It was further agreed that technical competence cannot be measured adequately through exit interviews of clients, but must be observed.

Measuring service functioning and quality at individual SDPs

The group discussed the possibility of measuring sub-system functioning and service quality for individual SDPs, and the feasibility of providing SDP-specific feedback on these issues, including comparisons with specific standards or other SDPs. It was apparent that SDP-specific measures of functioning are fairly straightforward, but measuring SDP-level quality requires more attention as there are many methodological problems. This issue is to be addressed in the Kenya study.

Planning for future studies

The group was concerned that too many Situation Analysis studies were being planned with insufficient Project resources available, and suggested that priorities needed to be established. While it has proven to be very difficult to scale back demand for these studies, an alternative strategy of expanding the number of consultants who can assist in study implementation has proven successful.

Collaboration with other institutions

Greater collaboration with other organizations was emphasized, both within the USAID-supported community of technical assistance organizations, and with other donors such as UNFPA, UN Population Division, World Bank, Rockefeller Foundation, etc. A number of meetings with these organizations have been held.

Data rights statement

The group agreed that The Population Council needs a more explicit policy on access to and analysis of data from Situation Analysis studies, and recommended that a clearer data rights statement be developed and included in future subcontracts. The group also suggested that the role of identifiers for clients, staff and SDPs be considered to both protect confidentiality and to allow for follow-up studies.

III Activities of the Subproject

Towards the end of the subproject it became clear that for the Africa region in particular, methodological issues were continuing to emerge requiring resolution, interest in collecting data on other reproductive health services was increasing, and there was now sufficient comparable data to undertake significant synthetic and comparative secondary analyses. Consequently, many of the activities initiated under this subproject have continued under a follow-on subproject entitled "Continuing the strengthening of Situation Analysis methodology an Africa focussed approach". In describing the subproject's activities, therefore, we have included those activities begun under this subproject which are continuing under the new subproject.

Given the direction from the Coordinating Committee, as well as inputs from field collaborators, USAID staff and other colleagues, the following activities were completed for each subproject objective:

Updating and improving instruments

Expanding into other reproductive health services

Of the many areas under development in the Situation Analysis instruments, none has proven to be more important than expanding to include other reproductive health (RH) services. USAID (and many others) has been expanding its efforts in this arena and made clear that it sees a special role for OR in analyzing issues and problems in reproductive health services, and in developing innovative solutions, especially in the area of integration of services. The recent SA studies in Turkey, Senegal, Burkina Faso, Zanzibar, Kenya, and Botswana have used instruments which included new items on the provision of information and services for RTI/STD/HIV/AIDS, on abortion practices, sexual behavior, and (where appropriate) female genital mutilation (FGM) amongst FP and MCH clients, and on provider and client attitudes and beliefs towards male involvement and services for adolescents.

The definition of RH adopted in Cairo, although dauntingly broad, served as an organizing principle for measuring reproductive health services. Although representation of reproductive health issues has increased in the Situation Analysis instruments, not all of the services in the comprehensive approach to reproductive health care defined in the Cairo Programme of Action have been addressed to date, for example, little or no information on pre- and post-natal care, safe delivery services, and prevention and treatment of infertility is currently collected. Whether the instruments can be expanded to measure these other services is an important methodological issue which is being addressed through country-specific adaptations of the core instruments. Appendix 1 contains an assessment of the current capacity of the Situation Analysis to measure the reproductive health issues identified at Cairo.

Several of the RH items collected in the Botswana, Kenya, Senegal and Zanzibar SA studies using these expanded instruments were brought together for a paper presented at APHA in November 1995 (Miller, Stein, *et al* , 1995) A sample table of the findings on STI/HIV/AIDS services is included as Appendix 2

The Botswana instruments contained a particularly broad expansion into STI/HIV/AIDS services, New York and Nairobi-based staff collaborated on the expansion of the "core" instruments, which focus primarily on family planning services One of the study objectives was the establishment of a baseline for evaluating a USAID-supported project which provides training for MCH/FP staff on RTI/STD/HIV/AIDS management through the syndromic approach and updates on family planning, the aim being to strengthen and integrate the two services A number of items were included to assess staff use of the Syndromic Approach, and because HIV/AIDS is so important in Botswana, we also operationalized some of the WHO programmatic/behavioral indicators for evaluating STD/HIV/AIDS programs in the client exit interviews Moreover, the Botswana instruments included items on the use of herbs and chemicals to clean the vagina, and/or to constrict or "dry" it for the purposes of enhancing sexual pleasure were included as this is an issue of particular concern to the Government of Botswana (this cultural practice may be promoting HIV transmission as it has been shown to dramatically increase the relative risk of sero conversion)

Direct and indirect questioning on abortion practices was tested in the Senegal Situation Analysis Half of the clients were asked a series of indirect questions about ever having had an unwanted pregnancy and whether they carried it to term, "tried to stop it," or took other actions The other half of the clients were directly asked how many of their pregnancies have been terminated by abortion Interestingly, the study found no significant difference between these groups (Diop, 1996)

Development of additional instruments

Several instruments, additional to the core set described above, have been produced or are presently under production An instrument for interviewing MCH clients has been produced and used in most SA studies recently The Turkey SA study included several new modules for the detailed investigation of surgical contraceptive methods (tubal ligation, vasectomy, NORPLANT® implants) and other reproductive health services (pregnancy termination, post-partum care, and ante-natal care), these instruments were developed with assistance from AVSCI

The Indonesia SA study also explored long term methods in more detail because the BKKBN was concerned with some deterioration in the proportion of clients using highly effective and long term methods (LTMs) such as sterilization, NORPLANT® implants, and IUDs Special attention had recently been focused on improving the distribution of supplies for these methods Additionally, BKKBN had been working on strengthening its national medical training program, increasing its number of training

centers, establishing special vasectomy training centers, expanding training for minilaps and vasectomies, developing sterilization counseling, and setting up a quality assurance system. In the light of these developments, new study instruments were developed to focus on issues related to LTMs, and the data were tabulated and analyzed separately for each province. Substantial programmatic differences between provinces were found: for example, equipment available (especially for implants), cost to clients, years since staff trained, management systems in place, and quality of care all varied significantly.

These new instruments, many of which were used in ANE, examine the quality of non-family planning services, and usually investigate the extent of FP integration into those services. Conversely, the expansion of the core instruments into reproductive health as discussed in the previous section gives a picture of the extent of RH integration into FP services. These are equal and opposing approaches, and give a different slant to the resulting data. The choice of approach is largely left to the local managers, many of the new modules were developed for ANE studies, whereas many of the African studies mainly used the expanded core instruments for information on other services.

