Management Strategies for Improving Family Planning Services

THE FAMILY PLANNING MANAGER COMPENDIUM

Editors

Janice Miller
James Wolff

Family Planning Management Development

Management Sciences for Health, Inc.
400 Centre Street
Newton, Massachusetts 02158-2084
USA

Cover Design
Linda Suttenfield
Jacki Forbes

Copy Editor
Ceallaigh Reddy

Book Layout
Ceallaigh Reddy

Printing
Foremost Impressions

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List of Authors and Editors

Principal Authors and Editors

Susanna Binzen
Division of Reproductive Health
Centers for Disease Control

Ann Buxbaum
Population Program
Management Sciences for Health

Saul Helfenbein
Population Program
Management Sciences for Health

Janice Miller
Family Planning Management Development
Management Sciences for Health

James Wolff
Family Planning Management Development
Management Sciences for Health

Deirdre Wulf
Alan Guttmacher Institute

Contributing Authors and Guest Editors

Claire Bahamon
Family Planning Management Development
Management Sciences for Health

Jaime Benavente
The Population Council—Peru

Mohammed Ali Bhuiyan
Local Initiatives Program
Technical Assistance, Inc., Bangladesh

Joseph Dwyer
AVSC International

Mike Egboh
Pathfinder International—Nigeria

Jack Graves
Division of Reproductive Health
Centers for Disease Control

Michael Hall
Family Planning Management Development
Management Sciences for Health

Riitta-Liisa Kolehmainen-Aitken
Family Planning Management Development
Management Sciences for Health

Benjamin Loevinsohn
Asian Development Bank—Philippines

Claire Madden
Strengthening Health Services
Management Sciences for Health

Marc Mitchell
Family Planning Management Development
Management Sciences for Health

Nancy Murray
Family Planning Management Development
Management Sciences for Health

Stephen Musau
Carr Stanyer Gitau and Co.—Kenya

William Newbrander
Health Financing Program
Management Sciences for Health

Promboon Panitchpakdi
CARE International—Thailand

Dick Roberts
MIS Program
Management Sciences for Health

Deborah Ruhe
Cotswold Ventures

Abu Sayeed
Local Initiatives Program
Technical Assistance, Inc.—Bangladesh

Sara Seims
Rockefeller Foundation

Linda Suttenfield
Family Planning Management Development
Management Sciences for Health

Robert Timmons
MIS Program
Management Sciences for Health

Ricardo Vernon
The Population Council—Mexico

Taryn Vian
HealthShare Technology, Inc.

International Review Board

Ms. Teresita Marie Bagasao
Kabalikat Foundation Incorporated
Philippines

Dr. Med Bouzidi
International Planned Parenthood Federation
Tunisia

Mr. Kimeli Chepsiror
National Council on Population and Development
Kenya

Mr. Mike Egboh
Pathfinder International
Nigeria

Mr. G. C. Ezeogu
Planned Parenthood Federation
Nigeria

Mr. Najmul Huq
National Institute of Population Research
and Training (NIPORT)
Bangladesh

Dr. Semra Koral
Family Planning Association
Turkey

Dr. Peter Mokaya
Seventh Day Adventist/Rural Health Services
Kenya

Ms. Kalimi Mworia
Family Planning Private Sector Project/John Snow, Inc.
Kenya

Mr. Godwin Mzenge
Family Planning Association
Kenya

Prof. G. Narayana
Administrative Staff College
India

Dr. Emmanuel Nkodo Nkodo
Ministry of Public Health
Cameroon

Dr. Carmencita Noriega-Reodica
Department of Health
Philippines

Mrs. Chinyere Nwufo
Planned Parenthood Federation of Nigeria

Dr. Cihangir Özcan
Turkish State Railways
Turkey

Mr. Promboon Panitchpakdi
CARE-Thailand

Ms. Maria Isabel Plata
PROFAMILIA
Colombia

Ms. Jewel P. Quallo Rosberg
Belize Family Life Association

Dr. Jovencia Quintong
Department of Health
Philippines

Dr. Eléonore Rabelahasa
MSH/APPROPOP
Madagascar

Mr. Abu Sayeed
Technical Assistance, Inc.
Bangladesh

Dr. Does Sampoerno
Pathfinder International
Indonesia

Dr. Enrique Suárez
FEMAP
México

Dr. A. B. Sulaiman
Planned Parenthood Federation
of Nigeria

Dr. Haryono Suyono
BKKBN
Indonesia

Mrs. Rose Wasunna
Mkomani Clinic Society
Kenya

Mr. Sixte Zigirumugabe
CARE-Togo

Dr. Alex Zinanga
ZNFPC
Zimbabwe

The Family Planning Manager
Editorial and Production Team

Editor-in-Chief
James Wolff

Foreign Editions and Review Board
Claire Bahamon

Consulting Editors
Susanna Binzen
Deirdre Wulf

Desktop Publishing
Jacki Forbes
Ceallaigh Reddy

Editor
Janice Miller

Case Scenarios
Linda Suttenfield
Susanna Binzen

Internet Editions
Kimberly Austin

Distribution
William Antebi
Thuy Nguyen

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Foreword

Management—a System, a Process, an Act, or an Art?

Ask people to define management, its elements, and why they are important, and you will get a range of different descriptions, explanations, and definitions. But most everyone would agree that management is a necessity.

Management deals with everything from organizing a day's work to long-range strategic planning, both of which are carried out to help organizations and programs achieve their goals. Management means that people must develop, guide, control, communicate, evaluate, and report on plans and programs that involve complex tasks, which, in aggregate, lead to the production of a product or service. Managers must communicate with and supervise people, plan and implement activities, track progress toward objectives, and productively use and account for human, financial, and material resources. Organizations, therefore, cannot function well without competent managers, and indeed, in their absence, organizations are often paralyzed or chaotic.

To help communicate and build effective management practices in health and family planning programs, the Family Planning Management Development project has been publishing and distributing *The Family Planning Manager* continuing-education series. The purpose of the publication is to promote a common understanding of strategies and systems for improving the management of family planning programs and communicate ways in which other managers have successfully addressed management challenges in their own programs.

In recent years, increasing numbers of readers have been requesting complete sets of back issues of *The Family Planning Manager*. To fill that need, and to provide a useful and easy reference to the wide range of management topics addressed in the publication, this compendium comprises the twenty-two issues and supplements that make up Volumes I-IV of *The Family Planning Manager* series.

How the Book is Organized

The book is organized into two broad areas—Program Management and Clinic Management. Within each section, each issue of *The Family Planning Manager* has been made into a chapter, each of which addresses a specific management topic. Each chapter contains "Working Solutions" from the field, sample charts and forms, "How to" guidelines, checklists, reviewers' comments, and references. Following each main chapter is a case scenario. Based on real situations, these fictitious management scenarios are designed to be used for staff development and training.

There are also four special supplements in this compendium. The *Manager's Toolbox for CQI* can be found in Chapter 3, the *Guide to Graphing Data and Taking Action* is in Chapter 10, and two pocket-sized supplements—the *Pocket Guide for Service Improvement*, and the *Pocket Guide for Improving Board Performance*—can be found at the back of the book.

The final section is devoted to "Working Solutions" from the field, followed by a comprehensive glossary of terms and a full index. The Working Solutions section, written in collaboration with eighteen of our readers, focuses on their solutions to management challenges they face in their work. These real-life experiences are innovative and exciting, and emphasize the key role of good management and the need for managers to work together with their staff to plan programs, solve problems, and make decisions together.

We hope that managers around the world will find this compendium a useful and practical reference for building effective, strong, and sustainable family planning programs into the next decade.

Catherine Crone Coburn
Project Director
Family Planning Management Development
Management Sciences for Health

Acknowledgments

The editors of *The Family Planning Manager* series would like to thank the contributing authors and guest editors, our faithful and committed reviewers, and all the readers worldwide for their enthusiasm and participation in the continued development of this publication.

One of the important ingredients that has made *The Family Planning Manager* series widely relevant and useful to family planning managers is that each issue represents a broad body of knowledge and experience. This comes from the constructive and professional advice that we receive from the members of our International Review Board, FPMD staff, and the staff of MSH's Population Program, who provide us with a critical review of each issue during its development. We are therefore indebted our colleagues for finding the time in their busy schedules to review each issue, provide us with technical input on the topics, and help us find examples from the field to illustrate how programs have successfully addressed their management challenges. Without their continued commitment and input, *The Family Planning Manager* would not have been able to reflect the breadth of experience represented by our readership.

When we first began publishing *The Family Planning Manager*, we did not fully realize the extent of the challenge we were facing in producing a bi-monthly publication in collaboration with authors, guest editors, and reviewers based in all parts of the world. It is through the incredible hard work and fine teamwork of the Publications Unit staff of the FPMD project that these challenges were met, and to their credit, that the publication has gained wide recognition in the field of international family planning. Each person has contributed so much to the success of the publication: Claire Bahamon worked closely with the members of the International Review Board to solicit their input on each topic and managed the translation and production of all the French- and Spanish-language editions; Linda Suttenfield and Susanna Binzen developed the case scenarios that accompany each issue; Jacki Forbes, Ceallaigh Reddy, and Alan Yost and developed and executed the layout of the issues in PageMaker; and Kimberly Austin assisted in the development of the country examples and is currently making each issue available on the World Wide Web.

Special recognition goes to the distribution coordinators, William Antebi, Jill Shulman, Thuy Nguyen, and Sarah Fenstemacher who over the years have worked with us to build a reliable distribution system and manage the ever-growing volume of requests for FPMD publications from our readers in over 180 countries

We would also like to thank all the public and private health and family planning organizations represented in the Working Solutions examples of this book for agreeing to discuss their management problems with us, and for being willing to allow us to publish the information, so that other managers around the world may learn from their experience.

Lastly, we would like to thank Roy Jacobstein and Maria Busquets-Moura of the Office of Population Office of the U.S. Agency for International Development (USAID) for promoting and supporting our efforts in developing *The Family Planning Manager* series and this consolidated four-volume edition of the publication.

Financial support for this book was provided by the United States Agency for International Development. We appreciate the Agency's commitment to the work of FPMD in improving management systems and practices in family planning programs worldwide.

Cairo and Beyond: Addressing the Critical Management Challenges

In September 1994, many thousands of men and women from every corner of the world—national leaders and representatives of governments, family planning organizations, women's groups, and health agencies—met in Cairo, Egypt to discuss what is probably the most important issue facing the world today: the limits to global survival resulting from rapid rates of population growth and slow rates of economic and social development.

To identify some of the major management challenges facing family planning managers in the future, the editors surveyed 100 key researchers, policy makers, and program managers in the international family planning field. These individuals identified as many as 30 different challenges facing family planning managers today.

This special issue of *The Family Planning Manager* provides a window on the ideas and experience of a cross-section of family planning managers around the world. It will be through the continued efforts of these managers, our readers, that high-quality family planning services will become accessible and affordable to all those who need them. These managers hold the key to making family planning services a global reality.

This introduction was originally produced as Volume III, Number 4 of ***The Family Planning Manager****. It was developed in collaboration with many of our colleagues working in the field of family planning, and distributed at the 1994 International Conference on Population and Development in Cairo, Egypt.*

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Identifying the Management Challenges of the Future

Preparations for the *1994 International Conference on Population and Development (ICPD)* have been going on for several years. There have been official United Nations meetings in every region of the world and parallel meetings of non-governmental organizations (NGOs) to hammer out the agenda for the conference. Many thousands of statements have been made about the key issues surrounding population and development including reproductive health, population growth, poverty, the environment, the status of women, and north-south inequities.

Estimates based on findings from the Demographic and Health Surveys (DHS) indicate that even though couples in most regions of the developing world, with the exception of sub-Saharan Africa, would like to have two to four children, they are actually having an average of four to seven children. About one-third of all women of reproductive age in Latin America and Asia and about one-fourth in sub-Saharan Africa do not want to be pregnant but do not know about, do not have access to, or fear using effective family planning methods. These figures suggest that at least 100 million couples worldwide still do not have access to the services that would make it possible for them to plan their families. By the year 2000, it is likely that this number will have risen to 120 million.

These estimates of the current and future scale of the unmet need for family planning attest to the magnitude of effort required to meet the needs of the world's people. Family planning managers play a crucial role in this global effort to overcome the obstacles preventing couples from having the number of children they want, when they want them. Although management is the backbone of any effective family planning program that makes quality services available and affordable to people around the world, it does not seem to have received as much attention as the broad global issues. This special issue of *The Family Planning Manager* is dedicated to our audience of family planning managers around the world who are working to solve the difficult management problems that limit the realization of this common goal.

In preparing this issue, the editors surveyed and interviewed representatives of international donor agencies, government family planning programs, private family planning agencies, and field workers at the local level to obtain their views on the obstacles and opportunities facing family planning managers today. These representatives identified six broad areas of concern: paying for family planning programs; improving the quality of services; reaching rural populations; integrating family planning into other health and development programs; coordinating public- and private-sector

activities; and helping successful family planning programs to grow so that contraceptive use does not level off or "plateau." In each of these areas, family planning managers are developing and using innovative management tools and techniques to respond effectively to the enormous demand for safe and effective contraceptives, and to improve their ability to deliver high-quality family planning services.

Good management is the key to connecting individual reproductive behavior with the larger public and global good—lower population growth and more sustainable world development. Full achievement of reproductive rights for both men and women the world over will require managers to improve program performance, to satisfy existing demand, to create new demand for family planning services, and to link the practice of family planning with efforts to improve the status of girls and women and the well-being of families. Success in this endeavor will largely depend on the management skills and dedication of all those who are involved in providing affordable, accessible, and safe family planning services.

Managers Choose the Critical Management Challenges

The editors of *The Family Planning Manager* conducted interviews with a wide range of family planning professionals, from international population experts to service providers, to gain their views on the critical management challenges they face in their work and what can be done to meet those challenges. These managers identified a broad range of management challenges, including building sustainable family planning organizations, improving service quality, addressing the reproductive health needs of refugees and displaced persons, managing the complications of incomplete abortion, and addressing the needs of youth and men. Of these challenges, the editors selected six that were most consistently cited by these managers as most important in their work:

- How can family planning programs be paid for now and in the future?
- What are the most important steps to take to improve the availability and use of family planning methods in rural areas?
- How can family planning programs provide high-quality services?
- How can family planning services be integrated into other health and development projects, and what aspects of program management can ensure that the family planning services in integrated programs remain visible and effective?
- How can family planning services be effectively coordinated to strengthen national programs?
- How can family planning managers help national programs serve greater numbers of people?

Financing Family Planning Programs

It is estimated that the annual cost of providing family planning services will rise to at least US$ 11 billion in the year 2000. If, in the future, a more complete array of reproductive health services is to be provided in addition to contraceptive services, the total will almost double to equal an estimated 17 billion dollars.

To meet these costs, there will have to be substantial increases in government spending, client fees, and donor funding. Yet governments are already having difficulty meeting the other basic needs of their populations such as education, jobs, health services, housing, water, and sanitation. Charging fees for services may prevent poor people from using family planning services. Finally, donor emphasis on sustainable programs may reduce overall funding levels, rather than create true self-sufficiency. Dr. Carmencita Reodica, Assistant Secretary of the Office for Special Concerns at the Department of Health in the Philippines, feels that government support for family planning services can be strengthened by "making family planning part of the national government investment package, and by making the government include a line item for family planning in the national budget." Although this will assure a specific allocation of resources for family planning programs, it will not necessarily provide additional funds for family planning programs.

Dr. Steven Sinding, Director of Population Sciences at the Rockefeller Foundation, notes that "up until now, developing countries have contributed about 75 percent of the total cost, and donor countries have provided the remaining 25 percent." Sinding asks: "Is this the right ratio, or should the donors assume a larger responsibility? Some people think the donors should pay the lion's share because the developing countries are having such problems with their economies. They're being squeezed by structural adjustment policies and declining terms of international trade. Others believe that if the developing countries reduce their financial support for family planning programs, the risk is that they will also reduce their commitment to those programs."

In their effort to increase financial support for family planning programs, family planning managers must develop multiple strategies that tap as many funding sources as possible, including national and international donor support, private commercial family planning services, cross-subsidization, and user fees for family planning services.

Financing Family Planning Services

Family planning services can be financed through one or more of the following major sources of funding:

Grants. Funds from the government or from local or international donors.

Third party payments (co-payments). A system of paying for services whereby the client pays a portion of the fee and a third party (such as an employer, an insurance company, or a health plan) pays the balance.

Cross-subsidies. A method of transferring the income from one service to pay for other services. This technique can be used to reduce the cost of one service (such as sterilization) by charging more for services in locations where residents are able to pay more, and using the money to provide lower-cost services in poorer areas.

Client fees. Registration fees, fees for individual services at the time of delivery, or membership fees.

Sales of other program services. The sale of program services or products, such as training or educational materials, to clients or other organizations. This can include innovative techniques for generating income, such as running a food concession in a service facility.

The private commercial sector offers the potential for expanding and financing family planning services. To be successful, family planning managers must develop ways to make family planning or reproductive health services profitable enough to interest traditional business enterprises in providing services to their employees. So far, approaches such as employer-based clinics or training midwives and introducing them into private practices have not led to the financial breakthrough that was first anticipated. In the future, managers must find ways to make these initiatives cost-effective and compelling. This will require new managerial philosophies and new ways of doing business.

> **"Some of our new general health centers even have dentists working in them. They give us 30 percent of their revenues, and we use the income to help subsidize other less profitable services."**
>
> ***– Alfonso López Juárez***

The cross-subsidization of existing clinics through diversifying services, building profit-making clinics, and introducing sliding fee scales can be successful if good management techniques and systems are implemented. Alfonso López Juárez, Executive Director of MEXFAM, the International Planned Parenthood Federation (IPPF) affiliate in Mexico, advocates cross-subsidization. "Some of our new general health centers even have dentists working in them. They give us 30 percent of their revenues, and we use the income to help subsidize other less profitable services." Steven Sinding agrees that "where people are willing to pay for services like dentistry or optical care, that money should be used to defray the cost of providing things people are less willing to pay for."

> **"When FPAK studied whether clients would be willing to start paying something toward the cost of our services . . . we found they were willing, so long as the money was used to improve the quality of our services."**
>
> ***– Margaret Thuo***

Other approaches to financing family planning services include user fees and private medical insurance. With regard to users fees, there is increasing concern that this strategy might instead reduce levels of contraceptive use, especially among the poor. Margaret Thuo, Program Manager of the Family Planning Association of Kenya (FPAK), notes that this concern is real. "When FPAK studied whether clients would be willing to start paying something toward the cost of our services...we found they were willing, so long as the money was used to improve the quality of our services." Medical insurance offers another way to finance services. Alex Zinanga, Executive Director of the Zimbabwe National Family Planning Council (ZNFPC), points out that "in Zimbabwe, some private medical insurance schemes cover the cost of family planning services. That means that if an employee of one of the large companies that offers such insurance comes to one of our clinics for services, that person's health insurance will reimburse us for the cost of the service. We use these payments to subsidize the cost of providing services to poor people."

MEXFAM's Alfonso López Juárez explains how his organization is restructuring to address cost-recovery challenges. "Our organization recently changed its strategic direction, transforming it from a small philanthropic organization dedicated to providing contraceptive services, to a non-profit health agency offering a wide range of health services in addition to reproductive care." Reflecting on MEXFAM's new business-oriented strategy and the enormity of the changes required to bring this about, Mr. López Juárez notes: "We have completely reorganized the way we work. We didn't just change our logo, we completely transformed our organization in the areas of administrative procedures and the use of computers and management information systems.

Our organization is completely different and so are our methods, and it is showing results too."

Despite all the emphasis on obtaining financial resources, other important components of financial sustainability must not be overlooked. Managers are the key to creating and developing sustainable organizations because they provide organizational leadership and vision and because they can continue to champion the causes of the poor and underserved.

How to . . .

Create a Sustainable Family Planning Organization

Obtaining financing for family planning programs is only one component of sustainability. Creating a sustainable family planning organization requires that managers develop organizational stability through their leadership and vision and their continued commitment to serve the less-advantaged. Here are some of the crucial managerial actions that will lead to sustainability.

To develop organizational stability:

Articulate a clear mission;

Develop strong, innovative leadership;

Recruit and reward excellence;

Strengthen management systems at all levels;

Develop an organizational culture that responds quickly to changing environments and client needs.

To increase client demand and expand the client base to the poor and underserved:

Understand client needs and how to meet them;

Introduce systems that ensure continuous quality improvement;

Market family planning services effectively;

Tailor information, education, and communication (IEC) messages to reach the poor and underserved.

To achieve greater control over resources:

Diversify sources of financing;

Find ways to reduce costs and increase cost efficiency;

Develop accounting systems that provide information on the costs of various program areas;

Plan and monitor expenditures;

Base decisions on actual program data.

No simple solution will generate sufficient funds to meet the increasing demand for family planning services that can be expected in the next decade. But one thing is certain—family planning professionals worldwide will have to meet the rapidly growing need for contraceptive and reproductive health services by helping to mobilize the combined efforts of governments, non-governmental organizations, the for-profit sector, and individuals. These efforts will have to be supported by managers with leadership qualities, a vision of the future, strong management skills, and an openness to new ways of doing things.

Using Market and Cost Data to Create a Foundation for Self-Sustaining Family Planning Services

The Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Comunitario (FEMAP) is developing a comprehensive strategy for moving towards financial independence. At the same time it is working to preserve the social mission of the organization, which is to provide services to those most in need. This sustainability initiative is based on information gathered to assess the ability and willingness of current and potential clients to pay for services, and on data about the characteristics of the population in their organization's service area. To get this type of information, FEMAP conducted market and cost analyses of its program with support from FPMD and the INOPAL II project.

Market Analysis

The market analysis consisted of three studies: a client survey, a community survey to develop a profile of potential FEMAP clients, and a survey of family planning service competitors.

Client Survey. The client survey provided a profile of the current clients in FEMAP's clinics and in its community-based distribution (CBD) programs. The profile included data on:

- clients' average monthly income;
- their reasons for selecting FEMAP's services;
- client perceptions of FEMAP's quality of care;
- client perceptions of FEMAP's proposed service fees;
- clients' willingness and ability to pay a higher price for services;
- how clinic clients heard about FEMAP's services.

Community Survey. The community survey assessed the potential for attracting more clients to FEMAP's services. It identified key characteristics of people residing within actual and potential areas of influence of FEMAP affiliate clinics. This information included:

- the community's perception of FEMAP's reputation and image;
- the respondents' current providers of health services;
- the respondents' average income.

Survey of Other Family Planning Providers. This study collected data on other family planning service providers that offer services similar to those provided by FEMAP affiliates. Through a series of observations and interviews, the following information was collected:

- types of services provided;
- location of services;
- pricing of services;
- quality of services;
- access, facilities, staff competence, and training.

Continued on next page

Cost Analysis

FEMAP conducted a cost study to obtain information that would allow the organization to control costs, set prices, and monitor improvements in the cost-effectiveness of their programs. Trained accountants interviewed FEMAP staff, observed FEMAP operations, and gathered information on the direct and indirect costs of the main administrative and program areas.

Analyzing the Market and Cost Data

FEMAP analyzed the information gathered in the market and cost studies to classify clients by socio-economic status, the price increases clients would be willing to pay, and the source of referrals to FEMAP, as well as to map out potential areas for service expansion. Information about other service providers is helping FEMAP reassess the organization's traditional assumptions about the service marketplace and to readjust prices and/or the volume of services provided to maximize income, while making sure to maintain a competitive price advantage.

In analyzing client and community survey data, FEMAP learned that their clients were happy with the quality of FEMAP's services and that, in general, their clients came from a higher socio-economic group than they had expected. They also learned that users of community-based services did not tend to use the clinics, and that there was a demand for family planning services that was not being met in areas served by FEMAP. In analyzing the services of other providers, the survey results showed that FEMAP's fees for services were consistently lower than those of other providers, and that in fact they could increase their fees and still charge less than other providers.

The analysis of the cost data showed that of the seven affiliates included in the study, one affiliate is making a profit (and reinvesting the income in other services), another is recovering 87 percent of its costs, and the others are recovering between 17 and 68 percent. Both of the affiliates with a high level of cost recovery provide hospital services, including laboratory services, in-patient care, birth and delivery services, and gynecological surgery. The income from these services helps to subsidize the cost of providing family planning services. In addition, the survey showed that of all the services offered, the number of family planning visits far outnumber any other type of visit, yet the income produced per family planning visit is less than other types of services. Lastly, in the affiliates providing maternity services, although the number of maternity visits are fewer, the fees received from these visits comprise approximately 45 percent of the total income because clients are willing to pay more for this type of visit.

Using the Market and Cost Study Information

Using the results of the survey, FEMAP is looking into ways of expanding into new areas and attracting greater numbers of clients to affiliate clinics. For instance, FEMAP plans to improve the image of the clinics and urge promoters to promote the use of the clinics and actively refer clients for services not offered in the CBD program. FEMAP is using data from the cost study to compare FEMAP programs in different service sites, develop program performance measures, reduce costs, set new prices, and target promotional activities.

Over the next year, with assistance from FPMD, FEMAP will be conducting further analyses of the data to guide their revisions in operational plans, initiate new activities, and make changes in either the pricing or volume of their services to improve the level of self-sufficiency of their affiliates.

As this example illustrates, to work towards greater self-sufficiency, organizations need reliable data on their market and their costs. Once these data have been obtained, costs can be controlled, cross-subsidization programs can be developed, and new pricing strategies can be introduced. These actions are the key to gaining financial independence while continuing to serve the most disadvantaged sectors of the population.

Providing Rural Populations with Better Access to Family Planning Services

Sixty-five percent of the population in the developing world, or approximately 2.9 billion people, live in rural areas where total fertility rates and infant mortality rates are often double that of urban areas. Even though rural-to-urban migration is increasing the size of the urban population, people living in rural areas will outnumber urban inhabitants until some time between 2010 and 2025, and most of the unmet demand for family planning services is in the rural areas and is likely to remain there into the foreseeable future.

Although levels of contraceptive use in rural areas are often half that of urban areas, family planning surveys indicate that the main reason that rural women do not practice family planning is not because they want larger families, but because they lack knowledge about family planning and have limited access to services.

Extending and improving family planning services in rural areas presents great challenges and opportunities for family planning managers in the next decade. As Dr. Peter Mokaya, Director of the Seventh Day Adventist Rural Health Services in Kenya points out: "In Kenya, 80 percent of the population is rural. This population doesn't have as much access as urban populations, and is not as informed or as empowered as urban residents. This is the population that really needs our help."

Earlier skepticism about whether family planning programs would be acceptable in rural areas, where children are valued for the contribution they make to family income, has slowly been dispelled as the average family size has declined in some countries with predominantly rural populations. In South Korea and Thailand, for example, the contraceptive prevalence rate (CPR) in rural areas is higher than 60 percent, and not very much lower than the prevalence rate in urban areas.

These results should encourage family planning managers to continue to focus on rural populations in the next decade. The family planning managers interviewed for this edition identified several critical issues for improving services to rural populations. These issues included the importance of economic and social development in changing attitudes about family planning and family size; the need to identify key communication channels to spread knowledge about family planning; integrating family planning with other health services at the village level; and making sure that a sufficient number of qualified staff are working in the rural areas.

> **"To change attitudes you have to have really good IEC campaigns that contain messages that make people say, 'Yes, that's about me and it's talking about all the things I'm worried about.'"**
>
> ***– Margaret Thuo***

It is important to create economic confidence in a community and to facilitate the acceptance of family planning in settings in which children would otherwise be viewed as assets to support parents in their old age. Mr. Lofti Labbane, Executive Director of the Family Planning Association of Tunisia, advises that "managers must develop strategic plans that place family planning within the fabric of development, including all aspects of social, economic, cultural, and environmental efforts." Social programs that provide increased opportunities for employment and for generating income will help to reduce the reliance on children for old-age security and will enable people to see the benefits of a smaller family size.

Managers must identify key communicators and communication networks in rural areas to spread knowledge about sources of contraceptive supplies and the use of family planning methods. Margaret Thuo of FPAK in Kenya stresses: "To change attitudes you have to have really good IEC campaigns that contain messages that make people say, 'Yes, that's about me and it's talking about all the things I'm worried about.' You've also got to improve the quality of programs in rural areas. You must treat a woman with dignity, with friendliness,

and in confidentiality. You must make her think 'I can tell you all my secrets, and I know you won't tell them to anybody.' You must empathize with her, listen to her, communicate—really communicate—with her. We don't fully understand how far communication can take us. But it requires proper training to do good counseling." Dr. Reodica of the Department of Health in the Philippines also stresses the critical importance of an IEC strategy for increasing family planning acceptance in rural areas. "In the Philippines, almost all households own a radio and listenership is very high. Filipinos love drama that depicts events happening in their own lives. For easier understanding and appreciation, the message should be simple and true to life."

> **". . . the key to making family planning services acceptable in rural areas is improved counseling."**
>
> ***– Steven Sinding***

Steven Sinding of the Rockefeller Foundation maintains, "As far as I'm concerned, the key to making family planning services acceptable in rural areas is improved counseling. Front-line workers must be trained to answer the hard questions, to allay people's fears about side effects, to explain thoroughly how the methods work and what the risks and benefits are. In many cases, distributors can't answer these questions credibly and convincingly, but we know that one of the major reasons why people don't practice family planning is fear of the methods. I realize this is a difficult goal. It requires training and re-training and improved supervision, and it means much more emphasis on client/provider interaction. And all of that costs money."

Institutions that provide services in rural areas will need to make organizational changes so that they can work together to provide more integrated health and family planning services at the village level. Dr. Mokaya advises that family planning managers must "try to establish clinics in rural areas in combination with community-based distribution of contraceptives. To attract prospective clients, these clinics must provide a wide array of quality services in primary and preventive health care. To develop and maintain client confidence, rural clinics must be able to rely on a good logistics system so that they have adequate supplies of contraceptives on hand at all times."

Local family planning managers, central level managers, and policy makers will need to work together to develop a corps of qualified family planning professionals in the rural areas who are trained in delivering a wider array of health and family planning services. Efforts will also have to be made to keep staff working in the rural areas, such as creating better work conditions and other attractive incentives. Margaret Thuo of FPAK advises: "We must also worry and care about our staff. Many of them are overworked, underpaid, and frustrated. Some of them are stuck in boring routines. We must think about what we can do to help them, what kind of incentives we can offer them." Alfonso López Juárez explains MEXFAM's efforts to provide such incentives. "The problems of Mexico's rural population are very serious. MEXFAM started a program to encourage and help recent medical school graduates to set up health clinics in unserved rural areas. The only thing we ask in return is that they make contraceptive services available. We help find them an office, we sometimes subsidize the rent for the first year or two, and we help them set up their health facility. It takes a lot of dedication to stay working in some of these places. There is nothing there for urban people who are used to city amenities." Mr. López Juárez advises: "We have found that it is best if the doctor is young, if he or she has a spouse who shares similar ideals, and if they have young children who help them become rooted in the community. I don't think social change is going to happen among Mexico's poor rural communities, except by example. If the community leaders like the doctor become trusted members of the village, and the doctor only has two children, its gets people thinking. It changes their attitudes. But it all has to start from a personal example."

Involving the Community: A Key to Successful Rural Services

The spread of family planning in Bali, Indonesia is a shining example of a successful family planning program in a predominantly rural setting. The results are encouraging.

- Women in Bali now have just over two children on average, which is close to the number they consider the ideal family size. Twenty years ago, the average family size was almost six children per woman.
- Today, almost all married women know of a modern contraceptive method and can remember where they learned about it.
- Slightly more than 70 percent of married women currently use a modern contraceptive method. This is a far higher level than in any other region of Indonesia. The level of contraceptive use in rural Bali is almost 20 percentage points higher than it is in metropolitan Jakarta even though the amount of time it takes women to reach a source of supply in Bali is practically the longest in the country.
- More than half of all women practicing family planning in Bali use the IUD—a much higher proportion than in other regions of the country.
- More than 70 percent of users pay for their contraceptive services. Though many people pay for services provided by the private sector, the majority pay for services provided by the government.

Factors of Success

The success of Bali's rural family planning program is due to a number of factors, including:

- The active involvement of the local community in all phases of planning and carrying out the family planning service;
- Information programs that make the local community aware of the problems associated with high population growth and high population density;
- The skill of program managers to make use of complex systems of membership in social and kinship groups. Through these membership groups, the people of Bali are drawn into community-based efforts to resolve the problems of over-population through fertility regulation.

Steps to Improve the Availability of Services in Rural Areas

- Improve the design of rural family planning programs so that health and family planning services are integrated with other rural development and social welfare services.
- Create mechanisms, such as cross-subsidization or community financing, to keep prices affordable for rural residents.
- Support those social and cultural conditions that facilitate the acceptance of family planning among rural couples (such as improvements in the status of women and improvements in female literacy).
- Create conditions and incentives that ensure that a sufficient number of qualified and motivated staff continue to work in the rural areas.
- Deliver appropriate IEC campaigns that show the link between smaller family size and increased health and economic status.
- Demedicalize family planning services to overcome the shortage of health personnel in rural areas and create good referral systems.
- Use rural-urban migrants as key persons to carry messages about family planning from their new environment back to their villages of origin.

Improving the Quality of Family Planning Services

The major criteria by which the quality of a family planning service is judged are widely known, and most program managers would recognize that poor-quality services discourage program acceptance and expansion. Most managers also agree that for family planning services to be appropriate, safe, sensitive to the needs of the user, and acceptable to a wide range of populations, the following basic conditions should exist:

- The widest possible choice of contraceptive methods should be available.
- Service providers should be well trained in clinical methods and technically competent to prescribe other methods, and they should receive frequent refresher training.
- All clients should receive confidential and careful counseling that includes information about the health benefits and disadvantages of each method, how to use their chosen method correctly, and the possibility that the method could fail.
- Program personnel should treat their clients with understanding and respect, because if clients believe that they are not being treated with sympathy and courtesy they are less likely to return for services.
- Program planners should design strategies that make it easy for clients to continue using a given method. These can include mechanisms such as media campaigns about the benefits of a particular method, home visits (where appropriate) to women who cannot leave their houses, appointment systems at the local clinic to avoid long waiting times, and reliable contraceptive supply systems.
- Program planners should try to provide a constellation of services that are acceptable to the client and that address the conditions of her daily life. Does the woman work long hours in the fields or factory? Can she afford to pay for services? Does she need the approval of her religious or community leaders, her husband, or her mother-in-law?

> **"Quality of care involves such a lot of intangibles . . . The key, of course, is respect—being respectful of the woman as a person.**
>
> ***– Kalimi Mworia***

Some program providers have argued that criteria as specific as these might be too stringent for governments with limited health resources, for small non-governmental organizations trying to establish new programs, or for small rural clinics. They question whether excessive emphasis on quality might discourage program planners from starting more basic services, and suggest that these standards might be attainable only in countries that already have high standards of medical care, few shortages in trained medical personnel, and generous levels of funding for family planning programs. Others argue that these criteria do not go far enough, and that family planning services are incomplete if they do not offer women the full range of reproductive health services including sex education, sexuality counseling, the diagnosis and treatment of sexually transmitted diseases (STDs), and infertility and abortion services.

In addition, representatives of activist health groups who promote greater participation by community residents in planning and monitoring family planning services believe that many national programs, especially large national programs, are not sufficiently responsive to local values and local

needs, and that many service providers are not sufficiently considerate of women and their special concerns. As Kalimi Mworia, Director of the Partnership Fund Challenges project at the International Planned Parenthood Federation points out: "Quality of care involves such a lot of intangibles, whoever the provider is. The key, of course, is respect—being respectful of the woman as a person. Some doctors tend to treat clients in the same way that they treat sick people. But people coming for family planning aren't sick."

> **"It seems clear that no single standard of high-quality family planning service can be applied universally. And the definition of quality will be different in different cultural and geographic settings.**
>
> ***– Jane Bertrand***

Should programs focus on providing a few services that they can do well, rather than no services? Or should they operate on the assumption that only high-quality services that fulfil these criteria can gain the confidence and loyalty of new or continuing users? Jane Bertrand, a professor at the Tulane School of Public Health and Tropical Medicine states: "It seems clear that no single standard of high-quality family planning service can be applied universally. And the definition of quality will be different in different cultural and geographic settings. That does not mean that it is not useful to formulate some standards for an 'ideal' service, if only as a goal toward which program planners should aspire." Kalimi Mworia points out that "if the pill is the only method available, is it better to close down the service until ten methods are available, or to give the woman that method, tell her about its side effects, and possibly help her from dying as a result of a dangerous pregnancy?"

> **"The quality of your services must be put in the context of how they are perceived by the client. Services must be responsive to the clients' stated needs and match their expectations."**
>
> ***– Peter Mokaya***

The issue of quality of care in family planning services, therefore, pinpoints a number of service problems that are difficult for many managers to resolve. Not the least of these is the question of how governments and NGOs with limited budgets can afford high-quality services. Dr. Peter Mokaya stresses: "The quality of your services must be put in the context of how they are perceived by the client. Services must be responsive to the clients' stated needs and match their expectations." Dr. Mokaya goes on to emphasize "that way clients will both use the services and be willing to pay for them. Even people with very little money can find a way to pay for something that they consider has value. In Kenya, Depo [Provera] is very popular, as are certain brands of the pill. We have found that there is a very high payment rate for services among clients accepting these methods." Results such as these indicate that a high rate of client satisfaction should be one measure of quality, and that quality in the long run will often pay for itself.

Steps that Providers Can Take to Increase Client Satisfaction

Service providers, more than any other family planning professionals, have the greatest impact on client satisfaction. Creating a satisfied client begins with improving the provider's attitude. Managers can use the following tips to help providers be more caring and sensitive.

Put the client first. Make the client feel as if she is the most important person and be aware that she may have other health needs in addition to her reason for coming to the clinic.

Provide information. Clients need to know how the service delivery process works, how long they can expect to wait for services and why, what services are being offered, and who is offering them.

Be courteous. Practicing common courtesy towards clients is a prerequisite to creating a satisfied client.

Be responsive. No matter how busy you are, never ignore your clients.

Be clear and confident. When providing information and education to your clients be sure to give clear messages and correct instructions as to the use of a method, and make sure that you have answered all their questions satisfactorily.

Value time. Be acutely aware of the value of your clients' time, not just your own.

Respect privacy and confidentiality. Make it your personal responsibility to protect the privacy and confidentiality of every client you encounter.

Respond to problems. Listen to complaints, don't argue with clients, and try to find resolutions to problems either immediately or in the near future.

Be efficient. Excessive waiting time is a common complaint. Adopt management strategies to reduce client waiting times.

Ensure access. Make sure that your clients have access to your services when and where they need them.

Create a positive ambiance/atmosphere. Keep your facility clean and neat, and provide chairs or benches for clients to sit in the waiting area.

Be sensitive to your client's feelings. Be aware that your behavior affects how the client perceives your service. Avoid inappropriate laughter, joke-telling, or frivolous conversations on the side while clients are being served.

Provide education. Make good use of your clients' time while they are waiting by showing videos or giving a brief talk on birth spacing, nutrition, or other health topics. The waiting time will seem shorter and they will learn about good health practices.

Integrating Family Planning Services with Other Health and Development Programs

More and more organizations are integrating health and family planning services. Integrated services are attractive because they offer managers the possibility of providing more convenient and comprehensive services to clients in a more streamlined and cost-effective fashion. Steven Sinding contends that "the debate about whether or not family planning services should be integrated is largely an academic one. At the field level most services are integrated, whether or not the policy makers intended it that way."

> **"The debate about whether or not family planning services should be integrated is largely an academic one. At the field level most services are integrated, whether or not the policy makers intended it that way."**
>
> ***– Steven Sinding***

The reasons for integrating programming for key maternal and child health and family planning programs are compelling. First, the resources for large vertical programs cannot be sustained year after year, and program sustainability is critical to future program success. Integrating family planning into the existing health infrastructures provides the best chance for sustained program growth and development. In fact, as Dr. Peter Mokaya of SDA Rural Health Services claims, "Integrating curative and preventive services has been the basis for our ability to sustain our rural preventive health service program." Dr. Cristina Rentería, Director of the Caja Nacional de Salud's reproductive health program in Bolivia, adds that "family planning should [at least] be integrated with maternal and child health services. More and more women are working, and a woman should be able to seek out multiple services in a single visit. This is our goal in our reproductive health program."

> **"Family planning should [at least] be integrated with maternal and child health services. More and more women are working, and a woman should be able to seek out multiple services in a single visit."**
>
> ***– Cristina Rentería***

Second, social, economic, and health development efforts are synergistic. For example, studies show that literacy in women is highly correlated with contraceptive use and that "for every year of schooling a woman receives, her fertility rate is reduced by 10 percent." [Hammond et al.] Unless women are empowered to make better decisions about their lives, they may not be able to act on their desire to limit their family size. Margaret Neuse, Deputy Director of USAID's Office of Population, believes that "education, health, and family planning all need more money. These are important social sector investments. The real challenge is not to just move money around from one program to another, but to find money to increase support for all the activities that improve opportunities for women."

There is a growing expectation that the scope of family planning programs will broaden to provide more comprehensive reproductive health services. Margaret Thuo of FPAK qualifies the conditions for integrating new services by stating, "It makes sense for FPAK to get involved in things like cervical and breast cancer detection, and the treatment of STDs, including HIV/AIDS, because those areas are important to women." Many managers have already established a reputation for providing services of a sensitive and intimate nature to women and men of reproductive age. In light of the spreading AIDS/STD epidemic, managers will have to new develop strategies for integrating reproductive health services for men and women.

Meeting the Challenge for Successful Integration

Integrated services must be effectively managed so that needed services do not become fragmented and unbalanced. A number of managerial challenges must be addressed for services to be effectively integrated. Managers have to:

- Link family planning education, referrals, and services with other development activities such as health, agriculture, water supply, education, and income generation;
- Include representatives from all administrative levels in the planning process and communicate plans widely before initiating the integration process;
- Structure your integration processes systematically and ensure the vital linkage between different administrative levels from the national level to the community level;
- Fully integrate budgets and financial management systems before integrating other systems;
- Redesign and integrate key management systems to effectively support and be consistent with the integrated service delivery system (systems include planning and budgeting, organizational structure, staff roles, training, supervision, logistics, information collection, and reporting);
- Standardize forms and requirements for collecting data and reporting;
- Promote an understanding among all levels of staff of the importance and value of integrating family planning into maternal and child health and primary health care programs;
- Modify the design and content of training curricula, provide training for existing staff to deliver a wider array of services, and even reorganize service delivery systems;
- Define staff roles and responsibilities for integrated programs, and develop indicators to measure the results of integrated program activities;
- Integrate IEC and family planning services into local community activities;
- Strengthen problem-solving skills of mid-level managers to ensure that local management problems can be addressed quickly and effectively.

For further discussion on managing programs in which family planning services are integrated with other health and development activities, please refer to Chapter Seven, "Managing Integrated Services."

Coordinating Service Delivery Activities to Strengthen National Programs

In an era when declining government and donor support and increasing demand have led to reduced per capita spending on family planning and health services, coordinating public- and private-sector activities can help to reduce the impact of declining resources. The private sector, consisting of a wide variety of organizations—large-scale profit-seeking corporations, small informal-sector entities, non-governmental organizations—plays a major role in both family planning service delivery and advocacy. However, the full potential of the private sector is sometimes compromised by the perception that public- and private-sector family planning organizations are competitors. As Abu Sayeed, Program Director of the Local Initiatives Program in Bangladesh, points out, "The working relationship between the public and private sectors needs to be collegial. Rather than compete, the private sector should complement and assist government family planning efforts and work together to achieve national goals."

> **"We built coordination with the government into our program from the start, and operate within the existing government infrastructure to avoid competing for clients and wasting resources."**
>
> ***– Abu Sayeed***

Coordination of activities within and between the public and the private sectors is critical. Coordination helps to reduce competition for clients and territory, support the decentralization of programs, create consistent policies and procedures, and increase demand through consistent IEC messages. Commenting on public and private coordination in Zimbabwe, Alex Zinanga recalls: "In 1982, when the government set up a parastatal family planning organization, the government gave it responsibility for everything. But now, the private sector is doing better. For example, it now provides most services in urban areas where contraceptive prevalence rates are high, and we found that we can rely on them to serve this population. The same thing is true for drug procurement. Private companies are doing so well that there's no point in competing with them. That leaves less profitable areas to the government. I honestly believe that the government should assume responsibility for helping the weakest elements of society. It should go into the most difficult areas. It's the government's responsibility to take care of the disadvantaged."

Through effective coordination, senior managers can help reduce wasteful inefficiency and fragmentation. Describing the successful Local Initiatives Program in Bangladesh, Abu Sayeed notes, "We built coordination with the government into our program from the start, and operate within the existing government infrastructure to avoid competing for clients and wasting resources."

Another challenge for managers is to encourage the development and application of standard, universally accepted policies and procedures for the delivery of family planning services. In addition, coordination is critical to developing a consistent communication strategy that broadcasts one message with a single voice. This means that managers at all levels must work together to share their program plans, develop effective communication strategies, and coordinate their service delivery activities. Abu Sayeed points out: "In the Local Initiatives Program we are trying to ensure coordination by linking local-level administrators with family planning professionals and community leaders to develop action plans and to be involved in their implementation. This same principle could be applied at the district level where a district coordinating committee already exists. Managers at the district level could expand the role of the coordinating committee to be more forward-looking, to develop district program plans on an annual basis, and oversee the implementation of district activities." Kalimi Mworia agrees that coordination among all provider groups at the district level is crucial to making quality family planning services available to

greater numbers of people. "At the district level, the district population officer must work closely with the district medical officer. Together, they need to collaborate with district hospitals and with all the various church groups and missions providing health and family planning services; that way, a CBD worker in any organization, in any part of the district will be able to appropriately refer clients to any government or private-sector programs within the district."

True coordination will reduce competition between the public and private sectors and within both sectors. Trust, however is a prerequisite for coordination. Abu Sayeed points out, "If we can rise above the competitive mentality, we can build trust. Trust is the critical element in good coordination." Managers can play an important role in building trust by ensuring good communication about all service delivery activities. The role of program managers in making coordination work is critical. Good management practices will help to ensure that managers share common goals, understand their respective roles, share responsibilities and resources, and resolve potential conflicts fairly and decisively.

Working Solutions—Zimbabwe

Collaborating with the Private Sector

Over the last several years, the role of the Zimbabwe National Family Planning Council (ZNFPC) has gradually changed from providing services to also include coordinating service delivery activities in the public and private sectors. ZNFPC's extensive experience in providing family planning services has positioned the organization to take on this important task. The collaboration covers several broad areas.

Policy development. ZNFPC has a board that sets policy. The board includes representatives from the private sector because it is not advisable to set policy without being aware of what is happening in the private sector or without their participation.

Quality improvement. ZNFPC has a private sector family planning committee made up of technical people who get together to decide how to improve services. When that committee identifies private sector training needs, ZNFPC does the training.

Training. ZNFPC works with the professional association of private general practitioners (GPs) to help them provide family planning services. For example, ZNFPC trains GPs to insert Norplant and do sterilizations, provides them with equipment, and helps them to set up services. Working with GPs is one of ZNFPC's major activities.

Integrating family planning and health services. ZNFPC is working with large companies to help them offer their workers on-site primary health care and family planning services. Many of these companies are training first-aid workers to talk to their employees about family planning, STDs, and AIDS.

What Managers Can Do to Improve Coordination

Coordinating program activities and services requires considerable effort, but the benefits of coordination make the effort worthwhile. Following are several ways that managers can coordinate with other programs, agencies, and donors.

- Gain donors' cooperation in coordinating information about quality of services, service expansion, and strategies for sustainability.
- Encourage donor agencies to develop consistent financial management and accountability requirements.
- Work with the government to formulate clear guidelines for coordinating and collaborating on all family planning activities.
- Develop common performance indicators for evaluating programs.
- Develop a variety of cooperative mechanisms for financing family planning and health services, including health insurance, risk coverage, pre-paid health systems, joint contributions by employee, employer, and government, social security coverage, and health maintenance organizations.
- Develop consistent policies and procedures for all service providers.
- Create and communicate consistent messages about family planning.
- Share resources, such as staff and materials for conducting staff training, vehicles (where possible) for transporting staff and commodities to clinic sites, and financial resources for IEC campaigns to inform people of the benefits of family planning and the location of service sites.
- Develop a formal mechanism, such as a quarterly meeting, for sharing information among representatives of government and NGO programs and for addressing problems and opportunities in family planning service delivery. Make sure that the meetings are conducted regularly and efficiently.
- List the major services provided by your program and those of other programs and chart the location of the services. Identify duplicated efforts and redistribute responsibility where feasible, so that clients have access to a full range of services.
- Coordinate efforts so that collaborating organizations and agencies take responsibility for activities that correspond to their strengths.

Helping National Programs to Grow

To bring about population stabilization in a country within a reasonable period of time, family planning managers must increase the demand for family planning services and then meet the demand for this larger population of clients. As family planning programs develop, they may go through periods of slow growth alternating with periods of rapid expansion. Managers sometimes find that although their program's infrastructure, personnel, and support services could sustain a higher level of performance, the number of people served remains static. This situation, called "plateauing," usually occurs when family planning programs have achieved contraceptive prevalence rates of between 40 and 50 percent. Getting to 40 to 50 percent contraceptive prevalence represents a major achievement. Unfortunately, to have a substantial effect on fertility and population stabilization, contraceptive prevalence rates must rise to levels of 70 percent.

> **"When contraceptive prevalence rates stop rising, research is critical. You learn things from research that you might never learn otherwise. For example, lots of people think that men are an obstacle to family planning. I think we've learned that that's not necessarily the case.**
>
> ***– Alex Zinanga***

Why does plateauing occur? A series of studies conducted by Management Sciences for Health in Bangladesh, Ecuador, and Zimbabwe, with funding from the Flora and William Hewlett Foundation, offers insights into the plateauing phenomenon. The study findings suggest that plateauing may occur because programmatic strategies do not match the new needs to sustain program expansion. Strategies that were helpful in the early stages of program development when contraceptive prevalence was low are not appropriate for programs that have successfully increased contraceptive prevalence to 40 and 50 percent. Plateauing signals a need for new policies, new strategies, and new management approaches. Alex Zinanga of ZNFPC notes that "programs go through various stages. Managers must keep their fingers on the pulse and look out for ways to do things differently. A lot of programs tend to do the same things over and over again, but people's needs change. I must constantly ask myself, 'Should I also do things differently?'"

First and foremost is the need to see the population as a combination of many different groups, each of which has special needs. To expand programs that have plateaued, managers must start to develop specialized strategies appropriate for each different segment of the population. Dr. Zinanga advises, "When contraceptive prevalence rates stop rising, research is critical. You learn things from research that you might never learn otherwise. For example, lots of people think that men are an obstacle to family planning. I think we've learned that that's not necessarily the case. Most men simply do not know the facts and are vaguely informed. They also fear a lot of methods, so you have to spend a lot of time working with them to bring about positive change. But it is a painfully slow process."

Another strategy being used to help national programs grow is to mobilize resources for family planning from different levels of government through decentralization. Decentralization involves transferring planning, decision making, or adminis-trative authority from higher to lower management levels within an organization, agency, or program. Margaret Neuse points out that "decentralization places responsibility for social service support on local-level government structures and on the commu-nity, and many governments are now looking toward decentralization to help them provide and expand services . . . whether decentralization will prove to be effective in increasing resources and expanding services has yet to be determined." Steve Solter, Principal Program Associate for Strengthening Health Services at

How to . . .

Accelerate Program Expansion

Over the next decade, as more family planning programs reach the 40 percent contraceptive prevalence level, developing multiple, coordinated strategies will become even more important. The Management Sciences for Health study, "Transforming Population Policy into Effective Action," provides some preliminary strategies for reinvigorating successful programs.

- **Develop service-delivery strategies to meet the needs of different client populations and give providers the skills to reach those groups.** As programs grow, service providers need to target specific clients who are not being adequately served. This will require managers to develop specialized training for providers working with these groups to help them respond effectively to the special needs of each underserved group.
- **Tailor IEC programs to reflect different stages in the demand for contraception.** To become satisfied and continuing users of modern contraception, people usually pass through several stages. This process begins with learning about modern contraception and trying a method, and ends with becoming a committed, satisfied family planning client. The process of transforming potential contraceptive users into satisfied clients can be accelerated by making IEC programs that are appropriate for each specific stage of client acceptance and demand.
- **Design programs that take into account regional variability.** National measures of contraceptive use often mask major regional differences. Family planning programs need to respond to the special characteristics of regions in which the growth in contraceptive use is stagnant.
- **Emphasize contraceptive services for the younger age groups.** Contraceptive prevalence rates of 40 to 50 percent have been achieved primarily among women over the age of 25, often after they have already exceeded their desired family size. Programs need to reach younger people, particularly adolescents and young unmarried men and women.
- **Focus programs on clients using less-effective methods.** Higher prevalence rates can conceal a significant portion of users relying on less effective methods. Although overall contraceptive use may increase over time, this increase is usually seen in the use of less effective or traditional methods. Therefore, it is important for IEC and service delivery programs to target users of less effective and traditional methods in order to increase program effectiveness.

Management Sciences for Health, suggests that "the reason you need to decentralize is because managers who are closer to the action are much more likely to know their problems and can devise better solutions than central-level officials who are hundreds of miles away."

Government managers planning to decentralize the management of services need to pay attention to several critical issues. First, managers must be clear about their reasons for decentralizing services and realistic about the anticipated benefits. Second, managers must define who will have responsibility for planning and implementing programs, authority for resource allocation and expenditure, and accountability for program performance. (These elements should not be widely separated in the organizational structure.) Third, managers should examine existing laws and regulations to find ways to transfer authority to lower levels of government and the community. Fourth, managers must be prepared to make fundamental changes in leadership and decision-making styles and operating procedures, and to develop institutional and staff management capabilities at the local level.

Working Solutions—Philippines

The Philippines Decentralizes Services

In 1991, the Philippine Government passed the Local Government Code, transferring the responsibility for providing social services (with the exception of education) to local government units (LGUs). Within four years of implementation, the LGUs are to receive 40 percent of the federal government tax revenues. In addition, LGUs can now keep the taxes they raise, and have the authority to introduce new taxes. Key components of the Philippines' decentralization plan include:

- Transferring responsibility for the provision of most government services, including family planning services, from the central government to local government units—provinces, cities, and municipalities (districts);
- Transferring staff from the Department of Health (DOH) to the LGU health offices;
- Providing specific guidelines detailing the responsibilities of the DOH, as well as the functions of the local health authorities;
- Making the LGUs responsible for developing their own plans (including targets and budgets), and monitoring and coordinating activities at the local level;
- Giving provinces and cities the responsibility for planning and managing programs, and coordinating the population activities and family planning services that are provided through provincial and city hospitals;
- Giving municipalities the responsibility for providing services;
- Keeping the responsibility with the DOH for monitoring and evaluating local programs, setting standards for service delivery, and providing technical support services including logistics, training, and aspects of IEC and MIS.

Making Decentralization Work

To make decentralization successful in the Philippines, managers at the central and local levels are devising strategies to carry out their new responsibilities. Some management issues that they are addressing are:

- Establishing population and family planning programs with broad-based support at the local level. This requires developing well-trained, capable local staff that can act as advocates for the program, and creating a base of support among local civil servants;
- Training local managers in planning, coordinating, and implementing family planning programs, and in budgeting, financial accounting, target setting, and using program information to make management decisions;
- Building the capability to collect, analyze, and use simple demographic data;
- Creating the opportunity for local governments to obtain additional funding from central-level sources;
- Creating accounting procedures that minimize the opportunities for misuse of resources;
- Changing the focus of the central ministry from implementing programs to assisting in policy formulation and providing technical assistance in planning and monitoring programs.

Source: McGirr and Smith

Meeting the Challenges of the Next Decade

The family planning field is rich in valuable lessons from countries and programs that have made significant gains both in expanding access to services and improving the quality of programs. There are many well-documented examples of successful programmatic strategies and interventions that can stimulate demand and expand the reach of family planning services.

Family planning managers are working hard to provide access to services that offer low-cost, high-quality, culturally-acceptable contraceptive methods to people in places where they live and work. Family planning managers are increasingly tailoring interventions to meet the changing needs of their clients, targeting appropriate services and family planning messages to special population subgroups, employing special strategies—IEC campaigns, CBD programs, social marketing, and postpartum and post-abortion counseling—to expand access and reach special populations. Their hard work has:

- Increased resources for development and population programs;
- Improved human resource capacity at the central and local levels;
- Integrated research findings into the decision-making process;
- Upgraded general management systems, particularly information systems;
- Increased user participation in the design and implementation of programs;
- Expanded partnerships between the public, private, and voluntary sectors in program planning and implementation.

"A principal challenge for managers will be to think about things differently and to get people to do things differently. First, governments need leaders who can imagine a different future. Then, the government needs to be able to communicate this vision in a clear, inspirational, and carefully articulated mission."

– Margaret Neuse

This special issue of *The Family Planning Manager* has examined six crucial management challenges facing the international family planning community, and has discussed management strategies for meeting those challenges. The next ten years will be marked by renewed efforts to obtain additional resources, address new concerns, and use new approaches to family planning, reproductive health, human sexuality, social and economic development, and the environment. This new thinking will have important implications for how future programs are designed, planned, implemented, coordinated, monitored, and evaluated.

The next decades will be marked by a broadened agenda that links:

- Reproductive health with reproductive rights;
- Population growth with the protection of the environment and sustainable development;
- Family planning services with education, empowerment, human sexuality, and relations between men and women;
- Urbanization, international and internal migration, and a burgeoning number of displaced persons with changes in the delivery of health and family planning services.

The broadened agenda of concern for the environment, for more equitable gender relations, and for reproductive rights will require managers to examine more closely the organization and delivery of family planning and reproductive health services. Creating demand for and supplying reproductive health services are mutually supportive processes. Improving performance will depend on the family

planning manager's ability to make services more available and accessible. Improving quality will require identifying and solving problems creatively. Managers will be called upon to think strategically and to build organizations with vision, community orientation, and fiscal integrity. Margaret Neuse stresses that governments will need to go beyond their current role of service provider and become visionaries and resource facilitators for all aspects of health and family planning program development. Ms. Neuse points out that "a principal challenge for managers will be to think about things differently and to get people to do things differently. First, governments need leaders who can imagine a different future. Then, the government needs to be able to communicate this vision in a clear, inspirational, and carefully articulated mission." To help managers meet these challenges, donors, international organizations, and national governments must increase their commitment to supporting the development of a critical mass of family planning managers who can provide quality reproductive services to increasing numbers of people.

Family planning managers have been the unsung heros of the past. They have designed and operated new service delivery systems such as community-based distribution, found innovative ways to finance programs, developed creative partnerships among different sectors, and established logistics and information systems that have helped couples and individuals to improve their reproductive health and exercise choice in bearing children. In the next decade, family planning managers will continue to be pioneers in improving the responsiveness of programs to the changing needs of the next generations of men and women, and in making family planning an integral component of the development process. These family planning managers around the world will implement this broadened agenda, translate the agenda into specific policies, and turn these policies into action.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On the importance of integration in gaining acceptance for family planning . . . *One reviewer adds,* "Family planning should be promoted in the context of women's health, safe motherhood, and child survival. This type of integrated approach makes it easier to gain acceptance for family planning in situations where there is strong opposition to it."

On the importance of logistics . . . *One reviewer points out,* "Although logistics was not featured as a major management challenge for the future, a functioning logistics system is critical to providing effective family planning services. In fact, I noted that logistics was a key component of meeting the challenges of providing effective rural services, improving service quality, integrating services, and helping national programs to grow."

On using fees to enhance client services and staff morale . . . *One reviewer comments,* "Experience shows that when clinics collect fees for services, the whole process is enhanced if the fees stay with the service site that collects them. The income can then be used to enhance client services or the clinic facility. This way both the clients and the service providers can experience the benefits derived from the fees."

On time spent with the client and quality of care . . . *One reviewer suggests,* "In terms of quality of care, I think that there should be a balance between time spent with the client and the efficient use of time. In small clinics where there may be only one nurse provider, the amount of time spent with the client becomes a key issue; it is important to find the right balance based on the situation in each clinic."

On sharing the cost of family planning programs . . . *One reviewer warns,* "A more realistic portion of the cost of family planning programs that developing countries must bear needs to be determined. Currently, the developing countries will pay two-thirds of the cost whereas the donor countries pay one-third. This ratio must change if targets contained in the World Programme of Action are to be achieved."

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Contributors to this issue of *The Family Planning Manager*

The editors would like to extend their appreciation to the numerous family planning professionals who helped to develop this issue of *The Family Planning Manager*. Without the opportunity to interview a wide range of family planning managers from field workers to policy makers, it would have been impossible to gain such a breadth of perspective on the critical management challenges facing family planning managers today. The editors greatly appreciate the expert review and feedback provided by the International Review Board of *The Family Planning Manager* and by several additional experts in the population field. Finally, the editors are grateful to their FPMD colleagues who helped to write this issue and provided valuable input during the review process.

Personal Interviews

Jane Bertrand, Professor, Department of International Health and Development, Tulane School of Public Health and Tropical Medicine

Alfonso López Juárez, Director, MEXFAM, Mexico

Peter Mokaya, Director, Seventh Day Adventist Rural Health Services, Kenya

Kalimi Mworia, Director, Partnership Challenges Fund Project, International Planned Parenthood Federation

Margaret Neuse, Deputy Director, Office of Population, U.S. Agency for International Development

Cristina Rentería, Director, Reproductive Health Program, the Caja Nacional de Salud, Bolivia

Steven Sinding, Director of Population Sciences, The Rockefeller Foundation

Margaret Thuo, Program Manager, Family Planning Association of Kenya

Abu Sayeed, Program Director, Local Initiatives Program, FPMD/Bangladesh

Alex Zinanga, Executive Director, Zimbabwe National Family Planning Council

Contributing Authors

Catherine Crone Coburn, Director, FPMD project; Nancy Murray, Director of the Latin America and Caribbean Unit; Alison Ellis, Director, Asia/Near East Unit; Paul Fishstein, Senior Program Officer for Asia/Near East Unit; Saul Helfenbein, Deputy Director of MSH's Population Program; Riitta Liisa Kolehmainen-Aitken, Senior Program Officer for Evaluation; Walter Mertens, Director of Evaluation; Marc Mitchell, Director, Technical Unit; Edgar Necochea, Senior Program Officer for Latin America and Caribbean Unit; Melanie Powers, Director of Operations; Deborah Ruhe, Senior Family Planning Management Advisor; Marjorie Smit, Director, Africa Unit; Sylvia Vriesendorp, Organization Development Specialist.

CHAPTER ONE

Learning to Think Strategically

Strategic thinking is a powerful skill that clinic managers and supervisors can use in creating clinic or program plans designed to meet future goals and effectively use available resources. In the past, formulating strategy has been reserved for senior managers and policy makers of large organizations. However, family planning programs ultimately succeed or fail where contact with clients occurs, so strategic thinking at the clinic and community level is absolutely essential.

The clinic manager's time is usually consumed with the critical activities of daily operations: giving staff assignments, responding to requests from the central office, assuring that supplies are ordered, scheduling staff time, and handling the emergency of the day. With so much attention on immediate needs, it is easy for the manager to develop an internal focus and lose sight of the big questions: "Why are we here?" "Is my program doing the right things?" and "What other services should we be providing?"

This issue of *The Family Planning Manager* explains how clinic managers and their staff can learn to use strategic thinking skills. It discusses the strategic issues of improving quality, expanding access, and increasing demand; shows managers how to address these issues by asking pertinent questions and getting appropriate information; and explains how to use the answers to make difficult choices about what to do and how to do it to ensure program success.

This chapter was originally produced as Volume III, Number 1 of ***The Family Planning Manager****, including the case scenario, "Analyzing Strategic Issues for San Miguel Clinic." The guest editors for the issue were Saul Helfenbein, Sara Seims, and Deborah Ruhe.*

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Developing Strategic Thinking Skills

Strategy is used in sports, games, military campaigns, business, and even in personal endeavors like home building, and career or vacation planning. Developing strategy allows managers to design approaches that help them to successfully meet the challenges of an often unpredictable future. Throughout history ancient tribes, villages, nations, armies, and merchant groups have engaged in strategic thinking in order to improve living standards, extend political influence, conquer enemies, or increase wealth.

In order to serve their clients, family planning managers need strategies that are appropriate to the geographic, demographic, economic, social, and cultural conditions in which their programs operate. By developing strategic thinking skills, managers can more easily ensure that their programs respond to the demographic and social changes that occur in the enviroment in which they work.

To think strategically, family planning managers must step back from the daily activities of providing services, running their clinics, managing outreach, or administering information, education, and communication (IEC) programs. They start thinking about the future needs of their clients, how best to serve these clients, and how to link what they are doing today with what they need to do in the future. A good strategy can provide a road map to the future. It shows you where you want to go and helps you choose the best route(s) to take you there.

Making choices about how you will achieve your program goals is difficult because the best choices are not always obvious. Strategic thinking enables managers to identify issues that are critical to the long-term success of the family planning program and to ask questions whose answers will help to anticipate the future needs of their clients and programs.

The main strategic issues of **improving quality**, **expanding access**, and **increasing demand** for services are well understood by family planning managers. What is less well understood is how to meet the future needs and how to take appropriate actions to address them. While the people who work at the national or organizational level may develop strategies on a much broader scale than people working in a clinic, *everyone* needs to think strategically to ensure that their strategies make sense, are realistic, and produce the intended results.

This chapter presents the kinds of questions that family planning managers need to ask that will help them to gather the information they need to effectively improve the quality of their services, and expand access to and increase the demand for their services. It demonstrates how managers can structure their strategic thinking and work with their staff to answer the strategic questions and formulate effective strategies for achieving program and organizational goals.

Creating Clinic-Level Strategic Thinkers

When you hear news about clients, donors, technology, economy, politics, or employment, and find yourself asking what this news will mean for the future of your clinic, you are thinking strategically. When you envision what your clinic could be like in three years and what it will take to get it there, or begin to anticipate the future needs of clients or the future role of donors, you are thinking strategically. When you identify groups of clients with special needs, choose a new service delivery approach, or introduce new ways to attract clients to become acceptors or to motivate them to use contraceptives effectively, you are thinking strategically.

Strategic thinkers ask questions like **"Is my program doing the right things?"** This is a strategic question and forms the basis for setting future directions for your clinic or program. The strategic thinking approach discussed in this chapter will help to ensure that your future directions are compatible with the mission and goals of your organization and can be achieved by using existing resources, or resources acquired as a result of your strategic thinking efforts.

Strategic thinking is fundamentally different from thinking about your daily operations, which involve multiple activities including counseling clients on the choice of contraceptives, collecting data and filling out forms, ordering supplies, making sure vehicles are working, giving staff assignments, selecting personnel for training, organizing continuing education activities, analyzing and using information on family planning services, and working with the community to promote family planning awareness and services. When managers think about day-to-day operations they usually are asking **"Is my program doing things in the right way?"** This question helps to continually examine whether activities are being carried out in the most effective and efficient way. Management techniques such as Continuous Quality Improvement (CQI) are focused on addressing this type of question.

This chapter focuses on the question **"Is my program doing the right things?"** Discussing and answering this type of question will shape the future direction of your clinic or program because it leads you to think about the types of clients you serve, the kinds of services you offer, and whether your particular program will significantly contribute to improving the well-being of your clients, as well as helping to address the population and health challenges in your country.

Reviewers Confirm the Benefits of Thinking Strategically

The Family Planning Manager asked reviewers to provide examples of how strategic thinking made a difference to the delivery of family planning services in their programs. Following is a sample of their comments:

- "Thinking strategically about the unmet need for family planning among our clients resulted in the addition of special programs for youth."
- "Over the past two years, we have utilized strategic thinking at both the Board and field staff level. This has resulted in changes in our program and a reallocation of program resources to emphasize 1) fundraising and resource development, 2) advocacy for inclusion of family planning services in government clinics, 3) providing family planning services, and 4) providing IEC services."
- "When project support from donors ended without a new agreement in the pipeline, strategic thinking saved our program. By thinking strategically, we anticipated this situation and were able make critical changes to keep our program going, including borrowing funds from other non-governmental organizations (NGOs) that were still receiving support from other funding sources."

Asking "Is my program doing the right things?" Kinds of Questions

Are we serving the right people? Managers ask this question to examine whether the clinic is attracting and serving all those who need services. A good program will tailor its services to meet the needs of many different groups including, for example, sexually active youth, men, and low-parity women.

Are we offering the right mix of services? This question looks at whether you are providing the services that your clients need. To determine what services you should offer, you must know your client characteristics: age, sex, marital status, number of children, desired family size, location, as well as what services you are able to make available to them. This information will help managers to decide what types of services they should be providing in order to reach the largest number of clients.

Are we overcoming barriers to services? Asking this question helps family planning managers to look at the barriers to service delivery that often prevent programs or clinics from performing as well as they might. There are medical, cultural, management, resource, technological, political, and legal barriers that all play a part in limiting the growth of family planning programs. Managers must identify and try to eliminate such barriers to ensure future progress in their program.

Does the clinic staff set a good example for our clients? When clinic staff use reproductive health and family planning services themselves, they become more effective advocates for the family planning program.

Are our clients satisfied with the services that we provide? Asking this question focuses your attention on fulfilling the needs of your clients. Are you doing everything that you can do to ensure that your clients' needs are being met so that they continue to use family planning?

Are we creating support for family planning in the community that is being served? Many managers recognize that community ownership of the family planning program is critical to its long-term success and viability. Managers must develop ways in which the community can participate—individually and collectively—in promoting and providing services.

As in a jigsaw puzzle, your answers to these different questions will supply small pieces of the big picture. They will help you to understand what your program looks like today and to visualize how it may look in the years to come. This type of big picture provides multiple points of view from which you can evaluate future options. Although there is no way to guarantee that you will make the best choice, strategic thinking will help you reduce the chances of making poor choices.

Assessing Your STQ: Are You Thinking Strategically?

People who look at the big picture and see the relationship of different elements of the family planning program generally are thinking strategically and are likely to use the skills described in this chapter on a regular basis. To find your strategic thinking quotient and see to what extent you are thinking strategically, take this brief quiz.

Strategic Thinking Quiz (Answer each question by circling YES or NO.)

1.	Can you identify the primary target group(s) in your program (i.e., adolescents, low-parity women, rural couples, men, etc.)?	**Yes**	**No**
2.	Do you know the special characteristics of these clients (income level, marital status, parity, catchment area)?	**Yes**	**No**
3.	Do you know the contraceptive preferences of your clinic's target group(s)?	**Yes**	**No**
4.	Do you know which characteristics of your target group(s) most influence their choice of contraceptive?	**Yes**	**No**
5.	Do you know if the contraceptive needs of the client groups have changed over the past three to five years?	**Yes**	**No**
6.	Do you know what changes are likely to occur over the next three to five years in terms of client groups, contraceptive preferences, and service delivery approaches?	**Yes**	**No**
7.	Do you know if the national family planning program has identified new priority target groups?	**Yes**	**No**
8.	Do you know if your clients are seeking other sources of supply in order to find a better selection of contraceptives?	**Yes**	**No**
9.	Do you know, on the average, how long clients must wait before being seen by a provider in your clinic?	**Yes**	**No**
10.	Do you know which ways of delivering contraceptives are the least costly?	**Yes**	**No**
11.	Do you know to what extent unmet demand exists in the area that your clinic serves?	**Yes**	**No**
12.	Do you know what complaints your clients have about your services?	**Yes**	**No**
13.	Do you know if your staff have any prejudices against certain contraceptives and are not offering them to clients?	**Yes**	**No**
14.	Do you know if nurses or doctors in the nearby hospital or health center give priority to the clients you send for long-term methods?	**Yes**	**No**
15.	Do medical and reproductive health problems such as sexually transmitted diseases (STDs) prevent your program from increasing the number of users of long-term methods?	**Yes**	**No**
16.	Do you know which segments of your target group(s)are likely to be able to pay for services?	**Yes**	**No**
17.	Do you know how much clients would be able to pay?	**Yes**	**No**
18.	Do you know how much income you need in order to cover all the costs of your family planning services?	**Yes**	**No**
19.	If there are other family planning providers in your area, do you know why your clients choose to come to your clinic and not to the others?	**Yes**	**No**
20.	Do you know what barriers clients experience in obtaining contraceptives?	**Yes**	**No**

Scoring: For each question that you answered YES, give yourself five points. Total your points to find your score. If you have a score of 75 points or higher you are already thinking strategically and you can use this chapter to help other people think strategically. If you score between 50 and 75 points, you are on your way to becoming an strategic thinker and you can use the skills explained in this chapter to improve your strategic thinking ability. If you score below 50, read this chapter carefully and try to incorporate the strategic thinking process into your daily activities.

QED for Strategy

Strategic issues are those that directly affect the ability of the family planning program to attract and retain clients. Addressing these issues helps to guide the program so that it can expand services to reach specific client groups and work with those groups to change behaviors that are critical to improving maternal and child health (MCH), as well as to achieving family planning program goals.

Over the years family planning managers have identified many strategic issues that fit these criteria. These can be summarized as QED for strategy:

- **Q - improving the quality** of services;
- **E - expanding access** to family planning services;
- **D - increasing demand** for services among key groups in the population.

Q: Improving the Quality of Services

The quality of family planning services is an important strategic issue because it deals with client satisfaction and service effectiveness. Attracting new contraceptive users, reducing discontinuers, ensuring that contraceptives are effectively used to prevent pregnancies as planned, and reducing or preventing contraceptive side-effects or other complications all depend on offering quality services. Providers who do not continuously seek to improve quality may have a difficult time making their program grow, or may experience high numbers of discontinuers.

To think strategically about improving the quality of services, consider how you can:

- Make sure that a wide range of contraceptive methods is available, so that clients can choose methods that are appropriate to their reproductive needs and health status;
- Develop a system for continuous quality improvement (CQI) within your programs;
- Integrate counseling and IEC programs to help clients make informed choices in selecting contraceptives and to ensure that they use contraceptives effectively;
- Develop an effective follow-up system to identify potential discontinuers and to ensure that clients continue to use and be satisfied with your services;
- Reduce barriers to services within the family planning service delivery system by setting more convenient clinic hours, managing client flow to reduce waiting time, treating clients respectfully so that they keep coming back to your program, and eliminating provider prejudices for and against certain types of contraceptives.

Examples of Barriers to Acceptance of Vasectomy in Kenya

This example illustrates the kind of information that providers need in order to effectively address and reduce the barriers to acceptance of surgical contraception for men.

- Men have limited knowledge about the vasectomy procedure.
- Men have fears about the health and side effects, especially loss of sexuality.They often equate vasectomy with castration.
- Men fear that their children may die and they will be unable to have more.
- Many men believe it is the women's responsibility to use family planning.
- Men want to talk to other men who have had vasectomies, but since the pool of acceptors is so small this is difficult.
- Many service providers are misinformed or don't have complete information.
- Men want to obtain information from male health workers, but most family planning service providers are women.
- Men want to talk to doctors about the procedure, but many doctors have little knowledge of vasectomy.

Source: AVSC Working Paper No. 4, 1993

E: Expanding Access to Services

Expanding access to family planning services is important for meeting clients' needs as well as for achieving lower fertility levels. There are many factors that can affect a clinic's ability to bring services to a larger population. These include: the socio-economic status of the client, the special needs of the client (for example, young adults will probably not want to attend the same clinics as their parents), rural or urban geography, the ability of providers to provide follow up to clients, the supply systems for contraceptives and other pharmaceuticals and equipment, the capacity of the referral systems, the scheduling of services, the charges for services, and the skills and attitudes of service providers. Expanding access may be further limited by medical, technological, administrative, political, and legal barriers that are deliberately or unintentionally imposed.

Expanding access becomes increasingly important as family planning providers start to address unmet demand in the population or divide the population into different client groups in order to serve the specific needs of those groups. Can your current service delivery system meet all needs in a highly diverse client environment? What changes should be introduced?

To think strategically about expanding access, consider how you can:

- Coordinate work and give support to other providers in your area (including private physicians, nurses, and midwives in both the public and private sectors);
- Develop ways to expand your family planning services and maintain or lower their cost *(for example, expanding or changing hours of operation, or having separate entrances and waiting areas for adolescents)*;
- Enlarge the community's role in the service delivery system *(for example, training community-based volunteer workers to provide family planning services)*;
- Identify groups where there is a high degree of unmet demand and determine how you can increase access to your services to meet the demand *(for example, employing mobile teams in areas where there are no fixed clinics)*;
- Integrate family planning services with MCH services, primary health care activities, and hospital/clinic maternity services where feasible;
- Create or strengthen referral systems to improve access to more effective long-term clinical methods.

D: Increasing the Demand for Services

Even if a program offers high-quality services and provides good access to those services, it will not be sustainable without stimulating strong demand for services. If demand is weak, instituting even a small fee for services in an attempt to recover costs could cause clients to stop coming to your clinic, or worse, to discontinue contraception altogether.

Family planning managers realize that many people do not seek, want, or think that they need family planning services. Managers must actively work to increase demand for services by reaching out to these people and by providing opportunities to discuss their concerns, provide information and education, and encourage them to seek and accept family planning services. Family planning managers also know that they must provide regular and accurate information and advice about reproductive health concerns and family planning services if they want to attract new clients and retain current clients. Only by continually motivating and educating clients can a program expect to realize long-term changes in attitudes and behaviors that will induce clients to continue to practice family planning effectively.

To think strategically about increasing demand for services, consider how you can:

- Identify and use satisfied customers to inform, educate, and motivate their neighbors to use family planning;
- Identify ways to educate and motivate specific groups of people whose use of services is low or inconsistent;

- Provide information and services geared to the needs of specific groups *(for example, having youth or women work with their peers to educate and motivate them about reproductive health)*;
- Anticipate changes in the social and demographic patterns that will affect demand over the next few years;
- Integrate family planning programs with other development activities in your area in order to increase knowledge of family planning, encourage positive changes in attitudes and practices, and secure local financial support.

Working Solutions—Kenya

The Kenya Seventh Day Adventist/Rural Health Services (SDA/RHS) program recently held a series of meetings to discuss strategic issues and formulate strategic directions for their program. The purpose of the exercise was to explore ways to improve their services, strengthen management systems, utilize resources better, and improve the prospects of future sustainability. During a four-day workshop the SDA/RHS team addressed the following five strategic issues.

1. How can RHS attract, motivate, and retain appropriately skilled and trained staff who understand and share its philosophy? (Quality)
2. How can RHS improve its management systems and effectively utilize its governing board as a resource? (Quality)
3. How can RHS strengthen its weak financial base while ensuring future sustainability and consistency with its mission? (Access)
4. How can RHS improve its service delivery network and capability? (Access)
5. How can RHS maximize its linkages with government agencies, donors, other development organizations, and the local community? (Quality, Access, and Demand)

Thinking Strategically in Family Planning

Thinking strategically requires that you exercise certain skills so that you can more easily choose the best course of action. Many managers are natural strategic thinkers and almost unconsciously follow a logical process in moving from thought to action. The process outlined here—made up of five steps—can help all managers structure their strategic thinking.

- Create a guiding framework
- Identify your strategic options
- Evaluate your options
- Select your options
- Transform your strategies into actions

Step 1: Create a Guiding Framework

Charting your future directions requires that you have a clear idea of where you want to go. Developing or clarifying your organizational mission and program goals is the first step to thinking strategically.

If your clinic or organization has a mission statement, start by reviewing it with your staff. If you do not have a mission statement, work with your staff to develop one. At the end of this step you should have a shared understanding of your program's purpose and values. This understanding will be the foundation on which you will build your future goals, strategies, and activities.

How to . . .

Define Your Mission and Strategic Goals

The mission statement is a broad, general statement that explains the type of organization, its main purpose, and its values. The mission statement helps to unify the vision of the organization's purpose. It should answer the questions, "Why does our organization exist?" and "Who are our beneficiaries?"

Sample Mission Statement

Parsante Health Services believes that access to reproductive health services is a fundamental human right and strives to provide high quality, low-cost reproductive health information and services to men and women of reproductive age.

Goals are directly related to the organizational mission and describe, in general terms, the benefits to the specific populations that will result from your activities.

Sample Goals

To serve the needs of the rural poor and underserved populations.

To ensure that women have a choice of a wide range of contraceptive methods.

Step 2: Identify your Strategic Options

Once you have developed your guiding framework, you need to identify specific strategic issues that are important to your program. To facilitate this process, it is important to examine your clinic's capabilities and identify any opportunities or constraints that exist in your setting for improving quality, expanding access, and increasing demand. This type of analysis is called a QED analysis.

A QED analysis will help you and your staff to collect and analyze basic data that you can use to develop strategic options for your clinic that both build upon the clinic's strengths and take advantage of any potential opportunities.

How to . . .

Conduct a QED Analysis

A QED analysis can be done quickly and inexpensively and should be done with other clinic staff. Form a team of clinic staff to work on the QED analysis and conduct a series of meetings and discussions within and outside the clinic. Be as open as possible about the weaknesses and do not pass over significant problems that exist, as future plans will be based on this assessment. To facilitate the analysis process, you can formulate a list of questions for your group to address.

Sample Questions for the QED Analysis

The following questions are some that you should consider in your planning sessions. Review these questions and add any that may be more relevant to your particular program. As you discuss and formulate answers to each of these questions, decide whether they represent your program strengths or represent opportunities for future program development.

Continued on next page

When considering these questions, think about your program from a marketing perspective, and how you can attract, serve, and retain clients by keeping in mind:

- the *client* (how to satisfy client needs);
- your *organization* (how best to use your organization's strengths);
- other *providers* (how to coordinate your services with those of other providers to reach the largest numbers of clients, while keeping program differentiation in mind).

Concerning Quality:

- Are staff trained and motivated adequately so that they can do their jobs properly?
- What are the main areas where training is needed to upgrade staff capacities?
- Do staff have the necessary materials and equipment to provide quality services?
- Are family planning services offered to clients who come to your clinic for other types of health care?
- Do staff have positive attitudes toward family planning and service delivery?
- Are your counseling and IEC messages consistent so that your clients can make informed choices about contraceptive use?
- Is the clinic staff attentive to the clients' needs, questions, and concerns?
- Is your program appropriate to the socio-economic and health status of families in your area?
- Are your clients offered a wide range of contraceptive methods?
- Are all the contraceptives you offer always available to your clients or do you have supply problems?
- Are clients going to other clinics to receive services? If so, why?
- Do other clinics offer contraceptives or other services that your clinic does not offer?
- What types of outreach and follow-up services do you provide to your clients?
- Is your facility in good condition?

Concerning Access:

- Is your facility being fully utilized?
- Is there room for expansion at your facility?
- Does your information system give you the information that you need to plan for and assess the performance of the clinic?
- What kinds of specialized services are you providing for special groups, for example men, sexually active unmarried adolescents, newly marrieds, and others?
- What is the greatest unmet need for family planning in your catchment area?

Continued on next page

- Does your program provide long-term methods or facilitate referral to programs that do provide these methods?
- Does your program offer community-based services that operate in conjunction with your clinic?
- Is family planning available from other sources in your area? What are these sources? (Include private physicians, social marketing outlets, government clinics, non-governmental clinics, etc.)
- What coordination mechanisms exist or could exist with other providers?
- What are your clinic's current and projected sources of funding for the next 3 to 5 years?
- What can be done to increase your financial resources?

Concerning Demand:

- In what ways has your program been effective in creating demand for your services?
- What are the characteristics of your clients and how might these be changing? (Consider ages, percent female/male, marital status, types of methods used, number of children desired, etc.)
- Have you identified specific groups of potential clients where demand is low or the use of services is inconsistent?
- Do you provide services geared to the special needs of these groups?
- Do you offer services at hours that are convenient to your clients?
- What activities has your program initiated that change the attitudes and behaviors of clients and potential clients?
- Have you integrated family planning with socio-economic development activities, such as income-generating initiatives or school programs?
- What are the community and religious attitudes towards family planning in general and in your clinic in particular?
- What is the status of women and how does this affect their ability to seek quality family planning services?
- What are the anticipated changes in the social and demographic patterns that will affect demand over the next few years?
- Does it make sense to open a branch clinic in a growing neighborhood?
- How can the media be used to help increase demand?

The QED analysis will help you to identify opportunities for improving quality, expanding access, and increasing demand within the context of your management capabilities and constraints that exist in your setting. Use the information in the QED analysis to identify potential future strategies that you can employ in your program. Concentrate on how your services can be refocused to better serve your current clients, attract new clients, and increase the demand for family planning.

Step 3: Evaluate Your Options

Identify options that are compatible with your mission and goals. Once you have identified some strategic options, you need to evaluate each option to see the extent to which it furthers your organizational mission and brings you closer to achieving your long-term goals. Discard those that do not seem to be compatible with your organizational mission and goals.

Weigh the advantages and disadvantages of each option. Prepare a simple table to compare the advantages and disadvantages of each option. The table should include the potential benefits and risks of implementing each option in terms of both your clients and your organization. Often this kind of analysis reveals that it is better to develop a combination of service delivery systems where one system can support another, rather than investing exclusively in one type of delivery system.

Sample Table for Weighing Advantages and Disadvantages

In this example, the QED analysis had indicated an opportunity to expand services to clients by developing additional delivery systems. In this step, the manager and clinic staff had identified several strategic options for expanding services, including mobile clinics, community-based distribution (CBD), and a variation on CBD, depot holders. They then created a table to weigh the advantages and disadvantages of each option and began with the CBD option. Part of this table is shown below.

Advantages of CBD Delivery Systems	Disadvantages of CBD Delivery Systems
1) Will provide more regular and frequent contact between service provider and client.	1) Will require high degree of supervision, as CBD workers are often nonprofessionals or volunteers.
2) Will minimize burden on clients in traveling and waiting time—may improve client satisfaction.	2) Promotes temporary methods—may make program dependent on temporary methods—causing problems in use effectiveness.
3) Would reduce risk of discontinuation or interruption in contraceptive use, since contraceptives will be brought regularly and on schedule to the client.	3) May be difficult to link with clinic services—will need to develop effective referral system.
4) Is more economical—we can mobilize a large cadre of CBD workers for the same cost as a smaller group of nurses, midwives, or doctors.	4) May not be a good fit with our organizational goal of increasing use of more effective long-term methods.

The clinic staff then developed a similar table for the other service delivery approaches and went on to compare the advantages and disadvantages among the three systems.

Step 4: Select Your Options

Evaluate each option in terms of your available resources. Consider the availability of technology and the existence of expertise to design and plan programs, as well as the funds and personnel for implementing programs and services.

Make a list of human and financial resources that you estimate would be required to implement this option. Make an assessment of your ability to acquire the resources that you have identified and select the strategies that have the most likelihood of success.

Step 5: Transform Your Strategies into Actions

Managers who *think* strategically do not *act* strategically unless they can transform their ideas into action. The final step in this process is to communicate the mission, goals, and the strategies that you have decided to pursue to all interested parties, including your clients, your staff and superiors, government officials, and the community at large. The following example illustrates how you can communicate your strategic directions and show how you intend to achieve your goals.

Communicating your Mission, Goals, and Strategies for Effective Action

Mission Statement

Parsante Health Services believes that access to reproductive health services is a fundamental human right and strives to provide high quality, low-cost reproductive health information and services to men and women of reproductive age.

Long-Term Goals

- To provide high-quality family planning and IEC services delivered with care and respect to meet the needs of the individual client.
- To assure that women, men, and youth have access to the family planning services they seek.
- To assure that women, men, and youth know where they can obtain family planning services.

Strategies for Improving Quality

1. Establish a referral system between the clinic and the local hospital to provide clients with sterilization and Norplant services.
2. Assess training needs of staff and develop a plan to ensure that staff skills are adequate to meet the needs of clients.
3. Establish a client advisory committee to assist in assessing client satisfaction with clinic services and to recommend service delivery improvements.

Strategies for Increasing Access

1. Assess the needs of youth and create a program to specifically address their needs.
2. Work with the hospital to provide postpartum women with family planning services.
3. Develop an outreach program that provides a forum for men to discuss family planning and prevention of STDs.

Strategies for Increasing Demand

1. Create enthusiasm and support for family planning among religious and community leaders.
2. Organize discussion groups in rural villages to encourage family planning acceptance.

Strategic Thinking in Action: Addressing Missed Opportunities

Strategic thinkers constantly scan the environment for information that they can use to identify potential strategies for improving quality, expanding access, and increasing demand. In this Working Solution, family planning managers used the results from a hospital-based study to increase demand and expand access to family planning services.

In Kenya, a study of 1,000 Kenyan women who gave birth at two hospitals revealed that very few of the women had previously used contraception, but 90 percent of them expressed a desire to use contraception and most said their last pregnancy was unwanted or mistimed. The study found that very few women were comfortable raising the subject of family planning while they were in the hospital, citing that the nurses were often too busy, they were afraid to approach the nurses, or there was not adequate privacy.

Clinic managers used information from this study to consider how they could transform this missed opportunity into strategies for increasing demand and expanding access. Subsequently they developed the following strategies for addressing these issues:

- Use CBD workers to visit women in maternity wards to provide them with information about your clinic's services, education about contraceptives, and some temporary methods for them to use.
- Train maternity ward personnel to provide family planning services and to inform women about the services available at the clinic.

Source: AVSC News

Using the Results of Your Strategic Thinking

Strategic thinking is a natural process of anticipating future client and program needs. It requires asking the right questions and effectively using the answers to these questions in a structured way. There are many different ways to use the information. Some managers may choose to embark on a formal process of strategic planning; others may incorporate the information they obtain from strategic thinking directly into their operational plans.

Once strategic issues have been identified and a plan has been developed to respond to these issues, strategic management begins. The resulting plan should be a dynamic tool to guide managers and staff. It should be referred to frequently for guidance and used to assess progress and clinic or program performance. At three- or six-month intervals it is helpful to ask questions such as:

- Are we meeting our goals?
- Are our assumptions and strategies still appropriate?
- Do we need to make changes or adjustments, and if so, what are they and how will the changes be implemented?

Since strategic thinking is based on making assumptions about trends, there will always be surprises. New trends will emerge and unforeseen events will require that portions of the plan be modified. Remember, strategy is like a road map that will guide you towards your destination and the occasional detour will be inevitable, but by thinking strategically, you can anticipate the need for change and turn it into an opportunity for making program improvements.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On the differences between strategic thinking and operational thinking . . . *One reviewer points out,* "It is true that strategic thinking helps to ensure that future program directions are compatible with the mission and goals of the organization. But sometimes, strategic thinking may actually *change* the direction, mission, or goals of an organization. I think this brings out a major difference between strategic thinking and operational thinking—that flexibility and change is an essential part of strategic thinking."

On the importance of training to improve the quality of services . . . *One reviewer stresses,* "When it comes to thinking strategically about upgrading the quality of services, it is important to be sure to include training for those who are the first to encounter clients, such as promoters, vehicle drivers, receptionists, cleaning staff, and others. Initial staff hospitality and information-giving, based upon a sympathetic understanding of client concerns and knowledge of available services, go a long way in building trust and positive attitudes. These people may figure as importantly in a client's decision to return for services as product reliability or the delivery of medical and health care services."

On the importance of thinking strategically . . . *One reviewer writes,* "Strategic thinking and the development of new strategies is key to making our program more client-centered." *Another reviewer writes,* "A very important reason for thinking strategically has to do with the limited and sometimes decreasing funding for family planning programs. Thinking strategically can help us meet our clients' needs while making the best use of limited resources."

On stimulating the strategic thinking process . . . *One reviewer suggests,* "Clinic managers could be refreshed or reminded to think strategically at semi-annual clinic management meetings. Issues to be discussed during these meetings could be similar to those explained in this chapter."

On the issue of decentralization . . . *One reviewer points out,* "Our program is very dependent on foreign donor support, and program performance changes according to the availability of funding. Currently our program is undergoing a restructuring process that gives administrative control of the program to local providers. In this situation, clinic managers and supervisors need to think strategically to ensure that they provide services according to the plans and standards developed at the national level."

On achieving QED results . . . *One reviewer suggests,* "One technique that works well in achieving the kinds of things under QED—reaching new clients and understanding barriers and client attitudes—is the *promotora* program widely used in Mexico and other countries. In these programs, volunteer promoters are trained as peer counselors, information providers and, in some cases, providers of contraceptives. Promoters can be found among any population group. Sometimes they are paid a stipend, but mostly the acquired self-esteem and status among peers is adequate compensation."

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Checklist for Learning to Think Strategically

For Clinic Managers

- ☐ Introduce the concept of strategic thinking to your staff by explaining the difference between "doing *the right things*," and "doing things in *the right way*."
- ☐ Formulate critical questions that concern your clinic that deal with the question, "Is my program doing the right things?"
- ☐ Initiate a strategic thinking process to help structure your discussions with your staff about ways to improve quality, expand access, and increase demand.
- ☐ Work with your staff to clarify, or redefine, your organizational mission.
- ☐ Develop two or three organizational goals that relate directly to your mission.
- ☐ Conduct a QED analysis that focuses on answering specific questions that pertain to quality, access, and demand in your program.
- ☐ Determine which areas represent organizational or program strengths or opportunities for future program development.
- ☐ Evaluate your strategic options, taking into consideration your mission and goals, and the advantages and disadvantages of each option.
- ☐ Select your strategic option(s) and communicate your decisions to your staff and supervisors.
- ☐ Make concrete plans for putting your strategies into action.

For Mid- and Senior-level Managers

- ☐ Help clinic managers to think about the kinds of broad program changes that would influence quality, access, and demand.
- ☐ Assist clinic managers in conducting a QED analysis by looking at successes from other organizations and programs and how you can learn from their experience.
- ☐ Support strategic decisions and goals that result from the strategic thinking process at the clinic level.
- ☐ Use the strategic thinking process to focus your program so that you can use your existing resources and strengths to achieve your goals.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Analyzing Strategic Issues for San Miguel Clinic

The San Miguel clinic is located in a large town in the mountainous region of Rio Alto. The clinic opened in 1986 after the last national DHS survey, conducted in 1985, revealed that three districts in the Rio Alto region with predominantly rural populations, had significantly higher fertility rates and lower rates of contraceptive acceptance and use than other rural areas in the country. The districts also showed higher rates of infant mortality and serious nutritional problems among children under the age of five.

In the seven years since the San Miguel clinic opened, it had successfully attracted increasing numbers of clients. In fact, because of the popularity of the clinic, clients were now having to wait longer to see clinic staff. The clinic had been trying unsuccessfully to get their one half-time doctor to increase his hours to meet the client demand, particularly as the demand for Norplant and IUDs had been increasing—methods that only the doctor could provide. In addition to the half-time doctor, the current staffing for the clinic included: Mrs. Muñoz, the Nurse Supervisor; two nurses; a receptionist; a laboratory technician; and a housekeeper.

Though encouraged by the clinic's success in attracting new clients, Mrs. Muñoz, the Nurse Supervisor, had recently conducted an analysis of clinic data to learn more about the characteristics of the clinic's client population, to compare with the regional data from the Ministry of Health. The analysis had shown that 87 percent of the clients served at the clinic were from the town. This was disturbing because the clinic had been established specifically to serve the underserved, rural population. In addition, although less than seven percent of San Miguel Clinic's clients were adolescents, Mrs. Muñoz had noticed that more than half of these clients were coming to the clinic for pregnancy services.

Next month it would be time to conduct the annual operational planning sessions and Mrs. Muñoz needed her staff to help her to think strategically about the future of the clinic and the services that they provide to their clients. The success of the previous seven years was encouraging, especially since many women were now stating that they wanted to have 3 or 4 children instead of 5 or 6. Mrs. Muñoz wondered: Were clients able to get the contraceptive of their choice? What other factors were changing among the client population? What new or different services might their clients be wanting in the future? At what age were women or couples beginning to use birth control? Was this changing? What kind of services were other clinics in the area providing? What were the strengths and weaknesses of the services offered by San Miguel Clinic? What would the clinic's financial situation look like for the next two years? How could they better serve the adolescent and rural populations?

Mrs. Muñoz was anxious to work with her staff to find out more about what services their clients were asking for and to discuss with them how they could reformulate the clinic activities, so that they could improve the quality of their services, expand the access to their services to better serve the rural population, and be more prepared to deal with future changes in demand. She felt that these factors were the key to the sustainability of the clinic over the next five to ten years. Before beginning their regular workplanning and budgeting process, Mrs. Muñoz and her staff decided it was important to look at the strategic issues facing the clinic, given the increasing rate of pregnancy among teenagers and the number of women asking for IUDs or Norplant insertions.

Case Discussion Questions: Strategic Issues for San Miguel Clinic

1. **Identify three broad strategic issues that the staff at San Miguel Clinic should focus on during their discussions. Explain why these areas are strategically important.**
2. **For each strategic issue you have identified, suggest at least three critical questions that need to be answered that will help Mrs. Muñoz and her staff to develop strategic goals for the clinic.**
3. **Given the information provided in the case, what strategic directions do you recommend that Mrs. Muñoz and her staff consider during their upcoming operational planning session?**

Case Analysis: Strategic Issues for San Miguel Clinic

1. **Identify three broad strategic issues that the staff at San Miguel Clinic should focus on during their discussions. Explain why these areas are strategically important.**

The San Miguel Clinic staff could focus their discussion on the areas of improving the quality of services, expanding access to services, and increasing demand for services. These three areas are critical for improving the overall services of San Miguel Clinic.

Improving Quality:

The quality of services affects how satisfied your clients are and how effectively your clinic delivers services. In order to attract new clients and retain the clients you have, you must continually seek to improve quality.

Expanding Access:

San Miguel Clinic has a goal of serving a previously underserved population. In an effort to promote human rights and lower fertility, the services offered by the clinic must try to be responsive to the different needs of their client population.

Increasing Demand:

Without demand, the program will never be sustainable. It is just as important to create more demand as it is to serve unmet demand. Managers must provide opportunities to hold discussions with groups who do not seek out family planning services, to learn about the needs and concerns of these potential clients. Demand for services can be increased by tailoring programs to meet the needs of targeted groups of clients.

Case Analysis: Strategic Issues for San Miguel Clinic

2. For each strategic issue you have identified, suggest at least three critical questions that need to be answered that will help Mrs Muñoz and her staff to develop strategic goals for the clinic.

Improving Quality:

1. Are our staff sufficiently trained in every aspect of service delivery?
2. Are clients satisfied with how they are treated at our clinic?
3. Are we offering the widest range of contraceptives possible?
4. Are clients satisfied with the length of time they wait for services?
5. What barriers to services exist? Areas to examine include:
    - clinic location
    - ability of the clinic to reach specific groups of clients
    - hours of operation
    - transportation to and from the clinic

Expanding Access:

1. What groups are most in need of our services?
2. Can we expand services and maintain or lower the cost?
3. Do commercial outlets in the rural area sell contraceptive methods that can be purchased without a prescription?
4. Can we train nurses in Norplant and IUD insertion?
5. Can we establish an outreach or community-based service project?

Increasing Demand:

1. How could we work with various community groups to increase current knowledge about family planning and encourage positive changes in attitudes and practices among target groups?
2. Which specific groups of clients could most benefit from information or services tailored to their needs?
3. What changes in social and demographic patterns might affect demand for family planning services in the Rio Alto region over the next few years?

Case Analysis: Strategic Issues for San Miguel Clinic

3. Given the information provided in the case, what strategic directions do you recommend that Mrs. Muñoz and her staff consider during their upcoming operational planning session?

List at least two proposed strategies for each strategic area. For an example, please refer to page 39.

Improving Quality:

1. Train nurses to insert IUDs and to provide Norplant.
2. Assess the degree of client satisfaction with clinic services.
3. Provide referrals to maternal and child health services.

Expanding Access:

1. Establish special clinic hours for serving adolescents.
2. Provide IEC to adolescents through community youth programs.
3. Develop a community-based service for rural clients.

Increasing Demand:

1. Establish a volunteer, community-based IEC program to motivate clients in the rural areas to come to the clinic.
2. Interview current clients who come from the rural areas to learn how the clinic might attract and better serve more clients from the rural areas.
3. Organize IEC activities for men in the community.
4. Organize IEC activities in the schools for adolescents.

CHAPTER TWO

Developing Plans and Proposals for New Initiatives

Governments and donor organizations are eager to support program initiatives that create new family planning services, or expand existing services to reach underserved populations. Funders are interested in a wide variety of new initiatives, such as adolescent services, mobile clinics in rural areas, in-school information, education, and communication (IEC) programs, and many others. Family planning managers who develop well-thought-out and detailed project plans will have a powerful tool for implementing their programs, and for finding funding for their new program initiatives.

A good plan describes how an organization intends to improve or expand its services, and helps an organization clarify its goals and objectives and implement strategies to meet those objectives. It also helps potential funders to understand the funding needs of the organization and to see the potential value of their support.

This issue of *The Family Planning Manager* provides a framework for developing a plan for a new program initiative. It then suggests how to turn this plan into a proposal for funding. In addition to providing basic guidelines on writing each section of a plan, this issue gives advice on how to create proposals that will improve an organization's chances of securing funding for their new program activities.

This chapter was originally produced as Volume II, Number 4 of ***The Family Planning Manager****, including the case scenario, "A Proposal for Río Blanco Region." Authors of the issue were Janice Miller and James Wolff.*

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Using a Plan to Structure Your Project and Achieve Your Objectives

As a manager, you must constantly look for new challenges, better ways to serve your clients, and effective techniques that will maintain or improve the quality of the services you offer. Developing well-thought-out and detailed plans allows you to continually modify your programs and add new program elements to meet the changing needs of your clients.

Studies have consistently shown that planning and goal-setting can improve program performance. Developing a plan requires managers to look at the entire scope of work for an initiative or a program, and to break it down into its smaller parts to determine which activities must be completed when and by whom in order to achieve the planned objectives. Once the plan is broken down activity by activity, managers can then rebuild the plan. A total plan provides the structure for implementing the program, serves as a guide for effectively using human, material, and financial resources, and creates a common understanding of program goals and objectives among staff.

Many perfectly feasible projects fail to achieve their intended results, not because the idea underlying the project was flawed or because there was a lack of resources, but because the project lacked the full commitment of senior staff. Developing and using project plans helps managers think through a new project together with their supervisors. By involving senior staff in developing a plan, managers will be able to more easily convince senior managers that the project will work, and they will be more likely to get the full and active high-level support that is critical to the project's success. The reverse is also true. If senior managers are developing plans, it is essential to involve more junior staff in the development process. Often junior staff who are working with clients on a day-to-day basis have a more realistic sense of which changes would be most practical and would most directly serve the needs of the clients.

A plan also can be used as a marketing tool for your idea or initiative, and can serve to make a case for increasing financial support for the program. With a good plan in hand, you can easily create an effective proposal that can be used to convince potential funders of your ability to design and implement a successful project that will expand access to family planning services and improve their quality.

This chapter both emphasizes the skills needed to develop an effective plan for a new program initiative and provides guidelines on developing a detailed budget for that initiative. In addition, the chapter goes on to explain how to take the same plan and turn it into a proposal for funding the initiative. Managers who can effectively use their planning skills to develop plans that can be used as tools for finding funding will ultimately have more control over their resources and will be more likely to achieve their objectives.

Organizing and Developing a Written Plan

A good plan should describe the type of project that you intend to implement, the expected results, the plan of activities for setting up and implementing the project, the way that progress will be tracked, the reporting system, and the cost of carrying out the project. The plan should contain distinct sections that clearly describe:

- The existing problem or need that the project will address and the proposed solution;
- The goals and objectives of the project, and the time frame for achieving the objectives;
- A general activity plan for the term of the project, including how the activities will be carried out, who will be responsible for each activity, and when each major activity will be completed;
- A plan for monitoring progress and evaluating the results of the project;
- A reporting plan and schedule, including how the project will manage its finances;
- A projected budget for at least the first year of the project, and a summary budget for the life of the project.

Explaining the Purpose of Your Initiative

Each new initiative or project should be created to respond to documented needs or problems in the community or region your program serves. Thus, the first part of the plan should justify the need for the project. This part of the plan can be divided into two sub-sections: the **problem statement** and your **proposed solution**.

The Problem Statement. This is a statement of the specific problem or need to be addressed by the project. It should include some basic data (baseline data) that help to explain the problem, including the following information:

- A description of the extent, scope, or severity of the problem, so that the proposed results can be put in perspective.
- A description of the geographic area and demographic characteristics of the population in the area in which the problem exists.
- An analysis of the causes of the problem.
- The results of previous efforts, by your program or other programs, to solve the problem.

An example of a problem statement:
Within the state of San Pedro there is a large peri-urban population of 250,000 that at the present time does not have any access to family planning services. Ten government clinics are located within and near this area but these offer only Maternal and Child Health services. At 52 births per 1,000 population, the birth rate in this peri-urban area is roughly two times that in other areas within the state.

The Proposed Solution. In this section of the plan you should explain the design of your project, emphasizing those aspects of your approach that you think best address the problem you have described. The description of the project design should answer the following questions:

- What approach will you use, and why have you chosen this approach over other possibilities?
- What other local programs are addressing this problem and how does your proposed approach complement their activities?
- What changes do you expect will result from this project?
- How does this project fit in your organization's overall strategic plan?
- What sources of support are likely to be available to you for continuing the project in the future?
- In what ways is the project designed so that it can be replicated in other areas?

An example of a proposed solution: *Within the peri-urban area of San Pedro there are 10 MCH clinics staffed by government MCH nurses. This initiative, "Project Expand: San Pedro," would use existing government clinics to introduce family planning services to these peri-urban areas. Family planning services would be provided by a family planning trained physician and MCH nurses in each of the existing 10 clinics. In addition, a network of local promoters would be formed to disseminate family planning information, distribute non-clinical contraceptives, and refer clients to clinics for clinical methods. By building on the accessibility of the existing government clinics and linking community outreach activities with clinic services, this project is expected to significantly decrease the birth rate in the peri-urban area of San Pedro. It is expected that this model will be replicable in other urban areas in the country.*

Being Specific About What the New Initiative Will Accomplish

A well-designed project should have both **overall goals** and **specific objectives**. The goals and objectives set forth the intended results to be achieved by the project and the degree to which the problem described will be resolved. Once the objectives have been determined, a set of **activities** that describe how each objective will be achieved should be specified in the activity plan that follows.

Goals: The overall goals should describe, in a broad way, the long-term changes that will result from *your project's* work on the problem outlined in the problem statement. Normally one or two general statements describing the proposed long-range benefits to the target population are sufficient to describe the overall project goals.

An example of an overall goal: *To reduce the birth rate in the peri-urban community of San Pedro, by providing clinic- and community-based family planning services.*

Objectives: For each overall goal that you develop, there should be several specific, measurable objectives. These objectives relate to the problem statement and describe anticipated results that represent changes in knowledge, attitudes, or behavior of the project clients or participants. The objectives should used to develop corresponding evaluation criteria (see page 55) to ensure that evaluations conducted later in the project will measure the results that the project intends to achieve.

Your objectives should:

- Be measurable, observable, or otherwise documentable.
- Refer to qualitative and quantitative targets as much as possible.
- Indicate the specific time periods required for completion.

How to . . .

Write SMART Objectives

Specific - to avoid differing interpretations
Measurable - to allow for monitoring and evaluation
Appropriate - to the problems, goals, and strategies
Realistic - achievable, challenging, and meaningful
Time bound - with a specific time period for achieving them

Examples of specific objectives: *To form an active network of 10 associate physicians delivering family planning services in three peri-urban communities by the end of the first year of the project.*

To select, recruit, and train a network of 60 family planning promoters by the end of the first year of the project.

To attract 4,000 new family planning acceptors during the first year of operation of the project, and an additional 9,500 during the second year of the project.

To be serving 20,000 family planning clients by the end of the third year of the project.

Developing Detailed Project Activities

The plan of activities constitutes the core of your plan and should describe the major activities needed to accomplish each project objective. To fully develop the plan, you should list the key activities that must be carried out in order to achieve each objective. One or more staff members should be assigned to each activity, and these people will be responsible for overseeing or carrying out the activity. The activity plan will provide the project staff with a clear picture of their responsibilities and activities during the project. Even though changes might have to be made during the project, the activity plan provides a vital aid to project management.

The plan of activities can be divided into two sub-sections: a **detailed description of project activities** and a **project activity timeline**.

Project Activities. In this section you should describe each project activity and explain how the activity will contribute to the achievement of project objectives. You may want to begin by listing under each objective all the activities that would be required to fulfill that objective. You should also describe the proposed staffing plan for the project by outlining job descriptions and describing the skills of individuals already enlisted in the project.

The descriptions in this section should be specific enough so that there is no question about the appropriateness of each expense listed in the budget. The description should explain the items in the budget that are critical to the achievement of the stated objectives; *for example, hiring a trainer to train new family planning promoters*. This section could be organized to include the following:

- A description of the major activities to be carried out that answer the questions "what, where, by whom, and when?" This description should also include activities that might require technical assistance from another organization or program.
- A description of the management systems supporting these activities (e.g., supervisory, management information, and financial management systems).
- A list of activities to be carried out by other organizations or programs in order for the project to proceed on schedule. *For example, a time schedule for shipping contraceptives, or an allocation schedule for the disbursement of funds.*

Project Activity Timeline. This section outlines the major project activities and staff responsibilities, and illustrates the chronological sequence of the activities. The project activity timeline (also known as a chronogram or Gantt Chart) is an essential tool for planning a project, but should also be used for monitoring activities and short-term results, for keeping the project on schedule, and for managing the project's resources.

A complete project activity timeline is a condensed summary of the major project activities in their planned chronological sequence. It should show the month or quarter in which each activity will be conducted and the person(s) responsible for carrying out that activity. At a single view, the timeline enables the project planners to assess the workload of each staff member, and determine whether staff members that have multiple responsibilities will be available when they are needed (see Sample Project Activity Timeline on the next page). A project activity timeline that is developed at the beginning of the project can be updated periodically and referred to by project staff on a regular basis.