Standardizing instruments

The guidance from the Coordinating Committee on standardizing the instruments was conflicting -- standardize and be flexible -- and so the implementation of this guidance proved somewhat elusive. Initially emphasis was placed on flexibility as in each instance, the implementation of the SA studies having taken place under the strong influence or overall direction of Host Country FP Program Managers. These managers usually have strong opinions about what issues do and do not make sense according to local needs. At the same time, Population Council researchers strove to improve data collection by requesting experience-based adjustments to questions that did not work well, and by testing rewording according to their own instinct, adjustments in the instruments commonly needed to be negotiated. While appreciating the need to standardize the instruments, staff on both OR/TA Projects felt that the methodology required improvements before it could be standardized.

Toward the end of this subproject, it became abundantly clear that this process needed a more focussed direction as a set of "core" and "standard" instruments was becoming essential. However, no individual researcher had sufficient knowledge of everything that had been tried in data collection, the reasoning behind the trials, and the results, and so no individual could arbitrarily decide the final product. It became apparent that standardization could only take place if the key researchers met together to share ideas and negotiate decisions about finalizing the core data collection instruments. All of the instruments have been reviewed with regard to standard survey research principles, and numerous changes in the wording of questions have been made as a result of this review to ensure that questions are relatively unbiased in wording, use codes consistently, do not include double issues, etc.

This process has recently been finalized for the Africa Region under the follow-on subproject, and the resulting core instruments will be published in early 1996 as a Situation Analysis Handbook. A caveat will be included that although they are generic instruments they have been developed in the context of African MCH/FP programs and thus may need adaptation for the more mature programs in other regions. In the ANE region, a standard analysis plan was developed for the Turkey study, and it proved extremely useful in facilitating the analysis by local researchers.

Experience from the Botswana SA study reinforced this need for a "standard" handbook. The conduct of this particular study illustrated the need for a written record of the intent, specific objectives, and planned uses of each item as a reference during instrument development and training. The study experience also illuminated the limitations of the methodology, including the amount of data that can be collected in a one day visit by a reasonably sized team, the amount of concentration and cooperation that is reasonable to expect from SDP staff and clients in interviews, and technical limits imposed by data processing programs which are commonly known and used in the field.

Exploring and solving methodological issues

Investigating reliability and validity

In the Turkey SA study, the reliability of the observation module was tested. 194 observations were performed by two observers simultaneously, and their responses on 100 variables were examined for the degree of agreement between them (Miller, Huntington, and Mensch, 1995). Overall, the amount of agreement was quite large: the judges agreed on an average of 95% of the cases for each variable. This result was confirmed through testing with Kappa¹, the average kappa score among the 100 variables was 0.75, meaning that the judges achieved fully three quarters of the possible agreement above chance.

These results demonstrate a very high level of agreement between observers. Sources of contamination that could affect the agreement were ruled out, such as observers talking to each other, poor supervision or insufficient training of observers. A preliminary conclusion about the high level of agreement relates to a limited measurement technique in the SA studies. The observation guide, in the interests of being quickly done and easily replicated, tends towards utilizing simplistic measures that are quite easy for raters to agree upon. More refined measurement in the observation guide would require modifying the data collection techniques away from the observation methodology to include the use of audio or video tapes. This would permit the study's measurement to break down the verbal and physical cues of the

¹ Kappa is a statistic that corrects for chance agreement and skewedness by measuring the percent of possible agreement above chance that the judges achieved. It ranges from 0 to 1.

provider and client into discrete components, but would substantially alter the nature of the Situation Analysis study, and would only be feasible for very small studies

The validity of data from direct observation is constantly questioned by social scientists. Researchers strongly suspect that the providers, who know they are being observed, demonstrate their *best* rather than their usual practices. The amount of positive bias introduced is unknown, though it frequently appears that "the best" performance still demonstrates enormous latitude for improvement. Because most one-day visits to SDPs only allow one or two observations of provider-client interactions it is unknown how much bias is introduced.

This issue may be addressed by the Turkey study. Moreover, under the follow-on subproject, the most SA study in Kenya will investigate the extent of positive bias introduced by the presence of an observer by testing the assumption that the first observation is the most biased by the observer's presence, and that over a number of observations the provider's behavior will retreat towards more usual behavior as they become accustomed to the observer's presence. Any differences in the quality of care observed at the beginning and the end of a series of observations over a five-day period may provide an indicator of the extent of the bias in behavior.

Measuring provider technical competence

To date provider competence has been measured through provider-client observations and provider interviews. Observation is an inherently problematic approach in that there is the probability of observer-induced positive bias (discussed above), and is not possible to develop a tool that exactly follows the course of an interaction as no two interactions are the same. Consequently, the observer needs to retain certain items mentally and record them on the instrument whenever convenient, and to be so familiar with the instrument that she can move quickly through it. A much shorter format of the observation guide that should make it easier for observers to record data correctly is currently available for field testing. This revised format is included as appendix 4, as an example of the evolution of the Situation Analysis instruments.

To date, technical competence has been measured primarily by observing whether providers engage in some general actions that are believed important for all family planning clients. During this subproject both data collection and analysis procedures were modified to include measures of whether providers undertake the particular actions that are important for the specific contraceptive method being adopted by the individual client.

The original provider interviews included questions about basic knowledge items for contraceptive methods. These questions provide invaluable information to managers, but have proved difficult to administer because they are perceived as testing or evaluating the respondent, which is not the intention. It is also not clear whether

providers actually use their knowledge about methods during counselling, and this can only really be measured through the observation. Consequently, these questions have been removed from the core instruments but can be added as modules where there is an interest in including them.

Developing universal indicators and summary scores

Staff working on this subproject have been instrumental in undertaking much of the work relating to indicators and scores. A strong interest has been expressed by managers and researchers in creating more parsimonious sets of indicators for measuring subsystem functioning and quality of care, and in developing summary scores that can be used for evaluation purposes. Most attention to date has been paid to developing scores for describing service quality, but there is a growing recognition of the need to also consider summary scores for subsystem functioning. The inappropriateness of a single approach to calculating summary scores and a single set of indicators has become apparent, and many methodological issues need to be explored more fully, especially the sensitivity of indices to changes in scoring procedures. Efforts to expand work in this area which were initiated under this subproject are continuing under the follow-on subproject.

Four broadly different approaches to using Situation Analysis data have been used for calculating service quality indicators (Askew, Miller, and Mensch, 1995)². The "standard" approach relies on the use of simple frequency distributions of virtually all items from the observation and some from the client exit interview. These indicators serve program managers who are interested in the details of service provision. However, the number of variables is too large to make sense conceptually and to manipulate statistically and thus this approach is inappropriate for evaluation purposes and so other approaches have been explored.