During the course of the project, new activity timelines also can be developed by individual staff members to outline activities that relate to specific objectives and targets of their own work. Activity timelines used in this way will help project planners and supervisors to integrate and coordinate their work and more accurately monitor the progress of the overall project.

Sample Project Activity Timeline

Project Activity (partial list)	Project Quarters												Person(s) Responsible
	Year 1				Year 2				Year 3				
	1	2	3	4	1	2	3	4	1	2	3	4	
Review project plan and activities with State Medical Director and clinic directors	▬												State Project Coordinator
Select and recruit project personnel-													
10 physicians	▬	▬											State Medical Director/State Project Coordinator
3 outreach supervisors	▬												State Project Coordinator/Clinic Directors
60 promoters	▬	▬	▬										Clinic Directors/Outreach Supervisors
Order contraceptive supplies and IEC materials	▬		▬		▬		▬		▬		▬		State Project Coordinator
Train physicians and MCH clinic nurses		▬	▬										State Medical Director/Local Medical Trainer
Train supervisors in techniques for supervising CBD workers/promoters		▬											Local Family Planning Trainer
Develop monitoring and reporting forms	▬												State Project Coordinator/State Medical Director
Receive contraceptive supplies and IEC materials		▬		▬		▬		▬		▬		▬	Supplies Manager/Clinic Directors
Provide family planning services in clinics			▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	All clinic staff and physicians
Train family planning promoters/refresher training (3 sessions of 20 promoters each session)		▬	▬	▬				▬					Local Family Planning Trainer/Outreach Supervisors
Provide community-based IEC and family planning services			▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	Family Planning Promoters
Supervise promoters		▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	Outreach Supervisors
Conduct monitoring visits to outreach sites		▬		▬		▬		▬		▬		▬	Clinic Directors/Outreach Supervisors
Make project monitoring visits		▬		▬		▬		▬		▬		▬	State Project Coordinator
Submit financial and programmatic reports			▬		▬		▬		▬		▬		Clinic Directors
Evaluate project progress and impact						▬						▬	State Director MCH/FP and Local Consultant

Critical Elements to Consider When Developing a Plan

To develop a successful plan, managers must address four areas of critical importance: contraceptive supplies, equipment, and materials; training; service delivery; and sustainability. The sections below suggest the kind of information that your plan should cover.

Contraceptive supplies, equipment, and materials. Your plan should include a section that describes both the types of contraceptives or other supplies that your project will consume (or dispense) and thus will need to replace during the project, and the way that you will manage the inventory of these items so that you do not run out of needed supplies. For each type of commodity you should indicate who the supplier(s) will be, and if possible who the alternate suppliers will be in case you need to use them. This section could include:

- A description of the system for logistics management and for the distribution of supplies to service points. This should include the record-keeping and reporting systems, and the dates when physical inventories will be performed.
- An estimate of the number of contraceptives or other types of supplies that you will need in order to serve the estimated number of clients in the project, or at least an estimate of the amount you expect to distribute in the first year.

For more information on managing contraceptive supplies see Chapter Thirteen, "Improving Contraceptive Supply Management."

Training. The larger the training program, the more detailed your plan should be. You should be sure your training plan includes the following details:

- The program content: theme, topics, date, venue, speakers, agenda;
- The number of participants and the criteria for selecting the participants;
- A list of resource persons, including their qualifications, scope of work, and topics they will cover;
- The logistics plan, including the selection of participants, invitations, arrangements for travel, meeting space, training equipment, and preparation of background documentation.

Service Delivery. If you are planning on offering new services or expanding existing services, you should consider and provide details on any program activities that will be needed to support the implementation of the plan. These activities might include:

- The replacement of existing equipment, purchase of new equipment (and any recurrent costs of operating the equipment), the need for new suppliers, and the development of a maintenance contract;
- The construction or renovation of new service sites. (indicate where the sites will be, who will perform the work, and when the work will begin and end);
- The development of any new service policies or protocols;
- Outreach and follow-up activities (indicate who will do the work, in which areas, how often they will visit the sites, and how they will travel to and from the sites).

Sustainability. Most funders are looking for initiatives that will continue after donor support has ended. The best plans clearly address this important issue of sustainability. The critical elements of sustainability include positioning your organization to meet future changes in the environment and in the needs of its clients, increasing client demand and expanding the client base to serve the disadvantaged and underserved, and achieving greater control of human and financial resources. Income generation is a key element to consider in achieving greater control over financial resources. When developing your plan always try to consider how you might finance a portion of project activities by selling contraceptives, charging fees for services, or fundraising. Include in your plan a description of the activities that will generate income and the way in which that income will be used.

The ability of a project to generate income and to increase the amount of income raised in future years will greatly help in establishing the financial sustainability of the project, and will reduce the dependence on external donor support. For more information on charging fees for services, see Chapter Twelve, "Charging Fees for Family Planning Services."

Tracking the Progress Toward Meeting Objectives

Plans for monitoring and evaluating your project should be included in the initial project design.

Monitoring. Monitoring is the process by which project activities and the budget are regularly reviewed. Monitoring helps to ensure that the activities planned in the work plan are being completed and that the costs are in line with the budget. Financial monitoring also enables the project director to see whether the budget is being followed, to document the reason(s) why it is not being followed, and to determine whether budget revisions are needed. The monitoring plan should include at least the following information:

- A list of the project personnel who will be involved in monitoring the project, and their specific monitoring responsibilities;
- How and when project managers will monitor activities;
- A plan for the development of criteria that will be used to monitor project activities, including measures of service quality;
- A plan for the development of forms that will be used for monitoring activities.

An example of a monitoring plan: *The State Project Coordinator assigned to the project will monitor the progress of activities and the costs incurred in carrying out these project activities. On a quarterly basis, the State Project Coordinator will compare the completed activities and the expenditures against planned activities and the budget, by making site visits to clinics and outreach worker sites. Clinic directors will be responsible for monitoring the activities of the promoters on a quarterly basis by making visits to selected outreach worker sites with the supervisors assigned to each area. The State Medical Director will monitor the quality of care provided by the physicians on a quarterly basis by making site visits to the clinics and by conducting random exit interviews with clients. Early in the first quarter of the project, the State Project Coordinator and the State Medical Director will develop specific monitoring criteria for the project and will revise existing government monitoring and reporting forms for use in this project. The forms will be designed to collect basic family planning data, to track potential discontinuers so that the outreach workers can provide timely and effective follow-up visits, and to assess client satisfaction with clinical and outreach services.*

Evaluation. It is vital to have a plan for assessing project achievements during and after the implementation of a project. The evaluation of the project should analyze the **implementation process** (that is, whether the planned activities were carried out and completed) as well as the **impact** (or long-term effect) that the project has had on the target population. By developing this section of the plan, you will define and let other project personnel know in advance what aspects of the project will be evaluated, and how and when the evaluation(s) will be conducted. Knowing what and how projected achievements will be measured helps to build a common goal among project personnel and keeps staff focused on meeting the objectives of the project.

Your evaluation plan should specify the following:

- How the evaluation criteria will be developed;
- Who will perform the evaluation and when the evaluation(s) will occur;
- How evaluation data will be collected and submitted, including how qualitative data, such as information on user satisfaction, will be collected;
- How and when evaluation data will be analyzed and reported;

- How the evaluation findings will be used.

To establish the evaluation criteria, base the criteria on specific project objectives. Because these objectives are SMART, they are measurable and observable, and can be easily converted into evaluation criteria. The example below shows how you can use evaluation criteria to chart your achievements.

Charting Your Achievements

You can present evaluation criteria in chart form, leaving spaces to indicate the percentage achievement of your stated objectives. A similar chart could be used to measure the percentage increase or decrease against the baseline data collected at the beginning of the project, if desired.

Evaluation Criteria	Target (Yr.1)	Actual		Target* (Yr.2)	Actual		Target* (Yr.3)	Actual	
		No.	%		No.	%		No.	%
Number of associate physicians providing family planning services in peri-urban communities	10			10			10		
Number of family planning promoters selected and recruited	60			60			60		
Number of family planning promoters oriented and trained	60			60			60		
Number of family planning acceptors served by promoters	2,000			6,500			9,250		
Number of family planning acceptors served by the clinics	2,000			7,000			10,750		
Total number of family planning clients served by the project	4,000			13,500			20,000		

* Targets refer to projected cumulative totals

Reporting Your Achievements

You should have forms for reporting on both programmatic achievements and financial activities. If you do not already have reporting forms, you will need to develop new forms, or modify existing forms used by your program or other similar programs, so that they can be used for this project. The plan for your new initiative should indicate both the frequency with which you will prepare the reports and an outline of the type of information the reports will contain.

Programmatic Reporting. Programmatic reports provide detailed information on the activities undertaken in the project. Your reporting plan should specify the non-financial information that these reports will cover. These reports (usually written in narrative form) should explain the activities that the project has undertaken during the period covered by the report, and the achievement (or progress toward the achievement) of your stated objectives. It is also helpful to include graphics that illustrate the project achievements to date. The narrative reports should refer to the stated objectives, activity plan, and evaluation criteria to be used in analyzing project progress.

Financial Reporting. Financial reports show how much money has been expended during a specific reporting period and for what purpose, and whether the money that was spent was in line with the budget. This information is critical for determining whether the amount of money budgeted for the next period of the project is going to be sufficient to carry out the planned activities.

Developing a Budget for Your Initiative

The principal functions of a budget are to record the goals and objectives of your initiative in monetary terms, and to provide a tool with which to monitor financial activities and project performance throughout the life of the project. It is helpful to prepare both a **detailed budget** for the first year of the project and a **summary budget** showing the financial needs for the life of the project.

To prepare the detailed budget, you will need to carefully examine each project activity to determine the costs that are associated with implementing the activity. This is a very important step, since there are often hidden costs that can easily be overlooked, such as the cost of renting a training facility for conducting quarterly training, or the cost of purchasing materials for a training program. All costs will then need to be sorted into budget categories. The first draft of the budget should contain only *direct project costs*, meaning costs that are directly associated with a specific project activity, and each item listed in the budget should be clearly identifiable in the activity plan. The budget categories listed below, and the explanations of the types of expenses to include under each category, provide a guide to how you might organize your budget.

Sample Budget Guidelines

The following descriptions of budget categories provide examples of the types of costs that can be included under each budget category. There is no single correct way to develop a budget. What budget categories an organization uses and what is included in each of these categories will vary from organization to organization. If you are preparing a budget, check your organization's budget categories and the types of costs included in each category before preparing your budget. The categories listed here provide a basic guide for developing and organizing project costs.

Salaries and Wages. This category includes the amounts to be paid to project personnel for salaries and wages. A *salaried* employee is generally paid on an annual or monthly basis regardless of the number of hours worked. A *wage* employee is generally paid on an hourly basis, and if additional hours are worked beyond the time agreed, overtime, time-and-a-half, or double time may apply if such practices are consistent with those of similar occupations or organizations in your area. For each position, list the title, the amount of monthly or yearly salary, and the percentage of time to be devoted to the project (for instance, 100% or 50%), or list the hourly wages to be paid.

All salary or wage amounts should be consistent with your regular salary or wage policies. If a new position is being created, salary or wage levels should be consistent with those of similar occupations or organizations in your geographic area.

Salaries and wages included under this cost category must be for individuals who are, or will be, employees of the project, or who are employed by your program and will spend part of their time on the project. Otherwise, all compensation for individuals who are not legal employees, such as consultants and those hired under contractual agreements, should be included under the category "Fees."

Benefits. This category includes all expenditures for benefits that are in accordance with labor laws and your program's usual policy and practice. These might include Social Security, severance pay, annual vacation, sick leave, housing allowance, medical insurance, and others. Benefits should be included only for individuals listed under "Salaries and Wages." In most countries, individuals listed under "Fees" are not generally entitled to benefits. However, if local law mandates such entitlement, you should put these costs under "Benefits."

The costs of the benefits for each employee or group of employees should be shown separately and the basis for the calculation of the benefits should be explained in accompanying notes. Some organizations are able to calculate benefits as a fixed percentage of salaries and wages. However, unless your organiza-

tion has developed a benefit rate by working with an financial auditor or has documentation of government regulations that specify the rate to be used, you should not base benefits on a percentage of salaries (see box on indirect costs on page 58).

Fees. This category includes all costs for professional services performed by individuals not listed under Salaries and Wages. These costs include short-term consultants and contract personnel who perform accounting services, lectures, training sessions, research, and evaluations. This category also includes honoraria paid to individuals for professional services rendered. Customarily, fees are paid through contractual agreements with individuals for a specific period of time and individuals receiving fees generally are not entitled to benefits.

These contractual obligations may be made with individuals who work for your program but who otherwise would not be part of this project, such as a program trainer, or they can be made with an outside consultant. List the type of service, the individual providing the service, and the cost(s) of the service. Indicate how the costs were calculated, for example cost per hour, per week, per month.

Travel and Associated Expenses. The type of travel normally included in this cost category is regular and customary travel associated with the activities of the project. These costs might include travel for supervisory visits, staff meetings, outreach, and other field visits. Include all estimated costs for travel such as air fares, bus or train fares, taxis, out-of-pocket expenses, short-term vehicle rentals, fuel, mileage, and per diem. You should not include any costs connected with education and training; such costs should be listed under "Education and Training" described below.

Supplies and Equipment. All office and clinic supplies, commodities, and equipment to be purchased in-country should be listed here. The cost of each commodity and piece of equipment should be shown. Examples of items to be included in this category are office furniture, clinic furniture and equipment, cleaning supplies, vehicles, audio-visual equipment, computer hardware or software, and typewriters.

Purchased Services. These costs generally refer to long-term contractual services or agreements with institutions. Examples include: building rental, long-term leases on equipment or vehicles, maintenance contracts for equipment or vehicles, construction services, janitorial services, and advertising or promotion services that are critical to the success of the project, such as a radio spot promoting family planning services. List the type of service contracted, the individual or firm providing the service, the cost of the service, and the basis for the calculation. Since this is a budget for the first year of the project, be sure to include only the cost for one year of services, even if a service is contracted for more than one year.

Education and Training. Generally, the expenses associated with this cost category refer to the costs of having participants attend specific training workshops, seminars, or conferences. This section could include costs associated with hosting a training program or sending participants to another training program. Include all amounts for tuition, training, fees, conference registration fees, participants' travel costs, per diem, books, and other costs associated with conducting or attending a training workshop. You should not include any costs you have already listed under "Fees" or under "Travel and Associated Expenses."

General Administration. All expenditures anticipated in the normal course of doing business that are not contractual agreements can be listed here. The specific cost item should be directly attributable to the project. These expenditures include postage, freight (and any necessary shipping insurance), photocopying, printing, telephone, faxing, telexes, utilities, bank charges, dues, subscriptions, publications, vehicle registration, employment advertising, casualty insurance, and other usual and customary administrative costs.

Other Costs. Occasionally there are costs that do not fit into any of the categories listed above. Such costs can be listed here with a justification for each item. Indirect cost rates can also be listed here, although there are specific guidelines for charging these indirect costs to your project; these are outlined in the following section.

Determining an Indirect Cost Rate

If you are planning on seeking outside funding, you will need to determine a rate for calculating and including in your budget *indirect costs*, such as the cost of depreciation of program equipment, the program's proportion of the cost of maintaining the grounds or facilities that benefit all the projects of a larger program, or any expenditures for administrative services that cannot be allocated to specific project activities. (All administrative expenditures that can be assigned directly to project activities should be included under "General Administration.")

If programs plan to have any of these costs paid for by outside sources, most donors require that an indirect cost rate be determined by a licensed accounting firm. Programs that have centralized administrative operations and multiple funding sources may wish to allocate their administrative costs to each funding source proportionally. An indirect cost rate, calculated by an independent firm, will help in determining how a portion of these costs can be recovered. Always keep complete documentation in your files that explains the indirect costs and the rate by which they are calculated.

If your organization has not had an indirect cost rate determined and the expenses cannot be attached to the project activities, an outside funding agency will not be able to pay for these costs. They should then be considered part of that portion of the budget that your program plans to cover.

Calculate the total budget. To complete the budget you will need to calculate the sub-total of each budget category, then calculate the total budget for the first year of the project by adding the sub-totals of each budget category. Record the Grand Total at the bottom of the budget. Below is an example of the costs for one budget category, "Salaries and Wages" for the first year of the sample project.

Sample Budget Detail (in local currency)

Salaries and Wages:

1 State Project Coordinator (75% time)	(800/mo. x 75% x 12 mo.)	7,200
1 State Medical Director (10% time)	(1000/mo. x 10% x 12 mo.)	1,200
3 Outreach Supervisors	(300/mo. x 100% x 10 mo.)	9,000
40 Family Planning Promoters	(200/mo. x 100% x 6 mo.)	48,000
20 Family Planning Promoters	(200/mo. x 100% x 3 mo.)	12,000
10 Clinic Directors (25% time)	(500/mo. x 25% x 12 mo.)	15,000
10 MCH Clinic Nurses (25% time)	(400/mo. x 25% x 12 mo.)	12,000
Subtotal Salaries and Wages:		**104,400**

Following the example outlined in this chapter (see Sample Project Activity Timeline, page 52), this budget detail shows that 40 of the Family Planning Promoters will be hired during the first 2 quarters of the project, and an additional 20 will be hired by the end of the third quarter. Therefore, the budget for their salaries reflects this staggered hiring schedule. Also note that the costs of hiring the associate physicians, trainers, and outside consultants are not included under "Salaries and Wages," because in this example only employees receiving benefits are included in this budget category. The physicians, trainers, and outside consultants should be included under the category "Fees," since a special contract for their services needs to be developed; thus all costs of paying them is listed under "Fees."

The Budget Summary. It is also helpful to summarize how the funds will be spent over the entire duration of the project. By creating a budget summary, you can see in outline form the projected financial requirements of your new initiative. The summary for the first year can be derived from the sub-totals of each budget category that you have already figured. You will then need to estimate the costs for the following years. As the Sample Budget Summary shows, the summary presents an overall picture of the financial requirements of a three-year project, the extent to which the project intends to decrease its reliance on outside funding sources, the assumptions that have been made in developing the budget, and the year or years in which principal up-front costs will be incurred.

Ideally, the summary will reflect gradual reductions in outside donor support. If not, the need for the same levels of funding over time should be explained at the bottom of the budget. You should also include an explanation of the assumptions used in forecasting the project's future budgetary needs. Such assumptions may include the expected inflation in the cost of living, increases in self-financing projections, expected project expansion, and other factors.

A budget summary is a useful tool at the planning stage to provide a more objective view of the financial needs of the project in the early phases and to project the operating (or recurrent) costs of implementing the project over the long term. A projection of recurrent costs is critical to effectively planning for the future, because these are the costs that the program will need to sustain.

Sample Budget Summary (in local currency)

Budget Category	Project Period (three 12-month phases)			
	1993	**1994**	**1995**	**Total**
1. Salaries and Wages	104,400	190,200	199,710	494,310
2. Benefits	41,760	76,080	79,884	197,724
3. Fees	150,000	100,000	75,000	325,000
4. Travel & Associated Expenses	30,000	5,000	5,000	40,000
5. Supplies & Equipment	12,000	4,000	5,000	21,000
6. Purchased Services	15,000	15,750	16,540	47,290
7. Education and Training	17,000	5,000	1,000	23,000
8. General Administration	7,000	7,350	7,718	22,068
9. Other Costs	N/A	N/A	N/A	
Total Cost	**377,160**	**403,380**	**389,852**	**1,170,392**
Outside Funding Needed: Percent of Total Budget	250,000 (66%)	200,000 (50%)	150,000 (38%)	600,000 (51%)
Costs Covered by Program (or other local resources): Percent of Total Budget	127,160 (34%)	203,380 (50%)	239,852 (62%)	570,392 (49%)

Assumptions: 5 percent average annual inflation
Project fully staffed in Year 2

Turning Your Plan into a Proposal

Once you have developed your new initiative and prepared a plan detailing the objectives, the activities that will allow you to accomplish those objectives, the way the project will be monitored and evaluated, and the cost of implementing the project, you can turn the plan into a proposal for funding. This can be done by adding a few sections to your plan. Along with the plan, your proposal should include sections that explain the **qualifications of your organization and of key personnel** who will be involved in implementing the project, the factors that will further the **project's sustainability**, and a **brief summary of the project**.

Donors are particularly interested in funding projects that are submitted by organizations or programs that have clearly demonstrated their commitment to the issues addressed by the project, and have both the technical skills to conduct the project and the ability to adequately staff the project. In addition it is important to show, by explaining previous experience in managing human, material, and financial resources, that the organization has the administrative skills to manage the project.

Explaining Your Organization's Qualifications

A section of the proposal should demonstrate that your organization has the necessary experience and qualifications to carry out the proposed project. To do this you should:

- Briefly state the mission of your organization.
- Describe your organization's type (public agency, non-governmental organization, family planning association), its facilities, and its administrative and management capabilities.
- Indicate the major projects your organization has already implemented and their major achievements. Highlight related projects or activities that will serve to support the efforts described in your proposed project. If outside sources of funds were used for these projects, indicate the sources of these funds.
- State any other sources of financial support your organization is requesting or has received for this project.

Describing Key Personnel

A donor organization will want to consider the qualifications and experience of the people who will be responsible for carrying out the project. In your proposal you should state the qualifications of key personnel such as the Project Director, Senior Managers and Supervisors, doctors and nurses, and any other personnel who will have major responsibility for achieving the expected results of the project. You should:

- Include the qualifications and curricula vitae of all key personnel who have already been identified to work on the project.
- Identify new positions to be filled in the project and provide job titles and descriptions of these positions.
- Provide an organizational chart.

Describing Project Sustainability

Donors are particularly interested in projects that have a clear plan for how the project will be able to continue in the future while decreasing its reliance on donor funds. You should be sure to include a section in your proposal that discusses this issue of sustainability, and describes how the project will contribute to and strengthen organizational sustainability. To do this you should:

- Describe how the project will contribute to organizational stability. Discuss the ways in which the new initiative will help develop and maintain strong leadership, strengthen existing internal management systems, enhance staff capability, and respond to the changing environment and client needs.

- Explain how the new project will increase client demand and expand services to the poor and underserved;
- Show how the project plans to achieve greater control over resources by finding ways to reduce or recover costs without compromising the quality of and access to services.

Developing a Summary Sheet

Develop a one- to two-page summary of the project in outline form that will be attached to the front of your plan. It should contain the following information:

Title of the Project or Initiative. Develop a brief and descriptive title for your project.

Name of Your Organization. Give the name, address, and telephone number of your organization or program and include cable, fax, or telex numbers if available. If you know who the Project Director will be, provide the name of that person. Always provide at least one name of a person to contact.

Project Dates. Give the dates that the proposed project will begin and end.

Project Budget. Give the total amount of funds needed to conduct the first phase of the project, that is, the total estimated cost of the project as figured in the budget summary. Separately, you should also note the total budget amount for the first year of operations that you figured in the detailed budget. It is helpful to the donor to provide these figures both in your local currency and the foreign currency equivalent, noting the current rate of exchange. For each of the totals, you should show the portion being requested from the outside donor.

It is also important to note other project resources or in-kind contributions that are not listed in the budget (financial or material resources, such as office space, vehicles, etc.) that will be provided by your organization or by other local organizations. You can also indicate in this section whether the project intends to generate income and how much income is expected to be generated in the first year.

Project Summary. Briefly summarize your proposed initiative in one or two paragraphs. The summary should answer the following questions:

What problem or need does the project address? (Problem Statement)

What will be the long-term effects of the project? (Overall Goal)

What measurable results will be achieved by the project? (Objectives)

How will the results be achieved? (Activities)

Estimated Costs and Achievements. This section, which can be presented in table format, helps to show at a glance the results that will be achieved by the project in relation to their costs. Make a row for each year of the project and show the total projected budget for each year (in local currency), separating out the portion your organization will provide from the portion you are requesting from the donor. Adjacent to these figures you should show the corresponding major results expected for each year of the project. These results can be taken from the objectives section or from the evaluation section that you prepared in your plan. Using this table, you can present rough estimates of the costs per unit of output, or achievement, on a yearly basis (in this case, the costs of providing services to each user you anticipate serving in your project).

Sample Chart of Estimated Costs/Achievements
(in local currency)

Project Year	Project Costs		Achievements
	Donor Portion	Program Portion	Total Users (cumulative)
Year 1:	250,000	127,160	4,000
Year 2:	200,000	203,380	13,500
Year 3:	150,000	239,852	20,000
Totals:	**600,000**	**570,392**	**20,000**

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On developing a plan of activities . . . One reviewer recommends, "*It is often useful to develop the Project Activity Timeline before writing the activity plan. Once the timeline is completed, showing who will be responsible for each activity and when it will be done, then the description of activities, the staffing pattern, and the budget can be derived from the timeline.*"

On responding to donor requirements . . . One reviewer writes, "*Many donors have their own formats for writing proposals and often require that the grantee organization develop new monitoring and reporting forms, or use the forms developed by the donor for use in monitoring and reporting on project performance.*"

On working with foreign currencies and anticipating inflation . . . One reviewer warns, "*Always keep in mind the inflation/devaluation factor when working with foreign currencies. Projects can suffer greatly if the rate of exchange has changed significantly by the time the donor money arrives, the result being that the project has less money to work with.*"

On building partnerships . . . One reviewer stresses, "*The success of a new initiative is enhanced by building a working partnership between the donor, the managers, the providers, and the users. It is the manager's responsibility to keep the team focused by constantly reviewing both financial and program objectives to ensure that their intended outcomes, both short- and long-term, are achieved.*"

On contacting donors in the planning process . . . One reviewer advises, "*Often donors prefer that organizations send a two-page letter describing the scope of the proposed project before developing the entire proposal. This gives the grantee organization an opportunity to market the project and highlight its particular approach, and also allows the donor to see whether the project is a good "fit" with the philanthropic goals of the donor organization.*"

How to . . .

Increase Your Chances of Receiving a Grant

Once you have identified several donor organizations or public-sector programs from which you might seek funding, you should contact them to determine the types of projects that they customarily fund (if yours is not the type of project they usually fund, they could refer you to another source), any format guidelines you should follow, and the level of funding they are likely to consider for a project such as yours. Some donors have only small amounts of money available for certain types of projects, and while your project may be perfectly viable and worthy, you may be requesting more than the donor can give to one single project. Knowing this will help guide you in the process of turning your plan into a proposal, and will increase your chances of having your initiative funded.

Proposals should be written in the format required by the donor organization and submitted to the appropriate address for review. Many international donor organizations have country or regional offices to which the proposal should be sent. Other organizations prefer that the proposal be sent to their central office. Be sure to submit the proposal to the right person at the right address to avoid undue delays in the review process. Do not hesitate to contact the donor organization or the representative of the governmental agency if you have any questions at any step of the process of developing your proposal; it will save you time if you can make changes in the proposal earlier rather than later.

Continued on next page

Donors will favor proposals that:

- Clearly define the problem that your project will address;
- Explain how your project will address the stated problem;
- Are complete and detailed, with reasonable objectives that directly relate to the proposed solution to the problem, and a well-designed activity plan for achieving these objectives;
- Present expected results of the project that are quantifiable, reasonable, and attainable, considering your human and financial resources and the environment in which you work. (Donors might look unfavorably on a project whose intended results and costs are unrealistic—either too high or too low—considering the political, economic, and social environment);
- Present a detailed and reasonable budget whose items are justified in the activity plan;
- Demonstrate that the organization is excited about the project and convinced that its approach to addressing the problem is sound and meets existing needs;
- Provide evidence of your program's capacity to manage the project;
- Show the potential for the project to continue after the end of the grant;
- Show that the project is linked to other efforts—governmental or non-governmental—to solve the stated problem or need. Show that the addition of your project will enhance the work of other programs, making the proposed long-term impact even greater.

The following is an example of an outline of a well-organized proposal that incorporates every aspect of a basic plan for a new initiative.

Sample Project Proposal Outline

I. Project Summary

II. Why this New Initiative?
- A. Problem Statement
- B. Proposed Solution

III. Organizational Qualifications
- A. Organizational Experience
- B. Key Personnel

IV. Goals and Objectives
- A. Goals
- B. Objectives

V. Detailed Activities
- A. Project Activities
- B. Project Activity Timeline

VI. Project Sustainability

VII. Tracking Progress
- A. Monitoring
- B. Evaluation

VIII. Reporting
- A. Financial
- B. Programmatic

IX. Budget
- A. Detailed Project Budget (Year 1)
- B. Project Budget Summary

A Proposal for Introducing Norplant in Morocco

The Directorate of Prevention and Health Education of the Ministry of Public Health (MOPH) in Morocco developed a plan for introducing the Norplant contraceptive implant in Morocco. However, they found that, in order to implement the plan, outside funding and technical assistance were required. As a result, the Ministry staff developed the plan further and wrote a proposal to collaborate with other institutions that would provide the initiative with the necessary technical assistance and financial support.

The Proposal

The project proposed to collaborate with three international population organizations: the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), the Population Council, and the Association for Voluntary Surgical Contraception (AVSC). Each organization, along with the Morocco Ministry of Public Health, would provide technical assistance in its own area of responsibility as well as financial support for the initiative.

The overall goal of the project is to increase contraceptive prevalence in Morocco through the introduction of Norplant. The introduction of this method will broaden the range of modern and effective contraceptive methods available to Moroccan women.

The plan includes:

- Assisting the MOPH in Morocco in establishing a model program for the delivery of Norplant services at four full-service clinics;
- Helping the MOPH to develop these four sites as training centers;
- Evaluating the overall user and provider acceptability of the Norplant method in Morocco;
- Analyzing the service delivery requirements for Norplant in Morocco.

The Results

Since the inception of the program, Norplant has been successfully introduced at four regional service delivery sites in Morocco, as well as at the National Training Center in Human Reproduction and at a University Teaching Hospital. The MOPH is currently in the process of analyzing the data from the first 400 acceptors.

The collaborating organizations plan to present the findings and recommendations of this project to key decision-makers in Morocco, and hope to extend the project to other areas in Morocco.

Using Your Plan to Achieve Results

Once you have completed your plan and secured the required funding from internal and external sources, you can begin to implement your new initiative. Often, in order to begin implementing a project, it is necessary to go back to the activity plan and timeline and define in more detail the sub-steps that are required in order to complete each major activity. *For example, if your plan calls for interviewing prospective community promoters or other staff, arrangements may have to be made for a space or an office that can be used for conducting the interviews. You will also need to contact the key personnel and other staff who are written into the project and begin to work with them to specify their responsibilities in getting the project underway.* You, as a manager, should review the overall project objectives and develop targets that relate to your work group.

Although the plan identifies those people who will be responsible for submitting progress reports and for monitoring and evaluating project achievements, it is the responsibility of staff members and supervisors to regularly review and update the specific targets and achievements of their own work groups, and to make any necessary adjustments to activities in the work plan that relate to their level. Decide with your staff how frequently the achievements of your work group will be reviewed. It may be advisable for such review to occur more frequently than scheduled in the overall project reporting periods. This will allow you to see ahead of time whether you are meeting your own targets so that, if necessary, you can take corrective action before the end of the reporting period. If corrective actions are required, they should be communicated to the next higher supervisory level so that these can be incorporated into the overall project plan.

The project plan provides a basis for initiating the project and can be continually updated and revised to respond to changing circumstances. With regular updating, the plan will remain current and useful to managers for planning and guiding the work of their working groups. By using and regularly referring to the plan, staff are more likely to see how their contribution fits into the overall project and to stay motivated. Managers will more easily be able to maintain a spirit of teamwork, keep the project on course, and achieve the project objectives.

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Checklist for Developing Plans and Proposals

For Clinic Managers and Supervisors

- [ ] Analyze your service delivery program to determine how your services could better meet the needs of your clients or attract new clients.
- [ ] Brainstorm ideas with your staff for developing a plan for a new initiative.
- [ ] Ask senior-level managers to be part of the planning process; this is the best way to gain their commitment and enthusiasm for a new initiative.
- [ ] Develop a clearly written statement of the problem to be addressed, or the identified need, and describe how you propose to address it.
- [ ] Develop an overall goal and specific objectives for your initiative and make sure that your objectives are S M A R T.
- [ ] Describe in detail the activities that will be undertaken in implementing the initiative and develop a Project Activity Timeline.
- [ ] Think through and describe how you plan to monitor project activities, and how the project's achievements will be evaluated and reported. Establish evaluation criteria that correspond to the stated objectives of the initiative.
- [ ] Develop a detailed budget for the first year of the initiative, making sure that each cost in the budget corresponds to a planned activity.
- [ ] Work with senior managers to identify potential funding sources, and use your plan for creating a proposal for funding for your initiative.

For Mid- and Senior-level Managers

- [ ] Analyze survey reports to determine critical areas of need and brainstorm ideas for projects that might address the unmet needs of family planning clients or potential clients.
- [ ] Work with clinic managers and their supervisors to identify specific client needs that could be addressed by developing a program initiative.
- [ ] Provide guidance in planning and budgeting for new clinic-level initiatives, and be committed to implementing the projects.
- [ ] Encourage directors at higher levels and donors to support special program initiatives at the service delivery level.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

A Proposal for Río Blanco Region

Mr. Aguilar, Director of Family Planning Services for Río Blanco Region, looked up as Mr. Cárdenas entered the room, "Ah, there you are, Mr. Cárdenas. We're so sorry you had trouble getting here this morning," said Mr. Aguilar. "Your secretary rang to tell us about the problems with your car. Why don't we break for coffee now so that I can fill Mr. Cárdenas in on what we have discussed so far."

As the four other clinic directors from Río Blanco Region and several members of the regional staff chatted over their coffee, Mr. Aguilar led Mr. Cárdenas, Director of the Rosario Clinic, to one side of the room. "The situation is this," began Mr. Aguilar. "The Director of our National Family Planning Program is worried that contraceptive prevalence has not increased very much in the past three years. The service statistics for our region show that while we continue to attract new users to our clinics, our rate of discontinuation is 27 percent. This is of particular concern because we know proper child spacing could reduce the high rates of morbidity among women and children. As you know, a recent survey showed that the primary reason that clients discontinue using contraceptives is due to misunderstandings about the methods and their potential side effects. Two weeks ago, at the country-wide meeting of all the Regional Directors, the Ministry asked for proposals for projects from each region that would be designed to increase contraceptive prevalence and to reduce discontinuation to a national average of 15 percent. They have some funds available and will select the best proposal as a pilot project for the country."

A few minutes later everyone returned to their seats. Mr. Aguilar began, "During the past two weeks, Mrs. Rodríguez and I have met several times and have come up with an idea for a pilot program to reduce discontinuation in our region. We would like to present that project to you now and get your input before Mr. Escobedo, our Finance Officer, develops the information we need for the budget. Mrs. Rodríguez will present our ideas to you."

Mrs. Rodríguez, Director of Program Planning for Río Blanco Region, arranged her notes and began, "As Mr. Aguilar mentioned before our coffee break, the recent contraceptive prevalence survey revealed that we have a problem with new acceptors who stop using their contraceptive method because of misunderstandings about their method and its side effects. This could be because clients don't fully understand the information they received in the clinic, or because they don't remember how to use the method. We realize that since such a high percentage of our clients can't read, written materials don't help. You might want to discuss the issue with your clinic staff, and think about other ways to improve client education.

"What we want to discuss today," continued Mrs. Rodríguez, "is how we might better serve new users and keep them in the program. We are proposing a project that would use outreach workers to visit the homes of recent discontinuers. Each clinic in the region would have one outreach worker who would be given the names of clients who recently missed appointments and asked to visit these clients and interview them. Since some of your clinics serve a larger population base, we are proposing to create a position, at 50-percent time, for an outreach worker for each of the two smaller clinics, and full-time positions for the three larger clinics. The outreach

worker's job would be to find out why each client has stopped coming to the clinic and to try and find our what her concerns are. The outreach worker will make sure that each client fully understands the choice of methods offered by the program and will ask whether the client is experiencing any side effects, and if she is, will explain the risks of these side effects."

Mrs. Rodríguez paused, and Mrs. Diaz, one of the clinic directors asked, "Will the program be hiring new people for these positions?"

"Yes," replied Mrs. Rodríguez. "We plan to hire people for all five positions at the same time and provide them all with a three-day orientation and training. Mr. Aguilar has asked if I could rearrange my responsibilities and take on the role of Regional Coordinator for this outreach program as 50 percent of my job, so I will take care of all the training arrangements, including selecting and contracting for the trainer."

"How will the outreach workers get to the villages?" asked Mr. Chavez, another clinic director.

"By bus," responded Mrs. Rodríguez. "The outreach workers will be based at the clinics and will travel to the clients' villages by bus. We will need to budget bus fares for their visits to clients, as well as the bus fare for each of them to attend a quarterly meeting of all outreach workers at the regional office. I will also be meeting with them individually once a month."

"From my experience," said Mrs. Diaz, "the outreach workers will need to have some materials with pictures in order to explain things to the clients. Do you have anything like that in mind?"

"Yes," answered Mrs. Rodríguez. "I was planning to order a set of educational materials for each outreach worker as well as one for myself. I also planned to provide each of them with a carrying bag and two notebooks for recording information about their client visits."

"This sounds excellent," commented Mr. Cárdenas. "We have been wanting to work on the discontinuation problem in my clinic for quite some time. How long will this project run?"

"It will be a two-year pilot project designed to begin in January 1995," said Mrs. Rodríguez. "At the end of the first year we will conduct a mid-term evaluation to see how well we are keeping to our implementation plan, and at the end of the project we will have a full evaluation to assess the project's impact on discontinuation. The Evaluation Officer from the central office will spend one week working with us during the first year of the project and two weeks during the second year. I know there are still a number of details to be discussed, but once we have secured the funding we can meet again."

"Based on your experience, Mr. Aguilar," inquired Mr. Chavez, "what do you think the chances are that we will receive funding for this project?"

"I think the chances are very good," replied Mr. Aguilar. "There is clearly a need in our region for this project and I think we have a number of strengths. First of all, our staff is very well qualified. Mrs. Rodríguez recently completed advanced training in program management. Our region has received recognition from the Ministry for consistent monitoring and accurate reporting. In addition, people at the Ministry are still talking about the success we had three years ago with our STD initiative. In fact, someone mentioned it at the Regional Directors meeting I attended two weeks ago."

"If you all agree with this idea," said Mr. Aguilar, "Mrs. Rodríguez and I will draw up a budget for the project and write up a proposal, including a project summary, to submit to the Ministry."

Everyone nodded in agreement.

Later on that afternoon, Mr. Escobedo put together preliminary budget information for Mr. Aguilar and Mrs. Rodríguez to use in developing the proposal. His budget preparation notes contained cost information and budget categories for them to use in preparing the budget.

Case Scenario: A Proposal for Río Blanco Region

Budget Preparation Notes

Cost Information (in local currency):

Regional Coordinator (Annual salary 9,600)
Outreach Worker (Annual Salary 3,600)
Evaluation Officer (Daily Rate 75)
Trainer (Daily Rate 50)
Expenses for organizing quarterly outreach worker meetings (20 per meeting)
Project stationery and supplies (5 per month)
Materials for client education (25 per package)
Carrying bags for outreach workers and Coordinator (5 per bag)
Notebooks for outreach workers and Coordinator (1 per notebook)
Regional Coordinator monthly travel (45 per month)
Vehicle Lease and Maintenance for Regional Coordinator (200 per month)
Vehicle Lease and Maintenance for Evaluation Officer (10 per day)
Outreach worker bus fare for client visits [1,000 person-days per year] (1 per round-trip bus ride)
Fuel and travel expenses for Regional Coordinator (45 per month)
Fuel and travel expenses for Evaluation Officer (5 per day)
Bus fare to Regional Office for outreach workers (2 per person per round-trip)
Training materials for outreach workers and Coordinator (10 per set)
Per diem for outreach workers while attending training (15 per person)
Postage and Photocopying (15 per month)
Communications expense (25 per month)
Benefits (40% of gross salary [government policy based on government audited rate])

Budget Categories:

Salaries and Wages
Benefits
Fees
General Administration
Travel and Associated Expenses
Supplies and Equipment
Purchased Services
Education and Training
Other Costs

Case Discussion Questions: A Proposal for Río Blanco Region

1. **Formulate one overall goal and one objective for the Río Blanco pilot project. Make sure the objective is S M A R T.**
2. **Using the discussion in the case scenario, list the activities that should take place in Year 1 of the project.**
3. **Using the budget preparation notes and the budget categories provided in the case scenario, prepare a budget for Year 1 of the project.**
4. **Prepare a summary sheet for the project that is being proposed.**

Case Analysis: A Proposal for Río Blanco Region

1. **Formulate one overall goal and one objective for the Río Blanco pilot project. Make sure the objective is S M A R T.**

Specific - to avoid differing interpretations
Measurable - to allow for monitoring and evaluation
Appropriate - to the problems, goals, and strategies
Realistic - achievable, challenging, and meaningful
Time bound - with a specific time period for achieving them

Goal:
To improve the health of mothers and children in the region by reducing the discontinuation rate among first time users of contraceptives in Río Blanco Region.

Objective:
To reduce the discontinuation rate among first time users from 27% to 15% by the end of the project.

2. **Using the discussion in the case scenario, list the activities that will take place in Year 1 of the project.**

Appoint Regional Coordinator

Recruit and select 5 Outreach Workers

Select and contract trainer

Set-up Orientation and Training Workshop

Conduct Orientation and Training Workshop for Outreach Workers

Purchase training materials for workshop

Purchase educational materials for client education

Purchase carrying bags and notebooks

Regional Coordinator to visit each Outreach Worker monthly

Regional Coordinator to conduct quarterly meetings with all Outreach Workers

Design Project Evaluation with Evaluation Officer

Conduct mid-term evaluation

Case Analysis: A Proposal for Río Blanco Region

3. Using the budget preparation notes and the budget categories provided in the case scenario, prepare a budget for Year 1 of the project.

By using the information presented in the case scenario, you should have been able to develop a budget similar to the one that follows.

Budget for Year 1 (in local currency)

Salaries and Wages	
1 Regional Coordinator (800/month x 50% x 12 months)	4,800
2 Outreach Workers (300/month x 50% x 12 months)	3,600
3 Outreach Workers (300/month x 100% x 12 months)	10,800
1 Evaluation Officer (75/day x 5 days)	375
Subtotal: Salaries and Wages	**19,575**
Benefits	
40% of gross salary (government policy based on government audited rate)	7,830
Fees	
1 Trainer for 3 days (50/day x 3 days)	150
Subtotal: Fees	**150**
General Administration	
Postage/Photocopying (15 x 12 months)	180

Communications Expense (25 x 12 months)	300
Expenses for organizing quarterly meetings with all Outreach Workers (20 x 4 meetings)	80
Project stationery & supplies (5 x 12 months)	60
Subtotal: General Administration	**620**
Travel and Associated Expenses	
For Regional Coordinator *Fuel and Travel expenses* (45 x 12 months)	540
For Evaluation Officer *Fuel and Travel expenses* (5 x 5 days)	25
For Outreach Workers *Bus Fare for Client visits* (1 x 1,000 person days)	1,000
Bus Fare for quarterly meetings (2 x 5 Outreach Workers x 4 meetings)	40
Subtotal: Travel and Related Expenses	**1,605**
Supplies and Equipment	
Materials for Client education (25 x 6 [Outreach Workers and Regional Coordinator])	150
Carrying Bags for Outreach Workers (5 x 6 [Outreach Workers and Regional Coordinator])	30

Notebooks for Outreach Workers (1 x 12 notebooks x 6 [Outreach Workers and Regional Coordinator])	72
Subtotal: Supplies and Equipment	**252**
Purchased Services	
Vehicle Lease and Maintenance for Regional Coordinator (200/month x 50% x 12 months)	1200
Vehicle Lease and Maintenance for Evaluation Officer (10/day x 5 days)	50
Subtotal: Purchased Services	**1250**
Education and Training	
Training Materials to be given to Regional Coordinator and Outreach Workers (10 x 6 [Outreach Workers and Regional Coordinator])	60
Transport to training (2 x 5 Outreach Workers)	10
Per diem (15 x 5 Outreach Workers x 3 days)	225
Subtotal: Education and Training	**295**
Other Costs	**N.A.**
Total Budget Year 1	**31,577**

4. Prepare a summary sheet for the project that is being proposed.

Summary Sheet

1. **Project Title:** Río Blanco Region Pilot Project: Reducing Discontinuation Rates Through Outreach and Education

2. **Organization:** National Family Planning Program — Río Blanco Region

3. **Dates of Project Period:**

   Start Date: January 1, 1994

   End Date: December 31, 1995

4. **Project Budget:**

   Year 1 Budget: 31,577

   Total Budget: 63,629 (based on doubling the budget for Year 1, subtracting all start-up costs, or costs that will occur in order to begin the project, and making adjustments to the costs related to the Evaluation Officer)

5. **Narrative Summary:**

Río Blanco Region has been collecting data on discontinuers for the past two years and has found that the discontinuation rate for new users is significantly higher than the surrounding regions. A small survey conducted in the region indicates that clients are discontinuing the use of contraceptives because of misunderstandings about the methods and side effects. In contrast to the surrounding regions, the literacy level in this region is quite low. This means that written educational materials are of limited use, and information needs to be reinforced face-to-face.

Due to high rates of morbidity and low rates of contraceptive use, encouraging users to continue contraceptive use should have a significant impact on the health of mothers and children in the region.

The program proposes to institute a pilot outreach project throughout Río Blanco Region. This would be staffed by one Regional Coordinator, at 50 percent time, and 5 Outreach Workers. Each Outreach Worker will work with a clinic and will receive lists of recent discontinuers to follow up and provide with information about the benefits and possible side effects to expect from each contraceptive method. Mid-term and final evaluations will be conducted to assess the project's impact on discontinuation in the region.

CHAPTER THREE

Using CQI to Strengthen Family Planning Programs

Continuous Quality Improvement (CQI) is an exciting management approach that is being introduced in family planning programs around the world. CQI is based on the belief that *anybody* at *any level* of the organization can make valuable suggestions about ways to improve operations. Unlike traditional management approaches, which focus on improving only the processes that are not functioning well, CQI assumes that any process within an organization can benefit from some improvement. Because CQI emphasizes a process of constant improvement in operations, it requires long-term organizational commitment and teamwork. Family planning programs that use CQI can raise staff morale, and improve productivity, efficiency, and client satisfaction.

This issue offers some practical suggestions for using CQI in your organization. Included with this issue is a supplement called the *Manager's Toolbox for CQI*, which contains important tools and techniques that managers can use to implement CQI.

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The CQI Process

The principles and techniques of quality improvement were formulated in the 1950s by W. Edwards Deming, an American management expert, using the ideas of Walter Shewart from the 1930s. These principles and techniques have been applied in corporations all over the world, particularly in Japan, where they have revolutionized corporate thinking and practice. Although quality improvement was first introduced and most widely used in business and manufacturing, its usefulness is not limited to these types of organizations. Recently, the concept of quality improvement been used in managing health services, including those offered by family planning programs.

CQI can be implemented across an entire organization such as a business, hospital, social or health agency, or school. Managers can adapt and use CQI to improve services in individual organizational units, or in several units combined. Clinic managers can adapt the techniques presented in this chapter to suit their work setting. Whether CQI is implemented across an entire organization, or within a single unit, strong commitment from management, appropriate resources, and adequate time are all required to make the CQI process successful.

CQI recognizes that many organizational problems result from *systems and processes*, rather than from individuals. CQI encourages staff members at all levels to work as a team, to draw on their collective experience and skills, to analyze systems and processes, to use information to identify the nature and size of each problem, and to design and implement activities to improve services. When staff begin to make improvements, they themselves monitor the impact of their changes. If at first the desired outcomes of the process are not achieved, then the staff can continue to make improvements until these results are achieved.

This chapter presents the principles of CQI. It discusses what you need to do to prepare for CQI, how to initiate CQI in your organization, and the steps involved in implementing the CQI cycle.

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

Once the preparation for CQI has been completed, CQI teams must be formed and trained to **initiate** CQI. There are seven steps involved in **implementing** the CQI cycle.

Step 1: **Identify an area** where opportunities for improvement exist.

Step 2: **Define a problem** within that area, and **outline the sequence of activities (the process)** that occurs in that problem area.

Step 3: **Establish the desired outcomes** of the process and the **requirements needed** to achieve them.

Step 4: **Select specific steps** in the process to study and for each step, list the factors that prevent the achievement of the desired outcome.

Step 5: **Collect and analyze data** about the factors that are preventing the achievement of the desired outcomes of the specific step being studied, and quantify the outcomes of that step.

Step 6: **Take corrective action** to improve the process.

Step 7: **Monitor the results** of the actions taken.

It is essential to build CQI into routine organizational procedures by continuously repeating the CQI cycle. This will help to maintain improvements and to identify and address new areas where services can be improved on a regular basis.

Differences Between Traditional Management and CQI

Aspects	Traditional Management	CQI
Quality standards	Quality is based on pre-determined program objectives and is monitored periodically.	Quality is based on clients' feedback and needs. Quality is monitored continuously and is built into the work process.
Problem solving	Problem solving and decision making done by senior managers and specialists.	Problem solving and decision making done in collaboration with staff and based on hard data.
Improvement process	Short-term improvements made, often at point of crisis (reactive).	Gradual, continuous improvements made in all functions (proactive).
Program clients	Clients are not usually consulted for their opinions.	Clients are partners and are regularly consulted.
Work environment	Staff work individually.	Staff work in teams.
Performance recognition	Authority is rewarded.	Capabilities are rewarded.
Source of problems	Problems come from people.	Problems come from complex processes and systems.
Style of supervision	Control and direct staff.	Encourage staff to take initiatives.
Financial perspective	Quality costs money.	Quality saves money.

Adapted from Llewelyn Leach and Mayer articles, 1992

Understanding the Principles of CQI

Managers who initiate the CQI process must incorporate the five basic principles of CQI into their management style.

Leadership Must Provide Firm Commitment and Support for CQI. CQI requires new ways of thinking, a willingness to change, and mutual support among management and staff. Therefore, the family planning manager, whether a director of a large country program or a manager of a busy clinic, must be willing to initiate CQI and provide ongoing leadership and guidance to the staff at every stage of the process. Managers must consider the improvement of quality to be a top priority, must communicate the importance of quality to their staff, must allocate enough resources to make the CQI process work, and must be prepared to implement changes proposed by their staff.

CQI's Major Principles

- Secure full commitment and support of leadership.
- Satisfy internal and external clients.
- Focus on processes to solve problems.
- Respect the contributions of all staff.
- Collect and use data to improve processes.

Adapted from Hardee and Gould, 1992

Satisfy Your Clients. In family planning programs there are two kinds of clients—internal and external clients.

Internal clients are the *program staff* who are served by organizational operations. For example, service providers become satisfied internal clients of a commodities supply system when managers, warehouse staff, and delivery agents have ensured that sufficient levels of contraceptives are always in stock. CQI requires that managers believe in the importance of serving internal clients well. To improve the satisfaction of internal clients, managers need to be ready to involve every level of staff in quality improvement activities, and must create a cooperative work environment.

External clients are the *women and men who receive family planning services.* When external clients are satisfied, a clinic or program not only gains more new acceptors and continuing users, but significantly contributes to the impact of the family planning program on health and fertility. CQI demands that managers believe that meeting clients' needs and expectations will improve services and will better satisfy those clients.

Focus on Process to Solve Problems. A process, or system, is a set of operations or activities that are performed repeatedly to produce services. CQI assumes that problems in service delivery are the result of inefficient, poorly designed, or malfunctioning processes, rather than ineffective staff. If you improve the appropriate part of a process or system where a problem has been identified, you will usually fix the problem. CQI therefore focuses on defining and improving processes to achieve an organization's desired service outcomes.

Respect Your Staff's Ability to Improve Processes. Managers who respect the skills and abilities of their staff can empower them to work together to prevent or solve problems and improve the quality of services. In a busy program or clinic, it is difficult for even the most conscientious manager to be completely aware of every step involved in delivering services. Staff who carry out the day-to-day activities of the clinic know which aspects of their work function well and which don't. They are in an excellent position to use this knowledge to propose practical changes that they themselves will ultimately carry out. Managers who implement CQI need to create an environment in which staff members contribute ideas, make decisions, and do not fear reprisals. This environment empowers staff and increases job satisfaction, which in turn contributes to improved client satisfaction and quality of services.

Collect and Use Data. Decisions about process improvements must be based on facts. Most family planning facilities already generate considerable amounts of service data that can be analyzed to suggest possible solutions. In CQI, managers must use data to determine the nature and size of the problems, and to justify any decisions made to improve processes.

Preparing for CQI

Preparing for CQI involves making senior managers aware that CQI can improve organizational management, and creating a core group that will implement the CQI process.

Raise Awareness and Secure the Commitment of Leadership

A senior manager should be the initiator of the CQI effort. This senior manager should gain the full participation of all managers by helping them to understand the principles of CQI, the improvements it has brought to other organizations, and the risks involved in implementing such an effort. To do this, managers may wish to read about CQI and, if possible, visit other organizations that are using CQI. Local business schools, universities, or schools of management are resources for finding these materials. For a list of references, see the reference section on page 93.

Managers must develop a realistic vision of what they would like CQI to bring to their organization, and be able to communicate that vision to staff at other organizational levels. During this preparation stage, managers can identify and adapt training materials that will be used to introduce and explain CQI to staff. These materials should include information about the steps involved in implementing the CQI process, staff responsibilities for supporting the process, the resources needed, the demands that CQI will place on their staff, and the potential benefits of CQI.

Create a CQI Core Group

In a large organization, the initiating manager will be most effective if he or she organizes a group of senior managers, often called the "CQI core group," who will lead the process. This core group will be responsible for planning the implementation of CQI, getting the process started, and supporting it at all levels of the organization. They will lay out the steps for the ongoing CQI process, develop training materials, organize training for all staff, and provide technical assistance to the teams that will subsequently be formed to carry out CQI. If CQI is being implemented on a small scale, a single unit manager or a designated staff person may perform most of the functions of the core group.

If you are leading the CQI initiative, you will find that even if you form a core group you are the one who will ultimately be in charge. Your job will be to support the entire process. You should make sure that your core group is trained, and that CQI responsibilities are included in the job descriptions of the group members. Their performance should be monitored and rewarded in the same way as their performance in other job functions, and they should be properly trained and helped to grow in the job through feedback and in-service education. You should lead by example and encourage the other core group members to do the same. You must listen to criticism, work closely with your core group, and encourage their full participation in the CQI process. As the CQI teams are formed, and throughout the CQI process, the core group will perform the same support functions for the teams as the CQI initiator has for the core group.

Tools and Techniques for CQI

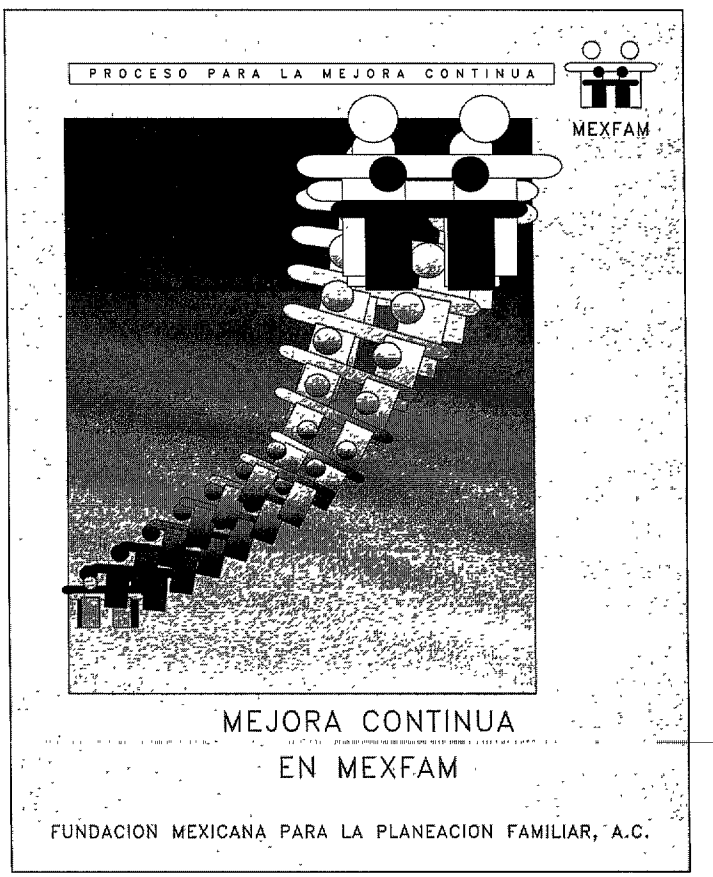
This chapter refers to a number of tools and techniques that can be used in implementing the CQI process. The accompanying supplement, *Manager's Toolbox for CQI*, explains when in the CQI process to use these tools and techniques, and how they can be applied in implementing CQI in a family planning program. Please refer to the *Manager's Toolbox for CQI* to learn more about:

- using a matrix for selecting areas for improvement;
- flowcharting;
- brainstorming;
- cause-and-effect diagrams;
- client flow analysis;
- tally sheets;
- bar charts and histograms;
- "Pareto" analysis;
- benchmarking.

The Importance of Preparation: Highlights from MEXFAM's CQI Training Program

In 1991, MEXFAM, the International Planned Parenthood Federation's (IPPF) affiliate in Mexico, initiated a CQI program to improve the quality of the family planning services provided at its headquarters and at six regional service delivery sites. Initially, only some of the departments and regional centers who had been trained, actively embraced the CQI program. As a result of this uneven acceptance, the core group realized that they needed to tailor the general CQI philosophy to MEXFAM's environment, and to develop a uniform conceptual approach that was appropriate to the organization. Consequently, a manual was developed to orient the staff about the purpose, principles, and benefits of using the CQI approach at MEXFAM. The manual was used to train the staff about CQI and provided them with reference material that they could use during the entire implementation process.

The manual stressed the importance of following the key principles of CQI, outlined the implementation schedule of MEXFAM's CQI program, and emphasized the critical elements of the program.



Critical Program Elements:

- CQI is a long-term process.
- CQI results are permanent because they become institutionalized.
- Basic support systems for CQI include knowing the needs of both internal and external clients, producing and managing information, and measuring outcomes.
- Leaders in the process are also responsible for promoting change, facilitating the process, and being active participants who lead by example.
- CQI activities are an investment rather than an expenditure. The positive long-term results of CQI will more than compensate for the effort.
- The CQI process does not necessarily eliminate all of the normal problems and conflicts that always arise.
- CQI provides better tools for identifying and solving problems. Using CQI as a problem-solving technique develops staff's maturity and intellectual skills.

Source: Sistema de Calidad en MEXFAM

Initiating CQI Activities

To initiate CQI in your organization, you will need to form CQI teams and train the members in CQI methods.

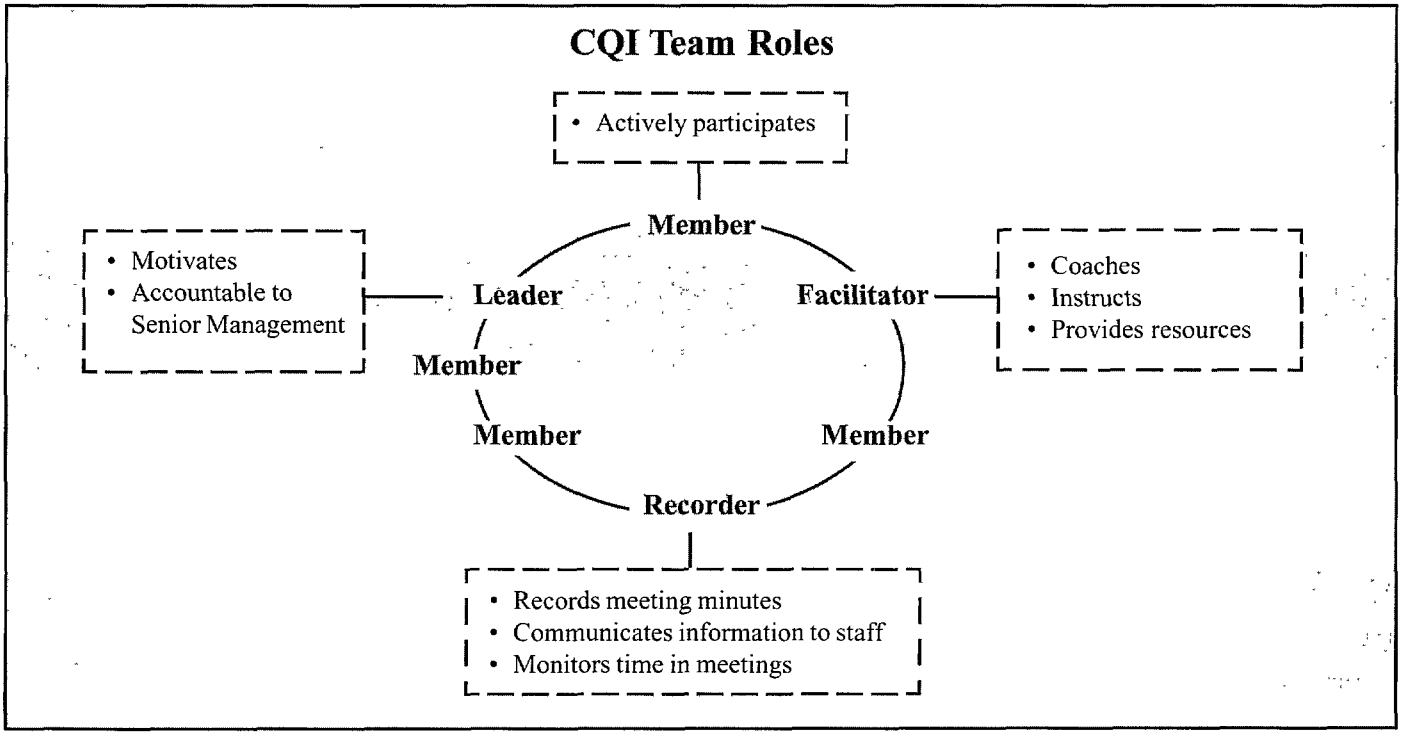
Form CQI Teams

Once you have formed and trained your core group, you are ready to perform the support functions for the CQI initiative. The first task is to form a CQI team made up of staff members who will look at management processes and activities and identify areas for improvement. Members of the CQI team are sometimes made up of staff within a single department of the organization. Another possibility is to form a **cross-functional team** made up of staff members from several departments, such as nursing, laboratory services, and administration. Cross-functional teams have the advantage of being able to look at processes, systems, and problems from different perspectives. The CQI team should include members of the CQI core group, at least in the beginning, to help guide the process. Once the team is formed, the roles and responsibilities of each team member should be determined by the team. At a minimum, each team should have a leader and/or facilitator, and a recorder. If the team is small, the leader and the facilitator may be the same person.

The composition of the CQI team may change once its members have agreed on the first area for improvement. Adding people with expertise in a chosen area can strengthen the team's ability to effectively address the selected problem. On the other hand, members of the CQI team with few skills in that particular problem area may become less active until the team has completed its work on that problem and meets to decide on another area for improvement. CQI teams may be permanent, or they may be formed for a specific quality-improvement activity and then disbanded when the improvement has been instituted. Depending on the situation, either approach can be successful.

Conduct Training

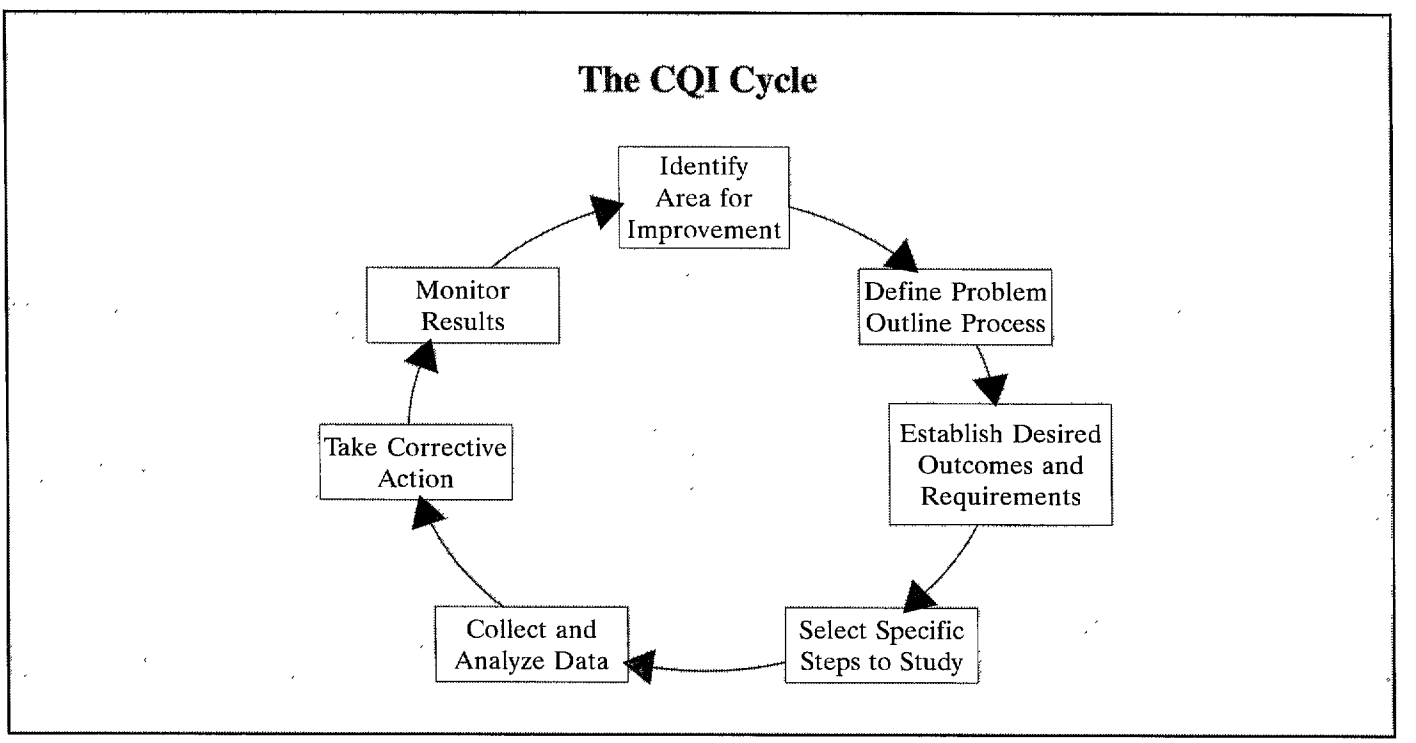
The members of the CQI team must be trained in the techniques that they will use to implement CQI. These include teamwork, process analysis, the measurement and interpretation of data, problem solving, and the monitoring of activities. Staff may be trained formally, through seminars, or informally, through reading and discussion groups. Any materials used in training should be gathered or prepared well ahead of time so that the training can begin as soon as the CQI teams have been formed. Immediate training of new CQI teams is the most effective way to motivate staff.



Implementing the CQI Cycle

CQI is a cyclical process. It involves identifying an area where there is an opportunity for improvement, defining a problem within this area and outlining the sequence of activities (the process) that occur in that problem area, establishing the desired outcomes of the process and the requirements needed to achieve them, selecting specific steps in the process to study, collecting and analyzing data about the process, taking corrective action, and finally, monitoring the results of those actions. Once the cycle is completed, the CQI team must determine whether the problem has been solved. If the problem continues, the cycle should be repeated: the process should be restudied and new actions taken until the desired outcome is achieved. If the problem has been solved, the CQI cycle starts again to identify and address a new area for improvement.

The CQI core group supports the CQI team to implement the CQI cycle, and should encourage flexibility in using the CQI process. There is no one right way to do CQI. The contribution of individual ideas and differing work styles will enrich the CQI process and enhance the likelihood of success.



Step 1

Identify an area for improvement. Opportunities for improvement exist in many areas of a family planning program, such as the management of clients, cost recovery, cost reduction, client satisfaction, staff satisfaction, and administrative systems. Ideas for improvement may come from a variety of sources both inside and outside the organization. Organizational assessments, client focus groups, interviews, suggestion boxes, supervisors or managers, staff members themselves, and service statistics are some of the sources the CQI team can use to identify areas for improvement. If a team comes up with a lot of different ideas, the members will want to develop criteria to help them to determine which ones to focus on first. (For an example of selection criteria, see the supplement to this chapter, *Manager's Toolbox for CQI.*)

An example of an area for improvement: A clinic nurse brings to the attention of the CQI team recent complaints from clients about how they are treated when they arrive at the clinic.

Step 2

Define a problem and outline the process. Once the area for improvement has been selected, the CQI team must define a problem within that area and outline the sequence of activities (the process) that occurs within that problem area. This step lies at the heart of CQI success.

> **An example of a problem:** The CQI team discusses and lists the types of complaints clients made about how they are treated when they arrive at the clinic. The CQI team decides to focus on delays in the client registration process, as one important aspect of how clients are treated.

After the CQI team defines the problem, the members must describe the entire process (the sequence of activities) related to that problem. Developing a **flowchart** helps to break up a routine process, or set of activities, into a series of sub-steps that make up that process (see Sample Flowchart of the Client Registration Process, page 84). The team will need to define the beginning and the end of that process, and outline (in sequence) the activities that complete the process. This allows the team to further define and analyze each step in the process.

Step 3

Establish the desired outcomes of the process and the requirements needed to achieve them. The team must establish the desired outcomes of the *entire* process, as well as the desired outcomes of *each step* in the process. These desired outcomes are used to define standards that should be consistently achieved for each step in the process, and for the process as a whole.

> **An example of a desired outcome of the entire process:** Registration process is completed within 30 minutes of client's arrival at the clinic.

> **An example of a desired outcome of one step in the registration process (pulling the client's record):** Registration clerk always locates the client's record within 5 minutes of her arrival at the clinic.

Once the desired outcomes have been determined, the team identifies the conditions or requirements needed in order to achieve each step in the process. Requirements are usually related to resources (human, financial, and material).

> **An example of the requirements needed to achieve one step in the registration process (pulling the client's record):** A filing system exists, and the registration clerk is proficient in using the system.

The desired outcomes and the requirements needed to achieve them are then written next to each step on the flowchart. They should be discussed and fully understood by the team. The completed flowchart should be widely circulated among the staff and referred to frequently in staff meetings and discussions, so that staff will understand what the CQI team is working on and can contribute their ideas.

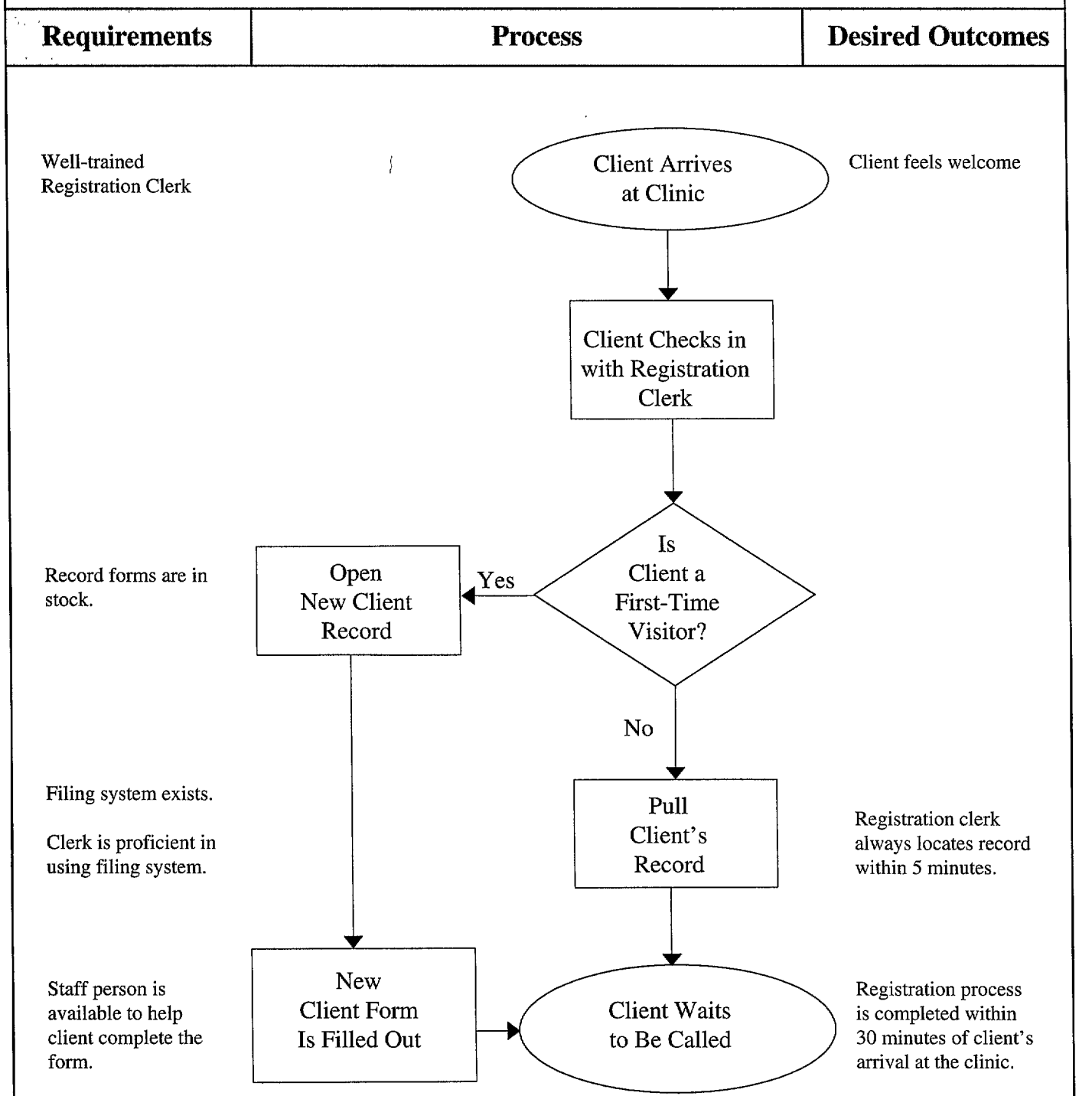
Step 4

Select specific steps in the process to study and, for each step, list the factors that prevent the achievement of the desired outcome. The team will need to identify the specific steps in the process where they believe the desired outcomes are not being achieved. Focusing on these steps will help them to understand the main factors (causes of the problem) that are contributing to an ineffective or inefficient process.

> **An example of a step in the process to study further:** After discussing the steps in the flowchart, the CQI team decides to work on the step labeled "Pull client's record." The CQI team agrees that the client files are not being located quickly. Because the desired outcome of this step is not being achieved—"Registration clerk always locates the client's record within 5 minutes"—the team discusses the factors that are responsible for the desired outcome not being achieved.

There are several techniques that can help the team to identify the possible causes of process failure, including reviewing the process flowchart, examining the factors that influence the problem, and conducting a brainstorming session where the team can discuss all the possible reasons why the desired outcomes are not being reached. (For more information about these techniques, see the supplement to this chapter, *Manager's Toolbox for CQI.*)

Sample Flowchart of the Client Registration Process



Adapted from Hardee and Gould, 1992

An example of several factors that prevent the desired outcome of this step "Pull client's record" from being achieved: The CQI team conducts a brainstorming session to identify the possible factors that are preventing the achievement of the desired outcome of the activity, "Registration clerk always locates the client's record within 5 minutes." The team identifies several possible factors that may be preventing the clerk from achieving the desired outcome. These include lost records, misfiled records, files are too far away from registration area, inadequate storage space for client records, and illegible records.

The team should consider and list *all* the possible factors so that they are sure not to overlook some of the most significant, but less obvious, causes of the problem. The team can develop a list of possible causes and develop a diagram which arranges and groups the causes of the problem in a way that helps the team to identify the primary and secondary causes of the problem (see Cause-and-Effect Diagram in the supplement to this chapter).

Step 5

Collect and analyze data. The CQI team initially needs to collect data in order to verify their impressions about the specific problem being studied and the potential causes of the problem, such as those listed in Step 4. Later, the team will collect and analyze data to make sure that the requirements are in place and that they are indeed leading to the desired outcomes.

An example of data that can be collected: The CQI team designs a study to collect data on the factors that delay registration. To do this, they observe the registration process for two days. During the observation, they use a tally sheet to record each factor that causes a delay in finding a client's record and the number of times the record is delayed for each factor listed. Calculating the frequency of each factor that delays registration enables the team to identify the most important causes of delayed registration. These causes should be the focus of the team's efforts to improve the process.

Since collecting data is costly and time-consuming, the CQI team needs to set limits on the amount of data they collect. As data are collected the team should regularly analyze them to determine if they are helpful in verifying the size of the problem, prioritizing its main causes, and suggesting what corrective actions should be taken. Once useful results have been obtained, special studies usually will not have to be repeated. If useful results are not being obtained, the team should re-evaluate this activity and consider collecting other data.

Using Data in the CQI Process

The CQI team may be able to use routine data from service statistics and medical records to verify the existence of problems and to identify causes. Alternatively, they may have to collect non-routine data through different types of surveys or special discussion groups. The CQI team should start with data from routine sources, and, as they need more information, they can introduce non-routine data sources to deepen their study.

- Routine **service statistics** on acceptors, dropouts, or method mix often provide the first indication that a problem exists, and often suggest which processes may be hindering the delivery of high quality services.
- Selected information from **medical records** may further pinpoint the nature and size of the problem as it affects the health and welfare of clients. *For example, calculating the percentage of clients with pelvic infections who receive IUDs, or the percentage of clients with high blood pressure who receive pills, will suggest how well clinical protocols are being followed.*
- Special **assessments** can shed more light on the problem. *For example, using a tally sheet to determine what percentage of providers follow all the steps in a protocol can help indicate the nature and size of a problem, as well as the source of the problem.*
- **Interviews** with clients, either in groups (focus groups), or individually when they leave the clinic (exit interviews), can identify which aspects of the service delivery system cause satisfaction or dissatisfaction, as well as the extent to which various desired outcomes are being achieved.

Analyzing Data in CQI. Analyzing data can help the CQI team to:

- Quantify the difference between the actual and the desired outcomes. These results will indicate how serious the problem is, and whether it may be affecting other aspects of service delivery.
- Determine whether the problem is confined to a specific step or to several steps in the process.
- Determine whether clients are concerned about the problem.
- Determine how long a problem has existed and whether or not the problem is getting worse.
- Indicate whether progress has been made in improving the process.

As the team analyzes the data, they will be able to identify with greater certainty the primary factors that are most responsible for preventing the achievement of the desired outcomes. Analyzing the data will also help them to identify the types of actions that can be taken to correct the problem.

An example of analyzing data: The CQI team prepares a frequency table of the causes of delays in registration. They graph this data and perform a Pareto analysis to show the primary causes of the problem. The sample Pareto analysis indicates that misfiling and inadequate storage space are the two primary causes or reasons why the registration clerk was not able to locate the client records within 5 minutes. Together, these 2 causes account for 70% of the problem.

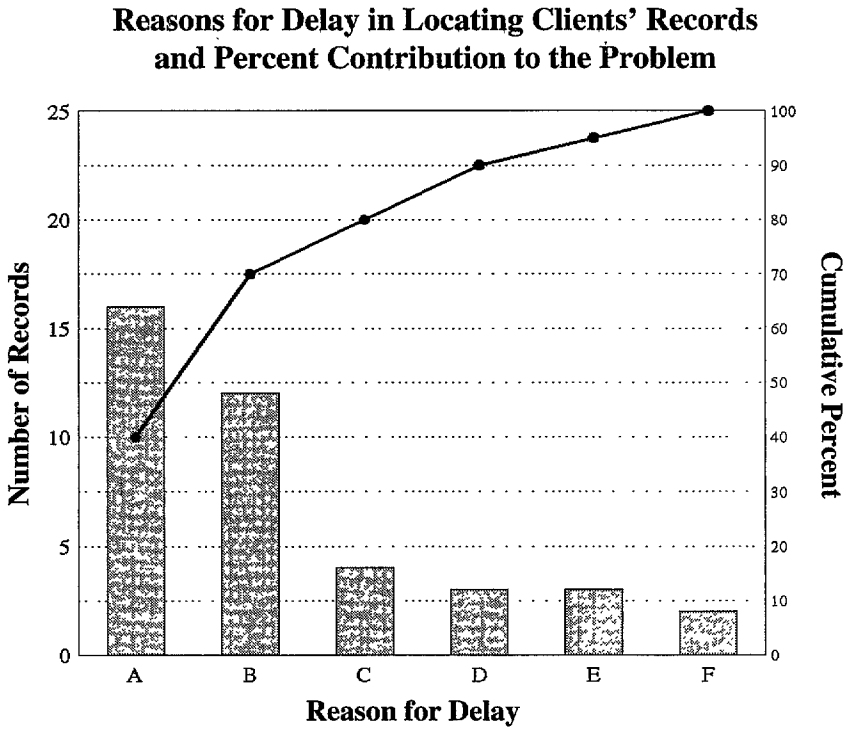
The CQI team can use basic graphing techniques to present the data and to illustrate the magnitude of the problem being studied. It is important to display the data in a way that allows the team to spot trends, so that they can discover the root causes of the problem. Using pie charts, bar charts, and line graphs to display the data will facilitate data analysis and the primary cause of the problem can often be seen more clearly. Performing a "Pareto" analysis helps the team to determine which two or three factors are most responsible for causing the problem. (For information on how to prepare and use pie charts, bar charts, and line graphs, see Chapter Ten, "Using Service Data: Tools for Taking Action." For data display techniques specific to CQI and how to perform a Pareto analysis, see the supplement to this chapter.)

Sample Pareto Analysis: Frequency Table

Reasons Identified by CQI Team for Delays in Locating Clients' Records

Reason for Delay (Ordered by frequency of occurrence)	**Frequency**		**Cumulative Percent**
	Number of Records	**% of Total Records**	
A. Misfiling	16	40	40.0
B. Inadequate storage space for client records	12	30	**70.0**
C. Record is far away from registration area	4	10	80.0
D. Illegible record	3	7.5	87.5
E. Lost record	3	7.5	95.0
F. Other	2	5.0	100.0
Total	**40**	**100.0**	**100.0**

Sample Pareto Diagram



Legend

A. Misfiling
B. Inadequate storage
C. Record far away
D. Illegible record
E. Lost record
F. Other

Adapted from Hardee and Gould, 1992

Step 6

Take corrective action. As a next step, the CQI team members will decide on a course of cor-rective action. The data analysis alone will not determine the specific actions that should be taken, but it will suggest some good alternatives to try. The CQI team can use a technique called "benchmarking" to compare the processes followed in their organization with those of a recognized leading organization in the same field (see the supplement to this chapter). Benchmarking is especially useful when managers wish to redesign a process. Since staff often tend to cling to the procedures that they have always followed, this type of comparison often yields valuable new ideas for improving performance that your staff might not necessarily think of.

Examples of corrective actions that could be taken: Relocating the registration desk to be closer to the files, moving the files closer to the registration area, purchasing a filing cabinet, relabeling the files, creating a less congested work space for the registration clerk, and providing refresher training to the registration clerk in filing procedures. In this example, the corrective actions that the team decides to take are to buy a filing cabinet and to provide refresher training to the registration clerk in filing procedures.

The team should develop an action plan that specifies each action to be taken, the proposed outcomes of these actions, the person who has the primary responsibility for implementing each activity, and a timetable for activities, including the points at which new data will be collected and monitored. The action plan should be integrated with other organizational work plans, to ensure that it is realistic, taking into consideration the staff's other obligations.

It is reasonable to expect that the action plan will change during implementation—dates may have to be adjusted, different staff members may become involved, and intervening events may suggest adding or removing an activity. These changes should be communicated to the staff, agreed upon, and added to the plan, so that the written document always reflects reality and always provides an accurate record of the implementation process.

Step 7

Monitor the results. Using the same techniques as those used in data collection, a CQI team can determine whether the actions they have taken have, in fact, corrected the problem. There are three likely possibilities:

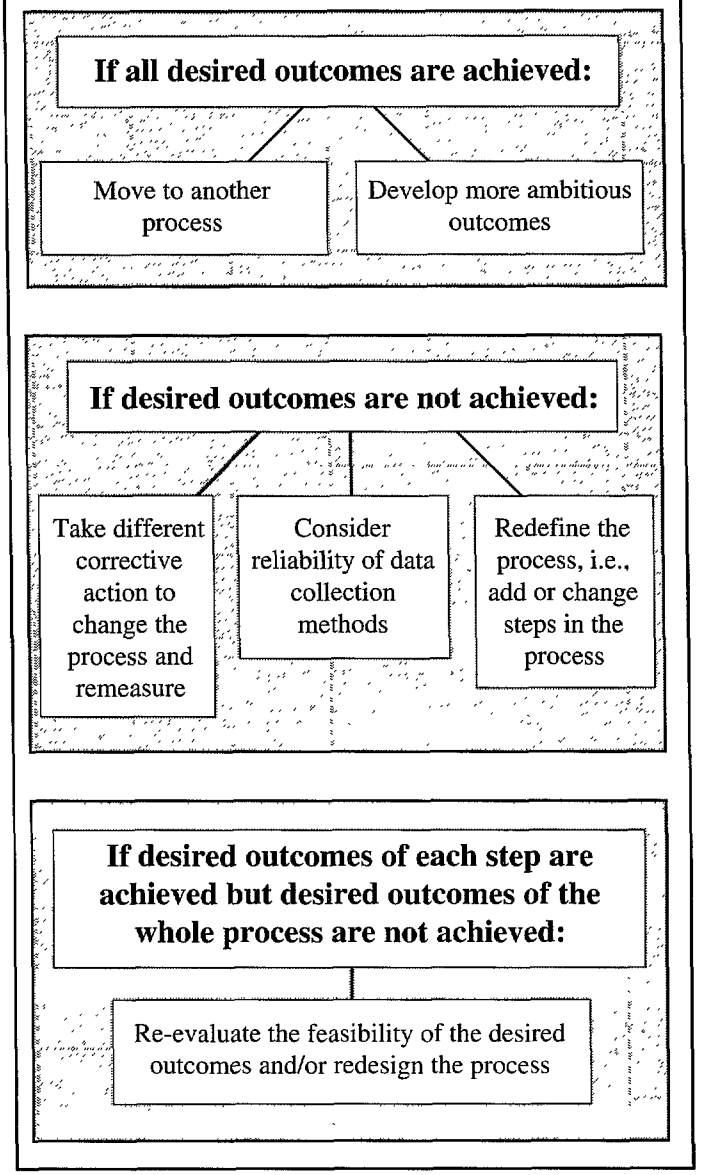
- Desired outcomes of both the process steps and the process as a whole *have* been achieved;
- Desired outcomes of both the process steps and the process as a whole *have not* been achieved;
- Desired outcomes of the process steps *have* been achieved, but the desired outcome of the whole process *has not* been achieved.

Each possibility requires a different kind of response. The ultimate goal of CQI is to develop a process that continuously improves the services that your organization provides.

An example of monitoring results: After the corrective actions have been implemented (purchasing a filing cabinet and retraining the registration clerk in filing procedures), the CQI team has to determine whether these actions have brought about the desired outcome of the specific step in the process being studied and of the overall process. The CQI team repeats the observation for one day to find out whether the registration clerk is locating each client's record within 5 minutes, is using the filing system effectively, and is completing the entire registration process within 30 minutes of each client's arrival. Conducting random interviews with clients as they leave the clinic helps the team to determine whether clients are satisfied with how they are treated when they arrive at the clinic.

Once staff have adopted the new (revised) process, a team member should be assigned to periodically monitor the process, to ensure that the staff continue to follow the modified process. This team member should look out for changes in the data that might indicate a return to the patterns that caused the problem in the first place.

Achieving Results with CQI



If the desired outcome of the step is still not being achieved—"Registration clerk always locates the client's record within 5 minutes"—the CQI team should consider implementing some of the other corrective actions that they identified, and monitor the effects of these interventions. If the **desired outcome of the step is being achieved** but the **overall desired outcome is not being achieved**—"Registration process is completed within 30 minutes of client's arrival at the clinic"—the CQI team should re-evaluate the registration process and determine whether the desired outcome is realistic, or redesign the process.

Implementing the CQI Cycle: The Experience of MEXFAM's Management Information Systems Department

Under MEXFAM's CQI initiative, MEXFAM's Management Information Systems (MIS) Department began meeting regularly to discuss operations that needed improvement. During these discussions, several members of this team expressed concern that they were spending more time providing ad hoc training and technical assistance to staff in the use of computer software than in carrying out their most important task: developing computer systems and software that were necessary for the organization to maintain its level of growth *(Step 1: Identify an area for improvement).*

The MIS Department agreed that the problem was that they had too little time for software and systems development. They determined that the process most related to the problem was how ad hoc training and technical assistance for computer problems was being handled. The team decided to develop a flowchart to illustrate the training and technical assistance process *(Step 2: Define a problem and outline the process).*

The team agreed that the final outcome of the training and technical assistance process should be fewer requests for technical assistance to solve software problems. A requirement should be that all staff have a basic level of computer skills that would allow them to solve most software problems on their own, so that almost all MEXFAM documents could be produced without special assistance *(Step 3: Establish desired outcomes of the process and requirements needed to achieve them).*

Unanimously, the team agreed that the training step was not being satisfactorily carried out, because staff could not solve basic software problems on their own. They did not know how to produce and print documents using all the basic software packages; nor did they know how to interact with the basic computer disk operating system (DOS), on which all the software packages were run *(Step 4: Select specific steps in the process to study and list the factors that prevent the achievement of the desired outcome).*

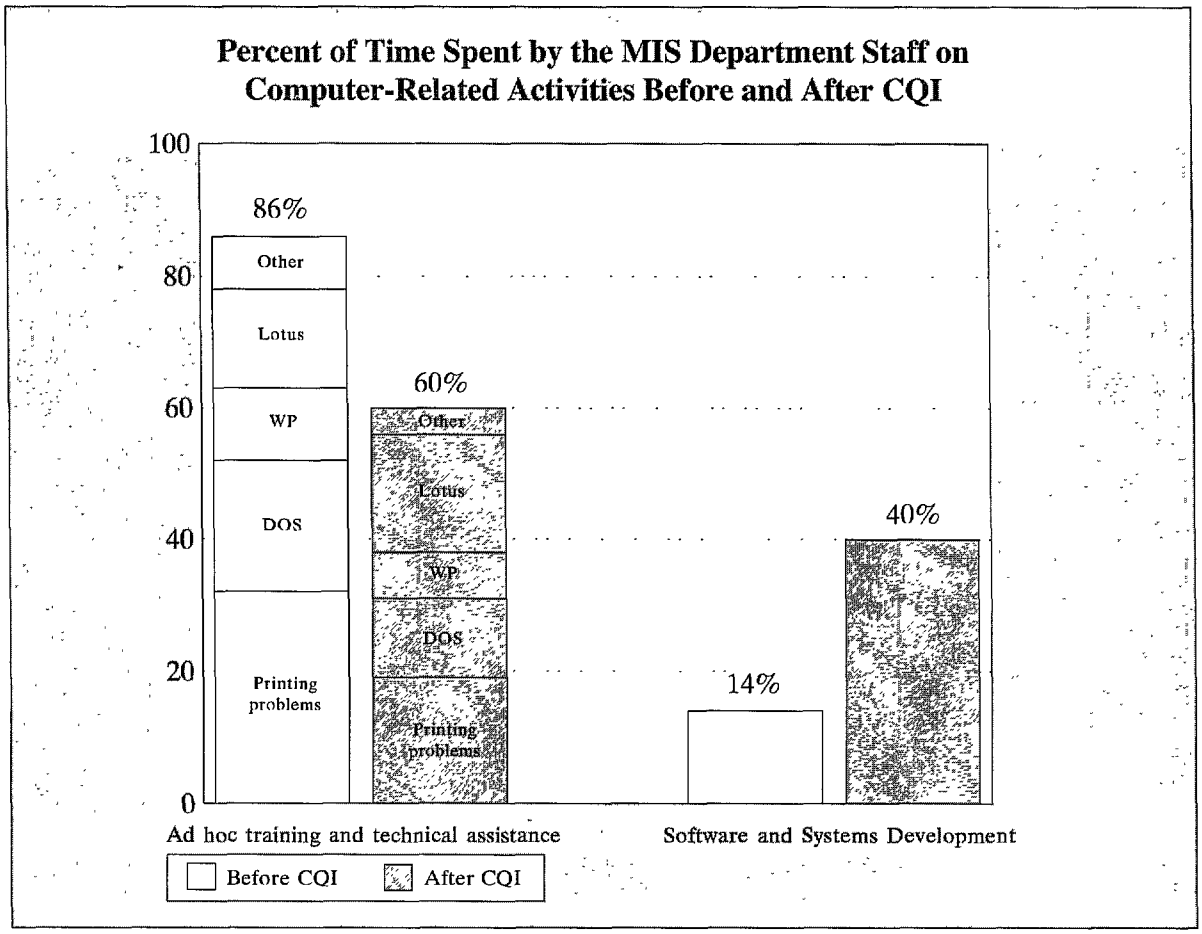
The team carried out the simple exercise of quantifying the amount of time each MIS Department staff member spent providing basic technical assistance to MEXFAM employees in solving problems related to printing documents, interacting with the DOS-system, using WordPerfect and Lotus, and other computer-related activities. They also quantified the time spent developing computer systems and software *(Step 5: Collect and analyze data).* The unshaded bars in the bar chart show the results of this initial analysis. The analysis verified that the MIS Department staff were spending so much time responding to requests for computer assistance that they had very little time to develop computer systems and software for MEXFAM, which was their primary responsibility.

As a first step towards reducing the amount of time spent providing technical assistance, the MIS Department staff developed an action plan to provide training to groups of MEXFAM employees from different working areas. The training was given for two hours a week over a six-week period *(Step 6: Take corrective action).* When the MIS Department staff remeasured the time they spent on various activities, they found that there had been no change in the number of requests for technical assistance *(Step 7: Monitor the results of the corrective actions).*

They re-examined the training program and discovered that because of absenteeism, many of the employees had not been able to attend the training sessions. They then developed a series of one-week training courses tailored to the needs of staff in each department *(repeat of Step 6: Take corrective action).*

Continued on next page

They again measured the proportion of time spent by MIS Department staff on the various activities *(repeat of Step 7: Monitor the results of corrective actions)*. The shaded bars in the bar chart show the results of this second measurement. The proportion of weekly staff time spent providing ad hoc training and technical assistance decreased from over 85% to 60%. The MIS Department had achieved their goal of reducing the amount of time spent providing ad hoc training and assistance, thus increasing the amount of time they could spend developing software and systems packages. As a result of the changes in the training and technical assistance process, the time spent developing software and systems jumped from 14% to 40%. This also resulted in the introduction of 3 new packages in the first 3 months, as compared with the previous year, when only 2 new packages were designed during the entire year.



After the second training program, all MEXFAM employees had learned how to fully utilize the computer software programs, were able to work more independently, and could more often solve computer-related problems on their own. Organizational communications also improved significantly. The CQI initiative had successfully reduced a major source of inefficiency, and had boosted staff morale.

In order to permanently reduce time spent on providing ad hoc training and assistance, MEXFAM's computer training and technical assistance process was modified to include two new steps:

- assess computer skills of all current and new staff;
- provide computer training to staff in each department, tailored to the needs of the department.

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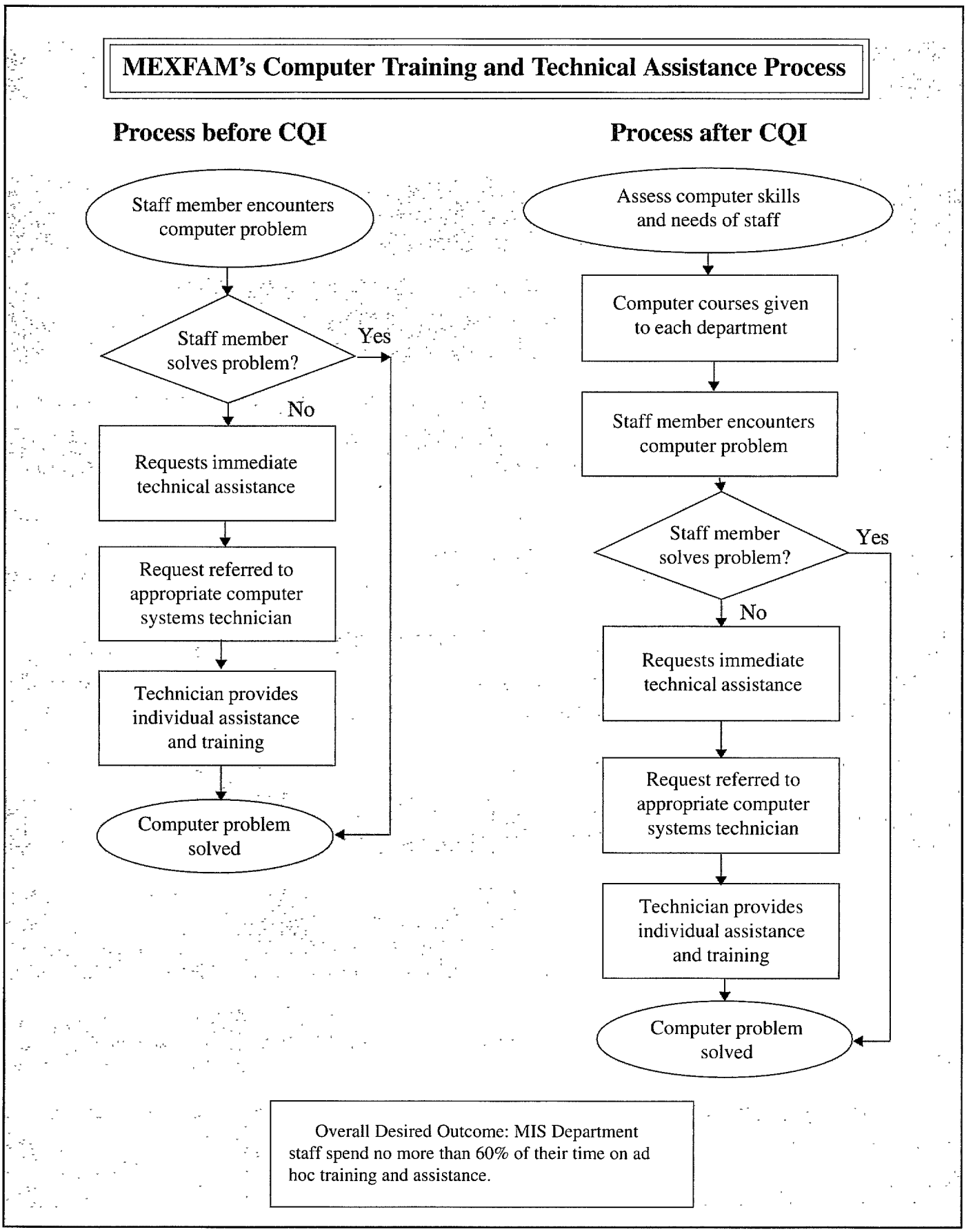

Information supplied courtesy of Lic. Alfonso Lopez Juarez, Executive Director of MEXFAM, and Dr. Pedro Manuel Acosta and Lic. Jesus Vertiz, of MEXFAM's Evaluation Department.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On institutionalizing the CQI process . . . *One reviewer comments,* "Program managers should consider incorporating CQI into routine organizational procedures. The processes described in CQI are similar to those that are typically applied to problem solving. What differentiates normal problem solving from CQI is that CQI is a management philosophy that is designed to be incorporated into routine organizational operations, and can be used to constantly improve operations as the systems evolve. This allows CQI not only to solve existing problems, but also to prevent other problems from developing, by recognizing the potential for a problem before it occurs."

On organizational improvement . . . *One reviewer offers,* "CQI creates an opportunity for the staff who carry out the day-to-day routine to work with top management to improve those routine operations. This is very important, because staff who feel that their concerns about clients are not heard or taken into account often become easily discouraged about their work. CQI makes a vertical organization more horizontal, which allows senior staff to exchange ideas and learn from staff who deal with the problems directly."

On the timing of implementing CQI . . . *One reviewer advises,* "It is important to initiate the CQI process immediately after training staff in CQI, in order to maintain enthusiasm and to obtain their full and active participation in the process."

On the risks involved in carrying out a CQI process . . . *Several reviewers offered advice about the potential risks involved in initiating and implementing the CQI process.*

On creating false expectations . . . "CQI teams have to be careful not to create 'false expectations' about whether the changes will completely solve the problem. Raising and then not meeting expectations can discredit the process."

On overburdening the staff . . . "It is extremely important not to increase the workload of the staff who carry out the day-to-day routine. CQI often involves additional tasks, particularly in data collection and in time spent in brainstorming, analyzing, and planning solutions. Overburdened staff soon become exhausted, particularly if no immediate improvements are apparent. This can lead to a rejection of the process by the staff because they see it as a waste of time and effort."

On alienating clients . . . "Although the goal of CQI is to improve service quality, the process may create disruptions as solutions are tested, or as staff take the time to meet to analyze processes and problem areas. Additional clients may drop out as a result of these inconveniences. Proposed solutions may also create unexpected problems in service delivery in other components of the family planing program, which can have a negative impact on client satisfaction."

On half-hearted leadership . . . "CQI depends on complete, unqualified commitment from the leadership of the organization. Changes in top-level management, or the emergence of pressures from the external environment, can often compromise such commitment or divert the leadership's attention from the process. This can negatively affect the quality of the analysis of the problems and the choice of solutions, and can ultimately worsen the outcomes of the CQI process."

Supporting Your Staff

It is important to remind your staff that the CQI process is cyclical, and that sometimes steps may need to be repeated in order to fully achieve the desired outcomes. Even after corrective actions have been taken, some process outcomes may still not be satisfactory. If a goal has not been reached the first time around, the CQI team can work through the implementation steps again and incorporate the experience gained in the previous efforts. In this way, they can:

- Examine the problem and its process steps from a new perspective (Step 2).
- Review the desired outcomes and requirements (Step 3).
- Review specific steps and factors that inhibit the process (Step 4).
- Collect and analyze other relevant data (Step 5).
- Take corrective action (Step 6).
- Monitor the new results (Step 7).

If staff discover that they need to repeat the CQI cycle again, your enthusiasm as supervisor will help to maintain morale and motivation. Remind your staff that CQI is not a computer program or a scientific formula. It is a skill that harnesses the combined contributions of the entire staff, and, like all skills, it must be built up through experimentation and practice. With consistent effort and commitment, incremental, ongoing improvements will provide a solid foundation for building and sustaining a high-quality program. Whatever the results, be sure to recognize the team's contribution to the CQI process.

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Checklist for Using CQI

For Senior-level Managers

- [ ] Raise awareness and secure commitment of leadership for CQI initiative.
- [ ] Become active participants in the CQI process.
- [ ] Create a CQI core group, and provide training and support to the group.
- [ ] Empower staff to carry out the CQI process and provide incentives for successful CQI efforts.
- [ ] Assess CQI results and adopt effective CQI improvements.

For Clinic Managers and Supervisors

- [ ] Establish a CQI team.
- [ ] Empower staff to carry out the CQI process.
- [ ] Become active participants in the CQI process.
- [ ] Monitor the effects of the improvements.
- [ ] Restart the CQI cycle to make more improvements.

For the CQI Team

- [ ] Identify areas where there are opportunities for organizational improvement.
- [ ] Select one area for improvement, and outline the sequence of activities that occur in that problem area (the process).
- [ ] Establish desired outcomes of each step in the process.
- [ ] Select and study the most important steps in the process.
- [ ] Collect and analyze relevant data to quantify the existing outcomes of critical process steps.
- [ ] Develop effective techniques for analyzing and discussing those data within your team.
- [ ] Make improvements in the process to narrow the gap between existing and desired outcomes.

SUPPLEMENT TO CHAPTER THREE

Manager's Toolbox for CQI

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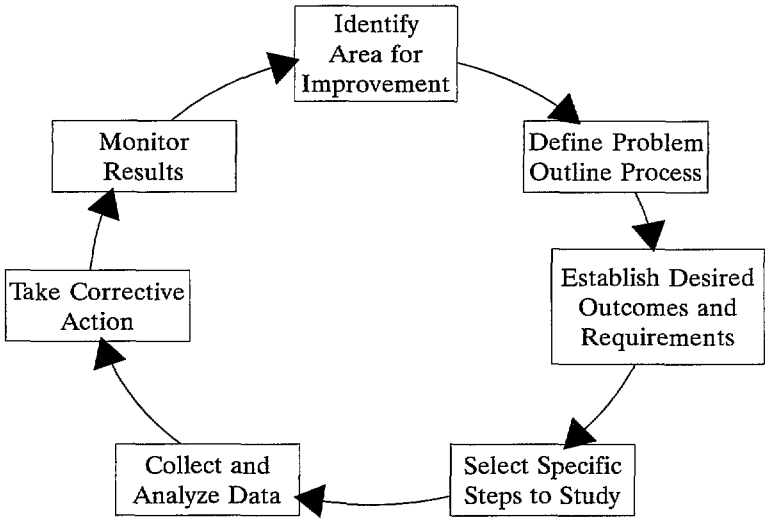
Checklist for Using the Manager's Toolbox for CQI 108

This supplement contains guidelines for using important tools and techniques to enhance the Continuous Quality Improvement (CQI) process in your organization. It describes how each technique can be used, and provides examples that illustrate how the techniques can be applied in a family planning program. This supplement also suggests when, and under what circumstances, each tool or technique can be used in implementing the CQI cycle.

The CQI Cycle



Using a Matrix to Select Areas for Improvement

The first step in implementing the CQI process requires identifying areas in which improvements are both necessary and feasible. This can be done by selecting areas that the organization has control over changing, and by determining which changes will have the most impact on improving the quality and/or efficiency of services. Often CQI team members will identify many areas where improvements should be made, but will find it difficult to decide which of those areas to study. This step can be made easier by developing a list of criteria that reflect organizational priorities, resources, and constraints, and by assessing each proposed area for improvement in the light of these criteria.

Once the team develops the list of criteria, a comparison table (or matrix) should be prepared that will allow the team to consider each proposed area for improvement against each criterion. By developing and using this matrix, the team can more easily identify which area for improvement will have the most impact on improving quality and/or efficiency. The matrix will also help the CQI team members to decide which problem they should work on first, and to prioritize other areas that they will study next.

Sample Selection Matrix

Area for Improvement	Criteria									
	Organization Has Control Over Changing	Process Is Important to External Client	Process Is Important to Internal Client	CQI Team Members Agree on Importance of Problem	Process Has High Visibility	Scope of Process is Limited/Changes are Feasible	People Involved in Process will Cooperate	Process Has Short Cycle	Data on Process Are Regularly Collected	Resources Are Available for Making Changes
Client Registration	x	x	Some	Some	x	x	?	x	x	x
Oral Contraceptive Supply System	x	x	x	x	x	x	x		x	x
Follow-up System for Clients who Miss Scheduled Appointment	x	?	x	x	?		?			
Old Records Storage	x		x			x	x	x		x

Adapted from Hardee and Gould, from Institute for Healthcare Improvement, 1992

In this example, the oral contraceptive supply system was determined to be the most important area for improvement, since making sure that the program did not run out of pills fulfilled most of the criteria that were important to the program. Next the team would have to define a problem to study within that area for improvement, such as the ordering process, the inventory control system, the record keeping system, etc. The team would then outline the process for that problem area, using the flowcharting technique (Steps 2 and 3).

Flowcharting

Flowcharting is a technique used to analyze the sequence of activities that occur in a particular process that you have chosen to study. Developing a flowchart helps you to break up a routine process, or set of activities, into a series of sub-steps that make up that process. A flowchart also helps you to define the relationship between the activities and the desired outcomes of those activities. To develop a flowchart, you need to define the beginning and the end of a particular process or system, and outline (in sequence) the activities that complete the process.

How to . . .

Make a Process Flowchart

1. Determine the first and last steps of the process.
2. Record the first step at the top of the page and draw an **Ellipse** around it.
3. Write down each step in the process in sequence.

   Use **Rectangles** for activities.

   Use **Diamonds** for decisions.

4. Mark the path of the flowchart from the beginning to the end by connecting all the rectangles (activities) and diamonds (decision points).
5. Return to the beginning of the path and repeat Step 4 for any paths that branch off from the main path.
6. Record the last step at the bottom of the page, draw an **Ellipse** around it, and connect the primary path and any branching paths to the last step.
7. Review for accuracy.