The "Nigeria" approach (developed using data from the Nigeria SA study) served as an exploratory, starting point for developing a smaller set of summary indicators. The procedure used was to identify, *a priori*, some reasonable indicators that would describe the elements of the Bruce-Jain framework, guidance was provided by the set of indicators proposed by the EVALUATION Project. This approach produced a set of six summary scores, one for each element. In calculating the scores for each element, every constituent indicator (and their constituent items) is assumed to contribute equally to its respective element. A simple procedure was used whereby the values for each indicator were aggregated to give a sum total for the element, and then the mean score across the indicators was used to obtain the element's summary score. The logical extension to this would be to then aggregate and average the six elements to give an overall program score (Askew *et al* , 1994).

2 Another approach using data from a Situation Analysis study has been developed by Brown and her colleagues (Brown *et al* 1995) at Tulane University.

The distinguishing characteristic of the approach developed for the Senegal SA study is its orientation toward an evaluation perspective. A list of 37 program evaluation indicators was developed by the Senegal Child Survival / Family Planning (SCS/FP) Project managers, a group that includes local, national, collaborating agency and donor agency staff. This broad list of indicators encompasses both child survival and family planning services, and includes indicators of quality of care, the functional capacity of SDPs, and some demographic indicators. These indicators were developed through a lengthy collaborative process during which the most valuable information was identified by the program managers themselves. The purpose of the indicators is to evaluate the impact of the SCS/FP Project activities through measuring them over two points in time, and by comparing areas where the Project is being implemented with areas where it is not being implemented (i.e. a quasi-experimental design). Two SA studies are being undertaken to assist in this evaluation.

The Situation Analysis data describe twelve of these indicators directly or indirectly. Of these twelve, eight are concerned with the functional capacity of SDPs, that is the SDPs' "preparedness" to offer quality services, and four with the actual quality of care provided. One of the SCS/FP Project's indicators, "Percent of family planning providers who follow the norms and protocols of MCH/FP service delivery," actually contains the entirety of a Bruce/Jain quality of care analysis, including 44 indicators. One notable aspect of these indicators is that the measurement unit is the provider, rather than the client. (Population Council and Senegal Ministry of Health and Social Action, 1996)

A third approach has been developed using data from the Peru SA study. This attempt was based on the need to develop indicators to explore whether current contraceptive use (as measured through the DHS) is affected by the service environment in which a woman resides. To answer this question required the creation of indicators that measure the service quality at SDPs which are accessible to the population of a defined geographic area. Given that direct information on client experiences was limited to those clinical settings where clients were present on the day of the research teams' visit, an assessment of cluster-level quality was somewhat problematic (Mensch *et al* , 1994b)

Developing quality of care and sub-system functioning measures for individual SDPs

To date, the SA data have been used to describe an entire program rather than individual SDPs (except in Peru). This is because the one-day visit to each SDP is thought to be inadequate to measure SDP-level quality as the number of provider-client observations is too small, but it is felt that aggregating measures across SDPs provides more valid data, however, the validity of these program-level measures has yet to be addressed. Under the follow-on subproject the generation of clinic-specific data is planned as part of the on-going Kenya SA study by expanding the number of

provider-client observations per SDP to 6-10 in a subsample of approximately 20 SDPs

Measuring sub-system functioning at the SDP level has been much easier, as the inventory and staff interviews produce data which are felt to be valid for each SDP. These measures have been used at both the aggregate, program-wide level, to give managers and donors an overall picture of program functioning to guide resource allocation and technical assistance planning, and at the SDP-specific level to improve the readiness to offer services at individual SDPs. The latter approach has been followed in the Zanzibar and Mbeya Regions of Tanzania, and subproject staff assisted local managers in listing the equipment, infrastructure and training needs of each SDP in their administrative area.

Measuring impact of quality using Situation Analysis data

To date, the quality of care paradigm has been widely embraced despite the fact that there have been very few tests of whether important dependent variables, such as client satisfaction, continuation, or ability to meet reproductive goals are related to the quality of care provided. Mensch, Arends-Kuenning, and Jain (1994b) related quality of care at individual SDPs to the ability of DHS-sampled women in the SDP catchment areas to achieve their reproductive intentions over the two years since the initial DHS interview. Mensch et al concluded that

"While it is difficult to separate out the effect of region of residence from the effect of quality, it appears that quality does have an impact in reducing unwanted and unplanned births and it does so net of potentially confounding variables."

Although this study illustrated one approach to assessing the nature of this relationship, it had a number of weaknesses, not least of which was the inability to follow clients over time and the inability to measure quality at the SDP-level.

Both the Senegal and Botswana Situation Analysis studies have established a panel group of clients available for follow-up interviews during which their ability to meet their reproductive intentions could be measured in the future and related to the SDP-level of functioning and quality to assess the impact of quality on reproductive behavior. This will require additional data to be collected at some SDPs to obtain valid measures of quality and the possibility of additional funding from other sources is being explored. Subproject staff will participate in the implementation of these studies.

Exploring DHS linkage

Meetings have been held between staff of the Population Council, Macro International, the EVALUATION Project and USAID to explore potential linkages of various types between DHS and Situation Analysis data/studies. While such linkages promise greater efficiency and increased utilization for research purposes, this may be to the detriment of addressing program managers' needs. This issue will benefit from a wider discussion of the pros, cons and issues involved, and attention will continue to be paid during the follow-on subproject. Some of the issues which have emerged during discussions held during this subproject are summarized in Appendix 4.

Further diffusing the skills required to implement studies

Through support from this subproject two regional workshops were held in mid-1994, one for anglophone Africa in Nairobi, Kenya and one for francophone Africa in Dakar, Senegal. The purpose of the workshops was to develop a team of resource persons who could act as consultants to assist with the implementation of future Situation Analysis studies, and particularly with the training of fieldworkers. The objectives of the workshops were to train African researchers and managers in the overall Situation Analysis approach and in the administration of a typical Situation Analysis study, including the training of others in the core data collection instruments. A total of 26 participants were trained, 13 at each workshop, from 11 African countries: Senegal, Mali, Burkina Faso, Côte d'Ivoire, Cameroon, Kenya, Tanzania, Zimbabwe, Botswana, Ghana and Nigeria.

Following the workshops, most of these consultants have participated in at least one of the SA studies undertaken in Kenya, Zanzibar, Senegal, Botswana, Burkina Faso and Mali. The Mali SA study was implemented almost entirely by a team of trainees from CERPOD who attended the Dakar workshop, with only minimal technical assistance from Population Council staff. The follow-on subproject will continue this approach to skills diffusion by holding two more workshops aimed at strengthening program managers' ability to interpret and utilize results from SA studies (to be held in mid-1996). Management Sciences for Health (MSH) will be undertaking a SA study in Madagascar in mid-1996 with technical assistance from the francophone consultancy team and The Population Council.