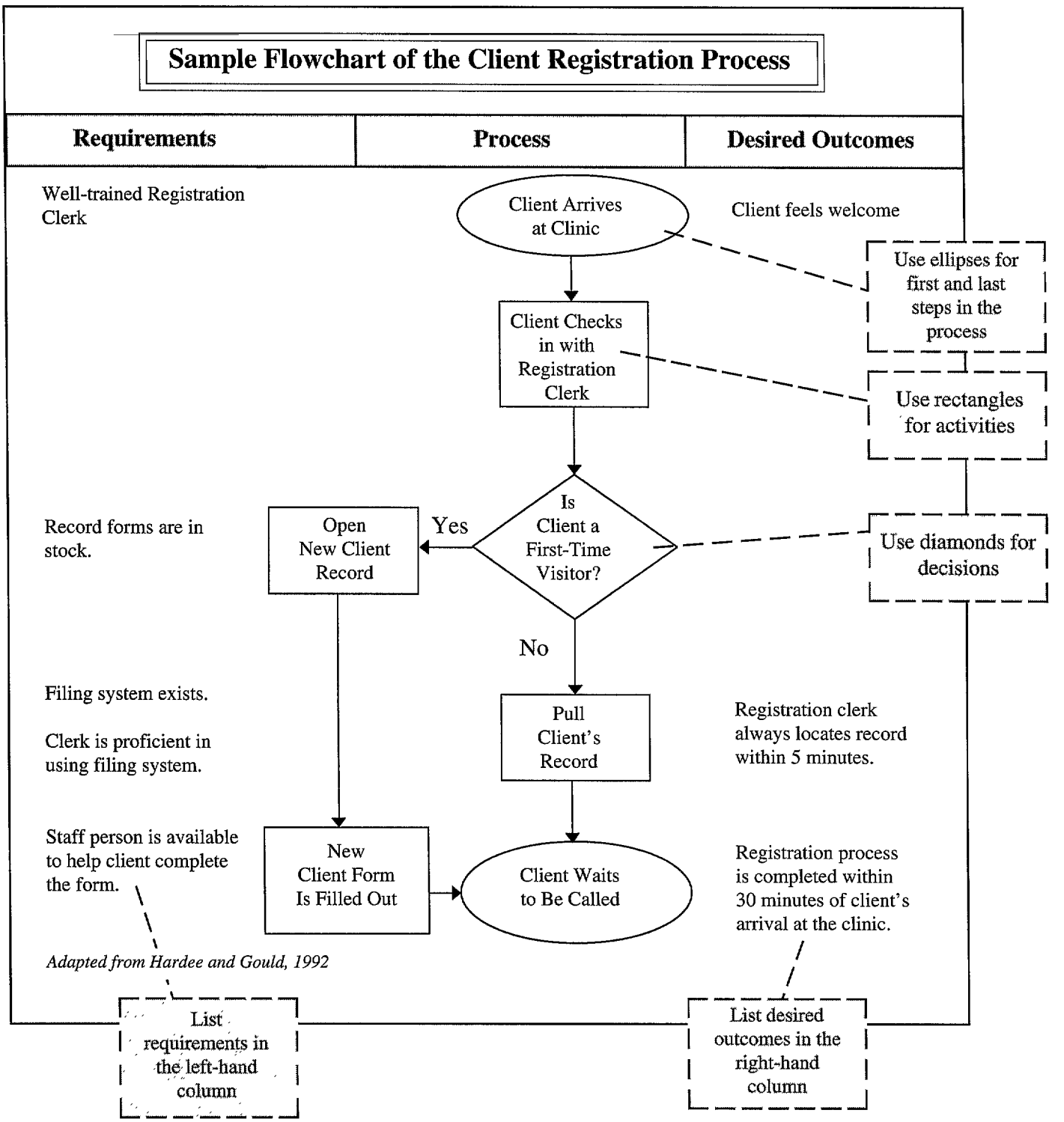
On more complicated flowcharts there may be smaller paths that will branch off from a decision point, since each decision point indicates an alternative process that may take place before it rejoins and completes the process later.

Determine requirements and outcomes

To complete the diagram, write the **requirements** that are needed in order for each activity to occur. Write the requirements in the left-hand column next to each activity. These requirements are often related to resources, such as human, financial, and material resources. Then, in the right-hand column, write the **desired outcomes** of each activity in the process. Write the desired outcomes of the whole process at the bottom of the flowchart. When determining the requirements and desired outcomes of the process, it is also important to consider the time needed to carry out each activity, as well as other constraints.

Once the flowchart is completed and requirements and desired outcomes are noted, the flowchart can be used to compare the differences between the desired and actual outcomes. Often, problems are found where the desired outcomes are very different from the actual outcomes. Making this comparison will help you to select the specific steps on which the team should focus its efforts.

Flowcharts are used at Steps 2 and 3 in the CQI process, and should be revised as new recommendations for improvement are made during the CQI process. It would also be helpful to create a flowchart of any new or revised system, which you can then use to present that new system (or process) to other staff in your organization. The flowchart will help staff to see where changes have been made, and how the changes will produce a positive result.



Brainstorming

Brainstorming is an excellent technique for generating ideas about all the possible causes of a problem. This technique is based on the assumption that all ideas are useful, thus encouraging the team to think creatively. By inviting people who have very different perspectives (for example, a clinician, a staff member, an administrator, a client, a finance officer, etc.), to a brainstorming meeting, the meeting is more likely to produce innovative ideas that may not have been considered before. This technique can be used at any step in the CQI process, but can be particularly helpful when the team is discussing the possible causes of a problem, or the factors that are preventing the desired outcomes from being achieved (Step 4).

How to . . .

Brainstorm About the Possible Causes of a Problem

1. Form a group of people to generate a list of possible causes of a problem.
2. Write the problem clearly on a flip chart or blackboard. Check to make sure everyone understands the problem.
3. Agree on rules for the brainstorming session and post the rules:

Rules of brainstorming

Every idea is valid.

Every idea is written down in the words of the speaker. If an idea takes a long time to explain, the speaker should list the major points for summary on the blackboard.

No one may interrupt or criticize.

Only questions of clarification may be asked.

4. Ask the group to identify the possible causes of the problem being studied, and record every idea. (The facilitator can assist this process by asking *why* the desired outcomes are not being achieved.)
5. Continue until no more ideas are offered.

Cause-and-Effect Diagrams

A cause-and-effect diagram is a tool that the CQI team can use to group, in an orderly way, people's ideas about the causes of a problem. A cause-and-effect diagram (also known as a fishbone diagram) helps the team to determine both the primary and the secondary causes of a problem, and is helpful for organizing the ideas generated from a brainstorming session. The sample "fishbone" diagram shown here, lists the primary and secondary reasons (causes) why clients may have decided to discontinue using oral contraceptives.

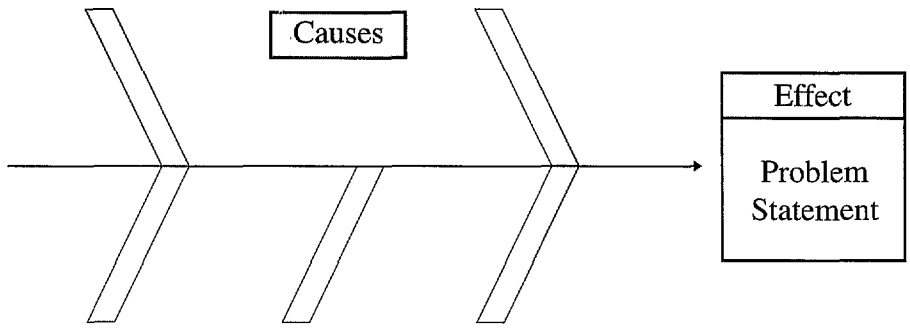
Using a cause-and-effect diagram forces the team to consider the complexity of the problem and to take an objective look at all the contributing factors. Otherwise, the CQI team members may think that one or two causes related to the most recent occurrence of the problem are the most important, when in fact there may be other more important underlying causes. Constructing a diagram does not solve the problem, but it ensures that the team does not overlook any possible causes of the problem. Data collection tools such as tally sheets, surveys, and clinic registers are some of the sources the team can use to pinpoint the possible causes of a problem. A cause-and-effect diagram should be used when the team is deciding which specific steps in the process to study (Step 4).

By examining a cause-and-effect diagram, team members can more easily choose one or more aspects of the problem that they have some control over changing, and identify those that they believe will significantly improve the situation.

How to . . .

Develop a Cause-and-Effect Diagram

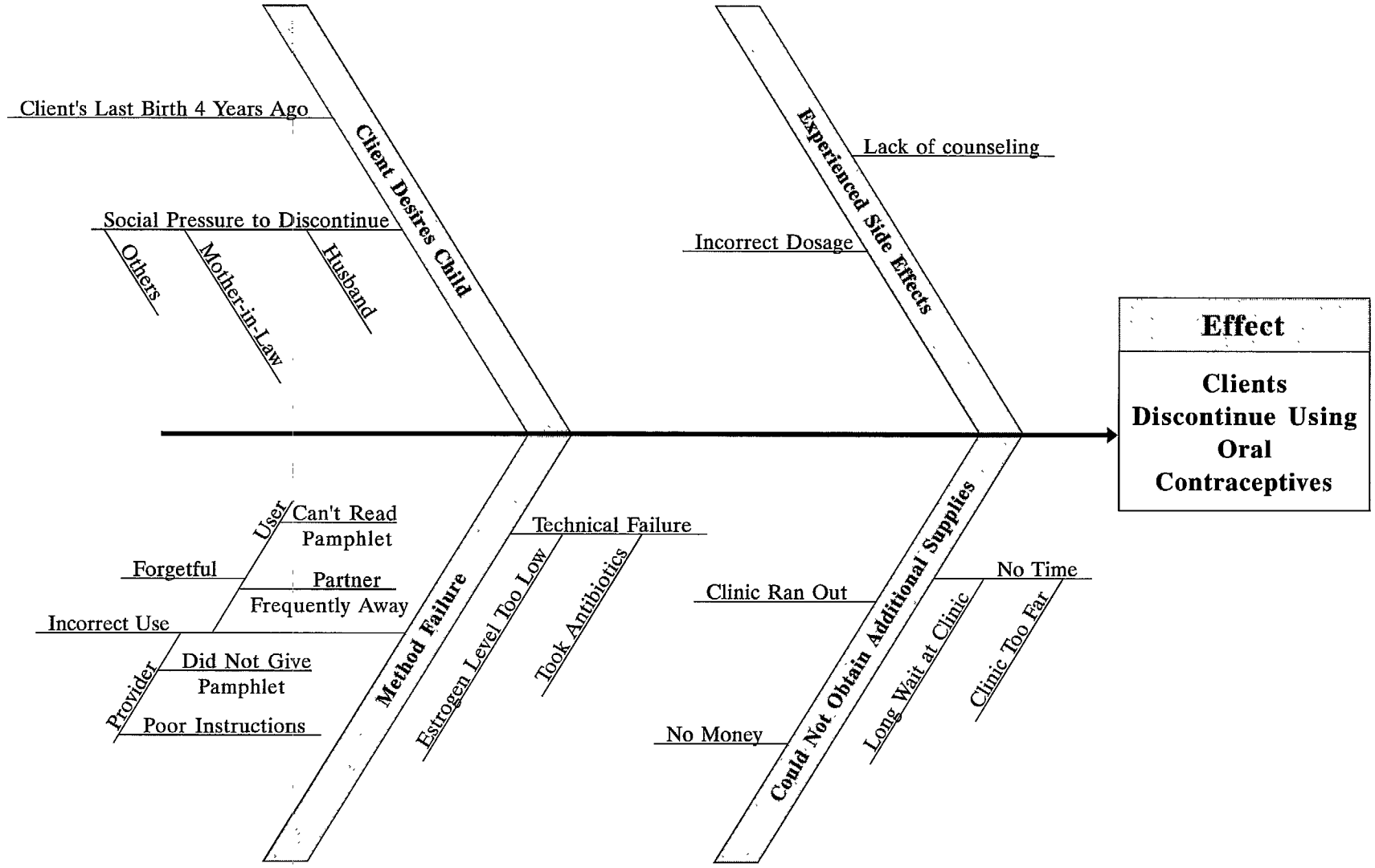
1. Draw a preliminary sketch or outline of a "fishbone" diagram, and fill in the box marked "Effect" with a statement of the problem.



2. Review the process flowchart that you have drawn, and consider the various aspects of the problem you are studying.
3. Brainstorm about the factors (causes) that affect the outcomes of each process step. To help determine the causes of the problem, remember that causes can be related to many aspects of service delivery: the facility itself, material resources, processes of implementation, people, or the system by which performance is measured.
4. Fill in the diagram so that the causes are organized in a logical way, and show both the primary and secondary causes of the problem.
5. Examine the diagram, summarize the primary and secondary causes of the problem, determine which causes the team has control over changing or improving, and collect data to determine which factors contribute most to the problem (Step 5).

Sample Cause-and-Effect Diagram

Problem: Clients Discontinue Using Oral Contraceptives



Adapted from Hardee and Gould, 1992.

Client Flow Analysis

In many clinics clients often have to spend a long time waiting before being served by a provider. Conducting a client flow analysis is helpful for discovering the primary causes of waiting times (Step 5). It can also help to analyze and understand overall clinic operations, including the route that clients follow as they progress through the clinic, and can indicate changes that will ensure a smooth and efficient process as clients are seen by different clinic staff members.

A client flow analysis consists of keeping track of the time it takes each client to proceed through the various activities involved in a clinic visit. Client flow forms, which can help the CQI team to collect and analyze this type of data, are designed to be used by staff members, and can produce valuable information about clinic procedures. At the end of the day, the information from the client flow analysis can be graphed to show, for example, the amount of time the clients spend waiting, instead of being served by a provider. Other information, such as the amount of time staff spend with clients, or where the client flow becomes particularly congested, can provide the CQI team with suggestions on which factors are impeding the efficient use of staff, time, and materials. For more information about how to conduct a client flow analysis, please see Chapter Nine, "Reducing Client Waiting Time."

For more information on client flow analysis, please refer to the following sources:

- "Reducing Client Waiting Time," Volume I, Number 1, *The Family Planning Manager*. Available from Family Planning Management Development, Management Sciences for Health, 400 Centre Street, Newton, MA 02158, USA.
- "COPE: A Self-Assessment Technique for Improving Family Planning Services." Available from the Association for Voluntary Surgical Contraception, Distribution Unit, 79 Madison Avenue, 7th Floor, New York, NY 10006, USA.
- "Patient Flow Analysis." This is a computerized program available from the Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, Clinic Management Unit, Mail Stop K22, 4770 Buford Highway Northeast, Atlanta, GA 30341-3724, USA.

Tally Sheets

Tally sheets are one way to easily and efficiently collect and organize data (Step 5). Tally sheets do not need to be complicated and can be used to collect data that may already be available in the existing Management Information System (MIS). Data collection tools, such as registers, surveys, and logs, are good sources for examining the possible causes of a problem.

Tally sheets should be used to list the types of data that will be collected and to record the number of observations or occurrences that are counted in each category. The sample tally sheet shows how a tally sheet can be used to track client complaints in six different categories. The data collected on the tally sheet can then be used to produce graphs, which can help the CQI team to visualize and pinpoint the factors that have the greatest impact on a problem.

Sample Tally Sheet for Client Complaints

Date: _____

Clinic Name: _____

Staff Member Completing Form: _____

Remarks: _____

_____

_____

Type of Complaint	Tally	Frequency
Lack of privacy	II	2
Clinic not clean	I	1
Method not available	III	3
Waited too long	~~IIII~~ II	7
Staff impolite	IIII	4
Clinic hours inconvenient	~~IIII~~ IIII	9
No bathroom available	III	3
Other	II	2

Adapted from Hardee and Gould, 1992

Bar Charts and Histograms

Bar charts and histograms can be used to display data graphically, which will help the team to organize and interpret a large number of facts, and to pinpoint the causes of a problem (Step 5). Bar charts and histograms are similar in that they both show the frequency distribution of data, in other words, they provide a graphic representation of the number of occurrences measured in *different categories of data* (bar charts), or in the *variables within a single data category* (histograms).

Examples of different categories of data: Different types and brands of contraceptives, different reasons given for not using contraception, different complaints about the clinic services.

Examples of a continuous variable within a single data category: The age groups (20-24, 25-29, 30-34, 35-39, etc.) of women using the IUD, the number of minutes (less than 5, 5-9, 10-14, 15-19, etc.) spent waiting to been seen by a provider.

Continued on next page

A simple **bar chart** compares different categories of data, such as *the average lead time promised by the distributor for **each method of contraception**; in other words, the average number of weeks it will take to receive delivery of each contraceptive method, after it has been ordered.* The data categories in a bar chart have no natural sequence on the horizontal axis since it doesn't matter in what sequence the data categories (in this case, the methods) are listed.

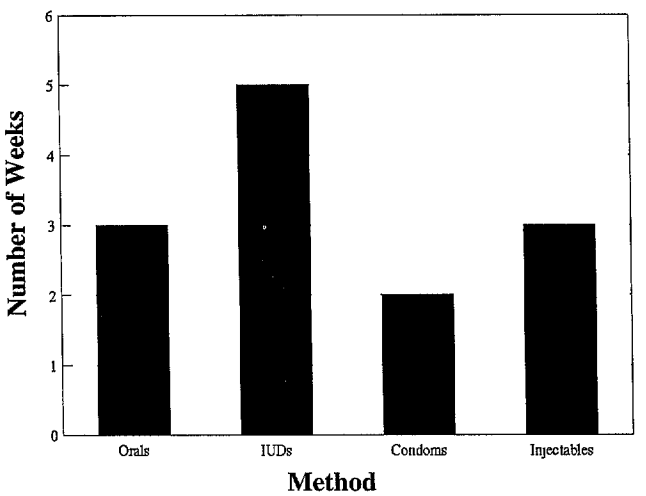
The sample bar chart shows that the distributor has promised a lead time of three weeks for orders of oral contraceptives, five weeks for IUDs, two weeks for condoms, and three weeks for injectables.

A **histogram** is a type of bar chart that compares variables within a single data category, and compares the number of occurrences based on a continuous variable, such as *the actual lead time for orders of oral contraceptives placed in the last two years; in other words, the number of orders of **oral contraceptives (single data category)**, graphed in terms of the **number of weeks (continuous variable)** it took to receive each order.* Since the continuous variable (number of weeks) has a natural sequence (lowest to highest number of weeks), the variable on the horizontal axis of the histogram is ordered sequentially from one to six.

A histogram displays the distribution of data and reveals how much the data vary. There will always be a pattern in the variation, and a histogram allows you to see the pattern. *The sample histogram shows that the number of weeks that it takes for orders to arrive has varied over the last two years, but the pattern reveals that the lead time for oral contraceptives is most likely to be closer to 4 weeks, rather than the 3 weeks promised by the distributor.* Discovering (and displaying) this variation will greatly increase the team's knowledge about a process. In this case, the clinic manager might want to increase the order quantity for pills, to ensure that the clinic doesn't run out of pills while waiting for a new supply to arrive.

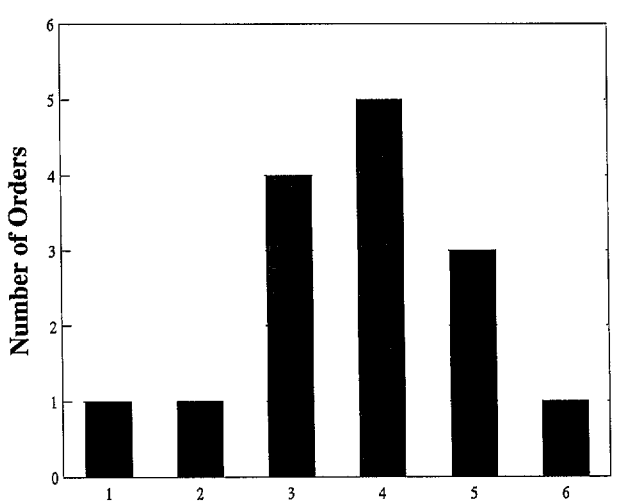
Sample Bar Chart

Lead Time Promised by the Distributor for Each Contraceptive Method Offered by the Clinic



Sample Histogram

Actual Lead Time for Delivery of Oral Contraceptives (1990–1992)



Pareto Analysis

The "Pareto" analysis originates from the work of an Italian economist, Vilfredo Pareto. The Pareto principle states that only a *few* factors are responsible for producing *most* of the result (positive or negative result). This principle was later applied to quality improvement theory by Dr. Joseph Juran, who stated that these "vital few" factors need to be identified so that quality improvement resources can be concentrated in those areas.

The goal of any quality improvement effort is to improve the "vital few" causes of problems in a process, and in so doing, achieve breakthroughs in the overall performance of a process. Focusing on the "vital few" achieves the greatest potential gain from quality improvement efforts. Like a bar chart, the Pareto analysis shows the frequency of responses, or occurrences, of different data categories (or different causes of a problem); however, in a Pareto diagram the responses are ordered from the highest to lowest number of responses tallied. In addition, for each response, the Pareto analysis shows the cumulative percentage of the total problem contributed by each additional response. This allows the team not only to see which two or three factors (causes) are responsible for most of the problem, but also to quantify how much of the total these "vital few" factors represent.

How to . . .

Perform a Pareto Analysis

1. Divide the data into categories, *such as each reason given for not using contraception.* Count and record the number of times each reason was cited.
2. Construct a frequency table by ordering the responses from the one most frequently given to the one least often given. Fill in the number of times each reason was given. Then total the number of all the responses at the bottom.
3. For each data category (or reason), calculate the percentage of the total responses it represents, and round to the nearest whole percent. *In this example, a total of 84 responses were counted. Of these 84 total responses, 35 responses (42 percent) referred to a lack of information about family planning (35 divided by 84 = .416 or 42%). The next highest number of responses, 25 (.297 or 30%), indicated a lack of access to family planning services.*
4. Calculate and record the cumulative percentages. Begin by recording the response with the highest percentage *(in this example, 42%)* at the top of the third column. Add to it the percent contribution of the next type of response *(for example 42% plus 30% = 72%)* and record the cumulative percent (72%) in the third column. Continue to record the cumulative percentages for each additional type of response to complete the table.
5. Using the data from the frequency table, construct a bar chart that presents the number of times (frequency) that each response was given, ordered from the most common response (on the left), to the least mentioned response (on the right). The vertical y-axis on the left indicates the number of times (from zero to the maximum) the response was given, and the vertical y-axis on the right marks the cumulative percentages (zero to 100%). Plot the cumulative percentages for each additional type of response, and draw a line to connect the points.

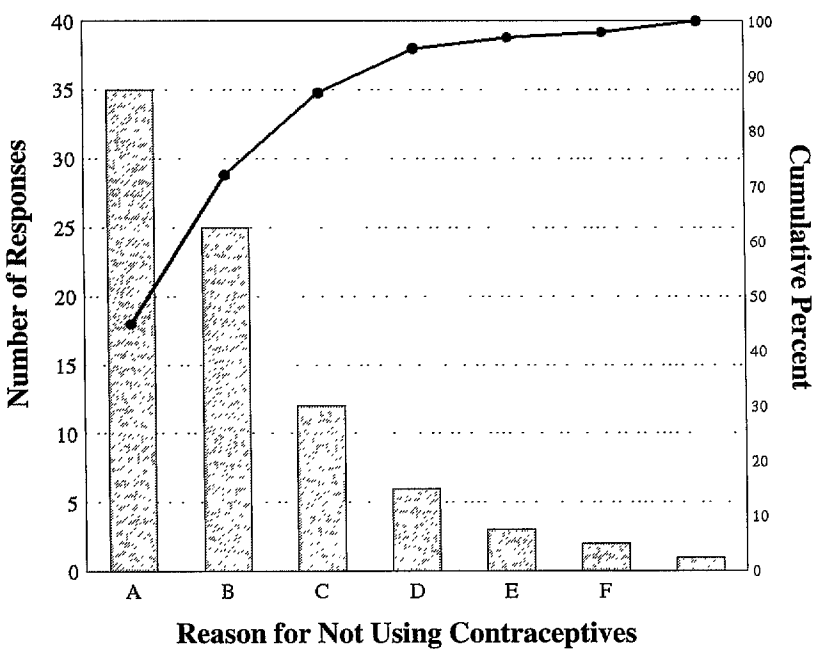
In any CQI effort, the team members should ask themselves, "Which few factors are contributing most to the overall problem?" The Pareto analysis is a technique for finding the answer to this question. *In the sample Pareto analysis, two reasons for not using contraceptives—lack of information and no access to contraceptives—account for 72 percent of the problem. In this example, the CQI team should focus their efforts on those two causes of the problem.* The Pareto analysis is generally used at Step 5 in the CQI process, but it can be used any time during the CQI process when graphing data might help the team to better understand a problem and its causes.

Sample Pareto Analysis

Reasons Given for Not Using Contraceptives By Eligible Couples in the Community

Reason for Nonuse (Ordered by frequency of occurrence)	**Frequency**		**Cumulative Percent**
	Number of Times Cited	**% of Total Responses (rounded)**	
A. Lack information	35	42	42
B. Have no access to contraceptives	25	30	72
C. Concerned about safety of contraceptives	12	14	86
D. Don't think pregnancy will occur	6	7	93
E. Partner objects	3	4	97
F. Desire pregnancy	2	2	99
G. Other	1	1	100
Total	**84**	**100**	**100**

Reasons for Not Using Contraceptives and Percent Contribution to the Problem



Legend

A. Lack information

B. No access to contraceptives

C. Safety concerns

D. Don't think pregnancy will occur

E. Partner objects

F. Desire pregnancy

G. Other

Adapted from Hardee and Gould, 1992

Benchmarking

By comparing the process followed in your organization with that of another family planning or health services organization, a technique called "benchmarking," you can develop new ideas about how to modify and improve the process that you have selected to study. Not all CQI efforts will require using the benchmarking technique. Whether or not you decide to take the time and resources to conduct a benchmarking exercise will depend, in part, on the size and complexity of the problem you are studying, and how critical that process is to achieving the goals of your organization. This technique can be used during Step 6 in the CQI process, when you are deciding what actions to take to correct a problem.

How to . . .

Use the Benchmarking Technique

To determine whether benchmarking would provide useful ideas for changing the process that you have selected for improvement, you should ask the following questions:

- Does the process produce one of your most important services?
- Are clients dissatisfied with the service they receive as a result of the process?
- Will improvement of the process support the program's overall strategy?
- Can the necessary data be obtained to analyze this process, so that comparisons can be made with other organizations?

Designate a benchmarking travel team. Include in the team someone who has expertise in the process you are trying to improve. Team members could also include a person who has been designated to implement changes in your organization, a person made responsible for coordinating the benchmarking process and, if appropriate, a program client. Designate one person as the team leader.

Select another organization to use as a "benchmark" for your organization. Identify an organization that provides family planning or health services (ideally, a non-competitor), or a leader in the process you are benchmarking who will be likely to share information with you. For example, to benchmark your contraceptive supply system, choose an acknowledged leader in warehousing and distribution, or choose an organization that has effective methods for storing, tracking, distributing, and ordering contraceptive supplies.

Contact the benchmark organization to explain the purpose of your proposed visit, gain their support for the visit, and set a date for the visit.

Make a site visit to collect data. Determine in advance the kind of information that you want. Send a list of your questions to your benchmark contact, so that he or she can prepare for your visit. Agree on an agenda for the visit. Arrange a meeting, tour the benchmark organization, and obtain answers to your questions. Ask about the organization's future plans for the process you are investigating, and be prepared to share comparable information about your own organization.

Determine any important differences between the process used by your organization and the process used by the benchmark organization.

Present your findings to the team, set new goals, and use the results to propose improvements in the process.

This supplement has described some of the fundamental tools and techniques that can be useful in implementing CQI in your organization. For more detailed information about these and other techniques that can be used in implementing CQI, please refer to the references section on page 93 of this chapter.

Checklist for Using the Manager's Toolbox for CQI

Tool or Technique	When to Use	Reason for Using
Selection Matrix	Step 1	To help the CQI team select an area for improvement to focus on first, by developing and using a set of selection criteria.
Flowcharting	Steps 2-3	To show the sequence of activities (the process) that occurs in the problem selected for improvement.
Brainstorming	Step 4	To generate ideas about all the possible causes of a problem. This technique encourages creative thinking among team members because all ideas are considered valid.
Cause-and-Effect Diagrams	Step 4	To organize ideas generated from a brainstorming meeting and to define the primary and secondary causes of a problem.
Client Flow Analysis	Step 5	To analyze client waiting time in a clinic and to determine the causes of the long waits.
Tally Sheets	Step 5	To easily and efficiently count, record, and organize data.
Bar Charts and Histograms	Step 5	To display data in graphic format so that trends can be seen and comparisons made.
Pareto Analysis	Step 5	To analyze and identify the "vital few" causes of a problem, so that resources can be focused in those specific areas. (This analysis assumes that there are usually only a few factors that are responsible for causing most of the problem.)
Benchmarking	Step 6	To compare the processes followed in your organization with the processes of an acknowledged leader in the same field.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Pursuing Quality at the Santa Rosa Clinic

Note to Trainers:
This case is divided into three parts and there are several ways to use it. We suggest that you stop after each part, and answer the questions related to that section before going on to the next one.

Part I

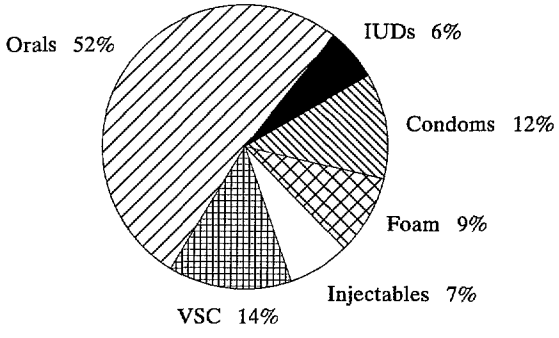
Mr. Alvarez, Director of Clinical Services for the Santa Rosa Clinic, walked into the small meeting room where the members of the cross-functional Continuous Quality Improvement (CQI) team were assembled around a table. The team was composed of two nurses, Nurse Lozano and Nurse Cruz; the office manager, Mrs. Gutierrez; the logistics manager, Mr. Diaz; and the laboratory manager, Miss Leon. The team had been organized by a district supervisor who had been trained with other staff in CQI. A year ago, the team had received training in the CQI process, and had been meeting every month since then to consider ways to improve the quality of the services in the clinic. Although the members of the CQI team had had some trouble at first in constructing flowcharts, analyzing problems, and drawing cause-and-effect diagrams, they had discovered that the more they used these tools, the easier it became to use them.

Mr. Alvarez, who served as the team facilitator, opened the meeting by congratulating the members on the results of the recent Client Flow Analysis. "The results show a significant reduction in client waiting time since our first analysis," he said.

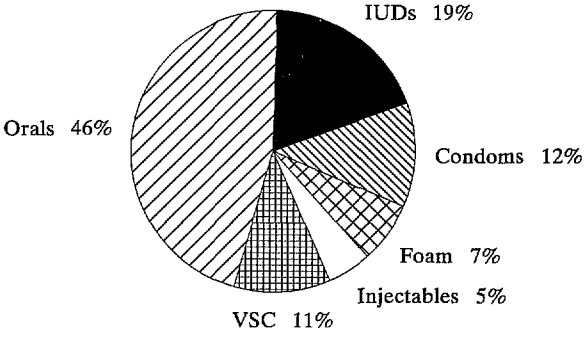
"All of us should be very proud that we identified this problem and led a successful effort to correct it. We have also begun to interview clients about our services to try and find out their reactions to the improvements."

"Preliminary results of the first two focus groups show that people feel that the waiting time has been shortened," continued Mr. Alvarez. "They also reveal something unexpected. Several of the women indicated that they wanted an IUD, but weren't able to get one and left with pills instead. Also, on the subject of IUDs, when we met last month and brainstormed to create a list of areas this team could investigate, one of the problems we identified was that many women who had selected IUDs did not return later to have them inserted. In addition, I just received a report yesterday from our Central Office that contained pie charts showing the method mixes of all the clinics in the Santa Ana region. These charts show that our clinic provides proportionally fewer IUDs than other clinics in our region that serve similar populations."

Santa Rosa Clinic



All Clinics in Santa Ana Region



"So the lower use of IUDs that we noticed informally seems to have shown up in the service statistics," said Mrs. Gutierrez. "I think this is something we should definitely look into. What does everyone else think?"

The rest of the team agreed: they felt that clients not receiving the method of their choice was more urgent than the other areas they had been considering. After some discussion, they defined the problem as the fact that women who selected IUDs as their contraceptive method often did not have them inserted.

Mr. Alvarez stood up, walked over to the flip chart, and picked up a pen. "Let's begin by walking ourselves through the steps that a client at our clinic would go through to get an IUD, and draw them on a flowchart. We'll begin with the client's arrival at the clinic. What happens first?"

Mrs. Gutierrez began. "On arrival, the client sees the Registration Clerk, who begins a new medical record if it's the client's first visit, or pulls out her existing record from the file if she's been in the clinic before. Then the Registration Clerk asks what sort of appointment the client has come for, and the client waits for the next available provider."

"Then the client has a family planning interview with one of the nurses," said Nurse Cruz. "If it's a first visit to obtain a contraceptive method, we describe all the methods and discuss the advantages and disadvantages of each one with her. We also take a medical history and the vital signs."

"Now, if the client selects an IUD," said Nurse Lozano, "we take a medical history and then conduct a physical exam to find out if there are any contra-indications. If there are, we have to go back and discuss other methods. If there aren't any contraindications, we ask if there is any possibility that she might be pregnant. If she says yes, then we provide her with an interim method and ask her to return when she has her menses, so that we can be sure she is not pregnant. If there is no chance that she is pregnant, then she can have the IUD inserted."

"But only on the days that the nurse supervisor is here," said Nurse Cruz. "She is the only one who is trained to insert IUDs. If she is not here, then the client has to come back on one of the days that she is in the clinic."

"Is there anything else that would prevent you from providing a client with an IUD?" asked Miss Leon.

"If we ran out of IUDs, or if we didn't have enough instruments sterilized on a given day, then we wouldn't be able to provide the client with an IUD," said Nurse Lozano. "So, sterilized equipment and adequate supplies are also necessary."

"What happens after the IUD is inserted?" asked Mr. Diaz. "Does the client go through any more steps before leaving?"

"After she has rested for a while and we are sure she is fine, we give her instructions on what physical signs she should look out for, and we ask her to return for a check-up visit after her next period," said Nurse Lozano.

See Case Discussion Questions—Part I (page 4)

Part II

"Good," said Mr. Alvarez, "Next we need to discuss each of these steps and see if we can find out the causes of the problem. So, let's begin with the client registering with the registration clerk. Are we achieving the desired outcome? Is the registration process completed within 30 minutes of the client's arrival? Are the clients directed to wait for the right kind of service?"

"Yes, I think everything is going well there," said Mrs. Gutierrez. "I recently completed the registration clerk's performance review and did a random check of some of the records. Everything seems to be in order."

"And as far as I know," said Nurse Lozano, "the clients are always assigned to wait for the right kind of visit. We have had no problem with communication between the registration clerk and the nurses."

"All right, next is the family planning interview," said Mr. Alvarez. "How are we doing on that desired outcome?"

"The nurses all give complete information," said Nurse Lozano. "We have done some training on that, and have discussed it in interviews. In general the clients are satisfied with the information they receive, and the exit interviews show that they understand the different methods and have been able to make an informed choice."

"So, there is no problem there," said Mr. Alvarez. "What about the physical exam? On our flowchart we have divided the physical exam into three parts. The first part is to determine whether there are any contra-indications. Do we have any problems with this step?"

"Contraindications are identified in two ways," said Nurse Cruz. "One is through the medical history the nurses take, and the other is through the physical exam. Since we revised our medical history form two years ago, we feel it serves as an excellent screening tool. All the nurses are very experienced in giving physical exams, and are observed and evaluated twice a year."

"And what if the client has no contraindications but can't tell us for certain that she is not pregnant?" asked Mr. Alvarez.

Nurse Lozano responded, "The clinical protocol states that we can only insert an IUD when pregnancy has been ruled out. If the client has had unprotected intercourse since her last menses, then we ask her to return at the time of her next menses. I think some of the problem lies here; often it seems that women don't return to get the IUD."

"All right, we'll discuss this further in a minute," said Mr Alvarez. "Let's keep going through the process. What if there are no contraindications and there is no chance that she is pregnant?"

"The nurse supervisor is the only person who is trained to insert IUDs," said Nurse Cruz. "If her client chooses the IUD on one of the days that the nurse supervisor is at the clinic, the nurse supervisor does the physical exam and inserts the IUD. If the nurse supervisor is not at the clinic that day, one of the nurses does the physical exam and the woman has to come back another day to get the IUD inserted. This may be another point at which we lose some IUD users."

"We'll also get back to this point in a minute," said Mr. Alvarez. "What about supplies of IUDs and sterilized instruments? Are there ever any problems with those?"

"We have never had a problem with supplies of IUDs, and we rarely have trouble autoclaving our instruments for 20 minutes," responded Nurse Lozano. "If there is a problem with the autoclave, then we boil the instruments for 20 minutes."

"What about the instructions about physical problems to look out for that we give clients when they leave? Are there any problems with those?" asked Mr. Alvarez.

"The exit interviews we've conducted show that the clients know what to look for," replied Nurse Cruz. "We've also found that when clients come back to the clinic for their one-month check-up, they still remember what these problems are."

See Case Discussion Questions—Part II (page 4)

Part III

"Well,"said Mr. Alvarez, "we have gone through the entire process, and it seems that there are two steps in which we might have some problems. Let's go back and look at these more closely. First, let's talk about the clients who aren't sure whether or not they are pregnant so they have to return at their next menses to have the IUD inserted. What is the problem here?"

"One aspect of the problem is that the women don't come back," responded Nurse Lozano. "We don't know why exactly, but maybe they don't like having to wait again, or they've changed their minds, or it's difficult for them to come back. Perhaps it's too expensive, or they live too far away, or maybe they're just too busy. However, the fact of the matter is that we can't provide an IUD if we're not sure of a client's pregnancy status. If she has had unprotected intercourse since her last menses, then she will have to return at her next menses to have the IUD inserted."

"The most important thing is to protect these clients from getting pregnant," added Nurse Cruz. "We need to make sure that they have a method to protect them in the interim."

"But we would still have the problem of the nurse supervisor not being here for every clinic session," replied Nurse Lozano. "It is so important that they be able to get the IUD when they come back and we know they're not pregnant. Few women are willing or able to return a third or fourth time."

"We don't know how often clients are asked to come back because we can't verify their pregnancy status or exactly why they aren't coming back," said Mr. Alvarez. "Perhaps we should collect some data on this."

"Yes, I think we should definitely collect data on this so we know how big a problem this is," volunteered Miss Leon.

Mr. Alvarez continued, "I think we should wait until after this meeting to look at the service statistics and find out what proportion of clients who want IUDs are not coming back. For now, let's talk about the fact that only the nurse supervisor can insert IUDs."

"Well, the nurse supervisor is here on regularly scheduled days," answered Nurse Lozano. "But women often ask for IUDs on the days when the nurse supervisor isn't here, and it is even more complicated to try and schedule women who have to come back during their next menses to return on a day when the nurse supervisor is here."

"I know that in Santa Marta clinic all the nurses are trained to insert IUDs," said Miss Leon. "Maybe we should find out what other clinics in our area do."

"All right," said Mr. Alvarez. "That's a good idea, let's talk about what kind of information we need on that subject."

Case Discussion Questions: The Santa Rosa Clinic

Case Discussion Questions—Part I

1. **Review the discussion and create a flowchart for women who select IUDs.**
2. **For each step in the flowchart, suggest a desired outcome.**

Case Discussion Question—Part II

3. **Using the flowchart, select the specific steps for which it is most difficult to reach the desired outcome. Propose a corrective action that might help the program reach the desired outcome of those steps.**

Case Discussion Questions—Part III

4. **How will the team collect and analyze data to quantify the outcomes of the specific steps that have been selected for study?**
5. **Describe the additional steps that will need to be done in order to complete the CQI cycle.**

Case Analysis: The Santa Rosa Clinic

Case Analysis—Part I

1. **Review the discussion and create a flowchart for women who select IUDs.**

The flowchart shown on page 113 is provided as a guideline. The flowchart that you have drawn will not be identical, but it should show a similar sequence in the process. Your flowchart may be drawn more vertically than the one shown on page 113, which has been drawn in a limited space.

2. **For each step in the flowchart, suggest a desired outcome.**

The desired outcomes listed on the flowchart on page 113 correspond to the each step listed in that flowchart. No two flowcharts are identical. If your flowchart is different, your desired outcomes may be stated differently. Because of limited space, the requirements needed to achieve the desired outcomes of each step have been omitted in this example. On your flowchart, the requirements should be listed to the left of the steps (see page 84).

Case Analysis: The Santa Rosa Clinic

Flowchart for Clients Selecting an IUD

Process	Desired Outcomes
Client Arrives at Clinic → Client Checks in with Registration Clerk	Client feels welcome.
Is Client a First-Time Visitor? — Yes: Open New Client Record → New Client Form is Filled Out; No: Pull Client's Record → Client Waits to be Called	Registration process is completed within 30 minutes of client's arrival. Client is treated with respect, courtesy, and efficiency.
Client Waits to be Called → Client Receives FP Counseling Medical History and Vital Signs Taken → Client Selects IUD → Provider Conducts Physical Exam	Client is directed to the appropriate provider.
Client is provided with information on all available methods in order to make an informed decision.	
Are There Contraindications to IUD? — Yes: Client Selects Another Method; No:	Provider determines all possible contraindications.
Is it Possible that the Client is Pregnant? — Yes: Provide Client with Interim Method and Advise Her to Return for Insertion; No:	Client's possible pregnancy status is determined.
Are Sufficient Equipment and Supplies on Hand? — No: Provide Client with Interim Method and Advise Her to Return for Insertion; Yes:	
Is Provider Trained in IUD Insertion Available? — Yes: IUD Inserted → Give Client Instructions → Client Departs; No: Provide Client with Interim Method and Advise Her to Return for Insertion → Client Departs	Trained provider inserts IUD safely according to protocol. OR Client is provided with interim method.
Client returns to clinic.	
Client fully understands instructions and warning signs.	

Case Analysis: The Santa Rosa Clinic

Case Analysis—Part II

3. Using the flowchart, select the steps for which it is most difficult to reach the desired outcome. Propose a corrective action that might help the program reach the desired outcomes of those steps.

Process Step	Desired Outcome(s)	Corrective Action
Is it possible that the client is pregnant? Pregnancy must be ruled out prior to IUD insertion and women who have had unprotected intercourse since their last menses are asked to return at their next menses. These women often don't return to the clinic.	Client's possible pregnancy status is determined. Client is provided with interim method. Client returns to clinic.	Make sure there is always a provider trained in IUD insertion on hand so client won't be discouraged from returning. Set up flexible appointment system so client can be seen during menses. Design and implement a system to follow up clients who don't return.
Is provider trained in IUD insertion available? Women who select an IUD and have no contraindications are asked to return if the Nurse Supervisor is unavailable for insertion.	IUD is safely inserted by a trained provider on the same day.	Train more providers in IUD insertion.

Case Analysis—Part III

4. How will the team collect and analyze data to quantify the outcomes of the specific steps that have been selected for study?

In order to study the patterns of women's IUD choice and subsequent insertion, keep a register of all women who select an IUD, and note whether they had it inserted the same day, whether they had to come back another day, why they had to return (because they were asked to return during their menses, or because a trained provider was not available that day), the date(s) of their return visit(s), and the final outcome. Try to contact the women who didn't return to have an IUD inserted, to find out why they didn't return to the clinic.

This is the type of problem in which benchmarking could be very useful. Find a clinic in the region that has a higher proportion of IUDs inserted, and work with that clinic's staff to identify the strengths of their program. Collect information on provider training, clinic protocols, clinic scheduling and staffing, etc.

5. Describe the additional steps that will need to be taken in order to complete the CQI cycle.

After corrective action is taken, keep collecting information to see whether there is a change in the percentage of women who have the IUD inserted the same day, versus those who have to come back later for insertion, and in the percentage of those who actually come back to the clinic when they are supposed to. By continuing to monitor both the number of women who don't return for insertion, and their reasons for not returning, you can determine whether the changes you have implemented have resulted in a decrease in the number of women who don't return, and whether their reasons are changing. Using this information, you can respond to the needs of your clients and continue to improve the effectiveness of your program.

CHAPTER FOUR

Increasing Community Participation in Family Planning Programs

Community participation has long been recognized as an effective means of helping rural and urban people focus energy and mobilize resources to solve their health, environmental, and economic problems. When people from the community organize, plan, share tasks with professionals, contribute financially to projects or programs, and help make decisions about activities that affect their lives, programs are more likely to achieve their objectives.

Several countries have created ways for communities to participate in their family planning programs. They have found that individuals make better choices about contraception when they participate in the family planning program activities in their villages or urban neighborhoods.

Drawing on experience from Indonesia and Bangladesh, this issue explores ways that communities can participate in promoting and providing family planning services. It presents the conditions needed for effective community participation, and discusses approaches to planning, monitoring, and supporting community teams so that they can actively participate in local family planning program activities.

This chapter was originally produced as Volume III, Number 2 of ***The Family Planning Manager****, including the case scenario, "Male Leaders Participate in Mrs. Ndere's Family Planning Program." The guest editors for the issue were Saul Helfenbein and Abu Sayeed.*

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Understanding the Need for Community Participation in Family Planning Programs

Over the next decade, as resources become increasingly scarce, managers of family planning programs will have to rely more on the community for promoting, delivering, and paying for family planning services. To do this, managers will need to create an environment in which the community can actively participate in the family planning program.

By involving the community in promoting the family planning program, managers will gain greater support from the community and will find that the community takes more responsibility for making sure the program achieves its objectives. In addition, because practicing family planning frequently means that people need to make behavioral changes, involving community members in the family planning program can make these behavioral changes more acceptable and consistent with community norms.

By involving the community in delivering services, family planning managers can build on existing resources to improve service quality and expand access to services, for example, by organizing a team of volunteers to provide basic family planning services in rural villages.

To pay for services, managers will need to introduce cost recovery schemes. These schemes will allow managers to diversify their financial base. For example, managers may wish to cover some of the program costs by charging small fees for services, selling contraceptives, or subsidizing program costs by using people, materials, buildings, and equipment made available through the community.

This chapter discusses some of the benefits of having the community participate in the local family planning program and explores ways to organize people in the community so that they can participate in family planning activities. It also explains how to prepare and implement a community participation initiative within a family planning program and how to measure the results of the community participation activities.

The Benefits of Community Participation

Having the community participate in the family planning program has many benefits; some of these are discussed below.

Benefits of Community Participation	How Benefits are Achieved
Increased commitment to family planning	When residents of a community actively participate in making decisions about family planning, people gain a better understanding of the health and economic benefits of family planning and thus increase their commitment to strengthening and expanding the program to reach a wider population.
Additional program resources	In addition to offering some of their time, community members often bring financial and material resources to the program. Existing stores or buildings may be offered to the program to be used on a shared basis at little or no cost.
Increased client motivation	Communities that take an active interest in the progress of a family planning program will develop improved approaches to motivating non-users to use contraceptives such as having citizen role models advocate for and promote responsible family planning practices.
More rapid program expansion	Working with community volunteers can help the family planning staff of governmental or non-governmental organizations (NGOs) to reach more clients and expand program coverage.
Motivates government to include family palnning in health services	In cases where family planning programs are not yet accepted as a part of government services, community participation can be an important source of pressure to get the government to recognize the need for family planning services.
Better solutions to service delivery problems	Involving the community in the program can lead to a greater awareness of service delivery problems and often members of the community can suggest appropriate and effective solutions.
More consistent demand for family planning	Meeting regularly to discuss family planning issues and program operations and to make decisions about how to carry out activities is important to building a feeling of community ownership of the program.
More effective planning and management	Involving the community in the program can lead to more effective planning, management, and use of resources for the whole community-based program.
Creates a bridge to other populations	Members of the community can serve as a bridge to segments of the community that may be hard to reach through formal program channels.

Making Community Participation Effective

Community participation in family planning programs occurs when members of the community actively participate in local family planning activities. Sometimes a community will select representatives who are designated to work in partnership with medical and administrative counterparts from family planning organizations to plan, implement, and monitor family planning activities. The activities carried out by these community representatives supplement and support the activities of the family planning organizations.

By collaborating with members of the local government, citizen leaders, and people from the private sector, family planning managers can obtain access to additional human and financial resources. Organizing and managing these community resources can help managers to improve client motivation, service delivery, and contraceptive use.

Does Your Community Participate in Family Planning?

Do members of the community work on behalf of your program with governmental and non-governmental groups to promote a family planning agenda that supports your program?

Does family planning get on the agenda of public meetings?

Are special community meetings regularly arranged to discuss family planning?

Do community members help to set family planning program objectives and monitor the program's performance?

Does your family planning program benefit from human, financial, and material resources available from within your community?

Do members of your community educate and motivate potential clients to use family planning services?

Are members of the community actively engaged in family planning activities, such as distribution of contraceptives, client follow up, and referral services?

Requirements for Effective Community Participation

Community participation in family planning does not come about through good intentions alone; it must be carefully managed in order to be successful, sustainable, and beneficial to the community. Effective community participation requires that managers find ways for community members to participate in the family planning program.

Managers should help the community establish:

- clear goals and objectives for their participation;
- clear responsibilities and functions for working with the family planning team;
- specific activities related to the objectives they have set.

Creating Ways for the Community to Participate in the Family Planning Program

Creating a program that actively involves community members usually requires bringing family planning services as close to the community as possible. Managers need to identify individuals in their community who can actively participate in their programs, and develop a clear set of activities that these community members can undertake to actively support family planning.

As a manager, you should discuss the strategies presented below with your staff, members of your community, managers of other programs, and local government officials. Work with the community to make a plan for incorporating some of these approaches into your program. You may need to phase in activities over time, or combine several different approaches that are appropriate to your particular setting.

Organizing People to Participate in the Family Planning Program

Managers can create program bridges to the community by organizing people to promote and deliver family planning services. You can start by developing and establishing relationships with some of the following types of organizations.

Local non-governmental organizations. Program managers from the public or private sectors can work with other local NGOs to mobilize community members concerned about family planning. These community organizations can carry out a variety of activities that will promote and educate members of the community about family planning.

Community-based service organizations. Program managers can work with community-based organizations that provide services in areas such as literacy, education, agricultural extension, and water and sanitation systems. Family planning education can be incorporated into the activities of these organizations.

Local governmental organizations. Program managers can collaborate with local governmental organizations such as schools, health agencies, or hospitals. By sharing information and resources, including government officials in local program planning, and looking for ways to promote the local government agenda through family planning activities, managers can help to encourage participation in the family planning program.

Special clubs for user groups. Program managers can work with existing clubs for mothers, youths, and men. These clubs can address the special needs, issues, and problems that club members are likely to face in using contraception effectively and can help prevent discontinuation. Clubs can promote greater awareness of the benefits of family planning, link members to income-generating activities, and inspire members to motivate other members of the community to accept family planning. Clubs often give rewards or prizes for exceptional performance in continued use of contraceptives or for motivating other community members. This helps to provide an incentive to be a model contraceptive user and creates role models for other community members to emulate.

Promoting the Use of Family Planning

You can build into your program some opportunities for the community to promote and reinforce the use of family planning.

Create public recognition. Program managers can give awards to those community members whose behavior and public support for family planning provide a good example to the community. These awards create public awareness of the importance of family planning and provide the recipients with greater social prominence and a larger voice in community affairs.

Continued on the next page

Develop new clubs or forums. Program managers can identify special groups in the community that are hard to reach and can work with community representatives to develop new clubs or forums for promoting family planning among these potential clients. Often an existing community center can be used for holding meetings, or community participants may be willing to hold meetings in their homes.

Provide opportunities for skills development. Program managers can provide formal or informal vocational training to continuing family planning users that can result in greater employment opportunities.

Develop economic opportunities. Program managers can develop simple agricultural credit and income-generating activities that provide continuing users with access to capital for developing and supporting their business or agricultural initiatives.

Delivering Services to the Greater Community

You can create a wide range of service delivery activities in which the community can participate. Following is a discussion of several types of community-based service delivery systems for promoting family planning and distributing contraceptives.

Community-based services (CBS). The program site is the community. Usually, several members of the community are selected and trained to visit people in their homes on a regularly scheduled basis to motivate them to use contraceptives; to supply oral contraceptives, condoms, and injectables; and to follow up on clients who have questions, complaints, or side-effects. These community members, neighbors, or relatives of the clients can often make family planning more acceptable to clients and can serve as role models for potential users. Because they often live in the community, they can respond rapidly to questions or problems which, if unattended, could lead to discontinuation or ineffective use of a contraceptive. These community representatives are sometimes paid for their work or may receive payment in kind.

Depot services. A "depot holder" system is a variation of the community-based distribution system. In this arrangement, a member of the community stores several months' supply of condoms and oral contraceptives and is responsible for distributing them. This person is often paid a small fee as compensation for time and effort and as an incentive for continuing to provide the service. The depot holder system ensures that a person in a permanent location is available all the time to provide information and contraceptive supplies. This approach requires that only a few community members be involved in the family planning program. However, the depot holder represents an important first step in promoting participation in family planning at the local level.

Satellite services. Family planning and maternal and child health (MCH) services can be provided by clinic personnel and volunteers at specific times and at designated locations in the community. These services help to increase the acceptance of family planning services because they provide a setting where family planning can be integrated with MCH services. This approach also provides an opportunity for many different community members to contribute to the program and advances the institutionalization of family planning in the community.

Volunteer services. These services involve community members who may work up to several hours a day to assist government workers or professional field workers employed by local NGOs. Similar to full-time family planning workers, these volunteers carry out functions related to motivation, resupply, and follow up but generally serve only 20 to 30 households. They may receive some tangible rewards: a small honorarium for their efforts, reimbursement for their travel expenses, materials or uniforms that identify them as volunteers, or refreshments during volunteer meetings. Often volunteers come from the same social sector as the clients they serve, so they can be very effective in generating enthusiasm for family planning within their community. With some training and supervision, they can be a powerful force for expanding program coverage.

Using Volunteers to Provide Family Planning and MCH Services

In Indonesia, the major responsibility of government field workers is to manage a complex set of community activities, to perform on-the-job training, and to supervise a large team of volunteer workers. Government field workers no longer carry out direct motivation and contraceptive distribution; that role has now been almost entirely taken over by grassroots volunteer workers of various kinds.

The Posyandu

The major event for which these volunteer workers are responsible is called the *Posyandu*, an acronym for "post for integrated services." It signifies both the event and the location for the major source of maternal, child health, and family planning services in rural Indonesia. *Posyandus* are conducted once a month in 225,000 sub-villages in Indonesia each year. A *Posyandu* might be held in a villager's house, in the village community hall, or any place large enough or easily accessible to village residents. The staff of the sub-district health center provide immunizations and other types of simple medical care in about one fifth of the *Posyandus*, but in the others volunteer workers provide most of the services.

The Five-Table-System

Posyandu activities are organized around the "five-table-system," and the specific functions performed at each table are identical throughout Indonesia. Children are registered at Table 1, weighed at Table 2, and the results are recorded in the child's growth chart at Table 3. At Table 4, the mother is given information on how to improve her child's health (through better nutrition, oral rehydration, immunization, breastfeeding, and/or postponing the birth of a subsequent child). At Table 5, the child is given any medical treatment needed and a supplementary snack prepared by the volunteers.

Family planning clients follow a similar system. A potential or existing contraceptive user goes first to Table 1 to be registered, then to Table 4 (the information and motivation table) to discuss with the volunteer her interest in becoming a contraceptive user, any problems with her existing contraceptive use, or her desire to change her contraceptive method. If the woman is new to family planning, or if she has problems beyond the capability of the worker at Table 4, she is referred to Table 5 where she is seen by the government health center official who is usually a trained midwife. If the woman presents serious health problems, or needs a contraceptive method not provided at the *Posyandu*, the midwife will refer her to the sub-district health center or to the hospital in the nearest urban community. In many cases *Posyandus* offer IUDs and contraceptive implants as well as simpler contraceptive methods.

Volunteer Responsibilities

Volunteers use the preparatory and evaluation meetings that take place before and after each *Posyandu* to plan their family planning activities. The time, the location, and the broad objectives of the *Posyandu* have usually been decided beforehand, but volunteers meet three days before to make decisions about which women and children should receive special attention, who will be responsible for providing that attention, and who will be responsible for providing the supplementary snack. Two days before the *Posyandu,* volunteers go house-to-house to encourage their neighbors to attend. The day before the *Posyandu*, they check to see that all the equipment and provisions are in place. After the *Posyandu*, they meet to evaluate their achievements and prepare data to report to higher levels.

Source: Hamijoyo and Chauls, 1992

Creating a Favorable Environment for Community Participation

Before beginning efforts to promote community participation, managers must strengthen their programs so that they are able to support the work of community members. Following is a discussion of some of the things that you can do to help introduce a community participation initiative.

Encourage local decision-making in the family planning program. A national family planning program that promotes decentralization as a means of improving its performance will increase the local manager's ability to get support from community members, local program providers and administrators, and local government authorities. Decentralization helps to bring the decision-making process closer to the people who will be most affected by the decisions. Under decentralization, the program office at the national level gives authority to local levels such as provinces, districts, subdistricts, or municipalities to make certain types of decisions concerning resource allocation and the implementation of various programs. Policies that support decentralization permit managers to develop strategies that are appropriate to the local environment, encourage positive attitudes toward family planning, and improve program performance.

Involve other voluntary organizations in your program. Family planning programs that involve local NGOs in their work are often able to mobilize additional resources for implementing their programs. These additional resources can be used to carry out a variety of activities that the government program may not be able to afford. Such activities, planned and implemented by community members who belong to the NGOs, help the community to identify more closely with the family planning program. Furthermore, by adding its own resources to the program, the community is likely to be more interested in program success and to hold family planning program managers accountable for program performance.

Identify leaders in the community. Community participation may require new strategies for delivering family planning services, including new types of service sites or personnel. Community participation may also require establishing relationships among government and NGO facilities and may involve changes in the roles of family planning providers as they work more closely with the community. To make community participation effective, resources may need to be transferred from government agencies to the community. This type of change may be met with strong resistance from firmly established interests. Strong leadership that encourages managers to take risks and try out new approaches becomes imperative. Effective leaders will defend the interests of the community and advocate for change among policy makers and other sectors of society.

Develop skills within the community. As the community becomes more involved in implementing the family planning program, community members will need new skills in order to perform their new functions. Family planning managers can provide different kinds of technical support to community members so that they can assume a greater role in preparing action plans, training volunteers and members of different committees to help implement the program, accounting for resources, monitoring expenditures, supervising activities in the field, and monitoring the progress of the program.

Find resources within the community to encourage and support participation. Incentives that promote change are more effective motivators than incentives that compensate for work done. Incentives can take many different forms and include increased access to agricultural, credit, and small business programs. Managers should emphasize to community members the improved social and economic status that having a smaller family will eventually bring about.

Obtain outside sources of funds to initiate community activities. Even when the community mobilizes some of its own resources through donations, levies, user fees, or reallocation of budgetary sources, it may still require additional funds for starting new activities, training volunteers, or equipping satellite service sites. Small incentive grants can help to give communities the extra push they need to maintain momentum for their community participation initiative.

> **Guard against creating dependencies**
>
> Often donors are the principal sources of incentive grants. However, once the community approach takes off and starts to produce tangible results, managers should consider ways to increase community contributions. Whenever outside resources are being used as incentives, managers need to be on guard against creating dependencies that can subvert sustainability.

Preparing for Community Participation

The community participation initiative needs to be carefully prepared. Acquiring basic information about the current program and meeting with key people are important first steps in ensuring that your community participation initiative will be successful. The final step in the preparation process is to develop a long-term plan for community participation.

Prepare a geographic and demographic profile of the local area. To prepare this profile, which you will use when you define and select the community or communities you will serve, you will need maps that identify the location and distribution of the population, the administrative divisions, and the physical geography of your region. Local planning and administrative offices may be able to supply you with this information. If you cannot obtain it, you may have to create your own map. Communities that you identify can be of various sizes and encompass different administrative groupings, depending on whether they are in urban or rural areas. The communities can be based on existing divisions such as villages, or on various groupings that you determine. (For more information on how to prepare and use maps, see Chapter Five, "Using Maps to Improve Services.")

Conduct a baseline survey of family planning program performance. Baseline information for the local family planning program can be taken from the program's information system or, for larger administrative units, can usually be obtained from special national surveys such as the Contraceptive Prevalence Survey (CPS) or Demographic and Health Survey (DHS). If the data from the information system are not reliable or if the special survey results are difficult to obtain or out of date, you can conduct a rapid survey in the communities in the region. Data in the baseline survey should include the number of men and women of reproductive age and the number of current family planning acceptors. Baseline information will help to define community boundaries and set performance objectives for individual communities.

Meet with local government officials and local NGO staff. To develop a common understanding of the goals of community participation and to identify resources for providing community action incentives, it is important to meet with local government and NGO staff. *All senior officials who have influence or decision-making authority at the local level should be contacted and involved in the planning process from the start.* Their help will be needed in getting administrative approvals, in allocating resources, and in expanding the program as time goes on. In meetings with local medical officers, representatives from the interior or local government ministry, board members and executive directors from local NGOs, and local elected officials, you should build consensus about the meaning of community participation, what elements should be included, how communities should be defined, and how the strategy fits into the national program.

Never underestimate the importance of including national and senior officials

Even after your plan has been completed, make sure you continue to include national and senior officials in special community events. The presence of senior officials tells the community that its work is important and that it is valued by the nation. These officials should be present when the action plan is presented at a community meeting, at the opening of special events such as campaigns, or at special training programs. It is also very beneficial to include senior officials in meetings or workshops in which the results of the program are presented.

Develop a community participation plan. Once this consensus is reached, you should draft a preliminary community participation plan together with members of the community. The plan should show how the process of introducing community participation will proceed over a specified period of time. This plan should focus on elements related to community participation, such as establishing a definition of community, developing criteria for selecting communities, and identifying resources that the community will contribute. The same principles used in developing a program plan should be applied to developing a plan for community participation. (For more information on developing program plans, please refer to Chapter Two, "Developing Plans and Proposals for New Initiatives.") When developing your plan, consider the following questions.

What defines a community unit? The community unit will depend on the size of the population, its density, and its rural-urban distribution. In selecting the unit, you should try to find a community group that has a sufficient number of women of reproductive age, resources, and potential leaders to support local activities. In rural areas, units can be large villages or groups of small villages under one administrative authority. In urban settings, the units can be wards or municipal subdivisions that have their own representatives or local government institutions.

How will the communities be selected? Performance criteria should be considered first. In countries where contraceptive prevalence is generally high, many managers prefer to choose communities with the highest contraceptive prevalence rates. Often such performance indicates that the community is well-organized, motivated, and suitable for taking on the responsibility of managing its own program. The selection can be made based on the baseline data that you have collected.

In areas where contraceptive prevalence is low, managers may choose communities on the basis of interest, commitment, and leadership. Usually a community's willingness to contribute resources as well as the amount of resources, whether in cash or kind, is a good indicator of its interest.

What resources will be needed? The program manager needs to be assured that resources will be made available from within and outside the community. The manager will have to negotiate these resources with the national program, donors, and community leaders. As part of your negotiations, you should plan for the community to make contributions in cash or in kind that represent a certain percentage of the total budget for the action plan. (Ten percent is reasonable for the first year.) In general, the first year's budget may be relatively large because of start-up costs. Therefore, you may need to find some additional outside funding to supplement the community's contribution in order to provide the necessary incentives for the plan to be implemented.

How to . . .

Build a Community Team

Because the community team will represent the larger community, it is important to create a diverse team that represents different social, commercial, and political sectors of the community. The team members will need to be oriented to work together collaboratively, be focused on achieving common goals and objectives, and be adequately trained so that they can effectively plan and implement their community activities.

Form your team. As a manager, your task will be to develop a team of different community members who can represent the community at large so that the community participation is not seen as a special interest of one group in the community. The ideal team could be composed, for example, of four or five persons such as a medical officer, a local family planning provider, a prominent community member such as a teacher or business owner, a religious leader, and a local administrative officer. Ideally, the team should have at least as many women as men.

Educate your team about the benefits of community participation. Team members will need an orientation that will show them how they can become effective participants in the family planning program. It is helpful to provide examples—from your country and other countries—of successful community participation in family planning or other development programs. Team members who have the opportunity to see community participation in action in neighboring communities are usually highly motivated to adopt new techniques or adapt them to their own situation.

Establish an organizational chart. The community action plan should include an organizational chart showing how the community will be organized to carry out the activities. Special committees that are set up to bring people together to discuss planning, implementation, and monitoring, or to carry out specific activities, will help ensure that action takes place. Task descriptions for each of the committees should prepared. As the committees begin to function, it may be helpful to provide additional training on how to prepare agendas, hold meetings, and prepare reports.

Train your team in planning and implementation skills. The training for community members should be simple and brief, focusing on the skills that are essential for carrying out their activities: preparing action plans, organizing and conducting meetings, supervising volunteers, and accounting for funds and other resources.

In working with the team, you should provide models of action plans, supervisory checklists, and accounting procedures that the team can adapt as they plan and implement their local program of activities. Emphasize learning by doing.

Working Solutions—Bangladesh

Conducting Observation-Study Visits to Educate your Team

The Local Initiatives Program in Bangladesh has developed a program of visits to neighboring communities where family planning programs are already working with the local community. These visits are called *observation-study visits*. They are carefully planned visits with clear objectives and a well-organized program of observation, meetings with community members, and time for reflection and discussion about the observations. The observation-study visits emphasize how the community plans and chooses activities to support the national program, and how it makes decisions, implements activities, solves problems, and monitors its programs. These visits usually take about one week, not counting travel time.

The visits also emphasize the roles of different members of the community such as government officials, NGO leaders, health personnel, family planning providers, and volunteers from the community at large, especially women. The managers of this program offer the following advice:

- To explore the possibilities of conducting observation-study visits to other communities, the family planning manager should contact national program officials, counterparts in other development sectors, and donors working at the community level. Very often the donors will know about community development programs that can serve as models and will have resources available to sponsor observation-study visits.
- If observation-study visits are not feasible, approaches to orientation may have to be more theoretical with some trial and error until the appropriate approach is developed. Access to books on community development activities can facilitate this process. There is a considerable amount of literature available on this subject. In many instances there are local organizations that specialize in community development, and these organizations are usually willing to help.

Developing the Action Plan

The action plan is one of the most important elements of the community participation initiative. The action plan sets forth the objectives for improving program performance, the activities that will be carried out to supplement the activities of the national program, the persons in the community who are responsible for carrying out the activities, and the resources that will be used to support the activities. Managers should work with the community team to develop the action plan.

Prepare a budget for carrying out the plan. One of the most important elements of a successful action plan is a realistic budget. In developing the community's action plan, you should set an upper limit on the budget to help minimize the possibility of community members building in costs that the program cannot afford.

The budget should be as detailed as possible and show the cost of each activity. The budget might cover costs for equipment, reimbursement for transportation of volunteers, refreshments for meetings, special signs for information, education, and communication (IEC) campaigns, or materials for making maps. Wherever possible, the community should make contributions in kind. The budget should not include salaries, honoraria, or any materials already provided by the national family planning program. When working on the action plan

How to . . .

Develop Effective Objectives for Your Community Participation Plan

The objectives of an action plan should be aimed at improving family planning program performance through community involvement. They should describe the contribution that community participation activities will make toward the achievement of the overall objectives of the family planning program. Community participation objectives can focus on: conducting a specified number of special campaigns to recruit additional volunteers; a targeted number of people to be educated about family planning; a number or percentage of clients to be referred for follow up; the number of satellite service sites to be set up to provide long-term methods; the number of clubs to be established for different community groups; or the number of users to be linked to income-generating programs or credit schemes.

Try to write your objectives so that you will be able to measure the extent to which the planned activities contribute to achieving the program objectives. For example, a current objective for your program might be to decrease the percentage of teenage pregnancies. To support this program objective, your community team can develop a plan to organize youth clubs and special events to educate sexually active youth about the prevention of pregnancy and sexually transmitted diseases (STDs). The community participation objective would then be related to the program objective as follows:

> **Sample community participation objective:** ***To establish two community youth clubs in the next year to educate sexually active youth about the prevention of pregnancy and STDs and to provide access to contraceptives to decrease the number of teenage pregnancies.***

with the community family planning team, you should call attention to all unnecessary items and costs in order to help the team keep the budget to a minimum. (For more information on developing budgets, please refer to Chapter Two, "Developing Plans and Proposals for New Initiatives.")

The first year's budget is likely to be close to this limit because of start-up costs such as uniforms, equipment for volunteers, or tables and chairs. Subsequent budgets should be lower because the costs for these items will not need to be repeated and because everyone will have gained more experience and will have a better idea of what costs are necessary. As the total budget decreases, the community's share should gradually increase until it can cover all costs.

Set up an accounting system to track the disbursement and use of funds. Along with the budget, the family planning manager must help the community to set up a simple accounting system. An accounting system is one way of ensuring accountability for the implementation of the action plan. It will help to ensure that all resources are used as planned, and that the community family planning team operates within the guidelines of the plan.

The accounting system should be simple but compatible with the accounting procedures used by the clinic or program. To the extent that it is possible, the family planning manager should audit community finances at least annually. This will also help to reinforce the concept of accountability.

Check your plan. When developing the plan, make sure your objectives are specific and measurable. An effective plan should be widely replicable, show results quickly, and be cost effective. It is helpful to check your plan against these three criteria:

- **Replicability.** Although community participation takes place on a community-by-community basis, managers must be able to mobilize enough communities in a relatively short time to affect program performance. Community participation should be implemented in several communities simultaneously, and new communities should be brought into the program annually.
- **Timeliness of results.** The plan should be designed so that some results will be visible within a reasonable period of time after community participation activities have begun. For example, if a national program sets a five-year period to meet its objectives, managers at lower levels should expect to see results within two or three years.
- **Cost.** The plan should be designed so that the cost of the initiative is reasonable and the results can be determined. Tangible benefits in the areas of improving quality, expanding coverage, and strengthening demand and sustainability should be identifiable.

Monitoring and Supervising Community Participation

Community participation requires supervision and monitoring. Staff should coordinate a visit to the communities at least three times per year, and more if the community needs additional support. Each visit will take at least one day and possibly longer, so the family planning program will need to be able to cover the food and travel expenses of the supervisors.

Developing guidelines for supervisors and the community to use during these visits is extremely useful and will help to direct attention to critical elements in the community participation initiative. The guidelines should specify indicators and suggest questions to ask, observations to make, and records to check. The guidelines should also include criteria that help to assess how well the community is conducting activities and achieving the intended results. The following general indicators and specific information on the community's ability to carry out activities can be monitored jointly by the supervisor and community team members.

Status of the action plan implementation. Determine which activities have been completed, rescheduled, or are currently scheduled for implementation. Check with local family planning providers to verify the status of special activities. Also review the status of community contributions in cash and in kind.

Knowledge and attitudes about the community participation plan and special activities. Try to determine how aware people in the community are of the objectives of the community action plan and how well the plan has been accepted. If any special activities have occurred, determine if they were well attended, how they were received by the community, and the extent to which the community provided support for these activities.

Organization of the community to carry out special activities. Determine whether the community at large has been informed about any special or planned activities. Also check to see whether local family planning providers and other community members attend meetings regularly and jointly implement special activities.

Quality of implementation. Examine the activities being conducted by the community. These might include such activities as motivational visits by volunteers, depot holder activities, satellite services, and special users clubs. Assess the representativeness of community participation, how frequently volunteer turnover occurs, whether volunteers have been trained, and the need for resources to support the activities of the community team members.

Control systems for managing supplies and money. Make sure that contraceptive supplies are accounted for and that all accounts are in balance.

Assessing Community Participation Performance

Once community participation has begun, the performance of the initiative should be assessed from two perspectives:

- How successful the communities are in assuming responsibility for selected family planning activities;
- How successful community participation is in improving family planning program performance.

Remember that the purpose of involving the community is to improve the performance of the family planning program. Keep in mind that the plan has been developed to *improve quality*, *expand coverage*, and *strengthen the sustainability of the program*—through the continued use of family planning and the contribution of resources by the community in support of the program. You will need to develop indicators of quality, expansion, and sustainability to determine in what ways community participation is contributing to the performance of the family planning program.

Sample Indicators for Assessing the Performance of Community Participation

The following sample list shows some indicators that may be useful in assessing community participation and program performance. The community family planning team should be involved in selecting the indicators. If you use some of these indicators, you will need to determine with your community team members what performance levels you expect to achieve. The indicators below should be expressed as numbers or as percentages.

Quality Indicators

- Women who had ob/gyn problems diagnosed and treated correctly at satellite service sites before receiving a contraceptive method
- Men and women of reproductive age at high risk of pregnancy or STDs referred to clinic for services
- Discontinuers who were brought back into the program by community workers
- Volunteers who received refresher training
- Clients referred for long-term methods

Expansion Indicators

- New contraceptive users
- New male and adolescent users
- Men and women accepting sterilization
- Clients requesting long-term methods
- People attending motivational meetings

Sustainability Indicators

- Active community members
- Facilities providing special services for sexually active youth
- Communities charge fees for servicess while maintaining or increasing contraceptive use

In addition to looking at the long-term indicators of quality, expansion, and sustainability, you should measure short-term performance using standard *input* indicators, such as the numbers of people visited for motivation, as well as standard *output* indicators, such as the number of new contraceptive acceptors. The family planning manager can use focus groups, exit interviews, and a variety of rapid assessment techniques to determine if changes in these indicators can be attributed to the community participation strategy.

Providing Technical Support

A community participation initiative is relatively easy to launch, but sustaining the effort requires considerable support over time. As a manager, you will need to make sure that you support the community family planning team. This support should be closely linked to the periodic assessments that will help to show the community's ability to implement and manage their activities. As you find weaknesses in their capabilities, you should take immediate action to improve their skills.

Types of Support the Community Team May Need

There are many different types of support that you may need to provide depending on the capabilities and experience of the community members and representatives. Most of the skills required will be practical techniques in organizing and using time efficiently. Some will be more sophisticated techniques involving problem-solving and integrating family planning with other development projects. The following list suggests the types of support you may need to provide to your community teams.

- Organizing planning workshops to prepare subsequent action plans
- Ensuring that women are involved in planning and implementation meetings
- Establishing criteria for selecting volunteers
- Training community field workers to supervise volunteers
- Identifying income-generation projects
- Preparing agendas, taking minutes, and leading discussions
- Keeping accurate records of activities
- Determining suitable ratios between volunteers and eligible couples
- Preparing schedules for satellite services
- Preparing annual schedules for monthly meetings of the committees
- Training in how to use information on family planning services to assess program performance
- Conducting supervisory visits to assess special activities carried out under the action plan
- Preparing schedules for supervisory visits to the field that are based on the action plan
- Auditing accounts
- Preparing financial reports

Publicizing and Sustaining the Community Participation Effort

All community participation efforts should include an annual one- to two-day program review workshop in which community teams and others involved in carrying out community-led activities meet to share their experiences; discuss specific approaches to improving quality; expanding coverage, and strengthening sustainability; and have a good time. These review workshops can help communities to share important lessons about improving program performance and can result in replicating successful approaches in neighboring communities. They can serve as a means of recognizing the achievements and contributions of all those from the community involved in the family planning program.

National family planning leaders should be invited to attend and participate in these workshops. The organizers should produce a report on the workshop deliberations for wide distribution. Popularizing such workshops can often influence other managers and communities to launch community participation initiatives to improve family planning program performance.

As in all other endeavors, trust and confidence in the managers, providers, leaders, and officials who support community participation efforts will play a critical role in determining whether and how far the community goes in taking responsibility for the local family planning program. You can help to develop this trust and confidence by forming a strong partnership between the supporters of the initiative and the staff of the local family planning program. This partnership will unify the commitment to the goals of community participation and will help to make family planning an integral part of the community's efforts to improve its well-being.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On replicating programs in other communities . . . *One reviewer emphasizes,* "Because different communities often have different local needs, managers should be careful not to replicate a community participation initiative without first conducting a survey of the community's needs, including knowledge, attitudes and practices.

On using community participation to recognize family planning needs . . . *One reviewer suggests,* "In cases where family planning programs are not yet an acceptable part of government service delivery programs, community participation becomes an important source of pressure and an effective strategy for getting politicians to recognize the needs of their constituents."

On working with local shopkeepers . . . *One reviewer adds,* "Every community has a small shopping center or market area where people can buy common household items. These shopkeepers are usually trusted and respected members of the community and can serve as service delivery outlets in a community participation approach."

On motivating volunteers . . . *One reviewer writes,* "Sometimes information can be a powerful incentive for volunteers. In our program, CBD workers are provided with service statistics so that they can readily see the results of their work. The data serves as a basis for discussion at meetings and has provided workers with an incentive to perform and has even resulted in some competition among workers. Now workers have a better understanding of why they need to collect data, what the data mean, and how the data is used."

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Checklist for Increasing Community Participation

For Clinic Managers and Supervisors

- [ ] Explain to your staff the potential benefits of community participation and discuss ways in which your clinic might involve members of the community in your family planning program.
- [ ] Prepare a profile of the region and collect baseline data on the existing family planning program.
- [ ] Identify leaders and other members of the community to work with your program and create a community team.
- [ ] Develop a community participation action plan that sets forth a budget and clear objectives for the initiative.
- [ ] Train the community team in planning and implementation skills and work with them to clarify their roles and functions in the family planning program.
- [ ] Determine what kinds of technical support the community team needs and make sure that their essential needs are met.
- [ ] Publicize the results of the community participation program so that the community can see how the program is benefitting them.
- [ ] Invite senior government officials, local politicians, and influential members of the community to participate in your program and in any special events that you plan.
- [ ] Hold an annual review workshop to review the impact of the community participation initiative, making sure to look at the impact on the community and on the family planning program.

For Mid- and Senior-level Managers

- [ ] Encourage clinic and program staff to work with the community to develop community participation plans and provide support to them in implementing those plans.
- [ ] Encourage local decision making in the family planning program.
- [ ] Identify other clinics or programs in the country that could serve as community participation models.
- [ ] Secure the necessary resources for clinic and program managers to make observation-study visits to other family planning programs that have implemented a community participation initiative.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Male Leaders Participate in Mrs. Ndere's Family Planning Program

Mrs. Ndere just had returned from a special meeting with other regional Nurse Supervisors. The meeting had included a study tour to two successful family planning programs that were operating in the northeast region of the country. Mrs. Ndere had been surprised that these programs were actively working with community members to promote the goals of the family planning program. She had spent a morning talking to the manager of a local food processing factory who had been recruited by an outreach nurse of the local health center to organize weekly talks about family planning and reproductive health during lunch break. The clinic director was very excited about this new initiative because six months after this program had begun, staff at the local clinic were able to clearly document that the number of condoms that they dispensed had in-creased two-fold, and the number of factory workers using contraception had risen from twelve percent to twenty-five percent. Building on the success of this experience, the clinic manager had made plans to recruit a number of influential community leaders to conduct similar activities in her area.

After returning from her trip, Mrs. Ndere wondered whether involvement of local male leaders in her program might help her meet program goals and objectives. By using male volunteers, she could solve one of her major program problems—insufficient resources to recruit, hire, and train new personnel for IEC activities. In Mrs. Ndere's area, awareness of, and access to, family planning was lower than in many other regions in the country. In fact, the results of a recent study showed that among men in the area, knowledge of condoms was below 50 percent and knowledge of spermicides was only 11 percent. Women, on the other hand, were considerably more knowledgeable about family planning methods. It also revealed that men in the community preferred talking with other men about reproductive health issues. Mrs. Ndere believed that if males in the community were more aware of the benefits of family planning they would be more likely to support their wives' interest in family planning. In addition, increased understanding of family planning methods among men might lead to better reproductive health practices and prevention of sexually transmitted diseases—a real problem in her community. She recalled that several months earlier there had been a major public health and sanitation initiative and that the male leaders had done an excellent job in organizing men in the community to work on this project. She wondered, "Could she organize these male leaders to help support her family planing program and to promote family planning activities within the community?"

Mrs. Ndere decided to try. Her first step in organizing the male leaders was to invite eight prominent men from the community to a meeting with two of her IEC outreach workers. During the first meeting, she focused the discussion on the benefits to the program and the community that the participation of these men might bring. This discussion generated considerable interest among the male leaders. In a second meeting, with Mrs. Ndere's

Case Scenario: Male Leaders Participate

help, the group looked at the objectives of the family program and then developed objectives for their own participation. For example, one objective of the family planning program was to expand family planning method use by five percent within one year. Based on this program objective, the group developed their own community participation objectives:

- to increase knowledge of family planning and sexually transmitted diseases among males;
- to double the number of condoms dispensed by the program within the first year.

In subsequent meetings, the group developed a plan to involve other men in the community. Some members were assigned the task of preparing a plan detailing the activities and training that the men would undertake to achieve the objectives which had been set. There was a lot of discussion about the role of the male leaders and their potential activities in the area of family planning. Some thought that the male leaders should be trained to distribute condoms. Recently, Mrs. Ndere had learned that the Ministry would provide the community with free condoms if a system for distributing the condoms could be established. As a step in preparing the plan of activities and training, the group generated a list of the possible activities that the male leaders might undertake.

Case Discussion Questions: Male Leaders Participate

1. **How might community participation benefit the community?**
2. **How might the involvement of the community benefit the family planning program?**
3. **What activities do you think the male leaders in this case could be trained to do?**

Case Analysis: Male Leaders Participate

1. How might community participation benefit the community?

There are many ways that the community could benefit from involvement of male leaders in the family planning program. Participation of an influential group of men has the potential to:

- Provide greater support for family planning services among women in the community.
- Improve health of mothers and children by providing services not currently available, for instance, pre-natal referral, or distribution of oral rehydration solution.
- Increase interest in using contraception among males in the community.
- Improve knowledge and prevention of sexually transmitted diseases among men.
- Promote awareness of family planning and the family planning program within the community.
- Strengthen management capability within the community.
- Provide training for community members that may lead to other formal or informal employment opportunities.
- Provide income from family planning activities that can be used for other community projects.
- Increase prestige of community members associated with the program.

2. How might the involvement of the community benefit the family planning program?

Involving the community in its program can provide many benefits to the family planning program. The involvement of male leaders, as described in the case, has the potential to:

- Increase commitment to the family planning program.
- Establish social and political prominence for the family planning program.
- Link the family planning program with other types of development activities in the community.
- Increase support for the program from influential leaders of the community.
- Expand program coverage to male and female clients not previously served by the program.

Case Analysis: Male Leaders Participate

- Increase general knowledge and awareness of program activities.
- Tap resources from outside the program.
- Improve motivation among potential clients.
- Encourage more consistent use of family planning among current clients.
- Improve referral services by developing stronger links between the clinic and the community.
- Increase management capability within the community that can be used to develop other family planing program initiatives.
- Expand service delivery capacity through community distribution of program products.

3. What activities do you think the male leaders in this case could be trained to do?

Male leaders can perform a variety of different activities. What the community and the family planning program determine as appropriate activities should be based on the objectives of the family planning program and the needs of the community. Often, additional data gathering may be necessary to make a final decision on the scope of activities for the community participants. In addition, the community will need some training in management in order to assume responsibility for the program. In this case the male leaders could:

- Educate the community about family planning and the prevention of sexually transmitted diseases by organizing periodic community meetings.
- Conduct informal family planning education with families and social networks, and role model good reproductive health practices.
- Provide referrals to the clinic for family planning, vaccination, and pre-natal care.
- Provide oral rehydration solution for the prevention diarrheal dehydration.
- Provide follow-up to clinic clients.
- Distribute non-prescription contraceptives.

CHAPTER FIVE

Using Maps to Improve Services

The experience of community-based family planning programs in Indonesia and Bangladesh, demonstrates that simple geographical maps can serve as useful information tools in helping family planning workers or volunteers to understand their community and its contraceptive needs. Family planning workers can use the information shown on a map to plan information, education, and communication (IEC) activities, to distribute contraceptives more efficiently, and to improve the quality of the service statistics they keep. Supervisors can use the maps to monitor the fieldworkers' performance, to maintain up-to-date information about contraceptive trends in the community, and to involve both volunteers and residents in the management of the family planning program.

This issue of *The Family Planning Manager* describes how fieldworkers, community workers, or volunteers can prepare and use maps to improve management and decision making in community-based family planning programs. In Indonesia and Bangladesh, fieldworkers and volunteers have developed a special type of map called an ELCO map, which shows where the **EL**igible **CO**uples (married couples of reproductive age) live and what method of contraception they use.

ELCO mapping requires obtaining personal information from couples about their reproductive lives, so in some parts of the world, cultural norms of individual and family privacy might limit its use. Nevertheless, in many societies, in which fieldworkers have gained the trust and respect of their neighbors, the information needed to create an ELCO map can be obtained without compromising the confidentiality of the client.

This chapter was originally produced as Volume I, Number 5 of ***The Family Planning Manager****, including the case scenario, "Mrs. Rahima's Village: A New Look at Family Planning in Kalishpur." The guest editors for the issue were Abu Sayeed and Mohammed Ali Bhuiyan.*

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Using Maps to Improve Planning and Decision Making

Maps are among the earliest tools used to gather, analyze, and present information. A map, whether it is large or small, is a condensed and selective picture of a particular environment showing how the various elements of that environment are related to one another. Maps of varying kinds are widely used in geography, environmental studies, astronomy, and epidemiology, and are also commonly used for management purposes. When used as part of an overall planning process, maps can provide insight into such decisions as the most appropriate location for a new health facility. When used for work planning, maps can help volunteers to identify the most efficient route to follow when making their household visits, particularly if the volunteers are not residents of the community. Maps can help supervisors to monitor the effectiveness of a work plan, and they make it easier to revise a work plan. When maps are used as part of an evaluation process, they can help supervisors assess the achievements or weaknesses of a program.

For family planning managers and their staff, maps can provide a simple and accurate snapshot of the family planning situation in a given community. The type of information that is shown on a map:

- is readily available and easy to understand;
- can help fieldworkers and volunteers to manage their caseload;
- can be quickly and easily updated to reflect changes in the reproductive and contraceptive status of community members;
- is important for assessing program performance and effectiveness and for analyzing trends in contraceptive practice;
- can be used by fieldworkers to organize their activities and to help them extend services to the maximum number of clients.

Increasingly, family planning programs depend on fieldworkers or volunteers to reach large numbers of the population, especially those living in remote rural areas or parts of the country without a good network of health care. Such community-based providers need accurate information that can be presented in a simple way. Information presented in a chart or map is likely to be easier for the fieldworker to understand than similar data organized into a table or written report. Maps can also be quickly updated to reflect changing contraceptive practices that the fieldworker must be familiar with in order to serve the people in his or her community effectively.

Maps can be especially powerful tools for family planning programs that depend heavily on community involvement. In Indonesia, for example, maps are used to help volunteers to identify the married couples in their community who are using a contraceptive method, where those users live, the type of method they are using, any broad changes in contraceptive practice over time, the pregnancy status of women in the community, and the number of children under five in each family.

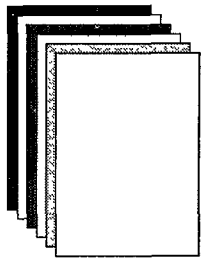
With access to up-to-date information of this kind, community-based family planning fieldworkers can make decisions about such matters as:

- which couples are in need of a home visit;
- the reason for a home visit (to resupply or to motivate a client);
- special arrangements for clients who might need more extensive counseling about family planning or referral to other health care sites;
- clients who might be ready to learn about more long-term contraceptive methods.

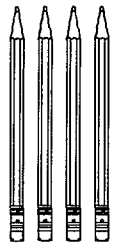
The process of creating a map helps family planning managers and fieldworkers to better understand how the family planning program works in their community. Updating a map allows managers to continually refresh their knowledge about the family planning program.

Family planning program supervisors in Indonesia, Bangladesh, and Colombia use maps to obtain a picture of how well volunteers and fieldworkers are performing, to find out about trends in the acceptance or discontinuance of various methods, to identify couples resisting family planning, and to motivate women to use maternal and child health services.

Materials Needed

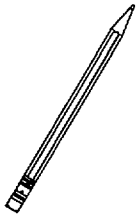


Art Paper



Colored Pencils or Markers

Ball Point Pen



Pencil

Scissors

Wooden Rods

Thread

Mapping Family Planning Services: The ELCO Map

In Bangladesh, community-based family planning fieldworkers use a map called an ELCO map to show where each of their clients live and the type of contraceptive method they are currently using. The map is also used to keep track of each couple's reproductive status and any changes in the contraceptive method they use.

An ELCO map is a graphic representation of the location of married couples in the community who are eligible for, or potential users of, family planning services. Data from ELCO maps can provide a wide range of information about the family planning status of residents of a community:

- the couple's contraceptive and general reproductive status;
- identification of couples who tend to change their contraceptive method frequently;
- the number of users for each type of contraceptive method;
- the number of pregnancies in the community.

The detailed information provided by the maps is important for planning, monitoring, and supervising the performance of the individual service provider and of the program as a whole.

Getting the Information You Need to Make an ELCO Map

Before you can prepare a map, you must decide what information you want the map to contain. The preparation of a map is a simple task once the basic family planning data have been collected.

First, you must develop a standard definition of an **EL**igible **CO**uple. Although the definition varies, in most cases eligible couple means a married couple in which the wife is between 15 and 49 years of age and is capable of childbearing. Whatever definition you decide to use, the map should include only those people who fit your definition. To collect this kind of data, volunteers or fieldworkers who are responsible for providing family planning services in the community are trained to conduct a simple household survey (also called a baseline survey). By means of a brief interview with the woman or couple of reproductive age in each household, the fieldworker can obtain information about the couple's contraceptive use and reproductive health history.

How to . . .

Prepare a Household Survey

In general, the steps to be followed in carrying out a household survey for an ELCO map are as follows:

1. Determine the area to be covered by the ELCO map. If the community or area covered by the map contains fewer than 75 households, this task can be done quickly.
2. Choose one household where an eligible couple lives as a starting point. Give the couple in this household the number 1. This is their ELCO number, and they will retain this number in all future record-keeping, even if they subsequently move to another household in the community.
3. Give the number 2 to the eligible couple living in the household nearest to the first one, the number 3 to the next couple, and so on, until all the eligible couples have been numbered.
4. Make a separate information card or an entry in a register designed by your program for recording personal information on the ELCOs in the community. The information card (or register) is important because it will give more specific information than is noted on the map, such as the number of children born to the couple or dates of method changes. Mark the couple's ELCO number on the card (or register). While interviewing the couple, collect the following information:

- The husband's name and occupation;
- The wife's name and occupation;
- The contraceptive method they currently use (any methods used in the past, and if they are not using a method, possible reasons for not using contraception);
- Whether or not the woman is pregnant;
- Whether or not she has just given birth;
- Whether or not she is breastfeeding;
- The number of children born to the couple.

When conducting a household (baseline) survey, remember that the information is very personal and that even though you assure couples of confidentiality, some of them will not be willing to discuss these matters. Some women may not want their relatives to know that they are using a contraceptive method. In programs that gather information about married and unmarried women of reproductive age, unmarried women who are sexually active may be in need of services but may not want other members of the household to know about it. In such cases, arranging to meet at a location outside the home may be necessary. For these same reasons it is important to consider, for each community, who is the best person to conduct the survey. This person could be someone from the same community, someone from outside the community, a volunteer, or a nurse.

Other Uses of Survey Data

The survey data that you have collected and recorded on cards or on a community register can be summarized and made available in a separate reporting form for each community or area. The summary information should include the:

- total number of eligible couples in the area covered by the map;
- number using any type of modern contraceptive method;
- number of couples using each different method;
- number of couples not using any contraceptive method, with the reasons for non-use if known;
- number of women who are currently pregnant;
- contraceptive prevalence for the area.

To calculate contraceptive prevalence for the area covered by an ELCO map, take the total number of eligible couples who are using any modern method of contraception, and divide this number by the total number of eligible couples represented on the map. For example, if the total number of ELCOs is 50, and the total number of couples using a modern method of contraception is 10, divide 10 by 50 to get .20 or 20 percent.

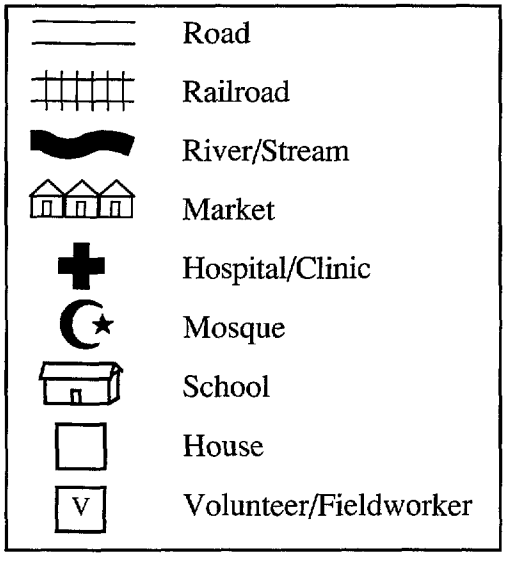
The fieldworker or volunteer should keep one copy of the summarized data for her own records and send another copy to her supervisor. A new community survey should be carried out periodically, and a revised summary should be made each time a new survey is completed.

Developing Symbols and Colors for an ELCO Map

Once you have the necessary information from the survey, you are ready to prepare an ELCO map. First you will have to decide on the symbols you will use to represent various features and landmarks in your area, and the colors you will use to indicate each possible contraceptive or reproductive status of a couple. Map makers usually place examples of these symbols and colors, with an accompanying explanation, inside a small box at the bottom of a map. This is called the legend (or key), and it helps readers to understand the information contained in the map. It is a good idea to have every family planning worker in a program use the same colors and symbols, so that it is easy to compare the performance of each of the various services within that program.

Sample Legend for the Map

Landmarks



Your choice of symbols and colors to represent the different landmarks, contraceptive methods, and categories of reproductive status will depend on the materials available in your community. You can use colored pencils, crayons, colored stickers, or draw appropriate symbols. The sample ELCO map shown in this chapter uses commonly used, easy-to-draw symbols to represent geographical landmarks. Different colored circles on the map represent the various contraceptive methods used in the community. The symbols are only examples; you can, of course, choose your own that are appropriate to your particular setting. Colors can also be used to indicate pregnant women, women who have recently given birth, and breastfeeding women. Once the legend is complete, you are ready to draw the map, using the data that you have collected.

Using the Map to Record Survey and Geographic Data

A typical ELCO map illustrates the following general features of a community or locality:

- The location of all households in the community inhabited by a couple of childbearing age. *In the sample map in this chapter, each household is indicated by a small square. If there are two eligible couples living in one household, make two connected squares, one for each couple, and give each square (thus each couple) a separate number.*
- The major landmarks in the community, such as roads, rivers, lakes, schools, health centers, markets, churches, temples, and mosques. This type of landmark can help to identify how households are distributed in the community, and might reveal certain sub-groupings of households. *Each landmark is indicated by a different type of symbol. In the sample map, which is appropriate for Bangladesh, the familiar symbol for a Muslim mosque is used. The symbol would be changed for different cultures and different religious faiths.*
- The most direct or efficient route for the fieldworker to take to ensure that all clients receive a regular visit. *The pathway is marked by arrows going from one household to the next.*
- The home of the fieldworker if the worker lives in the community. *On the sample map a special symbol denoting the volunteer's house (a square with a V in it) is used. The pathway marking his or her route generally starts and ends at his or her house.*

The map also contains information about the following aspects of the *family planning environment*:

- The home of every married couple of childbearing age in the community, that is, every eligible couple. *The number assigned to each eligible couple is written inside the square that represents the household where the couple lives.*
- The reproductive status of the woman in the household (for example, whether she is pregnant, wanting to become pregnant, postpartum, or breastfeeding). *Each of these conditions is shown by a colored circle that is drawn around the numbered square that indicates an eligible couple.*
- The current contraceptive status of each eligible couple. *Each contraceptive method is identified by the use of a different color.*
- Changes in the contraceptive method used by each eligible couple. *Every time a couple changes the type of contraceptive method they use, a colored circle is added, representing the new contraceptive.*
- Eligible couples who are not using a contraceptive method. *These couples are also identified by a different colored circle that represents non-users.*

Updating the ELCO Map

The main geographic landmarks on a map are not likely to change very much over time, but the contraceptive methods and family planning status of each couple may change frequently. This information, therefore, may have to be updated during a fieldworker's visit. Similarly, information will need to be updated on the information cards (or ELCO register). Necessary updates will include:

- **Addition of new households or eligible couples, or changes in an eligible couple's location in the community.** The number of ELCOs will change, as people leave or move within (or outside of) the community, as young people marry and form a new eligible couple, or as couples no longer need family planning as a result of death, aging, or divorce. Whenever a new ELCO is identified, add a household (a new square) to the map and give the couple a new number. *Remember that the number refers to the couple and not to their place of residence. When a couple moves to another house in the community, their ELCO number needs to be moved on the map to show their new location. If a new couple moves into the community, a new ELCO number should be assigned to that couple.*

Continued on page 146

How to . . .

Prepare an ELCO Map

ELCO maps should be small enough for the fieldworker to be able to carry, but large enough to show the necessary information clearly. A reasonable size would be 36 cm by 50 cm. It should contain only relevant and required information to avoid overcrowding symbols, colors, and other items on the map, and the items should be large enough to be easily readable.

Because there is a limitation on its size, an ELCO map should not cover too large an area, and the number of eligible couples represented on any map should not exceed 75. If the fieldworker serves more than 75 couples, she or he may need to draw more than one map. Here are some general instructions on preparing a map:

1. Take a large sheet of paper about 36 cm by 50 cm. On the top of the paper, write the name of the program, the name of the fieldworker who covers the area, the name of the area or community, and the date of the last survey.

2. Draw the general shape of the area in the lower three-quarters of the sheet of paper. Put in the major features or landmarks in the area, such as roads, rivers, schools, health centers, mosques, temples, churches, market places, canals, bridges, or other appropriate and recognizable landmarks. On the bottom of the sheet, make a box for the legend (or key) to explain the meaning of the symbols.

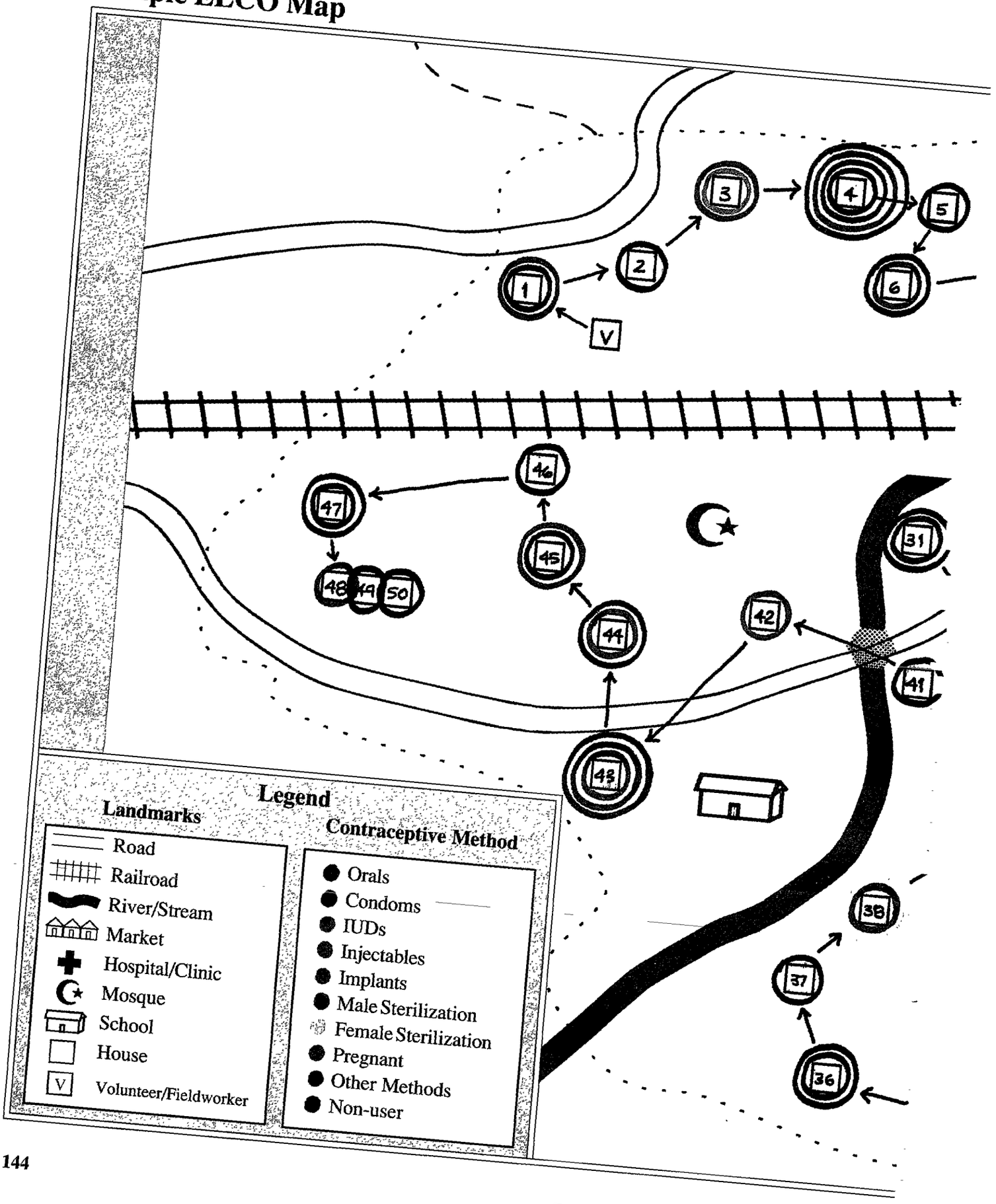
3. Show where each household with an eligible couple is located by drawing a square at that point on the map. Number each square in sequence, making sure that the ELCO number on the map corresponds to the number assigned to that couple on the information card that you have prepared.

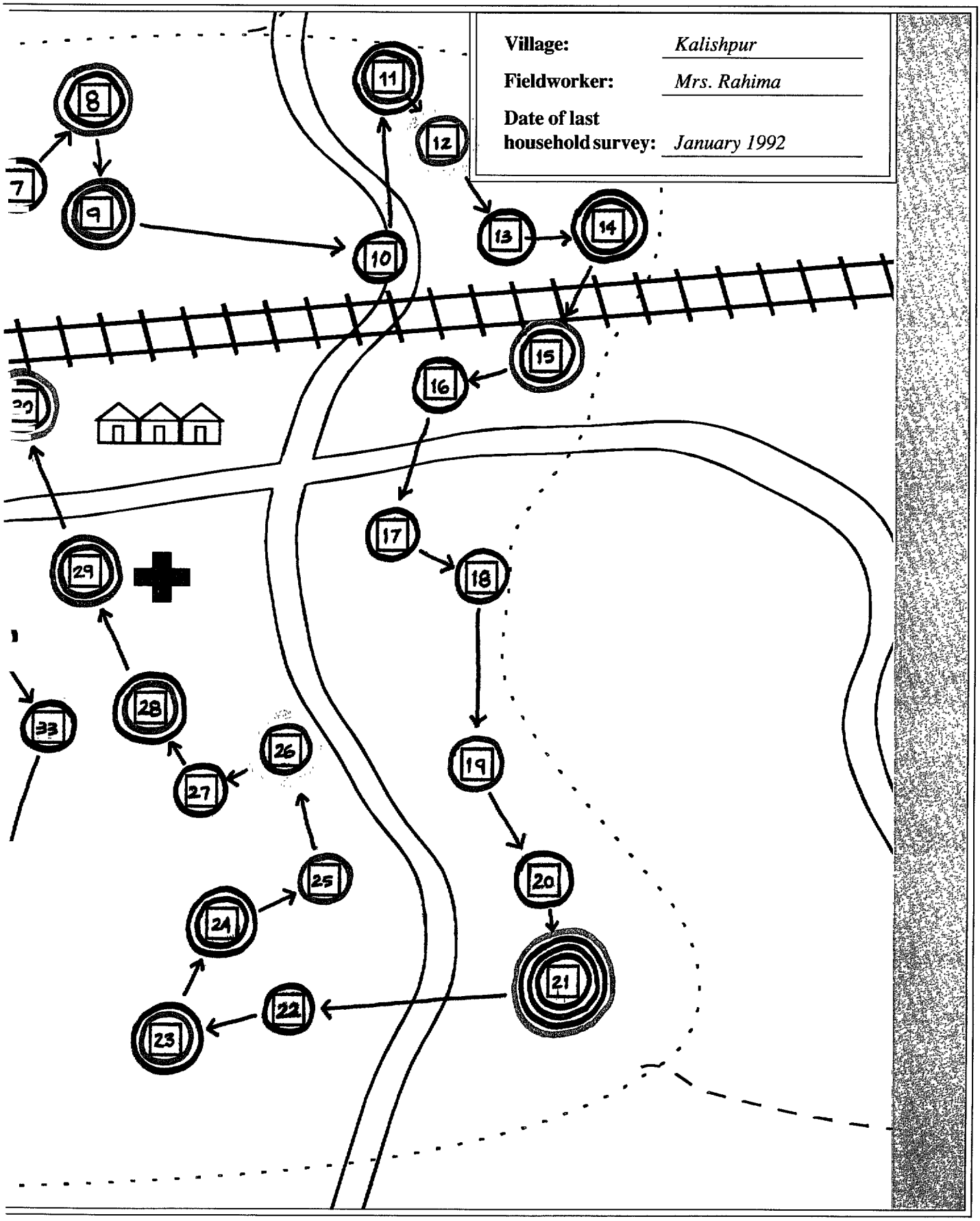
4. Show the contraceptive method that each eligible couple currently uses by drawing a circle around the numbered square that represents the couple's house. Each contraceptive or reproductive status should be represented by a specific color. The legend in the box should explain the meaning of each color.

5. Draw a square marking the location of the fieldworker's (or volunteer's) house if he or she lives in the community, and put a "V" inside the square. Using arrows, mark the quickest route that the fieldworker can take to go from one household to another. The routes or paths that you mark do not have to be completely accurate, but they should give a general idea of how the fieldworker or volunteer could best organize his or her visits to ensure that each household is visited regularly (for example, once every 4-6 weeks).

6. When the ELCO map is completed, attach it to a thin stick or wooden rod, using glue, tape, or thread, so that the volunteer can roll it up when she goes on her round of visits. Then, using a needle and thread, attach a loop to the top of the map, so that the volunteer can hang it in her house, or from a tree or wall, when she is showing it to her supervisor, or to the managers of other programs providing services in her community.

Sample ELCO Map




Village: Kalishpur
Fieldworker: Mrs. Rahima
Date of last household survey: January 1992

Continued from page 143

- **Changes in the contraceptive method used by each couple.** Whenever the couple changes contraceptive methods, draw a new circle of the appropriate color around the outside of the previous circle. In this way, the last color will always signify the most recent contraceptive method used by that couple. If you are using colored stickers, update the map by placing a new sticker on top, and slightly to the side, of the old one. Then update the information on the ELCO register. *Since the map does not indicate when a couple started using a method or when a couple changed methods, always write the dates in the register.*
- **Changes in the reproductive status of each couple.** Whenever an ELCO is no longer in need of contraception, add a colored circle to show the new status of that couple. For example, if a woman becomes pregnant, gives birth, begins or stops breastfeeding, or if the eligible couple is not currently practicing any method of family planning.

When a map is routinely updated, it provides both fieldworkers and their supervisors with a rapid review of the changes in contraceptive use in a given community or area. It indicates trends in the use of the various contraceptive methods and helps to identify discontinuers who may be in need of special motivation. It also shows if contraceptives are effective in helping couples avert unwanted births. To keep abreast of changes of this type, some fieldworkers in Bangladesh draw a new map every year, or whenever they conduct a new household survey.

Working Solutions—Colombia

The use of maps stands behind Colombia's success in family planning. Beginning in the early 1970s, the "Walking Women" in Colombia have been using maps to facilitate the delivery of family planning services and improve maternal and child health in rural areas. The so-called "Walking Women" are Rural Health Promoters under the State Health Department in Armenia, Central Colombia. The Health Promoters work in areas where doctors can only visit once or twice a month. In addition to providing Oral Rehydration Salts to children with diarrhea, promoting breast feeding, and improving environmental sanitation, they promote family planning and provide new contraceptive supplies to women who are using oral contraceptives or condoms.

Maps were a powerful tool that the Health Promoters used to effectively identify and target services to the women and children who were the most in need of primary health care and reproductive health services. Keeping track of how many women the Health Promoters had to visit was difficult because they worked in rural communities with populations often greater than 100 people. To assist the promoters in their day-to-day work, the Maternal and Child Health (MCH) program decided to teach these women to draw and use maps. The use of maps has played an important role in improving contraceptive prevalence. Between 1970 and 1990 the contraceptive prevalence in rural areas increased from 10 to 59 percent.

After taking a quick census in the community where they work, the Health Promoters draw maps that show the health needs of individual families in their community. Equipped with these maps and a bag full of basic medicines and contraceptives, the Health Promoters are then able to provide improved services to their communities as well as to improve their own efficiency. For example, they can determine ahead of time how many pregnant women may need iron and vitamin supplements, or how many children may need immunizations, or how many couples need a new supply of pills or condoms.

Maps have also made life easier for the supervisor whose role is to reinforce health education, and to support the Health Promoter in areas where the Health Promotor has met resistance to immunization and family planning services. Using the maps, the supervisor can tell, for example, where non-contraceptors or children who have not been immunized are located. With this information, supervisors can better target appropriate interventions and provide special attention to groups or individuals who are most in need of services.

Using Maps to Improve Service Delivery

Maps can help family planning managers to improve service delivery in a wide variety of ways. The maps can help them to plan their work, to improve client services, to manage volunteer activities, to strengthen record-keeping, and to improve supervision and program performance.

Using Maps for Work Planning

Both preparing and consulting a map can help family planning managers and fieldworkers to:

- plan and organize their work;
- provide information for setting targets;
- monitor progress towards meeting those targets.

Supervisors will find that maps can help them to:

- divide up the work among different fieldworkers;
- plan program activities.

Community outreach workers will find that maps provide an excellent way for them to plan their itinerary and daily schedule of household visits.