Although specific training courses have not been held for staff from other CAs, several CAs have nevertheless proceeded to use the methodology successfully, using technical advice and instruments provided by the Africa OR/TA Project II. For example, the SEATS Project has conducted Situation Analysis studies in Madagascar, Morocco and in several urban centers in East Africa (Mombasa, Kenya, Blantyre, Malawi, Bulawayo, Zimbabwe). In Nigeria, the USAID-supported Family Health Services Project undertook a SA study of the IPPF-affiliate's clinics. In India, the Centre for Operations Research and Training conducted a SA of clinics in Gujarat. AVSC has

conducted a Situation Analysis study in Bangladesh and closely collaborated with the Asia and Near East OR/TA Project, and with staff from this subproject, on the Turkey SA study (Turkey MOH, 1995) With assistance from subproject staff, PCS/JSU has adapted the SA approach to produce a set of instruments specifically designed to assess the quality of counselling provided in clinical settings, using their GATHER framework, and have applied this approach in a number of settings (JHU/CCP, 1994)

In response to a proposal prepared by The Population Council, UNFPA recently agreed to fund Situation Analysis studies in Morocco and Jordan Additionally, interest in the Situation Analysis methodology is diffusing into several developed country settings, thus offering the unusual opportunity for a "south-north" transfer of skills We have supplied background materials and technical advice to researchers planning studies in three such settings (1) James McCarthy in Ireland, (2) Merino and Pullum in Chile, and (3) Denise Shervington, Head of Family Planning Services for the State of Louisiana Institutions in the State of California are also in communication regarding a possible study

Increasing the availability and utilization of data

Our strategy for increasing the availability and utilization of the data included establishing a database of approximately uniform and comparable datasets from country-specific studies, establishing a data use policy, and using the existing data for secondary analyses

In order to establish the database, existing data files and instruments from ten African studies have been gathered from field offices and stored in centrally in New York Requests for data have been made in several other countries With the evolution towards a standardized core set of instruments it has been possible to develop a standardized variable naming system, which we anticipate will be used during future SA studies We decided to focus more on preparing standard data sets the future than on trying to make the earlier studies comparable because of substantial changes in wording and variables of interest These data sets are now being distributed to the Africa OR/TA Project field offices in Nairobi and Dakar, and may be supplied to other appropriate institutions

A revised data rights statement for inclusion in subcontracts for Situation Analysis studies has been drafted and was approved by USAID Contracts Office in December 1995 Feedback from OR directors had indicated that there may be different orientations toward making data available to other researchers in the different regions We are still discussing whether we will adjust the policy to different regions or adopt one policy that can be supported by all regions The approved statement reads as follows

"The data collected under this contract may be used for statistical analysis by the subcontractor, the Population Council and USAID. The Population Council, upon request, may make these data available to other scientific organizations and individuals for statistical analysis with a clear understanding that they will not utilize these data to identify information related to a particular service delivery point (SDP) or provider. In order to preserve anonymity, the data files will not include any geographic identifier such as district unless there are enough SDPs to provide estimates at this level."

We have, on an *ad hoc* basis, informed specific USAID Missions about requests for study data collected in the host country, and supplied it to legitimate research institutions such as Family Health International (which wanted to follow up on examining provider-imposed restrictions to FP method distribution (Stanbeck, 1995)) and to Population Communication Services (which wanted to study aspects of counseling)

Data have been supplied for other analyses on numerous occasions in response to requests from JHPIEGO (staff training in Ghana), Fred Sai (Quality of Care), Judith Bruce (availability and use of clinic equipment, outside referrals, number of available methods mentioned to clients), Judith Bruce and John Bongaarts (reasons for use of clinics which are not closest to a woman's home), Anrudh Jain (data for charts for Council's ICPD pamphlet). In addition, a series of comparative quality of care indicators were computed and analyzed for seven African studies, and the results were published in *Planned Parenthood Challenges* (Mensch, Miller, and Miller 1994), Appendix 5 provides a summary table from this paper. Subproject staff have worked also with Judith Bruce, the OR Directors, and other Council staff on an overall presentation on quality of care and its measurement through Situation Analysis studies. To date, drafts of this work have been presented by Judith Bruce to UNFPA's Africa Division staff in New York and in India, by Diouratié Sanogo at the USAID-supported MAQ Meeting in Ouagadougou, Burkina Faso, and by Robert Miller at USAID, Washington.

IV Lessons and conclusion

In view of widespread interest in promoting collaboration between agencies and projects, the interregional scope of the project may provide worthwhile insights and lessons

- *Collaboration between regions had positive results. Collaborative implementation of the subproject resulted in better understanding of various countries' family planning and reproductive health programs, and a strengthened Situation Analysis methodology. The improvements in instruments in one country or region became starting places for the next projects executed*

Instruments developed to look at non-family planning reproductive health services in Turkey and Egypt were made available to African program managers and researchers, and observations made in Turkey illuminated issues of interest to African researchers. And the connections between SDP quality and productivity that projects in Peru and Nairobi suggest are important to the entire field.

- *Using a single contractor for all three regional projects facilitated collaboration between regional projects.* Despite their shared contractor, the regional OR Projects remained relatively independent and separate. The benefits accrued by this Situation Analysis subproject suggest that increasing institutional linkages between OR projects is a justifiable and profitable step.
- *Increased resources and/or creative planning might have allowed closer, more continuous interaction between the subproject coordinating committee and field implementation staff.* No financial resources were allocated to fostering this relationship. Involving and linking The Population Council field researchers with various U.S.-based experts outside the Council on a continuing basis was difficult. Appendix 6 notes that none of the PC field staff were expected to attend the Coordinating Committee meeting, because it was not considered cost effective for field staff to attend a one day meeting.
- *While considerable achievements were made under the subproject, greater attention to creative mechanisms for strengthening communications/collaboration might have improved outputs still further.* Attention to linking projects was paid primarily by project directors and staff members with experience and continuing interest in the methodology. But as demand for Situation Analysis expanded, staff in some countries were called upon to participate in the planning of studies without the full benefit of prior experiences in other countries.
- *Interregional collaboration led to wider interregional contacts and wider donor, host country, and CA interest in and support for the methodology.* Examples to date include a commitment from UNFPA to conduct two SA studies in North Africa and the Middle East, and the World Bank's inclusion of the methodology in training programs for their staff. Wider familiarity with and use of the data has resulted.
- *The establishment of an operational database creates opportunities for substantial collaboration between regional subprojects and a wider group of parties in the future.* Wider dividends are expected in the future through the normal process of information and data dissemination and utilization.

This subproject has been a productive and worthwhile activity which has strengthened Situation Analysis methodology, produced insights on a variety of important programmatic issues, prepared a wider group of researchers to conduct studies, and brought increased coordination and improved methods to researchers implementing in SA studies. Over the period of the subproject there has been increasingly widespread utilization of the research methodology and the data produced, both by program managers and researchers. There has also been growing interest and support for related work by other funding agencies beyond USAID. The need to continue specialized technical support to the individual country-specific Situation Analysis studies being undertaken in Africa and to strengthening the approach generally has been recognized by USAID through the granting of a follow-on subproject to continue many of the activities started under this subproject. The follow-on subproject will continue for the life of the current Africa OR/TA Project II.