Using Maps to Improve Client Services

Fieldworkers can improve client services by:

- **Attending to the needs of potential clients and of those who discontinue use of a method.** Clients who have never used a contraceptive method, who are resistant to family planning, or who have stopped using a method (discontinuers) can be identified, and special motivational activities can be developed for these groups.
- **Reducing frequent method switching or discontinuation.** Fieldworkers or volunteers who know the location of clients who are unhappy with their contraceptive method can better plan their household visits to these couples. The fieldworker will then be able to plan for the extra time needed to answer a couple's questions, to discuss their concerns, to describe other methods, or to refer the man or woman to a health center to obtain other contraceptive or reproductive services.
- **Identifying clients who may be candidates for long-term clinical methods.** When fieldworkers know the contraceptive history of couples, they will be able to identify clients who might accept more long-term clinical methods and can refer them to a clinic for these services.
- **Providing effective maternal and child health (MCH) referral.** Fieldworkers who know which women in the community are pregnant or have recently given birth can plan activities to refer these clients to an MCH center to ensure safe deliveries, and to obtain appropriate primary health care and child survival interventions.

Using Maps to Manage Volunteer Activities

Preparing and using a map can be the cornerstone for initiating and training new family planning volunteers. Maps are effective tools for managing volunteer activity because they:

- are easy to prepare and use;
- do not place too great a record-keeping burden on volunteers;
- help volunteers and fieldworkers to gain a better understanding of the community program, and so they are likely to feel a stronger sense of motivation in their work, and develop a long-term commitment to the program;
- encourage stronger community support for the program and for the work of the volunteers by educating managers of other service programs in the community about the work of the volunteers.

Working Solutions—Mexico

The Mexican Federation of Private Health and Community Development Associations (FEMAP) is a private non-profit institution that was established in 1973. Its 44 affiliate members cover 95 cities and thousands of rural communities throughout Mexico.

Assisted by over 9,000 volunteer community outreach workers who are supported in their outreach work by health and social science professionals, FEMAP serves 400,000 continuing clients and 70,000 new clients each year. Eighty-five percent of FEMAP clients are served by community workers and 15% by clinic staff. FEMAP's community work is based on active and informed volunteer involvement in the community and is rooted in the belief that people have the potential to overcome their difficulties.

In its search for efficiency and quality of care, FEMAP developed the first community family planning service in Mexico. Each CBD program is staffed by one social worker who supervises 8 outreach worker coordinators who in turn supervise 180 outreach workers who serve up to 3,200 clients.

In 1975 FEMAP began house-by-house mapping of clients in each of the neighborhoods where the community family planning program was being implemented. FEMAP modeled their mapping campaign after a strategy developed by local health authorities to cover communities during national vaccination campaigns. The mapping exercise had three basic objectives:

- to publicize the program;
- to find potential clients;
- to recruit new acceptors.

In 1985 the mapping strategy was modified and expanded to incorporate the following elements:

- preparing a map as the initial activity for family planning work in the community;
- making home visits to potential clients by outreach workers;
- updating the map every year;
- using students from schools of social work in the community mapping process;
- providing mapping results to community outreach workers.

Mapping has proven to be an extremely valuable management technique for FEMAP and has contributed to increasing project productivity, expanding coverage, reducing start-up costs, and strengthening community operations and program efficiency. Because of this success, variations of FEMAP mapping techniques have been used with some modifications by the rest of FEMAP's associates.

Using Maps to Improve Record-Keeping

As part of a wider reporting system, information from a map about the contraceptive and reproductive status of individual couples should be used to update the information maintained by supervisors in registers and on other forms.

- By using a common numbering system for the maps and registers, the supervisor can easily update her register after every supervisory visit.
- Maps covering small communities often contain information of very high quality. By using these maps as a data source, managers can improve the accuracy, completeness, and timeliness of regular program performance reports.

Using Maps to Improve Supervision and Program Performance

Supervisors can improve supervision and program performance by:

- **Verifying the accuracy of program data and monitoring service quality.** Program supervisors who know the location of all the contraceptive users in a given community, as well as their contraceptive and family planning status, can more easily monitor service quality and verify the accuracy of the data in the registers. The supervisor can occasionally make a random check of households, in order to confirm that the reported data about the couples living there are accurate. This might be a satisfactory substitute for carrying out an entire new household survey.
- **Identifying specific performance objectives for the service provider.** Supervisors who understand the overall family planning situation in their community can develop and set realistic performance objectives for the fieldworker.
- **Planning program activities.** Since maps facilitate understanding family planning trends and individual client histories in a community, they can help address the special characteristics and needs of that community.
- **Estimating contraceptive supply needs.** A better understanding of trends in contraceptive preferences can help managers make more realistic estimates of future contraceptive needs in a given community.
- **Identifying potential service delivery problems.** Managers who understand patterns of contraceptive method-switching are more likely to be able to detect commonly experienced problems with a particular method, or inadequacies in client education, and they can then target IEC programs more effectively.
- **Dividing overall target groups into smaller, more manageable units.** When fieldworkers in a family planning program are responsible for hundreds of clients, the use of maps can help them to divide their target group into smaller, more manageable, area units. Each area unit can then be treated independently, and the service provider can organize her activities to meet the contraceptive needs of that particular area.
- **Developing clinic outreach activities.** A clinic-based program can use maps to manage outreach activities. The map can be a useful tool for planning, developing strategy, implementing an outreach program, and monitoring the results. The map can show where different services are needed, will reduce time searching for clients with similar needs, and keep track of movements of clients.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On mapping other groups in need of reproductive services . . . *Several reviewers stress the need to change the definition of eligible couple to include other family planning target groups. For example, in some countries, it may be more useful to map all men and women who are sexually active and of reproductive age, whether or not they are married. One reviewer writes,* "ELCO mapping should be used to target more groups than just married women . . . particularly in low income communities where there are sizeable numbers of sexually active men and women who are not married. These groups need to be identified and targeted for contraceptive and reproductive health services."

On the cultural acceptability of conducting a household survey . . . *One reviewer suggests,* "In addition to problems relating to cultural acceptability, program managers will have to decide about the political feasibility of conducting a household survey. It is possible that authorization from local authorities may be needed for such a purpose. The fieldworker may need to be accompanied by someone who is known to the community."

On using maps for serving adolescents . . . *One reviewer advises,* "I felt while reading this chapter that mapping would be a good method for targeting teenagers as a subgroup of the 'women in reproductive years.' We have started a program to provide contraceptives to teens and we have had difficulty getting them to come in to use the center. This method could help us to define the problem and perhaps provide us with some solutions for serving this group better. It would also allow us to get some needed information about the sexually active adolescents, such as the extent to which contraception is being used and which methods, whether they have adequate access to contraception, and the incidence of pregnancy."

On assigning eligible couple numbers where several maps represent a single program . . . *Several reviewers suggest,* "It is important to develop a careful system of assigning numbers in a program so that a supervisor can distinguish between the ELCOs of one community and the ELCOs of another when looking at the register or information cards. For example, if there are several maps for one family planning program it is easier if one community has numbers beginning with A and another community has numbers beginning with B and so forth. This way when there are two ELCOs with the number 33 (one numbered A33 and the other B33) the supervisor will know to which community the ELCO belongs."

On using maps to target other clients in the community . . . *Several reviewers point out,* "To get the full benefit from conducting a household survey and developing a map, managers should consider mapping information about other important health needs, for example, the immunization status of children under 5 years old. A map with this information would be helpful in locating children who need immunization services."

On ways that maps might be used . . . *Several reveiwers indicated that program managers, district managers, CBD workers, and family planning volunteers could all benefit from developing and using maps. One reviewer writes,* "Mapping will fit into our program very well. It seems like an excellent way for volunteers to become involved in the program and become more supportive of our family planning activities."

Maintaining Maps as a Management Tool

Like any tool, once a map has been introduced it must be used and updated regularly in order for it to continue to be valuable and useful. In countries such as Indonesia, Bangladesh, and Colombia, maps have been key to the success of the community distribution component of the national family planning program. By using maps, fieldworkers, volunteers, and health promoters develop the abilities and skills they need to collect reliable information about contraceptive use, and to use this information to better serve their clients. In order for a map to remain a useful tool, both supervisors and fieldworkers must work together to ensure the following conditions:

Commitment. All staff members must be committed to collecting and using simple and reliable information.

Regular updating. Maps should be updated regularly to ensure that the information is complete, accurate, and timely.

Consistency. Colors, symbols, and numbering should be the same from one map to the next, and should be consistent with other records used in the program.

Use of information. Information from the map should be used to update registers and other reporting forms. This process also serves to demonstrate the value placed on the map.

Verification. The data on the map should be verified by the supervisor, and appropriate feedback and approval should then be communicated to the fieldworker or volunteer.

Decision-making. Local-level planning decisions, strategy development, and performance supervision should be based on information from the map.

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Checklist for Using Maps to Improve Services

For Fieldworkers

- [ ] Conduct a household survey to collect data for your map and assign a number to all ELCOs in the area.
- [ ] Assemble your map-making materials.
- [ ] Draw major landmarks and the location of ELCO households in the community on an appropriately sized sheet of paper.
- [ ] Mark the ELCO numbers on the map in the square that signifies each ELCO's house.
- [ ] Draw circles to identify the contraceptive method or reproductive status of each eligible couple.
- [ ] Mark arrows to show the best route for household visits.
- [ ] Update maps regularly.
- [ ] In collaboration with your supervisor, develop methods to analyze and use the information on the maps.

For Supervisors

- [ ] Develop a plan for introducing maps into the community-based family planning program.
- [ ] Provide guidelines for making maps and for using the data acquired from them: determine the area to be covered, the information to be collected, the symbols and legends to use, and a method of summarizing the data in a useful format.
- [ ] Train fieldworkers to prepare and use maps.
- [ ] Support the use of maps by fieldworkers, and help them to use information from the maps to improve their performance.
- [ ] Analyze and use information from maps to make service delivery improvements.

For Mid- and Senior-level Managers

- [ ] Identify areas within existing programs where maps can be used to improve and support service activities (i.e., CBD, community outreach, or IEC programs).
- [ ] Identify ways in which maps can improve and support service activities.
- [ ] Decide what data should be collected and mapped.
- [ ] Implement activities that use the maps to strengthen the delivery of family planning services.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Mrs. Rahima's Village: A New Look at Family Planning in Kalishpur

Mrs. Rahima rolled up the eligible couple (ELCO) map for the area she served. She was a community-based distribution (CBD) family planning worker, and had just visited the last of the clients in her village of Kalishpur and had resupplied them with the contraceptive method they were using. Now she had up-to-date information on the contraceptive methods being used by the eligible couples in her area, and on some of the changes in family planning status that had occurred since her last visit. As she headed toward her home across the railroad tracks, Mrs. Rahima reminded herself that now she should update the map of her area, and have the revised version ready to show her supervisor, who was due to visit her the following day.

Although Mrs. Rahima had been using the map for almost a year, she had only recently been trained to use the map for analyzing trends in her community. The director of the family planning program had decided that more accurate data on contraceptive prevalence and method mix in the community was needed, and all CBD workers had recently been trained to use the ELCO maps to analyze various aspects of contraceptive practices within the community.

The next morning when her supervisor, Mrs. Salina, arrived, the map was already spread out on Mrs. Rahima's table. Mrs. Rahima had finished updating the map showing the current contraceptive method being used by each couple, those couples who had switched methods, those who were pregnant, those who had discontinued family planning, and those who had never used any form of contraception. "Good morning, Mrs. Salina," said Mrs. Rahima. "Can I offer you some tea?"

"Thank you. That would be very nice," said Mrs. Salina.

"I have just updated my map," said Mrs. Rahima. "Why don't you have a seat while I prepare the tea. We can discuss the changes in a moment."

Mrs. Salina examined the map closely and noted the changes in her register.

"Well, Mrs. Rahima, you have done a very good job in updating your map," said Mrs. Salina. "Did you have any difficulty collecting the information?"

"No, it has always been quite easy," responded Mrs. Rahima, "although this time there were several houses that I had to visit more than once because no one was at home. However, I found that with the map it was easy to plan the quickest route to visit those houses again. Even with the changes since my last visit, the map makes it quite clear that condoms and pills are still the most popular methods in my area."

"It certainly looks that way," said Mrs. Salina. "Now let's get a piece of paper and look at the actual numbers. We need to let the program director know the contraceptive prevalence and the method mix for your area. Later I will combine your figures with others from the region."

Case Discussion Questions: Mrs. Rahima's Village

To answer the following questions, please refer to the ELCO map on pages 144 and 145 of this chapter.

1) **What percentage of the eligible couples in Mrs. Rahima's village are using a modern method of contraception (oral contraceptives, condoms, IUDs, injectables, implants, or sterilization)?**

2) **What is the modern method mix in Mrs. Rahima's village? What actions might she take to increase the percentage of couples using longer-term methods?**

3) **Which couples appear to have been dissatisfied with the contraceptive method they were using? What should Mrs. Rahima do about this situation?**

4) **List five other ways in which Mrs. Rahima might use the map.**

Case Analysis: Mrs. Rahima's Village

1) **What percentage of the eligible couples in Mrs. Rahima's village are using a modern method of contraception (oral contraceptives, condoms, IUDs, injectables, implants, or sterilization)?**

Formula for Calculating Contraceptive Prevalence

$$\frac{\text{\# of couples using modern contraception}}{\text{Total \# of ELCOs}} = \text{Contraceptive Prevalence}$$

Looking at the map, Mrs. Rahima can count the total number of couples using a modern method of contraception. This number is 17. The total number of ELCOs on the map is 50. Mrs. Rahima can calculate the percentage of couples using a contraceptive method by dividing 17 by 50, to get 0.34, or 34 percent. This measure, the proportion of eligible couples who are using a modern method of contraception, represents the contraceptive prevalence in her service area.

2) **What is the modern method mix in Mrs. Rahima's village? What actions might she take to increase the percentage of couples using longer-term methods?**

Mrs. Rahima's first step in calculating the method-mix was to make a table showing the number of couples using each contraceptive method. From that table, shown on the next page, the percentage distribution of the contraceptive methods was calculated by dividing the number of couples using each method by the total number of couples using any method (in this case, 17 couples).

Case Analysis: Mrs. Rahima's Village

Number and Percent of Couples Using Each Method

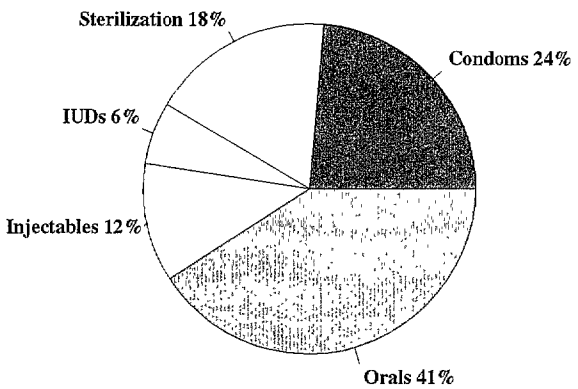
Kalishpur, November 1992

Contraceptive Method	Number of Couples	Percent distribution of Contraceptive Methods Used
Orals	7	7/17 = 41%
Condoms	4	4/17 = 23%
IUDs	1	1/17 = 6%
Injectables	2	2/17 = 12%
Implants	0	0%
Sterilization	3	3/17 = 18%
Totals:	**17**	**100%**

Using the data from this table, Mrs. Rahima could now draw a pie chart or a bar chart that would graphically illustrate the relative proportion of each of the contraceptive methods that her clients are using. See the supplement to Chapter Ten, "Guide to Graphing Data and Taking Action," for a reminder on how to draw a pie or bar chart.

Method Mix (modern): Kalishpur

November 1992



Looking at the pie chart she has drawn, Mrs. Rahima can see that the majority of the couples in her village are using pills or condoms. Mrs. Rahima might compare this method mix with the method mix found in other nearby villages or areas, to see whether other means have been more successful in motivating clients to use more effective methods. This way she can see whether the situation in her community is unique, or common to the entire program. She could also ask her supervisor to provide her with more educational materials on longer-term methods and ask her supervisor to accompany her on one of her rounds of visits to make sure that she is providing complete and up-to-date information on the longer-term clinical methods.

Case Analysis: Mrs. Rahima's Village

3) Which couples appear to have been dissatisfied with the contraceptive method they were using? What should Mrs. Rahima do about this situation?

The map shows that 10 couples in her area have stopped practicing family planning and three couples have switched methods quite frequently. Using this information, Mrs. Rahima should try to find out why this has happened. She might discover, for example, that some women were experiencing side effects from the method they were using, or that there were negative rumors about certain methods going around the village, or that the husband or another family member had objected to the woman's use of a certain method. With this additional information, Mrs. Rahima can plan household visits that will be long enough to give her time to correct the rumors, reassure some users about the safety of the method they are using, answer the questions of others, and generally discuss any problems or concerns the couple is experiencing.

4) List five other ways in which Mrs. Rahima might use the map.

Mrs. Rahima might use the map to:

- **Identify couples who have never practiced family planning and find out the reasons why.** Looking at the map, Mrs. Rahima can see that 18 couples have never used contraception but are not pregnant. First, she should find out which of them are not using a contraceptive method because they want to have a baby, or because they believe that the husband or wife is infertile. Mrs. Rahima should then consider the remaining couples as potential new acceptors of family planning, and devise a strategy to gain their interest, for example by explaining the health advantages for the woman and her children to be gained from spacing births and from limiting unplanned pregnancies.
- **Keep track of the women in the community who are pregnant.** Knowing this, Mrs. Rahima can help the women obtain adequate prenatal care and care during labor and delivery. She can then arrange for the new mother to receive post-natal care for herself and her baby.
- **Provide support and reassurance to couples who have chosen sterilization.** Mrs. Rahima can continue, on occasion, to visit couples who have chosen sterilization, to reassure them of their decision and answer any questions that they may have. She might also inquire as to whether these couples might be willing to discuss their decision with other couples who are contemplating sterilization.
- **Set performance targets.** Knowing the CPR for her village allows Mrs. Rahima and her supervisor to set realistic targets for the number of new acceptors she might expect to be able to recruit in her area over a certain time period.
- **Schedule her time.** Mrs. Rahima can use the map to plan and schedule her time effectively, so that none of the couples in her area are left without the contraceptive supplies they need, and none of the potential users go without a home visit.

CHAPTER SIX

Decentralizing Health and Family Planning Services

In recent years, some ministries of health around the world have embarked on a process of decentralization. Many non-governmental organizations are also interested in transferring decision-making powers to the field level, and donors are promoting decentralization by supporting initiatives that increase the management capacity of field-level managers, so they can use their new powers wisely and effectively.

Whether your government or organization is planning a decentralization initiative or decentralization has already begun, you should know what the goals of the decentralization initiative are, how it can benefit your clients, and how your job and your role in the overall program will be affected. This issue of *The Family Planning Manager* explores the changing roles of managers at the central and local levels and the management skills they must have to function effectively in a decentralized environment.

This chapter was originally produced as Volume IV, Number 2 of ***The Family Planning Manager****, including the case scenario, "Angelino Regional Clinics Deal with Decentralization." The guest editors for the issue were Saul Helfenbein, Riitta-Liisa Kolehmainen-Aitken, and Bill Newbrander.*

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Decentralizing Family Planning Program Management: Look Before You Leap

Decentralization is about power. The term is usually used to describe the transfer of power from higher to lower management levels in diverse organizational settings, although the degree of power that is transferred varies widely. It can mean transferring only control over *specific management functions*, such as planning and budgeting, from a central office to field offices, or shifting the responsibility for an *entire program* to an institution with a distinct geographic boundary, such as a provincial or district government.

The rationale for any decentralization initiative is to increase efficiency, cost effectiveness, and program performance. Decentralization is also expected to improve intersectoral coordination and promote community participation. Although decentralization may be initiated with the best of intentions, it may take many years to develop the skills of and support from managers at the central and field levels before these objectives are achieved.

Some experts warn that some governments decentralize simply to pass off the responsibility for managing programs to the field because the central level has run out of options for improving health services. In such situations, the lack of political commitment and insufficient resources will impede the ability of field-level managers to plan and manage their programs successfully. If help is not available to build field-level capabilities, managers at the local level will not be able to make good use of their new leadership role.

Decentralization works if several key elements are in place. These include formulating clear goals, carefully defining the boundaries between the functions controlled by central-level managers and those controlled by their field-level counterparts, and helping to build local-level capacity by providing technical and material support to field staff. Issues that are specifically related to family planning will have to be addressed, such as how standards of care will be set and monitored; how national and local information, education, and communication (IEC) activities will be integrated and coordinated; and how local service delivery strategies will support national population goals. To find appropriate ways to address these issues, managers at the central and field levels will have to collaborate closely as they redesign and implement their family planning programs.

This chapter will help you to assess both the opportunities and the risks inherent in decentralizing your program. It will help you identify the new relationships that must exist between the central- and local-level managers, and the types of skills that local-level managers must have in order for decentralization to have a positive impact on family planning program performance.

Understanding Decentralization

Decentralization can occur as a result of policiesset by the highest levels of government: administrative orders issued by a single ministry or directorate that is responsible for implementing the program, or a strategic decision made by a private organization. When a government agency or private organization decides to decentralize, it may use a combination of approaches to reach its goal. This chapter discusses approaches to decentralization in the public and private sectors.

Public-sector decentralization. Decentralization in the public sector can be introduced by means of a broad national policy to decentralize one or more public service sectors or it can take place incrementally, by transferring responsibility for specific management functions to lower levels over a period of time. In the public sector, decentralization can be carried out by transferring varying degrees of power from the central level to:

- field divisions or units within the same ministry or agency;
- other government levels, such as regional, provincial, or local government units;
- semi-autonomous public authorities (such as hospital boards), or private for-profit or non-profit organizations.

In the first case, limited power is transferred to lower field levels within the ministry or agency. In the second case, substantial power for managing programs and activities is transferred to one or more lower-level government units, leaving only limited functions under the control of the central ministry or agency. In the third case, the government relinquishes responsibility for specific programs by handing these programs over to a public entity or private organization.

Private-sector decentralization. In the private sector, a large organization may decide to transfer the management of specific programs or functions to one or more field departments within the organization, or to other private groups that can carry out those programs. The impetus for this change may be to streamline services, to make decisions faster and more relevant to the local level, or to coordinate programs at the local level so that services are not duplicated. Private-sector decentralization, which can occur independently of any government initiative, may even inspire the public sector to decentralize.

Understanding Decentralization Terms

Four terms are commonly used to describe and categorize the means by which decentralization occurs: deconcentration, delegation, devolution, and privatization. Although this chapter does not use these terms, the methods for transferring power defined by these terms are treated in the discussion.

Deconcentration means that some management functions, such as developing program budgets, are transferred from the central level to *lower-level field units within the same agency or organization*, but overall control of the program remains at the central level.

Delegation describes an approach in which the central level transfers the responsibility for specific managerial functions, such as developing and conducting management training, to *organizations that are outside the regular bureaucratic structure*, and thus only indirectly controlled by the central government.

Devolution refers to the transfer of power to newly created or strengthened *sub-national units of government*, the activities of which are outside the central government's direct control. In this approach, responsibility, authority, and accountability for a family planning program is usually transferred to a provincial or municipal government.

Privatization refers to the transfer of specific management functions, such as contraceptive procurement, logistics, and training, to *private non-profit or commercial organizations* outside the government structure. Some experts believe that privatization is not a means of decentralization because in privatizing, a government relinquishes responsibility, rather than transferring powers to lower levels.

Recognizing Opportunities in Decentralization

Many initiatives to decentralize family planning programs come from the central or headquarters level of an organization or agency. But occasionally, when local managers demonstrate their capacity to achieve high levels of performance in large-scale family planning programs, such as in Bangladesh, their success may convince the central level to decentralize. Central managers may recognize that it is in their interest for programs to be able to respond rapidly to client needs and will transfer more and wider power to the field.

When an agency or organization decides to decentralize, local managers should seize the opportunity to have a larger leadership role in the program. Local managers will need to analyze the situation by asking the right questions and, with the answers, develop the necessary skills to use their new powers effectively. In the long run, by successfully advancing program goals and by producing good results, local managers can prove that decentralization is the right way to go.

Answering the Key Questions

Enthusiasm to pursue decentralization must be accompanied by clear goals and adequate planning. Whether decentralization has already begun or is about to begin, all managers should obtain the answers to several key questions to get a better understanding of who will be responsible for planning programs, who will have the authority for allocating and managing resources, and who will be accountable for financial and program performance.

What are the stated goals of the decentralization initiative? Managers must understand the reasons why the agency or organization is decentralizing. These reasons may be to cut costs, reduce bureaucracy, improve efficiency, increase community participation, or make services more client-oriented. Having a thorough understanding of the reasons for decentralization will be helpful in developing strategies for achieving the goals of the decentralization initiative.

How will the decentralization initiative be authorized and implemented? Managers need to know if decentralization will be instituted by passing a constitutional law or through an administrative order. For example, if decentralization is instituted by an administrative order, the scope could be changed more easily in the future. In either case, managers must know whether the powers will be transferred incrementally or all at once.

What programs or functions are being decentralized? Managers need to know which functions are being decentralized and how decentralization will affect the management of their programs. For example, when the responsibility for logistics is transferred, lower levels may find they have to deal with many agencies and get approvals from customs or other agencies before procurement can take place or contracts can be issued.

To whom are these programs or functions being transferred? In order to assess the impact of these changes on their programs and on the overall role of their organization, managers must know where the responsibility, authority, and accountability for specific management functions or for entire programs will reside after decentralization. When management functions are transferred to another level, organizational relationships and reporting requirements may be permanently altered. For example, decentralization may mean that family planning services will be taken over by maternal and child health (MCH) centers at the local level, or that contraceptive logistics may be transferred to the district hospital.

What impact will these changes have on service-related jobs? The transfer of power often comes with new expectations regarding roles and responsibilities of staff in the field. Family planning

supervisors may, for the first time, be required to supervise maternal health activities or to oversee the work of traditional birth attendants. New referral procedures may place additional burdens on primary-care units and may require managers to monitor health-post activities more closely. For these reasons, managers need to look at how decentralization will affect the jobs of their staff and decide whether their staff have the necessary skills to carry out their new responsibilities.

What skills will managers need to have? Decentralization changes the roles and responsibilities of managers at all levels. Central- and local-level managers need to know what their new roles will be in the program, what new powers they will have, and what new skills they and their staff will need to acquire in order to perform their jobs effectively. For example, increased accountability may require the field manager to be more actively involved in managing finances or information systems, while the central level manager may need to take on a new teaching and technical assistance role.

Identifying the Necessary Conditions for Successful Decentralization

A number of conditions must be present for decentralization to be successful. Without these basic requirements, managers at the central and local levels risk seeing their good intentions fail. At a recent meeting of the Francophone Regional Advisory Committee (FRAC), members from Haiti and sixteen Francophone countries in Africa met to share their experiences and concerns about decentralizing family planning program management. At the meeting, the participants identified the following prerequisites for decentralization:

- sufficient political will at the central and local levels of governments to support the initiative and the process;
- adequate management skills at all levels;
- a clear implementation plan;
- a legal administrative framework that sets limits to authority;
- adequate resources;
- interest, involvement, and commitment of local leaders.

Having identified the prerequisites for decentralization, FRAC members developed a list of management actions that would help make decentralization successful. This list included:

- defining the powers that are being transferred and the mechanisms for the transfer. (responsibility, authority, and accountability for management functions should always go together);
- maintaining a regular dialogue between central-level resource planners and local-level health care planners and program managers;
- articulating the goals and objectives for the decentralized programs;
- making a commitment to providing annual financing that corresponds to program needs;
- developing accounting procedures that allow managers to monitor the flow of money between central and local levels;
- making a list of the skills that managers at the central and local levels will need in order to function in their new roles, and making sure that managers receive the necessary training;
- developing personnel policies, appropriate salary scales, and performance compensation mechanisms that will allow managers to retain qualified staff;
- instituting adequate supervisory systems that reflect local-level problems and needs.

Working Solutions—Bangladesh

Making Community Participation a Goal of Decentralization

In Bangladesh, an initiative that started as a means of supporting government decentralization efforts eventually became the means by which the government now carries out its national family planning program at the local level. In just eight years, the Local Initiatives Program (LIP) in Bangladesh has grown from a small program experimenting with giving communities a role in managing local family planning activities, to a program that covers nearly 20 percent of the country. From its inception, the LIP has focused exclusively on the community.

The national policy to decentralize the planning and financial management of family planning programs to the sub-district level greatly helped to start the process. But even when national decentralization policies were rescinded and local administrative powers were withdrawn, the community approach remained strong and was a crucial factor in furthering family planning program decentralization. By then, community participation had demonstrated a measurable impact on performance: In the community-managed programs, contraceptive prevalence had increased on average by 20 percent.

Program successes convinced government officials and program managers at the district, regional, and central levels that community participation was the route to achieving national goals. They continued the policy of allowing local governments to allocate locally-generated funds to their family planning program, so that local plans could be implemented. This practice became increasingly popular and in November 1994 it became national policy.

Forming a Local Family Planning Management Team

Working within the framework of the national family planning program, the decentralization process followed a philosophy of community-based action to support government service providers. To support communication and collaboration between all administrative levels of the program, the LIP designed a management structure that brought together people from various walks of life and professions to plan and deliver family planning services to the community.

The team is composed of elected community leaders, the local government administrator, and professionals of the government family planning program (the Family Welfare Visitor, Family Planning Inspector, and Family Welfare Assistant). These team members work together, pooling their resources, knowledge, and expertise. Working together, the team has a sound knowledge base of the family planning and maternal and child health needs and customs of the community, and has the commitment and active support from government officials.

Developing Action Plans

The tool that serves to coordinate all the facets of the family planning program is the Action Plan. Community leaders develop the Action Plans and are encouraged to put new ideas for improving program performance into their plans. For the communities, it provides a blueprint for action, specifying activities to be carried out and the roles and responsibilities of community members. For the program administrators at the local government level, it serves as a tool for identifying and addressing problems as they occur and for monitoring the performance of the program.

The Action Plans have since become the basis for the sub-district family planning program. In areas covered by the LIP, local-level government officials and community members now work together to develop annual Action Plans, manage program finances, and arrange for or provide training to program staff and volunteers. In addition, they have assumed accountability for program performance based on objectives established in their Action Plans. The result is effective Action Plans that provide greater access to high-quality services.

Providing Effective Support

A host of interventions were necessary to support the initiative in its early days and to give it a chance to show results:

- The National Family Planning Directorate provides guidance and support in settingup local management systems, training local personnel, supervising local family planning managers, and helping to solve problems to sustain local management initiatives through various difficult transitions.
- USAID provides small grant incentives to help community leaders implement theAction Plans they prepare after visiting other sites. Now, developing Action Plans has become an annual event for the communities, and other donors are joiningin to provide incentives to other communities.
- Initially, community leaders were introduced to other successful community participation programs in a south-to-south collaborative arrangement with the familyplanning program in Indonesia. The process of learning from other successfulprograms has been institutionalized and is now carried out entirely withinBangladesh through in-country study tours.
- The communities mobilize volunteers to support government workers, so that the government officials can concentrate on developing strategies, planning programs, and solving problems. The number of volunteers has now grown to more than 25,000women. These women are successfully helping their neighbors become active, satisfied contraceptive users, while their role in the family planning program has significantly increased their social status in their communities and families.

As the LIP coverage grows and communities assume a greater share of program costs, the LIP strategy is being expanded to entire sub-districts to make this approach the standard for decentralized family planning program management in Bangladesh.

Recognizing the Potential Benefits and Problems of Decentralization

The transfer of power in a decentralization initiative can create both benefits and risks at the central level, at the local level, and for the family planning client. There are many potential benefits of decentralization, but decentralization will not necessarily solve existing problems, and the anticipated benefits will not always be realized. With this in mind, the benefits summarized on the next page should be viewed with caution, and decisions to decentralize should be made only after carefully examining both the potential benefits and the potential problems.

Potential Benefits and Problems of Decentralization

Activity	Potential Benefits	Potential Problems
Strategic Planning	Greater emphasis can be placed on strategic planning and program performance.	Local ownership or control of the program can conflict with leadership from the central level.
Decision Making	Local decisions can be made more quickly with less bureaucratic restrictions, and are usually more relevant to regional/local needs.	Local decisions may not support the national family planning program goals. Decisions may be strongly influenced by local politics.
Coordination	Central level can pay more attention to improving inter-sectoral coordination and collaboration at all levels.	Too many organizations working at the local level can make coordination unmanageable.
Local Participation	Local service providers can participate in the program and coordinate their programs.	Local participants may divert program activities from national goals.
Performance Planning	Local-level staff can establish performance objectives and be held accountable for meeting those objectives.	Local objectives may not be consistent with national program goals.
Financial Sustainability	The government is compelled to seriously address the issue of financial sustainability as it reduces the subsidization of family planning programs.	Less money may be available for implementing the program, which can worsen regional and local inequities and compromise the quality and availability of services.
Financial Management	Program coverage can be expanded and local revenue generation can be increased.	Local-level staff may not have the skills to manage finances and/or funds may be misused.
Resource Use	Determination of resources needed for IEC, clinic services, logistics, and supervision activities can be more appropriate.	Central level may not agree with local priorities and may not be willing to finance local initiatives.
Staffing	Staff recruitment can be done at the local level and within the communities served by the program.	Local loyalties and affiliations may inappropriately influence the selection and promotion of staff.
Supervision	Supervison can be directly linked to and influence planning at the local level.	Weak supervisory skills may result in mistakes in applying national standards of care.
Service Standards	Central level can focus more on national issues such as service standards and norms, and program evaluation criteria.	National service standards and norms may be inappropriate or non-implementable at the local level.
Client Satisfaction	Family planning services can be more easily integrated or coordinated with other health services and better organized to meet client needs and convenience.	Referral systems may break down and outreach activities may be cut if the local government doesn't have sufficient funds to cover transportation costs.
New Services	Opportunities are greater for developing new or innovative services or service delivery mechanisms.	Inadequate local planning capacities or lack of vision may lead to unrealistic service delivery objectives and strategies.

Assessing the Impact of Decentralization

Decentralizing health and family planning programs can include several management functions or be limited to only a single function. It is common for organizations or agencies to have some decentralized management functions and some centralized functions. For example, although the Philippines government transferred most service delivery functions to provinces and municipalities, the central office of the Department of Health continues to manage contraceptive procurement and distribution.

Organizations or agencies that have already begun to decentralize some management functions should periodically assess the impact of the changes on program performance. They should also analyze the potential for advancing organizational objectives by transferring further responsibility for management functions to lower levels. Without systematically reviewing the results of their efforts, managers will not know if and how the changes are helping or hindering program performance, or if improvements in skills are having a positive impact.

The following "Working Solution" from Honduras provides an example of how one organization is dealing with the complexities of regionalizing their program and increasing the management responsibilities of their regional managers in an effort to improve the quality and efficiency of their programs and services.

Working Solutions—Honduras

ASHONPLAFA Analyzes the Management Functions of Central and Regional Managers

ASHONPLAFA is the principal provider of family planning services in Honduras. Presently, ASHONPLAFA has 260 employees, runs six medical centers and 1,900 community distribution service sites in six regions of the country, and administers a social marketing program from its head office in Tegucigalpa. As a mark of success, ASHONPLAFA has grown significantly in the last several years. To respond to their increased growth and make sure that ASHONPLAFA's programs were able to respond quickly and effectively to clients' needs, senior managers at ASHONPLAFA began considering ways in which the organization could increase efficiency, expand service coverage, and recover more program costs.

In order to expand service coverage and continue to provide high-quality services, ASHONPLAFA initially created regional centers, staffed by a regional manager and several technical staff. The central organization was restructured so that the work was distributed by functional area and delegated some functions to mid-level managers within the central office. ASHONPLAFA soon realized that in order to move forward with the process and have real service delivery impact, they needed to create a more participatory decision-making process that included the regional managers. Although the initiative is still in the early stages, the changes meant that ASHONPLAFA staff needed to analyze not only the systems they used to manage their programs, but also the various management styles of their staff and the institutional culture in which they had become accustomed to working.

Through this process, ASHONPLAFA has consistently examined the extent to which program functions were being successfully managed by the central and regional managers, assessed the impact of the changes on program performance, and determined what additional training might be necessary for managers given their new roles.

Continued on next page

General issues:

- ASHONPLAFA analyzed the appropriateness of how program functions were allocated between the central and regional levels. Some functions within the organization were centralized, such as strategic planning, information systems management, and setting prices for services. Other functions had begun to be managed by the regional centers, such as income generation, marketing, and IEC campaigns.
- The management styles and skills of regional managers were not uniform. This created some inequality and inequity between regional centers, as some managers took more control of their programs and developed new initiatives, while others continued to depend on the central level for direction.
- The strengthening of local management capabilities in some areas, such as marketing, created a positive impact on organizational performance, while the strengthening of other management capabilities at the local level, such as fund raising, did not significantly influence performance.
- ASHONPLAFA staff realized that the change process is slow. Creating a new institutional culture in which managers at the central and regional levels share decision-making power requires making difficult changes in management styles and practices and how staff relate to one another in order to adapt to a more participatory approach to managing a large organization.

Analysis of specific management functions:

Strategic and operational planning. Strategic planning was identified as a central-level function with opportunities for regional staff participation. Operational planning already took place at the regional level. Their assessment recommended improving the operational planning process at the regional level so that regional managers would be more involved in the strategic planning process, and their operational plans would relate more closely to the overall strategic plan.

Information systems. Their analysis revealed that the information system needed to be modified so that it would be more appropriate to the new structure and so that managers could use the information to develop their operational plans. In addition, modified financial systems were needed so that central and regional managers could more easily project financial needs, monitor cash flow, and keep more accurate accounts of expenditures.

Mass media communication. The planning and management of family planning IEC activities was conducted by the regional centers, but the activities needed to be coordinated with the centrally-managed social marketing program that developed mass media promotional campaigns.

Income generation and fund raising. Regional managers had the authority to raise funds, receive donations, and designate the use of those funds. But in most regional centers, fund raising generated very little money. It was recommended that regional managers continue to generate funds at the local level as much as possible, but not make fund raising a priority activity.

Marketing. Regional managers were responsible for developing campaigns to market program services. They encouraged regional managers to conduct marketing campaigns at their level, as this would likely result in expanding the scope and increasing the use of services.

New services. Regional managers were free to suggest such initiatives as constructing birth facilities, but for a variety of reasons diversifying services beyond those directly associated with family planning was difficult. It was felt that because these activities involved significant investments, such decisions should be made by the central office.

Service fees and clinic hours. The central level normally determined pricing structures and hours of operation. The regional managers have begun to participate in making these decisions because they are more likely to know and be able to respond to the needs of their specific client groups. ASHONPLAFA feels that this change will help to advance the overall organizational objectives.

ASHONPLAFA's plans to strengthen regional management:

As a result of their analysis, ASHONPLAFA is planning to gradually transfer more management responsibilities to the regional centers and will provide additional support for others that have already been transferred. The following initiatives were determined to be those that would directly support the achievement of ASHONPLAFA's objectives for 1995:

Transfer of new responsibilities. The regional centers are now participating in making decisions about the prices of services, the hours of operation for clinics, and the types of program data to be collected. Final decisions are made jointly with the central level.

Technical assistance. To support the change process, the central office agreed to provide technical assistance and regular management training to help the regional managers develop and carry out their new responsibilities.

New initiatives. New initiatives, such as setting up laboratory services, would be planned jointly by central and regional managers. The central level would provide financial and technical assistance, and once the new service was established, the regional managers would be responsible for the daily management of the service and accountable for the quality of the service.

Evaluation. Regional and central managers will share the responsibility for measuring the effect of the changes on performance.

Transferring Management Functions

For decentralization to work well, senior managers and policy makers must make decisions about the kinds of management functions to transfer to lower levels and to whom those functions will be transferred. The chart on the next page presents various ways that organizations can decentralize program management. It illustrates differing degrees of central-level involvement in relation to the amount of control that is transferred to the field level. For each of the eight management functions listed on the far left, each column describes a different degree of decentralization by describing how that management function is carried out or by whom, what the managers are in charge of, and how much autonomy they have.

- **The first column** represents a situation in which minimum responsibility for implementing programs is transferred to lower field divisions or units within the same agency or organization. In this situation, the central level retains considerable control over the program.
- **The second column** represents a situation in which the responsibility to plan and implement programs is transferred to lower government or organizational levels. They may have a large degree of autonomy, but the central level still retains some degree of oversight for the programs.
- **The third column** represents a situation in which considerable responsibility to plan and implement programs is transferred to one or more public or private entities. These entities or organizations are to a large extent autonomous and operate their programs independently of the government, but within the overall context of national program goals and strategies.

Management Function	Degree of Decentralization		
	Low	Moderate	High
Program Planning and Implementation	Planning is done at the central level. Field units of the agency or organization are responsible for implementation. Programs are fully managed by central-level employees with the central level handling all administrative, research, and training functions.	Semi-autonomous or autonomous local/government units are responsible for planning and implementing programs. Programs are managed by a mix of government and private employees through wage or service contracts for certain services.	An autonomous public or private legal entity is given responsibility for planning and implementing a program or may be contracted to do so. Programs are privatized and employees are hired largely from the private sector.
Financial Planning/ Management	Program budgets are developed at the local level. Funds are allocated to field units by the central level. Field units submit financial reports; the central level usually manages finances.	Block allocations are made by the central level to subsidize funds generated by local units. Budgets are set by the local level. Financial management is conducted by the local level.	Contracts for services or facilities are made with an outside entity, which budgets for and manages all its contracts and finances independently. Funding is provided through contracts for specific services.
Staffing	The central level hires and assigns staff to central or local-level posts. Terms and conditions of employment are set by the central level.	Staff are selected at the local level or assigned to local posts through the public service system. Terms and conditions of employment are set by the central or local level.	Staff are selected or appointed by the organization or entity. Terms and conditions of employment are set by the organization.
Staff Supervision	The central level sets performance objectives; supervision is done by the field level.	The local level sets performance objectives and supervises staff.	The organization or entity sets performance objectives and supervises staff.
Logistics/ Vehicle Management	Commodities and equipment are procured and stored at the central level. Ordering by requisition is done by the field units.	Commodities and equipment are procured, stored, and maintained locally. Local managers order through regional public or private stores.	The organization purchases commodities, equipment, and maintenance services through private sources. Ordering is done largely by private companies.
Quality of Care/Service Standards	Standards of care are set and monitored by the central level.	Standards of care are set by the central level and monitored by the local level.	Standards of care are set and monitored by the organization.
MIS/ Reporting and Program Monitoring	Data-collection requirements are set at the central level. The local level submits reports to the central level. Program monitoring is performed by the central and local levels.	Data collection and reporting requirements are differentiated to serve needs of the central and local levels. Program monitoring is performed by the local level.	Data collection, reporting, and program monitoring requirements are determined and performed by the organization. Data may be reported to the government to fulfill national-level information requirements.
Program Evaluation	Central-level staff or consultants conduct evaluations.	Central-level staff, or consultants hired by local-level managers, conduct evaluations.	Staff or consultants are hired by the organization to conduct evaluations.

Identifying the Skills Managers Will Need at the Central and Local Levels

Decentralization can take a variety of forms depending on how much control is being transferred to lower levels and which functions are being decentralized. Because decentralization can be achieved in many different ways, managers need to be aware of the wide range of implications for their own roles and functions. Managers at the central level must understand that it is not enough to transfer program management and control to the lower levels. They must also make sure that lower-level managers have the necessary management skills to take an effective leadership role in the family planning program.

Local-level managers need to know how much control they will have and what control will be retained by the central level. The central level, being the level that transfers power to the field, can never really give up everything. The central level should always retain a degree of oversight for the program, and must see to it that the powers invested in the field level effectively support a common goal, even if the pathways to that common goal are diverse.

Managers' Skill Set for Decentralization

In order for decentralization to work, central- and field-level managers need to have complementary roles and skills. Managers at both levels must master skills in the key management areas that will be most affected by decentralization. Following is a summary of the major skills that family planning managers at the central and local levels must have in a decentralized setting. Each section begins with selected comments from the International Review Board of *The Family Planning Manager.*

Program Planning and Implementation

Review Board members pointed out that the primary role of the central level is to define policy and strategy. They noted the need for national policies that define service standards and norms and evaluation criteria. They also emphasized the importance of helping local-level managers develop the necessary skills in program planning and implementation.

Central-level managers should be able to:

- Make major demographic projections and use those projections for setting long-range goals and strategies for the national population and reproductive health programs;
- Establish national goals for reducing fertility rates, improving the health status of women and children, and increasing contraceptive prevalence;
- Develop strategies for stabilizing population growth, including reducing unmet need, encouraging smaller family size, and raising the age of marriage;
- Analyze and use research and survey data to develop a national strategic plan;
- Involve local-level managers in formulating a strategic plan that is based on realistic objectives and feasible strategies that can be implemented at the local level;
- Determine performance standards in order to achieve national goals and evaluate the degree of achievement against these standards;
- Conduct special national IEC campaigns and determine when a campaign would help to invigorate programs that are not performing well.

Local-level managers should be able to:

- Analyze clients and services and know how to use the information to make program improvements;
- Manage integrated services and develop or target services for special groups such as adolescents and men;

Continued on next page

- Determine an optimum contraceptive method mix and set total fertility reduction and contraceptive prevalence targets for their local government units that are consistent with national goals;
- Create conditions that encourage community members to participate in planning and implementing the local family planning program.

Financial Planning/Management

Review Board members stressed that when resources are limited, as they usually are, the central level can help to distribute the resources equitably. Nevertheless, lower levels should be encouraged to raise and manage other resources obtainable at their level. One reviewer warned that the central level may not agree with local priorities and may be unwilling to finance local initiatives.

Central-level managers should be able to:

- Make long-range projections for financial needs and determine how family planning program performance will influence future expenditures in other development sectors, such as education, housing, urban development, and agriculture;
- Set up systems that allow for funds to be allocated to local levels on an equitable and timely basis;
- Establish guidelines that allow local managers to have access to central, local, and private funds for covering their capital and operating costs;
- Mobilize additional resources from bilateral and multilateral donors to support local initiatives.

Local-level managers should be able to:

- Analyze and estimate service costs, prepare budgets, and manage funds allocated to them by the central level;
- Control expenditures in accordance with accepted accounting practices;
- Identify and initiate new sources of revenue for the programs from local government or private sources;
- Introduce and manage income-generating projects to supplement their financial resources;
- Manage contracts for personnel, transportation, procurement, and other outside services.

Staffing

Most reviewers felt that staffing should be decentralized. They pointed out that local managers are in a better position to evaluate their staffing needs and decisions can be made more quickly.

Central-level managers should be able to:

- Review and establish professional standards for key technical and administrative staff involved in service delivery. (This responsibility is particularly important, since these standards affect hiring practices and training requirements at the local level. For instance, by establishing standards that allow paramedical staff to provide clinical and long-term methods, managers can help to increase access to these methods in areas where medical staff are scarce.)
- Offer training and resources at the central level or lend trainers to the local level so they can provide training locally;
- Negotiate with medical, midwife, and pharmaceutical associations to gain agreement on clinical service standards and to determine how each profession will support the others;
- Communicate these professional norms and standards to all local-level managers.

Local-level managers should be able to:

- Use established guidelines to recruit and hire qualified staff for the various service delivery and administrative positions at the local level;
- Analyze the structure of the organization and determine the appropriate balance of job functions, staff skills, and experience that will increase program performance;
- Assess training needs and develop realistic plans for training staff;
- Work with professional associations to integrate appropriate pre-service and refresher clinical and management training into the programs.

Staff Supervision

All reviewers thought that supervision should be decentralized because it is more efficient, more timely, and more effective.

Central-level managers should be able to:

- Organize and coordinate training programs for supervisors;
- Develop new tools and materials that support the routine tasks of supervisors and encourage innovative thinking and problem solving;
- Evaluate how their supervision efforts have improved staff and program performance.

Local-level managers should be able to:

- Understand the importance of supervision and allocate appropriate resources for supervisory activities;
- Establish a supervisory system that can be carried out in a timely and supportive manner;
- Establish appropriate guidelines for supervisors to use in solving problems and developing the skills of their staff.

Logistics and Vehicles Management

Several reviewers felt that it was more advantageous for the central level to manage logistics and vehicles, including the procurement and storage of spare parts and maintenance of equipment. Some reviewers felt that commodities purchased from local sources were likely to be more expensive and that centralized bulk purchasing was preferable. Still others thought that decentralizing logistics and vehicle management might lead to more rapid and appropriate solutions to problems.

Central-level managers should be able to:

- Set up systems for maintaining contraceptive product mix and for setting up ordering and delivery schedules that are consistent with local usage;
- Determine when it is in the national interest and most cost-effective to manufacture contraceptives in-country;
- Monitor the efficiency of the entire logistics system, identify problems that can adversely affect timely orders and deliveries, and decide under what circumstances it might be appropriate to centralize logistics management or to contract logistics out to an outside organization;
- Set guidelines for purchasing vehicles or maintaining and replacing equipment as necessary;
- Provide assistance to local managers in determining minimum stock levels and managing inventories of contraceptives.

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Local-level managers should be able to:

- Determine both the appropriate contraceptive method mix and the ordering and delivery schedules that are consistent with local contraceptive usage patterns;
- Ascertain under what circumstances it would be appropriate to contract with private transport companies for delivering supplies, and negotiate contracts for those services;
- Determine the type of transport that is most suitable for activities requiring travel, such as delivering supplies to clinic sites or making supervisory visits, and manage the use of vehicles in the most efficient way.

Quality of Care/Service Standards

Reviewers noted the need for quality of care standards and policies to be set by the central level. When they are in place, local-level managers could incorporate them into local service policies and standards. Since decentralization encourages providers to seek feedback from their clients, they can improve quality to meet clients' needs.

Central-level managers should be able to:

- Establish quality of care standards for the national program;
- Develop incentives, such as clinic accreditation, to encourage local programs and clinics to maintain high-quality services;
- Analyze and use the results from studies of clinical and non-clinical services and other components of family planning programs, such as IEC campaigns;
- Determine whether service quality problems are due to poor techniques, old or outdated equipment, client attitudes, community relationships, or local politics, and assess the impact of these deficiencies on program performance;
- Identify solutions to problems and develop general strategies for involving local-level managers in finding solutions and mobilizing resources to improve service quality.

Local-level managers should be able to:

- Adapt national guidelines to local conditions and maintain standards of care in their programs that are consistent with national guidelines;
- Carry out continuous quality improvement (CQI) programs and use the results of their CQI efforts to reorganize services, modify staff functions, revise job descriptions, and develop refresher or continuous education programs to support program performance;
- Incorporate the CQI process in the monitoring and supervisory systems to transform CQI into an essential management system.

MIS/Reporting and Program Monitoring

Most reviewers felt that local managers should define MIS needs and use the information in planning and implementing local programs. The central level can help the local level by providing guidelines and mechanisms for collecting and analyzing data. Data collected at the local level could be used by the central level to compare program performance, analyze trends, and maintain performance standards.

Central-level managers should be able to:

- Determine a basic set of indicators required for maintaining essential national data, and establish a reporting system so that local managers can easily report these data. (These indicators are used for making demographic and programmatic projections and for establishing long-term goals.)

- Monitor the efficacy of the information flow and the quality of the information provided, and update or revise systems as needed;
- Determine when progress has begun to level off (or plateau) and when major strategic changes may be necessary.

Local-level managers should be able to:

- Determine which indicators that are useful in planning, monitoring, and evaluating local program performance. (These may include indicators concerning client characteristics, attitudes, and practices, or types of service delivery systems.)
- Maintain the information systems and use the results to plan new or improve current programs.

Program Evaluation

Most reviewers thought that evaluation should be centralized. One reviewer commented that the central level should evaluate programs at all levels and undertake a review for the purposes of developing future program strategies. Another reviewer pointed out that local managers should take part in evaluating programs in order to improve local-level program implementation.

Central-level managers should be able to:

- Determine whether local and national program strategies are contributing to the achievement of national goals;
- Evaluate the appropriate balance of strategies for stabilizing population growth, such as fulfilling unmet need, modifying family size desires, and raising the age of marriage;
- Determine what levels of resources are necessary to achieve the goals, and how to mobilize these resources effectively.

Local-level managers should be able to:

- Evaluate the ways the different components of the family planning program are contributing to program goals;
- Identify critical indicators that will provide the most useful information on program achievements, including those that relate to program inputs, processes, results, and impact.

Central and local-level managers must be able to understand and use the results of routine monitoring systems and periodic national surveys. They must know how to analyze the results of national surveys, such as Demographic and Health Surveys, Contraceptive Prevalence Surveys, or Situation Analyses of service delivery. Finally, they must know how to design and implement program changes based on survey results to improve the programs or functions for which they are responsible.

When decentralization occurs, local staff may find themselves overburdened with their new management responsibilities, while being expected to continue to carry out their regular work. Transforming doctors, nurses, and administrative staff into managers is a slow process. However, theprocess can be made easier by carefully analyzing their new roles and responsibilities and the corresponding skills they need to perform their jobs, and providing them with the appropriate training.

For more information about developing strategic thinking skills, involving the community in managing family planning programs, and integrating family planning services with other types of services, please refer to Chapter One, "Learning to Think Strategically;" Chapter Four, "Increasing Community Participation in Family Planning;" and Chapter Seven, "Managing Integrated Services."

Strengthening Decentralization at the Local Level

Good planning and strategic thinking are essential skills for all managers who work in a decentralized environment. The authority and accountability that come with decentralization place a great responsibility on the local manager. How successfully a manager can create a cohesive team of co-workers and other members of the community will influence how well the family planning program performs in the new environment. Local managers need to work together with their colleagues to formulate clear goals for their programs, establish reasonable objectives, allocate resources for the various objectives, and find and motivate staff to implement program activities as efficiently as possible.

All decentralization initiatives require making changes in the structure of the agency or organization, which means making changes in how the work gets done. It means developing new management systems, training staff in the skills that they will need to perform in their new roles, designing or modifying service delivery systems, and developing strategies for enhancing the long-term sustainability of the program. The following guidelines can help you, the local manager, assess the status and implications of a decentralized environment so that you can function effectively in the new organizational environment.

Know the purpose of decentralization. Local managers must understand the reasons why their organization or government service decided to decentralize. Knowing this will help you and your staff to understand the purpose of decentralization and what needs to be done to make it work. It is important to know if the goals are to reduce costs or levels of bureaucracy, or to increase community participation and make program planning more responsive to local needs. If the goals are to increase community participation or make program planning more responsive to local needs, you may need to train your staff in assessing community needs or create new jobs that can be performed by community members.

Determine how the organizational structure and job functions will change. As in any reorganization process, it is important to determine how the new structure will affect the type of work to be carried out and the way it will be accomplished. Some departments may need to be merged and others may have to be created. It may be necessary to formally change job functions and job descriptions, as well as supervisory and reporting requirements. As you review your organizational chart and determine the changes that have to be made, it is important to keep in mind the purposes of the decentralization initiative, as well as the national and local goals of the family planning program.

Reallocate responsibilities to existing staff members. The process of reallocating responsibilities must be carefully thought out as though you were hiring a completely new staff. Under decentralization, some staff may be able to continue to do what they have done in the past. Other staff may need to take on new responsibilities, work in new departments or divisions, or change their job functions. The reorganization may involve giving people more power than they have had in the past, or even the power to make some decisions that you formerly had to make yourself.

Use available resources. To make decentralization work, local managers must be able to make decisions about acquiring, allocating, and using financial, human, and material resources. You need to know how to access and use all the resources available, including:

- central program money for program operations, capital expenditures, or special activities;
- local government funds;
- revenues from income-generation activities or outside donors;
- human resources (technical and administrative) and the good will of community and local government leaders;
- contraceptive supplies and clinic equipment.

Knowing what resources exist and how to take the most advantage of them creates opportunities for strengthening local family planning programs.

Determine the impact on the health care delivery system. Decentralization can affect the relationship between the different levels of a family planning program. For example, referral systems for providing long-term methods will not work if two levels are unable to coordinate services effectively. Local managers may be given the responsibility for managing primary and secondary health care facilities such as health posts and health centers, while the central level may retain control over the district hospital where sterilizations or contraceptive implants are performed. Such divisions can potentially complicate reporting and supervisory relationships, block communication, and impede rapid referrals between the primary, secondary, and tertiary levels.

For these reasons, local managers need to carefully consider how their relationships with staff at other levels of the service delivery system can affect clients' ability to receive high-quality services. In some instances, new mechanisms for guaranteeing effective referrals may have to be put in place, such as special meetings that allow managers from health centers and district-level hospitals to regularly meet and discuss their mutual concerns about providing high-quality services.

Increase staff skills. Decentralization works best when local managers can use the powers given to them to make good decisions. If local managers are not capable, senior-level managers may rescind authority, find new people to replace them, or start micro-managing the activities. Therefore, central and local managers need to carefully consider how to strengthen the skills of their staff in all departments.

Under decentralization, local managers may be responsible not only for preparing program budgets, but also for projecting revenues, monitoring cash flows, keeping multiple bank accounts for different sources of revenue, establishing financial controls, and determining the cost of services. You will have to analyze the skills and knowledge of current staff and provide or arrange for training in these areas or hire new staff.

Strengthening staff competence requires knowing what training programs are available, finding ways to take advantage of local, national, and international training opportunities, and being able to develop continuing-education programs for local staff. This requires close collaboration with other government agencies, negotiating with local government officials, and learning how to court donors and develop proposals for additional resources for training and skills development. When it is necessary to hire new staff, you will need to develop your own skills in writing job descriptions, recruiting and interviewing candidates, and performing other human resource management functions that may have formerly been the responsibility of central-level managers.

Determine the types of support needed. Frequently, local managers who feel empowered by decentralization think they can do everything by themselves. In reality, they will need material and technical support from the central level to make decentralization work. Therefore, it is important to assess local weaknesses and to differentiate between those problems that can be solved locally and those problems that need outside help.

Even when a considerable amount of control has been transferred, some support from the central level is advisable, and frequently is available. Often this support is in the form of technical assistance from central departments or regional subdivisions, which a local manager can request if she or he is open to seeking assistance. For example, help in analyzing family planning data or determining contraceptive prevalence rates or calculating discontinuation rates is often available from the central level.

In addition to asking for technical support, local managers should focus on ways to obtain material support such as equipment, and special funds that can support specific high-priority activities in the family planning program. Such resources are often available and only require doing the research and taking the initiative to find them.

Local-level managers should remember that decentralization has a better chance of working effectively when the central and other levels in the hierarchy have a vested interest in seeing that it works. By actively seeking support and establishing cooperative and collaborative relationships with the central government, local managers can create supportive relationships that benefit local staff and program performance.

Gain local-level commitment to family planning goals. When decentralization occurs, managers and their staff may be cut off from the support of the larger organization that is dedicated to family planning program goals and may find themselves at the mercy of local governments, which may have other priorities. For a variety of religious, economic, and philosophical reasons, local government officials may not necessarily support family planning programs. Some may believe that "economic development is the best contraceptive." Others may feel that an integrated maternal and child health and family planning program is the best approach.

For these reasons, you and your staff need to assess the level of local support for family planning, and develop strategies for maintaining or increasing the support. For example, you need to establish good working relationships with local government authorities, become active in leadership circles, solicit support from community members who are in favor of family planning, and persistently try to put family planning and reproductive health at the top of the local development agenda.

Anticipate problems and be prepared to address them. To encourage the likelihood of success, managers need to anticipate the range of potential problems that decentralization can cause, and develop strategies for overcoming these problems if they arise. One strategy is to involve more local government officials and community members in planning and implementing the program. By creating more opportunities for the community to actively participate in the future of the family planning program, managers can mobilize a broader range of expertise and experience in identifying and solving potential problems.

Below are some of the common problems associated with decentralization that managers at all levels must be prepared to address:

- The degree of responsibility, authority, and accountability transferred has not been clearly spelled out;
- Major problems that the central level cannot solve are transferred along with only minor powers;
- Reporting requirements are unchanged despite the transfer of powers;
- Local-level providers cannot get enough equipment or materials to deliver services;
- Local practitioners have difficulty obtaining enough experience to be certified to insert IUDs or provide Norplant and sterilization services;
- Staff do not get their salaries on time;
- Training funds are not received in time to pay the trainer or to buy materials;
- Equity problems between the regions that are receiving resources persist or get worse;
- Other ministries that family planning programs rely on, such as education, are not decentralized.

Institutionalizing Democracy: Decentralization in the Philippines

The decentralization effort in the Philippines was initiated as a means for institutionalizing democracy at the local level. With the adoption of the Local Government Code in 1991, the Local Government Units (LGUs) were made responsible and accountable for providing basic health services, including family planning, to their communities. For the first time, family planning and child survival services would be managed by the individual LGUs, rather than by the Department of Health.

Acting on the belief that local problems can be best addressed by the community, the Local Government Code gave local government officials the power to plan and implement their programs so that they would address the needs of their individual communities. The Code specifically states that provinces and cities are responsible and accountable for planning and coordinating population and development activities, including family planning services, which are provided through the provincial and city health facilities.

The Code made the LGUs responsible for planning their entire population and family planning programs, setting the program goals and objectives, developing budgets, and managing their finances. The LGUs were also made responsible for delivering services, coordinating and monitoring activities, and providing IEC to the communities. At the central level, the Department of Health retained the responsibility for monitoring and evaluating the performance of the local programs, for setting service standards, protocols and guidelines, and for providing technical assistance to the LGUs.

To support the decentralization process and make sure that staff at all levels have the necessary skills to perform in their new roles the Department of Health is implementing the LGU Performance Program. This program provides technical assistance and support to staff at the LGU level to increase their managerial skills and assists national-level managers in defining and adapting to their new responsibilities. As a result of decentralization, the LGUs will be allowed greater flexibility to tailor their programs to best meet the needs of their local communities.

Several key features are helping to enhance the success of the decentralization process:

Progressive benchmarks. Performance benchmarks are set for each of four stages of development: start-up, capacity building, service delivery, and performance. Each LGU must meet the benchmarks of one stage before receiving new funding for implementing the activities of the next stage.

Grants. Once a year, upon the achievement of their performance benchmarks, LGUs receive government grants to design and implement new activities that support the integration of their population, family planning, and child survival programs.

Technical assistance. Through the LGU Performance Program, staff from the central or regional level provide necessary technical assistance to staff at the LGU level in such areas as program planning, budgeting, financial management, monitoring, and supervision.

Local-level problem solving. Problems are identified and solved at the local level by the staff of the LGUs.

Integration of services. To provide a wider range of reproductive health services to their communities, local managers are encouraged to integrate family planning and maternal and child health services, and to share resources and management tasks across programs.

The decentralization process in the Philippines is expected to increase the managerial capacity of managers at both the central level and the LGU level, and to rapidly expand access to family planning and child survival services throughout the Philippines.

Making Decentralization Work

There are many reasons for decentralizing large public and private organizations and transferring a variety of powers to the field level. Perhaps the most important factor in making decentralization work in the family planning environment is involving the community in planning and implementing the program.

Allowing local staff to manage programs increases local interest and commitment and helps to make services more accessible because local managers know the needs of their local communities and can develop programs to meet these needs. Programs can be more sustainable because local commitment builds demand and encourages community financing. But these goals can be realized only if managers at the central and local levels are committed to sharing power and resources and if local-level managers are given the responsibility *and* authority to make decisions about their programs' directions and activities.

As the community takes ownership, managers can expect to see new approaches in service delivery, program financing, IEC activities, and other areas. Central-level managers can greatly increase the benefits derived from decentralization by looking to local-level managers for innovative ideas. Local-level managers can similarly prove the wisdom of decentralization by giving the community the opportunity to contribute resources for implementing programs. Decentralization works well when communication links are forged between central- and local-level government officials and between local managers and community members. These conditions will be seen as important ingredients in developing national family planning policies and strategies when local action leads to high performance.

Decentralization is often proposed as a solution to making programs more effective. In reality, it is a complex process, which requires central and local managers to coordinate and cooperate with one another, new skills and roles for both groups, and new ways of thinking about how a manager's responsibility, authority, and accountability can best serve the family planning and reproductive health interests of the client.

Reviewers' Corner

The editors of The Family Planning Manager *asked the members of their International Review Board to comment on why decentralization was introduced in their countries, what the goals of decentralization were, and how the roles and functions of the central and local levels changed. Their comments on these questions are summarized on the next two pages, followed by comments on a number of other issues concerning decentralization.*

"With the implementation of democracy, we have developed a sectoral policy for health in which decentralization plays an important role. One of our big problems was a weak management system that was partially the result of ineffective supervision of health centers from the central level. Our decentralization efforts have led to developing new roles and responsibilities. The central level has the role of defining strategy and policy. The provincial level provides technical assistance to the district. The district level provides services and is responsible for specific population areas."

"In my country, decentralizing the Ministry of Health advanced the national decentralization program. The main goal was to create new local health units that would manage finances, select local staff, and define performance objectives. These new health units were given the responsibility for all health activities. The only unit of the MOH remaining in the provinces is the regional health inspector's office, which continues to oversee financial management. Each local health unit has a team that is responsible for managing financial, human, and material resources. Budgets, however, are still determined by the central level with allocation of funds to the field units."

Reviewers' Corner

"Decentralization was introduced in recognition of the diverse nature of the country. The main goal was to bring government development programs closer to the people and to make their participation in the programs more effective. Decentralization has been a continuous process which has been rooted in the federal system of the country. Most programs including health and family planning are taking their cue from the decentralization that has taken place nationally. The national system has three levels: National, State, and Local Governments. Our NGO has adopted the same levels. At each level we have tried to:

- Share power and responsibilities;
- Define exclusive and concurrent areas of responsibility;
- Clearly define roles, functions, and structure;
- Maintain communication between the central and other levels to improve program implementation and coordination;
- Articulate goals, objectives, and strategies clearly;
- Develop financial policies and accounting procedures;
- Develop personnel policies, guidelines, and procedures;
- Develop strategic thinking and strategic management skills;
- Increase responsibility for supervision."

"Decentralization has been a response to general mismanagement at the central level. It has facilitated the privatization of some services that can no longer be provided free of charge. One of the principal goals of the decentralization effort was to get hospitals and health centers to study costs and services. Under the decentralized system they will be paid for what they actually do. Another goal was to finance the demand for services instead of the supply of services."

"In my country, decentralization was implemented for the purpose of improving access to and the quality of family planning services. We decentralized a number of management functions to the provincial and district levels, and pilot-tested the changes before any functions were completely decentralized. What we found was that decentralization is a long process. It took awhile for people to understand and appreciate their new roles. Initially, there was a lot of interference from the central level (which didn't want to let go) and resistance from lower levels (which thought there was no need for support from the center). Some structural changes were necessary; some departments had to be relocated to lower levels and some positions had to be abolished. For the staff, the changes were traumatic."

"At the government level, a process of decentralizing the National Health Program has already been initiated. In this process, only 10 of 32 states in the country have benefitted and it has been a very lengthy process. It is necessary to carefully analyze the factors that could prevent decentralization from having a positive impact. These include management factors (planning, administration, and training); political factors (resistance to change and resistance to giving up power); and economic factors (those interests that are affected by the changes). Nevertheless, I believe that the process of decentralization will have a positive impact in the end and will create a more equal and just sharing of resources and programs that are operated by local people who know the local or regional realities. In the end, they will be able to respond better and more appropriately to the local and regional needs."

Continued on next page

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On transferring responsibility and authority . . . *One reviewer warns,* "Decentralization will not work when the responsibility for planning and management is decentralized but financial control, particularly resource allocation, is retained at the central level. This leads to managers having responsibility without real power."

On the range of skills required of local managers . . . *One reviewer stresses,* "Frequently, supporters of decentralization underestimate the skills that local managers must have in a decentralized system. The range of skills required inevitably expands. For example, clinic managers may be forced to spend more time in meetings, which may affect their clinical responsibilities."

On the need to change skills and roles of managers at the central level . . . *One reviewer emphasizes,* "Decentralization requires different, not necessarily fewer, skills at the central level. For example, contracting for outside services requires new skills in drawing up contracts and managing contractors. Setting norms and policies are also often new and different skills for managers who are used to making operational decisions."

On understanding and adapting to new roles at the central level . . . *One reviewer advises,* "It is just as important to deal with effects of taking away responsibilities from some people as it is to deal with giving new responsibilities to others. Central-level managers may tend to cling to former ways of doing their work and thereby slow the decentralization process. The decentralization process works better when central-level managers learn to relate to local managers as colleagues and partners rather than as subordinates and when they understand that they still can have influence over the program, even if they no longer have control over it."

On the benefits of decentralization . . . *One reviewer comments,* "In one region of the country, one of our clinic directors developed a very comprehensive community program in conjunction with the local public health program. This was the first time our organization really worked closely with the public sector as partners to solve the problems in the city."

On being able to respond effectively to local needs . . . *One reviewer writes,* "One benefit of decentralization in our program was the decision to use traditional birth attendants for providing community-based IEC services and for distributing contraceptives. This change is allowing the local level to respond to local situations and is helping to reach women in purdah."

On involving key stakeholders . . . *One reviewer stresses,* "I cannot overemphasize the importance of making sure that all the key stakeholders clearly understand and support the goals of decentralization before it is implemented. Particular attention should be paid to the policy makers, the board of directors, and senior management in the Ministry or private organization headquarters. Attempts should be made to clearly articulate the benefits of decentralization such as increased community participation, improved program performance, and long-range program sustainability."

On having access to and using local data . . . *One reviewer emphasizes,* "Census data for small areas is very important, especially for local governments and population officers, who often need to use the data to inform local decision-makers about the implications of population growth, size of catchment areas, prevalence of high-risk births, school drop-out rates for girls, and the potential implications for adolescent fertility."

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Checklist of Issues Concerning Decentralization

Managers who are planning to decentralize health and family planning services, or those who are already involved in a decentralization initiative, should answer the following set of questions. Your answers will help you to make informed decisions that will be useful in planning or implementing the management changes that are required for developing a more dynamic organization and one that is responsive to client needs.

- ☐ What are the major goals of the decentralization initiative?
- ☐ How will decentralization advance the national population program?
- ☐ Is there support and commitment from the regional/local level and the national level to decentralize?
- ☐ What organizational instruments (laws, administrative orders, etc.) will be employed to institute decentralization?
- ☐ To which level or entity will the responsibility for planning and managing the health and family planning programs be transferred?
- ☐ Which managerial functions will be transferred to the lower level?
- ☐ Do local managers have the responsibility and authority to perform their jobs effectively?
- ☐ What changes will be required in the organizational/program structure and what are the new roles and responsibilities of staff at all levels?
- ☐ Do staff at the central and regional/local levels have the skills to carry out their new responsibilities?
- ☐ How will the necessary skills be developed in planning, budgeting, managing financial and human resources, logistics, MIS, continuous quality improvement, etc.?
- ☐ How will the success of decentralization and its impact on program performance be measured?
- ☐ How will conflicts in resource allocation between the decentralized management levels be resolved?
- ☐ How will the new management levels collaborate with each other and with other sectors or non-governmental organizations?

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Angelino Regional Clinics Deal with Decentralization

"I'm sorry I'm late, I had a phone call from Dr. Cardozo, the head of the Ministry of Health's Task Force on Decentralization," Dr. Mendoza apologized. As the chief of family planning in the Angelino Region, Dr. Mendoza supervised seven district clinics and presided over the monthly supervisory meetings. After looking through her papers she began, "I think we should depart from our normal agenda today. There's been so much buzzing in the corridor about decentralization, I thought it would be a good idea to discuss the Ministry's decentralization initiative that everybody is so upset about. We've been told that the government is going to decentralize many management functions within the Ministry of Health. The focus of the first part of the decentralization initiative will be limited to financial management and will require clinics to charge for services and to use the fees they collect to support clinic operations. This will give us the authority to manage the money that comes from the central level. It will also require us to develop ways to charge for the services we provide. What is distressing, I think, is that they haven't said how we should do this. Everyone in the region seems to be worried that our lack of experience in managing money and making financial decisions could compromise our ability to provide the same level of service that we have in the past."

"Let's face the facts," said Dr. Cruz, one of the clinic managers, "We just aren't prepared for this kind of change. We don't know anything about charging fees, and we don't know how to manage the money. How could we possibly figure out how much to charge our clients?"

"I'd like to ask a few questions," said Mrs. Arroyo, a manager of one of the smaller rural clinics in the region. "Who is going to decide how to account for the money? Who will have the responsibility of keeping the account books in order? How will we decide how much we should charge? What about you Dr. Mendoza? Will you still supervise us?"

Dr. Mendoza nodded. "I know you all must have a number of questions. I'm sorry that I can't answer them all, but there isn't anything definite yet. Dr. Cardozo didn't give me a clear picture of the roles and responsibilities of the Ministry's central office in carrying out decentralization, but it's clear we will need help from the government."

"I don't know about everyone else," Dr. Rojas, a manager of one of the newer urban clinics in the region, said, "but my staff don't have the skills to manage our finances. We're talking about complicated things here, like projecting financial needs, preparing budgets, and learning standard accounting practices. I'm a doctor. I never studied any of these things in school. For us, this will require an enormous investment in training, technical assistance, and supervision."

Case Scenario: Angelino Clinics Deal with Decentralization

Mrs. Suarez, manager of the clinic in the regional capital, interjected. "I don't feel as nervous about this change as many of you. For me, this seems like a real opportunity. Some of my staff have some excellent financial management skills. We've been wanting to have more control over our budgets for a long time. This is a real opportunity for us, but we'll need to get some training and experience in learning more about our clients and how much they can afford to pay. If we can figure out how much it costs us to provide services, and how much revenue we need to run our clinics, we'll be able to carry out this change without too much difficulty."

"I think you're naive," Mr. Gonzales, the clinic manager who had been in his position the longest, broke in. "Right now, we don't have a bank account for our clinics. We haven't ever been responsible for writing checks. We don't even have an accountant who can show us how to set up our financial systems."

Mrs. Arroyo spoke up, "We have so many poor people in my area, covering our budget with fees collected from clients will be impossible. How are we going to provide services for those that are unable to pay?"

"What about the IEC program?" asked Dr. Rojas. "Are we going to have to develop our own brochures and posters?"

Dr. Mendoza responded, "That's a good question, not only for IEC activities, but for many other areas in which the Ministry's central office has played a major role. I hope the central Ministry will take responsibility for developing IEC strategies and for some other areas as well, like contraceptive logistics."

"Doesn't it seem strange to you, Dr. Mendoza, that the Task Force hasn't asked us what kind of support we think we will need to be able to make these changes?" asked Dr. Cruz.

"The program is still being discussed," replied Dr. Mendoza. "I'm meeting with Dr. Cardozo next month. Maybe we could start now to make a list of things we hope that they will consider before they launch this decentralization initiative."

Case Discussion Questions: Angelino Clinics Deal with Decentralization

1. **In making the decision to decentralize the authority to generate revenues and manage finances, how should the central level support the local level?**
2. **What main advantages will managers of the district clinics in the Angelino Region have when they have the authority to manage and use their own program money?**
3. **What are the skills local-level managers may need to implement the decentralization initiative?**

Case Analysis: Angelino Clinics Deal with Decentralization

1. In making the decision to decentralize the authority to generate revenues and manage finances, how should the central level support the local level?

As Dr. Cruz implied, the central level plays a critical role in the success of decentralization. First, the central level needs to clarify exactly what responsibility, authority, and accountability will be transferred and what organizational relationships and reporting changes will occur. Although the Ministry has yet to finalize the decentralization initiative, Dr. Mendoza and her colleagues are worried that at the regional level they will not have the skills required to manage finances well. They understand that they will need training and support from the central level to acquire the skills necessary to keep the clinics financially viable. Dr. Rojas raises the possibility of being unable to generate enough fees to cover costs from his client population. One role for the central government is to develop mechanisms that will continue to distribute resources equitably among all regions and among clinics within those regions.

The central office of the Ministry could develop a training program in collaboration with the managers of the district clinics in the Angelino Region based on their program and the skills of their staff. Although central-level managers know how to set up and conduct a training program on financial management, they may be unaware of local constraints that need to be taken into account to make the training useful to Angelino program managers. Obviously, the need in Angelino varies from district to district. In order to be useful, training will need to be tailored to account for the different conditions in each district.

Technical assistance could also help smooth organizational changes that might be brought about by decentralization. This technical assistance should take into account the need for field testing new procedures. Family planning managers in the Angelino Region will most likely make changes in supervision and reporting systems, revise job descriptions, etc. This can be quite difficult without adequate support and help. Without the necessary support, some services could be disrupted and quality could be compromised. Those providing technical assistance should work with managers of the district clinics to review the existing organizational structure and management systems to determine what changes correspond best with the new responsibilities that the local managers will have. Together, central- and local- level managers will need to plan how they will institutionalize the changes with minimal disruption of services. Technical support may be required for a long time, and the central level must monitor and evaluate how effectively field managers are able to make the transition from a centralized to a decentralized family planning program.

Case Analysis: Angelino Clinics Deal with Decentralization

2. What main advantages will managers of the district clinics in the Angelino Region have when they have the authority to manage and use their own program money?

The principal advantage to the clinic managers in the Angelino Region in decentralizing financial management is having greater control over their financial resources. However, with greater control over resources comes greater responsibility for using the funds to help maintain high-quality services and to manage the funds in accordance with accepted accounting practices.

The other advantage to district clinics is that they will have more freedom to introduce different types of income-generating activities such as laboratory testing services, special women's reproductive health services, and other services. A third advantage is that they will be able to adjust fees in accordance with their clients' ability to pay. This can have an important impact on reducing discontinuation rates, particularly when economic hardship forces clients to make choices between contraceptives and other necessities.

3. What are the skills local-level managers may need to implement the decentralization initiative?

Decentralization can encompass many different aspects of the family planning program. Managers at the central level need to make sure that local-level managers are trained in the skills and systems they will need to run their programs effectively. Training programs should focus on developing some of the following skills:

- making demographic projections for their catchment areas;
- developing long-range goals and strategies for financial needs;
- setting up systems to allocate funds to the local level on an equitable and timely basis;
- establishing guidelines to give local managers access to funds for covering capital and operating costs;
- conducting operations research;
- monitoring programs;
- setting performance standards;
- developing procedures for collecting fees and handling cash;
- establishing banking arrangements;
- reporting income and expenses;
- analyzing and projecting service costs;
- preparing budgets;
- controlling expenditures in accordance with accepted accounting practices;
- identifying new sources of revenue;
- introducing and managing income-generating projects.

CHAPTER SEVEN

Managing Integrated Services

Family planning managers are frequently being asked to add or integrate family planning services into maternal and child health (MCH), nutrition, women's reproductive health, adult literacy, and other health and development activities. Consequently, managers are asking questions about exactly when, where, and how family planning services can be integrated with these other activities. These questions are often answered on the basis of personal beliefs, rather than on a rigorous framework for assessing the specific changes needed to deliver integrated services effectively.

Many experts believe that integrating different types of health services in one program results in serving the needs of the client better and makes services more cost-effective. Other experts caution that integrating family planning into other services can cause a loss of focus on family planning and dilute the resources available for family planning programs.

This issue of *The Family Planning Manager* explores the different faces of integration and examines the key management systems that may need to be adapted to effectively deliver services in an integrated setting. The issue also provides guidelines for assessing integration at several different organizational levels, and offers some practical advice on how to make integration work better in your program.

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Understanding Integration

Health and family planning services are integrated in many different ways. For a director of a private family planning organization, integrating services might mean adding pre- and post-natal and obstetric services to the program. For a director-general of a department of health, integration might mean adding family planning services to the existing program of health services. For a health center manager in a district clinic, integration might mean holding maternal and child health (MCH) and family planning sessions concurrently, rather than having separate clinics on different days. These are all examples of integrated services, the common denominator being that *two or more types of services previously provided separately are offered as a single, coordinated, and combined service.*

Integrating family planning services can be a means of improving the quality of service delivery, expanding access to services, or making services affordable and convenient to clients. Integration can be achieved in a variety of ways:

- Integrating existing programs or divisions;
- Integrating family planning services into existing MCH services;
- Adding services to serve a more diverse client population;
- Adding new reproductive health services to the existing family planning program.

Integrating existing programs or divisions. In the past, government programs in many countries have placed family planning services under ministries other than the Ministry of Health or in divisions separate from other types of health services. As a result, family planning services were not offered at many government health facilities. But as family planning has become a priority of many governments, and as long-term clinical methods have become more popular, these programs have tended to merge, and now most government health facilities offer a range of family planning services. Although most government programs are now offering family planning services throughout their clinics, the separation of health and family planning services at the administrative level remains. This administrative separation can create a situation in which health and family planning staff are in separate offices, are paid from separate budgets, have completely separate supervisory systems, and even different working conditions. While this administrative separation at the central level is intended to be a temporary organizational arrangement, it often remains in place for many years, thereby undermining the effectiveness of delivering integrated services.

Integrating family planning services into existing MCH services. Traditionally, maternal and child health (MCH) programs have focused primarily on the "C" and given less attention to the "M" in MCH service delivery. However, managers now recognize that improving child health requires paying more attention to the health and needs of the mother, including her contraceptive needs. In fact, one of the most effective interventions for reducing infant mortality is for women to space the births of their children. For this reason, many MCH programs, both governmental and non-governmental, are making family planning services an integral component of MCH services. Some programs accomplish this by simply adding family planning counseling and providing contraceptives at existing mobile and fixed health facilities. Other programs choose to reorganize their services completely to provide a full range of health and family planning services to their clients throughout all their service facilities. In either case, MCH programs of the future will most likely include family planning services.

Adding services to serve a more diverse client population. Many family planning managers are recognizing that their organizational mission goes beyond serving only the clients that currently come through the clinic door. These organizations are expanding their scope of services to meet the needs of underserved populations (such as adolescents and urban poor), to actively promote family life education in the schools, or to develop outreach programs to inform and educate potential clients.

Adding new reproductive health services to the existing family planning program. Many family planning organizations are adding reproductive health services to their family planning program. These services often include diagnosing, treating, and providing information on how to prevent sexually transmitted diseases (STDs), providing women with information on women's health and health risks, providing pre- and post-natal health services, and providing contraceptive services tailored specifically to men. In particular, the AIDS pandemic has led to high demand for STD/AIDS counseling and treatment of common STDs at family planning clinics. Since these services are often not available through other health facilities, and since family planning clinics often provide the best access to condoms, many family planning clinics are beginning to integrate these broader services into their existing family planning programs.

As these examples point out, programs can be integrated in different ways, and integration provides an opportunity to expand or improve current services so that you can serve the needs of your clients more effectively and efficiently.

Capitalizing on the Strengths of Vertical and Integrated Programs

Both integrated and vertical programs have significant strengths and weaknesses. Managers should carefully consider the strengths of both approaches so that they can create the most appropriate programmatic management system for their specific situation.

Integration can help to improve supervision, clinic scheduling, and logistics. For example, having one nurse care for the family planning needs of a mother and the health needs of her infant on the same visit means that the mother does not need to come to the clinic twice in order to receive both family planning and child health services. For the clinic nurse, it is better to have one supervisor for both family planning and child health than two different supervisors for the two tasks.

In the same way, an integrated approach might streamline logistics and make better use of resources. For example, a single trip can be made to various clinic sites to deliver contraceptives, vaccines, and drugs instead of making several separate trips to deliver each commodity. Integrated health and family planning services offer managers the possibility of providing *more convenient and comprehensive services to the client and more streamlined and cost-effective systems at the service site.*

On the other hand, family planning program managers may find that integrating family planning with other health services may weaken program effectiveness by placing too great a burden on service delivery staff and middle managers. Given the importance of family planning, managers may want

to have a special program dedicated only to providing family planning services. For example, these managers may prefer to be able to focus on simple straightforward objectives and top-down planning, which is often less time-consuming. Three key reasons why vertical programs are often seen as being more successful are: *staff roles and responsibilities are more clearly defined; results are easier to identify (making progress easier to monitor); and vertical programs invariably get more resources.*

Managers are now finding that a mix of integrated and vertical approaches provides an opportunity to tailor the approach to support their specific program goals. All managers need to weigh the advantages gained by integrating some services with the advantages of maintaining elements of a vertical program. They need to make programmatic decisions based on their specific situation and the program requirements in their own country and organization. The table on the next page highlights the main advantages of vertical and integrated programs in relation to key program management systems.

Being clear about your reasons for integrating

When integrating new services, managers should carefully define the specific health objectives that they wish to achieve. The question of *what* to integrate can only be answered when the overall program objectives have been defined. The table below provides examples for integrating family planning activities with other interventions, based on the overall objective(s) of the program.

Program Focus	Key Interventions
Fertility	Family planning, women's education
Maternal mortality and morbidity	Family planning, pre- and post-natal care, trained attendant at delivery, treatment for incomplete abortions, emergency obstetric care
Women's reproductive health	Family planning, trained attendant at delivery, STD prevention and treatment (including HIV/AIDS), treatment for incomplete abortions, prevention of harmful practices, sex education and counseling, education about breastfeeding
Infant and child mortality	Family planning, control and prevention of diarrheal disease and acute respritory infection, immunization and nutrition services, pre-and post-natal care, education about breastfeeding

Source: CARE International

When there is clarity about the specific objective(s) to be achieved, program managers can then decide on the appropriate package of integrated services, and more easily determine where and how to allocate resources.

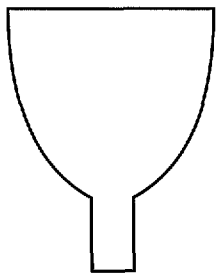
The Advantages of Vertical and Integrated Approaches

Management System	Benefits of Vertical Programs	Benefits of Integrated Programs
Planning/ Budgeting	• Plans are often made at the top level, and may be less time-consuming to complete. • Objectives are simple and straightforward.	• Planning and budgeting conducted at lower administrative levels facilitates local decision making • Plans made at the local level are usually more responsive to the needs of the client.
Internal Organization	• Organizational structure is more traditional and hierarchical, with more clearly defined lines of authority. • Key decisions are usually made centrally, allowing for more control of the system.	• Promotes decentralized decision making since decisions are often more complex, requiring local information about available resources and clients. • More decisions are made locally, resulting in decisions that are more appropriate to the individual program settings.
Staff Roles/ Responsibilities	• Staff roles are easier to define. • Performance is easier to monitor.	• Clients' needs are better met. • Staff can see their contribution to the overall success of the program.
Training	• It is easier to train staff to perform a single function than multiple functions.	• Integrated training offers the opportunity to improve the overall quality of the services offered to the client and the effeciency of the program.
Supervision	• It is easier to supervise the performance of discrete tasks. • Lines of authority are clearer.	• Supervision becomes more of a team approach as clinic staff share common goals and are trained to work together.
Logistics/ Vehicles	• Systems can be simpler since the number of commodities is limited. • Managing commodities is easier since staff are required to keep track of a limited number of items.	• Storage and transportation of items is more efficient. • Stock control and ordering systems can be unified for all supplies.
MIS/Monitoring	• Targets are simpler to define and measure. • Funds and other resources are easier to track to ensure they are being used as they were intended.	• Shared objectives and indicators promote team effort to reach targets. • Reporting and information systems can be combined and streamlined so that only the most essential information is collected and monitored.
Client Services	• Staff may be more knowledgeable in a particular functional area because their responsibilities are narrowly focused. • Client visits can be brief because clients are being provided a single service.	• Clinics can serve multiple client needs in one single visit, thereby reducing the client's time and travel costs. • Clients can establish a relationship with an individual provider who serves all her health needs. • Clients can receive preventive health services such as tetanus immunizations that they might not know they need.

Integration in Practice: Implications for Managers

A useful way to look at the extent to which a program is integrated is to assess how program services are integrated at each administrative level of the organization. Health and family planning programs often develop programs in which some program elements are integrated at one level but not at another. Two common integrated service delivery approaches are found in health and family planning programs. These approaches can be depicted by an "hourglass" and a "funnel" because of their characteristic shape when drawing an organizational chart.

Funnel Approach



National level (vertical)

District level (vertical)

Clinic level (integrated)

The "funnel" approach depicts an agency or organization that separates its programs vertically at the national and district levels, but integrates the programs and services at the clinic/community level. In this approach, there are separate staff for each program at the national and regional/district levels for family planning, immunization, infectious disease control, nutrition, and maternal health programs. But at the service provider level, staff are expected to handle *all* of these responsibilities.

Implications: This approach strengthens program planning by utilizing planning expertise at the top and by making service delivery efficient at the local level, but it puts an unrealistic burden on service providers who must respond to the demands of many supervisors who work independently and who are focused on a different set of priorities. This situation overloads the service provider, who often is unable to do all that is expected. This kind of pressure can cause a high degree of frustration among service providers, which often results in staff turnover and dissatisfied clients.

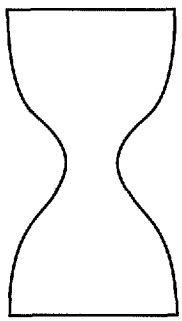
The "hourglass" depicts a different approach to a combined vertical/integrated program. As in the "funnel" approach, staff at the national level are divided into separate divisions for family planning, immunization, infectious disease control, nutrition, and maternal health. At the regional or district level, however, programs are coordinated by one or two individuals—often the regional or district health officer—who supervise and monitor all the programs. Then, at the service provider level, staff are again assigned to separate programs.

Hourglass Approach

National level (vertical)

District level (integrated)

Clinic level (vertical)



Implications: While supervision in this approach is, in principle, the responsibility of the district or regional staff, funding and technical supervision comes from national staff working in each separate vertical program. This approach often results in service delivery staff reporting to technical staff at the national level instead of reporting to their direct supervisors at the regional/district level. As a result, regional- or district-level managers often find it more difficult to coordinate and supervise staff at the service delivery level.

Meeting the Challenges of Integrating Services

Integrating services requires managers to consider both the potential benefits that will result, such as the possibility of cross-subsidizing services, and the potential complications and new management challenges. Managers will often find that people are reluctant to change and that coordinating logistics and sharing resources is not as easy to do as it would seem. To complicate matters further, as programs become integrated the kind of support donors – provide must change. To make integration work well, managers must be prepared to collaborate closely with providers, program managers, trainers, and senior-level managers to ensure that the quality of family planning services does not become diluted in the process of integrating services, and that the management systems are designed or modified to support the integrated program.

Managers will need problem-solving skills. While integrated programs offer important benefits to both the client and the organization, managers at all levels need to be skilled in identifying and solving problems. This is not because there are more problems in integrated programs, but because the problems are often more difficult to diagnose and solve. There are several reasons for this. Integrated programs involve more staff with a greater breadth of training and expertise than vertical programs, and the roles and responsibilities of the staff are broader.

Information systems for integrated programs are designed to identify critical outputs of the overall program, but because these outputs result from the combined activities of several programs, it is more difficult than in single intervention systems to detect the origin of implementation problems as they arise. Before a solution to a particular problem can be found, the manager needs to follow a problem-solving process and make inquiries about the systems in order to understand where in the process the problem arose. Continuous quality improvement (CQI) is a particularly effective technique for identifying and solving problems on an ongoing basis. For more information on CQI, see Chapter Three, "Using CQI to Strengthen Family Planning Programs."

Managers may be required to challenge vested interests. Going from a vertical program to an integrated program often brings resistance from staff who are reluctant to share already scarce resources such as personnel, vehicles, or equipment. Staff may also resist changing operating procedures, reporting systems, and training programs. For example, while a combined training workshop may be important to the success of a newly integrated program, managers or trainers in each vertical program may be reluctant to shorten or exclude any sessions that they feel are critical to their program. If the entire curriculum for each previously vertical program were included in the integrated curriculum, the resulting workshop might be too long to be practical. Some compromise must be reached so that the quality of the training can be maintained and staff from each program do not feel that their programs have been "watered down." As a manager, you need to remain objective when making these changes and decisions and work with other managers and staff to capture the essential elements of the previous systems, while developing comprehensive and high-quality systems to support the new integrated program.

Managers will need to gain donor support. Many donors are interested in integration but continue to support vertical programs. This may be because in vertical programs resources can be channeled to achieve specific family planning results more easily than in integrated programs. Consequently, cost effectiveness of family planning activities is more easily determined and provides a powerful rationale for program support.

Managers of integrated programs need to develop similar mechanisms for demonstrating the effectiveness of multi-service programs. For example, integrating STD services with family planning services may result in increased numbers of family planning users. Program data will need to show that this increase in family planning users can be attributed to the integration of STD and family planning services. In this way, managers can demonstrate the impact of service integration and provide a compelling rationale for donor support of integrated programming.

Should You Add New Services to Your Program?

There are many reasons why a manager might want to add new services to a program. As a manager do you want to reach a wider market by offering services that are attractive to a particular sector of the population? Do you want to broaden the services that you are currently offering because you feel it will benefit your clients? Do you want to add more services that are profitable in order to cross-subsidize your existing services? These are useful questions to ask when considering whether to expand the range of services offered in your program.

To help you to decide whether a new service is a realistic option for your program, answer the following questions:

- ***Will the clients who will use the new service be the same as or different from your current clients?*** If they are different, how will their needs be different? Consider hours of operation, need for child care during appointments, privacy and confidentiality, and the need for different IEC messages or materials.

- ***Will the current physical resources be adequate or will additions be needed?*** Determine whether changes will be necessary in the buildings, laboratories, examining rooms, waiting rooms, and surgical theaters.

- ***Will there be a need for new personnel, or can the current staff provide the new services?*** Consider what types of new skills will be required (counseling, supervising community-based distribution (CBD) workers, cold chain maintenance, laboratory).

- ***Will the new service require new commodities and will a change be needed in the current logistics system?*** Consider your needs for pharmaceuticals, laboratory supplies, and contraceptive, medical, or first aid supplies, and any refrigeration that these supplies may need throughout the distribution process. Consider whether the new commodities will require modifications to the existing logistics system (selection, procurement, distribution, and use).

- ***How will the addition of each new service contribute to the financial sustainability of your program?*** If the costs will be greater than the revenues, determine how these added costs will be covered. If the revenues will be greater than the costs, determine how this income will be used.

- ***Will this new service provide an opportunity for your program to cross-subsidize services in your program?*** Consider cross-subsidizing the cost of some services with other more profitable services. Experience shows that the services that have the best potential of being profitable are laboratory services, curative services, sales of pharmaceuticals, and treatment of STDs. These can be used to cross-subsidize preventive services such as reproductive health, family planning services, and CBD services that are generally not profitable.

Example: Adding STD Services to a Family Planning Program

Will the clients that will use the STD services be the same as or different from the current family planning clients? While family planning clients, STD clients, and the vast majority of women's health clients are potentially the same (sexually active adults), many more men usually attend STD clinics than attend family planning clinics.

Are current physical resources adequate for providing STD services? Because of the high reliance on laboratory facilities for diagnosis, clinics may need to either start a microbiology laboratory or arrange to use the services of a commercial or government laboratory. However, since results from laboratories can take months to receive, many clinics will want to consider starting a diagnostic laboratory, which will require new staff and equipment. If you choose to offer the new STD services with the other services currently being offered to women during their clinic visit, you may not need additional space. On the other hand, adding STD services to your family planning program may result in serving more male and adolescent clients. You may need to add waiting room space or examining rooms to ensure their privacy and confidentiality.

Will the program need new personnel or can the current staff provide the STD services? Many family planning clinics are staffed by nurses whose training included the diagnosis and treatment of STDs. However, in most cases, these nurses will need further training to upgrade their skills in this area. In addition, staff will require training in STD counseling to reinforce behaviors that will help to prevent recurrences of STDs.

Will the new service require new commodities and will a change be needed in the current logistics system? In general, the logistics systems required to support the provision of STD services will not be substantially different from those of family planning clinics. New commodities for the STD program might include antibiotics and laboratory reagents. These commodities might require special storage or refrigeration. The distribution system may need to be modified to handle larger quantities of commodities.

How will STD services contribute to the financial sustainability of your program? STD services can generate substantial revenues for family planning organizations. However, to benefit from these potential revenues, you must be sure that clients are willing to come to the clinic for these services. Because of the sensitivity of these types of services, clients will be very concerned about privacy, confidentiality, quality of care, cleanliness of the facility, convenience of the hours of operation, as well as how they are treated by the clinic staff. Paying attention to all of these factors will contribute to the profitability of these new services.

Will the addition of STD services provide an opportunity for cross-subsidization? Diagnosis and treatment of STDs may be a service that your clients are willing to pay for. The income can then be used to subsidize the cost of providing preventive health and family planning services.

Assessing Your Own Program

Most organizations, whether private family planning organizations or national Ministries of Health, are usually organized into three levels: national, regional or district, and local. The national level is usually responsible for setting policy, formulating budgets, allocating funds, and developing strategic plans. The regional or district level is usually responsible for developing operational plans, setting local budgets, providing in-service training, and supervising local-level staff. The primary responsibility of staff at the local level is to provide services to clients. At each administrative level, the degree to which programs are integrated is usually different. A first step in effectively managing integrated programs is to assess the extent of integration at each level.

How to . . .

Assess the Extent to Which Your Program is Integrated

Most multi-service programs are neither entirely vertical nor entirely integrated, but a combination of both. By using a checklist similar to the Sample Integration Assessment Checklist on page 198, you can determine how your program is managed at each administrative level—vertically, integrated, or a combination of both (mixed). Using the guidelines below, examine the extent of integration of each management system and record the administrative level by noting **N** (national level), **R** (regional/ district level), or **C** (clinic or community level) in the boxes provided in the checklist. This assessment will help you to understand where further integration may be appropriate in your program.

Planning/Budgeting: Is planning and budgeting for family planning service delivery done separately from the other services (nutrition, child health, maternal health, etc.)? Assess this management function at each level of the organization. Use the following three descriptive categories to rate the degree of integration at each of the three levels of your program or organization.

- **Fully Vertical:** Setting objectives, planning activities, and budgeting are done separately, with little coordination among the various types of services.
- **Mixed:** Setting objectives, planning activities, and budgeting are done separately, but are closely coordinated to ensure cooperation and sharing of resources.
- **Fully Integrated:** There is a single plan with a comprehensive set of objectives and a budget that covers the entire multi-service program.

Internal Organization: Are there separate reporting channels for each type of service, or only one reporting structure? Rate the degree of program integration at each of the three administrative levels by using the following three descriptive categories:

- **Fully Vertical:** Different types of service programs are housed in separate ministries or separate divisions of the organization, with linkages only at the very top level of the organization. At the national level, this would mean the only linkage is at the level of the Secretary-General or the Executive Director; at the regional level, it would be the Governor or the Regional Director; and at the local level it would be the local government officials. In general, the offices are housed in separate buildings.
- **Mixed:** All types of services fall within the same ministry or division, but have completely separate reporting structures. Coordination consists mainly of infrequent or ad hoc planning meetings.
- **Fully Integrated:** The organizational structure and staff of various types of services are fully integrated. While there may be some technical specialists who focus on specific technical areas, the administrative structure is fully integrated.

Staff Roles and Responsibilities: People are at the core of any program. How and whether activities are integrated ultimately depends on the roles and responsibilities of the staff. Rate the degree of program integration at each of the three levels for this component using the following guidelines:

- **Fully Vertical:** Personnel are assigned to work with a single service program. They have little information about each of the other service programs and have no responsibility for the success of the other services.

- **Mixed:** Personnel are assigned to separate service programs, but receive regular and accurate information about the other programs. All staff are responsible for the overall success of the multi-service program.
- **Fully Integrated:** Personnel are responsible for carrying out multiple types of services and have the skills necessary to offer a full range of services to the clients.

Training: Quality services cannot be offered in a vacuum. In order to maintain high-quality services, there must be adequate training systems to support the staff. Training provides the skills that staff need to perform their duties, whether they are single- or multi-service responsibilities. Rate the extent to which training is integrated in your program at each of the three levels.

- **Fully Vertical:** Training for each type of service is organized vertically. Separate training events are carried out and the curriculum for each type of service is not coordinated with that of others.
- **Mixed:** Training is done separately for each type of service, but the curriculum is closely linked to training curricula for other services.
- **Fully Integrated:** A single supervisor oversees all training activities. Training is done jointly for all types of services and there is cross-training in jobs so that personnel can work interchangeably to carry out multiple responsibilities.

Supervision: Supervision forms the bridge between the different levels of the organization. Because the programs often change from vertical to integrated between levels, as is the case in the "funnel" and "hourglass" approaches, careful attention must be paid to how supervisory support is given. If staff are expected to provide several types of services, supervision will need to be planned and implemented in a way that supports integrated roles and responsibilities. Rate the extent to which supervision is integrated at each of the three levels in your program.

- **Fully Vertical:** Supervision is organized vertically for each type of service. There is a separate supervisor for each service and there is little coordination of supervisory activities.
- **Mixed:** There is a separate supervisor for each type of service but supervisors actively share information and coordinate supervisory visits so that, when possible, visits are made by two or more supervisors at the same time.
- **Fully Integrated:** A single supervisor oversees all services.

Logistics and Vehicles: Perhaps nowhere is the push and pull of integration felt more strongly than in the area of logistics and vehicles. Rate the extent to which your logistics systems are integrated at each of the three program levels.

- **Fully Vertical:** Logistics systems are completely separate for different types of commodities. Supplies are ordered separately, stored and managed separately, and are delivered through separate channels on different days. Vehicles are not shared among different programs.
- **Mixed:** Logistics systems are managed separately, but systems are closely coordinated to allow for sharing resources such as delivery trucks or vehicles and storage facilities. Vehicles are used primarily by each individual service program, but are shared with other programs if space and time allow.
- **Fully Integrated:** There is one integrated logistics system for all types of commodities and supplies. The vehicles are shared by the different multi-service facilities.

Continued on next page

MIS and Monitoring: An information system can be made up of multiple different information collection systems, channels, and reporting forms or consist of a single system for collecting data. Rate the extent to which your MIS and monitoring systems are integrated at each of the three program levels.

- **Fully Vertical:** There are separate information systems for each type of service with incompatible forms and identification codes.
- **Mixed:** Information systems for different types of services are separate but some information is collected and shared between programs.
- **Fully Integrated:** A single information system is used to collect and report on multiple service delivery activities.

Client Services: The primary concern of the client is to get all of the services she or he needs in the most efficient way—usually this means getting all services at one time and in one place. Rate the extent to which different types of client services are integrated at the clinic level.

- **Fully Vertical:** Different services are offered only at different locations or at different times, with no possibility of receiving multiple services on a single visit.
- **Mixed:** All services are offered in the same facilities, but there are specific times when the different services are offered, which may require that clients make two visits to receive a different type of service.
- **Fully Integrated:** All services are offered all the time in the same facilities. Some services, such as STD services for men or adolescents, may be offered at special times or separate waiting areas may be provided to protect their confidentiality or to accommodate adolescents' school schedules.

Sample Integration Assessment Checklist

Management System	Fully Vertical	Mixed	Fully Integrated
Planning/Budgeting			
Internal Organization			
Staff Roles/ Responsibilities			
Training			
Supervision			
Logistics/Vehicles			
MIS/Monitoring			
Client Services (clinic level)			

Making Integration Work

Having completed your assessment, you will need to use your findings to improve your multi-service program. The following suggestions can help you to improve the effectiveness of an integrated program by improving key program management systems.

Planning/Budgeting

Focus on developing an integrated plan and budget. If the budget is integrated, the program will be integrated. If the budget is vertical, with separate allocations for each type of activity, those activities will remain vertical. Thus, the place to start with integrating services is with the budget. Unfortunately, this does not usually happen; instead the budget is usually the last thing to be integrated. The reasons for this are clear. Managers are reluctant to give up control of "their" money, and the finance department or Board of Directors is suspicious of any change in budget allocations. *But, when integration proceeds without changing the budgeting process, it does not work.*

> *There are several things managers can do to integrate budgets even when funds are allocated to programs separately. Managers at the regional or district level may be able to negotiate for funds to be reallocated to various integrated activities so that they can be distributed to facilities or local areas to be used to support all activities in an integrated program. The result is that activities can be planned and managed at the local level in an integrated way even when the plans and budgets are not integrated at the national level.*

Plan at the local level. Integration requires a good understanding of the local situation with regard to the availability of staff, staff capabilities, the local health and family planning situation, and the condition and size of facilities. Develop a process to allocate funds to each local area and then ask local-level staff to develop a plan and budget. This should be relatively easy since they will already know the amount of funds that are available to them. You must be able to provide assistance if they need help in preparing the plan and budget. Plans and budgets should then be reviewed to ensure that they are realistic, and that they are consistent with the policies and priorities that have been set at the national level.

> *Managers should involve local staff when they are redesigning how activities will be integrated and carried out. If local-level staff are not involved in the process, decisions may be made that are impossible to carry out and staff will likely become overwhelmed and discouraged and the program will suffer.*

Make plans flexible. Because of the complexity of integrated programs, it is more difficult to anticipate the changes that may be necessary in the future. This means that the plans must be flexible and allow managers to make mid-course changes if necessary. In integrated programs, managers need to be able to solve problems quickly, so it is important that the plans be flexible so that the managers can effectively do their jobs.

Internal Organization

Provide equal pay for jobs of equivalent responsibility. One of the problems managers often face as they integrate their programs is that pay scales differ among personnel who have jobs of equivalent responsibility. In an integrated program, the pay scales will need to be uniform.

> *In the past, nurses who provided family planning services have often enjoyed greater status and higher pay than nurses providing MCH services. If the programs are combined and all the nurses are expected to do both MCH and family planning, they must get equal pay and have equal status. This can pose a considerable challenge, since organizational or public service regulations may make it difficult to change salary levels. Unless this issue is addressed, there will be considerable resentment among the staff. Managers must assume that staff will know of salary discrepancies among staff with similar responsibilities. Address the issue with your staff and ask for their input to resolve the problem.*

Design programs so that form follows function. The form that an organization takes should reflect the way that the organization will operate. As programs become more integrated, the organizational structure will need to change to support the integration process. If, on the other hand, vertical services are to be delivered at separate locations by separate staff, a more vertical organizational structure should be designed. While no one structure is right for every organization, the structure should support how services are provided—in an integrated or vertical fashion.

Take the opportunity to reallocate staff to where they are needed. Managers generally have few opportunities to reallocate staff, given the constraints of employment rules and public service assignments. When a program is being integrated and organization charts are being redrawn, use the opportunity to reallocate staff according to where they are needed most. In the case of integration, streamlining central bureaucracy while strengthening the regional or district management capabilities can improve the performance of the overall program.

Staff Roles and Responsibilities

Staff must have a clear understanding of their roles and how they fit into the overall program. Because staff in integrated programs have multiple responsibilities and will have more experience in some areas than in others, staff must support each other and work together as a team in order to achieve organizational goals and objectives. Unless staff have a good understanding of the goals and objectives and how their roles contribute to achieving the program goals, they will have difficulty working together as a team.

Managers must work hard to achieve a shared understanding of goals and objectives. They must allocate time and effort to team-building and provide adequate opportunities for staff to learn about their responsibilities and the ways in which their work contributes to achieving organizational objectives.

Acknowledge and support staff expertise. In order to best serve the clients, it is important that staff have sufficient knowledge of all routine services being offered. However, it is also important that staff with special skills be supported and encouraged to use those skills, whether they are handling clients who have been referred for unusual or difficult problems, training other staff, or helping to maintain the quality of services in a specific technical area. The threat of integration is that special expertise will be lost and the quality of individual services will decrease. This does not need to happen, however, if staff expertise is recognized and supported so that staff can learn from each other, rather than creating a homogeneous cadre of mediocre staff. Excellence should be recognized and rewarded.

Training

Develop a case-based training curriculum. Integrated training programs should be carefully planned. If adequate time is not taken to plan and create an integrated training program, you may end up with a curriculum that combines the training sessions of each vertical program in one training marathon. A case-based training program facilitates integrated service delivery because it focuses on the different needs of individual clients. Case-based training teaches providers to assess each individual client and provide appropriate services for that client. When developing the training curriculum, it is also important to identify the combination of skills that staff and supervisors will need in order to support each other, so that together the entire staff at a service site will be able to delivery high-quality services to their clients.

Just as developing an integrated training curriculum is critical to delivering integrated services, so is training a special cadre of trainers who can provide the integrated training to health care workers and their supervisors. Because supervisors in an integrated setting will be supervising staff who are providing multiple types of services, the supervisors will need to be trained in the

whole range of technical skills as well as in supervisory and management skills. Making sure that supervisors receive proper training is critical to maintaining the quality of clinical services and to strengthening the management of an integrated program.

Select an appropriate training site. When training people who will be providing services in an integrated setting, it is particularly important to select an appropriate training site so that the training can include participatory patient care as well as theoretical training. If, for example, the training includes sessions on diarrheal control, acute respiratory infection, and clinical contraceptive services, you will want to have enough patients who have diarrhea and pneumonia, or who want to have IUDs or contraceptive implants inserted, so that by the end of the training the trainees have the experience they need to be certified and to provide the services without supervision.

On-the-job training or technical assistance can also be achieved by having supervisors be trainers. Supervisors can be involved in designing the training program, in training and re-training for specific skills, and in providing follow-up supervision to support training activities.

Supervision

Limit the number of supervisors. Health workers can have a difficult time prioritizing their activities and often become overburdened and discouraged when they have to respond to multiple supervisors. This is because these supervisors work independently and may be unaware of the demands being placed on the health worker by the other supervisors. For these reasons, it is important to train one supervisor to supervise MCH, nutrition, and family planning activities, instead of having separate supervisors for each of these activities.

Create supervisors who train and facilitate. Supervisors must see their roles as trainers and facilitators, not inspectors. Because of the range of services offered in an integrated program, service providers and supervisors are required to understand a much broader range of issues and diagnose a wide range of health problems. For this to be successful, training must be an ongoing process and supervisors must see this process as their responsibility.

Supervisors need to help service providers to carry out multiple tasks effectively. A community-based distributor of contraceptives will need to be able to assess the needs of a new or continuing acceptor, provide limited counseling, distribute two or three birth control methods, know contraindications and possible side effects, and know where to refer clients for further treatment, counseling, or other clinical methods. Good supervision will greatly increase the ability of the CBD worker to carry out these multiple tasks effectively.