Appendix 1 Reproductive Health Issues Addressed by the Situation Analysis Methodology, Number of Indicators, and Examples

Reproductive Health Issues Measured	≈ number of indicators	Examples of indicators
The quality of family planning services	500 individual variables, various indexes constructed	<p>Percent of family planning clients receiving information on method side effects (observation)</p> <p>Quality of care scores for specific procedures (observation)</p> <p>Contraceptive supplies and stockouts (inventory)</p> <p>Percent of SDPs receiving a supervisory visit within the last six months (inventory)</p>
Prevention and treatment of RTIs, STDs, and HIV/AIDS	50 individual variables, several indexes possible	<p>Percent of family planning clients who are asked about symptoms of reproductive health problems during consultation (observation)</p> <p>Percent of staff recommending against IUDs for clients with STDs (staff interview)</p> <p>Percent of SDPs with microscopes (inventory)</p>
Referral for/ receipt of additional services	10 individual variables	<p>Percent of family planning clients with whom other issues were discussed (observation)</p> <p>Percent of family planning clients who received other services from the service provider (exit interview)</p>
Male responsibility and participation / awareness of partnership issues	10 individual variables	<p>Percent of new clients asked about discussing FP with partners (observation)</p> <p>Percent of staff who ask clients about partner's sexual activity (observation)</p>
Addressing needs of underserved and vulnerable groups / access issues	5 existing variables	<p>Percent of providers who impose a minimum age limit on prescribing pills (staff interview)</p> <p>Percent of providers who will not prescribe pills to unmarried women (staff interview)</p>

Discouraging harmful practices such as female genital mutilation	4 existing variables more variables could be added	Percent of staff who disagree with the practice of female circumcision (staff interview) Percent of family planning clients who have ever used herbs/chemicals to clean the vagina (client exit interview)
Cancers of the reproductive tract including breast cancer detection and treatment	2 existing variables	Percent of clients who received a breast exam (observation) Percent of clients who received or were advised to have a Pap test (observation)
Sexuality, responsible parenthood, and reproductive and sexual health	2 existing variables	Percent of family planning clients who report having a new partner in the past 12 months (client exit interview) Of those family planning clients who had a new partner in the past 12 months, percent that used a condom during the first act of intercourse (client exit interview)
Prenatal, safe delivery, and postnatal care	Antenatal care module ≈ 200 variables Postnatal care module ≈ 200 variables	Percent of antenatal clients who heard about FP during antenatal visits (antenatal client exit interview) Percent of postnatal clients who are using or plan to use FP (postnatal client exit interview)
Safe abortion (where legal) and post-abortion care	Abortion modules ¹ ≈ 450 variables	Percent of abortion patients whose medical history was taken (abortion services observation) Percent of abortion patients who were adequately informed about the procedure (abortion client exit interview)

Not appropriately addressed by Situation Analysis methodology

Promoting gender equality
Ending discrimination against the girl child

¹ The abortion modules were used only in Turkey

Appendix 2 Prevention and Treatment of RTIs, STDs, and Other Conditions of the Reproductive Tract

Indicator			Botswana	Kenya	Zanzibar	Senegal
Percent of staff trained in RTI/STD management	As part of basic training		66 n=456	50 n=588	1	1
	Refresher course		46 n=456	7 n=588	1	1
Percent of staff trained in HIV/AIDS management	As part of basic training		23 n=456	14 n=588	1	13 ² n=361
	Refresher course		48 n=456	7 n=588	1	2
Percent of family planning clients with whom STDs/AIDS were discussed	STDs/RTIs	New clients	27 n=68	12 n=248	19 n=27	1 n=226
		Revisit clients	12 n=310	3 n=764	0 n=111	1 n=866
	HIV/AIDS	New clients	21 n=68	5 n=248	11 n=27	3 n=226
		Revisit clients	7 n=310	2 n=764	2 n=111	0 n=866
Percent of family planning clients who are asked about symptoms of reproductive health problems during consultation	Unusual vaginal discharge	New clients	45 n=70	19 n=248	7 n=27	13 n=227
		Revisit clients	10 n=321	6 n=774	3 n=112	13 n=866
	Pelvic pain	New clients	26 n=70	21 n=248	52 n=27	39 n=227
		Revisit clients	8 n=321	5 n=774	14 n=112	29 n=866
Percent of family planning clients who are asked about their sexual relations	New clients		9 ³ n=71	14 ^{3 4} n=254	59 ⁵ n=27	14 ⁶ n=227
	Revisit clients		3 ⁷ n=320	3 ^{7 4} n=772	8 ⁵ n=112	1
Percent of staff recommending against IUDs for clients with STDs			71 n=422	93 n=442	1	1
Percent of family planning clients who received STD laboratory tests or referrals ⁸	Performed by provider		0 n=305	0 ⁹ n=101 9	1 n=140	2 n=1093
	Referred		0 ⁹ n=395	1 n=101 9	2 n=140	2 n=1093
Percent of SDPs with microscopes			4 n=184	23 ¹⁰ n=253	1	1

Notes to Appendix 2

- 1 This question was not asked
- 2 This question is 'Have you ever taken any RTI/STD training course' Basic and refresher training are not differentiated
- 3 This question is 'Did the provider ask about the number of sexual partners in the past one year?'
- 4 In Kenya an additional question was asked 'Did the provider ask about the nature of current sexual relations?' For new clients (n=252) the result was 36% and for revisit clients (n=772) the result was 25%
- 5 This question is 'Did the provider ask about the nature of current sexual relations?'
- 6 This question is 'Did a conversation take place about the nature of the client's sexual relations?'
- 7 This question is 'Did the provider ask about any new sexual partners since the client's last visit?'
- 8 These percentages are taken of all clients regardless of whether they showed symptoms of STDs The Botswana and Kenya questionnaires found that between 2% and 4% of clients presented symptoms suggesting STDs
- 9 This percentage is slightly higher than 0, but was rounded down
- 10 This is the percent of SDPs with ordinary microscopes in addition, 2% of SDPs have microscopes with dark field capacity

Appendix 3 Proposed Revised Observation Module

**Observation Guide for Interaction Between
Family Planning Clients and Service Providers**

INSTRUCTIONS TO OBSERVER Obtain the consent of both client and provider before proceeding to observe the interaction between them. When observing, be as discreet as possible and on no account become involved in the interaction. Make sure that the provider knows that you are not there to evaluate her/him and that you are not an 'expert' who can be consulted during the session. Try to sit so that you are behind the client but not directly in view of the provider. Make notes as quickly as possible. Use the appropriate section of the Observation Guide Instrument based on the reason for the consultation. For each of the questions listed below, circle or tick the most appropriate response that represents your observation of what happened during the interaction.

Health facility visited (name)

Health facility code

District (name)

District code

Village/town (name)

Village/town code

Staff linking number

Client identification number

Client's location/ward

Staff identification number

Date of visit Day ____ Month ____ Year ____

Type of health facility

- 1 = Referral Hospital
- 2 = District Hospital
- 3 = Primary Hospital
- 4 = Rural Health Center
- 5 = Maternity
- 6 = Health Post
- 7 = Pharmacy
- 8 = CBD
- 9 = Other

Use local categories

Type of sector

- 1 = Government
- 2 = FPA
- 3 = Mission
- 4 = Private
- 5 = Other

Use local categories

Locality

- 1 = Rural
- 2 = Urban

Designation of staff member

- 1 = Doctor
- 2 = Nurse
- 3 = Nurse / Midwife
- 4 = CBD
- 5 =
- 6 =
- 7 = Two or more providers

Use local categories

Specify _____

Time observation began

Name of observer _____

Signature of team leader _____

Main purpose of visit as first indicated by client

- 1 = New FP acceptor New clients
- 2 = Restart FP acceptor
- 3 = Resupply or repeat visit
- 4 = Problem with method
- 5 = Wanted to change method
- 6 = Wanted to discontinue FP

Revisit clients

	New clients	Revisit clients
1 Did the provider ask or did the client spontaneously mention a specific preference for a contraceptive method?	1 = no (to q 3) 2 = yes	1 = no (to q 2) 2 = yes
1a If yes, which method?	Method code _____	Method code _____
2 Before coming to the Health Facility what contraceptive method was the client using?		Method code _____
3 Did the provider ask the client or did the client spontaneously mention any of the following?		
3a Whether the client wanted more children in future	1 = no 2 = yes	1 = no 2 = yes
3b Preferred timing of next birth	1 = no 2 = yes	1 = no 2 = yes
3c Age of youngest child	1 = no 2 = yes	1 = no 2 = yes
3d Whether the client is breastfeeding	1 = no 2 = yes	1 = no 2 = yes
3e Client's marital status	1 = no 2 = yes	1 = no 2 = yes
3f If client has had more than one sexual partner in past year	1 = no 2 = yes	1 = no 2 = yes
3g If client has previously used method	1 = no 2 = yes	
3h If client has concerns about using any method	1 = no 2 = yes	1 = no 2 = yes
3i If client has any concerns about STDs or HIV/AIDS	1 = no 2 = yes	1 = no 2 = yes
3j If client had previous symptoms/signs/treatment suggestive of STDs	1 = no 2 = yes	1 = no 2 = yes
3k If client wants to change methods or stop using		1 = no 2 = yes
3l If client has discussed family planning with husband/partner	1 = no 2 = yes	1 = no 2 = yes
3m If client had any problems with her method		1 = no (to q 4) 2 = yes
3n If client had problems with her method, did the provider take any of these actions? (Circle all that apply)		1 Counsellor client about problem 2 Gave medical treatment 3 Suggested/agreed that client change method 4 Referred client elsewhere for treatment
4 Please note the methods that the provider mentioned or discussed during the consultation (Circle all that apply)	Method codes 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	
5 During the consultation did the provider explicitly mention that the condom protects against STDs/HIV/AIDS?	1 = no 2 = yes	1 = no 2 = yes

	New clients	Revisit clients
6 Which IEC materials, if any were used during the consultation? (Circle all that apply)	1 Flipchart 2 Brochure/pamphlets 3 Contraceptive samples 4 Posters 5 Anatomical models 6 Other	
7 Did the provider ask about or did the client spontaneously mention any of these subjects? (Circle all that apply)	1 Any medical/family history 2 Date of LMP 3 Abnormal vaginal bleeding 4 Abnormal vaginal discharge 5 Genital itching 6 Lower abdominal pain	
8 During the consultation, did any provider take or perform any of these actions? (Circle all that apply)	1 Take weight (check card) 2 Take BP (check card) 3 Perform/refer for pregnancy test 4 Perform general physical exam 5 Perform/request/refer for a blood test 6 Perform/request/refer for a urinalysis 7 Perform/request/refer for a pap smear 8 Perform a syndromic analysis for STDs	
9 Did the client decide to use a contraceptive method?	1 = no 2 = yes (to q 11)	
9a If not, what is the main reason client did not choose a method? (Circle one only then to q 18)	1 Changed mind 2 Came for info only 3 Pregnancy suspected 4 Medical contraindications 5 Other health reasons 6 No obvious reason 7 Other	
10 What decision did the client make about family planning? (Circle one only)		1 Continue same method (to q 18) 2 Stop (to q 12) 3 Switch
11 What new method did the client choose/switch to?	Method code _____ (if code 13 to q 11a)	Method code _____ (if code 13, to q 11a)
11a If the client chose LAM, did the provider mention any of these points? (Circle all that apply)	1 Client must not have had menses since delivery 2 Infant must be less than six months old 3 Client must be fully/nearly fully breastfeeding	

	New clients	Revisit clients
<p>12 What is the main reason for stop or switch? (Circle one only If client is stopping, to q 18)</p>		<p>1 Wants pregnancy 2 Unwanted side effects 3 Inconvenient supply 4 Husband/partner doesn't like method 5 Switch spacing to permanent method 6 Other 8 Reason not clear</p>
<p>13 For the new method accepted, did the provider talk about any of these issues? (Circle all that apply)</p>	<p>1 How to use method 2 Advantages 3 Disadvantages 4 Medical side effects (e.g. bleeding, nausea, etc.) 5 What to do if client has problem with method 6 Possibility of switching 7 Ability of method to prevent STDs/HIV</p>	
<p>14 Was the contraceptive method that the client chose given to the client during the consultation?</p>	<p>1 = no 2 = yes (to q 15)</p>	<p>1 = no 2 = yes (to q 15)</p>
<p>14a If not, why was the client not given her method of choice? (Circle only one)</p>	<p>1 Referred to another place for method 2 Client to return with menses 3 Method out of stock 4 Client to return for ster/Norp/IUD procedure 5 Client changed her mind 6 Provider felt there were medical contraindications 7 Provider felt method inappropriate due to age, marital status etc 8 Pregnancy suspected 9 Other</p>	
<p>14b Was an alternative method provided to the client to use while waiting to receive her method of choice?</p>	<p>1 = no (to q 16) 2 = yes (to q 14c)</p>	<p>1 = no (to q 16) 2 = yes (to q 14c)</p>
<p>14c If yes which method was given for the interim?</p>	<p>Method code _____</p>	<p>Method code _____</p>
<p>15 If the client chose pills condoms spermicides, how many units of the method was the client given? (If not known, code 999)</p>	<p>_____ units Pill units = cycles Condom units = pieces Spermicide units = tubes (describe if otherwise)</p>	
<p>16 Was the client told when to return for resupply or follow-up?</p>	<p>1 = no (to q 17) 2 = yes</p>	<p>1 = no (to q 17) 2 = yes</p>
<p>16a If yes, did the provider give a written reminder to client of when to return?</p>	<p>1 = no 2 = yes</p>	<p>1 = no 2 = yes</p>