Logistics and Vehicles

Integrate the logistics system only when services are operating at similar levels of efficiency. Many managers have had the unfortunate experience of seeing a successful contraceptive logistics system fall apart as it is integrated into the general pharmaceutical distribution system. The two systems may have been integrated with the intention of improving the efficiency of one system by combining it with the other more efficient system, but instead the opposite happens. As a general rule, any two systems being integrated will be pulled down to the operating efficiency of the *less efficient* system.

Systems should be integrated only when they are both operating at the same relative level of efficiency. For example, before integrating contraceptive and pharmaceutical logistics systems, the less efficient system should be improved so that both systems are operating well. In this way, the efficiency of the more efficient system will not deteriorate when the systems are integrated. However, two systems at the same level that are operating poorly can still be combined and then improved as a single integrated system.

Allocate local vehicle use based on actual needs. Because vehicles are in such high demand, this is often the resource that is fought over and guarded the most by vertical programs. This is particularly true since donors often require that vehicles be used only for the specific purpose for which they were intended—a single (vertical) purpose. Yet it is more efficient to use a vehicle for multiple purposes on one trip.

To the extent that it is possible, managers should allow staff at the level at which the vehicle is used to decide how best to share the vehicles. These staff are in the best position to know about seasonal road conditions, driving times to service delivery points, and local maintenance facilities. To help decide how to allocate the use of a vehicle, keep an accurate log that records how the vehicle is being used. This log can then serve as the basis for discussing how the vehicle could be shared by all the staff who need to use it.

MIS and Monitoring

Make terms, identification codes, and forms compatible. One of the difficulties in integrating information systems is that existing vertical reporting systems are often incompatible. For example, the curative service division may code "location" by health facility catchment areas, while the immunization program may code "location" by local village boundaries. In the same way, health facilities may be coded differently for pharmaceuticals, vaccines, and contraceptive commodities. When the systems are put together, chaos ensues. To successfully integrate information systems, it is essential to first develop compatible codes, terms, and reporting forms.

Focus on single output indicators. One of the most important lessons that has been learned in the past decade about successful program management is the importance of monitoring results regularly. Programs that have clearly defined objectives and targets and simple systems for measuring the achievement of these targets on a routine basis are much more likely to achieve their objectives. For example, the Expanded Program of Immunization (EPI) has had remarkable success in increasing childhood immunization rates and reducing vaccine-preventable diseases. The high degree of success of this worldwide program can be partially attributed to its ability to clearly define the target population (children under 12 months of age) and the indicator of success (number and percent of target population who are fully immunized). Progress can be measured routinely by using a population-based survey technique (such as cluster surveys) developed specifically for the program. This allows managers to receive frequent objective feedback on how they are doing, so that they can make necessary changes to the program to achieve the desired results.

As in the EPI program, the major objectives and indicators for family planning programs are also clearly defined; the target population is women of reproductive age and the indicator of success is the number and percent of the target population who use contraception. Results are measured routinely through a variety of population-based measures, most commonly contraceptive prevalence. In these two examples, managers are able to collect information and report on results, using a population-based measure that is objective and easy to understand. The reason for this is that each of these vertical programs has a single objective, measured by a single indicator, which is directly related to the desired outcome; in the case of family planning, women who (correctly) use contraception become pregnant only when they plan to get pregnant.

In an integrated program there are multiple objectives, multiple target groups, multiple indicators, and the correlation between the indicators and the desired outcomes is difficult to define. For example, in an integrated family planning/maternal and child health program, the typical target groups might include:

- *children under 12 months (immunization);*
- *children under 2 years (breastfeeding);*
- *children under 5 years (diarrheal disease, nutrition);*

- *all children (acute respiratory infection [ARI]);*
- *all women of child-bearing age or adolescent girls (family planning, nutrition, immunization, AIDS, STDs);*
- *all mothers of children under 24 months (family planning, nutrition, breastfeeding).*

The indicators of success in an integrated program might include:

- *women of reproductive age using modern contraceptives;*
- *women fully immunized for tetanus;*
- *children fully immunized;*
- *mothers who know how to correctly treat their children with oral rehydration therapy (ORT);*
- *women who are breastfeeding children under 2 years of age;*
- *women with children under 6 months who are exclusively breastfeeding;*
- *children who are growing according to the desired growth rate;*
- *children who are receiving micronutrients;*
- *children given correct treatment for ARI;*
- *women and men who know how to prevent AIDS and who do so in their own sexual relations;*
- *women who are correctly treated for STDs.*

With so many target groups and indicators, it is not easy to routinely collect and monitor information and to ensure that the desired results are being met. This makes it difficult to report results to supervisors and donors. For these reasons, information systems for integrated programs should be designed so that programs can report on specific objectives related to family planning, MCH, and nutrition for example, and at the same time report on the achievements of the overall program.

Design a two-tier information system. In an integrated program, managers are responsible for monitoring progress in a number of technical areas. Having single output indicators will help managers to more easily identify problems as they arise. To find solutions to problems, managers will need additional information on the processes that have produced the problem. A two-tier information system should be designed that collects *output* information on a routine basis, and allows managers to search out *process* information when a problem has been identified.

Logistics information systems will show when stockouts occur (output information), but when there is a stockout, managers must investigate whether this is due to a stockout at the main warehouse, a delay in transportation, a miscalculation, or a faulty ordering system at the service delivery site (process information). Using a two-tier information system helps the manager to quickly identify and solve problems as they arise.

Use only a few forms and collect only the information you need. When programs are integrated, the temptation is to take all the data, forms, and records that are being used and combine them into one large information system. This means that staff either have to spend much of their time filling in forms or as more commonly occurs, the forms are not used at all and the whole system breaks down. While it is always true that information systems should collect only the information that will be used, this is particularly critical when programs are integrated.

Client Services

Offer many services to all clients. The goal of the manager is to meet the needs of the clients in the most efficient manner. Clients' needs include the need for specific services whenever they come to the clinic or facility, such as information, referrals, privacy, and brief waiting time. This means that many different services should be available at the clinic site whenever it is open, so that clients will not need to make several visits to the clinic to receive the health services they need.

Be sensitive to the needs of special groups. Clients coming to the clinic will have different needs. For some clients, especially those seeking MCH services, the waiting room offers an opportunity to meet with friends and chat, or to meet new people who may share similar concerns about their children. However, privacy and confidentiality may be of paramount concern to other groups of people who may not want to be seen at the clinic by the general public, such as men who are coming to a clinic for a vasectomy or adolescents seeking condoms or STD treatment.

As clinics increase their services to include reproductive health services, STD treatment, and counseling for youth, males, and other special groups, creating separate entrances, waiting rooms, and even special clinic hours may make the difference between being able to attract and keep these clients and scaring them away. In order to make sure your clients continue to be satisfied with your services or learn new ways to increase their satisfaction, it is important to ask your clients for feedback regularly. This can be done by holding focus group discussions and individual exit interviews with your clients.

Working Solutions—Peru

Integrating Family Planning into Other Development Activities

CARE International is a non-profit international development agency currently working with the Peruvian government in four sectors of development. In October 1992, CARE and the Peru Ministry of Health (MOH) developed a family planning services project with the purpose of expanding access to and improving the quality of family planning services in Peru. This project—the Multi-Sectoral Population Project (MSPP)—serves a population of approximately one million people living in five regions of the country. The project has two main components: first, to support the MOH clinical facilities in the delivery of family planning services; and second, to work with MOH staff to train, supervise, and manage 950 volunteer promoters to deliver family planning services and provide contraceptive supplies and IEC materials to their communities.

Integration by Design

What makes the CARE project unique is that it was designed to integrate family planning with other CARE-Peru projects that provide services in four different sectors—health, food support, small economic activities, and agriculture and natural resources. Each project selected volunteers from the community to deliver family planning services. In collaboration with the MOH, the MSPP project helps to train and to provide supervision and supplies for these volunteer family planning service promoters. In this way, each project described below was able to make family planning an integral component of their program.

The Community Water and Health Project improves health conditions in rural communities by training community members to build and run potable water systems. Health extension workers work with MSPP volunteer promoters to educate the community about family planning. The MSPP volunteer promoters distribute contraceptives and make referrals to the nearest MOH facility for clinical methods and for complications.

The Integrated Development and Food Support Project (PRODIA) supports women's groups that have established community kitchens in impoverished urban areas. Members of the kitchens select an MSPP promoter to work with them through the kitchen project. The kitchen is visited daily

by most of the local population, providing an excellent place for distributing IEC materials and reaching potential acceptors. The same promoter also serves the surrounding community.

Project Niños is a child nutrition and health project that operates in rural areas. The project trains mothers in health and nutrition and provides nutritional supplements for young children. Here, too, the project participants themselves select the promoters that serve their communities. The MSPP promoters work through the Niños project to provide family planning information and services to the mothers participating in the project as well as to other mothers in the community.

The Women's Income Generating Project (MUJER), which trains women in income generation and small enterprise management, works in collaboration with the same community organizations as the PRODIA project to provide family planning services to women participating in the project.

The Rural and Urban Economic Activities Development Project (PERU) supports small business development. Through two projects MSPP promoters provide IEC and CBD services to the employees of businesses developed under this project. In both projects the members participate in the selection of the MSPP promoters who will provide the family planning services.

The Agriculture and Natural Resources (ANR) projects provide training and supplies to increase agricultural output and improve living conditions in rural mountain and jungle communities. As in the other programs, the beneficiaries of each of the four ANR projects select MSPP promoters. ANR program beneficiaries also help to gain broader community support for the family planning activities. This is important because in rural communities people are particularly skeptical of outsiders who want to "help." Many of the ANR projects also have field extension staff based in the communities who help to coordinate activities with the MSPP promoters.

Key Factors of Success

Several factors have helped to make this integrated community-based family planning program successful:

- Integrating family planning with other well-established services proved to be essential in gaining support for the project from the community, local government, and the Ministry of Health.
- MSPP promoters are always selected by the communities or project participants themselves, affording strong acceptance by the community.
- Volunteer promoters have a limited scope of work: to provide family planning IEC; to distribute pills, condoms, and foaming tablets; to refer clients to MOH clinics as necessary for clinical methods or for complications; and to inform people about the other development projects.
- All MSPP promoters provide the family planning services in coordination with an established and well-known program. This not only provides immediate contact with potential family planning clients, but also provides a system for referring clients to other services offered in the program.
- All staff in each of the CARE/MSPP regional offices (including management, program, administrative, and support staff) were trained in family planning and informed of the objectives of the project. This strengthened the integration of the MSPP with other CARE project activities from the beginning and facilitated project implementation.

Organizations that offer a broad range of development activities have a unique opportunity to integrate family planning into their ongoing service activities. CARE's Multi-Sectoral Population Project provides an excellent example of how this can be accomplished.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On overloading the capacities of staff . . . *Several reviewers stress,* "It is unreasonable to expect community health or family planning workers to take on the all the responsibilities of providing basic health care and family planning services, let alone other development activities. A typical worker can only handle three to four interventions well. Beyond that, things are done poorly or they decide what interventions they can handle and ignore the others. This reality forces planners and managers to decide which specific set of interventions a specific type of worker should provide in order to achieve the desired results, provide services effectively, and maintain the quality of those services."

On the evolution of family planning programs . . . *One reviewer points out,* "In the early stages when family planning was just being introduced, there was a real need to have vertical programs. Establishing a vertical program reflected the importance and priority that a government attributed to family planning, and facilitated achieving definitive results. Now that most national programs have established family planning services, integrating family planning with other health and development activities is more appropriate."

On integrating family planning with other health and development activities . . . *One reviewer offers,* "In the Philippines, family planning services are integrated with other basic health services provided at all main health centers and village health centers. For example, rural health midwives deliver a package of health care services to clients that include family planning, maternal and child health, and nutrition services. Family planning is also integrated in industry-based health programs, school curricula, and in information, education, and communication programs in the Department of Environment and Natural Resources and the Department of Agrarian Reforms."

On integrating AIDS services . . . *One reviewer cautions,* "If managers intend to add AIDS services, there are a wide range of issues that will need to be considered. In addition to the need to provide counseling and possibly AIDS testing, managers will need to determine what the role of the clinic will be when AIDS patients get sick and need medical help. Some programs provide only counseling and condoms to clients and refer AIDS patients to another clinic that specializes in AIDS services, other programs provide more comprehensive care for their AIDS patients. This decision will greatly influence the program's financial and other resource needs."

On defining primary health and maternal and child health care programs . . . *One reviewer proposes,* "Combining different services is one way of achieving integration, but it is also important to go further to clarify the definition of primary health care and maternal and child health care. Family planning should always be considered an integral component of overall primary health and maternal and child health care programs. New definitions for these programs should be discussed among health and family planning professionals worldwide."

Linking Family Planning with Mobile Immunization

The community-based distribution (CBD) program of the Zimbabwe National Family Planning Council (ZNFPC) is responsible for providing family planning information, education, and contraceptive services and supplies to clients in rural areas where clinic services are not easily accessible. In some areas in fact, the CBD workers were virtually unable to reach clients and prospective clients because they lived in such remote and sparsely-populated rural areas. Reaching these clients on any kind of regular basis was extremely difficult and time consuming.

To address this problem, CBD workers in several areas linked up with the existing national MCH/EPI mobile outreach program that was working in their areas and began to go to the rural areas with MCH/EPI mobile teams. The CBD workers assisted the MCH/EPI teams on their visits and also continued with their own family planning visits. The two groups coordinated their schedules entirely at the local level. Although their supervisors were aware of these combined activities, they were not actively involved in organizing the activities.

Integrating the CBD program with the mobile MCH/EPI program proved to be highly successful and cost-effective.

- The CBD workers were able to reach far more women in rural areas who otherwise may not have been able to receive family planning services.
- The credibility of the CBD program was enhanced.
- The MCH/EPI mobile team staff appreciated the participation of the CBD workers as they assisted both in carrying out information, education, and communication (IEC) activities for the MCH/EPI program and in conducting individual family planning counseling.
- Family planning program coverage increased dramatically without incurring additional program costs.

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Checklist for Managing Integrated Services

For Clinic Managers and Supervisors

- [ ] Assess the level of integration in your clinic or program.
- [ ] Get input from your clients about what additional services they need.
- [ ] Consider making changes in the scope of services that you offer and how they are provided to your clients (hours of operation, types of services offered, clinic site).
- [ ] Consider developing or strengthening local-level planning and budgeting.
- [ ] Examine staffing patterns and staff responsibilities to improve how staff members function as a team so that they effectively support integrated services.

For Regional Managers

- [ ] Assess the level of program integration at the regional level.
- [ ] Work with clinic staff to identify training needs so that staff can handle the full range of services required in an integrated program.
- [ ] Train regional and clinic supervisors to provide on-the-job training for a full range of service activities.
- [ ] Allocate vehicle use based on local needs, so that vehicles are shared and used as efficiently as possible.

For Mid- and Senior-level Managers

- [ ] Assess the level of program integration at the central level.
- [ ] Work with central and/or regional managers to develop integrated plans and budgets.
- [ ] Design an organizational structure that is consistent with the extent to which your programs are integrated.
- [ ] Develop an integrated case-based training curriculum that includes components on management and supervisory skills for supervisors.
- [ ] Develop a two-tier information system that collects a small set of output indicators and permits managers to obtain process information when problems arise.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Dr. Dupont Integrates MCH and Family Planning Services in Munda District

Dr. Dupont, the Regional Health Director in Munda district, looked at the letter from the Director-General of the Ministry of Health (MOH) instructing him to begin to integrate Maternal and Child Health services (MCH) provided by the MOH and family planning services currently provided by the Institute for Family Planning.

MINISTRY OF HEALTH

April, 1994

Dear Dr. Dupont,

As you know, for some time the Ministry of Health has been discussing the full integration of family planning and maternal and child health services. The cabinet has agreed to move forward with this policy change immediately. The transition is to take place over a seven-year period and will begin next month.

As you are aware, family planning services are currently being provided by the Institute for Family Planning at all MOH Maternal and Child Health Clinics. I would appreciate any ideas that you might have about making the transition from partially integrated service delivery to fully integrated delivery of MCH and family planning services. Please contact me with any suggestions or questions that you might have.

Sincerely,

Dr. A. K. Rangara

Dr. A. K. Rangara
Director General, Ministry of Health

Dr. Dupont had been expecting this change in policy for several months and had already been thinking about how to bring about the transition from partially to fully integrated service delivery in the MOH facilities. In fact, he had just completed a tour of his region and had been surprised to find that Institute personnel in the region's clinics were working in quite different situations.

In Marasa, the MCH clinic director had little knowledge of family planning and no interest in the family planning program. Mrs. Bonnard, the nurse midwife from the Institute who worked in the clinic, had told him that the clinic director never spoke with her or supervised her work, and never invited her to participate in any other clinic activities. Dr. Dupont had questioned her about client referrals and she was unable to recall a single referral for services from the MCH staff across the hall. She had said she felt very independent from the MCH clinic. "It's like I work in a different clinic," she said. "But I like it that way—I've been practicing for a long time, I know my job well, and I have a wonderful supervisor at the Institute." Mrs. Bonnard had also brought up the fact that when she went on vacation or on her monthly field visits, there was nobody in the clinic who could provide family planning services. Clients were turned away and told to come back at a later date. The Institute was supposed to find replacements, but they lacked additional personnel and rarely succeeded in finding temporary replacements for clinic nurse midwives. When Dr. Dupont spoke with Mrs. Bonnard's supervisor from the Institute, she confirmed that Mrs. Bonnard was

Case Scenario: Dr. Dupont Integrates MCH and Family Planning

an excellent nurse midwife and that the program had been doing well under her direction.

The situation was quite different at the Besnini clinic. There, the clinic director was a woman who had some specialized training in family planning and was very enthusiastic about integrating family planning and other clinic activities. She had organized clinic activities to include the two Institute nurse midwives working in the clinic. She expected them to be part of the clinic team and took an active role in supervising their work. Dr. Dupont had asked the same question about client referral and both the nurse midwives had agreed that they got a number of clients referred to them by the MCH staff. "Since the new director started including us in the clinic activities," one nurse midwife said, "we receive lots of referrals from the MCH staff. Most of the time, they just send them across the hall after they have finished seeing them. It's something that the director really pushed."

At Luba clinic, situated in the remote northern corner of the district, Mrs. Geroux, the family planning nurse midwife, met weekly with MCH staff and felt well integrated with her MCH counterparts. Mrs. Geroux had told him that "she really relied on the support that she got from everyone at the MOH clinic." Because of her remote location, her supervisor from the Institute frequently canceled her supervisory visits and Mrs. Geroux had come to rely on Dr. Bruen, the clinic director, for support and supervision. Together they had arranged for Mrs. Geroux to see all post-partum patients and to give informal talks in the waiting area during well-baby clinics to inform mothers about the family planning services offered in the clinic.

Leaning back in his chair, Dr. Dupont thought about what advice he could give Dr. Rangara about the best way to integrate family planning services into the MCH clinic program.

Case Discussion Questions: Dr. Dupont Integrates MCH and FP

1. **What suggestions can Dr. Dupont make to Dr. Rangara on how to facilitate integration of family planning services provided by the Institute with other clinic services?**
2. **What kinds of things can be done to integrate MCH program staff and Institute staff?**
3. **How can the current supervision system for family planning providers be incorporated into the overall MCH/FP program without decreasing the quality of support the family planning providers receive?**

Case Analysis: Dr. Dupont Integrates MCH and Family Planning

1. What suggestions can Dr. Dupont make to Dr. Rangara on how to facilitate integration of family planning services provided by the Institute with other clinic services?

Dr. Dupont has already anticipated the MOH transition from partial to fully integrated service delivery. His recent trip provided him with a good basis for making recommendations to Dr. Rangara. Dr. Dupont understands well that any new policy change will be challenging to implement and will depend ultimately on his own leadership abilities and those of his clinic directors.

Recognize the importance of leadership: Successful integration of family planning services currently provided by the Institute with other health services provided in the MOH clinic will depend to a great degree on the leadership capabilities of clinic directors. As Dr. Dupont observed on his field visit, clinic directors who have a good understanding of technical issues related to family planning and who are aware of the benefits that integrating family planning services can provide to patients are likely to provide adequate support for an integration initiative. An enthusiastic and motivated clinic director, like the one in Besnini clinic, can transform the way people work together.

Develop leadership skills: A special program for developing the leadership capabilities of clinic managers is needed. Dr. Dupont decides to focus on creating technical competence for family planning service delivery and on developing the management skills necessary to lead and motivate staff to work together to provide integrated services. He could suggest that Dr. Rangara develop a program for clinic directors to help them to:

- create better awareness of the goals, objectives, and activities of the family planning program;
- understand the benefits of integrating services for family planning and health service users;
- develop the technical competence required to direct family planning service providers;
- develop a clear understanding of how integrated program services will be implemented.

2. What kinds of things can be done to integrate MCH program staff and Institute staff?

Dr. Dupont realizes that better integration in MOH clinics can be achieved by establishing new formal channels for staff communication, by creating systems that focus on the client rather than the provider, and by upgrading the training of all clinic staff.

Improve communication: Managers must create opportunities for both formal and informal communication where staff can share ideas and information. Communicating effectively about client/patient needs can dramatically improve the overall quality of health and family planning services. Regular staff meetings with staff from both the Institute and the MOH clinic can provide an opportunity for all staff to consider ways to improve services and overall client care.

Focus on the client: When integrating services in a clinic, focusing on the client's needs provides a convenient starting place for considering ways of developing or improving integrated services. Dr. Dupont can develop systems in which staff can work together to assess client needs and use this assessment as the basis for developing better integration. One way to do this is by following a system of continuous quality improvement (CQI). For more information on CQI see Chapter Three, Using CQI to Strengthen Family Planning Programs.

Develop referral mechanisms: An interfacility referral system is essential for effective integration of services. MCH staff must systematically assess the family planning needs of mothers who come to the clinic for maternal services other than family planning, and also of mothers who bring their children to the clinic but may not be seeking care themselves. When MCH workers identify family planning service needs, they must have a clear and systematic way to provide these patients with family

planning services, preferably on the same day. Clinic managers should work with their staff to develop a system both for identifying needs of mothers and children that come to the clinic, and for referring them for other services within the clinic as soon as these needs have been identified.

Cross train staff: When developing a program of integrated services within a clinic, it helps to have staff who are technically competent in the entire range of services provided by the clinic. Training family planning service providers in MCH and MCH providers in family planning may eventually achieve greater integration. In addition, it may help provide back-up coverage for vacation or illness for either MCH or family planning service delivery, and thus prevent disruption of clinic services.

3. How can the current supervision system for family planning providers be incorporated into the overall MCH/FP program without decreasing the quality of support the family planning providers receive?

Dr. Dupont is aware that the major advantage of the current dual supervisory system is that it focuses providers on family planning services. Merging the two systems may reduce the attention on family planning by focusing on other MCH activities. However, in Luba clinic, where the dual supervisory system doesn't function well because the family planning supervisor visits very infrequently, supervision appears to be adequately performed by the MOH clinic director. The transition to integrated supervision will require streamlining the supervisory system, focusing on supervising specific aspects important to integrated service delivery, and upgrading the technical and supervisory skills of all supervisors.

Streamline the supervision system: The current supervisory system requires two supervisors who work independently. These supervisors have some obvious differences. First, each supervisor deals primarily with issues related only to the services provided by their supervisees in the specialized areas that they supervise. Secondly, the Institute supervisor visits infrequently, while the clinic supervisor is present in the clinic continuously. No formal mechanisms exist for collaboration or communication between supervisors, reinforcing the separation of services within the facility and among the staff. Formal communication between different supervisors should be established to increase collaboration between MCH and family planning supervisors.

Develop integrated supervisory guidelines: To achieve integrated supervision, supervisory guidelines will need to be developed that help all supervisors address the needs of the client visiting the clinic for either family planning or MCH services. Initially, family planning and MCH supervisors can develop supervision guidelines that emphasize a common philosophy of supervision and focus on a few critical elements needed to support integrated services.

For example, MCH and family planning supervisors could work together to develop guidelines for identifying both the family planning needs of MCH mothers and children and the MCH needs of mothers seeking family planning. The guidelines could specify the actions staff should take once these needs have been identified. Supervisors could then reinforce these guidelines with both MCH and family planning staff, ensuring that the guidelines were in place and being used effectively.

Upgrade technical and supervisory skills of supervisors: Supervisors will need to upgrade their technical proficiency in all service areas in order to be able to effectively support and encourage clinic staff to achieve greater degrees of integration. MCH supervisors will need training in family planning and family planning supervisors will need to improve their technical proficiency in MCH. If this process is successful, the current dual supervisory system could be eliminated in favor of single supervisors responsible for both MCH and family planning activities.

CHAPTER EIGHT

Working with Boards of Directors

In the private as well as the public sector, volunteer boards of directors are being increasingly recognized as contributors to the success of family planning organizations. Organizations that work with a formal board of directors, or a less formal advisory or managing board can benefit from the broadened vision, experience, and skills that a board provides.

All boards of directors have similar roles and responsibilities. A board of directors can help an organization plan its strategy and make critical decisions, provide effective financial oversight to ensure the stability of the organizationm serve the interests of the community and government, and influence public policy in ways that promote the mission and goals of the organization.

This issue of *The Family Planning Manager* examines the major roles and responsibilities of volunteer boards and provides advice on how executive directors and board members can create productive working relationships and jointly guide the organization toward achieving its goals.

This chapter was originally produced as Volume III, Number 5 of ***The Family Planning Manager****, including the case scenario, "Mr. Mwangi Versus the Board: Conflict in Kanapi," and the accompanying supplement, the "Pocket Guide for Improving Board Performance," which can be found at the back of this book. The guest editors for the issue were Bill Newbrander, Deborah Ruhe, Michael Hall, and Saul Helfenbein.*

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Working With Boards of Directors to Strengthen Your Program

In striving to become sustainable, family planning organizations need to continually reassess their contribution to the national family planning program. As times change and as the national program evolves, family planning organizations will find that they need to become increasingly sophisticated in adapting their programs and services to meet the needs of the communities they serve. Organizations that succeed in this endeavor often can thank the expertise of their professional staff and senior management for keeping them attuned to changing needs and making the changes in service delivery to keep up with the changing environment.

The tasks of managerial and technical staff, however, can be made easier if they have a dedicated, active board of directors with diverse backgrounds and experiences who can provide guidance and direction for the many difficult decisions which the professional staff need to make in keeping their organizations robust, responsive, and effective.

Boards of directors can be positive influences on the organization. However, they can also be impediments to change. Members, who are usually volunteers, can interfere with the routine tasks of professional staff. Frequently, when board membership extends over many years, board members may feel that their role as a volunteer entitles them to special perquisites. On occasion, instead of being there to serve the organization, they may feel that the organization is there to serve them.

Such role reversals occur when boards of directors are established without clearly defining the roles of the members and their relationship with the professional staff, especially with the organization's executive director and senior staff. When new members are not recruited or when members do not keep up with new approaches to carrying out board functions, the board can become an obstacle to rather than a force for sustainability. Managers can also reduce the effectiveness of the board if they see board members as competitors in decision making or in carrying out vital functions in the organization related to quality assurance, resource allocation and utilization, and long-term planning.

Both family planning managers and board members need to work together collaboratively and use their mutual strengths to enhance the sustainability of the organization. This chapter focuses on the roles and responsibilities of boards and their relationship to senior management. It discusses the reasons boards are necessary, how they can best contribute to an organization's well being, and how they carry out their many roles to serve the goal of sustainability.

Why Do Family Planning Organizations Need a Board of Directors?

Boards are often required by law. A board of directors is often a legal requirement for a nonprofit or for-profit organization. Organizations that serve the public and do not operate for any individual's personal gain are usually eligible for special concessions and immunities, such as tax exemptions. These organizations are usually required to have a governing board to ensure that the activities of the organization continue to focus on serving the public.

Boards provide oversight functions. In exchange for indirect financial assistance from the government, governments often require that a group of individuals voluntarily serve on a board of directors and act as guardians of the "public trust." This structure makes the organization's management accountable to a diverse group of people who have the general interest of the organization at heart, are not directly involved in the individual activities of the organization, and, due to the voluntary nature of the board, can effectively provide financial oversight since no personal financial gain is involved. This ability of the board to remain objective is critical to its effectiveness in guiding the organization.

Boards promote the organization's cause. In addition to fulfilling legal requirements, a family planning organization needs a board of directors made up of individuals who support the organization's mission, believe in it, and seek to promote it. Advocating for the organization and its cause is an important function of the board and involves promoting the mission and goals of the organization within the community and with the government.

Boards help to raise funds. The ability to raise funds is an important measure of a board's effectiveness in serving an organization. Board members who are influential in the community can often successfully elicit major contributions from a variety of private and business sources. Building an active group of financial supporters who regularly donate money to the organization will increase the resources available to implement programs, making it easier for the organization to fulfill its mission and achieve its objectives.

Understanding the Purpose of a Board

Nonprofit organizations often have a board of directors (also known as a board of trustees, governing board, or oversight board) made up of volunteers with diverse skills and experience. In this chapter, we will use the term "the board" to refer to these different types of boards, meaning a grouping of individual trustees or directors who are responsible for ensuring the long-term viability of the organization.

A board is the policy- and strategy-setting body of an organization. How a board defines and assigns responsibilities will influence how well an organization can adapt to changing conditions and, ultimately, will influence the success and survival of the organization.

The board has several key areas of responsibility including:

- Developing a strategic plan;
- Supporting the leadership and growth of the organization;
- Providing financial oversight;
- Maintaining community and government relations;
- Ensuring that high-quality services are provided;
- Managing its own board activities.

The board represents an organization's leadership and ownership. It is the board that is ultimately responsible for guiding the organization and ensuring its viability. This involves articulating the mission and values of the organization, protecting and expanding

its assets, and ensuring that it provides high-quality services.

Boards of directors working on behalf of family planning organizations around the world have been instrumental in creating effective links between their organization and the community, and between their organization and the government. However, boards often are either not involved enough or too involved in the operations of the family planning organization. For instance, the board may not be active enough in developing the organization's mission and helping it to focus on its long-term goals to ensure that it is moving in an appropriate direction. Or, board members may be overly involved in the day-to-day operations of the organization so that they interfere and meddle with the roles of senior management. Effective boards help to guide and support the organization rather than manage its day-to-day affairs.

Matching the Role of the Board with the Stage of Organizational Development

New family planning organizations typically start out with a small number of clients, a small budget, and few staff. These start-up organizations may have an outside advisor who helps the executive director to plan programs and make decisions. At some point, organizations formalize their relationship with their advisors by creating a managing board or board of directors. In the early years, the board is often composed of the founding members of the organization who work on a volunteer basis at the grassroots level. But as organizations grow, their needs inevitably change. More mature organizations often operate at the wider regional or national level, serving a large number of clients through a network of service outlets. They manage large budgets and employ greater numbers of staff. These more mature organizations will require the input of a larger board made up of members with the special skills needed to establish and shape the mission and policies of the organization. The following table presents a summary of the different types of boards that are appropriate for organizations at three different levels of development.

Stage of Organizational Development	Type of Board	Board Functions
Emerging	Informal group of community volunteers	Works directly with staff who carry out the daily work of the organization.
Growth/ Consolidation	More formal advisory board or small board of directors	Oversees development of organization's mission, policies, and operations.
Sustainable	Large board of directors with established sub-committees	Shapes mission and policies, raises money, and oversees organization's financial and programmatic performance.

Understanding the Responsibilities of a Board

Board members of private for-profit organizations, non-governmental organizations (NGOs), and parastatal organizations are usually volunteers. They agree to serve an organization because they believe in the goals and objectives of the organization and the way in which the organization operates. Board members who work in family planning or health may feel that serving on the board of a particular organization allows them to do things they cannot do in their ordinary professional work. Other members from the business community may join the board because of a desire to do public service. In all cases, in order to be effective, board members need to maintain the voluntary nature of their commitment to the organization.

Since board members are volunteers, their activities should be part-time, short-term, and limited to well-defined areas of governance and oversight. Membership should rotate regularly in order to bring in members with new viewpoints and experience. Board members need to recognize when the base of skills and experience on the board needs to be expanded. For instance, when the organization begins to deal with issues such as adolescent sexuality or integrating health and family planning services, it may need board members with experience in these areas. The board must decide what types of skills and experience are needed and find new members with the necessary background so that the board can serve the needs of the organization more effectively.

To be effective, board members must have a clear understanding of their own roles and responsibilities, as well as those of the executive director and senior management. When a board is functioning well, its members support and guide the organization by asking pertinent questions about where the organization is going, the effectiveness of the services it provides, and the financial strength of the organization. Boards should not be involved in day-to-day operations or try to implement their own programs or policies.

The six major responsibilities of a board of directors are developing a strategic plan, supporting the leadership and growth of the organization, providing financial oversight of the organization, maintaining good community and government relations, ensuring that quality services are provided by setting high performance standards and values, and managing its own board activities. The following sections discuss these responsibilities and clarify the role of the board and the organization's senior management. For practical guidelines and checklists for improving board performance and board and staff relations, please refer to the accompanying *Pocket Guide for Improving Board Performance.*

Strategic Planning

Because the board of directors assumes a large share of the responsibility for the success of an organization, it must provide the critical link between the organization and the outside environment in which the organization works. It must also ensure thatthe organization reaches the population it intends to serve, and serves the needs of its clients. To fulfill this function, the board should help the executive director to establish a strategic planning process, should participate in the process, and should approve the final strategic plan.

Formulating the mission statement. The board must work with the executive director to formulate the organization's mission and decide whether particular activities and services fall within its expressed mission. The mission statement should define what the organization is and why it exists. It should clearly articulate the organization's main purpose and values, and identify the principal beneficiaries of its activities or services.

A good mission statement articulates the overall goal of the organization to everyone inside and outside the organization. It is used to guide strategic, long-term planning and helps to keep the organization focused during both smooth and turbulent times. The absence of a mission statement, or having one that is unclear, may cause confusion inside the organization as it faces various difficulties, or it may result in inappropriate decisions. For a mission statement to be useful, it should be reviewed periodically to ensure that it reflects the current environment in which the

organization operates and the changing needs of the people it serves.

Developing the strategic plan. The strategic plan charts the direction that the organization will take over a period of three, five, or ten years to achieve its goals and objectives and fulfill its mission. In developing a strategic plan, the board and the staff of the organization will need to analyze the internal and external environment, identify opportunities or limitations to fulfilling its mission, and consider its internal strengths and weaknesses. This information is critical to developing strategic goals and establishing strategies and programs designed to fulfill the organization's mission.

The board should help the executive director in developing the strategic planning process and provide guidance and input to the plan. The board can be particularly effective in providing and analyzing information about the external environment, current trends in social policy, or new financial opportunities. Because strategic planning takes time and effort, several sessions will need to be scheduled to complete all the strategic planning steps, including gathering program information, discussing current and proposed programs, projecting the financial resources that would be needed to implement the programs, prioritizing programs, and finalizing the plan. The board must formally approve the final plan, be committed to it, and support its implementation. For further discussion on developing a mission statement and program strategy, please refer to Chapter One, "Learning to Think Strategically."

Strategic Planning	
Board Responsibilities	**Management Responsibilities**
Form strategic planning committee. Define process and develop a schedule for completing the plan.	Participate in strategic planning process.
Develop the organization's mission statement.	Help the board define the mission statement by soliciting input from other staff and communicating their ideas to the board.
Provide information from the external environment that will help in considering strategic options.	Collect and analyze program and service data, and present results to the board.
Make strategic decisions.	Recommend strategic options.
Approve operational plan and budget that reflects strategic decisions. Periodically review operational plan and budget.	Develop the operational plan and budget for board consideration. Implement the operational plan.

Organizational Leadership and Growth

Organizations need good leaders and adequate resources. Boards are responsible for recruiting and supporting a dynamic director who can provide vision and leadership to the organization. Boards also must help raise the funds needed to support the programs and services provided by the organization.

Hiring and evaluating the executive director. The executive director acts as the bridge between the board and the staff of the organization. She or he is designated to act on behalf of the board to implement its decisions. The executive director is given the authority to hire, organize, and supervise the staff of the organization, develop appropriate policies and procedures, and allocate resources within budgetary guidelines. When looking for a new executive director, the board must assess the organization's specific needs, then seek a qualified individual who has the skills and experience to guide the organization in meeting those needs. The board should also periodically evaluate the performance of the executive director in carrying out the decisions of the board and other assigned responsibilities.

The Role of Board Members in Developmentand Fund Raising Activities

- Work with other board members and with management to create an ongoing development and fund-raising program.
- Establish the goals and priorities of the development and fund-raising program based on the organization's strategic plan.
- Assist in formulating a list of prospective donors.
- Estimate the giving potential of prospective donors.
- Demonstrate commitment by being the first to contribute to the organization.
- Cultivate and solicit major prospective donors and demonstrate the organization's strengths and accomplishments.
- Represent the organization to the community by discussing significant developments and speaking to community groups about the organization's work.
- Keep the organization's management fully informed of development activities and contacts so they pursue funding possibilities.
- Establish a range of gift options that can enhance fund raising success.
  These might include:
  - Membership fees;
  - Annual donations;
  - Grants for special projects.

Supporting the growth of the organization. The board can support the growth of the organization by raising additional funds for setting up new programs and services and making capital and other improvements that will help the organization both to serve the needs of the population effectively and to operate more efficiently. Fund raising typically involves soliciting annual contributions to cover operating costs, organizing campaigns to fund specific capital equipment or facility improvements, or acquiring targeted funds for very specific projects or special programs. Fund raising may also be used to establish an endowment through income from interest, dividends, rental of real estate, and contributed gifts which will help provide for future institutional needs. To raise funds effectively, board members must persuade prospective donors of the importance of the organization's work, and continually cultivate their goodwill and interest in the organization.

Organizational Leadership and Growth	
Board Responsibilities	**Management Responsibilites**
Hire and evaluate the executive director.	Provide the board with information on organizational needs.
Identify new financial resources to allow the organization to implement its mission and programs.	Develop budgets that identify the financial resources necessary for implementing programs that serve to accomplish organizational goals.
Solicit financial contributions through donations, grants, and contracts. Make financial contributions to the organization.	Develop mechanisms to help board members raise funds. Identify funding sources and prepare requests for board approval.

Financial Oversight

The board has the ultimate responsibility for the financial viability of the organization. In the early stages of an organization's development, the board may be in charge of formulating financial policies and monitoring all major financial and investment decisions. As the organization evolves and matures, the board will need to focus more on controlling costs, evaluating the economic environment within which the organization operates, and deciding how that environment affects the organization's ability to achieve its goals.

This oversight function consists of three main responsibilities. First, the board has to determine the financial goals of the organization and monitor management's progress in achieving those goals. Second, it needs to establish sound financial policies and monitor whether the organization's activities adhere to those policies. Third, the board must review the organization's financial control systems in order to safeguard the resources of the organization. In addition, most organizations are required to comply with donor or government regulatory provisions. To comply with these regulations, the board should arrange for a financial audit to be conducted by a licensed independent auditing firm at least annually or as otherwise required.

Monitoring the organization's financial position. While the board's role in helping to increase revenues is critical to the financial well-being of the organization, the board must also develop policies for reducing or controlling the cost of programs and services. Increasing the efficiency of management systems is one way that an organization can reduce costs while maintaining the quality of the services it provides.

To provide effective financial oversight, boards often create a special finance committee made up of members with experience in financial management. The members of such a committee should know the proper questions to ask, what information to review, and how to analyze and use the information to make financial decisions. If the organization has a number of large programs, or programs funded by different donors, the board may need to review each program individually. In any case, all financial information should be reviewed in the context of the programmatic results achieved during the period under review.

At each board meeting, the board will need to receive certain financial reports that detail the organization's income, expenses, and any surplus or deficit. The reports should highlight any deviations from the budget, projected revenues, and any actions management is taking to correct those deviations. The board must know how to review and interpret three key financial documents:

- **A cash flow projection worksheet.** This worksheet usually covers a 12-month period and shows all anticipated financial obligations and expected cash revenues based on the existing work plan and budget. This worksheet helps to reveal if there will be any periods when funds will be insufficient to cover expenses. The worksheet should be updated each month to reflect any changes in cash projections.
- **A balance sheet.** This report shows the financial position of the organization at a particular point in time. It summarizes the organization's assets, liabilities (debts or payables), and reserves (equity or fund balance), which the board can use to assess the financial stability of the organization and to see whether its liabilities can be met.
- **An income statement.** Also known as a profit and loss statement, this report presents an analysis of the net income or deficit of the organization over a defined period of time. The board can use this report to assess the overall financial performance of the organization by comparing actual income and expenditures with the budget. It can also be used to compare current income and expenditures with those of the previous year. Using this information, the board can advise the executive director to revise budgets or work plans or to take actions to reduce costs by changing fee structures or increasing program efficiency.

Capital investments should also be reviewed by the board. Since any capital investments will have long-term financial implications that will affect the operating costs of the organization, these potential acquisitions should be scrutinized to determine whether they are consistent with the organization's mission and strategic plan, and whether they are financially sound.

Keeping your board well informed. The executive director should make sure that the board, or the board's finance committee, receives the following information on a quarterly basis:

- A report of revenue and expenses (income statement) compared to the budget, with explanations of any significant variance;
- A cash flow projection update;
- A balance sheet showing the financial position of the organization at that time;
- A report on the number of current clients compared with the number projected, and compared with the number in same period of the previous year, and in previous quarters of the current year;
- A report on information, education, and communication (IEC) activities and outcomes;
- A report on fund raising activities and results;
- A report on public and community affairs activities and results;
- A list of critical issues that might affect the stability of the organization.

Financial Oversight	
Board Responsibilities	**Management Responsibilities**
Approve the format and frequency of financial and programmatic reports.	Recommend format for financial and programmatic summary reports for board approval.
Analyze financial information relative to programmatic activities.	Provide accurate financial and programmatic information to the board and alert board members to any concerns that could put the organization at risk.
Make recommendations for improvement.	Propose changes or corrective actions when necessary or when directed by the board.

Community and Government Relations

A family planning organization serves communities made up of people living within defined geographic areas. It may serve these communities alone or in conjunction with other public or private organizations. How well the organization relates to the community groups and other governmental and non-governmental agencies affects the organization's success and effectiveness in delivering services. By determining and addressing the needs and interests of different community groups, the board can help the organization maintain good relations with the community as a whole. The board should also work to maintain good relations with the government, communicate the mission and goals of the organization to the public, and promote and propose changes in public policy that will help further the goals of the organization.

Responding to the interests of the community and the government. Maintaining a mutually beneficial relationship with the community should be a goal of all strategic plans. A family planning organization is in a better position to address community needs when at least one person from the community serves on the board. Having community representation on the board will promote good communication between the organization and the community and will ensure that community needs,

concerns, and service opportunities are not overlooked. An open communication process also can lead to more effective ways of providing family planning services that are appropriate and acceptable to the community. Access to comprehensive information on the community also empowers boards to make better decisions. The organization's staff should periodically provide the board with updated information on the characteristics of the community as well as with information on how the services are perceived by the community.

Good relations with the government are also important. Because the public sector plays a major role in family planning, it is essential that the board of a private organization cultivates a good relationship with government departments and agencies. Having a representative from the public sector on the board allows the organization to develop a strong and supportive relationship with the government and facilitates communication about issues that might affect the organization's programs. A good relationship with the government also provides an opportunity for the board to be more effective in lobbying for changes in legislation and regulations that will help to promote the organization's interests or in preventing legislation that would be detrimental to the organization's mission.

30-Second Quiz for Board Members

1. Can you describe the communities served by your organization?
2. Do you know the health needs of those communities?
3. Do you know the role of your organization in relation to that of other organizations providing services to these communities?
4. How is your organization's role integrated with that of other organizations?

Articulating the organization's goals and programs to the public. The board can play a critical role in making sure that the community is informed about the organization's long-term plans, available services, and the fees for those services. A well-informed community will not only use the organization's services but will also support its mission and goals.

Part of the board's role is to promote the organization. By helping the organization to develop a marketing plan and promotional campaigns, the board can greatly increase the organization's ability to reach all of its potential clients and at the same time promote the image of the organization in the government and among potential donors. Promotional activities should focus on communicating the benefits of the organization's services to the community, the cost-effectiveness of its services, and the achievement of public policy goals.

The Board's Role in Public Affairs

The manner in which an organization promotes itself to the public will have far-reaching effects on its ability to further its mission, maintain financial stability, and keep good relations with the community. The board can help to promote the goals of the organization in the following ways:

- Provide guidance on the development of a public affairs program.
- Review, approve, and support the organization's long-term public affairs program.
- Work with the organization's staff to develop promotional campaigns.
- Work with the organization's management to promote the organization and its achievements to potential donors.
- Select board members with experience in public affairs.

Proposing changes in public policy. Board members are chosen because of their special skills and their reputation and stature within the community. For these reasons they are often able to influence national and local politicians and members of the press. The board can develop a public affairs strategy that includes contacts with high-level officials and directors of other organizations. Having such a strategy will help to further the organization's mission and influence public policy, both of which will help the organization to achieve its goals.

Board members' activities can include writing letters to legislators, lobbying legislators and policy makers on issues important to the organization, speaking at community meetings, and explaining the mission and goals of the organization to friends and influential colleagues. Management can assist board members by keeping them informed of public policy developments affecting the organization, disseminating this information to the board and staff, working with the media, and coordinating volunteer activities that deal with public affairs.

Community and Government Relations	
Board Responsibilities	**Management Responsibilities**
Confirm that the interests of the government and the community are being met.	Collect and analyze information on client needs and make sure those needs are being addressed. Keep the board informed of policy changes and of legislation affecting the organization.
Articulate the organization's missions, goals, and programs to the public.	Develop promotional materials and make sure that the board is fully informed of the organization's programs and services.
Propose changes to public policy that might help promote the organization's mission and programs.	Identify priority issues, develop strategies, and plan activities.

Service Quality

Organizations that provide family planning and reproductive health services must strive to deliver high-quality services. It is the board's responsibility to hold professional staff to the highest standards in providing these services and to support them in making necessary improvements when they are needed. Many boards feel uncomfortable with this role, are uncertain about how to carry out this responsibility, and may think that only medical professionals are qualified to oversee service quality. One way that the board can ensure that high-quality services are being maintained is to establish and support a continuous quality improvement (CQI) program. The board should set the goals of the program, review the results, keep in close contact with the community to learn about any complaints, and make sure that necessary actions to improve service quality are implemented quickly.

Supporting continuous quality improvement efforts. Many family planning organizations have or are initiating ongoing quality improvement programs. These quality improvement programs require new ways of thinking, a willingness to change, and support from senior management and the board of directors. It is critical for the board to approve and support this process if it is to be successful. The board must assign high priority to the quality improvement initiative, communicate the importance of the initiative to the organization, and provide adequate resources to make the process work successfully. Most important, the board must be prepared to accept the changes that result from the quality improvement program. For more information on developing a continuous quality improvement program, please refer to Chapter Three, "Using CQI to Strengthen Family Planning Programs."

Reviewing service quality. The board should receive information from the organization's management that allows board members to assess the quality of services. This may include service delivery summary reports, client satisfaction surveys, evaluation reports, and any other studies dealing with the quality of services. When the need for quality improvements is identified, the board should support and strengthen the ongoing continuous quality improvement efforts within the organization to resolve the problems.

Ensure that the interests of community and government are being met. To ensure that an organization is meeting community needs and that the community is informed about the services provided, it is important to make sure that at least one person from the community serves on the board. This will allow access to information about the community and ensure that there is always a forum for presenting community needs, concerns, and opportunities. It will also help the board to assess community needs and seek solutions to community health problems and make sure that the organization offers services that are appropriate and acceptable to the community. Maintaining a relationship with the community is mutually beneficial and is an ongoing process. Information about the community should be periodically reviewed and updated and input about the organization's service to the community should be continually gathered.

Government relations are also important. Because of the large role of government, it is also important for a private organization to cultivate its relationship with government departments and agencies that may have certain oversight, regulatory, licensing, or funding responsibilities. As leaders in the community, the board members are an important means for the organization to promote itself with the government. Having a good relationship with the government provides an opportunity for the board to lobby for changes in legislation and regulations that will be helpful or to prevent legislation that is detrimental to the organization's mission.

Service Quality	
Board Responsibilities	**Management Responsibilities**
Develop policies that emphasize the importance of quality.	Develop clinical guidelines for the delivery of high quality services.
Support continuous quality improvement efforts.	Implement a continuous quality improvement process.

Management of Board Activities

A board must have procedures that allow it to carry out its responsibilities effectively. It should also be involved in activities that help the board members stay interested and well-informed about the organization's work. Among other responsibilities, board members need to periodically review the composition of their board to make sure that it is made up of people with the diverse skills and experience that are needed by the organization. As the organization grows and changes, the board will need to recruit new members. To conduct its business, the board must create committees, such as a finance committee or a public affairs committee, which permit board members to work on special issues critical to the organization's future. Finally, the board must periodically evaluate its own performance, and make changes to increase its effectiveness in serving the organization's needs.

Recruiting and selecting board members. It is important for the board to be made up of members with diverse backgrounds, skills, and experience. This will secure for the organization a broad base of community support and professional experience in

areas such as fund raising, family planning service provision, and management. Many boards have a small nominating committee that searches for new candidates to serve on the board and presents a short list of qualified candidates to the full board. Management's role in this activity should be to help determine the kinds of skills and experience needed by the board to help the organization to achieve its goals.

Educating the board. Educating new and current board members is an ongoing process that is the responsibility of both the board and management. It can be accomplished in a number of ways. Initially, board members should receive orientation or training that helps them to understand their roles and responsibilities and to learn about the organization. Periodic retreats can provide a time for concentrated learning about the organization, the issues it is dealing with, and the general family planning environment. Conferences, family planning workshops, and visits to other family planning organizations can help increase the board's knowledge about key concerns, problems, and trends in family planning programs and provide insight on how to address key issues. Some organizations even have special guides that board members can use as self-training tools.

Conducting board business. Board business is usually conducted at quarterly or semi-annual meetings. Although board members are not paid for their work, bringing them together is still costly because of the time required and because board members will have to be reimbursed for their travel expenses. For this reason, it is very important for meetings to be well organized and well run. It is usually the responsibility of the board president, with the help of the executive director, to plan board meetings so that the board makes the most effective use of its time. Work done by the board is usually delegated to a variety of board committees. It is essential that the executive director of the organization be kept up to date on the work of the committees.

Evaluating the performance of the board. Every two to three years the board should formally evaluate its performance. This can be done by holding a retreat or by using a self-assessment tool. The goal of the evaluation should be to assess the board's ability to address the needs of the organization, the board's productivity, or the need for new members. The result should be a renewed commitment by its members to serve the needs of the organization and the community it serves.

What the Organization's Management Can Do to Orient its Board Members

The executive director and staff can help new board members learn about the organization and the board's responsibilities by providing them with an initial orientation that might include:

- A tour of the facilities of the organization;
- A forum for getting acquainted with current board members and staff;
- An overview of the organization and its history, structure, and strategic plan for the future;
- An explanation of the financial position of the organization;
- A discussion of major areas the organization will focus on in the next three to five years;
- An explanation of the structure of the board;
- Job descriptions of board members and senior staff.

Management of Board Activities	
Board Responsibilities	**Management Responsibilities**
Establish criteria for selecting new board members with skills and experience appropriate to the organization's needs. Recruit, select, and educate new board members.	Work with the board to establish a process for selecting new board members. Search for and recommend qualified candidates to the board.
Search for board members with strong leadership qualities and diverse backgrounds and skills.	With the board, identify leadership development needs and provide the necessary training.
Develop meeting agendas (with the executive director) and conduct board business.	Meet regularly with the board president to develop meeting agendas and to plan presentations.
Structure the board so that it can perform its duties through committees, working groups, use of outside expertise, etc.	Provide necessary staff support for all board activities.
Evaluate board performance periodically.	Provide technical support for evaluating board performance.

Helping the Board Grow with the Organization

As organizations grow, the issues they face become more varied and complex. The guidance and special expertise provided by an effective, active board will be critical to their success. Making sure that board members have or can develop the skills necessary to serve effectively on a board is just as important as training management staff. Board members must continually attempt to develop their skills, and must stay well-informed about the organization's activities as well as the needs and interests of the government and community. They need these skills to help the executive director and his or her staff to develop and implement effective and sustainable programs.

An effective board of directors makes the mission and purpose of an organization more significant as it guides the organization toward achieving its goals in the constantly changing family planning environment. Strong boards provide good leadership, instilling the organization's staff with enough courage and risk-taking to help them face the challenges of the future. Boards must serve as advocates for their organization and help the organization obtain the funds it needs to operate. Board composition should be diverse to reflect the community being served, the public sector agencies with which the organization collaborates, and the specific experience the organization needs to carry out its work effectively. Using their dedication, enthusiasm, and hard work, combined with a full understanding of their roles and responsibilities, board members can help executive directors and their staff meet new challenges as their family planning programs grow and the social context changes.

Working Solutions—Madagascar

Using a Board in the Public Sector

Although boards of directors traditionally are closely associated with private-sector organizations, the board structure and the principles of board governance can be applied to the public sector. Technical committees, informal advisory boards, and medical committees can function in a manner similar to private-sector boards to guide government agencies in setting policy and making strategic decisions.

In Madagascar, the USAID-funded APPROPOP project, which is managed by a consortium of private voluntary organizations, provides assistance to Malagasy organizations and the Ministry of Health to improve or expand family planning services. The assistance includes technical support, materials and equipment, and grants to cover operational costs. At the inception of this project, a technical advisory committee (TAC) was established. This committee functions as the equivalent of a Board of Directors for the project. The committee is made up of representatives from the Ministry of Plan, the Ministry of Population, the Ministry of Health, non-governmental organizations (NGOs), private for-profit organizations, USAID, and the APPROPOP project. Board members meet quarterly and make decisions by consensus. Members do not receive payment for their work.

The responsibilities of the technical advisory committee include:

- Reviewing and approving overall project activities;
- Reviewing and approving annual work plans and budgets;
- Developing the process and criteria for selecting or rejecting proposals for grants to organizations;
- Reviewing and approving grant proposals (after initial review by the project);
- Developing criteria for selecting candidates for long-term training and approving the final selection of candidates;
- Developing the need for and timing of periodic evaluation activities and selecting the members of the evaluation team;
- Assuring that APPROPOP strategies and plans are in harmony with those of other donors.

The project's senior managers support the board by providing comprehensive support services. Their responsibilities include scheduling meetings, helping to prepare the agenda for the meetings, providing secretarial services, writing the minutes, and collecting and disseminating information on critical project issues to committee members.

Because this technical committee is structured and has responsibilities similar to those of a board of directors, it has been able to help the project develop policies that accurately reflect the needs and values of a diverse community that includes the government and NGOs. For example, the committee has consistently emphasized the importance of sustainable programs and has helped to strengthen programs funded by the project by encouraging programs to include cost recovery mechanisms and by stressing the importance of managing project resources so that they are used effectively and efficiently.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On creating the ideal board . . . *One reviewer comments,* "In my experience, the board that you describe in this chapter is more a vision of an ideal board, rather than a reflection of how most boards operate. In reality, boards are either too controlling or not involved in the affairs of the organization at all, neither of which is helpful to the executive director and his staff." [Editors' note: It is the intention of the editors to present and discuss the role of an ideal board in the hope that boards of directors will learn to become more effective and work productively with the organization's management to successfully achieve organizational goals.]

On prioritizing board responsibilities . . . *One reviewer writes,* "In my experience, many family planning organizations confuse board and staff responsibilities. Unfortunately, boards often want to manage, and managers want to set policy. I would suggest that the responsibilities of the board be prioritized differently: 1) choose and evaluate the chief executive officer; 2) set policies for the organization (not operational guidelines); 3) create and sustain a positive public image for the organization; 4) provide overall financial oversight; 5) undertake strategic planning for the organization in collaboration with the management; 6) mobilize resources for the organization."

On the role of the board in start-up organizations . . . *One reviewer recalls,* "Several years ago I served on the board of a new family planning organization. Because we didn't have enough staff, we, as volunteers, were involved in the day-to-day activities of the organization. The organization now has more staff and we are functioning more as advisors, focusing on developing policies and long-term plans for the organization."

On avoiding conflicts of interest . . . *One reviewer advises,* "Conflicts of interests have several dimensions: personal, financial, business, and interpersonal relationships. Interpersonal relationships, particularly with regard to personnel management, is an area where the board and the executive director must avoid the perception of a conflict of interest, for instance when relatives or friends are hired or promoted in the organization or selected to serve on the board."

On the difference a board can make . . . *One reviewer reflects,* "In our organization, the involvement of the board has gone through several stages. In the beginning, the board provided the institution with the social and professional credibility that it needed to become a 'serious entity.' Today, sustainability and program diversification have become more critical to the organization's survival, and the administrative, managerial, and financial knowledge of board members has really helped to support the internal efforts of the organization."

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[Answers to Self-Test: 1 (M) Management should negotiate contracts and purchases; 2 (B) The board is responsible for making final determinations about implementing new programs; 3 (M) Management is responsible for monitoring day-to-day operations of the organization; 4 (B) The board is responsible for approving the final annual budget; 5 (B or M) The board and the management should meet with government officials to inform them of the mission and goals of the organization; 6 (B) The board is responsible for making the final decision about continuing or terminating current programs; 7 (M) Management handles personnel matters; 8 (M) Management prepares quarterly expense reports; 9 (M) Management is responsible for hiring all staff, with the exception of the executive director; 10 (M) Management is responsible for developing clinical guidelines and standards.]

Self-Test: Understanding Board and Management Responsibilities

This chapter has discussed the primary roles and responsibilities of a board of directors and an executive director of a family planning organization. But things are not so clear cut in the real world where you are faced with real decisions and activities and you must decide whose responsibility it is to handle them. Use this self-test to check yourself on which activities are the responsibility of the board and which are the responsibility of the organization's management. For each of the sample activities described below, indicate which party is responsible for each activity, the board (B) or the organization's management (M).

	Decision or Activity	Party Responsible	
1.	Negotiates contracts for purchase of clinic examination tables	**B**	**M**
2.	Makes final determination to add comprehensive reproductive health services	**B**	**M**
3.	Monitors client flow and waiting times	**B**	**M**
4.	Approves final annual budget	**B**	**M**
5.	Meets with government officials to inform them of organization's mission and goals	**B**	**M**
6.	Makes final decision to subsidize the CBD program with revenue from laboratory services	**B**	**M**
7.	Decides to terminate the employment of the accountant	**B**	**M**
8.	Prepares quarterly expense reports	**B**	**M**
9.	Hires clinic manager	**B**	**M**
10.	Develops clinical guidelines for IUD insertion	**B**	**M**

[Answers to self-test appear in References section.]

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Mr. Mwangi Versus the Board: Conflict in Kanapi

Mr. Mwangi felt discouraged this morning after his monthly Board of Directors meeting. Over the last five years, under his leadership as Executive Director of the Kanapi Health and Family Planning Agency, the program had successfully expanded services into rural areas. They now operated ten clinics in five districts and the strategic plan for the next five years called for adding two clinics a year. Each new clinic would have a community-based distribution program as well. The organization had also been contacted by the government to design a collaborative effort to reach more clients in rural areas. Overall, Mr. Mwangi was excited about these new opportunities, but recent staff turnover and vacancies in two senior positions made him very concerned about the agency's ability to meet these new challenges.

Just as he was thinking about last night's meeting with the Board of Directors, Mrs. Amolo, the Deputy Director, appeared in his doorway. "Good morning," she said. "How did the meeting go last night?"

Mr. Mwangi frowned, "It was very frustrating. The organization has so many exciting opportunities but the Board of Directors isn't providing us with the support we need. We started discussing the new proposal for collaborating with the government and I told the Board that until we resolved the problem of staff turnover and filled the vacant positions, we shouldn't proceed with the discussions."

Mrs. Amolo replied, "Don't they realize that the position for Director of Field Programs has been vacant for the past four months and that we haven't had a Medical Director for the past two months? We've told them over and over again that our salary structure isn't competitive with other organizations. Both of those people left because they found comparable positions with higher salaries and more attractive benefits at other organizations. Whatever happened with the candidate that you interviewed to replace the Director of Field Programs? I thought she seemed excellent."

"She was exactly the person we were looking for," responded Mr. Mwangi, "but she was already earning more than we could offer her. When I went to the Board to ask them to consider changing the salary structure to be competitive with similar positions all over this city, they said it was impossible. In fact, the same thing happened with two candidates I interviewed for Medical Director. But the Board keeps saying that there is nothing wrong with our salary structure. They're living in the past—they have barely changed the structure since the organization began ten years ago. There's no way we can fill either position with a good candidate if we can't offer more competitive salaries."

"What else did you discuss?" asked Mrs. Amolo.

"Well, it turns out that the new Board member, Peter Konbu, is a close friend of an aide to the Minister of Health," responded Mr. Mwangi. "They belong to the same club and the aide introduced Konbu to the Minister. Apparently Konbu has started talking to the Minister about our organization. The Minister told Konbu he wants us to sign a contract to provide services in government

Case Scenario: Mr. Mwangi Versus the Board

clinics and to start training their doctors immediately. I'm afraid Konbu has promised the Minister all sorts of things which we can't possibly take on at this point."

"Oh no, it sounds like Konbu is out of control," said Mrs. Amolo. "We could really be set back if he has been creating expectations that we can't meet."

"Exactly," replied Mr. Mwangi. "We haven't even had an opportunity to discuss this new initiative formally with the full Board of Directors and it isn't part of our current strategic plan. I was planning to hold a meeting with all of our program directors here this week to discuss some of our ideas and I have scheduled a special meeting with the Strategic Planning Committee of the Board at the beginning of next week to discuss our ideas with them. But we must resolve the issue about the vacant positions before we can make plans with the Ministry."

"Did you discuss the problem about the supervisory visits?" asked Mrs. Amolo.

"I brought it up again," answered Mr. Mwangi. "I told the Board that the supervisors have been complaining ever since they started sending a Board member on quarterly supervisory visits. I tried to get them to see it from the supervisor's perspective—that the presence of the Board member affects the willingness of the staff to be frank about problems and, in addition, staff feel that they need to impress the Board members. I also pointed out that the supervisors were often forced to change the dates of regularly scheduled visits in order to schedule a time that was convenient for the Board member."

"It sounds like a very frustrating meeting," said Mrs. Amolo. "What do you think we should do now?"

Case Discussion Questions: Mr. Mwangi Versus the Board

1. **Identify three main areas of conflict between the Board and management that are affecting organizational effectiveness.**
2. **For each of these problems, describe what you believe is the Board's responsibility and what is the responsibility of the Executive Director, Mr. Mwangi.**
3. **What specific suggestions would you make to Mr. Mwangi and the Board to resolve these problems?**

Case Analysis: Mr. Mwangi Versus the Board

1. **Identify three main areas of conflict between the Board and management that are affecting organizational effectiveness.**

   - There is conflict between the Executive Director and the Board over the need for a change in the current salary structure. At the present time, Mr. Mwangi cannot fill senior-level management positions because the salary structure is not competitive with other organizations.

   - Private discussions regarding expanding activities for the organization with the Ministry of Health by the Board member, Mr. Konbu, and potential misrepresentation of the organization's capabilities create a potentially embarrassing situation for the organization.

   - The Board is overly involved with the supervisory process and is making it difficult for the supervisors to do their jobs effectively.

2. **For each of these problems, describe what you believe is the Board's responsibility and what is the responsibility of the Executive Director, Mr. Mwangi.**

   In this case there is some confusion over the appropriate responsibilities of the Board and the Executive Director and senior staff. More appropriate responsibilities for the Board of Directors and the Executive Director are summarized in the table below.

Problem Area	Responsibility of the Board of Directors	Responsibility of the Executive Director
Salary Structure	Reviews and approves salary structure for key positions.	Provides information to Board on salary structure of comparable organizations. Hires qualified staff and negotiates salary within range determined by salary structure.
New initiative to expand services in collaboration with the government	Reviews and approves plan for expanding services. Works with the Executive Director to develop this program with the government.	Presents major new initiatives or programs to the Board before implementing them.
Supervisory visits	Sets policies, monitors activities through regular reports provided by staff.	Conducts supervisory visits, collects data for reporting to organization and the Board.

Case Analysis: Mr. Mwangi Versus the Board

3. What specific suggestions would you make to Mr. Mwangi and the Board to resolve these problems?

Salary structure:

Mr. Mwangi, the Executive Director, can conduct a management review to re-examine and revise job descriptions and qualifications for key positions within the organization. Part of this review should include researching salary data on similar positions in other family planning and health organizations. The Board will then have the information that it needs to assess the current salary structure and make changes. Establishing a salary structure is the responsibility of the Board. Final staff selection and salary negotiations should be handled by Mr. Mwangi.

Expanded activities:

First, the Chairman of the Board is responsible for managing the Board members and for communicating with the Executive Director. In this case, the Chairman needs to make sure that Mr. Konbu is acting within his role as a Board member. If Board members discuss the development of programs with others outside the organization without involving the Chairman of the Board and the Executive Director, problems will arise.

Second, Konbu should not be talking directly with the Minister on behalf of the organization, unless the Board has asked him to do so. It would be more appropriate for Mr. Konbu to approach the Board and discuss how he might be able to facilitate negotiations. Mr. Konbu's contact with the government official may be useful, but Mr. Mwangi needs to be in charge of planning and implementing any new activity.

Supervisory visits:

Conducting supervisory visits on a regular basis with organization supervisors is not a Board responsibility. In fact, their insistence on participating in supervisory visits is creating difficulties for both the supervisors and the staff. The supervisors are unable to exercise their responsibilities freely, and the staff aren't getting the full benefit of the supervisory visit. The Board can approve supervisory policy and make suggestions to improve the supervision process, but Board members should not be involved in direct staff supervision.

CHAPTER NINE

Reducing Client Waiting Time

Family Planning Management Development is happy to introduce the first issue of *The Family Planning Manager*. We have created *The Family Planning Manager* to help managers develop a common understanding of significant management problems and build organization-wide support for the delivery of high-quality family planning services. It is our hope that you will share this publication with as many of your staff and colleagues as possible, and that you will find the concepts, tools, and techniques it presents to be useful aids for staff development.

The topic for this issue, "Reducing Client Waiting Time," addresses a common problem for managers of family planning programs. Long waits in clinic waiting areas can create barriers that prevent your services from reaching family planning clients.

Analyzing client waiting time and then developing a program to reduce long waits can be done easily and inexpensively. This process usually improves clients' satisfaction, strengthens organizational capabilities, and increases staff productivity.

This issue of *The Family Planning Manager* describes a simple Client Flow Analysis that managers and their staff can use to assess client waiting time. It discusses how this information can be used to identify organizational factors which contribute to waiting time. It also suggests ways to promote a smooth and efficient flow of clients through your clinic.

This chapter was originally produced as Volume I, Number 1 of ***The Family Planning Manager****, including the case scenario, "Mrs. Manumbu's Wait." The guest editor for the issue was Joseph Dwyer.*

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Why Look at Client Waiting Time?

Clinics that have overcrowded waiting rooms, many clients who stop coming for services, staff who complain about rushing and waiting, and hurried counseling sessions may have problems with long client waits. Waiting times that exceed two hours are common. They have been reported in Costa Rica, Kenya, South Africa, Jordan, and many other countries around the world. Where managers have made organizational changes to improve the situation, these waits have been reduced by at least an hour.

If your clinics show any of the symptoms mentioned above, you will be able to increase your clients' satisfaction and staff's efficiency by assessing your clients' waiting times and then by making inexpensive changes.

Client Satisfaction. Potential and continuing clients see long waits as an obstacle to family planning. While some waiting is to be expected, waits in excess of one or two hours "are one of the most important factors in explaining the relatively high rates of program and method discontinuation . . . and may also discourage would-be acceptors from seeking program services" [Keller 1975].

Organizational Capabilities. On the organizational side, inefficient clinic sessions and policies which require numerous revisits for continuing clients increase the waits of all clients. They also reduce the number of family planning clients a clinic can serve each year.

For example, a clinic that makes continuing pill users wait in line with clients who are attending the clinic for the first time will have long waiting times for continuing pill users. By developing a fast, specialized service for this group of clients, managers can decrease the waiting time of both new and returning clients. This change might also permit the clinic to provide services to greater number of clients without expanding clinic hours or adding additional staff.

Addressing the Causes of Client Waits within Your Clinic. Before you begin to address client waiting time, be sure you understand the situation in your clinic. Determine the number of first visits, the number of revisits, and the types of services or methods that the clinic provides during these visits. Next, review your program and clinic policies that you think might affect client waiting time. Once you have described the general situation in your clinic, follow the suggestions in this chapter for performing an assessment of your client waiting time and for making simple changes to shorten client waits. These changes will increase your family planning program's ability to serve more clients more effectively.

A word of caution—reducing waiting time means reducing the time clients spend *waiting for* providers, not the valuable time they spend *with* providers.

Getting a Quick View of the Waiting Situation

One method for quickly assessing the waiting situation in your clinic is to look at the length of time clients spend in the waiting room and in other service areas of your clinic building. To do this, spend a morning (or afternoon) recording arrival and departure times for each client. Also count the number of clients in the waiting room at 15 minute intervals to get a rough idea of how smoothly clients are moving through the system.

Do this quick assessment on a peak day and a typical day to get an idea of how long clients are waiting. You may even want to repeat your observations every three to six months to keep up with changes in your clinic.

If your quick assessment suggests that clients are waiting a long time, you should do a more thorough study of client flow and waiting times. Be sure to do the more thorough study *on both a peak and a typical day*. The following method for doing a Client Flow Analysis will give you a comprehensive picture of client flow during a clinic session. It will help you to:

- measure the time clients spend at each station;
- identify bottlenecks in client flow, that is, places where clients wait longer to be served than elsewhere in the clinic;
- locate gaps in clients' contact with staff;
- measure total waiting time of clients.

How to . . .

Do a Simple Client Flow Analysis

- Assign a number to each client as they register (e.g., #01 for the first client).
- Attach a Client Flow Form (see below) to the client's medical record.
- Enter the family planning method obtained and indicate whether the visit is a first visit or a revisit.
- Ask your staff members at each station to enter the time they start and complete their service with the client on the Client Flow Form.
- Summarize data from all the Client Flow Forms on a Client Flow Chart (see page 238).
- Involve your staff in plotting data from each Client Flow Form on a graph to show the time each client spent in contact with staff and the time spent waiting (see page 238). Use a different color for each type of staff.

After completing your graph, you will be able to see how clients moved through your clinic and where the bottlenecks in client flow are.

Completed Client Flow Form

Date *2/14/92*

Client Number *01*
Family Planning Method ..... *Pill*
Type of Visit ..... *First*

Time of Client's Arrival in Clinic: 08 : 00 (Hour : Minutes)

Client Service Time

Client Contacts:	Type of Staff	Service started (hour : min)		Service completed (hour : min)		Total Service Time (mins)
First contact with staff	R	08 : 00	--	08 : 03	--	03
Second contact with staff	N	08 : 22	--	08 : 29	--	07
Third contact with staff	D	08 : 30	--	08 : 35	--	05

R = Registration Clerk **N** = Nurse **D** = Doctor or Nursing Officer

Client Flow Chart: Summary of Client Flow Forms

Client No.	Time In Out	Total Min.	Contact Min.	Waiting Min.	Percent Waiting	Visit Code	Method Code	Comments
01	*8:00 8:35*	*35*	*15*	*20*	*57%*	*F*	*P*	
02	*8:00 9:08*	*68*	*37*	*31*	*46%*	*F*	*U*	
03	*8:00 9:32*	*92*	*29*	*63*	*68%*	*R*	*U*	
04	*8:05 10:00*	*115*	*33*	*82*	*71%*	*F*	*I*	
05	*8:07 10:34*	*147*	*26*	*121*	*82%*	*R*	*U*	
06	*8:10 10:55*	*165*	*27*	*138*	*84%*	*F*	*CS*	
10	*8:20 11:50*	*210*	*21*	*189*	*90%*	*R*	*U*	
11	*8:24 11:45*	*201*	*7*	*194*	*97%*	*R*	*P*	
12	*8:27 11:54*	*207*	*6*	*201*	*97%*	*R*	*P*	

Summary Analysis	
Average Time in Clinic:	*138 Min.*
Average Waiting Time:	*115 Min.*
Average Contact Time:	*22 Min.*
% Time in Contact with Staff:	*16%*
% Time Waiting:	*83%*

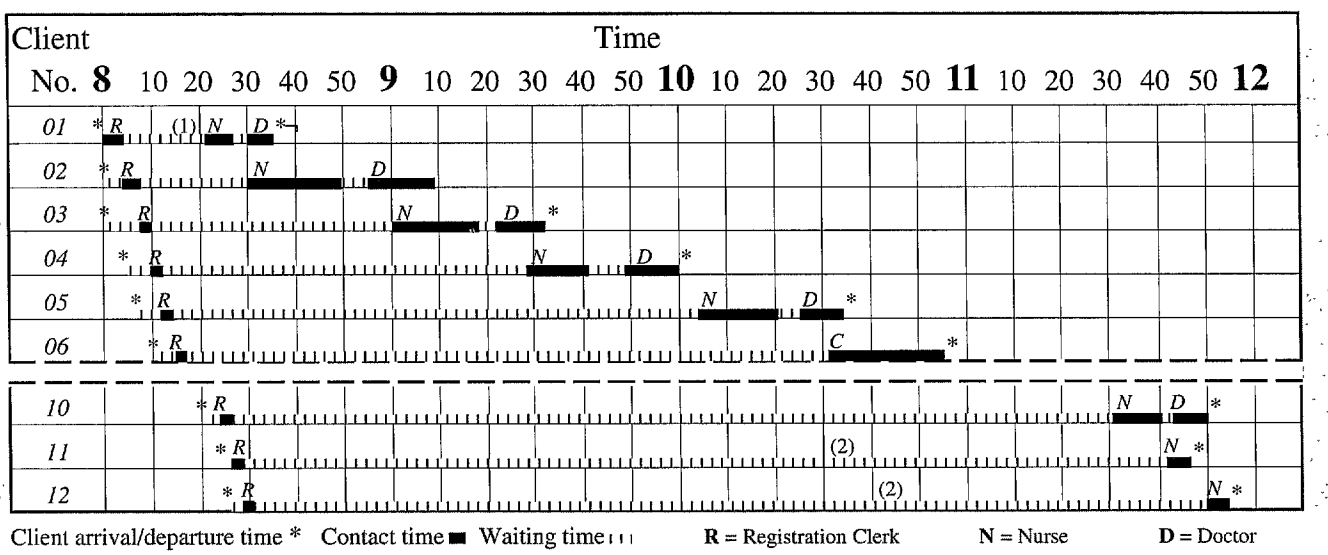
Visit Codes

F = First visit
R = Revisit

Method Codes

J = Injectable
I = Implant
CS = Counseling
O = Non-family planning clients
P = Pill
U = IUD
C = Condom

Graphing and Analyzing Results from Client Flow Forms



Client arrival/departure time * Contact time ■ Waiting time ı ı ı **R** = Registration Clerk **N** = Nurse **D** = Doctor

Analyze the graph as a whole and then line by line to see what patterns you can find. The short vertical marks (ı ı) in this graph show the gaps in clients' contact with staff. In this example, most clients saw the registration clerk, then the nurse, then the doctor. The (1) on the graph shows that the nurse started 22 minutes after the first client arrived. The arrows (¬) show that the doctor had to wait to see each client because the nurse's station created a bottleneck in client flow. The (2)s on the graph show that returning pill users (clients #11 and #12) waited over three hours for less than 10 minutes of service.

Next, use the results of the analysis to set attainable goals, streamline client routes through the clinic, and develop other solutions to reduce your clients' waiting time.

Based on AVSC's adaptation of CDC's Patient Flow Analysis system

Setting Goals for Client Flow

One of the most useful things a manager can do with information from a client flow analysis is to develop with staff some specific client flow objectives for first visits, revisits, and visits involving a physical examination. Be sure to set goals to reduce waiting time that make sense for your clinic.

For example, you might decide that for a first visit the client should:

- be in the clinic for no longer than 80 minutes;
- have no more than 40 minutes of waiting time;
- not wait more than 20 minutes between laboratory and examination;
- not wait more than 10 minutes between examination and checking out.

Try to have clients spend at least 50 percent of their clinic time with your staff and have your staff, as a group, spend at least 65 percent of their time with clients. As you set goals with your staff, review the sequencing of your client routes and discuss other solutions to your clients' waits.

Working Solutions

Staff in Zimbabwe family planning clinics reduced client waiting time for first visits by 32% and for revisits by 38% by making the following inexpensive changes:

- Posting large, clearly marked signs by service stations so that clients would not go to the wrong location and lose their place in the queue.
- Staggering tea and lunch breaks for staff in such a way that services could be provided continuously.
- Developing an appointment system for working clients in urban clinics.

Source: Zimbabwe National Family Planning Council (ZNFPC)

Streamlining Client Routes

In your clinic, how many stops does a new client make in order to receive all the services she needs? What about a continuing client? In some clinics, a new client may make six to ten stops during her visit. Even though some stops may be brief (e.g., stops for measuring weight and height or blood pressure), numerous stops generally increase waiting time.

To streamline client routes, diagram the movement of each type of client through your clinic. Then select from the following strategies:

- **Minimize the number of service stops.** The more stops a client makes, the greater the chance that she will wait, or be taken out of turn.
- **Minimize the number of staff clients see.** Research has shown that in clinics where each client sees only two staff members, for example a counselor and then a mid-level provider, a client's wait is usually shorter than if more staff provide these same functions. Further, clinics where clients are seen by a few staff are usually more cost-effective, and maintain equally high contraceptive continuation rates.
- **Make stops take equal amounts of time.** If you have many short stops such as a one-minute stop for height and weight and a two-minute stop for blood pressure preceding a long stop for the physical examination, you will end up with a bottleneck of clients. Combine the shorter stops into one about the same length as the longer stop.
- **Build fast routes for resupplying clients.** Sort clients as they register to identify people who can be served quickly. Some clinics have separate registration areas for continuing clients. Direct continuing clients seeking condoms and foam to a person who can quickly provide them with the supplies they need. Send clients returning for oral contraceptives to a blood pressure and history station where they can also be given more cycles of pills.

On the next page you will find other suggestions for shortening long waits.

Finding Ways to Shorten Long Waits

For Clinic Managers	Identifying Problems	Solutions
	Do your clients follow inflexible routes through your clinic? For example, does a client route always require that a client pass through registration, social worker counseling, education, physical examination, provision of methods, (payment) and exit, in that order?	Develop alternate routes for different types of clients. Or vary the order of services, such as counseling and education, for times when some staff are occupied with clients and other staff are not busy.
	Do your clients all arrive at the same time, usually before the clinic session begins? Does your clinic turn away clients who arrive later?	Have the registration clerk encourage clients to come during hours when the clinic is less busy. In urban clinics, schedule individual or small block appointments for clients who work or live close by. Keep regular clinic and staff hours so clients do not feel they need to come early in order to be served. Provide temporary methods when you must turn clients away.
	Does each staff member perform only a few specialized tasks? For example, do some staff only measure height and weight?	Combine staff functions and use fewer staff per visit. Train staff to perform multiple functions so less busy staff take on tasks of busy staff to relieve bottlenecks. For example, the counselor helps a clerk with registering or with resupplying pills.
	Do clinic sessions start late? Do contract physicians arrive late? Late starts and long lunch breaks have a multiplier effect. A half-hour delay in starting delays later clients by more than a half-hour.	Make sure staff arrive 15 minutes before the time the first client is to be seen so they can be ready to start on time. Monitor lunch and coffee or tea breaks to make sure they don't extend into clinic time.
	Do office or examining room supplies run out in the middle of a clinic session? Do staff have to search for missing items while clients wait?	Restock treatment rooms at the end of the day. That way clinic sessions can start on time.
For Supervisors		
	What kind of support do your clinic managers need for assessing client flows and making the changes they find are necessary?	Assist with resources for on-site cross-training of staff. Monitor clinics' progress in improving client flow and share results with other clinics. Monitor contraceptive supplies in clinics and warehouses.
	Once local changes are made, are your clinics still missing opportunities to see clients because of staffing or contraceptive shortages, or rigid policies requiring many client revisits?	Communicate with mid- or senior-level management about improvements in client flow at the local level. Ask them to consider changes at their level which will further improve client flow.
For Mid- and Senior-level Managers		
	Can policies be revised to safely reduce the number of visits a client must make for contraceptive checks or supplies?	Reduce numbers of revisits after a client is established in her contraceptive practice. For instance, give out a six-month supply of pills at the time of a second visit.
	Are the number of staff members or number of clinic hours insufficient to handle client loads? Even when staff have been trained to do other staff's tasks, client loads may exceed clinic capacity.	Evaluate possibilities for processing clients more quickly. Assess adequacy of clinic hours or staffing levels.
	Do shortages of medical or office supplies exist at the local level? Do clients have to be turned away without contraceptives?	Improve logistics and inventory systems for supplies.

Wait and Educate

Even in the most efficient clinics, clients will have to wait a short time but you can use this time to benefit your clients. In waiting rooms of family planning clinics or primary health care clinics, you can educate clients about the range of methods available to them. Avoid missing opportunities to provide education and family planning services to those women who come for maternal and child health care.

Effective methods for educating clients include talks, exhibits and posters, and videos and movies.

You can also play tapes of music which present educational messages between songs. For instance, in Tunisia childbirth songs and birth attendants' chants are played in postpartum clinics where mothers receive family planning counseling.

Every ten minutes, messages about breastfeeding, childcare, and family planning are heard.

Whatever the form of the educational program in your waiting room, it should be interesting and provide clients with the information they need to make decisions about the suitability of family planning for their families and about a choice of method.

Also, keep the comfort of waiting clients in mind. Train registration clerks to advise clients about how long their wait will be and to suggest to clients some activities they could do during that time. Train registration clerks to also make sure clients are kept informed if their wait goes over the expected time.

Provide comfortable seating in the waiting area. Leave sanitary facilities open to clients and have a policy which covers how often they should be cleaned. If you can, have a childcare area and a food concession nearby.

Getting Started — Involving Staff in a Client Flow Study

Staff can become very defensive about a client flow study. They may feel they have to be especially quick and efficient when time is being recorded. Therefore how you involve staff in the study will be critical to its success.

- Meet with key staff ahead of time to discuss bothersome aspects of client flow from their perspective. Staff will often complain about "rushing, waiting, then rushing."
- Initiate a discussion to help staff identify the relationship between long waits, clients' satisfaction, and the long-term survival of the clinic.
- Discuss ways of studying client flow problems. Develop and implement a method to acquire data to assess waiting times.
- Examine the data with your staff and develop solutions together, bearing in mind clinic organization, staff training, clinical policies, triage, and client routes.
- Prepare a plan with your staff for improving client flow.
- Monitor and evaluate the effect of the changes.

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Checklist for Reducing Client Waiting Time

For Clinic Managers

- [ ] Review client volume, types of services, and clinic policies and procedures that might affect client waiting time.
- [ ] Help staff become aware of the relationship between waiting time, clients' satisfaction, and the likelihood of the clinic's long-term survival.
- [ ] Work with staff to develop a method for measuring client flow.
- [ ] Measure waiting times by noting times of client arrival and contact with staff.
- [ ] Identify bottlenecks at service stations and gaps in clients' contact with staff.
- [ ] Set attainable goals for the appropriate length of waiting time for each type of client visit.
- [ ] Develop methods to meet these goals. Consider redesigning client routes, training staff to perform multiple functions, and designing fast routes for handling questions and resupplying clients.
- [ ] Monitor the effect of changes with quick assessments. Evaluate waiting times thoroughly at least every six months.
- [ ] Communicate with other clinic managers who are working to reduce client waiting time.

For Supervisors

- [ ] Make certain that contraceptive supplies in clinics and intermediate warehouses are at adequate levels for the number of users.
- [ ] Encourage and provide resources to clinic managers to assess and make changes to improve client flow. Support on-site training of staff.
- [ ] Communicate with mid- or senior-level managers about what the clinics have accomplished and what the rest of the organization still can do to help improve client flow.

For Mid- and Senior-level Managers

- [ ] Support improvements in client flow at clinics by evaluating the need for such changes as revising revisit policies and medical protocols, hiring staff, expanding clinic hours, and improving inventory systems.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Mrs. Manumbu's Wait: A Case for Reducing Client Waiting Time

Bright sunshine blinded Mrs. Manumbu as she left the registration area and headed towards the only source of shade where she could still hear her name called. The tree was surrounded by at least 35 other women and children. The more experienced women sat on mats they had brought with them, while the newcomers sat on the ground. The group chatted amiably and stretched out their stories and rumors to make them last as long as the wait ahead of them.

Because it was her first trip to the family planning clinic, Mrs. Manumbu did not know about the long, uncomfortable waits. Her eyes scanned the crowd for a neighbor who might let her and her five-week old son share a mat. Mrs. Saba, a good friend, said Mrs. Manumbu could join her, but she hoped to be called in to see the nurse soon. She had been waiting since the clinic opened at 8:00 am. It was now 10:00 am.

Mrs. Manumbu sat down and began to listen to a story Mrs. Kaguna was telling, ". . . and then, after waiting for three hours, the nurse told me I would have to come back tomorrow because they had too many people who wanted to see the doctor! All I wanted was a new supply of pills."

Mrs. Saba shook her head, "And you have to walk so far!"

"It's not the walk that bothers me," lamented Mrs. Kaguna, "so much as leaving my children alone. Keela, the oldest, is only nine."

Mrs. Manumbu thought about her own children whom she had left to fend for themselves. Would she have to spend three hours waiting to see the doctor? She had an hour's walk home and most of her daily chores waiting for her when she got there. She desperately wanted to get some counseling and learn how to keep from having another baby too soon. She and her husband had three children already and they were struggling to save enough money to buy a cow next year. She knew she had to wait until her name was called, but did it have to take up so much of her day?

Case Discussion Questions: Mrs. Manumbu's Wait

1. **Describe the characteristics of waiting at this clinic which could discourage Mrs. Manumbu from family planning.**
2. **What are some things this clinic might consider to improve the waiting situation?**
3. **What programs could mid- and senior-level managers introduce to reduce long client waits at this clinic? What policies could they change?**

Case Analysis: Mrs. Manumbu's Wait

1. Describe the characteristics of waiting at this clinic which could discourage Mrs. Manumbu from family planning.

Mrs. Manumbu could be discouraged from family planning by:

- the discomfort of the seating which she must tolerate for a long time;
- the long exposure to extreme weather;
- having to leave her young children alone;
- the length of time she will spend waiting during which she cannot take care of other responsibilities;
- uncertainty about whether she will be seen by a doctor that day because there are so many clients ahead of her;
- her long walk to and from the clinic;
- the discouraging experiences and rumors she hears.

2. What are some things this clinic might consider to improve the waiting situation?

The clinic could provide:

- benches;
- protection from sun and rain;
- childcare or earlier or later clinic hours so women can come when children can be watched or when chores are done;
- a food concession;
- educational sessions during clients' waits;
- transportation to the clinic if it would be welcomed by the clients; alternatively, the clinic could be relocated near a bus route;
- appointments and fast routes for resupplying contraceptives in order to improve client flow;
- a registration clerk who keeps clients informed about how long their wait will be;
- a clinic policy which allows only the clients who can be seen that day to wait, and schedules an appointment for other clients to come back another day. The clinic should give a temporary method to the clients who need to come back.

The clinic manager could also develop a method for analyzing client flow and make operational changes to reduce waiting time.

3. What programs could mid- and senior-level managers introduce to reduce long client waits at this clinic? What policies could they change?

Mid- and senior-level managers could initiate a community-based service delivery program in villages to resupply continuing family planning clients who use pills and condoms so that these clients don't have to travel so far.

They could support a triage policy which limits the types of clients who must be seen by a doctor.

They could institute higher level training for nurses to take on more medical functions.

CHAPTER TEN

Using Service Data: Tools for Taking Action

Family planning managers need a simple information system to help them monitor, improve, and expand services. Creating a practical decision-making system for the local level of a family planning program requires the participation of managers at all levels of the program.

This issue of *The Family Planning Manager* focuses on analyzing service data, making decisions, and taking action to improve your program. It provides clinic managers and their supervisors with simple monitoring techniques and decision-making methods, using client data common to most family planning clinics. It shows how managers can use the process of graphing, interpreting, and taking action on data as a powerful management tool to strengthen program performance.

Included in this chapter is a supplement, *Guide to Graphing Data and Taking Action*, a step-by-step guide to presenting data graphically and to interpreting and using the data to improve your program.

This chapter was originally produced as Volume I, Number 2 of ***The Family Planning Manager****, including the supplement, "Guide to Graphing Data and Taking Action," and the case scenario, "Mrs. Obi's New Acceptors: A Case for Analyzing Service Summaries." The guest editors for the issue were Robert Timmons and Mike Egboh.*

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Developing Local Data Systems for Decision Making

Does your clinic serve increasing numbers of new family planning acceptors each month? Are your new acceptors given a choice of the contraceptive methods most suitable to their needs? Is your community learning about family planning services so that they may benefit from them? The data you collect in your program should be used to answer such questions about your family planning services, so that you can then make the needed improvements.

Data Flow in Organizations. Because delays in receiving information back from central and regional offices can be expected, managers must develop a system to use the data they collect as they collect it. As a clinic manager, you cannot wait for senior managers or supervisors to analyze your data. If you want to make decisions quickly, you need to develop a system to regularly review your own program data and take timely informed action.

Local Decision Making in Organizations. It takes commitment from mid- and senior-level managers to encourage local decision-making which functions as an integral part of a program when decisions are often made at central levels. A principal advantage of local decision making is that services can be monitored and modified in ways that are more timely and responsive to client needs. In order to create an environment for local decision making, as in the "Model for Using Information to Make Decisions," on the next page, service delivery managers will need encouragement and support from their supervisors and senior managers. This support includes 1) simplifying local data collection so that only useful data are collected, 2) training staff in collecting, analyzing, and using data, and 3) developing a simple system in which managers can regularly communicate their analyses, decisions, and actions, and receive timely feedback.

Information Sharing at Each Organizational Level. The model also shows how managers at each level can share data and decisions with other managers and take action to assist each other. When decisions are being made at each level within an organization or program, active communication among all levels is essential. For example, managers at the service delivery level can share information with managers at the regional level. Both regional and central level managers may use data, make decisions, and take actions that affect the service delivery level. All their decisions in such areas as policy, planning, finances, logistics, quality control, and supervision must be communicated clearly to all levels so that appropriate action can be taken at the appropriate level.

A Model for Using Information to Make Decisions

At every level of a program, managers should go through a process of using information to make decisions. The steps in this process are:

Collecting Data - Gathering numerical and descriptive facts from client records, activity registers, financial and commodity reports, surveys, and other sources.

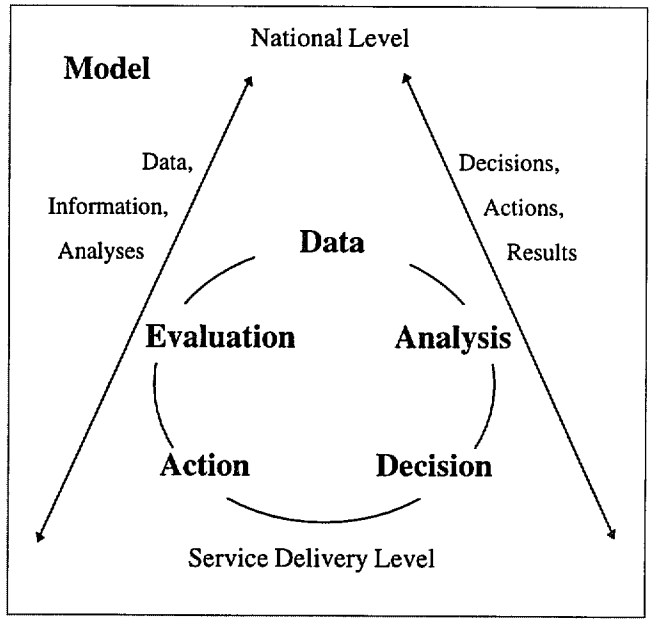
Performing Analysis - Interpreting and organizing data (in graphs, tables, etc.) to identify patterns and determine explanations for the patterns.

Making Decisions - Using data analysis to determine that 1) services are operating well and require no change, 2) services are operating well but can be improved through increasing support, or 3) services have problems that require specific strategies for removing constraints or providing support.

If a decision requires the cooperation of other staff to implement it, then the decision making step includes communicating to staff what the data analyses show and reaching agreement with staff on a plan of action.

Taking Action - Performing tasks according to the agreed-on plan.

Conducting Evaluations - Measuring periodically the progress towards achievement of program objectives (both qualitatively and quantitatively). An evaluation will show whether and to what extent the desired results are being achieved and examines the effectiveness and impact of program activities.



The flow of data and decisions to all levels of the program provides the basis for creating effective communication and feedback.

Data, Information, and Analyses are continually generated at every level of the program and passed to other administrative levels to provide both information and feedback on program performance.

Decisions, Actions, and Results, whether positive or negative, are communicated both upward and downward to all levels within the program.

Collecting Service Data

Clinic managers need to monitor data on both client visits and contraceptive supplies.

Client Data. Programs collect several types of client data. It is important to know whether the client is a new acceptor or a continuing user. New acceptors are typically defined as new users of contraceptives or new clients to the clinic. Upon the clients' return to the clinic, they are recorded as continuing users or as revisits. Programs often have strict definitions for new or continuing users or revisits. It is important to know and to use the appropriate definitions. After each visit, the type of contraceptive method a client selects and the quantity dispensed are always recorded. New acceptors can be asked how they learned of a clinic's family planning services. Some clinics also track clients who have stopped coming to the clinic and send outreach workers to the clients' homes to follow up. If these clients are determined to be dropouts, their records are placed in a file for inactive clients.

Contraceptive Supply Data. Clinics must maintain a sufficient inventory of unexpired contraceptive supplies. To do so, staff must record the commodities dispensed to clients, forecast their need for more supplies, and request the appropriate quantities of contraceptives from the warehouse.

Basic Clinic Forms

Family Planning Client Record - Completed for each client and includes (at a minimum) name, address, sex, age, parity, reproductive health history, and contraceptive method used. This medical record is kept at the clinic and is updated by the staff each time a client returns. It is also useful to record how the client learned of your services.

Client Referral Card - Given to a potential client who wants or needs services that your clinic does not provide and who is referred to another service facility. The card gives the address and directions to the appropriate service facility.

Appointment Card - Given to the client to remind her of the date of her next appointment.

Complication Card - Used to record any complications a client has with a contraceptive method. Information from this card is also recorded on the **Family Planning Client Record**. By using this card to compile data on complications by method, a clinic can identify needs for training staff in better techniques for taking client histories and for dispensing contraceptives.

Daily Family Planning Activity Register - Used to record visits (for both new acceptors and revisits) and the quantity of contraceptives dispensed. The number of client visits and contraceptives dispensed should be totaled daily.

Family Planning Activities Worksheet - Used in busy clinics (200 or more family planning clients per month) as an intermediary form between the **Daily Family Planning Activity Register** and the **Monthly Summary of Family Planning Activities**. The totals from the Activity Registers are transferred to the Activities Worksheet each day. Then they are totaled for the month, and transferred to the **Monthly Summary of Family Planning Activities**.

Monthly Summary of Family Planning Activities (see example, page 251) - Used to record the monthly totals for all the data on the **Daily Family Planning Activities Records.** The clinic manager keeps one copy and another copy is sent to the program supervisor who aggregates the monthly data for all the clinics in the district.

Commodities Request/Receipt Form - Used to maintain an unexpired supply of contraceptives at the clinic. It contains information on the quantities of contraceptives received, dispensed, and on hand at the end of the month. It is also used for computing the quantities of contraceptives needed for resupply. It is filled out on a monthly or quarterly basis, depending on the clinic's storage capacity and the level of demand for contraceptives.

Using Service Data

The data you routinely collect can be used to learn more about your clients, the kinds of contraceptives they request, and the sources of information that encourage them to seek your services.

Uses of New Acceptor and Revisit Data. Most family planning programs are interested in data on their new acceptors. An analysis of new acceptor data can show whether a family planning program is becoming more popular and whether it is achieving its program objectives, one of which could be (for example) to increase the number of new family planning acceptors by a certain percent per year.

Programs can also use data on continuing users to get a picture of the continuity of contraceptive use, which may also reflect the quality of the services. However, data on continuing users may be difficult to interpret. For example, in a community with many contraceptive distribution sites, decreasing numbers of revisits in a clinic may indicate that clients have gone elsewhere to obtain their contraceptives, rather than that they have stopped using contraceptives altogether. A clinic manager won't know which interpretation is correct unless he or she can get information by contacting clients who have stopped coming to the clinic.

Focus on New Acceptors. This chapter focuses on using new acceptor data, but the concepts and techniques described can be used to analyze trends in continuing clients as well, including their choice of contraceptive method and sources of information about family planning services.

Family planning programs define new acceptors differently. One program may define new acceptors as clients who *visit a program or clinic for the first time.* Another program may define new acceptors as clients who *are given a contraceptive for the first time.* Whatever definition of new acceptor your program uses, you can still apply the following suggestions for presenting and analyzing your data.

Presenting clinic data in graphic form can give you a good picture of your clinic's performance. A graph that depicts trends of new acceptors at your clinic can show you how well your program is continuing to expand. You can also graph and use information on contraceptive method mix and on how your clients learned of your services.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On performance targets . . . *One reviewer suggested that this chapter could have said more about the connection between data analysis and performance targets.* "Service data can be analyzed monthly at all levels of family planning organizations and compared with the targets for each level to determine if performance objectives have been achieved. Actual numbers of clients served can be graphed (in contrasting colors or patterns) on a bar chart next to the target number of clients. Review of performance through bar graphs can help to identify clinics which need support in solving problems."

On continuing users . . . *Reviewers mentioned the importance of analyzing data on continuing users.* "Concentrating on new acceptors is important because it is an easy and cost-effective way to assess program performance in emerging programs and programs with large numbers of potential clients. However, mature programs should also focus on continuing user data in order to look at the quality as well as the expansion of their services. To track continuing users and the methods they select, managers can first analyze their data on revisits."

On dropouts . . . *Many reviewers commented about the importance of using information on dropouts.* "Collecting and using data on dropouts on a continuing basis is difficult because data that describes them is usually obtained from the medical record and is difficult to extract. In communities where people often move, it can also be costly and sometimes impossible to follow up clients who are no longer coming to a clinic. *Several reviewers felt that* "Each program needs to develop its own way of collecting summary data on dropouts and following up on clients who have left the program." (For more information on discontinuation, see Chapter Fourteen.)

On decision making . . . *Several reviewers noted that well-organized local information systems could be used to motivate staff.* "Clinic managers and service providers derive satisfaction from evaluating what is happening in their clinic and making changes themselves, before their supervisor points out what they need to change. Supervisors who praise their clinic managers for submitting their monthly summaries on time are using effective nonfinancial means to motivate their staff. These unexpected benefits of collecting, analyzing, using, and transmitting data are extremely satisfying."

Continued on page 255

Conducting Staff Training

To manage information well, all staff members need to understand how the system works, how it can be used to improve clinic services, and what tasks the staff members need to perform. You can do this by conducting staff training in data collection and analysis.

Increase Staff Awareness. Review organizational objectives for your clinic's performance with your staff and explain the process of collecting and analyzing data, making decisions, and taking action. It is important for your staff to understand how the data they collect can be used to benefit their clients and achieve clinic performance objectives. That way, they are more likely to enter data correctly and legibly on clinic forms. They are also more likely to be interested in what the information means.

Train in Data Collection. Hold on-the-job staff training on data collection. Emphasize data that are often incorrectly recorded. Provide staff with training guides that they can refer to for complicated data entries and show them how to use the guides. Make sure that staff understand why each category of data is important and how they will be used to analyze the quality of your services.

Before you train your staff, review your data collection forms to make sure they contain the data you need for making decisions. Discuss with your supervisor ways to simplify the forms so that you only collect useful data. When a form is revised, go over the new form with staff.

Train in Data Analysis. Train your staff in how to prepare and analyze graphs. Interpret graphs of your clinic's performance with your staff and get their ideas for appropriate actions. Implement these actions as a team. If you take the above steps, staff will be able to see the connection between collecting and analyzing data, making decisions, and taking action. They will also understand how using information can improve the performance of the clinic.

Monitoring Clinic Performance Using New Acceptor Data

Monitoring Clinic Performance. You can assess your clinic's performance by checking to see whether there has been a steady flow of new acceptors and continuing clients to your clinic each month, whether clients are choosing effective contraceptive methods, and how they are learning of your services. If your clinic staff regularly complete daily records on your clients and total these records on the monthly summary form, *it will only take a short time to monitor the performance of your family planning program.* After you have collected this information, you will need to present it in graph form, analyze it, and then make decisions and take action based on the results of your analysis.

Seeing Patterns in Client Data. When you introduce family planning services into a community or conduct an information campaign about family planning, you will probably have an increase in the number of new clients coming to your clinic. Eventually, as everyone who is interested in family planning begins to use contraceptives, the number of new clients may begin to decrease while the number of continuing clients will hopefully continue to increase. Because there will always be young people entering their reproductive years who will be seeking family planning services, you should always have a flow of new clients. By presenting the data in a graphic form, you will more easily be able to see the patterns in your clinic's new (and continuing) clients and their contraceptive practice, as well as the effects of your information, education, and communication (IEC) campaigns.

Summarizing New Acceptor Data

The monthly summary form of family planning activities can give you all the basic data you need to analyze the trend in new acceptors at your clinic. In the sample monthly summary on the next page, the new acceptor data are found in sections A and D. Data for this summary are compiled from daily family planning activity registers.

Total of New Acceptors. Monthly summaries usually show the total number of new acceptors for a month. In the sample form under the column labeled "No. (Number) of Visits" and in the row marked "A. New Acceptors," the sum total of all new acceptors has been recorded.

Methods Used by New Acceptors. The monthly summary should contain information on the total number of new acceptors for each contraceptive method. In the sample form, the methods offered by the clinic are noted at the top of each column. Here, eight new acceptors received Lo-Femenal pills, and twelve received Micro-Gynon pills, etc. Row C shows the total number of each type of pill cycle that was dispensed to both new acceptors and revisits.

Information Sources Among New Acceptors. The monthly summary may also indicate how new acceptors learned about your clinic's family planning services. In the sample form, this information is recorded in the box labeled "D. Sources of Information Among New Acceptors." In this example, one source of information for each new acceptor was recorded. Therefore, the numbers in this box total 72, which matches the total number of new acceptors for the month.

How to . . .

Strengthen Data Analysis Using Additional Information

Consider:

- **External environment** such as national laws or policies (promoting or restricting family planning), donor support and supplies, increase or reduction in the number of distribution outlets.
- **Internal environment** in your program such as staffing, training, contraceptive stockouts, introduction of a new method, IEC campaigns, changes in organization or management of a clinic or a program.
- **Client characteristics** such as age, number of pregnancies, literacy rates, incidence of sexually transmitted diseases (STD), preference for spacing births or for ending reproduction.
- **Random variations** in the data. Small month-to-month variations may be insignificant and should be disregarded.

Sample Monthly Summary of Family Planning Activities

Total number of New Acceptors, includes all contraceptive methods

Total visits for all clients

Total number of New Acceptors of Copper T IUDs

	No. of Visits	Orals				Injections		Implants		IUDs		Barriers		VSC	Other
		Lo-Femenal	Micro-Gynon	Neo-Gynon	Other	Depo-Provera	Noris-terat	Nor-plant	Other	Copper T	Other	Foam Tablet	Condoms	Tubal Ster	
A. New Acceptors	72	8	12	4	0	6		2		5	0	7	26	2	0
B. Revisits	119	27	4	3	3	13		11		10	3	17	27	0	1
Total Visits = A + B	191	35	16	7	3	19		13		15	3	24	53	2	1
Commodities Beginning Balance (a)		604	120	160		19		65		200	0	1,300	5,654		
Amount Received (b)								24							
C Quantity Dispensed (c)		89	24	13		19		2		5	0	640	1,112		
Ending Balance (a + b - c = d) (d)		515	96	147		0		87		195	0	660	4,542		

D. Sources of Information of New Acceptors

Codes and Totals

Program clinic personnel	CP	17
Program outreach personnel	OP	0
Radio	RD	6
Television	TV	2
Print media	PM	2
Friend, relative	FR	21
Other clinic	OC	6
Community health worker	CH	8
Other	OT	0
No response	NR	10

E. Other Client Methods

Diaphragm	DP	
Rhythm, Natural	RN	
Vasectomy	VA	1
Other	OT	

Number of condoms available at the beginning of the month

Number of Copper T IUDs remaining in supply for the next month

Number of vasectomies performed

Total of New Acceptors who said they learned about the clinic's family planning services from a community health worker

Number of Lo-Femenol cycles dispensed

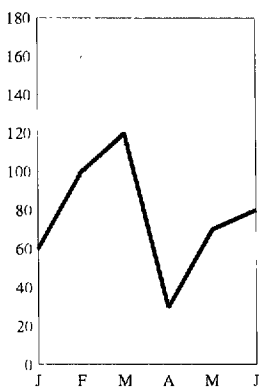
Total Norplant implants received from ware-house shipments that month

Analyzing New Acceptor Trends

Data presented in graphic form can be more easily interpreted and used to identify appropriate actions for improving service delivery. To know if your clinic is attracting a steady flow of new acceptors, examine the trend in new acceptors over several months. The best way to see a trend is to plot the total number of new acceptors each month on a line graph.

A line graph will clearly show whether the number of your new acceptors is increasing, decreasing, remaining stable, or fluctuating significantly from month to month.

Below are two different line graphs presenting new acceptor data, and interpretations of these graphs. You will also find some suggested actions that a clinic manager could take to help the trend in new acceptors make a sustained upward turn.

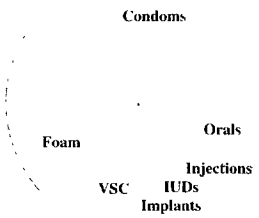
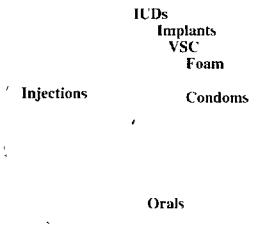
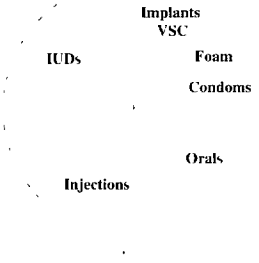
	Possible Interpretations	Possible Actions to Take
Why was there a steady increase in new acceptors followed by a gradual decline over the last three months?	Potential clients may not have learned of your family planning services. Long waiting times or other factors at your clinic have led to clients complaining to friends, relatives, and neighbors. Clients have not received good counseling, which has led to clients complaining to friends, relatives, and neighbors. Charges for services have been introduced which has made them less affordable for some families in the area. Competition from pharmacies, other clinics, or market vendors is cutting into your area's share of potential clients. Medical complications associated with IUD insertions, pill use, injections, or implants may have led to clients complaining to friends, relatives, and neighbors, thus discouraging potential new acceptors from seeking family planning services.	Conduct a promotional campaign in the surrounding communities. Conduct a survey to see why people have stopped coming before assuming it's due to long client waits. Interview clients and dropouts to determine whether they received good counseling on contraceptive methods. Interview clients and dropouts about whether your services are affordable, and evaluate the costs of services and commodities in other local outlets. Find out whether and why clients are going elsewhere by conducting a survey in your community. Evaluate the number of complications from IUD insertions, pill use, and other methods.
 **Why was there a steady increase in new acceptors followed by a drastic decrease and another rise?**	The increase could have been caused by mistakenly counting recipients of contraceptives during promotional campaigns as new acceptors. The decrease could have been caused by misinformation and bad rumors about family planning circulating in the community. The decrease could have been due to community health workers running out of IEC materials to distribute to the community.	Retrain clinic staff on the uses of the client and service records; develop separate recording forms for promotional campaigns. Determine whether there are bad rumors circulating in the community and launch an IEC campaign to dispel the rumors. Make sure that community health workers have a constant supply of IEC materials.

Analyzing Contraceptive Method Mix

One way to compare the use of contraceptive methods among new acceptors is to draw a pie chart to show the methods your new acceptors are choosing (method mix) in relative proportions. It may also indicate how well clients are being counseled on all the available methods.

National or local data for your country may be available which will allow you to look at your clinic's method mix in the context of cultural values, client practices, and specific client characteristics and preferences. Consider these factors when trying to determine the desirable method mix of new acceptors for your clinic. The three pie charts below represent different method mixes using monthly summary data on new acceptors. The interpretations and suggested actions may be helpful in improving the method mix in your clinic.

Draw a pie chart, using monthly summary data, at least once every 3 months to monitor how your actions are changing the method mix.

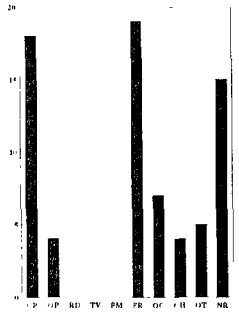
	Possible Interpretations	Possible Actions to Take
 **Why do condoms, orals, and foam account for the majority of contraceptive use?**	Stockouts of IUDs and injectables have caused prospective clients to be turned away. Service providers have not received clinical training for IUD insertions or surgical procedures. Medical equipment for IUD insertions or surgical procedures may be damaged or unavailable. Counseling has been biased toward more familiar, non-prescription methods.	Evaluate commodities inventories over the past six months for evidence of stock outs or expired goods. Work with your supervisor to obtain clinical training for staff. Inventory clinic equipment and request replacement of any damaged equipment. Interview clients and dropouts to determine whether they received good counseling on contraceptive methods.
 **Why are orals and injectables so popular, but condom and IUD use is so low?**	Stockouts of IUDs have caused prospective clients to be turned away. Service providers have not received training in IUD insertions. Counseling has been biased in favor of pill and injectable use.	Evaluate commodities inventories over the past six months for evidence of stock outs or expired IUDs. Evaluate the number and types of complications from IUD insertions. Interview clients and dropouts about their first visit to the clinic to determine whether they received good counseling on contraceptive methods.
 **Why is there a more even distribution of the more effective methods?**	The community is becoming more knowledgeable about the benefits of modern contraceptive methods. The clinic is regularly providing a full range of contraceptives but implants are still experimental. Potential clients are being counseled on the relative benefits of all methods.	Make sure that the increase in more effective methods is not a result of declining use of other methods. Identify and report to your supervisor significant events such as promotional campaigns, that may have contributed to favorable changes. Successes should be replicated.