	New clients	Revisit clients
17 Was the client told where to go for resupply or follow-up?	1 = no (to q 18) 2 = yes	1 = no (to q 18) 2 = yes
17a If yes, where? (Circle all that apply)	1 This clinic 2 Another clinic 3 Pharmacy 4 CBD/FWE 5 Other	
18 What other health issues were mentioned at any time during the consultation? (Circle all that apply)	1 HIV/AIDS 2 STDs 3 Infertility 4 Social/economic factors 5 Breastfeeding 6 Child health 7 Immunization 8 Nutrition 9 Abortion 10 Sexual behavior 11 Other	
19 Did the provider indicate to the client that she might have an STD?	1 = no 2 = yes	1 = no 2 = yes
19a If yes what did the provider do? (Circle all that apply)	1 Request laboratory tests 2 Treat 3 Refer elsewhere 4 Provide counselling 5 Other	

Time observation finished

Duration of interaction

Follow the client out of the consultation, introduce her,
and give this questionnaire to the interviewer

Procedure quality questions

	All clients
<p>If a pelvic exam was performed, which of these actions did the provider take? (Circle all that apply)</p>	<ol style="list-style-type: none"> 1 Inform the client what would happen before the exam? 2 Wash hands before the exam? 3 Visually inspect external genitalia? 4 Take a pap smear/specimen? 5 Perform a digital/bimanual examination? 6 Wash hands after the exam? 7 Inform the client about the result after the exam?
<p>If a speculum examination was performed, which of these actions did the provider take? (Circle all that apply)</p>	<ol style="list-style-type: none"> 1 Use a clean speculum? 2 Use gloves? (to next q)
<p>If gloves were used during speculum examination, were the gloves</p>	<ol style="list-style-type: none"> 1 Sterile 2 Clean but not sterile 3 Not clean 4 Don't know
<p>If an IUD was inserted which of these actions did the provider take? (Circle all that apply)</p>	<ol style="list-style-type: none"> 1 Sound the uterus? 2 Handle the IUD with aseptic procedures? 3 Use sterile/disposable gloves? 4 Offer emotional support?
<p>If an injectable was given, which of these actions did the provider take? (Circle all that apply)</p>	<ol style="list-style-type: none"> 1 Disinfect injection site? 2 Use a sterile needle? 3 Massage injection site?
<p>If Norplant was inserted, which of these actions did the provider take? (Circle all that apply)</p>	<ol style="list-style-type: none"> 1 Wash client's arm with soap and water? 2 Use sterile gloves during insertion? 3 Apply an antiseptic solution to insertion site? 4 Place client s arm on a sterile cloth?

Method codes	
1 Pill unspecified	8 Norplant
2 Combined pill	9 Female sterilization
3 Progestin only pill	10 Vasectomy
4 IUCD	11 Diaphragm
5 Injectable	12 NFP
6 Condom	13 LAM
7 Spermicide	14 Other

Appendix 4 Pros and Cons of Having a Single Agency Implement a Linked Situation Analysis and DHS

Area	Pros	Cons
Administration/ Cost/ Time/ Logistics	<p>Single agency doing in-country negotiations with government and USAID Mission may save time and some costs</p> <p>Single dissemination seminars may save some costs</p> <p>If studies conducted serially, best interviewers and supervisors from first study can be used for second and same mapping and logistics arrangements can be used</p>	<p>Almost always, two agencies (MOH and Census) would be involved with training, implementation, and data analysis and this could be troublesome</p> <p>Large number of interviewers, supervisors, vehicles required for field work, particularly if studies conducted at same time</p> <p>No cost saving of field implementation and data analysis costs</p>
Use of Results	<p>Greater potential exposure by managers and providers to DHS findings and by researchers to SA findings</p> <p>Wider distribution of DHS and SA study findings</p> <p>Greater use of SA findings for comparative analysis and research objectives</p> <p>Greater attention in SA studies to "international" issues such as AIDS, STDs, adolescents, abortion, FGM</p>	<p>Less country specific information of most interest to USAID Missions and managers may be collected</p> <p>Less use of SA findings for national and sub national planning and evaluation</p> <p>SA studies less likely to include a census of all SDPs which allows for systematic improvements of entire service system</p> <p>Possibly less use of SA studies as baseline for OR experiments</p>
Methodological	<p>More standardized data collection instruments and standard analysis plans</p> <p>Examine larger range of "impact" questions in more depth</p> <p>Examine relationship between supply and demand factors, quality of care and FP use</p> <p>Two or more SA studies with a panel of respondents should allow for the examination of impact questions</p>	<p>Facilities in DHS clusters do not constitute a representative sample of all SDPs in country</p> <p>Current observed levels of quality at SDPs cannot explain fertility which is based on past experiences</p> <p>If only one SDP exists in the cluster, all DHS respondents are assigned the values of that SDP even though some of these respondents may obtain their services from an SDP outside the cluster</p> <p>Users and non-users are assumed to be exposed to the same service environment</p> <p>In trying to relate the service delivery environment to family planning use there is a problem of endogeneity That is, if selected areas are targeted to receive services then the assumption that the explanatory variables are exogenous to the outcome variables does not hold</p>

Appendix 5 Selected Quality of Care Indicators from Seven African Studies

Indicator	Burkina Faso	Côte d'Ivoire	Ghana	Nairobi	Nigeria	Tanzania	Zimbabwe
Choice of Methods							
1 Told about method other than the one accepted	45% (62)	50% (163)	82% (204)	76% (100)	75% (121)	77% (171)	55% (147)
2 Mean number of non-permanent methods mentioned (5 possible)	2.2 (66)	2.3 (163)	3.4 (213)	3.2 (100)	3.0 (121)	3.4 (201)	1.4 (168)
Provider Competence							
3 Unusual vaginal bleeding asked	No Data	No Data	47% (213)	No Data	37% (121)	31% (200)	No Data
4 Provider washed hands prior to pelvic exam ³	No Data	70% ³ (163)	68% (69)	49% ³ (97)	83% (66)	58% (33)	No Data
Provider-Client Information Exchange							
5 How to use method accepted	87% (62)	58% (163)	69% (201)	88% (97)	46% (123)	12% (250)	67% (147)
6 Side effects of method accepted	42% (62)	30% (163)	54% (201)	49% (97)	42% (118)	25% (250)	41% (147)
7 Client asked about reproductive intentions	53% (66)	No Data	68% ⁴ (119)	No Data	87% (121)	28% (287)	68% (168)
Provider-Client Relations ⁵							
8 Auditory privacy during counseling	74% (53)	62% (13)	81% (399)	59% ⁶ (37)	61% (149)	64% (274)	74% (178)
9 Visual privacy during examination	83% (53)	No Data	85% (399)	92% ⁶ (37)	80% (178)	78% (278)	91% (181)
Mechanisms to Encourage Continuity							
10 Client told when to return	97% (58)	75% (122)	93% (630)	99% (100)	91% (394)	90% (443)	65% (463)

Notes to Appendix 5

- 1 These data were collected through observation of facilities or provider/client interactions
Sample sizes are in parentheses Samples for each indicator are
 - 1 Sample = New users who accepted a method
 - 2 Sample = All new users
 - 3 Sample = All new users
 - 4 Sample = New users receiving a pelvic exam
 - 5 Sample = New users who accepted a method
 - 6 Sample = New users who accepted a method
 - 7 Sample = All new users
 - 8 Sample = Service points
 - 9 Sample = Service points
 - 10 Sample = All clients (new acceptors in Nairobi and Burkina Faso)
- 2 In Cote d'Ivoire, no distinction was made between new and returning clients, figures refer to all clients One must exercise caution when making comparisons with other studies
- 3 In Nairobi City and Cote d'Ivoire, percentage refers to number of clients receiving aseptic services
- 4 In Ghana, includes only clients who did not first offer such information
- 5 If the number of clients at each service point is positively related to privacy then, in comparison to the other indicators, 8 and 9 are artificially low because they use a service point sample rather than a client sample
- 6 Includes only those SDPs where at least one client was observed (37 of 46)

Appendix 6 Participant List and Agenda for Situation Analysis Coordinating Committee Meeting

Participants

Lisanne Brown	Tulane, Evaluation Project
Trish Coffey	AID/W, Africa OR/TA
Andy Fisher	PC, Africa OR/TA, NY
Nick Gouede	PC, Africa OR/TA, NY
Anrudh Jain	PC, NY
Rod Knight	AID/W, Policy and Evaluation
Evie Landry	AVSC
Barbara Mensch	PC, Research Division, NY
Bob Miller	PC, Africa OR/TA, NY
Kate Miller	Columbia U (& HHRAA)
Vin Miller	PC, Sit Anal, NY
Karen Ringheim	AID/W, ANE OR/TA
Ann Way	Macro Systems
Gene Weiss	ICDDR, B

Invited, but not expected to attend

Ian Askew	PC, Africa OR/TA, Nairobi
Jim Foreit	PC, INOPAL II, Lima
Dale Huntington	PC, ANE OR/TA, Cairo
Martin Gorosh	Columbia U (& HHRAA)
Diouratie Sanogo	PC, Africa OR/TA, Dakar
John Townsend	PC, ANE OR/TA, Delhi
Ricardo Vernon	PC, INOPAL II, Mexico City

Situation Analysis Coordinating Committee Meeting Agenda

- 11 00-11 30 Introduction/agenda
Overview of strengthening Situation Analysis Subproject
Where we stand on collection of existing data
Late-breaking developments
- 11 30-12 00 Questions and discussion
- 12 00-1 00 Lunch
- 1 00-3 00 Discussion of issues
- Standardization
 - Reliability of provider-client observations
 - Summary indicators
 - Additional modules under development
 - Methodological issues and research questions
 - Planned/in-process studies as of June 1994
 - Analysis plan
 - Data rights
 - Follow-up developments with other agencies
- 3 30-4 00 Closing discussion

References

- Askew, I B Mensch, and A Adewuyi, "Indicators for measuring the quality of family planning services in Nigeria," *Studies in Family Planning*, 25, 5 268-283, 1994
- Askew, I , K Miller, and B Mensch, "Key Indicators for Measurement of Quality of Family Planning Services," paper presented at the Evaluation Project's Service Delivery Working Group Meeting, October 5, 1995
- Brown, L , M Tyane, J Bertrand, D Lauro, M Abou-ouakil, and L deMaria, "Quality of Care in Family Planning Services in Morocco," *Studies in Family Planning*, 26, 3 154-168, 1995
- Bruce, J "Fundamental elements of the quality of care A simple framework" *Studies in Family Planning* 21,2 61-91, 1990
- Center for Human Services *Primary Health Care Thesaurus A List of Service and Support Indicators*, Chevy Chase, Maryland, USA, 1988
- Diop, Nafissatou, personal communication, January 1996
- Frerichs, R and Khin Tar Tar "Computer-assisted rapid surveys in developing countries " *Public Health Reports* 104, 1 14-23, 1989
- Frerichs, R "Simple analytic procedures for rapid microcomputer-assisted cluster surveys in developing countries " *Public Health Reports*, 104, 1 24-34, 1989
- Jain, A , J Bruce, and S Kumar "Quality of Services, Programme Efforts and Fertility Reduction " In *Family Planning Programmes and Fertility* eds James Phillips and John Ross Oxford Oxford University Press, 1992
- JHU/CCP Tools to Assess Family Planning Counseling Observation and Interview JHU/CCP, Baltimore, 1995
- Mensch, B , R Miller, and V Miller, Focusing on Quality with Situation Analysis Africa, *Planned Parenthood Challenges*, (2) 1994
- Mensch, B , A Fisher, I Askew and A Ajayi 1994a "Using Situation Analysis Data to Assess the Functioning of Family Planning Clinics in Nigeria, Tanzania, and Zimbabwe " *Studies in Family Planning*, 25 1 18-31
- Mensch, B S , M Arends-Kuenning, and A Jain, "Assessing the Impact of the Quality of Family Planning Services on Contraceptive Use in Peru A Case Study Linking

Situation Analysis to the DHS," Research Division Working Paper Series No 67, 1994b, The Population Council, NY

Miller, K , D Huntington, and B Mensch, 1996, "The Reliability of Direct Observations of Family Planning Services in Turkey", The Population Council, report forthcoming

Miller, R , K Stein, K Miller, L Ndlovu, *et al* "Measuring reproductive health care after Cairo Findings from Four Situation Analysis Studies in Africa", paper presented at the Annual Meeting of the American Public Health Association, San Diego, CA, 1995

Population Council and Senegal Ministry of Health and Social Action, 1996, "Senegal Quality of Care and Functional Capacity Indicators", forthcoming

Stanback, John Provider rationales for restrictive family planning service practices in Ghana Final Report Family Health International, March 1995

Turkey Ministry of Health, The Population Council and AVSCI Turkey Situation Analysis Study of Selected Reproductive Health Care Services, Condensed English Report, June 1995