Analyzing Sources of Information

Changes in the numbers of new acceptors coming to your clinic may be strongly affected by your IEC efforts. A good way to see not only how new acceptors are learning of your services, but also the effectiveness your IEC campaign, is to draw a bar chart to show how your new acceptors learned of your family planning services. You can quickly see which sources of information in your community are the most helpful in attracting new clients and whether, for example, radio advertising more helpful in attracting new clients than printed materials.

Below are two bar charts and their possible interpretations, along with some suggested actions a clinic manager could take to more effectively promote his or her clinic's family planning services.

Draw a bar chart, using monthly summary data, at least once every three months to monitor the effectiveness of your IEC campaigns.

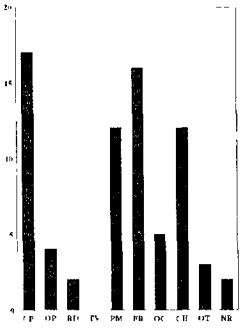


Why have friends and clinic personnel been so successful in reaching new clients but the radio, television, and printed materials have not been successful?

Possible Interpretations	Possible Actions to Take
Providers of other health services at the clinic are informing clients of your family planning services.	Thank clinic health providers for referring potential clients to the clinic and ask them to continue their good efforts.
New acceptors are pleased with the clinics services and reporting favorably to their community.	Motivate family planning service providers to continue providing high quality services.
Radio, television, and print media are not available or no IEC campaigns have been programmed.	Evaluate radio, television, and print media as potential vehicles for IEC campaigns.
Community health workers are not being effective in promoting family planning.	Provide training to community health workers to familiarize them with clinic services.

Codes used:

CP = Program clinic personnel	OP = Program outreach personnel
RD = Radio	TV = Television
PM = Print Media	FR = Friend, relative
OC = Other clinic	CH = Community health worker
OT = Other	NR = No response



Comparing this graph with the top graph, what programmatic changes may have been implemented to make it show that printed materials and community health workers are being more successful in reaching new clients?

New acceptors are pleased with the clinic's services and reporting favorably to their community.	Congratulate family planning service providers for providing high quality services to motivate them to continue.
Providers of other health services at the clinic are informing clients of your family planning services.	Motivate clinic health providers to continue referring potential clients to the clinic.
Community health workers are reaching new acceptors.	Motivate community health workers to continue promoting the benefits of family planning, and give them materials and resources to do so.
Radio advertising has not been effective in reaching potential new clients.	Evaluate the radio messages in your IEC campaign and make changes to increase the effectiveness of your advertising.
A poster, pamphlet, and logo campaign has been successful in attracting new acceptors.	Identify promotional campaigns and advertising that may have contributed to favorable changes and report them to your supervisor. Successes should be replicated.

Working Solutions—Thailand

Analysis in Action

In Thailand, a non-governmental family planning program has developed a simple and practical way for clinics to use information from their client cards to learn more about their clients and improve services. Each client coming to the clinic for the first time is issued a client card, which contains information that includes the client's age, number of living children, desire for additional children, and ever-use of contraceptives. The client card is updated at each visit.

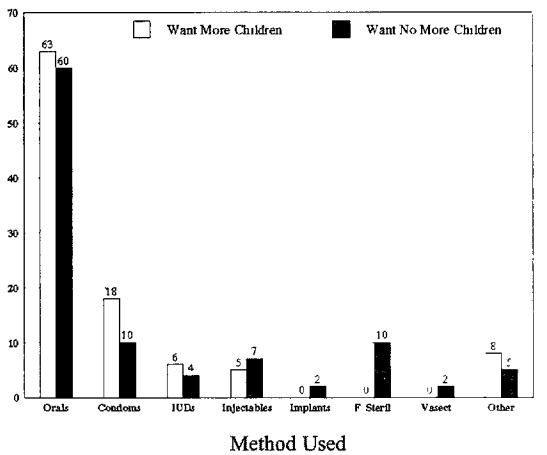
Here is an example of how a clinic manager and supervisor graphed, interpreted, and used data to better meet the contraceptive needs of their clients who did not want anymore children.

Using information from the client card, these managers compared the contraceptive method breakdown of those clients who no longer wanted more children with those that still desired children. The expectation (though not the rule) is that clients who do not want more children may prefer longer term methods such as the IUD or permanent methods such as sterilization. Clients who plan to have more children would probably use a temporary method such as the condom or the oral pill.

The graph shows that there was no difference in choice of contraceptive method between those clients who wanted no more children and those which did. From examining this graph, the manager and the supervisor realized that a large proportion of the clients who did not want more children were using temporary methods such as condoms and pills. As a result, they decided to provide more counseling on long-term methods and strengthen the clinic's system for referring clients to the government hospital for sterilization services.

Graphs which present service data from basic clinic forms are routinely displayed on the wall of the clinic so that staff can see and discuss their clinic's performance.

Comparison of Methods Used Among Couples who Want No More Children and Couples who Want More Children



Reviewers' Corner *continued*

From Ideas to Action

Setting up a System . . .

One reviewer suggested the following steps for setting up a system to use service data in local decision making:

1) Review the basic forms for collecting clinic data;
2) Review the use of service data for client benefit and for improving services;
3) Retrain clinic level staff in collecting, processing, and interpreting service data for improving services;
4) Emphasize the importance of monitoring trends;
5) Hold semi-annual or annual seminar for senior managers to review clinic performance and give feedback to the service delivery level.

Using Data in Performance Review . . .

The whole information system can strengthen performance review. One reviewer writes: "I will encourage my clinic managers to analyze the data they collect at their level. They have been collecting service data for onward transmission to our national headquarters without taking time to evaluate these three important areas of family planning client data: new acceptors, method mix, and source of information. By developing this approach of using information collected at the local level, clinic managers and staff will be able to review clinic performance and stay better informed about their own situation."

Checklist for Using Service Data

For Clinic Managers

- [ ] Decide what information you will be collecting, analyzing, and using at your level, such as new acceptors, revisits, method mix, or how your clients learned of your services.
- [ ] Decide how (and how often) you will present, analyze, and take action on the data that you have selected to use.
- [ ] Involve supervisors in the development of your plan and conduct staff training in data collection and analysis.
- [ ] Discuss with your staff what actions should be taken to maintain or improve acceptance of your family planning services and your method mix. Select actions and implement them.
- [ ] Evaluate the effect of your actions by totaling, graphing, and analyzing your data monthly.
- [ ] Forward copies of your service summaries, graphs, and analyses each month to your supervisor. Let your supervisor know the actions you are taking and indicate what kind of support you need from them.

For Supervisors

- [ ] Review each clinic's service summaries and graphs, or encourage managers to create them if they currently don't do so.
- [ ] Provide regular feedback by discussing decisions and setting priorities with your staff.
- [ ] Discuss with your clinic managers what actions they might take and what support they need that would help them to improve the performance of their clinics. Consider incorporating these discussions into your supervisory visits.

For Mid- and Senior-level Managers

- [ ] Clarify the procedures for data collection, analysis, presentation, and use of information.
- [ ] Review and simplify data collection forms.
- [ ] Monitor and support clinic decisions and actions, and support clinic growth with IEC materials and campaigns and contraceptive supplies.
- [ ] Program occasional site visits to evaluate the effectiveness of your information system.

Guide to Graphing Data and Taking Action

This guide contains instructions for making three graphs that will help you analyze and use the data that you collect in your family planning program. Below is a summary of the guide. It indicates the service data you will need to collect in order to make the graphs, and suggests ways in which you can use the graphs to make decisions about improving your family planning program.

- The ***first*** graph will allow you to monitor new acceptor trends.
- The ***second*** will provide information about your clients' choice of a contraceptive method.
- The ***third*** will tell you how your new acceptors learned of your family planning services.

Graph N° 1: Trend Analysis of New Acceptors

Data Required: Monthly summaries showing the number of new acceptors served by your clinic. If you summarize your records quarterly you can follow your clinic's performance by plotting the quarterly summary data on your graph instead of monthly data.

Interpretation and Use: This graph will show you the trend in new acceptors in your clinic—whether there has been an increase, decrease, or variation in the trend over a period of time. The graph can also be used to evaluate a trend in new acceptors for each contraceptive method you offer, by drawing a line for each method on the same graph and updating the graph each month.

Once you identify these trends in your clinic, you will know better what actions to take to change the trends and move toward achieving your program goals.

Graph N° 2: Method Mix of New Acceptors

Data Required: Monthly summaries of the methods chosen by the new acceptors in your clinic.

Interpretation and Use: After completing this graph, you will be able to easily compare the relative popularity of contraceptive methods chosen by your new acceptors. Knowing this will enable you to take actions which might include expanding the choices of contraceptives available to your clients and reinforcing or adding counseling activities to serve your clients better.

Graph N° 3: Sources of Information Among New Acceptors

Data Required: Data on how new acceptors learned of your clinic's family planning services.

Interpretation and Use: This graph will allow you to evaluate how new acceptors learned of your family planning services. Using this information, you can develop strategies to strengthen information, Eeducation, and communication (IEC) activities in your community, which will help you attract potential acceptors to your clinic.

This guide will help you monitor your program's performance and improve your family planning services

How to . . .

Draw a Line Graph—to show the trend in new acceptors at your clinic

Step #1. Label the small boxes below the horizontal line on the blank graph to correspond to the months of data that your graph will represent. There are 18 boxes, so your graph will show a trend of new acceptors covering a period of 18 months. *In the example below, data on new acceptors have been given for the period January - December 1991. Thus, the horizontal line on the graph is labeled to correspond to data from the monthly summary: "J" (for January) "F" (for February), and so on.*

Step #2. Starting at zero in the lower left corner, label the marks on the far left vertical line in increments of 5, 10, 20, or 100. The numbers on the vertical line represent the number of new acceptors. Choose a scale that will accommodate the largest number of new acceptors your clinic has had in a month, or might expect to have in the near future. *In the example below, the largest number of new acceptors the Yena clinic has had over the past 12 months is 101. The graph has been labeled up to 120 (in increments of 10) in order to accommodate an increase in new acceptors.*

Step #3. Plot the total number of new acceptors from each monthly summary that you have collected over the past 10-12 months. For each month, put a dot on the graph to show the total number of new acceptors for each month of the period your graph will cover. *In the example, a dot was marked on the vertical line at 89 (above "J"). Next a dot was made at 91 on the vertical line (above "F") and so on until all the data on new acceptors from the previous year were plotted on the graph.*

Step #4. Connect all the dots that you have plotted on the graph. This line will show the trend in the number of new acceptors over the past 12 months. Next month you only need to make a dot showing the total number of new acceptors for that month and then connect it to the previous month's dot. Continue to do the same for each month to monitor the trend of new acceptors and to see whether any changes you make have an effect on this trend.

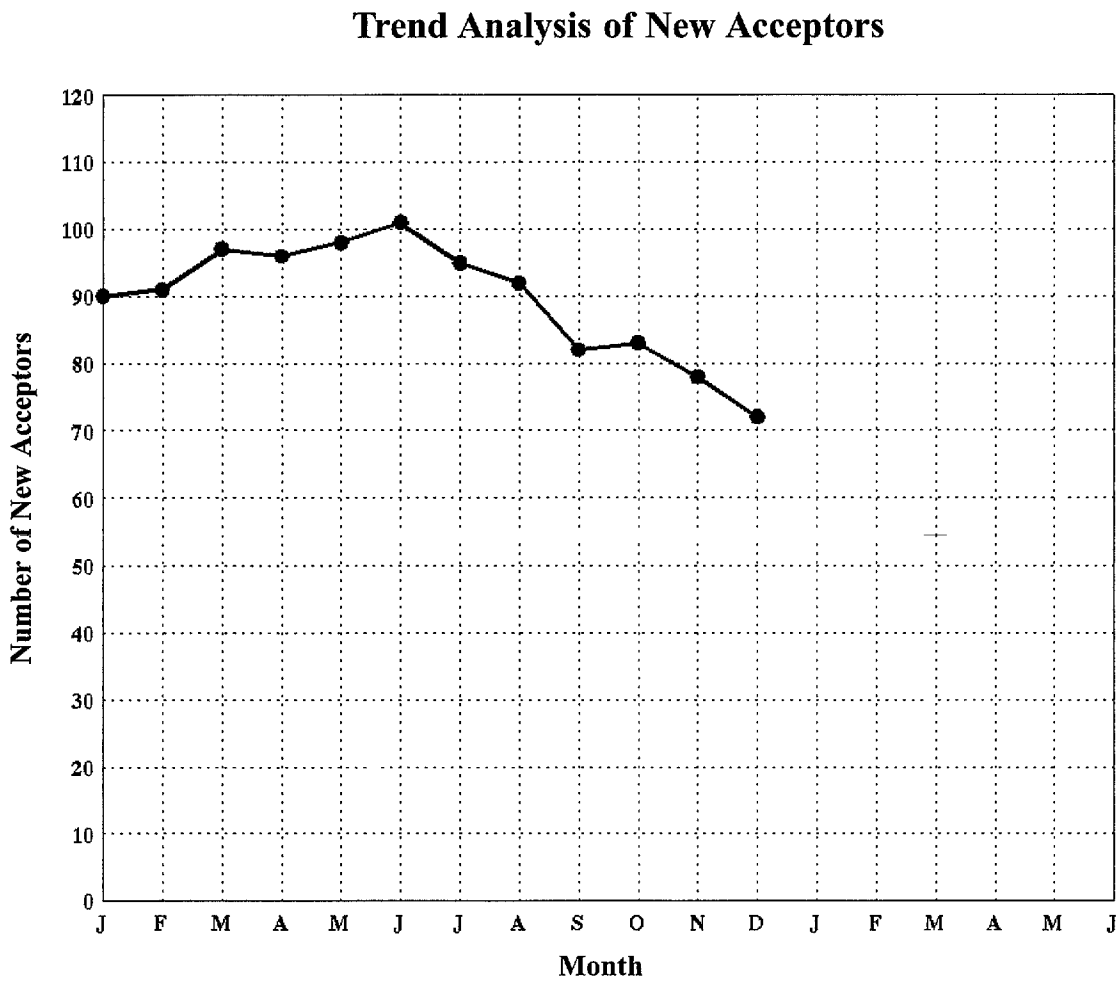
Example: How to Analyze the Trend in New Acceptors

In this example, the data listed represents data on new acceptors that were collected in the Yena clinic over a 12-month period.

Data: Number of new acceptors: Yena Clinic - 1991

January	89	May	98	September	82
February	91	June	101	October	83
March	97	July	95	November	77
April	96	August	92	December	72

Example: Line Graph

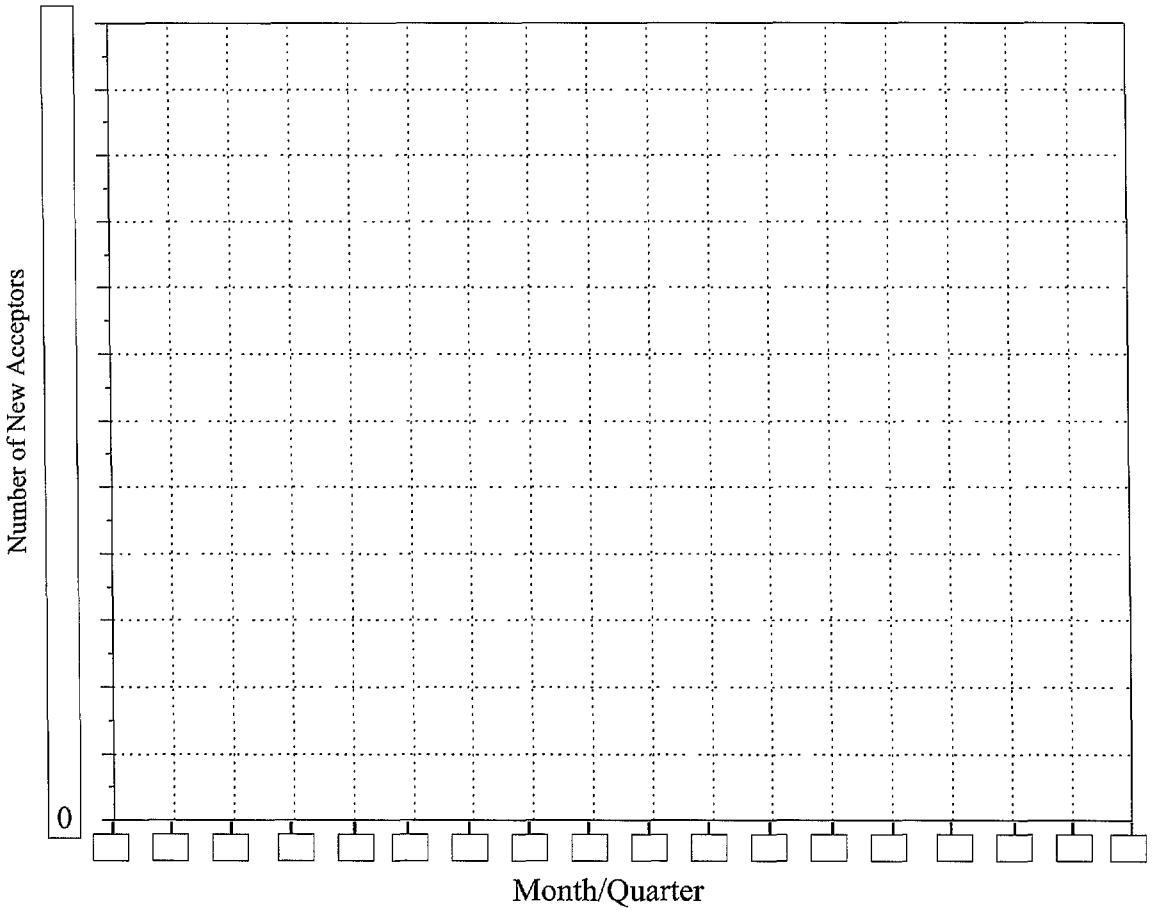


Clinic: *Yena*
Period Covered: *Jan 1991 - Dec 1991*

Observation: The number of new acceptors has declined over the last 6 months	
Possible Interpretations	Possible Actions
The clinic has started charging for services, making it less affordable for some clients.	Evaluate costs of services and contraceptives at other local facilities and interview clients about the affordability of the services.
Active opposition to family planning has raised doubts about safety of family planning methods.	Check the origins of opposition propaganda and develop and distribute materials assuring the safety of contraceptives.
This is an established program and may be serving a larger number of continuing clients rather than attracting new clients.	Analyze the trend of continuing clients served by the clinic over the past year by using monthly summary data on revisits.

Graph Nº 1: Line Graph

Trend Analysis of New Acceptors



Clinic: _____

Period Covered: _____

Observation:

Possible Interpretations	Possible Actions

How to . . .

Make a Pie Chart—of your clinic's contraceptive method mix

To use the data worksheet shown on page 263, follow steps #1 through #4. To make a pie chart, follow Step #5.

Step #1. Fill in the blanks under "A" with the total number of new acceptors for each contraceptive method for the month you have chosen to analyze. Add up this column of numbers; the total ("B") should be equal to the total number of new acceptors on your monthly summary report. *In the example below, the total is 72.*

Step #2. Divide the number of new acceptors **for each method** (in column "A") by the **total number of new acceptors for the month** ("B"). Fill in the results in the spaces provided in column "C." The results in "C" will always be decimals (fractions). *In the example, the total number of new acceptors for the month of December 1991 is 72. Each number in "A" was divided by "B" (72) to equal the decimals shown in "C."*

Step #3. Multiply each number in column "C" by 100 to obtain a percentage and round to the nearest whole percent. Enter the percentages in column "D." Each number represents the percentage of the total number of new acceptors that chose each method.

Step #4. Check your calculations by totaling the percentages listed in column "D." The sum of the percentages should equal 100. (Note: Due to rounding, the numbers might not total 100. For ease in drawing the pie chart, you may want to adjust one of the percentages so that the numbers do total 100.)

Continued on next page

Example: How to Determine Method Mix of New Acceptors

Data Worksheet

Methods	A	C	D
	(number of new acceptors for each method)	(fraction of total new acceptors for each method) [A ÷ B = C]	(percent of total new acceptors for each method) [C x 100 = D]
Orals	*24*	*.333*	*33%*
Condoms	*26*	*.361*	*36%*
Foaming Tabs	*7*	*.097*	*10%*
Injectables	*6*	*.083*	*8%*
Implants	*2*	*.027*	*3%*
IUDs	*5*	*.069*	*7%*
Sterilization	*2*	*.027*	*3%*
Other	*0*	*0.000*	*0%*
Totals:	B *72*		100%
	(total number of new acceptors for the month)		

Clinic: *Yena* Month: *December* Year: *1991*

How to . . .

Make a Pie Chart (continued)

Step #5. Choose one mark on the circle and draw a line connecting it to the center; this will be your starting point. Your blank pie chart has 100 marks; each mark represents one percentage point. To make a pie chart, you will be drawing a wedge for each type of contraceptive method selected by new acceptors in any given month. Each wedge represents one of the percentages you calculated in "D" above.

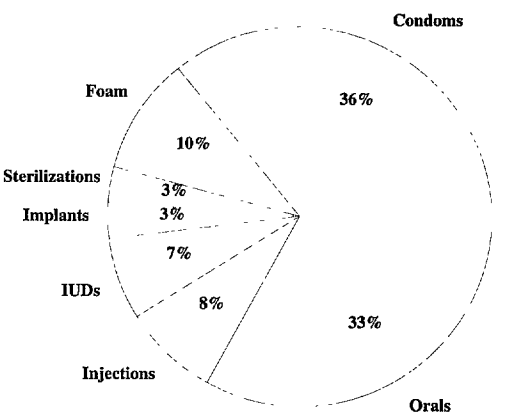
In the example below, oral contraceptive users represent 33% of the total number of new acceptors for the month of December 1991. This wedge was drawn by counting off 33 marks on the circle, and connecting the beginning and ending marks to the center of the pie. Condom users represent 36%. Starting where the wedge for orals ended, 36 more marks were counted to make another wedge representing 36%. In this way all the percentages from "D" were drawn to complete the pie chart.

Example: Pie Chart

The following pie chart was drawn using the data on the types of contraceptives selected by the new acceptors in December 1991. (See the calculations from the data worksheet on page 261.)

Method Mix of New Acceptors

Clinic: *Yena*
Month: *December*
Year: *1991*



Observation: Condoms and orals are more popular than IUDs and injectables.	
Possible Interpretations	Possible Actions
The doctor/nurse responsible for inserting IUDs and providing injectable contraceptives is at the clinic on only a limited basis.	Begin a system for making appointments for clients who require services provided by the doctor/nurse.
Clinic staff are more familiar with pills and condoms and have focused their counseling on these methods.	Provide staff training on the other more effective contraceptive methods.
Condoms distributed during a promotional campaign were mistakenly recorded as client data for the month.	Record supplies used for promotional purposes separately, making sure to note the quantities dispensed.

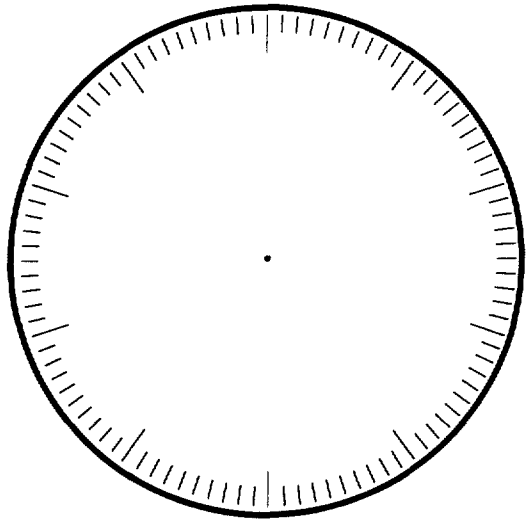
Graph Nº 2: Data Worksheet and Pie Chart

Data Worksheet

Methods	A	C	D
	(number of new acceptors for each method)	(fraction of total new acceptors for each method) [A ÷ B = C]	(percent of total new acceptors for each method) [C x 100 = D]
Orals			
Condoms			
Foaming Tabs			
Injectables			
Implants			
IUDs			
Sterilization			
Other			
Totals:	B		100%
	(total number of new acceptors for the month)		

Clinic: _____ Month: _____ Year: _____

Pie Chart



Method Mix of New Acceptors

Clinic: _____

Month: _____

Year: _____

Observation:

Possible Interpretations	Possible Actions

How to . . .

Make a Bar Chart—to show how new acceptors learned of your family planning services

Step #1. Label each small box, below the horizontal line on the blank chart, with an abbreviation of each source of information of new acceptors, used in your monthly summary report. There are 10 boxes, so your chart can show up to 10 different sources of information. If you collect data on more than 10 sources, consider combining some sources. *In the example below, CP was used for clinic personnel, RD for radio, and so on.*

Step #2. Starting at zero in the lower left corner, label the marks on the far left vertical line in increments of 5, 10, 20, or 100. The numbers on the vertical line represent the number of new acceptors. Identify the largest number of new acceptors for a single source of information, and choose a scale that will accommodate this number. *In the example, the numbers of new acceptors range between 0, for outreach personnel, and 21, for friend/relative; therefore the marks on the vertical line are labeled in increments of five ending with 25.*

Step #3. Mark the chart to show the number of new acceptors for each source of information. Draw a vertical bar for each source. Fill in the bars with colors or some design to distinguish them from the background. *Looking at the example, clinic personnel, and friends or relatives, are primarily responsible for attracting new acceptors to the Yena Clinic in December 1991.*

Example: Bar Chart

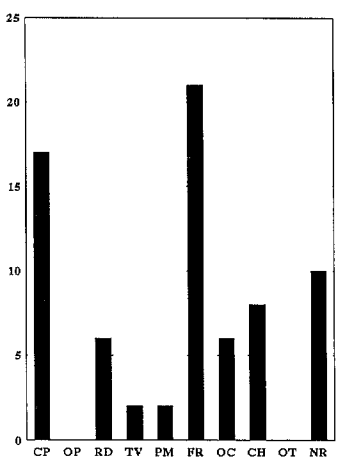
Codes used:

Program clinic personnel	CP	17
Program outreach personnel*	OP	0
Radio	RD	6
Television	TV	2
Print media	PM	2
Friend, relative	FR	21
Other clinic	OC	6
Community health worker	CH	8
Other	OT	0
No response	NR	10

*not applicable, no outreach program

Sources of Information Among New Acceptors

Clinic: *Yena*
Month: *December*
Year: *1991*

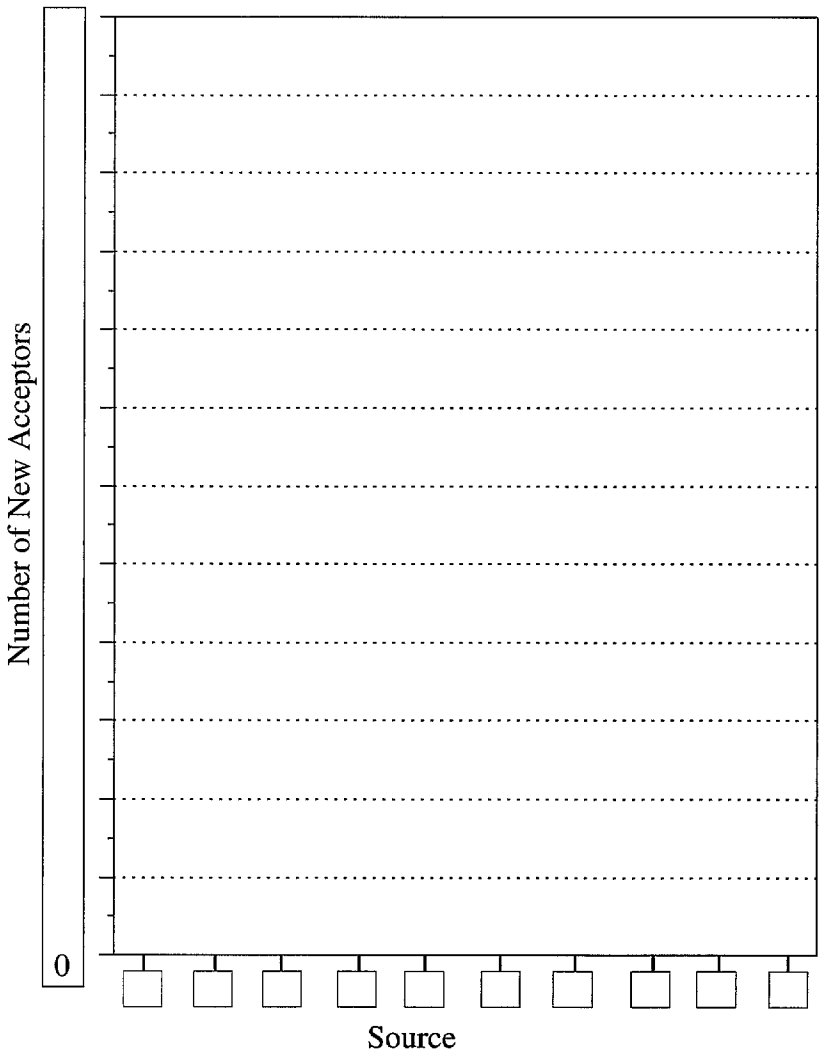


Observation: Friends and clinic personnel have been more successful in attracting new clients to the clinic, while IEC materials have been less successful

Possible Interpretations	Possible Actions
The community health workers are not actively referring potential clients to the clinic or may not have IEC materials.	Provide training to community health workers to familiarize them with the clinic services and provide them with IEC materials.
IEC messages on the TV and radio are not effective means of reaching new clients.	Use types of media to which the community has better access or review IEC messages to see how they could be improved.
New acceptors are pleased with the clinic's services and are encouraging their friends to come to the clinic.	Motivate clinic staff by praising them for providing high quality services.

Graph N° 2: Data Worksheet and Pie Chart

Sources of Information Among New Acceptors



Clinic:

Month:

Year:

Codes used:

Observation:

Possible Interpretations	Possible Actions

Checklist for Graphing Data and Taking Action

- [ ] Look at your program objectives and decide what information you need in order to track progress in achieving these objectives.
- [ ] Make sure that the forms you use for collecting data are designed to collect the information you must have about your clients and your program performance. At a minimum, the data should include medical history, age, number of pregnancies, type of contraceptive chosen and quantity dispensed to the client, and how the client learned about your clinic.
- [ ] Make sure that the forms are easy to fill out and designed so that the data can be easily aggregated for monthly or quarterly summaries.
- [ ] Decide what data you will be tracking over a period of time (such as numbers of new acceptors who come to your clinic each month).
- [ ] Decide what data you will be analyzing on a monthly basis (such as contraceptive methods of new acceptors for a given month).
- [ ] Develop an easy-to-use system (such as a wall chart) for regularly plotting and displaying data that will help you track service delivery trends over time.
- [ ] Use line graphs to analyze trends in new acceptors, continuing clients (revisits), or drop-outs. Each category of client can also be analyzed by method, such as the "trend of new acceptors using IUDs." Line graphs (updated every month) allow you to follow a trend over a period of time and take actions to manage the trend.
- [ ] Use pie charts to analyze the method mix (of any type of client) or any data that is more useful when expressed in percentages. Pie charts allow you to compare proportions and represent summary data for a specific period of time, such as one month, quarter, or year.
- [ ] Use bar charts to analyze the effectiveness of IEC activities, or the numbers of clients served by different service delivery systems (CBD, fixed or mobile clinics). Bar charts can be used to analyze most types of service data and emphasize the differences between several means of accomplishing an objective. Bar charts represent summary data for a specific period of time, such as one month, one quarter, or one year.
- [ ] Use your analyses as a first step, to investigate the reasons for any significant changes in demand. Discuss these changes with your staff and decide on a course of action.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Mrs. Obi's New Acceptors: A Case for Analyzing Service Summaries

Mrs. Obi unlocked the door to the Yena Women and Children's Health Clinic where she was the manager. Inside the door, she noticed a package from the national family planning office that had arrived in the morning post. It contained a number of new family planning posters and pamphlets. Mrs. Obi looked at the posters. They were very well done. She thought they would be an excellent addition to the clinic waiting area.

Mrs. Obi liked to arrive at work before the rest of the staff so that she could get organized for the busy day ahead. She pulled the records of all the family planning clients who had scheduled an appointment and looked to see what contraceptive methods they used. Then she went to the clinic stock room to see if she had enough supplies, since the quarter was ending on Friday and the clinic sometimes ran out of supplies at the end of the quarter. Today the clinic was almost out of injectables, so Mrs. Obi made a note to herself to request larger quantities for the next quarter.

Returning to the main clinic area, Mrs. Obi saw that most of the staff had arrived. She showed them the new pamphlets and posters. They like them immediately and discussed where to put them so that clients would see them easily.

A few minutes after the clinic opened, Mrs. Obi's supervisor, Mrs. Falade, arrived for her regular supervisory visit. Mrs. Obi was very surprised to see that Mrs. Ambe, the provincial family planning coordinator, was with her. Mrs. Obi was glad to see Mrs. Falade, as she would probably be able to give her some supplies of injectables, but she wondered why Mrs. Ambe had come. She asked a nurse midwife to take over registering a client so she could talk with her visitors.

"I know this is a bit of a surprise," said Mrs. Falade as they sat down. "But Mrs. Ambe has been studying data on new acceptors at all the clinics in the province and she has a new technique to show you. I think you might find it useful."

Mrs. Ambe placed several sheets of paper on the table. "I want to begin by complimenting you, Mrs. Obi, on the excellent job you have been doing in submitting your monthly reports on time and making sure that the summaries are complete and legible. We really appreciate your good work. However, I am concerned that the clinic is not attracting as many new acceptors as in the past. Looking at your data, it seems that the demand for family planning is beginning to fall off."

Mrs. Obi looked quite surprised. It had always seemed to her that family planning was becoming more popular in Yena. Mrs. Ambe smiled. "When you make your report every month and you see the number of new acceptors, the number probably seems similar every month," she said. "What I have done is to take all the numbers for twelve months and plot them on a graph so we can see the trend. Look, these are the numbers of new acceptors." She pointed to a sheet of paper. Mrs. Obi looked at it and saw the following:

New Acceptor Data: Yena Clinic - 1991

Jan ... 89	*May 98*	*Sept 82*
Feb ... 91	*June .. 101*	*Oct 83*
Mar .. 97	*July 95*	*Nov 77*
Apr ... 96	*Aug 92*	*Dec 72*

Continued on next page

"And here," continued Mrs. Ambe, "I have plotted each of these numbers on this graph paper. Can you see how the numbers have been decreasing recently?"

"Yes indeed," responded Mrs Obi, "I hadn't noticed the decrease in the monthly numbers, but this graph shows it very clearly. This graph will be helpful in explaining the situation to my staff. Maybe I can prepare simple graphs like this to help me monitor my clinic's performance in other areas as well. I think this graph will be easy to prepare and helpful in presenting the situation to my staff."

Excited by this graph, Mrs. Obi spent the next hour talking with her supervisors about possible reasons for the decline, what she could do to reverse the trend, and how she could graphically present and use other information that the clinic collected. She asked Mrs. Falade whether they could do a staff training session on creating and using different kinds of graphs during her next supervisory visit.

Monthly Summary of Family Planning Activities at the Clinic

Date of Report *December* 19*91* Clinic *Yena* 0 0 0 2

Region 0 0 3 State/Province 0 7

Reporting period: *1* (day) / *December* (month) to *31* (day) / *December* (month) 19 *91*

	No.of Visits	Orals				Injections		Implants		IUDs		Barriers		VSC	Other
		Lo-Femenal	Micro-Gynon	Neo-Gynon	Other	Depo-Provera	Noris-terat	Nor-plant	Other	Copper T	Other	Foam Tablet	Condoms	Tubal Ster	
A. New Acceptors	72	8	12	4	0	6		2		5	0	7	26	2	0
B. Revisits	119	27	4	3	3	13		11		10	3	17	27	0	1
Total Visits = A + B	191	35	16	7	3	19		13		15	3	24	53	2	1

Commodities Beginning Balance	(a)	604	120	160		22		65		200	0	1,300	5,654		
Amount Received	(b)							24							
C. Quantity Dispensed	(c)	89	24	13		19		2		5	0	640	1,112		
Ending Balance (a + b - c = d)	(d)	515	96	147		3		87		195	0	660	4,542		

D. Sources of Information of New Acceptors

Program clinic personnel	CP	17
Program outreach personnel	OP	0
Radio	RD	6
Television	TV	2
Print media	PM	2
Friend, relative	FR	21
Other clinic	OC	6
Community health worker	CH	8
Other	OT	0
No response	NR	10

E. Other Client Methods

Diaphragm	DP	
Rhythm, Natural	RN	
Vasectomy	VA	1
Other	OT	

Prepared by (name): Mrs. Obi Date: *January 7, 1992*

Signature: *Mrs. L. Obi*

Case Discussion Questions: Mrs. Obi's New Acceptors

1. **How can Mrs. Obi find out if her clinic is attracting more new acceptors to family planning each month? What actions might she take?**
2. **How can Mrs. Obi determine if her new acceptors are given an opportunity to choose from a range of contraceptive methods? What actions might she take?**
3. **How have the new acceptors heard of the family planning services available in Mrs. Obi's clinic? What might she do to more effectively inform prospective clients in her community about the available family planning services?**

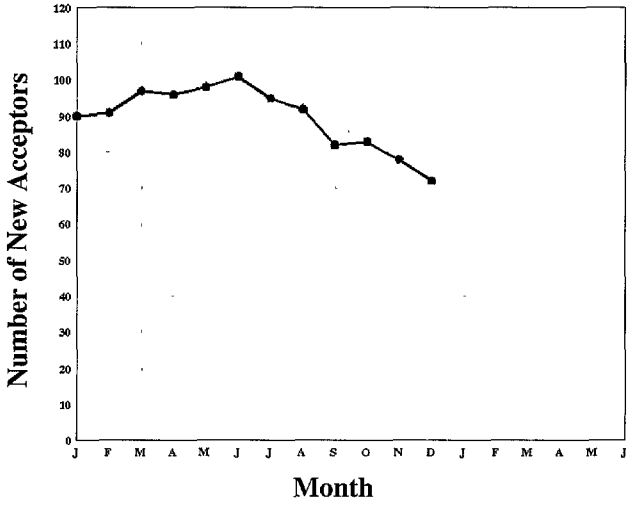
Case Analysis: Mrs. Obi's New Acceptors

1. How can Mrs. Obi find out if her clinic is attracting more new acceptors to family planning each month? What actions might she take?

A line graph showing the number of new acceptors for each month is a good way to see how well a clinic is attracting new clients. Ideally, the line should show a stable or upward trend in an emergency program.

Trend Analysis of New Acceptors

January-December 1991



Mrs. Ambe's graph, shown above, indicates a downward trend with some variability from month to month. Mrs. Obi and her supervisors might look into factors that may have contributed to the downward trend. They might discover that long waiting times at the clinic or possible side effects from IUDs or pills have caused clients to complain to their friends and relatives. The should also do a trend analysis using data from revisits to see what the trend has been with continuing clients.

2. How can Mrs. Obi determine if her new acceptors are given the opportunity to choose from a range of contraceptive methods? What actions might she take?

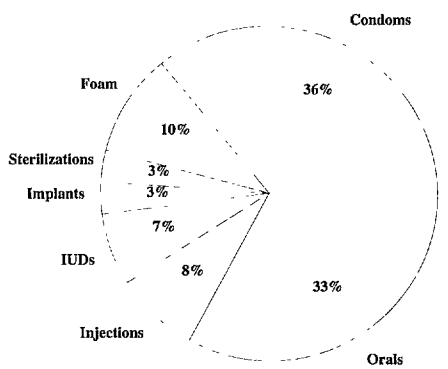
A pie chart showing the mix of contraceptive methods selected by new acceptors will help Mrs. Obi compare the relative popularity of different contraceptive methods selected by new acceptors. The pie chart may also reflect whether her clients are getting adequate counseling in all the available contraceptive methods and whether the methods are always in stock. In general, she should expect all the methods she stocks to be accepted by her clients in differing proportions. Mrs. Obi might decide to draw a pie chart every three months to analyze the method mix which would allow her to see significant variations during the year. Her supervisor could also review the pie charts of other district clinics for comparison.

Looking at the pie chart on the next page, Mrs. Obi can see that most of her new acceptors in the month of December 1991 have chosen to use pills and condoms. Mrs. Obi should be aware that the method mix will be affected by local cultural norms, by male attitudes towards

family planning, by the ways in which clients are counseled, and by good or bad publicity.

Method Mix of New Acceptors

December 1991



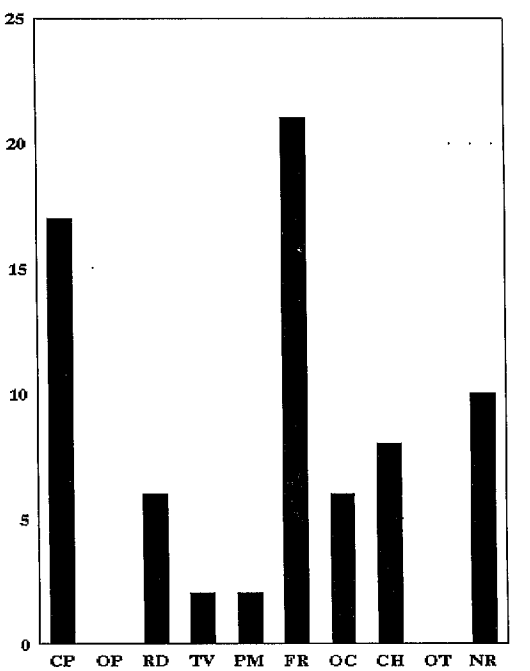
From the data in the pie chart, Mrs. Obi and her supervisors might decide to conduct staff training on the benefits of more effective methods, such as injectables and IUDs, to ensure that service providers are prepared to counsel clients on all the methods. Mrs. Obi may also want to draw a pie chart using data on revisits to analyze the method mix of continuing users.

3. **How have the new acceptors heard of the family planning services available in Mrs. Obi's clinic? What might she do to more effectively inform prospective clients in her community of the family planning services?**

A bar chart is a good way for Mrs. Obi to find out how new acceptors have heard of the family planning services she provides. In order to attract a steady flow of new acceptors, she needs to make potential family planning clients in her community aware of the benefits of family planning and inform them of the services that her clinic provides.

The bar chart that Mrs. Ambe drew shows that most of the new acceptors heard of the Yena Clinic's family planning services from other clinic personnel and from friends and relatives. This may mean that families in the area do not own televisions and radios, that they do not read newspaper advertising, or that the IEC campaigns using these media are ineffective. On the basis of this information, Mrs. Obi might decide to train community health workers to provide more comprehensive family planning information and to supply them with the new pamphlets she had just received. In addition, she might survey people in the community to find out their reaction to the media advertisements.

Source of Information Among New Acceptors



Codes used:

CP = Clinic Personnel	OC = Other Clinic
OP = Outreach Personnel	CH = Community Health Worker
RD = Radio	OT = Other
TV = Television	NR = No Response
PM = Print Media	
FR = Friend, Relative	

CHAPTER ELEVEN

Analyzing Costs for Management Decisions

As family planning programs expand, the mandate to do more with fewer resources becomes stronger. Family planning managers must strive to improve access and quality without increasing the financial burden on already under-funded programs. Perhaps you are concerned about future sustainability and the withdrawal of subsidies. You may worry about efficiency, and how to use existing resources more effectively. The tasks you face require an understanding of the financial implications of your management decisions. Can you provide services to 10 percent more clients without increasing the number of staff? Will it be possible to reduce service costs while providing the same or higher quality services? To answer these and other financial questions, you need to know what your family planning services cost.

This issue provides basic worksheets for calculating the costs of two items that make up the largest part of most family planning programs: **personnel costs** and **contraceptive product costs.** It deals with these two cost categories for three reasons. First, they account for the majority of costs in family planning service delivery. For instance, salaries accounted for 66 percent of service delivery costs in a study of 17 facilities in Morocco [Knowles, 1991]. Second, personnel and contraceptive costs are controllable—you are able to determine what your staff spend their time on, and how contraceptives are dispensed. Finally, measuring personnel and contraceptive costs is not difficult, and does not require large amounts of technical assistance from a financial expert.

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*This chapter was originally produced as Volume II, Number 2 of **The Family Planning Manager**, including the case scenario, "Determining Service Costs at Clínica La Villa." The guest editor for the issue was Taryn Vian.*

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Using Cost Data to Improve the Productivity and Efficiency of Services

Some people might argue that clinic managers aren't usually responsible for paying for personnel or contraceptive supplies. Others may argue that if a program has a policy to provide all services free of charge, it is not necessary to know the cost of providing those services. If budgets are handled at higher levels, why should clinic managers be concerned about costs? Yet, it is the clinic manager who is ultimately responsible for how these critical human and material resources are used...or misused.

One of the most important contributions a clinic manager can make to improve access to family planning services is to assure that resources are not wasted. Could your clinic provide more services with the resources it already has? Could you maintain the same level of services while reducing the amount of labor and supplies you use? If so, then your clinic is not yet operating efficiently. Inefficiency or waste can occur through poor use of resources such as labor, supplies, equipment, and space.

Some inefficiencies may be beyond your control. *For example, your clinic space and staff may be under-utilized due to low population density in your area.* But often, the proper use of resources is within the influence of the clinic manager. Some forms of waste, such as theft or loss of contraceptive supplies due to inadequate storage, can be reduced. In addition, changes in clinic operating hours can maximize access during peak demand periods and reduce the time when staff are idle. This kind of change helps to correct inefficiency due to the under-use of staff resources. Likewise, changes in policies that eliminate unnecessary laboratory tests or doctor referrals can result in savings of expensive, over-used resources.

Calculating costs is one way to measure productivity and efficiency in the use of resources, and having cost information is essential for knowing what actions to take to improve these aspects of program operations. This chapter includes a discussion of how you can put cost data to work for you to monitor operations, measure productivity and efficiency, evaluate performance, and plan for improvements to your clinic or program.

The costing procedures presented in this chapter include:

- Determining the total cost of family planning personnel;
- Allocating personnel cost to different types of family planning visits and methods;
- Determining the cost of contraceptive products;
- Calculating the total personnel and contraceptive supplies cost per unit of service, or type of visit.

Four basic worksheets will guide you through a process for determining the cost of each type of service you offer to your clients. Using this information you will be able to make better decisions about whether (or how much) to charge clients to help recover some or all of your costs; better ways to manage clinic operations; or possible ways to provide the same or higher quality services at a lower cost.

Understanding Each Type of Cost in the Analysis

First it is important to understand the basics of how each type of cost is obtained, and how you can use the information to make management improvements. Four basic worksheets presented in this chapter will help you to determine the overall **personnel cost**, the **personnel cost of each type of visit** your clinic offers, the **contraceptive product cost**, and the **total cost of visits** (including per-sonnel costs and contraceptive product costs). The section that follows provides a brief description of these costs.

Personnel Cost

Every family planning program employs a variety of different types of staff who, together, make it possible to provide services to clients. These staff include those who have **direct contact** with clients and those who have **indirect input** to client services. Staff who have direct contact with clients include doctors, nurses, counselors, and registration clerks. Other staff who only have indirect input to client services, but whose work is nevertheless an integral part of the family planning program, include clinic managers, bookkeepers, drivers, cleaners, and manual workers. "Total personnel cost" refers to the total cost of employing all these different types of staff.

Knowing what the total personnel cost is for your clinic is the first step in determining the true cost of each type of service that you provide.

Personnel Cost of Each Type of Visit

Once you know the total personnel cost, you can use this information to determine the personnel cost of each type of visit, or service, that you provide to your clients. To do this, you need to make a list of **all the possible types of visits** for each method of contraception that your clinic offers.

By analyzing both **how many clients you serve** for each type of visit and **how much time staff spend** providing each type of visit, you will be able to determine the personnel cost of providing each type of visit. Knowing the personnel cost per visit-type can help you to see whether the cost of each type of visit is appropriate relative to other types of visits. *For example, the personnel cost of a resupply visit for a pill user should be less costly than a first visit, since during a resupply visit there is generally less time spent counseling the client.*

Contraceptive Product Cost

After you have calculated the personnel cost of each type of visit, you will need to add the cost of the contraceptives that will be dispensed to clients as part of that visit. Even if you do not pay for the contraceptives directly, they are material resources that are expended when providing services, and their value should be accounted for. Therefore, you will need to determine the **approximate unit cost of each contraceptive product** that you stock in your clinic.

In addition to the cost of the contraceptive itself, the total unit cost of each contraceptive product should include any expenditures on international and local transportation, customs and taxes, and any other costs associated with getting the contraceptives to your clinic. If your program does not have this information, try contacting a local distributor, your central office, private agencies in your area who pay for contraceptives, or the donor of your contraceptive supplies.

Total Cost Per Visit

Using the information you have gathered on the cost of personnel and the cost of contraceptive supplies, the last step is to determine the **total cost of each type of visit**. This calculation combines total personnel costs and total contraceptive product costs for each type of visit and method provided. Although in reality there are other costs that should be included in the total cost, such as operating and maintenance costs, this analysis is simplified to include the two major costs of providing family planning services—personnel and contraceptive costs.

Knowing the total cost of each type of visit will allow you to make decisions about standard operating procedures, medical protocols, or changes to improve the efficiency of your services.

Check Your Calculations

The accuracy of your calculations in each worksheet is very important, because each successive worksheet is based on calculations from an earlier worksheet. An early miscalculation will distort the calculations in successive worksheets. Therefore, it is always a good idea to have someone else check your figures and calculations before moving on the next worksheet.

Determining Personnel Cost

If your clinic has a reliable accounting system and up-to-date records, determining personnel costs can be as simple as reading an annual report or talking to your accountant. However, many clinic managers do not have easy access to this information and must estimate it themselves. To do this, develop a list of all the staff who work in the family planning clinic. This includes doctors, nurses, paramedical, and administrative or general staff that have full-time or part-time tasks related to family planning. Make a list of these staff on a worksheet similar to Sample Worksheet 1. If staff are numerous, it is easiest to group them by salary grade or administrative class (e.g., Nurse Level 1A, Nurse Level 1B, Nurse Aid, etc.), leaving out names and indicating only the total number in each grade or class.

Managers of an integrated service delivery program that also offers other general primary health care should be sure to indicate the average percentage of time each category of staff spends specifically on family planning activities. These are just estimates and don't have to be exact, but they should distinguish someone who is spending 100 percent of her time in family planning services from an employee who spends only part-time working in family planning. As illustrated in the sample worksheet, if personnel within the same staff category spend unequal amounts of time in family planning, the category can be listed twice, so that the time each category spends on family planning is accurately represented.

How to . . .

Calculate Personnel Cost

1. For each staff category or grade that you have listed in Column A, list the number of staff employed by your clinic (Column B), and the percent time that each staff person or category spends on work related only to family planning (Column C). The time spent on family planning activities should include the time spent with clients, as well as the time spent providing indirect managerial or other support to the family planning services, such as record keeping and filing.
2. Next, for each category of staff, fill in the average yearly salary, including all paid employee benefits (Column D). You should use an *average* salary per year for each personnel category included in your list. An average salary is important because staff salaries within a single category may differ, and using an average is easier than trying to determine the actual salary of each individual employee.

   Salary amounts should include all allowances that the staff receive, including transportation or family allowances, housing, travel, health insurance (if applicable), taxes paid by the employer, social security dues, year-end bonuses, etc. Benefits are included because these are expenses related to staffing the clinic. Again, don't be concerned if you don't know the exact figure for these allowances; a rough estimate is all that is needed.
3. Once all these data are assembled—numbers of staff by category, percentage of time spent in family planning, and average salary including benefits—you are ready to calculate the cost of personnel in your program. To calculate total personnel cost for each category of staff, multiply the figures in each column and write the product in Column E (B x C x D = E). Do this line by line until the personnel cost for all the staff categories has been calculated.
4. Add the numbers in Column B to get the total number of employees who work in your family planning clinic. Then add all the amounts in Column E and write the total at the bottom. This is the "total personnel cost" associated with providing family planning services for one year.

Sample Worksheet 1: Total Personnel Cost (in U.S. dollars)

A	B	C	D	E
Staffing grade or Category	**Number**	**Percent time in family planning**	**Average annual salary including benefits**	**Total personnel cost [B x C x D]**
Doctor	*1*	*50%*	*$6,000*	*$3,000*
Nurse 1A (Clinic Manager)	*1*	*100%*	*$3,000*	*$3,000*
Nurse 1B	*1*	*75%*	*$2,500*	*$1,875*
Nurse 1B	*2*	*50%*	*$2,500*	*$2,500*
Pharmacy Assistant	*1*	*50%*	*$1,250*	*$625*
Nurse Aid	*4*	*25%*	*$1,150*	*$1,150*
Counselor/Educator	*2*	*50%*	*$800*	*$800*
Registration Clerk	*1*	*100%*	*$1,000*	*$1,000*
Manual Workers, Drivers	*3*	*50%*	*$350*	*$525*
etc.				
Total	*16*			*$14,475*

Note: *The U.S. dollar is used in all the examples in this chapter. Whatever currency you are using should be noted on each worksheet. This is a hypothetical example.*

Allocating Personnel Cost to Visits

Now that you know your total personnel costs, you need to find out how these costs are distributed across your program. The process of determining what portion of personnel costs should be allocated to what type of family planning visit (service) consists of three steps:

1. Deciding what different types of visits your clinic offers;
2. Counting the number of each type of visit clients make in a year;
3. Measuring how much time staff spend on each type of visit.

This information is then combined in one table to calculate "personnel cost per visit." The following section discusses each of these steps in more detail.

Step 1—What different types of visits does your clinic offer?

The first step is to define the different types of visits you want to cost. To answer this question, you need to name the various types of visits your clinic offers. For each type of family planning visit, you will need to define two aspects of the visit: the **contraceptive method** and the **types of visits required for that method.** (See also Bratt et al., 1992.)

First, list all the methods you offer, leaving some space between each method. Then, in the space under each method, list the different types of visits a client needs to make to the clinic for that method. *For example, a pill user might need to make a first visit and resupply visits, while a Norplant user might make a screening visit, an insertion visit, follow-up visits, and a removal visit.* The sum of all these different types of visits is the total number of services, that your clinic offers. The chart on the next page shows the visit-types that were defined by clinics in Colombia and Rwanda. Note that Colombia and Rwanda each developed a category called "other family planning visit," which is a catch-all category for visits that are difficult to classify or happen infrequently.

Examples of Visit-Types Used for Costing in Colombia and Rwanda	
Colombia	**Rwanda**
IUD Insertion visit Follow-up visit Removal visit **Norplant Implant** Insertion visit Follow-up visit Removal visit **Female Sterilization** Procedure visit Follow-up visit **Male sterilization** Procedure visit Follow-up visit **Other family planning visit** (visit for IEC, counseling, etc.)	**Injectable** First visit (2-month) Follow-up visit (2-month) First visit (3-month) Follow-up visit (3-month) **Pill** First visit Resupply visit **IUD** Insertion visit Follow-up visit Removal visit **Norplant Implant** Insertion visit Follow-up visit Removal visit **Other family planning visit** (visit for IEC, counseling, etc.)
Note: The Colombia study was based on a PROFAMILIA clinic. The clinic did not choose to cost out pill users separately, since most pills are distributed through community-based social marketing programs not directly managed by the clinic.	Note: The Rwanda study was based on a public sector primary care clinic, where sterilization is not offered. The clinic did offer two types of injectables, a 2-month and a 3-month type. Since the product cost of each one differed, the clinic decided to determine costs separately for these two types of injectables.

Step 2—How many visits do clients make in a year?

For each visit-type you have defined, you need to determine the total number of visits made by clients. It is easiest to use data from the past year, but if you prefer, the analysis can also be done using estimated or budgeted utilization figures for the current year. You will need to use a full year's worth of data, since the personnel cost data is also for a one-year period.

These service data can be found by reviewing monthly or quarterly summaries of the clinic's family planning activities. For each type of visit, you should determine the total number of visits that were made by clients in the last year. If your service data are not reported in this way, you can take a sample of all the records from the past year (or for a portion of the last year), and count the total number of visits by visit-type. Then use those numbers to estimate the yearly totals representing all clinic records. *For example, if you take a sample of records that represent 20 percent (or one-fifth) of all your records, tally the data on the number of visits those clients made for each visit-type for one year, then multiply each figure by 5 to arrive at a yearly estimate that represents all clinic records.*

Step 3—How do staff spend their time?

Now you have defined the different *types of visits* (services) your clinic offers, and the *number of visits* your clients make in a year. You still need to find out how much of your clinic's resources—your staff and their time—is spent providing each type of service to clients. How do your staff spend their time among different types of visits? You probably have some general notion about which methods and visit-types require more staff time. There are several techniques for estimating the use of staff time more systematically.

Conduct a client flow analysis. This will provide you with information on the amount of time each staff member spends providing each type of service in the clinic. This technique involves completing client flow forms, which record the amount of time each client spends in contact with staff and how much time is spent waiting for services. For more information on conducting a client flow analysis, see Chapter Nine, "Reducing Client Waiting Times."

Interview your staff. Ask your staff how much time they spend with different types of clients and how much time they generally spend doing paperwork and other administrative tasks. While studies have shown that these data are usually not the most accurate, this is a quick and easy way to start.

Observe staff. By using a stopwatch or regular watch, and noting on a pad of paper the amount of time each staff member spends with clients for each type of visit, you can quickly determine the average amount of time spent by all staff for each of those visit-types. You will need to observe all locations of client-staff contact, including registration, counseling, and consultation rooms. *For example, one day you can observe clients entering the registration area and time how long it takes for staff to greet the client, find the client's record, and fill in any new information. Another day you can observe clients in the counseling and consultation rooms, and record how long it takes from the time one client enters to the time the client visit is over. Note that this time should include the time that staff spend writing in the client record, or cleaning up between visits. Using this information, you can then determine the average amount of time each staff member spends with a client on each type of visit, and calculate the total amount of time spent by all staff for each visit-type.*

You should observe 10-20 clients for each visit-type on your list, in order to determine how long an "average" visit takes. One visit for a new pill user might be very long, while another might be very short. But the average of all 10-20 observations of new pill visits will probably be representative of what happens most often in your clinic.

Remember, if a client spends 10 minutes in a consultation room with two nurses, this is equal to 20 minutes of staff time (10 minutes x 2 nurses). *For example, a first visit for the pill might include five minutes with the registration clerk, 15 minutes with a counselor, and 10 minutes with 2 medical staff in the consultation room. This makes a total of 40 minutes of staff time. You do not need to consider the time the client spends waiting or traveling, unless staff accompany the client.*

If the volume in your clinic is low, you may want to make these observations over several days or even weeks, in order to include the full range of all the visit-method combinations. Once you have observed all the staff time directly related to client services for each type of visit, add up the average time spent by each staff person—registration clerk, counselor, consultation staff, doctor, nurse, and anyone else working with clients—to determine total personnel time spent providing each type of visit.

It is most important to know the direct client contact time. You don't need to worry about how to allocate administrative or general staff time to visits, since Worksheet 2 (Column F) accounts for their time by using the total personnel time you calculated in Worksheet 1 (Column E total). Therefore, Worksheet 2 is designed so that you will use the *percentage of time* that staff spend in *direct contact* with clients to *allocate the total personnel cost to each visit-type*, and this total already includes the cost of administration and general services.

How to . . .

Allocate Personnel Cost to Visits

Sample Worksheet 2 illustrates how you can use all the data described in Steps 1-3 on the previous pages to calculate the personnel cost of each type of visit. The worksheet requires using basic mathematical skills—multiplying, dividing, and calculating percentages.

1. Once you have made a list of all the different visit-types in your program, record them in Column A of Worksheet 2.

2. For each visit-type, record in Column B the total number of visits made by clients during the previous year. Add all the figures in Column B and enter the total at the bottom of the column. This total represents the total number of visits for all visit-types for the previous year.

3. Using the data you have gathered on how much time staff spend providing each type of service, record in Column C the average number of minutes that staff spend providing services for each type of visit. (Remember that these figures should include the total amount of time spent by all categories of staff who take part in each type of visit.)

4. For each visit-type, multiply the number of visits (Column B) by the minutes per visit (Column C) to obtain total minutes spent on each visit-type during the past year (B x C = D). Enter the results in Column D. Add all the figures in Column D and enter the total at the bottom of the column.

5. Next, calculate the percentage of the total minutes of **all** visit-types that **each** visit-type represents. To do this, divide the totals for **each** visit-type listed in Column D, by the total for **all** visit-types noted at the bottom of the worksheet. Each result will be in decimals. To obtain a percentage, multiply the decimal by 100 and enter the percentages in each row in Column E that corresponds to the visit-type. *For example, looking at Sample Worksheet 2, the total number of minutes for all first visits for pills is 2,720 minutes. By dividing 2,720 by the total minutes for* ***all*** *visit-types—64,745—you get 0.042. To obtain a percentage, multiply 0.042 by 100 to get 4.2%.*

For ease in figuring, you can round the percentage to the nearest whole percent, or nearest tenth of a percent. Check your calculations by totaling the percentages listed in Column E. The sum of the percentages should equal 100, but due to rounding, the total might not equal 100. It is acceptable if the total is between 98 and 102. For more information on calculating percentages, please refer to Chapter Ten, "Using Service Data: Tools for Taking Action," and the supplement to that chapter, "Guide to Graphing Data and Taking Action."

6. Enter the total personnel cost (from Worksheet 1) in the space provided at the top of Column F in Worksheet 2. To calculate the total personnel expense for each visit-type, multiply the total personnel expense by each percentage found in Column E. Enter the results in Column F. **These figures show, for each type of visit, the total personnel expense incurred by the clinic for the total number of visits in the past year.** To check your calculations, add the figures in Column F, and enter the total at the bottom of the worksheet. This total should be the same as the total personnel cost noted at the top of the column.

7. To calculate personnel cost for each visit-type, divide the total personnel expense for each visit-type (Column F) by the number of visits of that type (Column B). Enter the results in Column G. *For example, the total personnel expense for 160 first visits for pills is $608. By dividing $608 by 160 total visits, you get $3.80, which is the total personnel cost for one single visit of that type.*

Remember, the personnel cost per visit-type will not be the same over time or the same as other clinics, even if the personnel costs are exactly equal. This is because the cost per visit depends on the number of visits, which can change over time or be different from clinic to clinic. The general rule is that if personnel costs remain the same and the number of visits goes up, the average cost per visit will go down. But, if personnel costs remain the same and the number visits goes down, the average cost per visit will go up.

Sample Worksheet 2: Personnel Cost Per Visit-Type (in U.S. dollars)

A	B	C	D	E	F	G
Visit-Type	**No. of visits in past year**	**Average minutes per visit-type**	**Total minutes [B x C]**	**Percent of total number of minutes [(D ÷ *) x 100]**	**Personnel expense (E x total from Worksheet 1) Write in total below for easy reference ($14,475)**	**Personnel cost per visit-type [F ÷ B]**
Pill first visit	*160*	*17*	*2,720*	*4.2*	*$608*	*$3.80*
Pill resupply visit	*1,390*	*10*	*13,900*	*21.5*	*$3,108*	*$2.24*
Injectable first visit	*350*	*18*	*6,300*	*9.7*	*$1,408*	*$4.02*
Injectable follow-up	*3,050*	*10*	*30,500*	*47.1*	*$6,819*	*$2.24*
IUD insertion	*70*	*27*	*1,890*	*2.9*	*$423*	*$6.04*
IUD follow-up	*220*	*15*	*3,300*	*5.1*	*$738*	*$3.35*
IUD removal	*20*	*18*	*360*	*0.6*	*$80*	*$4.02*
Norplant insertion	*40*	*37*	*1,480*	*2.3*	*$331*	*$8.27*
Norplant follow-up	*20*	*9*	*180*	*0.28*	*$40*	*$2.01*
Norplant removal	*5*	*39*	*195*	*0.3*	*$44*	*$8.72*
Condom and/or other family planning visit	245	16	3,920	6.1	$876	*$3.58*
Total	*5,570*		*64,745 **	*100.0*	*$14,475*	*$2.60*

Determining the Cost of Contraceptive Products

The third important part of determining the cost per visit is calculating the cost of contraceptive products that are given to the client to take with her or him when the visit is over. To determine the cost of contraceptives, you will need data on the quantity and cost of contraceptives received by your program. This information may be obtained from the office that handles procurement for your clinic, from your supervisor, or from the family planning program accountant working at the central or provincial level. You will need to know:

- The total quantity of each contraceptive received by the program in the last year;
- The amount paid for all contraceptive shipments received by the program in the last year.

If your program purchases contraceptives in large quantities that are then distributed to a number of clinics, the same contraceptive cost data may be used for several clinics. These data should be available by type of product (i.e., pill cycles, condoms, IUDs, doses of injectables, Norplant implant kits, etc.). If the contraceptive products you use in your program are donated, the international market value (if available) should be considered in place of the amount paid. You can also contact private hospitals or clinics, who may have to purchase contraceptives, to find out their costs for each product.

Be sure to include in your figures the cost of customs fees, import taxes, and international transportation costs for contraceptive procurement during the year. These are called other procurement costs. Usually these costs are recorded on the invoice for each shipment. If your program has data about internal transport and warehousing costs, these can also be included.

How to . . .

Calculate the Unit Cost of Each Contraceptive Product

1. List all the contraceptive products that your clinic offers in Column A of Worksheet 3.

2. For each contraceptive product, record the total number of units received during the last year. Enter these totals in Column B.

3. By reviewing invoices for the past year, determine the total expenditures for each type of contraceptive product. Record these expenditures in Column C. (Note: It is acceptable to group different brands of the same product together. It doesn't matter if three different types of IUDs were purchased at different prices. You only need to know the cost of the product category as a whole.)

4. Record other procurement costs in Columns D and E, then add the figures in Columns C, D, and E to get the total product cost including other procurement costs (Column F).

5. To reach a unit cost per contraceptive method, for each product category, divide the figure in Column F by the total quantity received (Column B). Enter the result in Column G. This number represents the total cost associated with having one unit (or one cycle) of each contraceptive product in stock in the clinic.

Note: When filling out this worksheet remember to list the contraceptives and their related costs in terms of standard units, such as cycle of pills, individual condom, dose of injectable, etc.

Sample Worksheet 3: Unit Cost Per Contraceptive Product

A	B	C	D	E	F	G
Contraceptive Product	**Quantity Received**	**Expenditure on contraceptive products**	**Expenditure on international transport**	**Expenditure on customs, taxes**	**Total product and other costs [C+D+E]**	**Unit cost [F÷B]**
Pill (each cycle)	*497,040*	*$75,842*	*$42,212*	*$1,181*	*$119,235*	*$ 0.24*
Condom (each)	*2,334,000*	*$95,847*	*$72,839*	*$ 1,687*	*$170,373*	*$ 0.07*
Injectable (dose)	*703,950*	*$483,105*	*$36,225*	*$5,193*	*$524,523*	*$ 0.74*
IUD (each)	*9,000*	*$5,135*	*$ 1,998*	*$71*	*$7,204*	*$0.80*
Norplant (kit)	*4,300*	*$98,187*	*$9,225*	*$1,913*	*$109,325*	*$25.42*
Other (specify)	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
Total		*$758,116*	*$162,499*	*$ 10,045*	*$930,660*	

(Based on expenditures from the most recent year for a program covering several hundred clinics, in U.S. dollars)

Calculating Total Cost per Visit

Using the data that you have collected and calculated in Worksheets 1, 2, and 3, you are now ready to combine the costs of contraceptives and personnel. This will give you the total cost per visit, for each type of visit your clinic provides. In reality, other costs should go into the total cost calculation, including the cost of operating and maintaining your clinic. For this simplified analysis, however, total cost includes only personnel and contraceptive costs.

Suppose you have found that your program's cost for one cycle of pills is $0.24. This may also be the contraceptive product cost for a new pill user visit. Is the contraceptive product cost the same for a follow-up pill user visit? Not unless you give the client only one cycle of pills during her follow-up visit. Most family planning clinics offer clients more than one cycle of pills, so the cost of contraceptives per resupply visit is higher. If three cycles of pills are given during a follow-up visit, the contraceptives cost per follow-up visit is 3 x $0.24, or $0.72. The contraceptives cost is higher for the resupply visit because more cycles of pills are dispensed than on the client's first visit, but what about the personnel costs? Are the personnel costs higher or lower for the resupply visit? What is the total cost of the resupply visit when you consider both contraceptive costs and personnel costs? Sample Worksheet 4 illustrates how the total cost of each type of visit is calculated, including contraceptive costs and personnel costs.

How to . . .

Calculate the Total Cost per Visit

1. Using a worksheet similar to Sample Worksheet 4, list all the visit-types in Column A. (This is the same list that you made for Worksheet 2.)
2. For each visit-type, record the contraceptive unit cost in Column B. (This information can be transferred from Worksheet 3, Column G.)
3. Next, in Column C, record the number of products used or distributed for each type of visit listed. Be sure to count in terms of standard units, such as cycles of pills, doses of injectables, number of condoms, etc.
4. To calculate the total cost of contraceptives for each visit-type (Column D), multiply each contraceptive unit cost by the number of contraceptives used for each visit (B x C = D).
5. Record the personnel cost for each type of visit in Column E. (These figures can be transferred from Worksheet 2, Column G.)
6. To calculate the total cost per visit, add the figures in Columns D to those in Column E, and record the result in Column F (D + E = F). This is the total cost of each type of visit, including all contraceptive and personnel costs associated with the type of visit and method provided.

Sample Worksheet 4: Total Cost Per Visit (in U.S. dollars)

A	Contraceptive Cost per Visit			E	F
Visit-Type	B	C	D	Personnel cost per visit (Worksheet 2, Column G)	Total cost per visit [D + E]
	Contraceptive unit cost (Worksheet 3, Column G)	Number of products used or distributed per visit	Total cost of contraceptives per visit [B x C]		
Pill first visit	*$ 0.24*	*1 cycle*	*$ 0.24*	*$ 3.80*	*$ 4.04*
Pill resupply	*$ 0.24*	*3 cycles*	*$ 0.72*	*$ 2.24*	*$ 2.96*
Injectable first visit	*$ 0.74*	*1 dose*	*$ 0.74*	*$ 4.02*	*$ 4.76*
Injectable follow-up	*$ 0.74*	*1 dose*	*$ 0.74*	*$ 2.24*	*$2.98*
IUD insertion	*$ 0.80*	*1 piece*	*$ 0.80*	*$ 6.04*	*$ 6.84*
IUD follow-up	*$ 0.80*	*0*	*0*	*$ 3.35*	*$ 3.35*
IUD removal	*$ 0.80*	*0*	*0*	*$ 4.02*	*$ 4.02*
Norplant insertion	*$25.42*	*1 kit*	*$25.42*	*$ 8.27*	*$33.69*
Norplant follow-up	*$25.42*	*0*	*0*	*$ 2.01*	*$ 2.01*
Norplant removal	*$25.42*	*0*	*0*	*$ 8.72*	*$ 8.72*
Other (condom)	*$ 0.07*	*20 condoms*	*$ 1.40*	*$ 3.58*	*$ 4.98*

Going One Step Further: Estimating Cost per Year of Use

The data on *total cost per visit* (personnel costs plus supplies) that you have calculated in Worksheet 4 can also be used to determine the *total cost per year of use*. Cost per year of use is of interest to managers for evaluation and monitoring. It is a measure of the final output—the total cost of one couple-year of contraceptive protection—provided by a program or clinic, as opposed to intermediate outputs, such as clinic visits. It is also a measure that provides a common basis for comparing the costs of different methods of contraception and for reviewing cost trends over time.

How to . . .

Estimate Cost per Year of Use

To estimate cost per year of use, you will need two more pieces of information:

- Average length of time the method is used (in years);
- Average number of follow-up visits per user during the period of use.

With these data, the calculations are simple: Total the number of visits for each type of visit, multiply the cost of each visit-type, then divide the result by the average length of time the method is used.

Example: Cost per year of use for a pill user.

1 First visit x $4.04	=	$4.04
4 Follow-up visits x $2.96	=	$11.84
Total	=	**$15.88**
Average length of use (1 year)		
Cost per year of use ($15.88/1 year = $15.88)	=	**$15.88**

Example: Cost per year of use for a Norplant user.

1 Insertion visit x $33.69	=	$33.69
4 Follow-up visits x $2.01	=	$8.04
1 Removal visit x $8.72	=	$8.72
Total	=	**$50.45**
Average length of use (3.5 years)		
Cost per year of use ($50.45/3.5 years = $14.41)	=	**$14.41**

Be careful! Exercise caution in interpreting your results, because the calculations are only as good as the data you are using. It is important to check the baseline assumptions and the data you have used in the calculations, since errors in the data will be multiplied as you proceed through the calculations, and will make the results inaccurate. *For example, what if the cost per follow-up visit for pill users was $3.50 instead of $2.96? What if Norplant users make only one follow-up visit, or only use the method for two years instead of three and one-half years?* Length of use is sometimes difficult to determine, especially for new methods. While you may have a protocol for the number of follow-up visits clients *should* be making, do you know if they are actually being seen this number of times? Remember, too, that the cost per visit we have discussed in this chapter includes only personnel and contraceptive costs. There are other costs, such as equipment and supplies for sterilization, which have not been included and may influence your comparisons. If you want to use cost per year of use to make high-level policy or programmatic decisions, it is probably best to request assistance from an accountant.

Overcoming Resistance to Measuring Costs

Some people are not comfortable with measuring costs, and may try to avoid participating in a cost analysis or may disparage the results of a cost study. They might fear that an analysis of costs will make them appear incompetent or lazy and their suspicions may be heightened by their lack of understanding of the methods being used to determine costs. To help allay fears, try to include as many staff members as possible in the discussions of the cost analysis and findings. Encourage clinic staff to become involved in the data collection, and to discuss and interpret the results. Praise those who come up with good ideas about how to use the cost data to make improvements in service delivery and productivity. Below are some of the common complaints about cost measurement, and some responses that can help you to overcome any resistance you may encounter.

Complaint	Response
Our clinic doesn't manage the budget, so why should we care about personnel or contraceptive costs?	Although you don't manage the personnel budget, you *can* improve productivity by using staff time more efficiently, which will result in lower personnel unit costs. You can also use contraceptive supplies more wisely, thereby lowering unit costs.
Staff salaries are fixed, so why include them in unit cost calculations?	Again, while you may not be able to reduce total personnel cost, you can influence what people do during their work hours. You can move staff among different activities, and can decide to use different levels of staff for services. These decisions all have cost implications, and can help to increase the number of services delivered by the clinic—for the same cost!
The cost data aren't very accurate, so what good is the study?	A general idea of costs can tell you a great deal. Over time you can improve the accuracy of the data. Meanwhile, you can test your assumptions to see whether you would make the same decision even if costs were really somewhat less, or somewhat more, than you think they are.
Cost data say nothing about quality. High costs may mean high quality, rather than low productivity or poor management of resources.	True! Costs *alone* cannot tell you about quality. You should try to measure quality in addition to costs. Cost data need to be interpreted. There may be many reasons for costs to be high. You need to look at all the possible causes, and see which are most responsible for the high costs.

Other Kinds of Costs and Cost Analyses

The costing procedures described in this chapter provide you with information about how to determine the average cost of personnel and contraceptives for each type of visit provided by the clinic. There may be times, however, when this type of cost information alone will not tell you what you need to know to make an important management decision. *For example, suppose that you want to add a new service such as community-based distribution, or you want to discontinue an existing service? What if you must decide about whether to expand your clinic's volume of clients?*

To answer these types of management questions, you need to know how costs will vary under different circumstances. This requires that you differentiate between **fixed costs** and **variable costs**. Fixed costs are those that do not vary with the number of clients served, such as personnel costs, rent, building maintenance, etc. Variable costs are those that vary directly and proportionately with the volume of clients served, such as contraceptive costs, drugs, and medical supplies.

Knowing the difference between fixed and variable costs is particularly important in budgeting for clinic expansion. To determine how many more clients can be served before the existing personnel have full schedules and new staff must be hired, you will need to analyze the existing daily volume of clients, the average amount of time spent with each client, and the number of hours worked by staff. If you determine that staff are not too busy, you may be able to increase your volume of clients without increasing the total personnel cost. The contraceptive costs will go up, however. This kind of analysis allows managers to consider how different kinds of costs will change when clinic utilization increases or decreases, and helps them to estimate the effect of planned policy changes or management improvements.

Using Data on Costs to Improve the Efficiency of Service Delivery

The family planning clinic of the Centre Universitaire de Santé Publique (CUSP) in Rwanda conducted a cost study to compare the cost-effectiveness of Norplant with that of other methods. During the study, cost data collected from the clinic raised a number of questions for management. The cost data showed that a first visit for a 2-month injectable user was more costly than a first visit for a 3-month injectable user. Why might this be so?

Analyze the Data. The analysis showed that some of the cost difference was due to higher product costs. The 2-month injectable doses cost more because the product was newer to the market. But in addition, staff spent more time with the 2-month injectable users on the first visit. Because personnel time represents a large portion of visit costs, the visit cost was greatly influenced by client contact time, although there seemed to be no logical reason why staff would spend more time with the users of the 2-month injectable. This is an example of the kinds of questions that arise when conducting a cost study, and which need to be further investigated to make decisions about your program.

Consider Possible Actions. In this case, the clinic managers could observe and time more first visits of both types, to determine whether staff were somehow providing different services to the 2-month and 3-month injectable users, or whether the difference was simply due to bad data. The clinic could also review the circumstances under which the staff are recommending the 2-month injectable to women. Since the 3-month injectable is cheaper and lasts longer, it is a more cost-effective method and should be promoted, unless circumstances specifically indicate a need for the shorter-duration method. Managers will need to consider both the cost-effectiveness of the different methods and services that they offer, and the client demand for, and satisfaction with, the different types of contraceptive methods.

Calculate the Cost Effectiveness of Contraceptive Methods. Data from Rwanda also permitted the managers to calculate the cost per year of protection (or use) of each contraceptive method. This analysis showed that the cost-effectiveness of Norplant was very close to that of the pill and injectables when the expected duration of Norplant use was taken into consideration. Although the cost of a Norplant insertion was quite high, the duration of use was expected to be long, so the cost per year of use was close to that of other methods. This may be good news for Rwandan clinics seeking acceptable long-term methods, since women generally do not like to use the IUD for cultural reasons but seem to be willing to use the long-lasting Norplant implants instead. The cost data, however, can be adversely affected by the *actual* length of use. Norplant is so new that the managers do not know what the average length of use will be in Rwanda. Nevertheless, they will keep track of use patterns and adjust their calculations as they, and their clients, gain more experience with the method.

Consider Policy Changes to Improve Efficiency. Finally, the cost analysis conducted in the Rwandan clinic highlighted questions about the policy of requiring all clients—both new and continuing users—to attend a 40-50 minute educational lecture before being allowed to see the doctor or nurse for a private consultation. These educational lectures consumed a relatively large amount of time for some staff. They also created unproductive time each morning, since nurses had to wait for the educational session to finish before they could begin seeing clients. To alleviate this problem, the managers are discussing whether the lecture should be made optional for continuing users coming in only for resupply.

Monitor the Effects of the Changes. Making the educational lecture optional for some clients is expected to both increase staff productivity and reduce client waiting time. Some of the time savings could be used to provide longer individual counseling to clients who really want and need it. The effect of this policy change over time can also be monitored to see whether it lowers the unit cost of providing services or improves efficiency. Greater efficiency could be achieved if the increased staff productivity allowed more clients to be served each day. In addition, client knowledge and satisfaction could also be assessed to evaluate the effect on the quality of the services.

Taking Action on Cost Data

Cost data can help you to recognize problems with current operations and to plan for the future. Using cost information, you can take actions to improve efficiency and productivity, monitor changes in operations, and evaluate the financial implications of clinic goals and objectives. Remember, though, that cost information is only one ingredient in diagnosing problems, and that in order to interpret them correctly, costs must be viewed in relation to outputs and quality.

Cost data can be used to:

- **Reduce waste.** The cost of contraceptives for each type of visit is calculated using the expected number of contraceptive units a client receives during the visit. This cost figure doesn't take into account other variables, such as wastage, products used for demonstration or promotion, and losses due to theft or expiration. How important are these other costs? Should you be worrying about them and trying to get them under control?

To examine these other contraceptive costs, you can compare your expected contraceptive cost for the whole year with your actual expenditures on contraceptives. Expected expenditures are equal to the number of visits multiplied by the contraceptive cost per visit. Actual expenditures data can be calculated using the cost per product (Worksheet 3) and annual consumption data from stock records. The difference between actual and expected contraceptives expenditures is called a "cost variance." It is up to you, as a manager, to decide how much variance you think is normal, and how much is cause for concern. Often, managers like to investigate variances that are 10 percent higher or lower than ex-pected. (For more information on managing supplies, see Chapter Thirteen, "Improving Contraceptive Supply Management.")

- **Set standards for productivity.** You can use unit cost data to set standards for what you expect personnel costs per visit to be for the next year. In considering clinic operations, a standard is not an "ideal," but rather an expectation. You may wish that each client would receive 30 minutes of counseling at each visit, but this should not be a standard unless you have the staff and time to turn your wish into a reality.

Standards should be realistic expectations of what you feel can and should happen in the future. Working with your staff, you can set standards for the number of minutes each visit should take, and which staff should be involved. This standard number of minutes can then be used to calculate standard personnel costs per visit, against which actual performance can be monitored. Deviations from the standard, especially where costs are very much higher or lower, should be examined closely for possible explanations and remedial actions. Standards should also be re-examined periodically to determine whether they are realistic. In a decentralized work environment, you can reward staff who, without compromising quality of care, consistently meet or exceed the standards agreed upon for their work.

- **Make comparisons over time and across clinics.** Comparisons of cost data can reveal patterns that require management action. It may not be possible to say whether $2.00 per follow-up visit is a lot or a little, but if the cost has increased drastically in each of the last three months, you need to ask why. Once again, cost data will not tell you what to do; they only alert you that there may be a problem that needs action.

Comparisons among clinics can also illustrate a "performance curve," highlighting clinics with extremely high or low unit costs. These data need to be interpreted with great caution, since staffing patterns, quality of care, and operating standards are not the same at all clinics. Still, it is exactly these differences that cost analysis will help you to better understand. Publicizing these comparisons among clinics involved in a cost study can be very effective both in validating the results and in motivating low performers. Encouraging staff to examine and discuss comparative cost data can help them to grow in their curiosity about, and knowledge of, clinic operations.

- **Plan for change.** Cost data can provide input for the planning process. *For example, you may be adding a new contraceptive to your method mix, increasing clinic outreach activities, expanding your acceptor base, or considering a change in staff mix. By collecting data on the number of minutes staff spend providing services for each type of visit, you can analyze the effect of additional clinic visits on the current workload, and can estimate whether you will need new staff to handle the programmatic changes you intend. You can also estimate the cost to the client (in terms of increased waiting time), or potential savings (additional clients served) that will result from a change in staffing patterns or hours.* Over time, you will be able to see how your programmatic initiatives have affected costs per visit. Lower costs per visit mean higher efficiency, if wages, contraceptive costs, and the quality and type of services being offered remains the same.

- **Determine charges for services.** If you intend to introduce user fees, it is very helpful to view fees in relation to the true costs of the services provided. Once you know the cost of contraceptives per visit, you can try to set your fee to cover some or all of the product costs. You can also promote community acceptance of your fees by showing that the fees do not really cover all the cost of personnel and contraceptives used during client visits.

Using Your Resources Effectively

Resources—personnel, material, and financial—will always be less than you want them to be, and managers face the ever-present danger that the budget will run out before they have finished doing their job. A critical role of a manager, therefore, is to make the very best use of these scarce resources. Measuring costs will help you to become a better resource manager by allowing you to identify areas where staff, material, time, and other resources are being wasted or used in ways that may not maximize outputs. But, cost analysis cannot make decisions for you. Data must always be interpreted by managers who are familiar with clinic operations and who know about the quality of services being offered. Cost data can help you to identify possible areas for action, but taking action is up to you.

Working Solutions—Indonesia

Comparing Costs Between Clinics

In Indonesia, a cost analysis revealed that the average cost of a maternal and child health/family planning visit was 2.5 times higher in one clinic than in another clinic that had similar resources ($0.26 per visit compared with $0.63 per visit). The analysis showed that the primary cause of the difference in cost was due to the number of visits (services) delivered by the clinics. The first clinic, with the lower unit cost, provided 350 percent more visits than the second clinic. This indicated that the second clinic was not using resources well, since the same number of staff were handling less than one fourth the number of visits.

Further analysis revealed that personnel costs were higher in the first clinic, but that this was due to higher wages paid to more senior nurses, rather than more time spent with clients. Also, the second clinic was giving 65 percent more drugs (in value) to clients, even though the distribution of clients by purpose of visit was similar in both clinics.

The study recommended that staff at the second clinic be reassigned to outreach activities to increase their productivity in reaching clients. Both clinics were advised to review their prescription patterns to reduce inefficiencies in the use of drugs, although this was more of a problem in the second clinic. [Berman, 1986]

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On feeling time pressures . . . *One reviewer comments,* "Time is often a deterrent to collecting and analyzing cost data. This is a big issue in small agencies where staff feel overworked and so much is already expected of them. To them this may be just one more task. But having information on costs is so important for planning and making good decisions that it cannot be stressed too much."

On reductions in donor support . . . *One reviewer advises,* "In light of increased cutbacks in international donor support, it is of utmost importance that family planning programs know the costs of delivering services, and make necessary changes to increase the efficiency of delivering those services. This will allow them to better manage the cost of providing services, while maintaining the same quality and level of services offered to clients."

On considering other sources of supply . . . *One reviewers offers,* "Some clinics operate in areas where there are other family clinics nearby, so clients don't always use the same clinics for each resupply visit. This should not pose a problem for cost analysis because some clients will come to your clinic for the first visit, but not for the resupply visits, while others will come to your clinic for resupply visits but not for their first visit. What is important is that your data represent the average number of visits your clinic provides."

On using cost study results to reveal inefficient systems . . . *One reviewer points out,* "Doing a cost study can also serve to draw attention to systems or procedures that might otherwise be overlooked because everyone is so used to them. For example, a cost study will make you aware of the proportion of staff time devoted to certain activities that you didn't realize took so long to complete. Once you see how much time these activities take, you can make changes that might result in providing more, or better services."

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Checklist for Analyzing Costs for Management Decisions

For Clinic Managers

- [ ] Talk with your staff about the importance of analyzing clinic costs and address their concerns before initiating the cost study.
- [ ] Explain to your staff the steps involved in conducting a cost analysis, and how the study can be used to improve services.
- [ ] Make sure your staff understand why you need to collect data on the time they spend with clients. Let them know ahead of time when you will be conducting the observations.
- [ ] Involve staff in collecting, recording, and analyzing the data. Solicit their suggestions for changes that would improve the quality of services, lower the cost of services, or improve their own productivity.
- [ ] Use the cost analysis worksheets to determine personnel costs, personnel cost per visit-type, contraceptive product costs, and total cost of each type of visit your clinic provides including personnel and contraceptive costs.

For Supervisors

- [ ] Work with clinic managers in conducting cost studies in their clinics.
- [ ] Encourage clinic managers to analyze cost data and use the findings to suggest changes for improving the efficiency of clinic operations and the productivity of staff.
- [ ] Provide support to clinic managers to make the improvements to the quality and/or efficiency of clinic services.

For Mid- and Senior-level Managers

- [ ] Encourage program and clinic managers to conduct cost studies. Explain to them how the information can be used to improve efficiency and productivity, to set fees for services, and to manage their resources more effectively.
- [ ] Provide clinic managers and their supervisors with necessary information on personnel and contraceptive costs to make their task easier.
- [ ] Respect the ideas of staff at all levels, and encourage them to make improvements to services based on their analysis and interpretation of cost data.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Determining Service Costs at Clínica La Villa

Returning from her lunch break, Mrs. Torres, a full-time nurse for Clínica La Villa, knocked on the door of Mrs. Varela, the Nurse Supervisor who managed the family planning clinic. "Mrs Varela, do you have a minute?" Mrs. Torres asked. "I have just had an interesting discussion with one of our clients, a nurse from San Gabriel hospital, and I wasn't sure how to answer some of her questions."

"Certainly, Mrs. Torres, come in," said Mrs. Varela. "What did the client ask?"

"She asked me why we charge the same amount for an IUD insertion as we do for an initial visit for pills," replied Mrs. Torres. "She said she had used both methods and thought that it really must cost us more to insert an IUD than to dispense pills. I had to agree with her that it seemed as though it would be more expensive to provide some methods than others, but I have no idea why and I couldn't give her a good explanation."

"Well, that's an interesting question," said Mrs. Varela, leaning forward in her chair. "We have never needed to figure out what the costs are for each kind of method we offer. However, because of the information campaign that the Ministry of Health is planning to run soon on injectables, I am expecting a big increase in the number of clients asking for injectables in the coming year, and I don't have a good idea of how much it will cost us to provide more injectables. In fact, I don't know exactly how much it costs us to provide any of our methods. I think it's time we learn how much it is actually costing us to provide services for each method so I'm glad you brought this up. Would you help me conduct a cost analysis to find out how much it costs us for each type of visit we offer? We will have to look at the different types of visits, such as first visits and revisits, for each of the contraceptive methods we offer. I'd like to get started on it this week."

"If you tell me exectly what you need, I could try and get some information ready for you by Thursday morning, and since the clinic doesn't open until noon on Thursday we could begin working on the analysis then," suggested Mrs. Torres.

On Thursday morning Mrs. Torres arrived at Mrs. Varela's office with several file folders and her calculator. She sat down next to Mrs. Varela and they began with the Personnel Cost Calculations Worksheet. "I talked to the accountant," began Mrs. Varela, "and he gave me a list of our staff categories and average salaries for the last year. He included benefits like the taxes the clinic has to withhold for the government and family allocation. We need this information in order to complete the worksheet on total personnel cost for our clinic. I started to fill out this worksheet by listing each category of staff employed by the clinic. Let's go through the other information and complete this worksheet."

"Now that the clinic is fully staffed," said Mrs. Torres, "we have the following categories of staff. Two half-time positions for doctors at 50 percent of an average annual salary of 5,700. One position for a full-time nurse supervisor at an average annual salary of 3,800. One full-time nurse at an average of 2,800, and two half-time positions for nurses at a salary that is 50 percent of an average annual salary of 2,800. There are also positions for a full-time nurse's aide at an annual salary of 1,700, and a full-time laboratory technician at an average salary of 2,500. Other personnel include a position for a full-time receptionist/clerical worker earning an average of 1,500 and a housekeeper at 950 per year."

"Now let's take that information and use it to calculate the total personnel cost," said Mrs. Varela.

Case Discussion Questions: Clínica La Villa

1. **What is the total personnel cost for Clínica La Villa?**
2. **What is the total personnel cost of each type of visit offered by Mrs. Varela's clinic?**
3. **What is the total cost of each type of visit provided at Clínica La Villa, if both personnel and contraceptive product costs are added together?**

Case Analysis: Clínica La Villa

1. What is the total personnel cost for Clínica La Villa?

To determine the total personnel cost, complete Worksheet 1 by listing the staff categories, the percent time spent working in Clínica La Villa, and the average salary of each category of staff listed. Then calculate the total personnel cost of each category of staff in Column E, to determine the total personnel cost for Clínica La Villa.

Worksheet 1: Total Personnel Cost—Clínica La Villa (in local currency)

A	B	C	D	E
Staffing grade or category	**Number**	**Percent time in family planning**	**Average annual salary including benefits**	**Total personnel cost [B x C x D]**
Doctor				
Nurse Supervisor (Clinic Manager)				
Nurse				
Nurse				
Nurse's Aide				
Lab Technician				
Receptionist/Clerical Worker				
Housekeeper				
Total				

Note: *The local currency used in the worksheets should be noted on each worksheet.*

2. What is the total personnel cost of each type of visit offered by Mrs. Varela's clinic?

When they had completed Worksheet 1, Mrs. Varela and Mrs. Torres pulled out the file containing the results of the client flow analysis that the clinic had conducted three months earlier. The results showed the average number of minutes that clients spent in direct contact with a service provider for each type of visit provided by the clinic. The types of visits varied for each of the methods offered at the clinic, but generally included a first visit and a follow-up visit. Using this information and the summary service statistics for the past year, the two women began to fill out a worksheet to allocate personnel costs to each type of visit.

You must complete the worksheet. To determine total personnel cost for each visit-type, complete Worksheet 2 by performing the calculations for Columns D, E, F, and G. You must complete your calculations for Column D before you begin the calculations for Column E. The results for Column E will be in decimals. To obtain a percentage, multiply the decimal by 100 and enter the percentages in each row in Column E that corresponds to the visit-type. For ease in figuring, you can round the percentage to the nearest whole percent, or nearest tenth of a percent. (Note: Due to rounding, the total of the percentages might not equal 100. It is acceptable if the total is between 98 and 102.) You will use the total personnel cost from the bottom of Column E on Worksheet 1 to calculate the figures in Column F on Worksheet 2.

Case Analysis: Clínica La Villa

Worksheet 2: Personnel Cost Per Visit-Type—Clínica La Villa (in local currency)

A	B	C	D	E	F	G
Visit-Type	**No. of visits in past year**	**Average minutes per visit-type**	**Total minutes [B x C]**	**Percent of total number of minutes [(D ÷ *) x 100]**	**Personnel expense (E x total from Worksheet 1) Write in total below for easy reference (21,750)**	**Personnel cost per visit-type [F ÷ B]**
Pill first visit	*375*	*15*	*5,625*	*10.8%*	*2,349*	*6.26*
Pill resupply visit	*890*	*6*				
IUD insertion	*275*	*20*				
IUD follow-up	*963*	*13*				
IUD removal	*75*	*16*				
Condoms	*530*	*5*				
Norplant insertion	*56*	*27*				
Norplant follow-up	*165*	*11*				
Norplant removal	*9*	*36*				
Injectable first visit	*89*	*18*				
Injectable follow-up visit	*762*	*10*				
Other family planning visit (counseling)	*450*	*14*				
Total	*4,639*		*			

3) What is the total cost of each type of visit provided at Clínica La Villa, if both personnel and contraceptive product costs are added together?

With the information from Worksheet 2, Mrs. Varela was able to determine the approximate personnel cost of each type of visit. Mrs. Varela then pulled out her files on the unit costs of each of the contraceptive products provided by Clínica La Villa that had been sent to her by the Ministry of Health. (To see how to calculate the unit cost of each contraceptive product and use Worksheet 3 "Unit Cost Per Contraceptive Product," see page 280.) Mrs. Varela then read the numbers to Mrs. Torres so that she could enter them in Column B of Worksheet 4.

To arrive at a total cost for each type of visit, complete Worksheet 4 by performing the calculations indicated in Columns D, E, and F for each visit-type listed. The figures in Column F will be the total cost of each type of visit Clínica La Villa provides, including both personnel and contraceptive costs.

Case Analysis: Clínica La Villa

Worksheet 4: Total Cost Per Visit—Clínica La Villa (in local currency)

A	Contraceptive Cost per Visit			E	F
Visit-Type	B	C	D	Personnel cost per visit (Worksheet 2, Column G)	Total cost per visit [D + E]
	Contraceptive unit cost (Worksheet 3, Column G)	Number of products used or distributed per visit	Total cost of contraceptives per visit [B x C]		
Pill first visit	*0.24*	*1 cycle*			
Pill resupply	*0.24*	*3 cycles*			
IUD insertion	*0.80*	*1 piece*			
IUD follow-up	*0.80*	*0*			
IUD removal	*0.80*	*0*			
Condoms	*0.07*	*20 condoms*			
Norplant insertion	*25.42*	*1 kit*			
Norplant follow-up	*25.42*	*0*			
Norplant removal	*25.42*	*0*			
Injectable first visit	*0.74*	*1 dose*			
Injectable follow-up visit	*0.74*	*1 dose*			
Other family planning visit (counseling)	*0*	*0*			

Case Conclusion: Clínica La Villa

When they had completed Worksheet 4, Mrs. Varela examined Column F which showed the total cost of each type of visit. "That nurse who is a client here was right," said Mrs. Torres. "It costs us more to insert an IUD than it does to provide services to a new pill client. And all this time we've been charging the same amount for each type of visit."

"And look at the cost of providing injectables," said Mrs. Varela. "It's currently taking us 18 minutes of provider time for a first injectable visit and ten minutes for a follow-up visit, which makes the injectable somewhat more expensive than providing pills. Since we anticipate that we're going to have an increase in the number of people requesting injectables, we should see if we can provide injectables more efficiently without compromising the quality of our services."

"Could we also think about changing our fee structure so that the fees we charge for IUDs, pills, and injectables are more like the true costs?" asked Mrs. Torres.

"I will look into that, Mrs. Torres," responded Mrs. Varela. "However, I am a little concerned about prices influencing the client's method choice, so I think we should think this through carefully before making any changes to the fee structure."

Case Answer Sheet: Clínica La Villa

Worksheet 1: Total Personnel Cost—Clínica La Villa (in local currency)

A Staffing grade or category	B Number	C Percent time in family planning	D Average annual salary including benefits	E Total personnel cost [B x C x D]
Doctor	*2*	*50%*	*5,700*	*5,700*
Nurse Supervisor (Clinic Manager)	*1*	*100%*	*3,800*	*3,800*
Nurse	*1*	*100%*	*2,800*	*2,800*
Nurse	*2*	*50%*	*2,800*	*2,800*
Nurse's Aide	*1*	*100%*	*1,700*	*1,700*
Lab Technician	*1*	*100%*	*2,500*	*2,500*
Receptionist/Clerical Worker	*1*	*100%*	*1,500*	*1,500*
Housekeeper	*1*	*100%*	*950*	*950*
Total	*10*			*21,750*

Worksheet 2: Personnel Cost Per Visit-Type—Clínica La Villa (in local currency)

A Visit-Type	B No. of visits in past year	C Average minutes per visit-type	D Total minutes [B x C]	E Percent of total number of minutes [(D ÷ *) x 100]	F Personnel expense (E x total from Worksheet 1) Write in total below for easy reference (*21,750*)	G Personnel cost per visit-type [F ÷ B]
Pill first visit	*375*	*15*	*5,625*	*10.8%*	*2,349*	*6.26*
Pill resupply visit	*890*	*6*	*5,340*	*10.3%*	*2,306*	*2.52*
IUD insertion	*275*	*20*	*5,500*	*10.6%*	*2,327*	*8.39*
IUD follow-up	*963*	*13*	*12,519*	*24.1%*	*5,242*	*5.44*
IUD removal	*75*	*16*	*1,200*	*2.3%*	*500*	*6.67*
Condoms	*530*	*5*	*2,650*	*5.1%*	*1,109*	*2.09*
Norplant insertion	*56*	*27*	*1,512*	*2.9%*	*631*	*11.27*
Norplant follow-up	*165*	*11*	*1,815*	*3.5%*	*761*	*4.61*
Norplant removal	*9*	*36*	*324*	*.6%*	*131*	*14.55*
Injectable first visit	*89*	*18*	*1,602*	*3.1%*	*674*	*7.57*
Injectable follow-up visit	*762*	*10*	*7,620*	*14.7%*	*3,197*	*4.20*
Other family planning visit (counseling)	*450*	*14*	*6,300*	*12.1%*	*2,632*	*5.85*
Total	*4,639*		*52,007* *	*100.1*		

Case Answer Sheet: Clínica La Villa

Worksheet 3: Unit Cost Per Contraceptive Product

A	B	C	D	E	F	G
Contraceptive Product	**Quantity Received**	**Expenditure on contraceptive products**	**Expenditure on international transport**	**Expenditure on customs, taxes**	**Total product and other costs [C+D+E]**	**Unit cost [F÷B]**
Pill (each cycle)	*497,040*	*$75,842*	*$42,212*	*$1,181*	*$119,235*	*$ 0.24*
Condom (each)	*2,334,000*	*$95,847*	*$72,839*	*$ 1,687*	*$170,373*	*$ 0.07*
Injectable (dose)	*703,950*	*$483,105*	*$36,225*	*$5,193*	*$524,523*	*$ 0.74*
IUD (each)	*9,000*	*$5,135*	*$ 1,998*	*$71*	*$7,204*	*$0.80*
Norplant (kit)	*4,300*	*$98,187*	*$9,225*	*$1,913*	*$109,325*	*$25.42*
Other (specify)	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
Total		*$758,116*	*$162,499*	*$ 10,045*	*$930,660*	

(Based on expenditures from the most recent year for a program covering several hundred clinics, in U.S. dollars)

Worksheet 4: Total Cost Per Visit—Clínica La Villa (in local currency)

A	Contraceptive Cost per Visit			E	F
Visit-Type	**B**	**C**	**D**	**Personnel cost per visit (Worksheet 2, Column G)**	**Total cost per visit [D + E]**
	Contraceptive unit cost (Worksheet 3, Column G)	**Number of products used or distributed per visit**	**Total cost of contraceptives per visit [B x C]**		
Pill first visit	*0.24*	*1 cycle*	*0.24*	*6.26*	*6.50*
Pill resupply	*0.24*	*3 cycles*	*0.72*	*2.52*	*3.24*
IUD insertion	*0.80*	*1 piece*	*0.80*	*8.39*	*9.19*
IUD follow-up	*0*	*0*	*0*	*5.44*	*5.44*
IUD removal	*0*	*0*	*0*	*6.67*	*6.67*
Condoms	*0.07*	*20 condoms*	*1.40*	*2.09*	*3.49*
Norplant insertion	*25.42*	*1 kit*	*25.42*	*11.27*	*36.69*
Norplant follow-up	*0*	*0*	*0*	*4.61*	*4.61*
Norplant removal	*0*	*0*	*0*	*14.55*	*14.55*
Injectable first visit	*0.74*	*1 dose*	*0.74*	*7.57*	*8.31*
Injectable follow-up visit	*0.74*	*1 dose*	*0.74*	*4.20*	*4.94*
Other family planning visit (counseling)	*0*	*0*	*0*	*5.85*	*5.85*

CHAPTER TWELVE

Charging Fees for Family Planning Services

Governments in the developing world pay for between 63 and 75 percent of all family planning costs, international donor agencies pay for between 15 and 20 percent, and the clients themselves pay for between 10 and 17 percent of the costs of services [Lande and Geller 1991]. But, as the demand for family planning services continues to increase, governments and donors will find it increasingly difficult to cover the costs of providing these services. Recognizing this problem, family planning organizations are beginning to look at other ways to fund their health and family planning services. As part of this effort to find new sources of revenue, many managers are asking the question, "Should family planning programs charge fees for services?"

Surprisingly, some studies indicate that continuation rates do not decline when fees for services are introduced. In fact, they show that contraceptive use rates often remain the same even after moderately priced services are introduced. Other experiences indicate that introducing fees may actually improve the quality of services and make the client a more responsible contraceptive user [Ashford 1992].

This edition of *The Family Planning Manager* looks at the pros and cons of charging for services. It reviews how managers can assess the feasibility of charging their clients for services, and how to overcome resistance to introducing fees. It then reviews the basics of developing a system for charging client fees, and concludes by outlining a basic system for managing fees.

This chapter was originally produced as Volume I, Number 3 of ***The Family Planning Manager****, including the case scenario, "Mr. Ngao's Proposal: Introducing Client Fees." The guest editor for the issue was Stephen Musau.*

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Financing Family Planning Services

Family planning services are usually financed through one or more major sources of funding:

- **Grants:** Funds from the government, or from local or international donors.
- **Third party payments (co-payments):** A system of paying for services whereby the client pays a portion of the fee and a third party (such as an employer, an insurance company, or a health plan) pays the balance.
- **Cross-subsidies:** A method of transferring the income from one service to pay for other services. This technique can be used to reduce the cost of one service (such as sterilization) by charging more for another service (such as laboratory analysis), or by charging more for services in locations where residents can pay more and using this money to provide lower cost services in poorer areas.
- **Client fees:** Registration fees, fees for individual services at the time of delivery, or membership fees.
- **Sale of other program services:** The sale of program services or products, such as training or educational materials, to clients or other organizations. This can include innovative techniques for generating income such as having a program-run food concession.

This chapter looks at financing a portion of family planning programs by charging **client fees**. Client charges are the prices clients are asked to pay for family planning services. The level of these fees might vary from one program to another depending on the goals of each program. Some family planning clinics operate to make a profit; they attempt to recover all or a part of their operating costs and make a profit. Not-for-profit agencies, such as many government programs, try to make their services available to as many people as possible for little or no cost to the clients. Sometimes the differences between the two types of programs are unclear. Some for-profit organizations may seek to expand their services to reach as many clients as possible, and not-for-profit organizations may want to make a profit so that they can expand their services, invest in new equipment, or offer services free of charge to couples who cannot afford to pay.

Government clinics might charge very low fees to emphasize the value of the services they provide, or to help clients grow accustomed to paying. A government program might first introduce fees to cover a very small portion of total costs, and then, over time, gradually raise fees to cover an even greater proportion of costs.

Assessing the Situation

Perhaps you are considering charging for services, or thinking about subsidizing certain key services by charging fees for other services. How will you know whether either of these options is feasible? To make these decisions you will need to answer the following questions:

What is your objective in introducing user fees? If you decide to charge a fee, determining what services to charge for and how much to charge will depend on your objectives for introducing the fee. *Do you want to expand access to basic services? Do you wish to become less reliant on donor or government funds? Do you want to make up the difference between operating expenses and income?* The objectives for charging a fee should be clearly stated and discussed because they will form the starting point for your decision about what to charge for and how much to charge. For some programs, charging for services may be the only way for the program to survive; other programs may charge for services so that they can increase access to and use of their services.

Can your clients afford to pay for the services you offer? Fees should not be so high that clients cannot afford to pay. If clients cannot afford to pay, the introduction of, or any increase in, fees might lead to a large reduction in clients. You will need, therefore, to consider some way of helping people who cannot afford to pay so that fees do not prevent them from obtaining your services. The clients' ability to pay will help determine how much of your costs can be recovered by fees and how much must be covered by other means.

Continued on next page

How to . . .

Determine Whether Your Clients are Able and Willing to Pay for Services

In programs that are providing services free of charge, it is important to assess whether your clients are able and willing to pay for services. Some people who are *able* to pay may not be *willing* to pay. Or they may be willing to pay only for some services and not for others. To determine clients' willingness to pay, you can conduct a local survey of clients and potential clients in the community. The survey should assess:

- client demand—*do your services meet your clients' needs, or are there other services that should be added?*
- whether clients would be willing to pay for these services—*which services would they be willing to pay for?*
- how much they would be willing to pay—*would clients be willing to pay for each type of service received, or only a small registration fee or donation?*

You can obtain these opinions by interviewing:

- clients as they leave the clinic (exit interview);
- small groups of clients or potential clients in the community (focus groups);
- members of the community or a client advisory committee;
- other residents, through outreach workers already working in the community.

What is your clients' perception of the quality of services you offer? In many countries, family planning clients equate cost with quality. If clients believe that your program offers good quality services, they will be more willing to pay for the services. Improvements can be made in the standard of services by:

- providing sensitive and clear counseling to clients;
- maintaining an uninterrupted supply of contraceptives;
- increasing the range of services;
- improving the condition of the building;
- reducing waiting lines;
- offering more convenient clinic hours.

Clients who pay a fee are more likely to value the services they receive. It enables them to demand high quality services. It has also been shown that if a client pays for contraceptives, she/he is more likely to use them.

Will your organization permit you to develop a fee-for-service program? Whether your organization is a public sector Ministry of Health clinic, a non-profit non-governmental organization (NGO), or a for-profit private sector program, you will need to consider possible regulatory and political restrictions to charging fees. In many cases, government approval may be required. In the public sector, government authorization may be needed to collect and use funds at the local level. The difficulties of introducing fees in the non-governmental and private sectors are not as great as they are in the public sector. For this reason, NGOs can play an important role in pioneering the development of systems for charging fees and in demonstrating their feasibility. Government programs can then use this experience to reduce resistance to charging for services in their programs.

Can you develop a simple system for collecting and accounting for the fees that will be charged? The cost of implementing a system of service charges should always be less than the projected income from the fees. The system should be easy to use and should require minimal additional work for clinic staff.

Will your facility be able to keep and use some or all of the fees it collects? Most of the revenue generated by the clinic should be kept by the clinic. This income can be used at the clinic's discretion to support its own activities, such as improving the services or the facility. To determine whether charging fees will benefit your clients, your assessment should estimate how much of the total projected revenue will be retained for use by your clinic.

What does it cost your organization to provide services? Although it is possible to set fees without knowing the actual cost of each service, it is important to try to accurately estimate what this cost is. Knowing the cost of each service will help you to:

- determine how much of your costs you can reasonably recover;
- develop cross subsidies for recovering some of your costs;
- enable you to justify the level at which you set the fee.

Once you have considered these questions, you should be prepared to make decisions about which services to charge for, what portion of the program expenses should be collected from clients, and how much to charge your clients for different types of services. You should also be ready to decide how the funds you raise can be used to increase the quality and accessibility of your services.

The next section presents arguments against and in favor of introducing fees for services, and suggests ways to manage potential resistance from staff and clients.

Some Arguments Against and in Favor of Introducing Fees

Against	In Favor
Family planning is a human right; it is an essential health service and should be free of charge as a matter of principle.	Governments and organizations always have to pay something to provide services, and there can never be enough funds to provide all couples with free family planning services.
Charging fees diverts attention away from social and health goals toward a focus on profit making.	By charging people who can afford to pay, the fees generated can be used to increase the quality and availability of services.
Charging fees will prevent poor people from benefitting from family planning services.	Exemptions can be made for the poorest clients, based either on income or on where they live.
Clients will stop using the services.	Clients often value services they pay for more than those that they get for free, as long as those services are of high quality.
Collecting fees is too costly and time-consuming.	The collection of fees can provide incentives to clinic staff to maintain high quality services, especially when a portion of the money is used to make improvements in services.
The quality of services will diminish if the emphasis shifts to making money.	If income is used to improve services or clinic conditions, more paying clients will be attracted to the program.
Donors may perceive less need for funding and reduce support.	Revenues from fees give managers greater flexibility to plan activities, and give them more control over programs and policies.

Adapted from Ashford 1991

Overcoming Resistance

There may be resistance to client fees within your organization. When you suggest charging for services, you may hear statements such as "this is against our policy, our services have always been free," or "our clients are too poor to pay for services." In such cases, you might have to convince your staff, supervisors, or Board of Directors of the value and advantages of charging fees.

Staff resistance. Once a decision has been made to charge for services, other areas of conflict may arise. For example, the collection of the fee may involve staff in new administrative duties that they do not consider a good use of their time. If a clinic can retain some of the fees it collects and use the income to improve its services and facilities, staff will usually be convinced of the importance of this change.

Client resistance. Clients who have been accustomed to receiving family planning services free of charge may resist the introduction of fees. It will be important to let clients know well in advance that fees are going to be introduced. A good public relations campaign that begins several months before the introduction of fees will help to reduce the negative impact of the new fees on user rates and acceptance rates.

It is particularly important for clients to be able to see for themselves the beneficial effects of the new fee structure (for example, improved services, reductions in waiting time, more convenient clinic hours, newly painted waiting areas, etc.). Money collected from fees can be set aside for these kinds of simple improvements. Even if fees are only intended to enable the clinic to maintain its existing level of service, a small portion of these revenues should be made available for clearly noticeable improvements in the clinic facility and services. Let your clients know about the concrete improvements their fees have paid for by posting a list of these improvements in the clinic waiting area.

The level at which you first set a fee is important. If the initial fee is low, clients might not object to the idea of being charged for a service. As clients become accustomed to paying for family planning services, the fee can gradually be increased.

Deciding What Type of Fee to Introduce

There are a number of different types of fees that can be introduced: registration fees, membership fees, service fees, and fees for contraceptives. Whichever type of fee you decide to introduce, the fee schedule should be posted in a visible location so that clients know the cost of registration and/or the individual services offered at the clinic.

Registration fees are a set amount collected from the client at each visit.

Membership fees charge clients a fixed amount on a yearly basis, entitling them to a range of clinic services.

Service fees are charged for each service provided, for example, examination, counseling, or laboratory testing. Service fees often include a charge for the contraceptive method the client selects. Another option is to set standard charges for an initial visit and a revisit. An initial visit might include the cost of an examination, counseling, and a contraceptive method, whereas the revisit might cover the cost of a resupply of contraceptives or a consultation.

Fees for contraceptives can be charged to the client and can be separate from other services that they receive.

Working Solutions—Senegal

Registration fees are perhaps the simplest fees to introduce and administer. The Pikine Primary Health Project in Senegal introduced a registration fee that is collected by a registrar. In this system two kinds of tickets are issued (red for children, who pay a reduced rate, and green for adults). The ticket is torn out of a receipt book and issued to the client at the door. A supervisor uses the remaining stub to check against receipts.

Because of their simplicity, registration fees can be an effective way of introducing the idea of charging for services. Once the idea of registration fees is accepted, other methods of charging for services can be developed. [Jancloes et al., as cited in Griffin 1988]

Determining How Much to Charge

Ability to Pay. There are a number of different ways of deciding how much to charge for a service. The easiest way to set a fee is to base it on what your clients are able and willing to pay. This can be approached in various ways. For instance, you can set a fee based on what clients pay for services at other family planning facilities that already charge fees. Fees will range between the charges at private, for-profit clinics (which usually charge the highest fee), and the charges at government clinics (which are often free).

Price of Household Items. Another way is to set your fees in line with the price of common household commodities, such as a kilo of rice, a liter of oil, a bottle of beer, or a soft drink. In one health zone in Zaire, managers decided that the price of a monthly membership fee should not exceed the price of two kilos of soybeans. The Responsible Parenthood Association of Suriname bases its annual membership fee on what a client would pay for 12 soft drinks. This annual fee, which is the equivalent of the cost of one soft drink per month, entitles the client to a year's worth of family planning services.

Specific Objectives. Another approach is for managers to establish specific cost recovery objectives. For example, a manager might wish to recover 20 percent of operating costs by charging client fees. To do this, managers need to estimate the cost of each type of service using the actual costs of personnel time (based on salaries), contraceptives, and other commodities used in delivering that service. Once you have estimated the cost of each service, you can set a fee which will allow your program to meet its cost recovery objectives.

In the first two approaches, the fee is based on what clients can pay or are already paying for services and commodities. In the third, fees are based on program objectives, such as increasing financial self-sufficiency or recovering enough income to expand access to services to a specific population of clients in a poor or underserved area.

Developing a System of Controls for Fee Collection

For each service facility, it is advisable to have a central location where money is collected. Having a central location provides a site for making any needed and appropriate payment adjustments for those who may have difficulty paying the full amount. A receipt for any payment should be given to the client, and a duplicate retained for the clinic records. For those clients who are not literate, standard procedures need to be established to ensure that these clients receive appropriate information that is easy to understand.

The administration of a system of client charges will require some changes in clinic policies and staff functions to ensure that the money received is properly accounted for and productively used.

The introduction of client fees will require:

- a system for collecting and checking fees at service sites;
- exemption policies or waivers for those not able to afford the cost of services;
- internal financial controls;
- regular financial reporting.

When developing a system for charging clients, keep in mind the following:

The administrative costs required to implement user fees must be considered in making the decision as to whether or not to collect fees and in designing the fee structure.

A supervisory system should be developed so that the work of all those involved in billing clients or collecting cash can be checked by another person to ensure accuracy. It is very risky to allow one person to be responsible for several transactions on his/her own, such as registering clients and receiving and recording cash payments.

Information from financial registers should be regularly compared with other records in the clinic, such as inventory control cards, and daily activity registers. *For example, the daily activity register, which records the services provided and the contraceptives dispensed, can be compared with the financial register to make sure that all financial transactions are regularly recorded for each client.*

How to . . .

Manage Money Collected from Fees

- Use pre-numbered receipts for all cash received.
- Use a register to record all money received.
- Store all money promptly in a safe place.
- Make sure that all money collected is accounted for and deposited in a bank (or another safe place) before the money is used for other purposes.
- Keep a duplicate of all cancelled receipts for clinic records.
- Lock up all unused receipt books.
- Record the amount withdrawn in a cash book any time that money is taken out of the bank (or other location).
- Recalculate the balance in the cash book every time a deposit or withdrawal is made.

How to . . .

Develop a System of Financial Controls

A basic system of controls incorporates four processes: collecting fees, handling cash, accounting for cash, and reporting income and expenses.

Collecting Fees. The procedure for collecting fees will depend on the kind of fees you charge. In clinics charging a registration fee only, clients should pay when they arrive and should, preferably, give the money to a different person from the one who is doing the registration. After the client has been given a receipt (a duplicate is kept for the clinic records), she/he can then be seen by a family planning staff person.

In clinics that charge one fee regardless of what type of service the client receives, clients should pay the cashier at the beginning of the visit or at the time of registration. In clinics where different fees are charged for different types of services—for example family planning consultations, contraceptives, drugs, treatment, or laboratory tests—the time and place of payment will depend on the way that the services are organized. Many clinics often collect fees at the end of the client visit.

Handling Cash. The amount of cash received from a client should always be recorded in a consecutively numbered receipt register. The client should receive a numbered receipt; a copy of the receipt should be retained in the receipt register. At the end of each day, the cash and the receipts should each be totaled. When compared, these totals should be identical. If the totals are not identical, record the actual amount of cash received in the cash record book noting the reason for (and the amount of) the discrepancy, and make a copy for the supervisor. All cash should be deposited in a bank daily (if there is no bank, the money should be kept in a safe place under lock and key). In either case, the exact amount and the date of the deposit should be recorded daily in the cash record book.

Accounting for Cash. Cash must continue to be accounted for in other ways, even after it has been deposited. Each time money is taken out of the bank (or other location), the amount withdrawn must be recorded in the cash book and the new bank balance figured and recorded in the cash book. At the end of each month, the total cash book balance to date (subtracting any withdrawals) must be compared and reconciled with the balance shown on the bank record (bank statement). If the balance in both the bank's and the clinic's records are not identical, then you must determine the reason for the discrepancy and make the necessary adjustments in your records so that the balances match. This is called bank reconciliation.

Reporting Income and Expenses. Regular financial reports are essential for monitoring and managing revenue generated from client fees. At a minimum, a program should include information on total revenue and revenue by category of service. If possible, information should be collected on projected annual revenue (price per type of service *multiplied by* the expected number of clients receiving each service in a year) and projected number of clients who will qualify for exemptions or subsidies. Most financial systems will produce the following reports:

- **a daily revenue report,** which shows the amount of revenue generated for each visit and type of service provided. This report also indicates the exact amount of cash received and records the amount of waivers and exemptions that have been granted.
- **a monthly revenue report,** which shows the total amount of revenues received by each category of client visit and by type of consultation.
- **a quarterly revenue report,** which summarizes revenues received over a period of three months and is sent to the area supervisor.
- **an income statement,** which summarizes and compares total program revenues against expenses for an accounting period, usually 12 months. The totals of each major source of revenue and category of expense should be listed. The subtotal for expenses should be subtracted from the subtotal for revenues to show a surplus or shortfall. The income statement is a critical tool for determining whether client fees are covering the percentage of costs that you intended, and whether the actual costs are more (or less) than estimated.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On employer participation . . . *One reviewer commented on the advantages of offering family planning services through a company benefit package.* "Another way to bill for services is to arrange to provide services for employees of local companies and bill the companies directly. The clients benefit from the availability of low-cost family planning services, and the company benefits by having fewer women absent from the work place due to unplanned pregnancies."

On fees for each service . . . *One of our reviewers comments,* "We have been thinking of increasing our fees. Presently we have a membership fee which covers contraceptive services. We are now looking at the feasibility of increasing fees as well as charging separately for each service. Most family planning agencies in our region are beginning to charge for services."

On fees that empower clients . . . *Several reviewers pointed out the ethical issues surrounding client charges.* "If a man or a woman pays for services, then the program is assured of his or her consent. It is unlikely that anyone will pay for a contraceptive method that he or she has been forced to accept. By asking for a fee, the provider tends to be seen in a less paternalistic light and can be held responsible for the quality of the service. If services are free, the user cannot hold the provider accountable. By charging reasonable fees, we are actually empowering women."

On profit-making services . . . *One of our reviewers with extensive experience in cross-subsidization says:* "Concerning cross-subsidization, the golden rule is that fees charged for curative or laboratory services must always provide some profit. These services should never be subsidized by family planning services. If they are not profitable, they must be abandoned. Right from the start, the program should be structured so that family planning does not help pay the costs of the curative or the laboratory services."

On integrated services . . . *Our Guest Editor provided the following interesting information about cost recovery for family planning services in Kenya.* A study in Kenya of family planning providers (both for-profit and not-for-profit programs) found that the more integrated the program, the greater its ability to recover operating costs. Among clinics that integrated family planning and maternal and child health (MCH) with primary curative services, an average of 90% of direct family planning service costs were recovered. In comparison, an average of about 34% of direct family planning service costs were recovered by programs that offered family planning/MCH services alone. [Kibua, Stewart, Njiru, and Gitari, 1990]

Working Solutions—Kenya

In Kenya, the Marie Stopes/Population and Health Services Program has developed an innovative system for collecting and subsidizing service fees. A charge for each type of service is posted at the clinic and clients are asked to pay for the services they receive. The program retains a special reserve fund for clients who cannot afford to pay the full fee. Generally, clients pay a portion of the full cost and the fund pays the remaining balance. Clients are not told in advance that the fund is available, but in outreach sessions people are told that nobody will be turned away for lack of money.

The fund can only be used by clients who meet one or more predetermined economic and social criteria. The form on the next page is used at each visit to determine the client's eligibility for financial support through the fund. The form reports the amount of support claimed from the fund for each visit. The clinic maintains a permanent monthly record of the clients who have used the fund (including the amount each client used from the fund). Each month this record is submitted to the accounts department for reimbursement to the clinic.

Continued on next page

Special Reserve Fund Access Checklist

Name: _____ **Occupation:** _____

Address: _____ **Source of Referral:** _____

Client Number: _____ **Age:** _____ **Parity:** _____

All clients who are eligible to use this fund must meet one or more of the social/economic criteria listed below.

Criteria Checklist (check all that apply)

☐ **1.** Poor mothers who are either unemployed or very low-paid

- ☐ a) Minimum wage earners working in government or other institutions (clerical staff, office messenger, cleaner, security, etc.) SPECIFY_____
- ☐ b) All persons not regularly employed
- ☐ c) Persons working on tea and coffee estates
- ☐ d) Unemployed

☐ **2.** High-parity mothers who cannot afford to pay

☐ **3.** Clients who own one acre of land or less

☐ **4.** Married or single mothers with no financial support

☐ **5.** All clients who submit a fee waiver form supplied by a program staff person in the field

☐ **6.** School or college students who cannot obtain financial assistance from parents or other persons concerned

☐ **7.** Clinic staff members and their immediate family (mother, daughter, father, son)

☐ **8.** Clients referred from clinics located in low-income or underserved areas

Total Fee Charged ☐

Amount Paid by the Client ☐

Amount Claimed from the Fund ☐

Adapted from TYAGI Fund Access Criteria Checklist developed by Marie Stopes/Population and Health Services Program, Kenya

Developing a System of Exemptions and Waivers

In order to make family planning services more widely available to everyone, regardless of income level, it is important to establish a system to completely **exempt** certain categories of clients from having to pay a fee such as, the handicapped or the unemployed poor. For example, in Zimbabwe, clients earning below the minimum wage are exempt from program fees. A system should also be established to charge a reduced fee to clients who cannot afford to pay the full fee by **waiving a portion** of the fee based on standard income criteria. The "Working Solutions" example on the previous pages presents a waiver system that employs a standard set of criteria to determine which clients are eligible to draw on a reserve fund to pay part of the fee.

Any system for waiving or reducing fees needs to be made administratively simple so that it doesn't take up staff time. Such a system must also have controls to make sure that it is not abused. A simple questionnaire to help assess the client's economic status can be a useful tool to ensure a standardized approach. A sliding-fee scale based on household income and family size allows clients to pay what they can afford. The mode of payment should be flexible, so that if a client cannot afford the fee, she/he has the option of paying it in kind. For example, in one hospital in Zaire, women can pay by working in the hospital garden, where they grow vegetables to feed malnourished children.

Communicate and Motivate

Once you have developed an overall fee system, it is essential to inform the community of this change. The community has a right to know the fees that will be charged for each service, how the fees are being used, and whether the organization is making a profit or not. It is also important to explain that the income from the fees is being used to improve overall clinic services and to subsidize the cost of providing services for people who are unable to pay. If you use a promotional campaign to publicize your new fee structure, select media that are most likely to reach your target audience(s). Make sure that the messages are interesting, informative, and motivating.

Making the public aware of the existence of exemptions, waivers, price reductions, or payment options is an effective way to market a new fee structure. The existence of such systems demonstrates the organization's concern for the welfare of disadvantaged groups in the community. It is important to stress that the income from fees will enable your clinic both to continue providing services and ensure the quality of those services.

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Checklist for Charging for Family Planning Services

For Clinic Managers

- [ ] Conduct a promotional campaign to explain the purpose of the new fees, the fee levels, how the income from the fees will be used, the potential benefits to the client, and when the new fees will begin. Be sure to post a fee schedule in a visible location in the clinic.
- [ ] Train and supervise staff to implement a system of controls to manage client fees.
- [ ] Use the income from fees to make improvements in the quality of your services, and tell your clients about these changes.

For Supervisors

- [ ] Assess the feasibility of charging fees, and communicate this information to senior managers.
- [ ] Survey clients to determine whether charges for selected services and commodities are reasonable.
- [ ] Develop a training plan with your clinic managers for the introduction of the new fee structure.
- [ ] Develop a plan with the clinic managers to use the income to make improvements in the services or the facility. Tell the next higher level managers of these plans.

For Mid- and Senior-level Managers

- [ ] Support the elimination of organizational or regulatory barriers to charging client fees.
- [ ] Make the administrative changes necessary for the introduction of client fees or cross-subsidies.
- [ ] Develop new administrative procedures for collecting and reporting fee revenues.
- [ ] Support local clinics in conducting promotional campaigns to publicize the introduction of service fees.
- [ ] Develop consistent policies for waivers, exemptions, and fee reductions.
- [ ] Identify ways of helping to pay for family planning services with funds generated from other health services.
- [ ] Develop mechanisms that allow local clinics to use part or all of the income they generate to make necessary improvements to their own facilities.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Mr. Ngao's Proposal: Introducing Client Fees

Mr. Ngao, the regional field supervisor for government family planning services, greeted the eight clinic managers he supervised and presented the agenda he had posted on the wall.

"At our meeting last month," he began, "we discussed the pilot project that the Ministry of Health is planning to launch to test the feasibility of charging for family planning services. Yesterday, I was informed by the Ministry that our region has been selected as a site for this pilot project. When we spoke about introducing fees last month, some of you were worried that charging for family planning services might discourage people from coming for family planning services. I know that charging for services is a sensitive subject, but we have been asked by the Ministry for some ideas on how to introduce fees."

The clinic managers were silent for a minute. Mrs. Atieno was the first to speak. "Government services have always been free. I think it's wrong to ask people to pay for family planning services."

Mrs. Mwangi straightened up in her chair. "That's one view, but we are providing a valuable service. People often place more value on things if they pay for them, even if it is only a small amount. If they pay for contraception, I think that people might be more likely to use it."

"I agree with you," said Mr. Kibunga, "but some clients are really too poor to pay. Couldn't they be exempted from paying?"

"The clients at my clinic have some money at harvest time but eventually run out of cash," said Mrs. Awiti. "Perhaps we could waive the fee for them during those seasons when they are short of money?"

"We could suggest to the Ministry a system of waiving fees or exempting certain clients who can't pay," Mr. Ngao replied. "We would have to come up with criteria for identifying clients who could not pay."

"At our clinic some of our clients are able to pay and are also very busy," said Mr. Thuo. "These kinds of clients might be willing to pay for a fixed appointment if they didn't have to wait."

"Perhaps we could offer our clients the option of scheduling an appointment. We could charge more for appointments than for walk-in clients," said Mr. Ngao.

"I think that system would be difficult to implement," commented Mrs. Atieno. "I think that developing a sliding fee scale, which sets fees based on client income levels and family size, might be a more practical option. I'd like to understand better how the system would work and how we would administer it."

Mr. Ngao then asked his managers to prepare a plan that included: the information that would be needed in order to decide what to charge for, who to charge, and how much to charge; the administrative changes that would be needed to charge fees; and the steps that each clinic manager should take before introducing client fees.

Case Discussion Questions: Introducing Client Fees

1. **What factors should Mr. Ngao's managers consider in deciding what kind of services to charge for, who to charge, and how much to charge?**
2. **What kind of administrative changes will be required to introduce client fees?**
3. **What steps should be followed before introducing client fees?**

Case Analysis: Introducing Client Fees

1. **What factors should Mr. Ngao's managers consider in deciding what kind of services to charge for, who to charge, and how much to charge?**

Mr. Ngao and the eight clinic managers should gather information on such things as the:

- Ministry's objectives for charging fees;
- clients' ability to pay;
- clients' willingness to pay;
- client perception of the quality of current services;
- services which clients would be most willing to pay for;
- estimated cost of providing services;
- cost of new administrative procedures required to introduce fees.

2. **What kind of administrative changes will be required to introduce client fees?**

The administration of any fee system will require developing new administrative and financial procedures for handling the fees that will be collected. These include development of internal financial controls to ensure that money received is properly accounted for and productively used. In addition, waiver and exemption policies should be developed. After a detailed assessment, Mr. Ngao's managers need to clearly define the administrative procedures required for:

- collecting fees;
- handling cash;
- accounting for cash;
- reporting income and expenses;
- implementing a fair and flexible system of waivers and exemptions.

3. **What steps should be followed before introducing client fees?**

Mr. Ngao's clinic managers might consider some of the following activities in preparation for introducing client fees:

- Explain the new program to the staff and describe the benefits that can be expected from charging fees for services.
- Let clients know well in advance that a new system is being introduced.
- Make sure that both staff and clients know what the fees are being used for, and then make sure that the income from the fees is used for the purposes and improvements that were promised.
- Train staff in new financial procedures and then implement a fair and flexible system of waivers and exemptions.
- Discuss with staff how to manage potential complaints from clients about the fees.
- Consider what kind of drop in client attendance would be acceptable as a result of introducing fees. Decide what action to take if the decline is greater than expected.

CHAPTER THIRTEEN

Improving Contraceptive Supply Management

Having the right contraceptives on hand to meet the needs of all clients builds confidence in the services, helps ensure that clients will keep coming back to the clinic, and helps prevent unwanted pregnancies.

The contraceptive supply systems used by family planning programs differ from program to program. Some systems determine quantities to reorder using only historical data, such as distribution reports. In other systems, clinic managers order contraceptives based on estimates of the program's needs. Programs also differ in how often stock is ordered and how the quantity of the order is determined. In spite of these differences, the principles of supply management are the foundation of these systems and their variations, and are highly effective in improving the management of contraceptive supplies.

This issue of *The Family Planning Manager* is designed to help *all* clinic staff understand and apply the principles of effective contraceptive supply management. It presents basic techniques for storing, managing, and ordering contraceptive supplies. Following a discussion of the fundamentals of good supply management, this issue provides guidelines to help managers keep contraceptive supplies in good condition through proper storage, and reviews how managers and their supervisors can keep inventory information up-to-date through regular record-keeping.

The key to effective supply management in the clinic is the Maximum/Minimum inventory system. This issue of *The Family Planning Manager* explains how this system works and provides detailed instructions on how to set it up for the first time. The issue concludes with a discussion of how supervisors and program managers can help support effective contraceptive supply management in their clinics.

This chapter was originally produced as Volume I, Number 4 of ***The Family Planning Manager****, including the case scenario, "Mrs. Asuman's Emergency Order." This issue was written by Susanna Binzen, in collaboration with Jack Graves and Rich Owens.*

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Mastering the Basics of Good Supply Management

There are two important reasons why program managers, clinic managers, and health and family planning clinic supervisors need to know about contraceptive supply management. First, family planning clinics must always be able to obtain the contraceptives they need, when they need them, and in the quantities they need in order to provide their clients with an uninterrupted supply of contraceptives. Second, contraceptive supply systems must prevent wastage caused by overstocking or expiration of unused contraceptives. Poorly managed supplies often result in emergency procurement and shipping at expensive rates. In addition to financial issues, if contraceptives are not managed well, the program risks losing the trust and confidence of its clients and the community.

In order for managers to have an effective supply management system, they must have accurate information that is regularly updated. Most decisions are based on four key pieces of information:

- **Average monthly consumption (AMC)** - the amount of stock that your clinic uses each month;
- **Losses** - the amount of stock that is lost or is otherwise not usable due to damage, expiration, or other causes;
- **Inventory** - how much stock you have on hand;
- **Lead time** - the length of time between placing an order and receiving the supplies.

In this chapter, you will learn how to use this information to make decisions about ordering and stocking contraceptives. First, however, it is important to discuss two basic aspects of supply management: how to **store supplies**, and how to **ensure the quality of the contraceptives** provided by your program.

Storing Supplies

At every step in the journey from the manufacturer to the client, contraceptives have to be stored. Whether they are kept in a large warehouse, a small room, a cabinet, on a shelf, or in a desk drawer, they need to be stored under appropriate conditions to guard against damage, and storage time must be minimized to prevent expiration.

Contraceptives should be kept away from excessive heat (above 40° centigrade), humidity, direct sunlight, water, insects, and animals. The room or area where they are stored should be well ventilated. It should either have windows to provide cross ventilation, or a fan to provide good air circulation. The durability of each type of contraceptive varies, but proper storage conditions are particularly important for storing condoms, which are more susceptible to degradation due to poor storage conditions. Any storage area should always be kept locked to prevent unauthorized entry.

Clinic Manager's Checklist for Assessing a Storage Facility

Work Space	Is the storage facility large enough to allow for dispensing, receiving, and checking supplies?	YES	NO
Temperature	Is the temperature of the storage area:		
	below 40°C?	YES	NO
	between 15°C and 30°C where injectables are stored?	YES	NO

(If NO, try changing ventilation, insulation, windows, and cooling or heating systems to reach a storeroom temperature which is safe for the storage of these contraceptives.)

Lighting	Is there sufficient lighting to read product identification marks and labels easily?	YES	NO
	Are contraceptives kept out of direct sunlight or fluorescent light?	YES	NO
Dryness	Are floors and walls dry?	YES	NO
	Are roofs, windows, and doorways without leaks?	YES	NO
Properly Stacked Supplies	Are cartons stacked no more than 2.5 meters high?	YES	NO
	Are stacks off the floor and away from the wall?	YES	NO
	Are commodities that will expire first kept on top or in front?	YES	NO
	Are shelves used in storing contraceptives?	YES	NO
	Are pallets used to keep contraceptives off the floor?	YES	NO
Cleanliness	Are facilities clean, neat, and free of dust?	YES	NO
	Is there a regular schedule for cleaning the ceiling, walls, and floors of the storage facility?	YES	NO
Pest-free	Are storage areas free from signs of pests (live or dead insects, insect eggs, live rodents, rodent hair or feces, cartons that show signs of chewing or boring)?	YES	NO

(If pests are present, chemical insecticides or rat poison should be used regularly. Such chemicals should be stored away from contraceptives and medical supplies. Window screens may be needed. Rodent holes should be filled with stones or other hard materials or covered with sheet metal.)

Record Keeping	Are inventory records up-to-date?	YES	NO
	Are inventory records accurate?	YES	NO
Stock Levels	Are stock levels appropriate for established maximum and minimum inventory levels?	YES	NO
Quality Assurance	Is there a system for performing quality control checks to ensure that contraceptives are usable and have not reached their expiration dates?	YES	NO
	Are damaged/expired contraceptives removed and disposed of according to program guidelines?	YES	NO
Security and Safety	Is there a security system that limits access to the storage area?	YES	NO
	Are all doors and windows secured?	YES	NO
	Are fire extinguishers located in easy-to-reach places?	YES	NO
Access	Is an authorized person with a key available during all service hours so that clinic personnel can obtain supplies when they need them?	YES	NO
Physical Inventory	Is a physical inventory conducted at least once every 6 months?	YES	NO

If you answered NO to any of the questions above, you should consider making changes to protect the shelf life of your contraceptives, facilitate efficient cleaning and movement of your stock, and guard against losses of supplies.

Preventing Stock from Expiring on the Shelf

To make sure that contraceptives do not expire before they are used, always distribute the oldest contraceptives you have in stock first. The FEFO (First-to-Expire, First-Out) system is designed to help you do this. All cartons must be marked with an expiration date. Whenever new commodities arrive, you should check the expiration date and mark the date on the carton. If the supplies only show the date of manufacture, you should determine the product's expiration date based on the date of manufacture and the product's shelf life (see below). Expiration dates should be the standard point of reference. After all the newly arrived cartons have been marked, they should be stored behind or underneath cartons with earlier expiration dates. In this way the commodities that expire first will be distributed first. The FEFO system will minimize waste due to expiration.

Guidelines for Assuring the Quality of Contraceptive Supplies

Since contraceptives can become damaged, especially if they are kept under poor storage conditions, it is important for staff to know the warning signs that indicate that a contraceptive product may no longer be effective. The shelf life guidelines given here pertain to USAID-supplied contraceptives that are stored under correct conditions. Other types and brands of contraceptives may have different shelf lives. If a contraceptive shows any of these warning signs, even if it has not reached its expiration date, it should be disposed of according to program guidelines.

Oral Contraceptives **Shelf life: 5 years**

Do not use the pills in a packet if:
- a pill crumbles when it is pushed through the aluminum backing
- the aluminum packaging for any of the pills is broken
- the packet is missing pills
- some pills are not the correct color

Condoms **Shelf life: 3-5 years**

Do not use condoms from a batch if:
- the condom packets are sticky or brittle
- condoms or their lubricant have yellowed

Condoms can be damaged by prolonged exposure to sunlight, temperatures above 40°C, humidity, ozone produced by electric motors and fluorescent lights, or contact with mineral or vegetable oils. Chemical products should not be stored in the same warehouse with condoms, as petroleum vapors and various types of liquid solvents damage the condoms.

IUDs **Shelf life: 4 years**

Do not use if sterile packaging has been broken or perforated.

Because IUDs are made of plastic, they should be protected from heat or direct sunlight. All product contents should be in the sterile wrapper, and the insert information must be legible. It is acceptable for the copper on copper-bearing IUDs to darken. (Note: Shelf life is different from use life; many IUDs are now effective for up to eight years after insertion.)

Injectables (not supplied by USAID) **Shelf life: 5 years**

Vials will remain potent and stable up to the expiration date if stored at room temperature (15°-30°C).

Implants **Shelf life: 5 years**

Do not use if:
- the implant's sterile packaging is broken
- some of the capsules are missing

The implants must be protected from excessive heat and direct sunlight, and must be stored in a dry place.

Diaphragms **Shelf life: Variable**

Do not use if:
- the diaphragm looks dirty
- the diaphragm shows holes or cracks when held up to a light

Spermicidal Jelly **Shelf life: 3 years**

Do not use if:
- the jelly tube is wrinkled or leaking
- the applicator cannot be screwed easily onto the top of the tube

Spermicidal Foam **Shelf life: 3 years**

The can of foam should not be exposed to intense heat or extreme fluctuations in temperature or humidity. It should be stored upright.

Foaming Tablets **Shelf life: 5 years**

Do not use if:
- the package has broken or missing tablets
- the package is puffy (this indicates a moisture leak)
- the foil laminate has cracks
- the tablets vary in color
- the tablets are soft, crumbly, wet, or damp

Maintaining Adequate Supply Levels

Running out of supplies is a very serious problem, and having an oversupply is a waste of money and space. Therefore, it is very important to manage your contraceptives so that you always have sufficient quantities of contraceptives on hand to meet your clients' needs, but not such large quantities that contraceptives expire before they can be used. A commonly used and efficient system for keeping the right amount of contraceptives on hand is the **Maximum/Minimum** (Max/Min) system, where maximum and minimum supply levels are expressed in terms of a certain number of months of supply.

There are several variations of the Max/Min system. In some Max/Min systems, orders are placed only when the clinic manager determines an order is necessary. Other systems (such as the one described here) are based on placing regular orders, for example every three months. There are also different ways of calculating the maximum, minimum, and order quantity. This chapter presents a simplified version, but whether you use this or another method of calculating Max/Min, the purpose is the same: to make sure that you never run out of stock.

Under the Max/Min system, every clinic and facility has a maximum inventory level set low enough to prevent overstocking and wastage, and a minimum level set high enough to prevent shortages and stock-outs, even if deliveries are late or demand increases. The basic principle of the Max/Min system is that, under normal circumstances, facilities will have no more than the recommended maximum stock level on hand at any time, and will order (or be issued) additional supplies on a regular basis, even if the stock level is above the minimum.

Supply levels in a Max/Min system are expressed in terms of the number of months' worth of supplies needed to meet client demand. For example, simply knowing that you have 600 cycles of Lo-Femenal on hand doesn't tell you how long that supply will last. Once you know that your clinic dispenses an average of 200 cycles per month, you know that your supply could be expected to last three months. Thus, the maximum and minimum levels are expressed in terms of months' worth of supply.

> The **average monthly consumption** (AMC) of a contraceptive is the average number of units of a single type of contraceptive that are dispensed in a month. The average is usually based on quantities that have been dispensed over a period of six months. In situations where demand is changing rapidly, however, the average should be calculated based on shorter periods, such as two or three months.

The Max/Min system works best in programs where the demand for contraceptives is fairly steady. It does not work as well when there are great fluctuations in demand (more than 50% variation from month to month), when demand is changing rapidly (growing or declining by more than 10% per month), or when demand is seasonal. In such programs, you can still use the Max/Min system, but you will need to set your minimum level fairly high in order to ensure that you don't run out of stock. With seasonal variations, you will have to calculate the AMC based on demand during the same months in past years.

Using the Max/Min system you also have to watch product expiration dates very carefully, because if large quantities of stock expire at one time, you will suddenly find yourself with less usable stock than you anticipated. In addition, expired or damaged contraceptives take up valuable storage space. In order to keep your stock as current as possible, expired or damaged supplies should be disposed of promptly, following your program's disposal guidelines, so that you start off with a supply of unexpired and undamaged contraceptives. If your program does not already have guidelines for proper contraceptive disposal, you should establish them before setting up the Max/Min system. Disposal of any contraceptives should always be fully documented.

Keeping Track of Supplies

There are five forms needed for setting up and maintaining an effective inventory control system. These are the **Stock Card**, the **Status of Supplies Chart**, the **Contraceptive Data Analysis Chart**, the **Requisition and Issue Voucher**, and the **Quarterly Reporting Form.** Each form has a different purpose: recording supply transactions, calculating desired inventory levels, monitoring inventory levels, ordering new supplies, or reporting contraceptive and service information.

Basic Supply Management Forms

The **Stock Card** (also known as an Inventory Control Card) is used to provide an up-to-date record of all stock movement (contraceptives received and dispensed) and the quantities of the contraceptives both currently in stock and on order. A separate stock card is maintained for each type and brand of contraceptive. The stock cards should be kept in or near the storeroom or warehouse.

The **Status of Supplies Chart** is used for calculating average monthly consumption (AMC) and the desired minimum and maximum levels for all types of contraceptives. Monthly summary data on the quantities of each contraceptive that have been dispensed over a period of time (usually six months) are derived from the stock card. The Status of Supplies Chart serves as a worksheet and allows managers to record, on a single chart, information about all types of contraceptives the clinic dispenses. It is generally used by the clinic manager when setting up a Max/Min system. However, it can also be used to do periodic analyses (every six months) of contraceptive distribution levels, or to recalculate the AMC and the recommended maximum and minimum stock levels.

The **Contraceptive Data Analysis Chart** is a tool that helps managers monitor changes in the quantities of stock on a month-by-month basis by providing a summary of the stock transactions that cover a period of a year or more. A separate form is used for each type and brand of contraceptive dispensed by the clinic. It keeps track of monthly stock on hand and the amount of supplies ordered, received, and dispensed, and permits easy calculation and review of the AMC and the stock position (the number of months' supply on hand). Managers should keep the charts for each of the contraceptives together in a single notebook for easy reference.

The **Requisition and Issue Voucher** serves several purposes. This form is used by the clinic manager to order new supplies, by the warehouse manager to fill the order and record the quantities sent, and again by the clinic manager to check that the clinic received the correct quantities and types of supplies she/he ordered. It is the only form used for ordering new supplies from the warehouse (or other supplier). However, it is more than an order form because it also summarizes (for each type and brand of contraceptive ordered) the average monthly consumption for that contraceptive, the clinic's desired maximum quantity, and the quantity on hand at the time of the order. The information on consumption, maximum levels, and quantities currently on hand, therefore, serves to justify the quantities ordered. The form is designed to be used on a quarterly basis, but new programs may initially need to order on a monthly basis until consumption patterns have been established.

The **Quarterly Reporting Form** serves two main purposes, to summarize and to report on contraceptive use and on service delivery (client) data. The form summarizes (for each type and brand of contraceptive) the quantity on hand at the beginning of the quarter, the total amount received and dispensed during the quarter, any adjustments or losses, and an ending balance. In addition, it shows the number of new acceptors, revisits, and total visits, and how many of each type and brand of contraceptive were dispensed. Although service delivery data are not necessary for routine contraceptive supply management, they are needed for other program management purposes. These data can also be used to analyze trends in contraceptive use among different types of clients and patterns in client choice, thus improving the program's long range forecasts of contraceptive requirements. The form is designed to be used on a quarterly basis, but could be adapted for monthly reporting.

Using the Stock Card

The clinic record-keeping system described here is based on the use of a **Stock Card**. Every storage facility, large and small, should maintain a stock card for each item in stock (for example, each brand and formulation of pill, each size or color of condom). It is acceptable to use ledgers instead of stock cards, but cards are easier to manage and provide easy access to information.

The purpose of the stock card is to provide an up-to-date record of all stock movement (contraceptives both received and dispensed) and of the quantity of the contraceptives both currently in stock and on order, for a single type and brand of contraceptive.

The stock cards should be located near the entrance to the storeroom or on a shelf in the cabinet, so that the person who adds or removes stock from inventory can easily update the card at the time of the transaction. The date and the quantities of stock added or deleted from inventory should always be recorded on the stock card. (Note: Some facilities summarize stock transactions on a daily or weekly basis.)

Each stock transaction should be listed on a separate line even if several inventory activities occur on the same day. The column marked "Balance on Hand" should always be recalculated to show the current inventory level. It is not necessary to start a new form at the beginning of each month. Instead, draw a line indicating the end of a month. Then total all the columns that relate to inventory quantities and adjustments, making sure to note the inventory balance at the end of the month. Finally, draw another line indicating the start of the new month.

At least every six months, and more often if there are problems, a physical count of stock on hand should be taken. The date of the count and the actual quantities should be recorded on the stock card. If the actual count differs from the balance calculated after the last transaction, the reason for the difference should be determined, any adjustments recorded, and the reason noted in the remarks column.

When filling out this and other forms, *always remember to record the number of contraceptives in standard units* (such as cycles of pills or individual condoms) because the amounts packed by the manufacturer in boxes, cartons, or cases can vary.

At the top right hand corner of the card is a place to record maximum and minimum stock quantities. Every quarter when you calculate the AMC, enter it onto the stock card and calculate the new minimum and maximum quantities. Having these quantities on the card allows you to see at a glance whether the balance on hand falls within minimum and maximum limits and whether consumption is increasing or decreasing over time.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On insuring contraceptive supplies . . . *One reviewer advises,* "Programs should consider insuring their supply of contraceptives. In one sub-Saharan Africa program, $60,000 worth of contraceptives were lost due to a fire . . . . Program managers should also encourage staff to be cost conscious. Very few people who handle contraceptives have a clear idea of the value of the supplies they are managing."

On preventing loss of contraceptives due to expiration . . . *One of our reviewers suggests,* "To ensure that supplies are used before they expire, it is a good idea to redistribute contraceptives that are nearing their expiration date to clinics that can dispense them before they expire."

On multiple donors supplying contraceptives . . . *One of our reviewers commented on the problems that occur when donors provide different brands or strengths of contraceptives to one country or program.* "Logistics management problems at the clinic level are often compounded by problems at higher levels. Because multiple donors provide contraceptives to a single country, when programs run out of one type and brand of contraceptive, the donor will provide another brand, and this creates problems. For example, there are two different strengths of Depo-Provera which may be provided to a country by two different donors. If a program runs out of one strength of Depo-Provera, the other strength may be substituted, thus compromising the quality of care provided to the clients. Since multiple donors are the trend, donors and technical assistance organizations need to help countries and programs deal with this problem."

On the importance of training staff at multiple levels . . . *One reviewer reports.* "By training the District and Thana Level (sub-district) family planning officials in logistics management, and combining "Push" and "Pull" systems (in which warehouses supply the field stores according to current information on demand), the efficiency of the Bangladesh logistics management system has increased substantially. Managers in the warehouse now systematically monitor the commodities that are in the pipeline (including the flow of commodities between administrative levels) and project the need for new supplies for each level. Clinics can now be resupplied according to their consumption patterns because warehouse managers can issue new supplies to the clinic based on the clinic's average monthly consumption and its recommended maximum and minimum stock levels. Managers are also trained to properly manage and account for damaged commodities."

Sample Stock Card

Record No. 5

Period covered : *1 July* to

		End last yr.	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.
Item Description: *Lo-Femenal oral contraceptive*						
Item Number: *701-003*	AMC	*36*	*38*	*37*		
Location in Warehouse:	Maximum Quantity *6* mos. x AMC	*216* units	*228* units	*222* units	____ units	____ units
Quantity per Carton: *1200 per carton; 100 per package*	Minimum Quantity *3* mos. x AMC	*108* units	*114* units	*111* units	____ units	____ units

Date	Reference Number*	From/To Whom Supplied	Quantity Received	Quantity Dispensed	Adjustments**	Balance on Hand	Quantity Ordered	Remarks
1 July		*BEGINNING BALANCE From Card # 4*				*165*		
6 July		*Dr. Santos*		*20*		*145*		
20 July		*Dr. Espiritu*		*20*		*125*		
July Totals				*40*		*125*		
3 Aug.	*00483*	*District Store*				*125*	*100*	
5 Aug.		*Dr. Santos*		*20*		*105*		
24 Aug.		*Dr. Espiritu*		*20*		*85*		
Aug. Totals				*40*		*85*	*100*	
8 Sept.	*00483*	*District Store*	*100*			*185*		
8 Sept.		*Dr. Santos*		*15*		*170*		
18 Sept.		*Dr. Espiritu*		*20*		*150*		
Sept. Totals			*100*	*35*		*150*		

* Reference number (voucher number) from Requisition and Issue Voucher or Order Form.

** Loans, losses, damage, theft, disposals, inventory reconciliation. Note reason in remarks column.

Setting up a Max/Min System

Before you set up your Max/Min system, go through your inventory and separate out any commodities that have expired or been damaged. Count the number of units that are unfit for use, and then destroy or dispose of them according to your program's guidelines. This will ensure that you are beginning with a supply of usable contraceptives. Next, you will need to perform a physical count of each type and brand of contraceptive and record these data on the **Status of Supplies Chart**.

To set up a Max/Min system, you will need to collect summary data on the total amount of each type and brand of contraceptive that has been dispensed over the last six months. Calculate the average monthly consumption of each contraceptive, and determine the recommended maximum and minimum levels of stock of each. In order to determine the maximum and minimum levels of stock, you will need to know the **lead time** for receiving supplies and determine a **safety stock** level for each type and brand of contraceptive.

Lead Time is an estimate of the length of time (expressed in months or partial months) that it takes to receive supplies after you have ordered them. Lead time is important because you will need to know how many units of contraceptives you will dispense while you wait for your order to arrive; this is called **lead time quantity**.

To determine **average lead time**, look at your order and delivery information for the past six months. For each order, determine the length of time between when the order was placed and when the goods were received. Then calculate the average lead time. If the lead times vary considerably, you might consider using the longest lead time instead of the average, unless the lead time was long due to unusual circumstances that are not likely to happen again. To determine the **lead time quantity**, multiply the average lead time by the AMC.

Safety Stock is an estimate of the amount of stock that should be kept in reserve to prevent stockouts due to delayed deliveries or unexpected increases in demand. In the Max/Min system described here, the safety stock should be at least equivalent to half the amount of stock used between regular orders.

How to . . .

Use the Status of Supplies Chart

1. Count the number of units of each type and brand of contraceptive that are in *usable condition* and enter these quantities in the column marked A, "Units of Stock on Hand." Be sure to check exam and consultation rooms, desk drawers, and other places where contraceptives may be kept. (When you have a total physical count, check to see whether the totals match the balances shown on the Stock Cards. Since the physical count is the most accurate, now is a good time to make any necessary adjustments to Stock Card balances, so that they are in agreement with the physical count.)

2. Copy from your service statistics the total quantity of each contraceptive (Lo-Femenal, Microgynon, Copper T, Depo-Provera, etc.) that your clinic has dispensed during *each* of the past six months, and fill in all the columns in the section marked B, "Number of Units Dispensed." In the blanks at the top of each column, write the name of each month to which the data pertain. Be sure to enter the quantities dispensed in terms of the number of units, not boxes, cases, or cartons. Look at these numbers to see whether they vary significantly from month to month. If they do, you may not be able to use the simple six-month average described below.

3. Total these amounts for each contraceptive and enter the six-month total in the column marked C, "Six-Month Total."

4. Figure your Average Monthly Consumption (AMC) by dividing the total in Column C by 6 (or by however many months for which you have recorded data on the chart). Enter the result in the column marked D, "AMC."

5. Use the **Worksheet for Setting Max/Min Levels** on the next page to determine your minimum

Continued on next page

and maximum number of months of supply, unless these levels have already been set by your program.

To determine the minimum and maximum levels, find the number in the far left column that represents how often you order supplies, for example every month, every 2 months, every 3 months, etc. (This is known as the order interval.) Next, read along that line to find the minimum recommended safety stock level (in months) that your clinic should always have on hand. Add the lead time to the safety stock level to get your minimum stock level (Equation A).

To get the maximum stock level (Equation B), take the minimum stock level you just calculated, and add the order interval. The result is your maximum stock level, represented in months' worth of supply. You may wish to round your figures to the nearest whole number for ease in figuring.

Note: When you are determining your safety stock level, consider the month-to-month variations in the quantities dispensed, and the reliability of your source of supply. If there is high variability in the quantities dispensed and/or if delivery is unreliable, set the safety stock level higher to compensate for this. When in doubt, set the safety stock level high and adjust it after experience.

6. On the **Status of Supplies Chart** enter the minimum number of months of supply in the shaded space at the top of Column E in the space marked, "___ mos." Multiply this number by your AMC (Column D) and enter the result in the column marked E, "Minimum Quantity." This is the recommended minimum quantity for a single contraceptive, represented in number of units.

7. Enter the maximum number of months of supply in the shaded space at the top of Column F in the space marked, "___ mos." Multiply this number by your AMC (Column D) and enter the result in the column marked F, "Maximum Quantity." This is the recommended maximum quantity for a single contraceptive, represented in number of units.

Note: The minimum and maximum quantities shown in Columns E and F are the actual quantities of stock that correspond to the number of months worth of supply indicated at the top of the columns.

8. For each contraceptive, check to see whether the amount in Column A, "Units of Stock on Hand," falls between your minimum and maximum ranges written in Columns E and F.

9. Enter the minimum and maximum quantities from Columns E and F in the top section of the Stock Card for each contraceptive. Make sure to record the number of months of supply and the actual number of units that correspond to those levels.

Worksheet for Setting Max/Min Levels

This worksheet provides general guidelines for figuring minimum and maximum number of months of supply. The safety stock levels shown here serve as an example; you may need to make adjustments to allow for any unusual program characteristics, such as rapid changes in demand, uncertainty of supply, or other problems.

	Equation A					Equation B		
Number of months between placing orders (order interval)	Safety Stock (in months' of supply)	+	Lead Time (in months)	=	Minimum Stock Level (in months)	+	Order Interval (in months)	= Maximum Stock Level (in months)
1	.5	+		=		+	1	=
2	1	+		=		+	2	=
3	1.5	+		=		+	3	=
4	2	+		=		+	4	=
6	3	+		=		+	6	=

Sample Status of Supplies Chart

Product	A Units of Stock on Hand (Physical count)	B Number of Units Dispensed (past 6 months) Month						C Six-Month Total	D AMC [C÷6]	E Minimum Quantity [3 mos. x D]	F Maximum Quantity [6 mos. x D]
		Jan	*Feb*	*Mar*	*Apr*	*May*	*Jun*				
Lo-Femenal	*132*	*33*	*35*	*40*	*38*	*38*	*40*	*224*	*37*	*111*	*222*
Microgynon	*56*	*16*	*16*	*19*	*18*	*17*	*20*	*106*	*18*	*54*	*108*
Copper T											
Depo-provera											
Condoms	*3,400*	*1100*	*1300*	*1420*	*1160*	*1340*	*1110*	*7,430*	*1,238*	*3,714*	*7,428*
Norplant											
etc.											

Using a Contraceptive Data Analysis Chart

Supervisors and clinic managers can prepare a **Contraceptive Data Analysis Chart** to obtain a complete summary of the stock transactions for each contraceptive used at the clinic. Using it monthly as a monitoring tool, you can keep track of stock on hand and the quantity of supplies ordered, received, and dispensed. You can easily calculate and review the AMC and the stock position (the number of months of supply on hand). The chart also helps the manager to monitor monthly variations in the quantities dispensed. Managers should keep charts for each type and brand of contraceptive together in a single notebook. Program supervisors should have a similar notebook in which to record information from the Stock Cards and other forms at the time of their visit. In this way the supervisor can more easily monitor clinic performance and support the clinic manager's efforts to manage the contraceptive supply system.

The information for the Contraceptive Data Analysis Chart is taken from the monthly summary data on the Stock Card. Rather than having to go through a stack of Stock Cards, the chart allows both the manager and the supervisor to review supply information on one summary sheet. The Contraceptive Data Analysis Chart serves as a monitoring tool for both the manager and the supervisor, and provides useful summary information needed for adjusting minimum and maximum stock levels and monitoring the overall system. The Contraceptive Data Analysis Chart is also used when preparing a new order of supplies.

How to . . .

Use a Contraceptive Data Analysis Chart

Note: A separate Contraceptive Analysis Chart should be maintained for each type and brand of contraceptive.

1. At the top of the form, fill in the information on the type and brand of contraceptive, the time period covered by the chart, and the recommended maximum and minimum levels of stock (in months).

2. If this is the first time you are using this chart, you should start by filling in the column marked D, "Units on Hand at End of Month," in the row marked "Beginning Balance." This quantity can be taken from the Stock Card, or (if you are just starting the Max/Min system) from Column A of the Status of Supplies Chart. Column D keeps a running total of the amount of

Continued on next page

stock on hand at the end of each month.

3. Using summary information from the stock card, enter the number of units of the contraceptive product that were ordered in January (or whichever month you are starting with) in the column marked A, "Ordered." If none of this contraceptive was ordered, write 0 in this column or leave it blank.

4. Enter the amount of the contraceptive product, if any, that was received during the month in the column marked B, "Received."

5. In the column marked C, "Dispensed," enter the amount that was dispensed during the month.

6. To calculate the figures for Column D, take the quantity that was left on hand at the end of the previous month (Column D, one line up) and add to it the quantity that was received this month (Column B). Subtract from this sum the quantity that was dispensed this month (Column C). The result is the quantity of stock on hand at the end of this month. Enter this new number in Column D.

7. To calculate the average monthly consumption, add up the figures in the "Dispensed" column (Column C) for the most recent six months, and divide by six. Enter the result in the column marked E, "AMC." If you do not have six months of data, calculate the average using as many months as you have.

8. To calculate the stock position (the column marked F, "Months of Supply on Hand"), take the quantity in Column D, "Units on Hand at End of Month" and divide it by the AMC (D÷E = F). This will give you the number of months of supply you have on hand at the end of the present month (Column F). Check this number against your maximum and minimum levels set for your clinic, to see whether you are within the recommended limits.

When it is time to place an order, or if you determine that you must place an emergency order, you can use the monthly summary information from the Contraceptive Data Analysis Chart to obtain the quarterly summary information that is often needed for placing an order. The next section discusses how to figure order quantities using the Max/Min system, and how to use a **Requisition and Issue Voucher**.

Sample Contraceptive Data Analysis Chart

Contraceptive Product: *Lo-Femenal* Period Covered: *April 92 - March 94*

Maximum: *6* months Minimum: *3* months

Month	Quantity				E	F
	A Ordered	B Received	C Dispensed	D Units on Hand at End of Month	AMC	Months of Supply on Hand [D ÷ E = F]
Beginning Balance				*2,000*	*560*	*3.6*
April	*2,400*		*610*	*1,390*		*2.5*
May		*2,400*	*540*	*3,250*		*5.8*
June			*700*	*2,550*	*588*	*4.3*
July	*1,200*		*490*	*2,060*		*3.5*
August		*1,200*	*585*	*2,675*		*4.5*
September			*695*	*1,980*	*603*	*3.3*
October						
etc.						

Ordering with the Max/Min System

When you are ready to order a new supply of contraceptives, you must consider the **average monthly consumption**, the **stock on hand**, and the **stock already on order**.

- The **Average Monthly Consumption** (AMC) should be recalculated at least every six months (more often if the quantities dispensed are changing rapidly), or you may wish to recalculate the AMC each time you order. Knowing the current AMC for each type of contraceptive and comparing it with the trend in monthly consumption will help you to anticipate client demand and figure your order quantities. If monthly consumption has been steadily increasing, you may wish to consider increasing the number you use for the AMC above the average of the past six months. The AMC should always represent true demand; it may not if there was a stock-out, or if the item was substituted for another item that was out of stock.

- **Stock on Hand** is the quantity of each contraceptive you have in stock at any given time. This information can be taken from the balance on the stock cards. To calculate the number of months of supply you have in stock (stock position), divide the quantity of each contraceptive in stock by the AMC for that contraceptive.

- **Stock on Order** is the quantity of each contraceptive that has been ordered but has not yet been received by the clinic. This information can be taken from the stock card or from a previous requisition and issue form submitted to the warehouse.

The procedures described here assume that you will place an order at every order interval. To calculate the amount of each contraceptive to order, refer to the Contraceptive Data Analysis Chart for that product. Take the most recent AMC (Column E) and multiply it by the maximum level (in months) shown at the top of the form. The result is your **maximum quantity**, expressed in units. Subtract the amount of **stock on hand** (Column D) and subtract the amount of **stock on order.** The result is the quantity of that contraceptive you need to order to bring your supplies back up to the Maximum Stock Level.

Formula for Calculating Regular Orders:

Maximum Quantity [AMC x Max level (in months)]
– **Stock on Hand**
– **Stock on Order** (stock previously ordered but not yet received)

= **Order Quantity** (order in standard package quantities)

Example: Your clinic is preparing an order for a certain brand of oral contraceptives, and you have 1,200 cycles currently on hand. The AMC is 500, the maximum level of supply for the clinic is 5 months, and 120 cycles are on order.

*Analysis: Using the formula above, the **maximum quantity** is **2,500** [maximum level of 5 months x AMC of 500]. The **order quantity** (or **quantity needed**) to bring the level up to the maximum would be calculated as follows:*

	2,500	*(maximum quantity)*
–	***1,200***	*(stock on hand)*
–	***120***	*(stock on order)*
=	***1,180***	*(quantity needed)*

Once you have determined quantity need, you should check to see how supplies are packaged and order contraceptives in terms of package quantities. *For example, condoms from USAID are packed and shipped in cartons of 6,000, consisting of 60 boxes of 100 each. Pills come in cartons of 1,200 cycles (12 packages of 100 cycles), so in the example above you would order one carton of 1,200.*

The formula above works well if there are small variations in the quantities dispensed each month. You should order more if the amount dispensed fluctuates greatly, or if you anticipate increased demand of 10% or more. If you should ever have to place an **emergency order**, due to a sudden unforeseen increase in demand, order the amount that will leave you with stock levels equal to the minimum quantity at the time the next regular order is due.

Formula for Calculating Emergency Orders:

Minimum Quantity [AMC x Min level (in months)]
+ **Total amount expected to be dispensed between now and next regular order**
– **Stock on Hand**

= **Emergency Order Quantity**

Using a Requisition and Issue Voucher

Requisition forms vary from program to program. They usually contain only information on how much is being ordered. However, if the form contains some or all of the information listed below, managers will be more able to justify the amounts they order.

- average monthly consumption;
- maximum levels of stock;
- quantity (or months' worth of supply) currently on hand.

It is ideal if the form is used to compare:

- quantities *requested* against quantities *received*;
- quantities *shipped* against quantities *received.*

Clinic managers need to have a system for checking whether the same quantities of stock that they ordered were received, and warehouse managers need to know whether what they sent was actually received at the clinic. It saves time and improves accuracy if this information can be recorded on a single form. By using carbon paper and making four copies of your order, the form can serve as 1) a requisition form (order form), 2) a packing list, 3) a receipt voucher, and 4) a file copy (see the **Sample Requisition and Issue Voucher**). The Requisition and Issue Voucher should be always be pre-numbered so that you and the warehouse manager can use the same paperwork to place, fill, and receive orders. It is also helpful to be able to refer to the same voucher number if you should ever need to track an order that has been delayed or lost.

To use a form like the one in the sample, for each type and brand of contraceptive that you are ordering, record the AMC, the clinic maximum quantity, the quantity on hand at the time of the order, and the quantity you are ordering. This information is drawn from the corresponding Stock Card and Contraceptive Data Analysis Chart. At the top of the form, be sure to fill in all the necessary information, including the date on which you submitted the order. The dates are important since this is how you determine lead time. Both the person requesting the order and the person who approves it should sign at the bottom of the form in the section marked "Requesting Facility." Keep one carbon copy, and send the original and the two other copies to the warehouse or issuing facility. When the order is placed you should also note on each contraceptive stock card the date of the order, the voucher number, and the quantity of that contraceptive that was ordered.

When the order is packed and shipped, the warehouse manager fills in the column marked "Quantity Shipped," obtains the necessary signatures (and dates of signature), keeps one copy at the warehouse, and puts two copies in one of the boxes being shipped. These copies serve both as a packing list and as a receiving record.

When the goods arrive at the clinic, the person receiving the supplies should fill in the column marked "Quantity Received" on both copies. One copy of the form showing the receipt information should be sent back to the warehouse to be kept in their files. This confirms the receipt of the shipment and notes any discrepancies. The other copy should be kept in the clinic files. To complete the transaction, when the supplies are put in the clinic storage area, the stock cards must be updated again showing the receipt date, voucher number, and quantity received.

By using this system, clinic managers can easily check when and what supplies they ordered, and know whether the supplies that were received were in the quantities that they ordered. They can also check to make sure that they received their whole order and not just a part of it, and warehouse managers can check to make sure that what they shipped from the warehouse actually got to the final destination. Managers should maintain files of the paperwork related to contraceptive supplies for quick reference.

Sample Requisition and Issue Voucher (RIV)

To: *Rosales District Store*

Voucher No. *00483* Date: *3 August 1992*

Ship to: *Concepción Municipal Clinic*
(Service Delivery Facility Name)
Concepción, Rosales
(Address)

Requisition					Issue		
Contraceptive	A AMC	B Facility Maximum Quantity	C Quantity on Hand	D Quantity Requested	E Quantity Shipped	F Quantity Received	G Remarks
Lo-Femenal	*37*	*222*	*125*	*100*	*100*	*100*	
Cu T 380 IUD	*18*	*108*	*48*	*60*	*60*	*60*	
Condoms	*1,238*	*7,500*	*3,700*	*4,000*	*4,000*	*4,000*	

Requesting Facility

Requested by: *Juan de la Cruz* Date: *3 August 1992*

Approved by: *Dr. Jose Santos, Director* Date: *3 August 1992*

Issuing Facility

Approved by: *R. J. Ramirez* Date: *10 August 1992*

Shipped by: *J. Alou* Date: *1 Sept 1992*

Requesting Facility

Received by: *Juan de la Cruz* Date: *8 Sept 1992*

Variations of the Max/Min System

In the Max/Min system described in this chapter, stock levels are reviewed on a regular schedule, and contraceptives are *always* ordered to bring the stock level back up to the maximum. Two major advantages are that the transportation schedules at the warehouse are more manageable because all orders come in on a regular basis, and that the safety stock level is relatively low, which reduces the chance of losing contraceptives due to expiration or deterioration. A disadvantage is that there may be more small orders to process, since every clinic always orders each type and brand of contraceptive, even when only a small amount of stock is needed.

Another version of Max/Min system eliminates these small orders. In this version, stock levels are still reviewed on a regular schedule, but contraceptives are ordered *only if* the stock on hand is *below* the minimum level. Otherwise, the system is the same as the version described in this chapter, except that the safety stock level is set higher to include enough stock to cover the number of months between regular orders as well as the stock needed to protect against unexpected increases in demand or delays in delivery. The reason for increasing the safety stock level is that in this version of Max/Min you may effectively skip an order cycle. If the stock on hand is even one piece above the minimum at the time of review, you would not place an order. This version of Max/Min is likely to be more appropriate in distribution systems with few administrative levels and a short order interval. However, if the order interval is long, or if there are many administrative levels in the system, higher maximum and minimum levels will cause commodities to remain in the distribution system for too long before they finally reach the client.

A third version uses a continuous review system. In this version, there is no regular order schedule. Instead, the stock level is reviewed whenever a contraceptive is dispensed, and an order is placed when the minimum is reached for that contraceptive. This version does not require high levels of safety stock, but makes distribution more difficult, since contraceptives are not ordered on a regular schedule. The continuous review version of Max/Min system is likely to be appropriate only for programs that manage only a few types of contraceptives.

Using a Quarterly Reporting Form

Clinics usually have to report to higher program levels information about the number of each type and brand of contraceptive dispensed as well as the number of new acceptors, revisits, and total visits. It saves time if this information can be reported all on one form (see **Sample Quarterly Reporting Form**).

If you use a form like the one in the sample, you would fill in the summary information drawn from the Stock Card and the Contraceptive Data Analysis Chart, showing the balance at the beginning the quarter (or reporting period), the quantities received and dispensed, any adjustments, and the balance at the end of the quarter. In addition, you would record information on the number of new acceptors, revisits, and total number of visits for each type and brand of contraceptive that was dispensed. This information can be drawn from clinic monthly summary forms. While not strictly necessary for contraceptive supply management, combining service information with data on the number of contraceptives dispensed makes it easier for you and your supervisors to track trends in the use of certain types of contraceptives, the method mix, or to perform other analyses to monitor and improve your services. However, if your program already reports this client data separately, you would not need to include this information on this form.

Sample Quarterly Reporting Form

Region: *Three* Province: *Rosales* District: *Concepción*

Service Delivery Facility Name: *Conc. Munic. Clinic* Facility ID Number: *72-1838*

Facility Type: ☐ Warehouse ☐ Hospital ☑ Clinic Report of Quarter: ☐ 1 ☐ 2 ☑ 3 ☐ 4

Contraceptive	Contraceptive Data					Client Data		
	A Beginning Balance	B Received This Quarter	C Dispensed/ Used	D Adjustments*	E Ending Balance	F New Acceptors	G Revisits	H Total Visits
Oral Contraceptives								
Lo-Femenal	*165*	*100*	*115*	*0*	*150*	*16*	*33*	*49*
Ovrette								
IUDs								
Copper 380	*70*	*60*	*63*	*2*	*65*	*28*	*35*	*63*
Condoms								
Condom	*2,700*	*4,000*	*3,800*	*0*	*2,900*	*40*	*70*	*110*
Injectables								
Depo-Provera								
Implants								
Norplant								

* Explanation of loans, losses, damage, theft, disposals, inventory reconciliation:

2 IUDs were damaged during insertion

Other Comments:

Submitted by: *Dr. Jose Santos, Director* Date: *7 July 1992*

Supervising Clinic Supply Management

Program managers and family planning supervisors working in integrated health and family planning programs can play an important role in helping to support the person in charge of managing supplies in the clinic. To provide effective support, these managers must understand how the supply system works, build good working relationships with warehouse or logistics managers in their area, and collaborate and share information with the clinic managers they supervise. The following section provides managers and supervisors with concepts, tools, and techniques that they can use to work with clinic managers to improve contraceptive supply management.

Using a Warning System

It is useful to have a warning system to detect unusual increases in consumption and let you know when stock is getting low. If the stock on hand falls to the safety stock level, the manager should be alerted to a possible shortage and must determine whether an emergency order should be placed, or whether supplies will last until the next scheduled delivery. Generally, an emergency order should be placed if the stock on hand is *less than* the sum of your lead time stock plus the amount of stock that you will use between now and the next regular order.

Monitoring Stock Management Practices

Any supervisor or manager who visits a clinic should go to the clinic storage area with the clinic manager. Together they should:

- Check the stock cards. *Are the amounts of supplies on hand properly recorded and are they up-to-date? Have there been any stock-outs in the recent past?*
- Survey the storage area. *Is the storage area up to standards?*
- Confirm that the stock is organized according to a FEFO system. *Are cartons containing supplies that are due to expire first located above, or in front of, cartons with later expiration dates?*
- Check the average monthly consumption for each commodity. *Has the warning system been activated recently? Has there been a significant change in the AMC?* If so, you need to ask why.
- Confirm that the stock on hand is somewhere between the established maximum and minimum levels. *Is the amount of stock on hand appropriate for this point in time in the ordering and delivery cycle?*
- Check that deliveries are being made on schedule. *If deliveries are late, will there be a problem in maintaining adequate amounts of contraceptives?*

Developing a Clinic Contraceptive Supply Manual

The clinic Contraceptive Supply Manual is an essential tool for both the clinic manager and the supervisor; it is usually produced by the central office. The supply manual explains in detail how the contraceptive supply system works. Supervisors should make sure that every clinic has a supply manual. If there is no manual containing the information shown below, the supervisor should work with the clinic manager to write one. The manual should cover the following topics:

- organization of the contraceptive supply system
- storage guidelines
- frequency of resupply
- calculation of lead times and average monthly consumption
- calculation of Max/Min
- ordering procedures
- schedule of ordering and delivery (usually produced annually)
- copies of and instructions for using all forms in the clinic
- supervisory tools, instructions, and guidelines
- job descriptions for person(s) in charge of managing supplies.

Working Solutions—Belize

The Belize Ministry of Health has developed an Inventory Control Operations Manual that is provided to all district and clinic level personnel. It summarizes all the inventory management practices and provides examples and instructions for using the inventory forms. The annotated table of contents follows.

Introduction
Short introduction to the importance of stock management and the use of the manual.

I. The Inventory Card as a Management Tool
Describes the inventory card and explains why and how it is used.

- **A. Introducing the Inventory Card System**
  Reviews all the information found on the card.
- **B. Issues**
  Describes procedures for issuing stock.
- **C. Receipts**
  1. **Regular Deliveries**
  2. **Donations**
     Describes procedures for receiving and recording stock under different situations.
- **D. Adjusting the Inventory Card**
  1. **Expired Stock**
  2. **Physical Stock Count**
     Advises how to handle expired stock and physical counts.

II. Replenishing Stock with the Requisition

- **A. Regular Orders**
- **B. Emergency Orders**
  Describes procedures for placing orders and obtaining emergency supplies.

III. Forecasting Inventory Needs

- **A. Monthly Consumption**
  Explains how to calculate the quantity used in one month.
- **B. Annual Consumption**
  Explains how to calculate the quantity used in one year.
- **C. Average Monthly Consumption**
  Explains how to calculate average monthly consumption.
- **D. Stock Level in Months**
  Explains how to estimate how many months of stock are on hand.
- **E. Maximum Stock**
  Explains how to calculate maximum stock level.
- **F. Reorder Level**
  Explains how to determine when an order must be placed to avoid running out of stock before the next scheduled delivery.
- **G. Quantity to Order**
  Explains how to calculate order quantities.

Annex I: Sample Inventory Card
Annex II: Sample Requisition Form
Annex III: Sample Store Issue Voucher

Reviewing the Supply System

A specific person should be designated to be in charge of clinic supplies. He/she should be responsible for ordering supplies, record keeping, and reporting, storage, receipt, and distribution of supplies. A job description for this position should be included in the clinic supply manual.

Supervisors should understand how the supply system works and be familiar with current stock levels. Regular communication and good working relationships with warehouse managers and clinic managers are essential. For example, supervisors need to know if there have been any delays in deliveries at the warehouse, or if certain contraceptives are out of stock. The supervisor can then help the clinic manager make appropriate adjustments in ordering and managing the supplies. In addition, supervisors should help clinic managers to avoid ordering more than, or less than, they need. Because deliveries are often late, clinic managers may be tempted to order more than they need to keep a reserve stock. Ordering larger quantities than needed undermines the Max/Min system.

Using the Max/Min system simplifies contraceptive supply management, but it does not solve problems. It helps to identify changing circumstances, such as unexpected increases or decreases in demand, stock-outs of one product that raise demand for another product, the introduction of new methods, or transportation problems. To avoid some of these problems, you will have to monitor the system on a regular basis, examine the accuracy of your information, and investigate any discrepancies. In all cases you should use your judgment in making decisions to solve these problems.

Checklist for Improving Contraceptive Supply Management

For Clinic Managers

- [ ] Clearly define the roles and responsibilities of the person in charge of clinic supplies.
- [ ] Assess the storage conditions and make all necessary improvements.
- [ ] Check the storage facility and make sure that FEFO procedures are being followed.
- [ ] Check that the record-keeping system is accurate and up-to-date, including the Contraceptive Data Analysis Charts.
- [ ] Perform a physical inventory and set up a Max/Min system.
- [ ] Check for any significant changes in the AMC, and investigate the reasons for these changes.

For Supervisors

- [ ] Check that storage facilities conform to acceptable standards for the maintenance of contraceptive quality (including FEFO), thus reducing the loss of contraceptives.
- [ ] Monitor the Max/Min system to ensure that stock levels stay within the calculated limits, to avoid stock-outs, frequent emergency orders, or stock quantities that are too large.
- [ ] Check that stock cards are accurate and up-to-date.
- [ ] Check that commodities are being delivered as planned. Anticipate and make adjustments to compensate for late deliveries.
- [ ] Provide order forms to clinic facilities and train staff in their use.
- [ ] Ensure that each clinic conducts a physical inventory at least every six months.
- [ ] Maintain an updated Contraceptive Data Analysis Chart.
- [ ] Investigate the reasons for any significant changes in the average monthly consumption.

For Mid- and Senior-level Managers

- [ ] Urge donors to get sufficient quantities of contraceptives into the country on time.
- [ ] Provide financial support for the use of vehicles to distribute contraceptives to the clinic.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

Mrs. Asuman's Emergency Order

On a sunny morning early in September, Mrs. Asuman, manager of the Gurak Clinic, was in the storeroom copying stock level information from the stock cards into her Contraceptive Data Analysis Charts when the District Supervisor, Nurse Sema, arrived for her monthly supervisory visit.

"Hello, Nurse Sema, how nice to see you again. I hope your drive was not too difficult. Would you like some tea?" Mrs. Asuman inquired.

"The drive was not bad, thank you," said Nurse Sema, smiling. "How have things been since I was here last? The clinic looks very busy, and the staff seem to be in good spirits."

"Yes, the clinic is very busy all of a sudden," said Mrs. Asuman. "There has been a tremendous increase in the demand for condoms in the past three months. I suppose it must be due to the condom promotional campaign that the Ministry of Health has had on the radio for the past two months. When we placed our order for condoms two months ago, we didn't know that they were going to run this radio campaign. Last month we had almost three times the usual number of people asking for condoms, and now we're running very low. I have just noticed that our supplies of condoms have dropped below our minimum level, but we still have a month to go before our routine ordering time. If we don't do something, we may soon have to give our clients less than the three-month supply we usually give them."

"Yes, it must be a very successful radio campaign, because a number of clinics are having the same problem," said Nurse Sema. "However, let me do my routine check before we discuss what to do about the condom situation."

Nurse Sema and Mrs. Asuman went into the storeroom where Nurse Sema checked the temperature of the room, looked at the cartons of each contraceptive to roughly calculate how many units were in stock, and checked her figures against the totals on the stock cards. She also did a spot check to see whether the cartons with the earliest expiration dates were in front, and copied the monthly tallies from the stock cards for each type of contraceptive onto the Contraceptive Data Analysis Charts she had in her folder.

"Yes, you're right, demand has increased a lot," said Nurse Sema. "Let's sit down and fill out the Contraceptive Data Analysis Chart for condoms and see exactly what the situation is."

Case Discussion Questions: Mrs. Asuman's Emergency Order

1. **If the clinic uses the Max/Min system described in this chapter, how many condoms did Mrs. Asuman order in each of her January, April, and July orders, and what was the average monthly consumption (AMC) of condoms for the six-month period ending in June?**
2. **If the demand for condoms in September remains the same as it was in August, will the clinic have enough condoms to meet demand, assuming that it continues to provide the same standard number of condoms to each client?**
3. **Should Mrs. Asuman place an emergency order in September? If so, how much should she order, knowing that her regular order won't arrive until November?**

Case Worksheet: Mrs. Asuman's Emergency Order

1. If the clinic uses the Max/Min system described in this chapter, how many condoms did Mrs. Asuman order in each of her January, April, and July orders, and what was the average monthly consumption (AMC) of condoms for the six-month period ending in June?

Fill out the Contraceptive Data Analysis Chart for condoms, using the following information about Mrs. Asuman's clinic:

Worksheet Information:

Maximum Stock Level = 6 months' worth of supply
Minimum Stock Level = 3 months' worth of supply
Stock on Order = 0
Emergency Lead Time = 2 weeks
(Emergency orders can be placed at any time)
Beginning Balance of supplies on hand
at the end of December = 13,400.
AMC for six-month period ending in December 1991 = 3,942
AMC for six-month period ending in March 1992 = 3,883

Number of condoms dispensed each month:

Month	Quantity Dispensed
January	3,800
February	3,600
March	4,000
April	4,200
May	4,200
June	5,200
July	8,400
August	11,600

Calculate the new AMC:

Mrs. Asuman calculates the Average Monthly Consumption (AMC) quarterly, when she prepares her order. In January, she calculated it to be 3,942 for condoms (for the six-month period ending in December). In April it was about the same (3,883). She calculated it again in July, but you must do the calculation. Calculate the new AMC from the data listed above for the six-month period ending in June, and write it in the column marked "AMC" in the Contraceptive Data Analysis Chart, in the row marked "June."

The formula for calculating the (AMC) is:
Total quantity dispensed over the last six months divided by 6 (months).

Calculate Mrs. Asuman's orders for January, April, and July and finish filling out the Contraceptive Data Analysis Chart:

Mrs. Asuman places routine orders for supplies four times a year, in the first week of the months of January, April, July, and October. Orders should be rounded to case lots (i.e., cartons). Condoms are packaged 6,000 per case. Begin by calculating Mrs. Asuman's order in January *(remembering to order in lots of 6,000),* and fill out the rest of the chart through August. Remember that supplies are received the month after an order is placed, for example, the January order is received in February. Also, be sure to recalculate the figures in Column F, "Months of Supply on Hand" for each month, so that you can monitor the monthly stock levels.

The formula for calculating how much to order is:
Order Quantity = Maximum Quantity [Max. Level x AMC] – (minus) Stock on Hand
– (minus) Stock on Order

2. If the demand for condoms in September remains the same as it was in August, will the clinic have enough condoms to meet demand, assuming that it continues to provide the same standard number of condoms to each client?

Anticipating that the demand for condoms remains the same for the month of September, enter 11,600 in Column C, "Dispensed," in the September row. Looking at your Contraceptive Data Analysis Chart, you can see that only 4,400 condoms are on hand at the end of August, which will not be enough to meet the estimated demand for the month of September.

Case Worksheet: Mrs. Asuman's Emergency Order

Contraceptive Data Analysis Chart

Contraceptive Product: *Condoms* Period Covered: *Jan. 92 - Dec. 93*

Maximum: *6* months Minimum: *3* months

Month	Quantity				E AMC	F Months of Supply on Hand [D ÷ E = F]
	A Ordered	B Received	C Dispensed	D Units on Hand at End of Month		
Beginning Balance				*13,400*	*3,942*	
January			*3,800*			
February			*3,600*			
March			*4,000*		*3,883*	
April			*4,200*			
May			*4,200*			
June			*5,200*			
July			*8,400*			
August			*11,600*			
September						
October						
November						
December						
January						
February						
March						
April						
May						
June						
etc.						

3. Should Mrs. Asuman place an emergency order in September? If so, how much should she order, knowing that her regular order won't arrive until November?

Determine the AMC to use in calculating the emergency order:

Begin by determining a new AMC, and enter this number in Column E, "AMC," in the row marked "September." (Hint: While the AMC is usually based on a six-month average, in this unusual situation where demand has risen so rapidly you may want to make an exception and use the quantity dispensed in August as the AMC.)

Continued on next page

Case Worksheet: Mrs. Asuman's Emergency Order

Calculate the Emergency Order:

When you calculate the emergency order, remember that the emergency order amount should be enough so that you will be left with stock levels approximately equal to the minimum quantity (minimum level of 3 months x the new AMC) by the next regular ordering time (in this case, in the beginning of October). For figuring purposes make a note of this number. Once you know the desired stock level for the end of September, then you can calculate the emergency order. (Remember, orders are rounded to case lots of 6,000 condoms per case. Round to the nearest whole case. And don't forget to count the estimated number of condoms that will be dispensed during the month of September.)

The formula for calculating the emergency order is:

Emergency Order Quantity = Minimum Quantity + (plus) Total amount expected to be dispensed between now and next regular order – (minus) Stock on Hand.

Fill in the amount of the emergency order in Column A, "Ordered." Put the same number in Column B, "Received," since the emergency order will be received in September. To see the result of having placed an emergency order, continue to fill out the rest of the Contraceptive Data Analysis Chart through to the end of November. (For the purposes of your figuring, assume that demand will remain the same for October and November (11,600) and then keep the AMC at 11,600 when you calculate your order in October.)

Case Analysis: Mrs. Asuman's Emergency Order

"Well, the situation looks pretty serious, doesn't it?" said Nurse Sema. "Even though you just received supplies last month, you won't have enough condoms if demand continues at the present rate. And we don't know how long demand will be this high. Using the AMC you calculated two months ago, you have only a little more than a month's supply, but the present rate of consumption is almost three times the AMC. If we put in an emergency order now, you will run out of condoms at about the time the emergency order arrives, since at this rate you'll use up your current supply of condoms in about two weeks. Let's figure out how much to order."

Based on the demand in August of 11,600, use an AMC of 11,600 for calculating the emergency order. Stock on Hand at the end of August is 4,400. By the regular ordering time, at the beginning of October, you want to have on hand approximately the equivalent of the Minimum Quantity. ***Minimum Quantity*** *= 3 (months) x 11,600 (AMC) which equals* ***34,800*** *(condoms). Therefore, by the regular ordering time in October you will want to have approximately* ***34,800*** *condoms in stock.*

To determine the ***emergency order quantity,*** *add to the minimum quantity (34,800) the amount that will be dispensed in September (we assume this will still be 11,600) to get 46,400. Subtract from this sum the number of units currently on hand (4,400) to get the order amount of 42,000, which is exactly seven lots, or 42,000 condoms. By placing this emergency order it is probable that the clinic will avoid a stock-out. Fill out the rest of the chart through November (assuming distribution stays at 11,600) to see that, after the regular (October) order is received, the clinic will end up with 47,600 units on hand at the end of November. With an estimated AMC of 11,600 this is 4.1 months worth of supply, which will be enough to meet client demand until the next order is received in February 1993.*

"This condom campaign is not likely to continue," said Nurse Sema, "but it does show you how closely you need to monitor your supplies. Whenever demand for a contraceptive increases rapidly, a warning bell should go off in your head, and you should think about whether you'll need to order a larger supply next time. The same is true if demand suddenly drops; you don't want to have too many contraceptives in stock that expire before they are used. We don't know whether the high demand for condoms will continue at this rate, so be sure you monitor the amount dispensed more closely for the next few months until it stabilizes."

Answer Sheet: Mrs. Asuman's Emergency Order

Contraceptive Data Analysis Chart

Contraceptive Product: *Condoms* Period Covered: *Jan. 92 - Dec. 93*

Maximum: *6* months Minimum: *3* months

Month	Quantity				E AMC	F Months of Supply on Hand [D ÷ E = F]
	A Ordered	B Received	C Dispensed	D Units on Hand at End of Month		
Beginning Balance				*13,400*	*3,942*	*3.39*
January	*12,000*		*3,800*	*9,600*		*2.43*
February		*12,000*	*3,600*	*18,000*		*4.56*
March			*4,000*	*14,000*	*3,883*	*3.60*
April	*12,000*		*4,200*	*9,800*		*2.52*
May		*12,000*	*4,200*	*17,600*		*4.53*
June			*5,200*	*12,400*	*4,166*	*2.97*
July	*12,000*		*8,400*	*4,000*		*.96*
August		*12,000*	*11,600*	*4,400*		*1.05*
September	*42,000*	*42,000*	***11,600***	*34,800*	*11,600*	*3.0*
October	*36,000*		***11,600***	*23,200*		*2.0*
November		*36,000*	***11,600***	*47,600*		*4.1*
etc.						

Quantity needed is 10,252 rounded up to 12,000 condoms

Quantity needed is 12,596 rounded to 12,000

Estimated – based on August demand

AMC used to calculate the emergency order

Quantity needed is 9,298 rounded to 12,000

Quantity needed is 34,800 rounded to 36,000 condoms

Emergency quantity needed is 42,000

Sample Worksheet: Mrs. Asuman's Emergency Order

Sample Contraceptive Data Analysis Chart

Contraceptive Product: _____ Period Covered: _____

Maximum: _____ months Minimum: _____ months

Month	Quantity				E	F
	A Ordered	B Received	C Dispensed	D Units on Hand at End of Month	AMC	Months of Supply on Hand [D ÷ E = F]
Beginning Balance						

CHAPTER FOURTEEN

Reducing Discontinuation In Family Planning Programs

Anyone who has ever worked in a family planning program will be all too aware that efforts to attract and recruit new clients will be only partially successful if the program fails to *keep* those new clients. How can the universally troubling problem of discontinuers best be addressed by program managers?

This issue offers some practical suggestions on ways to measure and reduce the discontinuation rate in your clinic. It then describes how you can analyze the data that you have collected to find out both the characteristics of women who stop using contraception and why they have chosen to discontinue. It also examines the common factors associated with high levels of discontinuation, and explores changes managers can make in service delivery that can help to reduce the proportion of men and women who make an initial visit, or several visits to the clinic, but then don't come back.

This chapter was originally produced as Volume II, Number 3 of ***The Family Planning Manager****, including the case scenario, "The Tapong Clinic: Deciding Whether to Measure Discontinuation." The guest editors for the issue were Dick Roberts, Promboon Panitchpakdi, and Benjamin Loevinsohn.*

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Using Information on Discontinuation to Improve Services and Retain Clients

Losing clients is a serious problem—for the women themselves, for program managers, and for the community as a whole. It can lead to high numbers of unwanted pregnancies and births in women for whom unplanned childbearing may pose a serious health risk. It also affects a clinic's ability to meet its projected targets, and will often decrease the impact of even the best client recruitment efforts.

If family planning clinics paid as much attention to keeping existing clients as to trying to enroll new ones, they could achieve a greater impact on contraceptive prevalence with less effort and at lower cost. Yet, clinic managers are continually pressured to increase numbers of new acceptors. If managers put more effort into finding out why clients leave their programs, they could make necessary service improvements to reduce the number of clients who discontinue using contraception, and thereby increase the overall number of continuing users.

There are a number of practical ways that clinic managers can measure discontinuation and determine whether there is a significant problem in their clinic. Developing and using such a measure can help managers determine how many clients do not return after the first visit or stop coming after several visits.

Statistics Reveal the Problem

- In Niger and Gambia, it has been estimated that almost 30 percent of clients stop practicing family planning within the first seven months of using a contraceptive method. [Finger, ed., 1991]
- In India, one study showed that 35 percent of IUD users discontinued using contraception altogether after using the IUD for less than 4 months. [Prabhavathi, 1988]
- A study of a clinic in East Java, Indonesia, revealed that while the overall drop-out rate was 18 percent among all new users, it was as high as 72 percent among women who did not receive the contraceptive method they had asked for. [Pariani, 1991]

Because there are many aspects of discontinuation that are important to clinic and program managers, managers must decide which aspects are most useful to their own program or clinic. *For example, in one clinic the manager might want to know how many clients don't return to the clinic for resupply or checkups when they should. In another clinic, the manager may want to determine what proportion of new acceptors who have been given a contraceptive method stop using it within the first three or six months, what proportion of all clients stop coming to the clinic in the first year, or which methods have the highest discontinuation rates.*

Often concerned about their own clinic performance, managers want to answer questions like:

- What proportion of the clinic's new acceptors stop coming to the clinic within one year?
- Why do some clients fail to return to the clinic for resupply or follow-up services?
- What are the characteristics of the clients who don't return to the clinic?
- What types of contraceptives are most frequently discontinued?

To answer these questions, family planning managers need more program- or clinic-specific data that will allow them to estimate the size and nature of the discontinuation problems at the clinic level. Further, measuring clinic discontinuation can be combined with a system to track and follow up individual clients who don't show up for an expected clinic visit. With this kind of information in hand, managers can make changes in their program that will improve services and increase the number of clients using contraception.

Understanding the Reasons Why Women Might Stop Using Contraception

There are many reasons why a client might discontinue using contraception, some of which may have nothing to do with the quality or types of services your clinic provides. On the other hand, some of the reasons that clients discontinue using contraception or stop coming to your clinic may be related to the quality of your services. You need to distinguish between those reasons that your clinic may have some control over, and life events that your clinic cannot control. Understanding what aspects of clients' decisions can be influenced by clinic services will help you make effective service delivery improvements in your clinic.

Reasons Clinics Can Control	Reasons Clinics Cannot Control
Dissatisfaction with current method	Planning a pregnancy
Dissatisfaction with clinic services	Infertility
Concern over side effects	Widowhood
Unintended pregnancy due to incorrect use of method	Death
Lack of money	Divorce or dissolution of union
Stock-outs at the clinic	Beyond reproductive age
Bad rumors in the community	Relocated to another area
Objection by family member	Transportation problems*
Use of another clinic that offers more convenient hours	Change to method not offered by clinic*
Use of another source for resupply*	

* Whether a clinic has control over changing these reasons for discontinuing will depend on the resources that are available to that clinic.

Defining Clinic Discontinuation

It is up to you and your staff to determine how long a client can stay away from the clinic before being considered a discontinuer. It is not advisable to decide that as soon as a client has missed an appointment, or failed to return for contraceptive resupply, she or he is automatically lost to the clinic. For all sorts of understandable reasons, a client might fail to keep an appointment one month but return to the clinic a month later. The key decision you must make is how long a continuing user be can absent from your clinic before you decide that she or he has left the clinic for good. That is, what is a reasonable period of time by the end of which a **"no show"** (a client who doesn't show up for a visit) can be considered to have become a **clinic discontinuer**?

The decision about the best time period to use to classify a client as a discontinuer will vary according to each contraceptive method and your own clinic protocols. For example, if a pill user is given supplies that will last her three months, she should be given a return appointment to get a new supply *before* the end of the third month, or, if you don't use an appointment system, she should be told to return to the clinic before her supply runs out. Your records should then indicate when she is due to return to the clinic. However, if she does not return for resupply exactly when that revisit is scheduled, she should not automatically be classified as a clinic discontinuer because she might easily return a week or two later. If she doesn't return for two or three months after her current pill supply has run out, it is probably safe to assume that she will not return at all. In the same way, if a client using the three-month injectable does not come back after that time period has elapsed, it probably makes sense to wait another two or three months before assuming that she has stopped using the clinic (and the method) altogether.

Defining "No Shows" and Discontinuers: Examples from Rwanda and Thailand

Different clinics may use different time periods for determining when a client should be classified as a discontinuer.

In some clinics in Rwanda, a user is put on a list for a follow-up visit at the end of the month in which she or he did not return for a scheduled appointment (which coincides with the time when monthly clinic statistics are compiled). The client is not classified as a discontinuer (or "lost" client) until a whole month later.

In some clinics in Thailand, no shows are followed up within one week of a missed visit, but they are not considered to be "discontinuers" until another three months have passed.

Deciding Which Types of Discontinuers to Track

You, as a clinic manager, will need to decide which types of discontinuers are most useful to track for your clinic. You may want to determine what proportion of your clients who were using pills and/or injectables have stopped coming to the clinic for resupply. You may want to know what proportion of your new acceptors stop coming to the clinic within the first 6 months of contraceptive use. Or you may want to analyze the discontinuation rate of each different type of contraceptive to determine which methods have the highest discontinuation rates.

Deciding which aspects of discontinuation you will be measuring will determine what time period the rate will represent and what data will need to be collected and included in the calculation. It is probably most useful to begin by calculating the discontinuation rate of a specific method, such as the pill or injectables. Since the use of either of these contraceptive methods requires that the client return to the clinic for resupply on a *regular* basis, these measures are easiest to obtain and are most useful to the clinic manager.

While the same measures pertain to discontinuers of barrier methods (condoms and diaphragms), or spermicides (foam and tablets), these measures are often less useful because they may not accurately reflect discontinuation. This is because multiple sources of supply are available for these methods, and in many countries clients using these methods often seek, or are encouraged to seek, resupply at other types of service delivery outlets. As commercial sales become more popular, it is expected that many clients who use clinical and non-clinical methods will purchase methods through local vendors.

Because women using the IUD or the long-term implant (Norplant) probably continue to use those methods even after they have stopped coming for checkups or counseling, you may wish to exclude these women from the count of discontinuers. Instead, you may want to determine what proportion of clients do not show up for their first required checkup (or other annual checkups), and then follow up several of these clients to find out why they are not returning to the clinic when expected.

Some Simple Ways to Identify "No Shows"

Using Existing Client Records

Many clinics use client records that contain sufficient information to allow staff to track clients who haven't returned for a scheduled appointment, or who haven't come back within a recommended time period. If your clinic schedules appointments (for a given hour, day, or week), the registration clerk can be instructed to pull the records of every client who is expected to come to the clinic during that time period. If a client fails to show up for an appointment, the registration clerk can then file the record separately from the records of returning clients. The file in which the records of no shows are kept can be called the "no show" file, or "late" file, so that the registration clerk will know where to look for the client's record if she comes back for a checkup at a later date, but before she is officially classified as a discontinuer.

The "no show" file should have a separate section for each contraceptive method, and the records within each section should be filed in alphabetical order by last name so that the records can be located easily if the client returns for services. It is helpful to clearly mark each section, noting both the type of contraceptive and the length of time (in months) after a missed appointment that the clinic considers a client using that method to be a discontinuer. Periodically, maybe every six months, someone should go through the no-show file for each method, remove the records of those clients who have passed the designated time period for that method, and place those records in the "discontinuers" file in alphabetical order by last name.

If your clinic does not maintain an appointment system, client records should be filed after each visit, using a filing system that has sections organized by subsequent **months** of the year. The client's file should be placed in the section that corresponds to the month when she is expected to return for a resupply of contraceptives or a follow-up visit. Within each section the records should be filed alphabetically by last name. *For example, the record of a pill user who left the clinic in February with three months' worth of supplies should be placed in a file that is maintained for all clients expected to return in May of that year. The record of a woman who has had an IUD inserted and has returned for her first checkup in August can be placed in a file maintained for all clients expected to return in August of the following year (if you have decided that yearly checkups are advisable).* When the month in question is over, all records for that month that are still in the file can be put on a list for follow up. A month later, if after receiving a follow-up visit a client does not return for services, her record can be moved to the "discontinuers" file.

Using a Special Daily Register Tracking System

Family planning daily activity registers can be used to track clients over several years. If your clinic's daily registers combine family planning clients with other clients, you can develop a separate register just for family planning clients, such as the Sample Daily Activity Register shown on page 341.

This daily activity register is used to record selected data about each client who visits the clinic. It is not a substitute for the client record, which contains detailed information about the client's medical and reproductive history. This system can be used for tracking users of any method. However, for users of methods that do not require regular resupply visits, such as the IUD and Norplant, you may want to indicate on the register when they are due for annual or semi-annual checkups. If these clients do not return for their regular checkups you can have an outreach worker provide follow up to ensure that the clients are satisfied with the method.

How to . . .

Use a Daily Register to Track No-Show Clients

1. Give each new client a serial registration number when she registers for her first visit. Enter the client's name, registration number, and date of the first visit in the spaces provided.
2. At the end of the client's visit, in the columns to the right, fill in the appropriate letter or symbol indicating which method was provided to the client at that visit. Repeat that symbol under the month headings to show the number of months'worth of supply you have provided the client. *For example, if a client is given a one-month supply of pills, enter a "P" for the month of her visit. If a client is given a three-month supply of pills, enter a "P" for the month of her visit and also for the next two months. For a client receiving a three-month injection, enter three "IJ's," one for each month that the injection would protect her. In the Sample Daily Register, client number 414 received a three-month dose of an injectable contraceptive on her first visit, which was on Feb. 6, 1993, so an "IJ" was entered under each of the months of February, March, and April, indicating that she is protected through April. She is due to return to the clinic in May for another injection.*
3. At each subsequent visit, locate the client's name on the register (by the date of her first visit, or registration number), and again enter the number of months' worth of contraceptive supplies you have provided the client in that visit. If the client changes methods, mark the new symbol for that method and repeat the symbol to show how many months the client will be protected. When a client does not return in the month in which she is due for a new supply of pills or for another injection, leave the box under that month blank. This will indicate that she is no longer protected from getting pregnant and can immediately be classified as a no show.
4. Determine the number of no shows by counting the number of clients who have blank or incomplete boxes at the end of the month in which you are performing the tally. If after several more months the boxes are still blank, indicating that the client has not returned, you can then designate that client as a discontinuer. *For example, if you were performing a tally in April 1993 using this sample register, you would find that there were 6 blank boxes indicating the clients had not returned for a resupply of contraceptives—3 of these clients are no shows for March (clients #280, #381, and #413), and 3 appear to be discontinuers because they have not been back to the clinic for many months.*
5. The daily register can be designed to cover whatever period of time you choose. The Sample Daily Register is designed to cover 36 months. If you use a form such as this you can continue to use the same form for three years. At the end of three years you should start a new register by transferring all continuing users' names, registration numbers, and dates of their first visits to a new register. *For example, the Sample Register was started in January 1992 and shows several continuing users from 1991 whose names were transferred from the previous 3-year register to the new register. (In reality there would be many more names transferred from one register to the next at the end of the three-year time period.)* Discontinued clients should not be recorded on the new register, but the client records should be located and then placed in a file designated for discontinued clients. The records should be filed alphabetically by last name in the discontinuers' file so that, if the client does return at some future date, her medical record can be found more easily and she can again be listed on the new daily register.

Note: A registration system in which the client receives a registration card and the clinic retains a duplicate is very helpful when using this type of daily register. The registration cards should be pre-printed with registration numbers and should show the name of the clinic and its address. When a new client comes to the clinic, the registration clerk writes the name of the client and the date of her first visit on the card, and files the duplicate in a card box alphabetically by the client's last name. The client should be instructed to bring the card with her each time she comes to the clinic, making it much easier for the registration clerk to find her name in the master register (since it is organized by date of first visit). The date of the client's next visit can also be marked on the card—another reason for the client to keep, use, and refer to the card.

Sample Daily Activity Register

Reg. No.	Client Name	Date of first visit (dd/mm/yy)	Year: *1992* Months protected												Year: *1993* Months protected					Year: *1994* Months protected					Remarks
			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Au	Sep	Oct	Nov	Dec	
250	*KAYITETE Zaida*	*02/03/91*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*						
262	*NDUWAYEZU Caritas*	*07/08/91*	*IU*	*IU*	*IU*	*IU*	*IU*	*IU*	*IU*	*V*	*IU*	*IU*	*IU*	*IU*	*IU*	*IU*	*IU*	*IU*	*IU*						
280	*KANKAZI Triphonie*	*02/11/91*	*C*	*C*	*C*	*C*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*									
283	*BWASIRI Anifa*	*10/12/91*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*						
286	*UWIZEYE Vivianne*	*15/12/91*	*P*	*P*	*P*	*P*	*P*	*P*	*C*	*C*															*became pregnant*
311	*KAYITESI Theodosie*	*02/01/92*	*P*	*P*	*P*																				*side effects*
351	*TWAGILIMANA Béata*	*08/01/92*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*	*IJ*						
363	*KAGAZE Sylvie*	*15/01/92*	*C*	*C*	*C*	*C*	*C*	*P*																	*no reason given*
369	*UWIMANA Fortunée*	*03/03/92*			*C*	*C*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*	*P*						
381	*NABERA Judith*	*10/05/92*					*P*	*P*	*P*	*P*	*P*	*P*	*P*	*IJ*	*IJ*	*IJ*									
412	*NIKUZE Germaine*	*02/02/93*														*P*	*P*	*P*	*P*						
413	*KAYUKU Alvera*	*04/02/93*														*C*									*reason unknown*
414	*MUSAFU Hélène*	*06/02/93*														*IJ*	*IJ*	*IJ*							
etc.																									
Total No Shows			~	~	~	*1*	~	~	*1*	~	*1*	~	~	~	~	~	*3*	~							
Total New Acceptors			*3*	~	*1*	~	*1*	~	~	~	~	~	~	~	~	*3*	~	~							

Methods

IJ = Injectable
P = Pill
C = Condom
F = Foam
IU = IUD
V = annual visit or check-up

Advantages and Disadvantages of Using Existing Client Records or a Daily Client Register to Track No Shows and Discontinuers

	Existing Client Records	Special Daily Register
Advantages	• Client forms don't have to be redesigned. • Staff training is quite simple—they only need to learn where on the record to mark the date of the client's next expected visit, and how to file the record according to the month of the next visit.	• The numbers of continuing clients and no shows can be quickly and easily counted. • This is a good system for a clinic that serves a small client population.
Disadvantages	• In a large clinic, client records kept in a number of different filing areas can take up a lot of room. • If the records are not well managed, they might get lost, damaged, or filed out of order.	• As a clinic's client load increases, the registration clerk will need to flip through numerous pages in the register to find each client's name. • If the client has not brought her family planning card with her to the clinic (which shows her registration number and date of first visit), the registration clerk may need to consult the client's record to find the date of her first visit so that she can then find the client's name in the register. • At the end of the last year covered by the register, the registration numbers, names, and date of initial visit for each client need to be copied over to a new register.

Working Solutions—Kenya

Developing a Client Tracking System in a Community-Based Distribution Program

The Diocese of Maseno West provides community-based health care as part of its development activities. By recently adding an existing rural health project to its own health program, the Diocese now has 400 community health workers, 8 clinics, and 29 mobile clinics. As part of this program consolidation, two family planning community-based distribution (CBD) programs, each with its own information system, were combined. The information system of the expanded CBD program was reviewed to develop a record-keeping system that was consistent across the entire program and to improve the reporting and use of service data for program management.

During their review, the program managers became interested in following up on discontinuing clients as one way to monitor quality of care. But they found that the space for discontinued clients in the original data forms had rarely been filled in by agents or used by managers.

Continued on next page

Improvements in the Information System. To turn discontinuation data into a management tool, the managers **developed program definitions** for a **continuing user** and a **discontinuer**. A **continuing user** is a client whom a CBD agent expects to resupply on a regular basis, not a person whom the CBD agent only contacts once or to whom the agent provides supplies sporadically. A **discontinuer** is a client whom the agent has not been able to resupply on the client's resupply date or during the two months following that date, despite two additional attempts to contact the client.

As a second step, the program managers **changed the program data collection forms** to include a diary and a new monthly reporting form. In the back of the diary, CBD agents now record the following information for each client: date of first visit, name, age, sex, parity, method given, and next scheduled resupply date. They also use the diary to note pertinent health information about the client and if a client has been referred to a clinic for special services. When an agent cannot supply a client for two months despite three attempts, she or he strikes out the name of the client from the diary, and records the client's name as a discontinuer on the monthly reporting form.

The Supervisor's Role. Each supervisor of the CBD program **monitors trends** in numbers of discontinuing clients and **compares numbers of continuing users and discontinuers** for different agents. If the numbers of discontinuers for a single agent are high by program standards or are increasing, the supervisor **makes a follow-up visit** to a sample of discontinued clients to record their reason for discontinuing. The supervisor then distinguishes reasons for discontinuation that are positive (such as the client's decision to switch to a more permanent or long-term clinical method) or acceptable (such as a couple's decision to have a child) from reasons that are not acceptable (such as complaints about discourteous service or irregular supplies of chosen brands of pills). After the follow-up visits, the supervisor and other program managers develop appropriate strategies to reduce the number of discontinuers that result from service delivery problems. Strategies to reduce the discontinuation rate might include providing greater support and training for CBD agents who are not performing as well as their peers, or making changes in the contraceptive ordering system.

Calculating Discontinuation Rates

There are several ways that managers can measure discontinuation in their clinics. Discontinuation can be measured for discontinuers of:

- **each specific contraceptive method** offered by the clinic;
- **several types of methods** offered by the clinic;
- **all the methods** offered by the clinic.

For each measure, you will have to decide which types of discontinuers to include. The first step is to decide which measures will be most useful to you in your clinic. As a general rule, the broader the measure, the less accurate it will be. Narrower, method-specific measures will be more exact and useful to the clinic manager for monitoring clinic performance, but will be more difficult to use for comparing the performance of one clinic to that of other clinics.

When calculating any discontinuation rate you must take into consideration three important factors:

- The **denominator**: The total number of users of specific methods, against which the number of discontinuers will be compared.
- The **numerator**: The number of discontinuers for the types of methods you have chosen for your measure.
- The **time period** that the rate will represent.

How to . . .

Calculate a Method-Specific Discontinuation Rate

To determine the discontinuation rate of pill users in your clinic, identify all the clients who have failed to return to the clinic for a resupply of pills for the period of time that you have chosen to study. Defining which clients are discontinuers should be based on your predetermined guidelines for classifying discontinuers of each method. This will allow you to count the total number of discontinuers of the pill for the period of time you are studying.

For example, to calculate the discontinuation rate of pill users in your clinic for 1992, include in the numerator the total number of pill discontinuers for 1992. For the denominator you will need to count the total number of users of pills who were served in your clinic in 1992. (Thus, without counting any client twice, the denominator will include any new acceptors of the pill, any continuing users of the pill, as well as any pill discontinuers who did not come back for a resupply of pills during the time period under study.)

Formula for Calculating Pill Discontinuation Rate

$$\frac{\text{[Numerator]}\ \textbf{All pill discontinuers in 1992}}{\text{[Denominator]}\ \textbf{All pill clients in 1992}} \times 100 = \textbf{Pill Discontinuation Rate for 1992}$$

[All pill clients who are not expected to return and are considered discontinuers during 1992]

[All clientswho were provided with pills during 1992, including all pill discontinuers in 1992]

Remember: The types of clients that you include in the numerator and the denominator *must* be consistent. Also, the number of discontinuers noted in the numerator **must** be included in the denominator in order for the measure to show a relative proportion. *For example, if you want to calculate the annual discontinuation rate of injectables, make sure that you include only the number of discontinued injectable users in the numerator for a 12-month period. In the denominator, record the sum of all clients who were given injectables during the 12-month period, which includes those who discontinued during the same period.* The period of time covered by the count must be consistent—if you intend to have the discontinuation rate represent only the last 6 months, then you can only include the numbers in the numerator and the denominator that pertain to the same 6-month period.

Calculate a Discontinuation Rate for Several Methods

The formula used to calculate the discontinuation rate in your clinic of a single method can also be used to calculate the discontinuation rate of several methods. If you decide to include the discontinuers of *all the methods* that your clinic offers, then you will be calculating your overall **clinic discontinuation rate**, for whatever period of time you specify.

Use Your Calculations to Track Trends Over Time

Whatever period of time you use to measure your rate, there will be an arbitrary cut-off that will exclude some discontinuers from the calculation. For that reason, it is important to realize that the most useful rates you come up with will not be one hundred percent accurate. However, if you calculate the rate in exactly the same way each time (at quarterly, six-month, or yearly intervals), the figures you obtain will show you the trends in discontinuation over time.

Sample Formula for Calculating Discontinuation Rate for Several Methods

$$\frac{\text{All discontinuers of pills and injectables for the six-month period (July 1–December 31, 1992)}}{\text{All clients using pills and injectables during the six-month period (July 1–December 31, 1992)}} \times 100 = \text{Discontinuation Rate for Pills and Injectables (July 1–December 31, 1992)}$$

All discontinuers of pills and injectables for the six-month period (July 1–December 31, 1992)
[All users of pills and injectables who are not expected to return and are considered to be discontinuers during the period July 1–December 31, 1992]

All clients using pills and injectables during the six-month period (July 1–December 31, 1992)
[All clients who were provided with pills and injectables during between July 1–December 31, 1992, including all discontinuers for these methods, in the same time period]

Discontinuation Rate for Pills and Injectables (July 1–December 31, 1992)

Interpreting Discontinuation Rates

Once you have determined the various method-specific discontinuation rates for your clinic, you must decide what the rates mean. Are the rates acceptable or unacceptable? Do they identify an weakness in your program or indicate success? The first step is to meet with clinic staff and discuss the data and see what your staff think. Are there areas for improvement? What changes can be made to improve the situation? How long will any proposed changes take to show results? Should the clinic develop targets for reducing the discontinuation rates of specific methods?

Compare Your Rates with Those of Other Clinics

It may be helpful to compare your discontinuation rates with those of similar clinics in your region. This is only useful, however, if the other clinics have calculated their discontinuation rates in the same way that you have. By comparing your discontinuation rates with those of other clinics you will be able to see whether your discontinuation rates are above or below the average. If your discontinuation rates are considerably higher than the average, you should make a careful investigation of the quality of the services you are offering to your clients. On the other hand, if your clinic has lower discontinuation rates

than others in the region, you may want to identify what approaches your clinic is taking to keep such a high proportion of clients enrolled in your program. This information can be used to provide assistance to other clinics that are not performing as well as yours.

Monitor the Effect of Your Changes

Re-calculating discontinuation rates at regular intervals is an effective way to find out whether standards of care in your clinic are improving, declining, or staying constant. The changes in the discontinuation rates at a single clinic can be charted (using a bar or line chart). If your rates don't fluctuate widely, you can at least be satisfied that the quality of care in your clinic is not undergoing any major changes, even though you might find that level to be less than satisfactory. If the rates show an upward trend, you have reason for concern. If they vary widely from one year to the next, or from one quarter to the next, you might try to look at social and economic conditions in the community that might be creating these unstable patterns. *For example, if your clinic services a rural area in which many married men emigrate seasonally to work elsewhere, the outflow of males might be a reason for the drop in contraceptive use.*

Illustrating the Negative Impact of Clinic Discontinuers

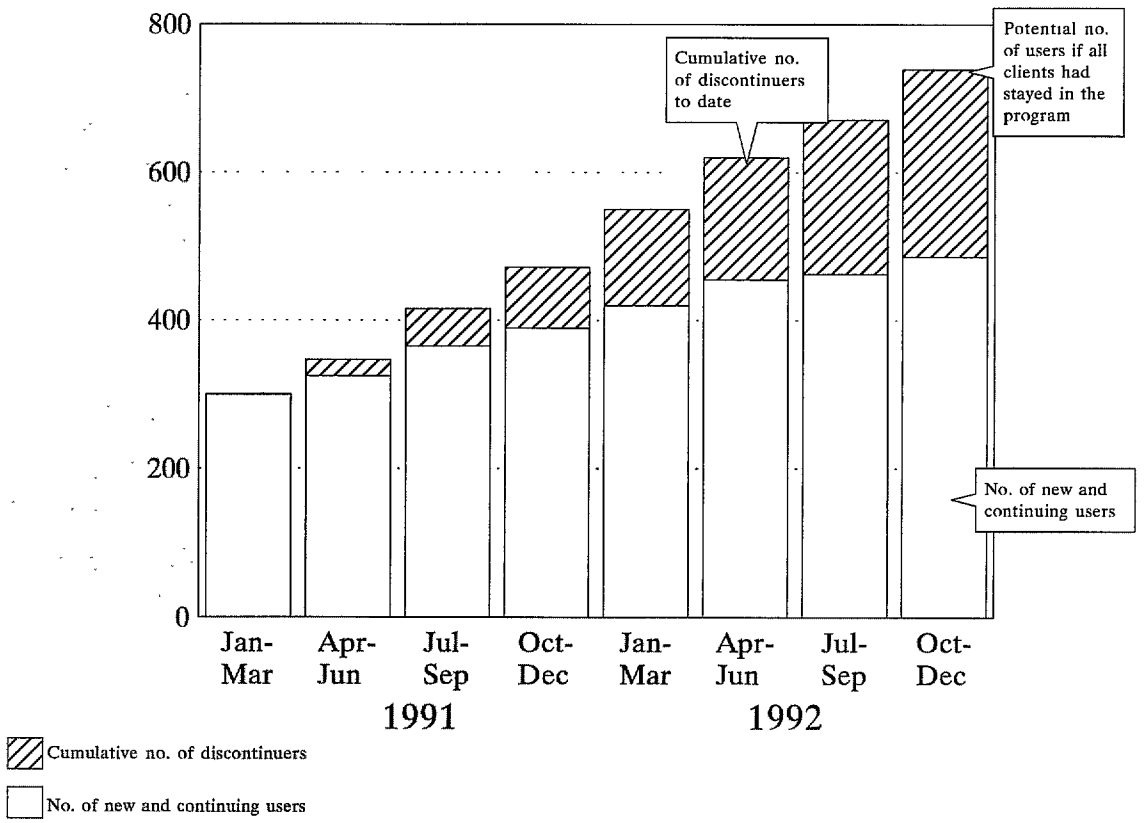
If you want to show your clinic staff the dramatic impact that the discontinuation rate is having on your family planning program, you can plot a stacked bar chart that shows, for every three-month period over a number of years, the number of new and continuing users served by your clinic, plus the cumulative number of discontinuers over time. Using the numbers in the table below, and charting the numbers from Columns A, B, and C in a stacked bar chart, you can help your staff see what the total acceptor rates in your clinic would have been if the discontinuers had in fact stayed in the program.

Quarter and Year	A No. of new acceptors	B No. of discontinuers in the quarter	C No. of continuing users	Cumulative no. of discontinuers
Jan-March 1991	—	—	300	0
April-June 1991	47	22	325	22
July-Sept 1991	69	29	365	51
Oct-Dec 1991	56	31	390	82
Jan-March 1992	78	48	420	130
Apr-June 1992	70	35	455	165
July-Sept 1992	51	43	463	208
Oct-Dec 1992	63	40	486	248
Total	**434**	**248**		

To calculate the figures in Column C "No. of continuing users," take the number of continuing users from the end of the previous quarter (in this case 300), add the number of new acceptors for the quarter (Column A) and subtract the number of discontinuers for the quarter (Column B). The result is the number of continuing users at the end of the current quarter (in this case 325). Continue these steps for each new quarter.

In this example, which represents a two-year period, the clinic actually lost more than half the number of clients it gained (248 discontinuers vs. 434 new acceptors). In that same period, if none of those new or continuing clients had discontinued, the clinic's overall number of clients would have been 734 instead of 486. This means that the clinic would have achieved an increase of 145 percent in the overall number of clients over a two-year period, instead of 62 percent. The graph shown below illustrates the dramatic impact that discontinuers have on a clinic's performance.

Potential Number of Users if Clients Do Not Discontinue



Using Information on Discontinuers to Find Out Who Is Leaving Your Clinic and Why

One simple way of determining how discontinuers differ from continuing users is to compare some of the basic characteristics of the two groups. This type of information is usually available on the clients' individual records (such as the client's age, her marital status, the number of children she has, the contraceptive method she chooses, and the length of time she has used that method). To learn about the characteristics of continuing users and discontinuers, you can look at a sample of records and, using a tally sheet, record basic information about each client in the sample.

How to . . .

Develop and Use a Tally Sheet to Study the Characteristics of Discontinuers

1. Develop a tally sheet for tracking characteristics of discontinuers similar to the Sample Tally Sheet for Discontinuers shown here. (A separate tally sheet should be used for tracking the characteristics of continuing users.) Decide what kind of information you want to know about the clients in your sample. At a minimum you should have columns for the client registration number, age, number of living children, age of youngest child, current contraceptive method (include a sub-column for each method that your clinic offers), duration of method use, and the reason for discontinuing (if it is noted in the record). Each of these primary categories should have sub-categories that will cover all possible ages, number of children, etc. *For example, in the Sample Tally Sheet under of age of client, there are six sub-categories: under 20, 20-24, 25-29, 30-34, 35-39, 40 and over.*

2. Retrieve the client records from the files that will be make up the sample. Once you have your two piles of records, go through each one and record the information needed for each tally sheet. Use one line for each client number.

> To obtain a reliable picture of discontinuers and continuing users, it is not necessary to examine every client record from both groups. You can pick a random sample of each by pulling every 10th record among continuing users and every 10th record among discontinuers. Because the total number of records of discontinuers will be less than the total number of continuing users, the sample, for a clinic that serves about 1,000 clients, should consist of a total of 70-120 records of discontinuers, and 100-250 records of continuing users.

3. After you have completed the tally sheet(s) you can create a **summary table** (also known as a **cross-tabulation**) to compare the characteristics of continuers with the characteristics of discontinuers (see Sample Characteristics Summary Table). The summary table will enable you to more easily compare the characteristics of the two groups. *For example, the Sample Characteristics Summary Table on page 350 shows that discontinuers are much more likely than continuing clients to be under 25 (91 percent vs. 8 percent), to have no children (70 percent vs. 4 percent), to be using barrier methods (such as condoms or foam, 80 percent vs. 17 percent), and to have used a method for 3 months or less (60 percent vs. 3 percent).*

Sample Tally Sheet for Discontinuers

Date: *2 April 1993*

Page No. *1* of *3*

Fill in one row for each discontinuer

Client Registration Number	Age of Client						Children				Youngest (mos.)				Method				Duration of Use (mos.)					Reason discontinued						Remarks
	<20	20-24	25-29	30-34	35-39	>40	0	1-2	3-4	>4	<12	12-23	24-35	>36	IJ	P	C	F	0-3	4-6	7-9	10-12	>12	1	2	3	4	5	6	
127	*X*						*X*										*X*		*X*											*reason unknown*
130		*X*					*X*										*X*			*X*										*"*
135		*X*						*X*			*X*					*X*			*X*					*X*						
145	*X*						*X*									*X*			*X*											*reason unknown*
175		*X*						*X*			*X*						*X*		*X*											*"*
190			*X*					*X*				*X*			*X*				*X*											*desires pregnancy*
192		*X*					*X*											*X*	*X*											*reason unknown*
200		*X*					*X*										*X*			*X*					*X*					
202	*X*						*X*										*X*		*X*											*reason unknown*
205				*X*					*X*			*X*				*X*				*X*										*"*
etc.																														
Total this page:																														

Methods

IJ = Injectable
P = Pill
C = Condom
F = Foam

Reasons for Discontinuing

1. Side effects
2. Pregnant
3. Stock-outs
4. No money
5. Social pressure
6. Moved away

Sample Characteristics Summary Table

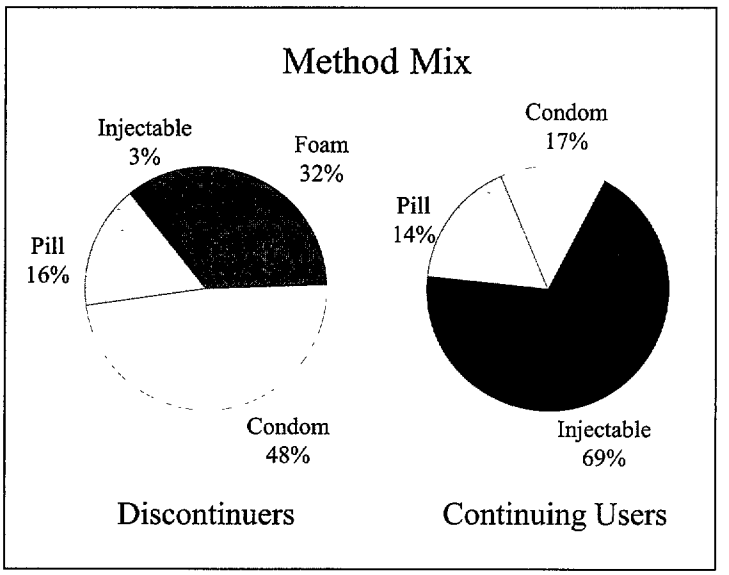
Characteristics		Discontinuers		Continuers	
		Number	%	Number	%
Age	<20	20	22	10	6
	20-24	62	69	4	2
	25-29	3	3	20	11
	30-34	4	5	70	39
	35-39	1	1	48	27
	>40	-	-	28	15
	Total	90	100	180	100
Number of Children	None	63	70	7	4
	1-2	27	30	25	14
	3-4	-	-	104	58
	>4	-	-	44	24
	Total	90	100	180	100
Age of Youngest Child	None	63	70	2	1
	<12 mos.	17	19	40	22
	12-14 mos.	4	4	104	58
	24-36 mos.	6	7	20	11
	>36 mos.	-	-	14	8
	Total	90	100	180	100
Method	Injectable	3	3	124	69
	Pill	15	17	26	14
	Condom	43	48	30	17
	Foam	29	32	-	-
	Total	90	100	180	100
Duration of Method Use	0-3 mos.	54	60	6	3
	4-6 mos.	18	20	6	3
	7-9 mos.	15	17	12	7
	10-12 mos.	3	3	16	9
	>12 mos.	-	-	140	78
	Total	90	100	180	100

Analyzing the Summary Table and Taking Effective Action

Findings such as those in the table above should make you aware that your clinic does not seem to be very successful in keeping younger, childless women in the program. These results also indicate that discontinuers tend to use the less effective, temporary contraceptive methods. This information could lead to a number of program changes. You might create special clinic hours for teenagers or, since many of these women may be unmarried, you might try to find out whether single women are being treated by your staff with less respect than married women, or you might try to interview some of the married younger women with no children to find out whether their husbands or mothers-in-law are exerting pressure on them to become pregnant, even though they themselves might prefer to wait for a

couple of years. If this is so, you could train your community outreach workers to explain to the village elders the value of a couple's postponing their first birth until they feel they have enough income to be able to raise that child comfortably.

You might also decide that following up on no-show clients and clinic discontinuers should be a much higher priority for your clinic. Outreach workers could focus their efforts on visiting the no shows and discontinuers to see whether they are being served by another clinic, or whether they had experienced side effects and were afraid to continue with the method. By showing your clients that you care about their reproductive health and their satisfaction with an effective method of contraception, you will ultimately retain more clients, and they will become more satisfied and consistent users of contraception.



Determining What Methods Are More Likely to Be Associated With High Discontinuation Rates

You can also use the information in the summary table to compare the method mix of discontinuers with that of continuing users. Drawing a pie chart is good way to easily see the differences. In this example, the pie charts reveal that continuing users are much more likely than discontinuers to have selected an injectable method, and much less likely to be asking their partners to use a condom. You might also want to compare the method mix of your continuing users with the method mix for your country or region. For more information on method mix in your country, method use by age group, and other information on characteristics and practices of continuing users, you can consult the Demographic and Health Survey (DHS) report for your country (see References, page 357).

Analyzing How Long Clients Use a Method Before Discontinuing Services

Another useful analysis of the characteristics of discontinuers could focus on how long they used a particular method, or any method at all, before they became discontinuers. This type of information is particularly valuable because it will tell you whether the problems the women encountered were so severe that they quit almost immediately after the first visit, or whether they tried to practice family planning for at least six months but then gave up attending the clinic for reasons that perhaps were unrelated to any side-effects or discomfort with the method.

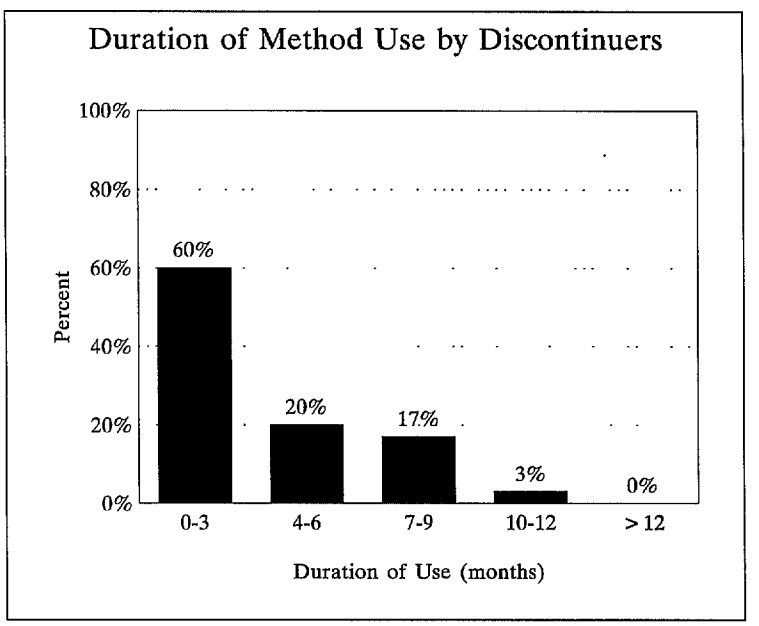
The duration of method use can be estimated in a number of different ways, each of which may be incomplete in some respect but will provide you with enough information to suggest patterns or trends. One way is to simply take the length of time between the woman's first visit and her last recorded visit to the clinic. If she only comes to the clinic once, receives contraceptive supplies at that first visit but then never returns, then you will need to make some assumptions about the length of time that she used the method. *For example, if she was given three months' worth of condoms or pills, you could assume that she and her husband practiced family planning for three months, even though she never returned to obtain more supplies and you do not know for sure whether the contraceptive was used for that period of time.*

Another way of calculating how long discontinuers used a contraceptive method supplied by your clinic is through historical data. This technique relies on the client's record being clearly marked with the date that the record was placed in the discontinuers file, or the use of a daily register similar to the Sample Register on page 341. The

duration of use could be estimated by measuring the length of time between her first visit and the date on which she became classified a discontinuer.

Once you have determined how you are going to measure this characteristic, you must decide what categories of duration are of interest to you (such as 0-3 months, 4-6 months, 7-9 months, etc.) and allocate all discontinuers to one of them in a simple cross-tabulation or summary table.

The data in this table can then be turned into a graph that will reveal how soon clients are discontinuing use of contraceptives after starting. Using the data from the Sample Characteristics Summary Table on page 350, the bar chart below shows that most discontinuers left the clinic within the first three months, and after that the decline was slower. That information should alert you to the fact that there is some problem in either the type of contraceptive method the women are choosing or the effectiveness of the counseling about the method they are being given.



Other Ways of Looking At Characteristics of Discontinuers

You can perform many other analyses of discontinuer data. You can compare the method mix among younger discontinuers (those under 25) with that of older discontinuers (25 and older). If your analysis reveals that the most common method used by the young discontinuers was the pill, you can go back to your staff and conduct a "brainstorming" session to find out the possible causes of dissatisfaction with this method among younger women.

If the same analysis of method mix among discontinuers shows that large proportions of older discontinuers were using the condom, you should then ask yourself why this temporary method is being provided to women who have probably had all the children they want and who might be eligible for, and wanting, more permanent or long-lasting methods.

You can also look at the reasons that clients discontinue using a method. This information is usually only available for clients who have switched methods and remained in your program, but it can provide meaningful information from the client's perspective on whether changes in method are primarily due to side effects, lack of money (if you charge for contraceptives), stock-outs, social pressure, pregnancy, or other factors. Although there are numerous personal reasons for discontinuing contraceptive use that are acceptable, dissatisfaction with services or methods is never acceptable and should always be addressed. Such information should motivate you to change or improve counseling techniques, ordering schedules, fee scales, or other aspects of service delivery.

Another way to look at discontinuers is in terms of the number of children that discontinuing users have had. If they have none, or few, this probably suggests that contraception is being practiced for the purpose of child-spacing rather than limiting family size. Discontinuing use of a contraceptive method in order to become pregnant is behavior that is to be expected among these low-parity women. If, on the other hand, most of your discontinuers have already had 4-5 children, they might be older women who believe that they are no longer fertile, or will no longer be sexually active, and who may think that they are no longer in need of contraceptive protection. These are all personal decisions and viewpoints that the counselors in your clinic must make certain of raising and discussing with their clients.

Developing a System to Reduce the Number of No-Show Clients

The National Office of Population in Rwanda, ONAPO, has recently developed a system for identifying and tracking no-show clients, known in their program as "missing" clients. The system is based on using a register to indicate when clients are due to return to the clinic—either for a resupply or a follow-up visit. The register identifies both the continuing users and the clients who do not show up when they are in need of a new supply of contraceptives or a planned checkup. This system has enabled ONAPO to quantify the no show and discontinuer problem, and has demonstrated the importance of putting more effort into trying to retain clients, not just recruiting new clients.

The Family Planning Service Delivery System. Rwanda's national health system is the main provider of family planning services and contraceptives through approximately 300 integrated health facilities. There are currently no non-governmental organizations (NGOs) in the country that offer clinical family planning services, the pharmacies charge high prices for contraceptives, and community-based distribution of contraceptives will not begin until mid-1993.

The Overall Picture. The National Office of Population, ONAPO, looked at the reported client figures for 1990 and saw that there had been 80,000 new acceptors during the year and a total of 100,000 clients (both continuing users and new acceptors) at the end of the year. Recruitment was going well. Then ONAPO compared these figures with available data on the total number of clients at the end of 1989 (60,000). They realized that the total number of clients had increased by only 40,000 (100,000–60,000) even though 80,000 new acceptors had been recruited. In other words, the program had to recruit approximately **two new acceptors** to add **one continuing user**. This finding drew attention to the fact that the loss of clients was a sizable problem for the program, and led to efforts to further analyze and actively monitor this loss.

Detailed Data Collection and Analysis. Rwandan clinics use monthly activity registers to track family planning clients. Clinics report to the regional level monthly statistics on new acceptors and continuing users by method. For regional monitoring purposes, the number of no-show clients is computed in the following way:

	Last month's continuing users (of any method offered by the clinic)
+	**Last month's new acceptors** (of any method offered by the clinic)
–	**This month's continuing users** (of any method offered by the clinic)
	Total no shows for the month (includes no shows for any method)

In other words, it is assumed that if all clients return during the month in which they are expected (making the total no shows equal to 0), then the total number of continuing users for the current month equals the total number of continuing users plus new acceptors for the previous month.

To obtain more detailed data on no-show clients, ONAPO surveyed a sample of clinic activity registers looking at the most commonly used contraceptives and determined both the rate of no shows for those methods and the duration of contraceptive use. ONAPO found that 23 percent of pill acceptors in 1989 discontinued all contraception within 6 months of their first visit. This figure rose to 33 percent in 1990. New acceptors of injectables showed lower percentages of discontinuation within their first six months of service—14 percent in 1989 and 18 percent in 1990. These no-show rates seemed higher than desirable for a program that was trying to increase contraceptive prevalence.

The rates indicated that clients had stopped using the services relatively soon after beginning services, suggesting service-related reasons for discontinuing services, rather than personal factors such as the client's desire to become pregnant. The increase in no shows from 1989 to 1990 was also a warning that the situation

Continued on next page

could become worse. ONAPO noticed, however, that a significant proportion of the clinics in the sample had no-show rates within the first six months of services that were much lower than the average. This indicated that lower rates were possible within the country, and even within the same region.

Feedback. ONAPO began to communicate information on no shows back to the 10 health regions in the country. ONAPO sent graphs and tables to inform each region how it was doing relative to other regions and how each region's clinics were performing compared to one another. This information was communicated to the clinics during supervisory visits. Based on local knowledge, the regions and clinics could interpret whether the no-show rate reflected a temporary situation in a clinic (such as recent staff turnover), a background situation (such as normal mobility among the local population), or whether the rate might indicate a clinic situation that required further investigation.

Feedback included sending a bar chart showing, for each clinic in the region, the number of no shows, the number of new acceptors, and the increase in clients for the clinic (new acceptors – no shows = increase in clients). This information graphically reveals which clinics may be successful in recruiting new acceptors but may not be able to retain them. Also, it allows smaller clinics to compare their performance with that of larger clinics. In some cases, a smaller clinic may recruit fewer new acceptors, but may successfully retain a higher proportion of those clients.

Management Improvements. An impressive number of changes in record keeping, client follow up, counseling, and supervision are occurring as a result of the ongoing analysis on no shows.

- In addition to introducing a daily activity register to track their clients, ONAPO is assisting clinics in setting up a new record-keeping system in which they **file their family planning client records by next appointment month**. Within the appointment month, the records or cards are filed by client registration number. Each time a client returns to the clinic for her appointment, her record is pulled from the file and updated, and after the visit the record is moved to the file for her next appointment month. At the end of each month, the remaining records (of clients who missed their appointment for that month) are moved to a section for no shows and filed by registration number. This method of filing facilitates follow up. After another month, if the no-show clients still have not returned, these records are moved to a third section for discontinuers. It is easy to use these records to analyze characteristics of clients who have not returned for two or more months.

- Clinic managers are **establishing linkages with family planning promoters for follow up.** Clinic managers are beginning to hold monthly meetings with the family planning promoters who serve their clinic service area. At these meetings, they pass their lists of no shows to the promoters. The promoters try to find out why these clients have stopped coming to the clinic and encourage them to return for services. They record the result of each follow-up visit in their notebooks and relay the information to the clinic manager at the next monthly meeting. The reasons for not returning are recorded on the register next to each no-show client's name, under a column labeled "Comments." The promoters' visits are resulting in clients returning to the clinic. They are also providing information that the district supervisors can use to help clinic managers reduce their numbers of no shows.

- Clinic staff have requested more **training in counseling** in order try to reduce numbers of lost clients by minimizing the number of clients who end up with unsuitable methods or who are not properly informed about possible side effects. As a result, extensive training in counseling is planned for the next year.

- **Supervisors of regional family planning activities now take data with them about no-show clients and new acceptors on their supervisory visits.** They discuss this information with regional and clinic staff and try to find ways to reduce the level of clinic discontinuers.

In the future, a study will be done to see whether staff training in family planning reduces the number of no-show clients. ONAPO has generated a list of all recently trained staff, organized by clinic. It will compare this list with individual clinics' data on no shows to see whether there is a difference between clinics that don't have trained staff and clinics that do. As this country example shows, the analysis of simple and easily obtainable data on no shows has already generated a number of valuable service improvements.

Using the Data to Improve Family Planning Services

Improvements in Clinic and Outreach Protocols

It is critical that clinics have established **medical standards of care** and **standards for client counseling**. Maintaining these standards helps to ensure that the services are consistently of high quality and responsive to clients' needs. If your clinic is not delivering high-quality contraceptive services based on the needs and concerns of the client, then you should not be surprised by high discontinuation rates. Even though the unmet demand for family planning services is high throughout the world, women who are desperately in need of contraceptive services are not likely to remain in a clinic that is not clean, and not staffed by highly trained, caring personnel, and where they are not treated with respect.

Written **protocols** should also be developed **for outreach workers** to contact clients who have not returned when expected. They should set forth clearly established procedures exists for:

- respecting the clients' privacy;
- recording no-show clients' reasons for missing the appointment;
- encouraging no shows to return;
- keeping track of the number and results of follow-up contacts
- checking on whether no shows have any contraceptive supplies left and have knowledge about the correct use of the method.

Improvements in Follow Up

A well designed follow-up system for contacting no-show clients will benefit the individual client and will provide information that can be used for making service improvements.

In clinics with very limited resources, simple follow-up systems can be developed. *For example, in integrated health facilities, staff can ask no-show family planning clients who come to the clinic for non-family planning services why they are no longer returning for family planning services. The registration clerk can be given a list of no-show family planning clients. The list can be updated once a month. When these clients register for a non-family planning visit, the registration clerk or the nurse can then ask them the reason for their missed appointment.*

A more systematic follow-up method would involve using community workers to do follow-up. If a clinic has **outreach workers or a CBD program** linked to it, then it already has the staff who can be used to do follow up. If a clinic does not have community workers, the clinic manager or supervisor will need to **build linkages to other community groups** who may be able to do such follow up. Some possible groups include separate community-based distribution programs, women's groups, community health workers, or other health or development workers who are likely to make house calls. By sending community workers to the homes of clients who have not come back to the clinic within a certain number of weeks of their expected visit, a clinic can reach out to these clients soon after they have stopped coming to the clinic.

For a follow-up system to work, clients should be asked at their first visit how and where they could be contacted should the clinic need to do so. This information should be noted in the client's record. At least once a month, a staff member from the clinic should review the record of each no show and make a list of the no shows for follow up, noting where they can be contacted or visited. The staff member can then meet with the community workers to go over the list and initiate the follow-up visits for that month. The follow-up task of the community worker is to contact these former clients, ask them why they did not return to the clinic for a revisit, and, if appropriate, encourage them to come back to the clinic. The name and answers of each no-show client can be recorded on a form, which is coded with reasons for discontinuing services and returned to the clinic at the next monthly meeting. The information from the community workers' forms can then be recorded on the client family planning records and, if appropriate, also on the client register.

Improvements in Training

By analyzing the characteristics of discontinuers and interpreting the data, clinic managers may realize that the clinic has a serious need for improvements in staff training, especially the training of medical providers and counselors. *For example, high numbers of unwanted pregnancies among clients who used the pill may point to a need for more staff training in how to educate clients better about the correct way to take the pill.*

Improvements in Counseling

In programs where side effects, fear of side effects, and opposition of spouses or partners are found to be the main reasons that women discontinue using contraception, staff can help to reduce discontinuation rates by creating supportive and respectful relationships with their clients. Good counseling is a critical aspect of developing trust between clients and providers. Staff need to let clients know that they will carefully monitor the client's use of a method, help identify side effects, and recommend another method if a client is unhappy with the first one.

If staff guarantee from the outset that they will work with a client until she is satisfied with her method and then follow through on that promise, a client is likely to keep returning to that clinic. Through sensitive discussion, a provider can either help a client find ways to deal with side effects or advise her to change to a different method. Counseling can help clients to feel positive about the method they select and help them deal with any negative attitudes of spouses or other relatives. Open discussion about negative rumors can also help clients distinguish fact from fiction.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On the timing of appointments and follow up . . . *One reviewer stresses*, "It is perhaps safer if the appointment for resupply is set for two to three weeks before the client's initial supply runs out. This way if the client is only a few days or weeks late for her appointment, she will still be protected against pregnancy. Further, when a client does not show up for an appointment and no longer has contraceptive supplies (according to your records), it is precisely at this time when it is most important to provide follow up, since this is when unplanned pregnancy often occurs."

On deciding which methods to measure . . . *One reviewer offers*, "Contrary to your example in Rwanda, where there is a single provider of contraceptives, in our area clients often go to commercial outlets for resupply of pills, so it is not as useful to calculate the pill discontinuation rate. Clinic managers should be careful to decide which types of users to track and for which methods the measurement will be useful."

On the defining your reason for measuring discontinuation . . . *One reviewer points out*, "Clinic managers need to decide the primary reason for counting discontinuers and calculating rates. In some clinics it may be less useful to calculate a rate than to institute a filing system for following up on clients who do not return to the clinic. Then you could determine whether these clients have discontinued or whether they are continuing users who obtain their contraceptive supplies from another outlet."

Continued on next page

On the accuracy of quarterly rates . . . *Several reviewers suggested,* "It should be noted that because the number of discontinuers in a three-month period of time may be small, quarterly discontinuation rates may fluctuate widely from quarter to quarter and may reflect a random variation rather than a true trend. For this reason, managers should view quarterly data with caution and make note of any conditions or circumstances during the previous six months that may have affected the calculation."

"It may be more useful to measure discontinuation rates over a longer period of time such as semi-annually or annually. Rates that pertain to a longer period of time will have the effect of averaging out these fluctuations and will be more representative of the overall clinic discontinuation problem. They can also be used for monitoring the discontinuation trend in your clinic and for making comparisons with those of other programs. Above all, managers should remember that the underlying reason for tracking discontinuers is to help them identify clients who are at risk of having an unintended pregnancy so that clinic staff can provide follow-up visits and make every effort to encourage clients to continue using contraception."

On the importance of protecting the privacy of clients . . . *Several reviewers cautioned,* "Frequently, women decide to use contraception without informing their husbands, partners, or parents, so a follow-up visit or a letter arriving my mail violates their right to privacy, and causes problems at home. Clinic staff should ask the client at her first visit how she should be contacted if the clinic needs to reach her, and her response should be noted on her record. Some clients may need to be reached through a friend, and met at an agreed upon location."

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Checklist for Reducing Discontinuation

For Clinic Managers

- [ ] Work with your staff to establish definitions for discontinuers of each method you provide in your clinic. Communicate these definitions to your supervisor.
- [ ] Set up a system for tracking no shows and discontinuers on a regular basis.
- [ ] Develop an active filing system for filing the records of all no shows and discontinuers.
- [ ] Design and implement a follow-up system to visit clients soon after they fail to return to the clinic.
- [ ] Work with your staff and supervisors to determine the method-specific discontinuation rates in your clinic.
- [ ] Use tally sheets to analyze the characteristics of discontinuers.
- [ ] Discuss the findings of your analysis with your clinic staff and together design changes in your service delivery systems that will help to reduce the discontinuation problem.

For Supervisors

- [ ] Work with the clinic managers to analyze discontinuation rates in the clinic.
- [ ] Share the mathematical formulas used by other clinics that have conducted discontinuation analyses, so that your clinic managers can use or refer to them as they conduct their own analyses.
- [ ] Facilitate the acquisition of regional or national data by getting necessary information from upper level managers at the regional or central level.

For Mid- and Senior-level Managers

- [ ] Encourage clinic managers and their supervisors to analyze discontinuation rates in their programs and clinics.
- [ ] Support the efforts of clinic managers and supervisors by providing them with information on discontinuation rates in other regional clinics, so that they can compare their performance with that of other clinics.
- [ ] Communicate successful strategies for reducing the problem of discontinuation so that other programs can use them.

CASE SCENARIO FOR TRAINING AND GROUP DISCUSSION

The Tapong Clinic Decides Whether to Measure Discontinuation

Nurse Chiraphan, the manager of Tapong Family Planning Clinic, looked at her watch, and was irritated. She was expecting Mr. Howe to arrive at ten o'clock and he was late. It seemed that all consultants from the family planning program's Central Office showed up late. She wondered if there would be enough time now to explain about the Tapong Clinic. Last week she had received a circular from the Central Office informing her of a new program initiative to improve the quality of the program's services. Mr. Howe, an international consultant who specialized in improving the quality of family planning services, had been hired to collect information from several clinics so he could make recommendations for the design and set up of a system to monitor client discontinuation.

Nurse Chiraphan was reviewing service statistics reports when Mr. Howe finally arrived. She concealed her irritation and welcomed him to the clinic. "Good morning," she said. "I am delighted to meet you, and I am ready to help you in any way that I can."

Mr. Howe was a small man who spoke rapidly and who apparently did not see any need to engage in the customary formalities. "I have a number of questions about your clinic," he said. "I'll get right to the point." He opened his notebook and, reading from his notes without looking up, he continued, "I understand that this clinic offers oral contraceptives, IUDs, injectables, and condoms. Let me begin by asking whether any of these methods are available from any other sources in your district."

Nurse Chiraphan was somewhat astonished by Mr. Howe's rapid speech and abrupt manner, but the question was one she was happy to answer. The Tapong clinic had been the first, and until recently the only, provider of family planning services in the area. Her pride in her clinic's achievements was clearly evident in her voice. "We are the only family planning service provider in this area," she responded. "We provide all the IUDs and injectables in our area. There aren't any other providers for these methods. Thanks to a special program initiated by one of our staff, condoms are available for a very small fee at a number of other places, although we still provide them free at our clinic. Until last month we were the only source for pills in this area. But the Central program has begun distributing pills to the three rural pharmacies in our area, where they can be purchased at subsidized prices."

"What resupply polices does your clinic follow?" asked Mr. Howe.

"Of course, we follow the policies that are developed at the Central Office," Nurse Chiraphan replied, wondering why he would ask such an obvious question. "At a client's first visit, we give her a three-month supply of pills and at her next visit, and at each subsequent visit, we give her a six-month supply. In our clinic we use a three-month injectable and ask clients using this method to return just before the three months are over. We provide condoms on request, and clients are not required to register at the clinic for resupply of this method."

Case Scenario: The Tapong Clinic

Nurse Chiraphan was somewhat amused by the way Mr. Howe wrote every word in his notebook. "How often do you ask people to come back for IUD checkups?" he inquired.

"Each new IUD user is asked to return for an initial checkup at three months and then annually thereafter," replied Nurse Chiraphan.

"How do you know if your clients are late for their resupply visit?" asked Mr. Howe, still bent over his notebook. "Do you have an appointment system?"

"No," she said. "We don't have an appointment system. That would never work here. We just remind our clients as they are leaving the clinic that they absolutely must come back to the clinic about two weeks before their contraceptive supplies run out." After a brief pause she added, "We file our records by the month that the client is expected to return for resupply. This way we can tell who hasn't returned to the clinic as expected."

Mr. Howe shifted in his seat and for the first time in several minutes looked up from his notebook and glanced at the wall clock. Just as Nurse Chiraphan had expected, there wouldn't be enough time to tell him about all the things her clinic was doing. Abruptly, he stuck out his hand and said, "Thank you for your time today, Nurse Chiraphan. I expect that I'll see you again in two weeks, after I have visited all of the clinics and had a chance to look at the data I have collected. I will be making a recommendation to the Central Office on whether you and the other clinic managers in the district should measure discontinuation in your clinics. If I do recommend that each clinic should begin measuring discontinuation, then you will be invited to a meeting so that I can get reactions from all the clinic managers to my preliminary design of the system."

Having gathered all the information he needed from Nurse Chiraphan, Mr. Howe set off to visit several other clinics before returning to the Central Office where he would begin drafting plans for the tracking system, make recommendations on whether or not the Tapong Clinic should measure discontinuation, and develop a system for following up discontinuers.

Case Discussion Questions: The Tapong Clinic

1. **Several factors must be considered when deciding whether to measure discontinuation and selecting which contraceptive methods to track. Considering the environment of the Tapong Clinic described in the case, what factors should be considered and would you recommend measuring discontinuation? If so, what methods would you recommend that they measure, and why? If you choose not to measure certain methods, explain why not.**
2. **For each method that you have selected to measure, recommend a definition that the clinic could use to identify no shows and discontinuers (that is, how long a client can stay away from the clinic before she is considered a discontinuer).**
3. **If Tapong Clinic wanted follow up on clients who are at risk of discontinuing, what system would you recommend that they use to identify these clients and follow up on them?**

Case Analysis: The Tapong Clinic

1. **Several factors must be considered when deciding whether to measure discontinuation and selecting which contraceptive methods to track. Considering the environment of the Tapong Clinic described in the case, what factors should be considered and would you recommend measuring discontinuation? If so, what methods would you recommend that they measure, and why? If you choose not to measure certain methods, explain why not.**

The decision as to whether to measure discontinuation is influenced by the following factors:

- program policies for resupply and check-ups;
- availability of supplies from other sources;
- competing service providers in the area;
- types of contraceptive methods provided (some are easier to track than others),
- ability to use the discontinuation data for follow up or program planning (including improving quality, assessing client satisfaction, determining suitability of method mix, and assessing the characteristics of discontinuers in order to make programmatic improvements);
- ability to obtain data on discontinuers from existing clinic data sources.

For Tapong Clinic, Mr. Howe might decide not to measure discontinuation for condoms because there are a number of sources of supply where condoms are sold at minimal cost. In fact, clinic policy encourages clients to seek condom resupply in these retail outlets.

For the IUD and injectables, however, the clinic is the only source of supply, and both require a clinic visit. Because injectables require regular clinic visits, they are easy to track for discontinuation. High discontinuation rates might indicate poor quality services, dissatisfaction with the method, inadequate counseling, or restricted access to services either due to pricing policy, location, or clinic hours. For IUDs, the clinic policy requires IUD users to return on a yearly basis for a check up. Their failure to return for the annual visit would classify them as no shows. If no show rates for annual IUD check ups were high, follow up visits to clients could be made to obtain more information on this problem.

The decision on whether to track pill discontinuers is not clear cut in this case. Because pills are also available from pharmacies, the discontinuation rate could look high even though clients may still be using the pill. An analysis could be done of a subgroup of discontinuers to determine whether they might be obtaining their supplies from a pharmacy. If, however, most pill clients are still being resupplied by the clinic, then the clinic might want to track pill discontinuers, perhaps on a semi-annual basis, to monitor the trend.

2. **For each method that you have selected to measure, recommend a definition that the clinic could use to identify no shows and discontinuers (that is, how long a client can stay away from the clinic before she is considered a discontinuer).**

It may be helpful to develop a chart similar to the one shown on the next page that indicates what methods are provided by your clinic, the protocols for dispensing that method, when a client becomes a no show, and when the client is determined to be a discontinuer. This chart can then be referred to by all clinic staff.

Case Analysis: The Tapong Clinic

Method	Protocol/months of supply given	Appointment/ expected date of return for resupply	When client becomes a no show	When client becomes a discontinuer
Pills 1st visit	3 months	2.5 months from date of first visit	As soon as client misses expected return	One month after pill supply is due to run out
Pills Subsequent visits	6 months	5.5 months from date of last visit	As soon as client misses expected return	One month after pill supply is due to run out
Injectables	3 months	2.5 months	As soon as client misses expected return	3 months after expected return
IUDs 1st vist	IUD inserted	3 months after insertion	1–2 months after scheduled check up	Not applicable
IUDs Subsequent visits	None	Annual checkup	6 months after scheduled annual checkup	2 years after most recent checkup

The definitions you chose for no shows and discontinuers will depend on clinic protocols and on assumptions about contraceptive use in the area. The information in the discontinuers column above is based on the protocols followed by Tapong Clinic. The date in the no-show column is based on how long the contraceptive method will remain effective. However, clients are asked to return several weeks prior to running out of contraceptives in order to provide adequate time to follow up clients who do not return on time, and before they are at risk of becoming pregnant. In this case, once this time has passed they are considered discontinuers. Your definitions may vary slightly.

3. If Tapong Clinic wanted follow up on clients who are at risk of discontinuing, what system would you recommend that they use to identify these clients and follow up on them?

Since Tapong Clinic already has a system of filing records by the month in which the client is expected to return for resupply, it would be easy to identify the clients who were at risk of becoming discontinuers. At the end of each month, all records remaining in the file for that month can be put on a list for follow up. The client should be contacted during the next month and, if after receiving a follow-up visit a client does not return for services, her record can be moved to the "discontinuers" file.

CHAPTER FIFTEEN

Improving Supervision: A Team Approach

Supervision is so important to getting things done that most family planning organizations have developed a formal supervisory structure staffed with "supervisors" to help them ensure that activities are supervised. These "supervisors" work alongside managers who also perform their own supervisory activities on a day-to-day basis. Yet in spite of the special effort to provide supervision, managers are often frustrated by how difficult it is to create a supervisory system that improves program performance.

Necessary resources and training for supervisors are often lacking, supervisory visits rarely occur on schedule, and supervisees often don't understand the benefits of supervision. To make matters worse, program planners rarely consider these limitations when designing supervisory activities. Stripped of resources and without a team approach or on-the-job education from the supervisor, supervision often becomes a monitoring and control exercise symbolized by the standardized supervisory checklist.

This issue of *The Family Planning Manager* explores ways to improve supervision in family planning clinics. It focuses on developing an interactive team supervision strategy that can improve the supervision of activities and individual performance. The issue explains how clinic staff can work together as a team to provide ongoing supervision and improve the quality of family planning services.

This chapter was originally produced as Volume II, Number 5 of ***The Family Planning Manager****, including the case scenario, "Mr. Traore Introduces Team Supervision," and the supplement, the "Pocket Guide for Service Improvement," which can be found at the back of this book. The guest editors for the issue were Jaime Benavente and Claire Madden.*

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Developing an Alternative Approach to Supervision

The purpose of a supervisory system is to ensure the quality of program and clinic operations and to enable staff to perform to their maximum potential. Traditional approaches to supervision emphasize "inspecting" facilities and "controlling" individual performance. However, improving program performance and maintaining program standards by supervising individual performance is impractical because most services are complex and are not dependent on the actions of a single individual. A family planning client is satisfied because the receptionist at the desk was courteous and efficient, because the counselor provided her with information she used to make an appropriate choice of method, because the physician reviewed her medical history and performed an adequate physical exam if necessary, and because the many people working to purchase, transport, and store the contraceptive she chose have made it available in the clinic.

Supervising individual performance may help managers to correct mistakes or know whom to reward. However, the results of individual supervisory visits are sometimes used by managers to blame individual workers for inefficiencies that are caused by the design and management of the service systems(s). In addition, systems that supervise individual performance are rarely designed to consider the impact of environmental, social, and cultural factors such as program and policy issues, resource constraints, and group dynamics that affect and individual's performance.

For a supervision system to be effective, the supervisor who visits the clinic periodically must develop a team approach with the clinic manager and staff. Establishing a team that has supervisory responsibilities makes it possible to have a supervisory system that functions between scheduled supervisory visits. To build a clinic supervisory team, supervisors visiting from the outside must develop the skills of the clinic manager and staff so that they can provide ongoing supervision.

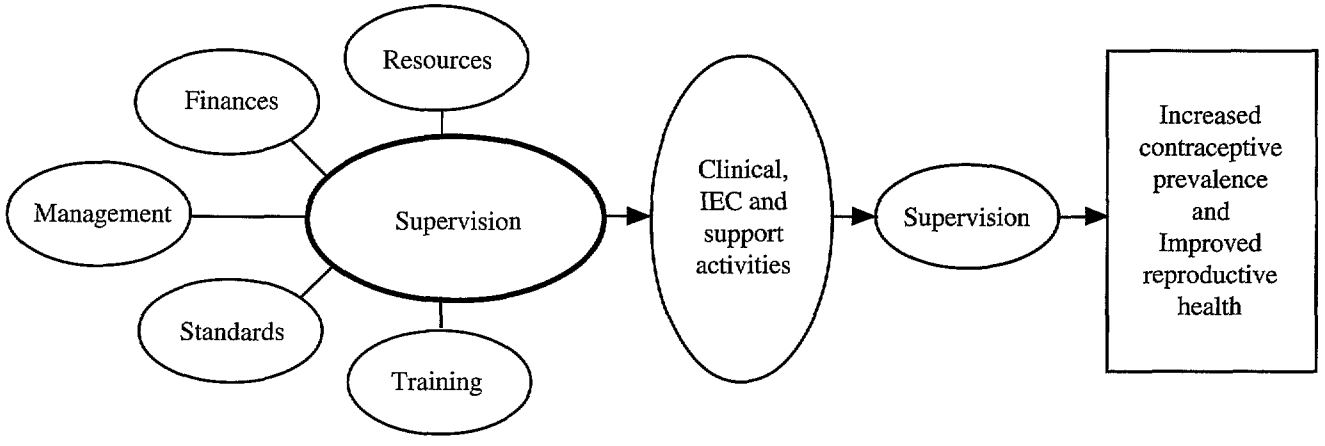
Using a team approach to supervision requires that the supervisor disregard conventional disciplinary attitudes and shift from the role of "inspector" to the role of "facilitator." Team supervision is oriented toward teamwork, where problem solving is the main focus of the interaction, and supervisors become on-the-job teachers who support their staff. This chapter examines how supervision can be improved by using a team approach. It shows how supervisors can work with clinic managers to develop an ongoing supervisory system within the clinic that continues to operate between scheduled supervisory visits to ensure high quality services.

Developing the Supervisory System

A family planning service delivery system is made up of a combination of components that together produce a variety of services. Supervisory activities aim to identify the parts of the overall system that need to be strengthened so that quality services can be maintained or improved. Within this supervisory system, different levels of supervisors and managers guide and coordinate the work of others to ensure that organizational goals, objectives, and standards are achieved.

An effective supervisor focuses on the internal *program environment,* including program planning, team problem solving, operations monitoring, and progress toward objectives, as well as on the *external environment,* including policy and guideline changes, training opportunities, communication with other levels of the health system, and advocacy. The following diagram shows how supervision fits in the service delivery system.

The Role of Supervision in the Service Delivery System



Supervision can be viewed as the coordinated use of information and resources from different components of the service delivery system that ensure quality outcomes. Brief definitions of these components follow:

Finance provides the **resources** for carrying out supervisory activities.

Standards are quality guidelines set by management that make supervision technically meaningful.

Management provides the strategy and plan of program activities.

Training ensures that the supervisor has the basic skills to conduct effective supervision and that staff understand the system and share the general objectives of the supervisory efforts.

Strengthening Your Supervisory System

In order to carry out supervisory activities regularly and effectively, and to ensure that supervision is a priority within the larger health care system, managers must make sure their existing supervisory system has the appropriate level of support from the institution or organization. By answering the following questions, you can assess to what extent your own supervisory system benefits from institutional support.

- Does your system have clearly delineated lines of authority and well-defined supervisory levels?
- Does your system clearly describe appropriate supervisory procedures and provide tools for effective supervision such as guidelines, job descriptions, and supervisory protocols?
- Do managers at all levels receive and use data generated by the supervisory system?
- Do senior managers within the organization understand how the supervisory system functions and how it should function, in order to improve quality and bring about desired outcomes?
- Do staff members at all levels of the organization understand the importance of supervision in achieving organizational goals?
- Is there an operational unit within your organization that has the responsibility for planning, implementing, and monitoring supervisory activities?
- Are adequate resources allocated in your organization's annual budget to carry out supervisory activities and to maintain the supervisory system?

If your assessment indicates a lack of organizational support for supervision, you need to develop a strategy for building this support within your institution. Linking supervisory activities to results may prove effective in demonstrating that supervisory activities lead to concrete improvements in service delivery. This, in turn, may lead to greater institutional commitment and additional resources for supervision.

Interaction Among Administrative Levels in a Supervisory System

Supervisory activities take place at three or more administrative levels. Each level has a unique role in the larger supervisory structure, and relationships between these levels are critical to overall program performance. In an effective supervisory system, these relationships are clearly defined.

Interaction between the central level and the regional (provincial or departmental) level. For a family planning supervision system to be effective, the central level must actively support supervisory activities by providing human and capital resources. The central level can support regional supervision by:

- Developing standards of service quality;
- Developing reporting and monitoring systems to assess service quality and identify where supervision is needed;
- Organizing and supporting supervisory skills training for regional supervisors and service delivery teams;
- Responding to the service delivery needs expressed by regional supervisors;
- Allocating necessary resources for supervision.

Interaction between the regional level and the clinic level. Regional-level supervisors play a critical and often difficult role in the

supervisory system. These supervisors are primarily responsible for supervisory activities carried out in the service delivery sites in their region. These supervisors need to communicate regularly with clinic managers to provide prompt and constructive feedback, assistance with problem solving, and guidance in planning so that clinic objectives can be achieved. They must write reports to record and monitor the results of the visits.

In order to be effective, supervisors need training and support for their activities, as well as clear guidelines and a schedule of supervisory activities that includes all the facilities for which they are responsible. A good supervisor will work with a clinic team to continually monitor activities in the clinic and will serve as an advocate for clinic managers at the regional office.

Interaction between the clinic manager and clinic staff. The clinic manager's job is to ensure that family planning clients receive quality services. Because supervisory visits are infrequent, the regional supervisor, clinic manager, and staff should form a team and share the responsibility for monitoring and improving day-to-day clinic activities. Working with the regional supervisor, the clinic team can track their progress toward meeting clinic objectives and communicate the kind of support they need from central and regional levels.

Working Solutions—Ecuador

Supervising Individual Performance is Not Enough

Studies have shown that focusing primarily on the performance of individuals is not enough, and does not ensure that the clinic will accomplish its goals and objectives.

A rural health project in the district of Salcedo in Cotopaxi Province in Ecuador that was conducted between 1985 and 1990 worked to strengthen local planning following the Pan American Health Organization's strategy of SILOS (Systemas Integrados Locales de Salud or "Local Integrated Health Systems"). An important aspect of this strategy was to strengthen supervision within the context of local planning.

The project conducted a study of the supervisory system and found that individual supervision was a barrier to participation in planning local activities. Supervisors were failing to motivate staff to participate in planning their local health system. When the focus was changed to supervising local teams rather than individuals, participation in local health activities increased markedly.

To build the local team, the district supervisor met with health center managers (usually a physician director or nursing administrator or both) to discuss planning and supervisory activities. The health center manager(s) then organized a health center team consisting of a dentist, a nutritionist, an environmental officer, and two to five staff nurses, depending on the size of the health center. Subsequent meetings with the supervisor and the clinic team at the clinic resulted in operationalizing the district plan at the health center level. In these meetings, the supervisor functioned as a facilitator and resource for the health center teams. The result was that the team members were able to see the connection between supervision and planning. In fact, supervision became the "normal" way to monitor the activities in the plan and to assess the achievement of objectives.

Supervising Family Planning Activities

Most family planning programs follow a conventional supervisory system where supervisors from the central or regional office make supervisory visits to clinic facilities once or twice a year. Often the visits are brief, and supervisors have many different activities to monitor but little time for discussion and on-the-job training. The focus of the visit is usually on *individual* activities. The supervisor often spends the majority of his or her time filling out a checklist rather than investigating, analyzing, and discussing the causes of the problems that have been identified. Time is usually limited, causing the supervisor to leave the service delivery site without developing or discussing specific recommendations for improvement. Often no written plan of recommendations or follow-up support is provided, and consequently staff find it difficult to improve their performance or the performance of the clinic as a whole.

Five Keys to Effective Team Supervision at the Clinic Level

To be an effective team supervisor you must:

- Support your staff.
- Pay attention to the needs of your staff and to the environment in which they work.
- Be a teacher—devote yourself to educating your staff.
- Discuss problems with your staff and work with them to find solutions.
- Understand the needs and demands of your clients.

Using a Team Approach to Supervision

By placing more emphasis on clinic team problem solving and on continuing on-the-job training, supervisors can overcome many of the shortcomings of conventional supervision. A team approach to supervision emphasizes individual performance as it relates to the ability of the team to achieve common goals. This approach has a forward focus; it looks at clinic performance to find areas where improvement can be made, rather than focusing on past individual shortcomings.

Within the context of limited resources and multiple infrastructural and cultural constraints to delivering family planning services, addressing problems as a team is a viable approach to problem identification and resolution. Identifying problems and finding solutions as a team helps to remove individual blame and builds consensus. Effective supervisors build and support a clinic team that works together to analyze shortcomings and identify and implement solutions. In this way, all team members can learn from each other's mistakes and successes.

Developing an Effective Team

A team is made up of a group of people working together to achieve a common goal. An effective team has certain characteristics that allow the team members to function more efficiently and productively. An effective team develops ways to share leadership roles and ways to share accountability for their work products, shifting the emphasis from the individual to several individuals within the team. A team also develops a specific team purpose and concrete work products that they produce together.

An effective team will have open-ended meetings and develop active problem-solving strategies that go beyond discussing, deciding, and delegating what to do; they do real work together. When necessary, individuals in a team will set aside their own work to assist other members of the team. In a well-functioning team, performance is based not on an individual member's ability to influence other members, but rather is assessed directly by measuring the work products of the whole team.

How to . . .

Develop an Effective Team

Because field supervisors make only one or two visits a year to each rural clinic, they must set up a system that allows the clinic staff to feel and work like a team and to have the skills to solve problems together.

There are several ways in which a supervisor can help clinic managers and staff become a strong team:

- **Establish objectives together.** Define performance objectives with the team and make sure that all team members understand the objectives and actions that will need to be taken in order to achieve them.
- **Develop a participative style.** Encourage staff to suggest ways to improve services. Listen to their ideas and acknowledge their points of view. Encourage team members to discuss issues and to find solutions together.
- **Organize meetings.** Hold meetings with the whole team during supervisory visits. Discuss supervisory and clinic objectives and encourage the team to discuss their concerns.
- **Organize the team.** Define roles and responsibilities together. If everyone has a clear role, individuals will be less likely to become frustrated and will be more willing to work together.
- **Explain the rules.** Discuss all norms and standards that have been established for this clinic by the Ministry or the organization. Explain the rationale for these rules and discuss their implications in day-to-day practice.
- **Promote team responsibility.** Encourage members of the clinic team to take responsibility for completing specific tasks and to solve problems as a team.

Six Characteristics of an Effective Team

- Team members share leadership roles
- Team develops own scope of work
- Team develops concrete work products
- Team members are mutually accountable for work products
- Performance is based on achieving team products
- Problems are discussed and resolved by the team

Determining Which Activities to Supervise

Supervision at the clinic level involves providing support to staff in three key activity areas: clinical activities, management activities, and personnel activities.

Every supervisory visit should address activities in each of the three activity areas. A supervisor who focuses on a single activity area, such as the provider's ability to prescribe oral contraceptives, but does not explore how commodities are managed or how staff treat clients at the clinic, will not have conducted a comprehensive visit. Each individual activity is important, but no activity has great value in isolation. Since it is not possible to focus on all the clinic activities during a single visit, when planning a supervisory visit the clinic manager and the visiting supervisor must identify which clinical, management, and personnel activities should be addressed during the next visit. Sometimes service statistics data can help to determine which areas are most in need of supervision.

Activity Areas

Clinical	Management	Personnel
• Service provision and screening for contraceptive methods • Counseling and IEC • Client follow up and referral	• Activity planning • Clinic organization and client management • Resource management • Supplies management • Information management	• Staff motivation • Professional development • Conflict resolution

Supervising Clinical Activities

To ensure quality family planning services, supervisors must become proficient at providing continuing technical support and training in clinical activities. Several areas where supervisors can provide clinical support are clinical service provision and screening for contraceptive methods, counseling and IEC, and follow up and referral.

Service provision and screening for contraceptive methods. Supervisors should work with clinic staff to ensure that they make appropriate client assessments and can accurately determine the suitability of different contraceptive methods for a specific client. This includes taking a comprehensive medical history, performing an appropriate physical exam, detecting contraindications to the use of specific family planning methods, and counseling on potential side effects that might occur.

Counseling and IEC. Supervisors should make sure that staff provide accurate information to clients and have supportive discussions so that they understand the options available to them and can choose the most appropriate method. Supervisors can assess by direct observation whether service providers make clients feel comfortable and treat them with respect.

Client follow up and referral. The supervisor should help staff to develop systems for providing follow up and referrals and for tracking discontinuers. The supervisor should remind staff of the importance of follow up and referral as a means to find out if clients are satisfied, provide additional supplies, ensure correct method use, reassure or treat clients with side effects, treat any medical complications, assist the client in selecting an alternative method, or refer the client to another facility if she/he wants a method that the clinic cannot provide. This client follow up is critical to minimizing the loss of dissatisfied clients.

Supervisors Can Be Teachers

Supervisors can improve counseling and follow up by helping staff to:

- Greet the client cordially.
- Talk with the client and determine her perceptions and desires.
- Explain different family planning methods.
- Help the client choose an appropriate method.
- Explain to the client how to use the method and explain any potential side effects.
- Urge the client to come for follow-up visits.
- Reach out to the client who is at risk of discontinuing contraception.

Supervising Management Activities

The skills required to effectively manage family planning services are often neglected in the formal training of supervisors, and as a result are also forgotten in supervisory routines. The recent trend to decentralize the management of family planning services makes it even more important to have effective managers at the middle and local levels. Supervisory visits present an ideal opportunity to advise family planning workers and clinic managers on how to manage more effectively. Activity planning, clinic organization and client management, resource management, supplies management, and information management are activities that supervisors can address during a supervisory visit.

Activity planning. Involving staff in planning activities allows the staff to see the entire scope of services the clinic provides, the level of effort required to provide each service, and how their individual roles fit into the overall service delivery program. Together, supervisors and their staff can set realistic objectives and intermediate targets, estimate the resources needed to accomplish the objectives, and keep track of the external factors affecting the proposed plan.

Clinic organization and client management. Supervisors can work with clinic staff to organize the clinic space and streamline client routes so that clients can be served efficiently. To streamline client routes, diagram the path of each type of client that comes to the clinic and make changes to minimize the number of stops a client makes, minimize the number of staff a client must see, and serve clients quickly who are only coming for resupply.

Resource management. Supervision requires resources. Good supervisors will not only help clinic managers to manage their resources, but will also coordinate with their superiors to ensure that there are adequate resources to conduct their supervisory visits. Supervisors can develop a number of different strategies to stretch the use of scarce resources, as illustrated by the following example in Burkina Faso.

Supplies management. By training clinic managers and staff in basic inventory control practices, helping them to estimate minimum and maximum levels of supply, and setting up a system for ordering supplies, supervisors can play a critical role in ensuring that clinics do not run out of or waste necessary contraceptive and medical supplies.

Information management. A supervisor must pay particular attention to the information and statistics collected at the clinic. Collecting, recording, interpreting, analyzing, and disseminating data should be an integral part of activities conducted by the clinic staff. Supervision of these activities should be included in any supervisory visit. Supervisors should explain how staff can use the information they collect to improve the services that they are providing.

Tips for Supervising Information Management

- Know the objectives for the clinic or region you are supervising.
- Understand what information you need to collect.
- Know how to analyze the information.
- Continue to improve the collection and use of the data.
- Work with clinic staff to use the data to improve the quality of services.

Maximizing the Use of Resources

Though supervisors cannot control the financial decisions that are made by their superiors, there are creative ways of maximizing the use of limited resources, as seen in the following two examples:

- **Integrate supervisory activities to maximize use of financial resources.** In the province of Bazega in Burkina Faso, funds allocated for supervision for various vertical programs were pooled, and the provincial medical director developed an integrated provincial plan for supervision in order to maximize the use of petrol and vehicles. At the beginning of each planning cycle, the provincial director of health meets with each member of the provincial supervision team to coordinate supervision visits to provincial clinics. Thus, though one supervisor may receive special funding for work on a vertical project, he can share his transportation with other supervisors. For example, two supervisors who need to travel to the same site (to supervise different aspects of the program) often go together on the same day, instead of making two trips at different times.
- **Develop a simple form to track transportation expenses.** UNFPA-funded provinces in Burkina Faso receive an allotment of funds to conduct supervisory visits and to repair vehicles. The funds are managed at the provincial level to promote the decentralized management of supervisory activities. A form has been developed to track the sites that were visited, the mileage to the sites, the money used for petrol, and miscellaneous repairs. The Provincial Director requires that all supervisors fill out and sign the form for each series of visits and that the form be returned to the provincial office before subsequent funds are disbursed. This enables the Provincial Director to track supervision expenditures over time and to plan for future resource needs for supervision activities.

Please refer to the following chapters for more information on how staff can support improvements in clinic management.

"Reducing Client Waiting Time," Chapter Nine, outlines steps for conducting a client flow analysis that will help clinics reduce the amount of time clients spend waiting for services and providers spend waiting for clients.

"Using Service Data: Tools for Taking Action," Chapter Ten, describes ways for clinic staff to graphically present and interpret their service data so that program improvements can be made.

"Improving Contraceptive Supply Management," Chapter Thirteen, helps staff to understand the basic techniques for storing, managing, and ordering contraceptive supplies so that adequate numbers of contraceptives will be available to clients.

"Reducing Discontinuation in Family Planning Programs," Chapter Fourteen, provides staff with ways to measure, analyze, and reduce discontinuation rates through improvements in clinic protocols, client counseling and follow up, and staff training.

"Developing Plans and Proposals for New Initiatives," Chapter Two, enables staff to develop a plan and budget for a new program initiative, and either use the plan to achieve program objectives, or turn the plan into a proposal for funding.

Supervising Personnel Issues

Interpersonal dynamics have a profound effect on program and clinic performance. It is the clinic manager's job to help maintain morale in the clinic, assist the staff in managing conflict, and motivate the staff to perform to their potential. The clinic manager is in the best position to know what interpersonal conflicts exist or what staff members need to be motivated or challenged. If the clinic manager lacks the necessary skills to address personnel problems, these problems may lead to poor clinic performance. In order to develop and maintain an effective clinic team, supervisors need to teach and reinforce the skills of clinic managers so that they can motivate staff, support professional development, and resolve conflicts among their staff.

Staff Motivation. Supervisors will not always have control over an employee's motivation, but there are still many things that a supervisor *can* do to improve an employee's sense of motivation and job satisfaction. Supervisors can have a positive effect on staff morale by providing positive feedback to staff on a regular basis, expressing appreciation for their efforts, and engaging them in problem solving and decision making. These actions will help to reaffirm the importance of their jobs to the achievements of the program.

Techniques for Motivating Staff and Increasing Staff Morale

- Tell your staff regularly and specifically what you value in their work.
- Encourage your staff to use their problem-solving skills.
- Create opportunities for staff to increase their responsibility.
- Involve staff in decision making about issues that affect them.
- Follow through on commitments to your staff.
- Create an organizational identity by using logos, special uniforms, etc.
- Above all, praise staff in public, but address personally sensitive issues in private.

Professional development. Supervisors must support staff development by continuing to provide (or help provide access to) training, educational, and professional development opportunities. Supervisors should provide staff with on-the-job training, and arrange for staff to attend training programs. Staff can also increase their knowledge and professional skills by visiting other family planning programs. Supporting the development of your staff's professional skills helps to maintain staff morale, increase job performance, build the institutional capacity of the program, and broaden the skills base of your staff. Staff development will also result in attracting and retaining a strong professional team.

Conflict resolution. A critical aspect of supervising staff is managing conflict among staff. The cause of these conflicts may be interpersonal or related to dysfunctional organizational systems. Supervisors must learn to become conflict managers. In this role they can resolve disputes by observing, analyzing, and helping the disputing parties to develop mutually agreeable solutions.

To resolve conflicts, the supervisor must learn to remain neutral. Avoid taking sides. Help the disputing parties to separate the problem from the people involved. Sometimes the disputing parties are so angry with each other that they believe that the other person is the problem. Even though this usually is not the case, it takes a good supervisor to help the two sides separate their personal differences from the real problem. A good supervisor will help disputing parties to see and understand their interests behind their positions. Once these interests have been identified, the parties can focus on areas of common interest instead of their individual positions. These areas often serve as a starting point for discussion. A good supervisor will help search for and develop solutions that meet the needs and interests of both parties. Finally, if you have remained neutral, you can insist that both parties agree on objective criteria to use to make any decisions to resolve the conflict.

Recognizing the Importance of the Supervisee's Perspective

An important and often overlooked aspect of supervision is the supervisee's perception of the importance and usefulness of supervision. Most approaches to supervision do not regard the supervisee's point of view as important. Yet the supervisee's perspective plays a significant role in the supervisee's ability to function effectively as part of a team.

Since every supervisor is also supervised by someone else, when you are supervising you should keep in mind what your perspective would be as the supervisee, and what information you would need to have. Inform those you supervise about the rationale for supervisory activities, including what they can expect from supervision, how they can benefit from it, how supervision can be improved, and how they can use supervision to improve their own performance and the overall performance of the team. By paying attention to the supervisees' roles in the supervisory system and to their attitudes and perceptions, supervisors can help those they supervise to become active and effective team players.

Tips for Encouraging Staff Participation in the Supervisory Process at the Clinic Level

- Help your staff to plan activities in the health unit.
- Develop and share the supervisory schedule with your staff so that they know and have input into what activities will be supervised.
- Encourage your staff to take an active role in their own performance analysis.
- Create an atmosphere in which your staff feel at ease when they communicate with you, by listening and acting on their ideas.
- Ask your staff for feedback regarding your supervision.
- Give your staff constructive feedback.

Working Solutions—Honduras

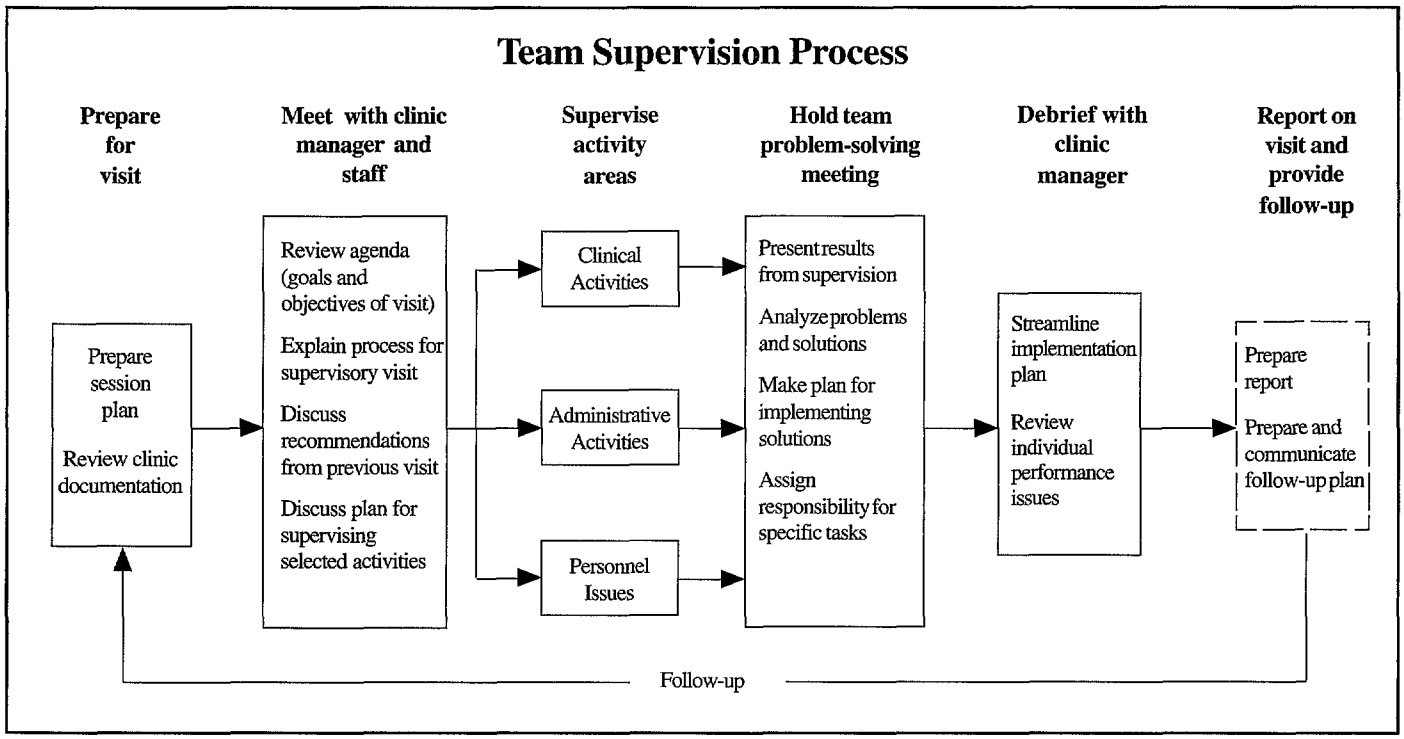
Using Supervision Results to Track Performance

The Honduras Ministry of Health has implemented a supervisory system whereby central-level staff, regional supervisors, and health center staff jointly develop a detailed supervision instrument. The instrument uses a YES/NO method for identifying problems in all clinic activities, from the availability of supplies to the correct medical examination of a pregnant woman. The answers convert to a value of 1 for YES or 0 for NO. The scores are then totaled and percentages are calculated for each program component by clinic staff. At each supervisory visit, supervisors review the activities related to the items on the supervision instrument. Problems are singled out for special attention and the supervisor and staff make a commitment, called a "compromiso," to solve the problems. The "compromisos" are written down and the person or persons who will be responsible for taking action on the situation and the approximate date when the actions will be taken are agreed upon.

The goal is for the health center to improve its own score, so the results of the supervisory visit are used to graph clinic performance. Graphs of performance scores help to motivate staff by permitting them to see their own progress toward clinic goals. The data collected on the supervisory visits can also be used to compare the performance among programs and health centers.

Conducting Supervisory Visits Using the Team Supervision Process

To conduct a useful supervisory visit using the team supervision process, a supervisor must follow certain basic steps. The following diagram illustrates the steps involved in a clinic-level team supervisory visit. The following guidelines for conducting a supervisory visit were developed in collaboration with the Burkina Faso Directorate of Family Health for regional health supervisors to use when conducting supervisory visits to local clinics. The same basic process can be used by a clinic-based supervisor who supervises staff within a clinic.



How to . . .

Conduct a Supervisory Visit

Step 1: Prepare for the Visit

Supervisory Schedule. For each visit or series of visits, prepare a simple schedule that includes the dates, times, and places, and the names of the supervision team members. The schedule should include the general objectives for the visit and should be sent to the clinic manager in advance. Use this communication as an opportunity to ask the clinic manager and other clinic personnel to prepare for the visit. (This may include preparing statistical reports, making a list of issues that the clinic staff feel the supervisor needs to address, or re-reading previous supervisory reports.)

Supervisor's Visit Plan. Developing a supervisor's visit plan involves determining what activities will be conducted before, during, and after the actual visit. All supervisory visits require good planning. Obtain and review the job descriptions for each staff member or, if those don't exist, a list of the tasks that each staff member performs. Get a copy of clinic objectives for each of the clinics you supervise. Your visit plan should include objectives of the visit, activities and tasks to be supervised and carried out, the supervision tools to be used, the type of supervision to be conducted, the resources needed, and a visit schedule.

Continued on next page

In preparation for the visit, review all documents related to the clinics you supervise. Make sure that both the clinic manager and staff review the previous supervisory report and the recommendations that you made at the last visit. Prior to the visit the clinic manager and staff should discuss any changes that have been implemented and whether they think the changes have been helpful. This preparatory work will enable you, the clinic manager, and the clinic staff to consider past problems, positive changes that have been made, and specific issues that need to be addressed. Remember, it is important to be prepared! On the appointed day, arrive on time at the clinic and bring all the material you need with you.

Step 2: Meet with the Clinic Manager and Staff

A supervisory visit includes collecting information, identifying problems, assessing work conditions, finding possible solutions to identified problems, and providing encouragement and on-the-job training to clinic staff. As a supervisor, it is your job to help the clinic manager and clinic personnel to improve their performance and their working environment. Make an effort to respond to the needs of the individuals and to the needs of the team, and to share with them any technical information that can help them to improve the quality of services.

First meet with the clinic manager and then with all the clinic staff together to:

- **Review the visit plan and discuss the goals and objectives of the visit.** As a supervisor you should build consensus around the objectives. *Does the staff feel that any objectives should be modified? Do they recommend that the supervisor adds any objectives or activities?*
- **Explain how the visit will be conducted.** Use this opportunity to describe the supervisory methods you will use. *Will you be observing their technical work? Will staff receive feedback and/or informal training? Will they have the opportunity to ask questions?*
- **Review recommendations and commitments of the last supervisory visit.** Discuss the solutions that have been implemented, the areas where the clinic has succeeded, and the areas that still need improvement.
- **Discuss the supervision of activity areas.** Discuss the specific activities that will be the focus of the visit and ask for input from the staff on what issues may need to be addressed in each of the three activity areas. *What specific issues have posed recurrent problems for the clinic, such as long waiting times or lack of needed contraceptive or medical supplies?*
- **Schedule a problem-solving meeting with the clinic team.** Explain the purpose of the team problem-solving meeting and schedule a time for it to be held at the end of the visit, so that the clinic team can be prepared to actively participate in the meeting. Explain that its purpose is to discuss problems, identify possible solutions, and give and receive feedback on the visit. *How should staff prepare for the meeting? How will the team meeting be structured?*

Step 3: Supervise Activity Areas

After the initial meetings with the clinic manager and the staff, you should observe the day-to-day activities you have decided to observe in each of the clinical, management, and personnel activity areas. Be aware of how these activities interact with other parts of the larger service delivery system. As you conduct the visit, consider what improvements can be made to strengthen both individual and clinic performance. Whenever possible and appropriate, provide on-the-job training to improve individual skills. Be sure to make a record of any issues to refer to for the next visit.

Assessing personnel issues is often difficult, but it is an important role for every supervisor. Communication, the distribution of responsibilities, and the resolution of conflicts are among the activities to which you should devote attention during your visit.

Step 4: Conduct a Problem-Solving Team Meeting

After supervising the selected activities, hold a meeting with all the clinic staff to discuss the strengths and weaknesses of the program, and the short- and long-term solutions that can be implemented. It is important to give feedback to staff in a way that enables the staff to accurately perceive the problems and to improve clinic performance. Team meetings are ideal in helping clinic staff formulate objectives, identify and discuss problems and possible solutions, and receive informal training in specific areas that affect everyone's jobs.

Giving and Soliciting Feedback

As a supervisor, you can give feedback individually or, if the information is pertinent to the entire clinic staff, to all staff members at the same time. If you give individual feedback, you should ask the staff member to propose solutions. You can also give feedback to the team by holding a group discussion during which staff can propose solutions and build consensus together.

It is just as important to *ask* for feedback on the usefulness of the supervisory visit as it is to *give* feedback to the staff on clinic performance. Before leaving the clinic, ask the staff whether the answers to their questions were satisfactory, whether they understand all of the technical areas that were addressed, whether they understand what you expect from them between now and the next visit, and what concerns and issues they would like you to present to central-level managers.

Before leaving the clinic, be sure to finalize plans with clinic staff for implementing the solutions and plan an approximate time for the next visit.

Step 5: Conduct a Debriefing Meeting with the Clinic Manager

After meeting with the entire clinic team, you can meet with the clinic manager alone. The debriefing meeting with the clinic manager should include a discussion of ways to improve clinic performance, the proposed implementation of solutions, and any individual performance issues that arose during the visit that the clinic manager should monitor. Include in the discussion what kind of follow up the clinic manager should do to ensure that the desired results are achieved.

Work with the clinic manager to review and identify specific clinic performance standards and to develop plans for improving the clinical, management, and personnel activities necessary to achieve these standards. Together, identify what performance measures will be used to assess the clinic's success in meeting these standards in the future, who will play leadership roles, and how the team will be held accountable for the results.

Step 6: Report on Supervision and Provide Continuous Follow Up

Supervision does not end when you leave the clinic at the end of a visit. You should take with you your own plan for how you can help to improve services, such as sending needed information and supplies to the clinic or referring issues to a higher level. Write a report of the visit and include the recommendations of the clinic team for improving service delivery. Send the report to the clinic and to the regional director. Between visits, you and the clinic manager and staff can use the report as a guide for implementing the recommendations. Provide follow up to ensure that any changes suggested during the supervisory visit are reinforced with training or support.

Team Supervision for Family Planning Service Providers in Guatemala

The Family Planning Unit (FPU) of Guatemala's Ministry of Health, working with the Population Council in the INOPAL II project, is using the team supervisory approach to identify and solve service delivery problems. This approach relies on team problem solving by clinic staff, technical assistance from supervisors, and a service provider self-evaluation checklist.

The FPU team supervision initiative provides all clinic staff in the district with training on how to use the self-evaluation checklist to identify problems in their clinics. Clinic staff then meet in teams and apply three criteria to determine which of the problems the team should address. These criteria are:

1) Clinic staff must agree that an identified problem needs to be solved.
2) Clinic staff must believe that they can solve the problem by themselves with the resources that are available in the district.
3) Individual team members must accept responsibility for the specific actions that they have outlined to correct the problem.

Using these criteria, the most frequent problems that have been selected for improvement are related to information, education, and communication with clients, followed by problems with client-provider relationships and the technical competence of providers.

The clinic teams then develop action plans for the problems they select. Supervisors visit periodically and provide technical assistance in resolving these problems. They also keep track of the status of the problems selected, the actions taken, and the results that were achieved. In this way, they find and share with clinic staff the most effective solutions in their district. In the future, this team supervision process may be evaluated using indicators of cost-effectiveness, couple years of protection (CYP), client and worker satisfaction, and quality of care.

Accompanying this volume is the *Pocket Guide for Service Improvement*, a self-evaluation guide designed to be used to identify opportunities for improving family planning services. The *Pocket Guide* is adapted from the self-evaluation checklist that the Population Council's Operations Research project in Latin America (INOPAL II) designed with the Ministry of Health in Guatemala to improve family planning services.

Reviewers' Corner

A forum for discussing additional applications of FPM concepts and techniques

On developing teams . . . *One reviewer recommended,* "To help develop a team approach, we held a workshop on a topic we knew interested everyone, such as gender issues and STDs. During the workshop we asked the participants to discuss problems they encounter in dealing with these issues in their work. We emphasized that they had to offer a solution to each problem, as a way of sharing new ideas and participating in problem solving."

On allocating time for supervisory activities . . . *One reviewer advises,* "In small organizations or programs, supervision tends to be less formal due to smaller numbers of staff and fewer resources assigned to supervisory activities. It is important nevertheless, for clinic managers to make sure that a supervisory schedule is developed and regular supervision occurs at the clinic even if a schedule is not institutionalized at the national or regional level."

On providing support and follow up . . . *One reviewer suggests,* "We have developed an additional method of supervision. We have established a free telephone line to the Central office that clients can use to ask questions or to register complaints. Then staff in the Central office follow up with the local clinic to discuss the issues and help find solutions for resolving the problems with the clients."

On making the importance of supervision visible . . . *One reviewer relates,* "During the year, program officers from the national level visit to discuss issues in specific program and administrative areas such as accounting, clinic management, youth programs, outreach, etc. During these visits, program officers discuss program goals and objectives with the staff and review program achievements. They also let us know of solutions that have been successful in other regions or programs. This aspect of supervision greatly helps to expand our base of knowledge and to learn from the experience of other programs."

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Checklist for Improving Supervision

For Clinic Managers

- [ ] Discuss with your supervisor ways in which supervision can be made more effective.
- [ ] Solicit input from your clinic staff about how the supervisory system can be changed to improve overall clinic performance.
- [ ] Develop guidelines with your supervisor for introducing a team supervision approach.
- [ ] Create a team supervisory system that functions between supervisory visits.
- [ ] Decide with your staff and supervisor what educational and training programs are necessary to improve clinical and management skills.
- [ ] Discuss problems with your staff and work with them to find solutions.
- [ ] Hold regular meetings with your staff to involve them in the supervisory process.

For Supervisors

- [ ] Develop a supervisory system that focuses on supervising clinic activities and achievement of clinic objectives, rather than on day-to-day individual performance.
- [ ] Discuss and agree on an approach to supervision that involves the clinic manager and staff as part of the supervisory team.
- [ ] Be an advocate for the clinic manager and staff to ensure that they can take advantage of educational and training opportunities.
- [ ] Be well prepared for a supervisory visit by reviewing previous recommendations and actions you have taken to support the clinic activities.
- [ ] At the end of each supervisory visit, prepare a list of actions with the clinic manager and staff that all of you agree to implement before the next supervisory visit.
- [ ] Be committed to providing timely and regular feedback to your clinics.

Mr. Traore Introduces Team Supervision

"So, tell me about your visit at Mirabel Clinic," said Mr. Traore, leaning back in his chair. "How did it go?"

"It went well, I suppose," said Mrs. Sangare. She had spent the previous day on a regular supervisory visit to one of the family planning clinics in her province, and was meeting with her supervisor. "They were quite well prepared for my visit, and had the items I had requested ready and waiting. I filled out all the regular supervisory checklists and met with each staff member to ask questions. I then went over the problems I found with the clinic manager and offered solutions."

"Did you follow up and make sure the staff had accomplished all they had said they would?" asked Mr. Traore.

"Yes, I met individually with each staff member, I checked their workplans and objectives, and if things had not been accomplished, I asked why. However, I found that staff morale was low. The clinic manager told me she was having problems with staff motivation; she wanted me to help her out, so I did try to reinforce the importance of their work and of doing a good job. But I hate being this inspector who comes in to look for things that have been done wrong, and even though I make a point to notice and praise them for jobs well done, my visits always seem to make them very nervous. I think they are reluctant to tell me about problems because it will reflect badly on them. So I think they often try to cover up their problems, which means they don't get resolved."

"I am very interested to hear you say this," said Mr. Traore, "and it leads very well into something I am going to discuss at our staff meeting today, but I'll tell you something about it now. We are going to be implementing a new kind of supervision in our program. As you might recall, not long ago we conducted an evaluation of our supervisory system. The evaluation found that our current system is not very effective, and recommended that we implement an approach called team supervision. Since the family planning program is well established, we think that the clinics are able to take on more of the responsibility now for their own management. This system will give more problem-solving and decision-making responsibility to the clinics, and will make you and the other provincial supervisors more like facilitators and less like inspectors. While you will still meet with individual staff members on your visits, you will also conduct a group meeting of all staff members where they will identify and analyze problems, and work with you as a team to come up with the solutions. The hope is that they will eventually learn to do this team problem solving even when you are not present. The focus will shift from assessing their individual tasks to assessing how well they—as a team—carry out the clinic's activities and meet clinic objectives. Your role as supervisor will change somewhat, and I will go into more detail about this at the meeting this afternoon."

"I like the sound of this new system," said Mrs. Sangare. "I'll look forward to hearing the rest this afternoon."

The next morning, Mrs. Sangare sat at her desk with two stacks of paper before her. One stack had the materials on team supervision that had been handed out at the staff meeting the previous afternoon. The other stack contained the materials she had assembled about Centreville Clinic, the clinic she was scheduled to visit in two weeks. In the stack

Case Scenario: Mr. Traore Introduces Team Supervision

were the clinic's recent quarterly report of service statistics, supply requests, her notes and report from her last visit, documentation of what she had done since the visit to follow up, and the most recent communications from the clinic. Mrs. Sangare began reviewing the information in both stacks as she started preparing for her first supervisory visit using the team supervision approach.

Case Discussion Questions: Mr. Traore Introduces Team Supervision

1. **What main differences between the new style of supervision and the old style will Mrs. Sangare need to explain to the clinic manager and the clinic staff? Prepare a brief list of ways in which the new supervisory system will differ from the old system.**

2. **Using the information on team supervision in the chapter, what actions would Mrs. Sangare take before her supervisory visit? What actions should the clinic manager take before the supervisory visit? Please answer in detail.**

3. **Using the information on team supervision in the chapter, what actions would Mrs. Sangare take during the supervisory visit? Please answer in detail.**

4. **Using the information on team supervision in the chapter, what actions would Mrs. Sangare take after the supervisory visit? What actions should the clinic manager take after the supervisory visit? Please answer in detail.**

5. **What additional training or organizational changes (if any) will be needed for this new system to be successful?**

Case Analysis: Mr. Traore Introduces Team Supervision

1. **What main differences between the new style of supervision and the old style will Mrs. Sangare need to explain to the clinic manager and the clinic staff? Prepare a brief list of ways in which the new supervisory system will differ from the old system.**

   - The new system is participatory; all staff will be involved in identifying, analyzing, and resolving issues and problems, rather than the supervisor alone.
   - The focus will shift from supervising individual performance to looking at activities as a whole and the ways in which the individuals contribute to them.
   - Goals and objectives will be for the team as a whole, and individual targets will be directly related to team goals and objectives.
   - Instead of acting as an inspector and rule enforcer, Mrs. Sangare will act as a facilitator in problem solving, and as an advocate for the staff by relaying their needs and problems to the higher levels.
   - The staff will be asked to take greater responsibility for the smooth operation of all the management systems, and will be able to bring about positive changes themselves, thus bringing them greater job satisfaction.

Case Analysis: Mr. Traore Introduces Team Supervision

2. **Using the information on team supervision in the chapter, what actions would Mrs. Sangare take before her supervisory visit? What actions should the clinic manager take before the supervisory visit? Please answer in detail.**

Before the supervisory visit, Mrs Sangare would:

- Draft a supervisory schedule, which states the objectives of the visit and names the date and time of the visit and everyone who will participate.
- Send this to the clinic manager, along with any requests she may have for information that she would like to have ready upon her arrival.
- Draft her own supervisory session plan. This should state her objectives for this visit, the tasks she plans to carry out and the people with whom she will carry them out, information she needs to gather, the issues she needs to discuss with each person, and the resources she'll need.

Before the supervisory visit, the clinic manager should:

- Review the previous supervisory report and the recommendations made at the last visit.
- Meet with the relevant staff to discuss the status of the implemented changes and to determine whether the changes have been helpful.
- Make a list of all the topics that need to be brought up during the visit to send to Mrs. Sangare.

3. **Using the information on team supervision in the chapter, what actions would Mrs. Sangare take during the supervisory visit? Please answer in detail.**

During the supervisory visit, Mrs Sangare would:

- Meet with the clinic manager to review the day's agenda, the session plan, goals, and objectives of the visit.
- Review the recommendations and commitments of the last visit and discuss progress and findings.
- Meet with all staff in order to plan the visit, including determining the objectives and schedule, and developing a plan for the later problem-solving meeting.
- Conduct supervisory activities in activity areas and with individuals. Systematically evaluate clinical, management, and personnel activities by selecting specific activities to observe, particularly those with problems.
- Conduct a team meeting.
- Give feedback on findings, including praise for progress and achievements.
- Present problems and ask the whole team for explanations and analysis.
- Encourage everyone to speak if they are at all involved.
- Make every staff member see that his or her contribution is significant.
- Facilitate to make sure the meeting doesn't become a blaming session, but rather a way to strengthen and improve how staff carries out activities.
- Make sure everyone knows their responsibilities for implementing the solutions, and make clear what the supervisor will be responsible for doing.

- Ask the staff if they have received adequate answers to their questions or have further questions.
- Ask the staff whether they have concerns or questions they would like to have communicated to the next organizational level.
- Conduct a debriefing meeting with the clinic manager.
- Discuss how to improve clinic performance (by identifying clinic performance standards and developing action plans for improving clinical, management, and personnel activities necessary to achieve these standards).
- Review individual performance issues.
- Help identify performance measures that assess whether the clinic is meeting these standards.

4. Using the information on team supervision in the chapter, what actions would Mrs. Sangare take after the supervisory visit? What actions should the clinic manager take after the supervisory visit. Please answer in detail.

After the visit, Mrs Sangare would:

- Develop a plan for what she will do to support the clinic's activities.
- Write the supervisory report of her visit, including a set of recommendations.
- Send the report to the clinic and the regional director.
- Provide follow up to ensure that any changes suggested during the supervisory visit are reinforced with training or support.

After the visit, the clinic manager should:

- Use the supervisor's report as a guide for implementing the recommendations.

5. What additional training or organizational changes (if any) will be needed for this new system to be successful?

Supervisors and clinic managers could receive training, if necessary, in problem solving, motivating staff, building staff into a team, and providing positive, constructive feedback.

The central level must actively support supervisory activities by providing human and capital resources. The central level must also take the following actions: develop reporting and monitoring systems to track supervision needs; organize and support supervisory skills training for regional supervisors and service delivery teams; respond to the service delivery needs expressed by regional supervisors by coordinating the use of resources, including vehicles and petrol.

The central level must train supervisors and ensure that they receive clear guidelines, that there is a schedule of supervisory activities covering all facilities, and that supervisors produce written reports that are used to record and monitor results of the visits.

The clinic manager and service providers must ensure that problem-solving skills and strategies are developed among staff to improve services. The clinic manager should build a team that can develop and implement ways to improve services, monitor day-to-day operations and progress toward meeting clinic performance objectives, and communicate with the external supervisor when outside resources or support are needed.

CHAPTER SIXTEEN

Working Solutions Worldwide

Results of a survey of readers of *The Family Planning Manager* suggest that management strategies and techniques can be successfully communicated and replicated across regions. These results also indicate that working collaboratively with an international review board of experienced family planning managers is critical to developing a management publication that both communicates effective strategies and techniques and is relevant to a wide range of family planning professionals around the world.

In the readers' survey, we promised to publish an issue of *The Family Planning Manager* that would focus on our readers' solutions to management problems. Many readers have written to us about the management problems they face in their work and the approaches they use to solve them. In tribute to our readers, this special issue of *The Family Planning Manager* features their efforts to address many common management problems and shows that when family planning managers have access to management materials written specifically for them, they use them not only to increase their personal knowledge, but also to train staff and introduce new management strategies into their programs.

This chapter was originally produced as Volume IV, Number 1 of ***The Family Planning Manager****. The guest editor for the issue was Ann Buxbaum.*

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Sharing Solutions to Common Family Planning Management Problems

Since launching *The Family Planning Manager* three years ago, the editors have received many unsolicited letters from readers describing the management challenges they face in their work and how *The Family Planning Manager* has helped them to meet those challenges. This enthusiastic and continuing dialogue with readers has allowed the publication to serve as a forum for introducing new management concepts and techniques for managing family planning programs, and for sharing the experiences of managers with other readers around the world.

Impressed with this interest and experience, the editors of *The Family Planning Manager* conducted a survey of its readers in June of 1993 to learn more about them and their work. This chapter highlights the results of the survey and presents who our readers are, where they live and work, and what management problems they face in their work. In addition, this chapter presents a number of examples of management challenges and the steps that managers have taken to address those challenges.

The "Working Solutions" presented in this chapter attest to the fact that managers throughout the world are working hard to make sound strategic decisions, expand access to services, and improve the quality of their services. Eighteen examples from our readers are featured in this chapter. Among them are examples from Belize, Zimbabwe, and Senegal that illustrate the importance of good information and a solid strategic planning process. Experience in Mexico in reaching new clients and in Nigeria, India, and Haiti using maps, shows how managers are expanding access to services. Contributions from Ethiopia and Uganda describe simple management interventions for improving service quality.

The value of *The Family Planning Manager* is based in part on being able to provide managers with innovative management tools that they can adapt and use in their own programs. An exciting example of this adaptability is presented in the "Working Solutions—South-to-South," which describes how *The Manager* has facilitated the transfer of management technology *between* countries, in this case, between Bangladesh and Kenya.

These real-life experiences are innovative and exciting. But for every "Working Solution" printed in this chapter, there are hundreds more in many other programs around the world. The work of managers documented in this chapter emphasizes the key role that management plays in providing quality family planning services to ever increasing numbers of people. But even more, these examples demonstrate that when managers work together with their staff to plan programs, solve problems, and make decisions, they make their programs work.

The Making of *The Manager*

The Family Planning Manager is designed to focus on specific management topics that are pertinent to family planning programs around the world and to discuss issues that are relevant to multiple levels of a family planning program. In this way, *The Family Planning Manager* aims to:

- Raise awareness of management issues within an organization;
- Share effective and practical management techniques, tools, and experiences;
- Fill the gap in the availability of practical family planning management materials in developing countries;
- Discuss complex management techniques and strategies in a concise format and in clear, uncomplicated language;
- Create a forum for the exchange of ideas and solutions across regions.

Developing the Issue

Each issue of *The Family Planning Manager* is developed in collaboration with individuals who work in health and family planning programs around the world.

Networking with Managers in the Field

Each issue is reviewed by an international review board of senior-level family planning managers. With their help, *The Family Planning Manager* has created a worldwide network of family planning managers and service providers, and provides up-to-date, practical information on management technologies. The members of the International Review Board are key to achieving the publication's objectives because they:

- Provide direct communication with family planning program managers and service providers;
- Bring fresh ideas and a field perspective to each issue;
- Make management issues and applications relevant and useful;
- Link management concepts with management practice.

Distributing *The Manager*

The distribution strategy for *The Family Planning Manager* involves mailing the publication directly to individual subscribers and also to distribution agents within an organization. These agents represent their organization and distribute *The Family Planning Manager* to their colleagues. This strategy has resulted in building a powerful in-country distribution base and in effectively reaching managers at different levels in family planning programs.

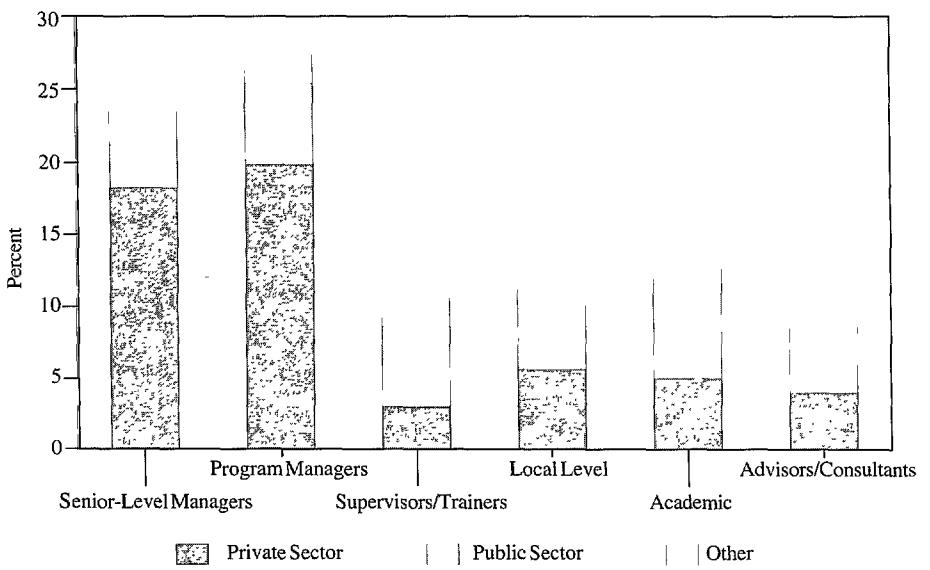
The Family Planning Manager Readership Profile

To better understand their audience of readers and address topics relevant to their work, the editors designed a survey consisting of thirty questions that asked where readers work, what types of jobs they have, how they use *The Family Planning Manager* in their work, whether the topics are relevant to their work, and what types of problems the publication has helped them to solve. The survey also inquired about the readability of the publication, the demand for foreign language editions, and suggestions for future topics. The next section summarizes the responses and profiles important facts about the readers of *The Family Planning Manager*.

Who are Our Readers?

Based on those readers who responded to the survey, results show that 53 percent of *The Family Planning Manager* readers are men and 41 percent are women (6 percent did not respond to this question). The majority of readers work in private organizations (59 percent), and the balance work in public sector programs (29 percent) and donor or other types of organizations (12 percent). Our readers include program managers, physicians, nurses, administrators, trainers, and technical advisors and researchers. The majority supervise ten or fewer people in their work.

Percent of Readers Working in Public and Private Sector According to Type of Position



The Family Planning Manager's readership has grown substantially since this survey was conducted, and French- and Spanish-language editions have since been published. At the time of the survey, 80 percent of the readers preferred receiving *The Manager* in English, even though for most readers (78 percent) English was not their native language. Ten percent of the respondents would have preferred to receive the publication in Spanish, nine percent in French, and four percent in Arabic. Overall, our readers speak over 140 other languages, including Bangla, Bengali, Hausa, Hindi, Ibo, Portuguese, Shona, Swahili, and Yoruba.

Where Do Our Readers Live and Work?

The Family Planning Manager reaches readers in 175 countries around the world including many small island nations and newly-formed nations. Forty-two percent of our readers live in Africa, 24 percent in Latin America and the Caribbean, 15 percent in North America, and 14 percent in Asia and the Near East. The majority of *The Family Planning Manager* readers (79 percent) work in organizations or agencies that provide health and/or family planning services, and 61 percent state that they themselves are primarily service providers. Fifty-six percent of all readers work at the central level and 43 percent at the regional/provincial level.

What Management Problems Do Our Readers Face in Their Work?

The editors were particularly interested to learn about the types of problems managers were encountering in their work and what steps they had taken to address those problems. This information has been important for selecting topics for future issues and for sharing those solutions with the other readers of *The Family Planning Manager*.

Based on reader response, the following list summarizes the types of management challenges readers face in their work in order of priority.

Strategic issues in family planning and reproductive health. Many readers cited the need to look beyond the current activities of their programs, identify new initiatives, and educate themselves on the technical and management aspects required to introduce new activities in their programs. Many readers were interested to know more about how to introduce new contraceptive methods, such as Norplant, and how to integrate HIV/AIDS information and services into their programs. Others were especially concerned with marketing their services to particular client groups, such as adolescents and men, and making male contraceptive services, such as vasectomy, available.

Communicating information about family planning. A principal concern among readers was how to develop and manage information, education, and communication (IEC) programs more effectively. Readers were particularly interested in ways to improve training for family planning educators and counselors, ways to evaluate IEC efforts, and ways to measure the cost and quality of IEC programs.

Personnel management. Issues involving personnel management were frequently cited as areas in which managers were challenged in their jobs. Among the personnel issues they specified were: dealing with interpersonal problems, developing personnel policies, analyzing staff roles, developing job descriptions, using methodologies to determine staffing requirements, working with volunteers, and motivating, supervising, and supporting staff.

Management information systems. In this area, readers were most interested in learning more about how to collect and use information about their programs and how to communicate the importance of their information system to their staff.

Program management. Many readers wrote that they needed continuing management education to strengthen their capabilities in program planning and evaluation. These included skills in setting clear program goals and objectives and developing effective ways to evaluate programs, including methods that would allow greater participation from field-level staff.

Generating revenues. Developing fund raising skills to acquire local and international funding was a topic that interested many readers who felt a need to be able to respond to decreasing support from their traditional funding sources. They also were interested in knowing more about attracting clients who could pay for services.

Finding Solutions to Management Challenges

The management challenges that readers of *The Family Planning Manager* are facing span almost every area of management. However, the greatest concern among readers was in the area of strategic decision making, closely followed by operational issues that include improving service quality and managing human and financial resources. The next section presents ways in which readers have attempted to solve some of these management challenges. Their approaches have been grouped into four broad categories:

- Planning and managing programs strategically;
- Providing outreach and greater access to services;
- Championing quality services;
- Managing resources.

Planning and Managing Programs Strategically

Today, managers are becoming increasingly attuned to the importance of looking at their programs from a strategic perspective. As government policies and cultural and religious attitudes towards family planning change and organizations grow and expand, so must the programs that provide client services. Jewel Quallo, Executive Director of the Belize Family Life Association, writes that in their effort to meet the challenges of program sustainability, "we went through strategic planning exercises with the Board of Directors, staff, and other volunteers." Ms. Quallo emphasizes the importance of a systematic and structured approach to strategic planning that includes both training and data collection. "Training was required in strategic thinking and planning. This included learning how to conduct cost studies to determine the actual cost of providing services, prepare a business plan, and write proposals.

Working Solutions—Nigeria

Developing and Using a Client Profile

Dr. A. B. Sulaiman, Executive Director of the Planned Parenthood Federation of Nigeria, writes that they did not have adequate knowledge of who their clients were, what services they wanted, whether they were satisfied with the services, or whether the services were affordable to their clients. Using one clinic as a test case, they collected data about their clients in order to develop a client profile.

Developing the client profile. Staff training was conducted in proper counseling techniques, data collection and reporting, and use of information. Data used to create the client profile included age, sex, parity, place of residence, educational level, occupation and economic status, source of referral, reason for visit, method chosen, services provided, other services requested, and any comments on the clients' satisfaction or dissatisfaction with their contraceptive method.

Results. Client information was collected and analyzed over a one-year period and client profiles for new, continuing, and revisit clients were developed. Dr. Sulaiman writes, "we now know who our clients are, what services are provided most frequently, how clients found us, and what other services they would like us to offer. We also know who is not likely to use our services, these being primarily youth and uneducated or unmarried men and women. We have used these results to focus our efforts on improving clinic management, addressing the needs of youth, providing STD/HIV education, serving the needs of men, and placing more emphasis on women's health and child survival."

We then did a cost analysis of our services, explored the possibility of expanding services to include those that could generate income, and considered ways to reduce costs by trying to make our services more efficient. These strategies, as well as others which included working with volunteers and gaining local funding, were outlined in the strategic plan, which is now being used to guide the organization in its efforts to enhance its sustainability."

Planning and managing programs strategically requires having accurate information about your current and potential clients and what services they need or want. It also requires being realistic about what you can offer your clients given your program's resources, communicating your program's goals and services to the public, and establishing systems to deliver high-quality services. Knowing your clients' needs and finding ways to attract new clients are often major objectives of a strategic planning exercise. Good programs will tailor their services to meet the needs of many different groups, including sexually active youth, men, and low-parity women.

Dr. Kabir U. Ahmed, Technical Specialist for the Urban Expanded Program on Immunization (EPI) in Bangladesh, writes about the limitations of programs that reach out only to women. "Most of the family planning programs focus their efforts on women's empowerment to bring about a positive impact." Dr. Ahmed believes that this single focus is short-sighted, since the support men provide to their partners is a critical factor in using a contraceptive method successfully.

A recent study in Ethiopia confirms this theory and demonstrates the importance of including men in family planning programs. Data from the study showed that contraceptive use among women whose husbands participated in the home health education session was 14 percent higher than those whose husbands did not participate. Dr. Ahmed explains that their program in Bangladesh, "Male Motivation in Family Planning," developed into a successful education, motivation, and social mobilization program in a slum area with a population of 45,000 people.

Working Solutions—Haiti

Involving Men and Couples in Family Planning

The RICHES Project, a community-based health project supported by CARE International in Haiti, used the results of a 1989 national contraceptive survey to guide their program strategy. The survey indicated that about 60 percent of men thought their partners should be involved in family planning decisions. Consequently, the project used four strategies to create opportunities for men and women to make decisions together about planning their families. These strategies were:

- Having volunteers make home visits to discuss family planning methods with both members of the couple;
- Recruiting married couples who were satisfied contraceptive users to promote the benefits of family planning in rural communities;
- Holding community meetings (after church or at other times convenient to men and women) to promote family planning and provide information about specific methods;
- Teaching women attending RICHES health posts ways in which they could comfortably discuss family planning with their partners.

These program changes resulted in significantly increasing the involvement of men in family planning and helped to empower women, allowing them to play a greater role in decision making. The RICHES staff believe that male involvement contributed significantly to the 13 percent increase in contraceptive prevalence in the pilot area during the five years of the project.

Working Solutions—Senegal

Laying the Groundwork for a Successful NGO

What does it take to turn a family planning project supported by foreign donors into a local non-governmental organization (NGO)? After learning that the private sector in Senegal was largely inactive in family planning, Mr. Alpha Dieng and his associates launched an effort to establish a private organization that would become a leading force in the national family planning program. Thus, SANFAM (Santé de Famille) was created and Mr. Dieng and his associates began to develop a solid, independent future for their organization by identifying some important strategic issues.

Working together in an intensive strategic planning exercise, SANFAM senior managers established their basic organizational principles, identified their special niche working in the private/commercial sector in the Senegalese national family planning program, determined their major areas of concentration and their staffing and management needs, and developed a realistic work plan and budget. Looking back, one can see how their imagination, talent, and patience laid the groundwork for the dynamic organization that exists today. SANFAM managers attribute their success to several key strategic decisions and activities:

- Establishing a relationship of trust with the medical directors of sugar, phosphate, fishing, and transport companies;
- Creating a demand for their expertise in technical assistance and training in clinical service delivery, IEC, and logistics management by showing company executives how family planning would help them improve employee health, reduce absenteeism, and increase production;
- Providing contraceptives, drugs for treating sexually transmitted diseases, and gynecological supplies and equipment to companies;
- Training medical staff (physicians, nurses, midwives, and auxiliaries) of the companies to provide family planning services;
- Devising creative strategies to motivate the staff of company clinics to provide accurate and timely service statistics by encouraging friendly competition between companies for numbers of new clients and by designing, testing, and revising reporting forms.

Today, SANFAM continues to pay attention to its role with respect to that of other organizations and agencies working in the Senegal Family Planning Program. SANFAM places a high priority on strengthening its relationship with the companies it serves and on demonstrating to new companies the financial benefits of introducing family planning in company clinics, so that family planning services may be offered to a growing number of people nationwide. These initiatives have resulted in assisting twenty-seven company clinics in establishing family planning services for their employees.

For more information about planning programs with a strategic perspective, please refer to Chapter One, "Learning to Think Strategically."

Providing Outreach and Greater Access to Services

Providing greater access to services will continue to be one of the biggest challenges of family planning managers in urban and rural areas alike. Although the urban and rural environments pose different types of problems for managers, all managers must develop mechanisms to effectively reach out to and educate all potential clients about the benefits of family planning and the services that are available. To meet the challenge of providing greater access, managers need to create active community-based outreach activities, develop effective counseling and referral systems, and establish fees that are affordable so that clients are not discouraged from using family planning services.

Reaching out by communicating. When MEXFAM, the International Planned Parenthood Federation (IPPF) affiliate in Mexico, first opened a new clinic in an urban area where the organization and its services were completely unknown, access to the clinic became a priority. Managers realized that in order to attract new clients to the clinic they needed to let people know about the types of services they offered and why clients should use their services. To make their services more visible and to attract clients, the clinic staff worked with a public relations firm to develop a marketing campaign to create awareness and attract clients to the clinic. Ms. Elvia Salazar Antónez, Executive Coordinator of the new clinic, described two techniques that proved to be particularly effective.

- **Communicating by radio.** Rather than directly advertising the clinic and its services, a series of 30-second radio messages provided concrete, useful health information and an invitation to call the clinic for further details. Many new clients first telephoned the clinic and then came to the clinic for services. Others who did not call in advance mentioned the radio messages when they came for services.
- **Organizing in-home discussion groups.** Several women in the clinic area agreed to invite their friends to their homes to meet some of the clinic staff. In a relaxed atmosphere with general conversation and refreshments, these meetings allow staff to present information on topics requested by the guests, hand out clinic brochures, and distribute coupons that entitle the recipient to a discount on clinic services. These home meetings have addressed topics such as pregnancy, family planning methods, menopause, sexuality education, and cervical and breast cancer. At one meeting in which they discussed prostate cancer, several men attended.

Ms. Salazar Antónez stresses, "Our idea was not only to emphasize the description of the clinic and its services, but also to provide information that people could use right away to improve their health." Clinic staff point out that building a client base takes more than imaginative outreach—it depends equally on clients having a positive and helpful experience when they come for services. "In the last three months, we have attracted many new clients who come to the clinic because they have heard about us through personal recommendations from friends, family, and neighbors. This means that the quality of our services has begun to have a positive impact."

Improving access through client referrals. Strengthening the links between outreach workers and clinic services makes outreach more effective. For example, having an effective referral system in a community-based distribution (CBD) program gives clients access to the full range of services offered by the program. Developing and strengthening a referral system requires training staff to make appropriate referrals, organizing your program to encourage referrals and meet the needs of referred clients, and providing ongoing support to outreach workers. The following "Working Solution" from Zimbabwe provides an excellent example of how one organization strengthened their referral system.

Working Solutions—Zimbabwe

Improving Client Referrals through Analysis and Training

In 1989, Anna Eniya Mashiri was appointed Provincial Nursing Officer by the Zimbabwe National Family Planning Council (ZNFPC). One of the first things she noticed was the virtual absence of referrals of family planning clients from CBD agents to clinics. To analyze the problem, Mrs. Mashiri visited, observed, and talked with CBD agents and clinic nurses. Her investigation revealed several underlying problems:

- The CBD agents and clinic staff each tended to see themselves as being in separate parts of the program, rather than as part of a larger family planning organization.
- The clinic nurses were primary health care providers who had received very little family planning training and felt uncertain of their ability to deal with contraceptive side effects. They would often send clients back to the CBD agents without addressing the clients' problems.
- When CBD agents did make a referral for a longer-lasting contraceptive method, they often "lost" the client to the clinic. Clients were not encouraged to return to their agents for follow-up.
- CBD agents didn't get credit from their supervisors for making referrals. In fact, when they did make referrals, they were often criticized for not handling the cases themselves.

Although these factors emerged quickly from her observations and discussions, Mrs. Mashiri realized that they could not be alleviated in an instant. It took four years of thoughtful, careful innovations to strengthen the referral system. The innovations included:

- Introducing family planning information and skills in the nursing training syllabus and reinforcing these skills through in-service training.
- Holding joint workshops for CBD agents and nurses to impart a common body of knowledge and create a sense of shared involvement in a single program. Case studies from *The Family Planning Manager* are used to foster group discussion of family planning management issues.
- Training CBD supervisors to encourage referrals. Referred clients are now entered in the agents' case books, and in meetings there is public acknowledgment of the agents who have the highest referral rate in a given time period.

Despite occasional individual resistance, the marked increase in understanding and confidence between agents, supervisors, and clinic staff has led to an effective and expanding referral system.

Improving outreach by using maps. Another aspect of providing effective outreach is to work with volunteers and other members of the community. Many of our readers have found that simple mapping techniques can help program managers, community-health workers, volunteers, and even semi-literate workers to plan their work, identify potential clients and their needs, and keep accurate records about the services provided.

Our readers have developed many ingenious ways of using locally-drawn maps to target informational campaigns, distribute contraceptive supplies efficiently, and improve the quality of services. From the Holy Cross Clinic in Natal, South Africa, Desideria Priscilla Dlamini, Project Organizer, writes that "maps help field workers take the easiest route to clients without wasting time. They also make it easy for me to supervise the field workers and locate the clients they identify who have problems."

In Tanzania, Alphonse Mkini, the Area Service Delivery Manager of the Family Planning Association of Tanzania, uses maps to ensure that "community-based distribution agents plan their work and maintain correct entries of when to visit, what was supplied, and when to revisit their clients."

In the Dadra and Nagar Haveli Territory in India, mapping was introduced to village health workers at the headquarters of a union territory surrounded by hilly terrain and widely-dispersed tribal villages. Dr. L. N. Patra, State MCH Officer, says that people living in these "scattered tribal villages were very hard to reach, but by introducing the mapping technique, village health workers can now focus on serving the eligible couples."

Ezekiel Ibrahim, Public Health Officer at the Police Clinic in Plateau State in Nigeria, writes that he used to receive complaints from clients who felt they were not being visited often enough. He has used the mapping method to "locate my clients' residences and know the current contraceptive methods used by each client." The result has been that Mr. Ibrahim can more efficiently plan and pace his visits and keep track of his clients' needs. In this way, he has been able to increase the satisfaction of clients to the point where "they are willing to discuss the services they need right at their doorsteps."

Susan Igras, of CARE International's RICHES project in Haiti, writes that community maps were the tool of choice to develop a more systematic approach to reaching potential clients. Staff and volunteers went together to the field to gather information and draw maps showing the numbers and locations of houses, the time required to walk to the health post, and key institutions (schools, markets, water sources, churches, and other landmarks). Based on the location of her home, each volunteer was assigned an area within which she would make home visits. But the power of the maps went well beyond simply charting the route and location of clients. Using the maps, new sites for community vaccination posts were set up, which meant that no one had to walk more than two hours for vaccination services.

The maps also helped to identify areas where similar services were also being provided by other NGOs. RICHES staff then began discussions with these other NGOs to reduce the duplication of services. "The maps have created a change in staff and volunteer perception in what coverage means and have helped us to move away from a clinic-based focus. Maps have been a key factor in our effort to develop a better outreach system for home visits and community family planning promotion."

For more information on mapping, please refer to Chapter Five, "Using Maps to Improve Services."

From ELCO Maps to MWORA Maps: Improving Quality and Access

Many development experts believe that technical assistance is most successful when developing countries provide technical assistance to each other. Yet many countries have been slow to adopt technologies employed in other developing countries, and opportunities have been missed in communicating successful experiences between countries.

From Indonesia to Bangladesh

Community participation techniques used in the Indonesian family planning program have been successfully adapted to the Bangladesh environment. This example of south-to-south collaboration began in 1980 when several teams of Bangladeshi family planning officials went to Indonesia to observe the community participation and local management of the Indonesian family planning program. This early south-to-south program has evolved into the Local Initiatives Program (LIP), managed since 1987 by the Family Planning Management Development project with funding from USAID/Dhaka.

At the center of locally-managed family planning programs in Indonesia and Bangladesh is a simple but effective management tool called an ELCO map. An ELCO map is a hand-drawn map that shows where the **EL**igible **CO**uples (married couples of reproductive age) live, whether they are using a method of contraception or not, and if so, the specific method that they have chosen to use. In Indonesia and Bangladesh, volunteers draw the maps and record information about each couple through pictures and color coding. The maps are particularly useful for volunteers who are pre-literate. Supervisors use the maps to monitor the volunteers' performance, to maintain up-to-date information about contraceptive use and trends in the community, and to involve both volunteers and the community in managing the family planning program. ELCO mapping is now used in about ten percent of all Unions in Bangladesh, and is being expanded rapidly in other parts of the country.

From Bangladesh to Kenya

ELCO mapping is now being adapted for use in the family planning programs in Kenya. After reading about ELCO mapping in *The Family Planning Manager*, the Family Planning Association of Kenya (FPAK) wanted to introduce ELCO mapping into their program. Since community-based workers often tried to keep track of too much data and did not have a simple record-keeping tool that would allow them to use the information to serve their clients effectively, the mapping system suited their needs perfectly.

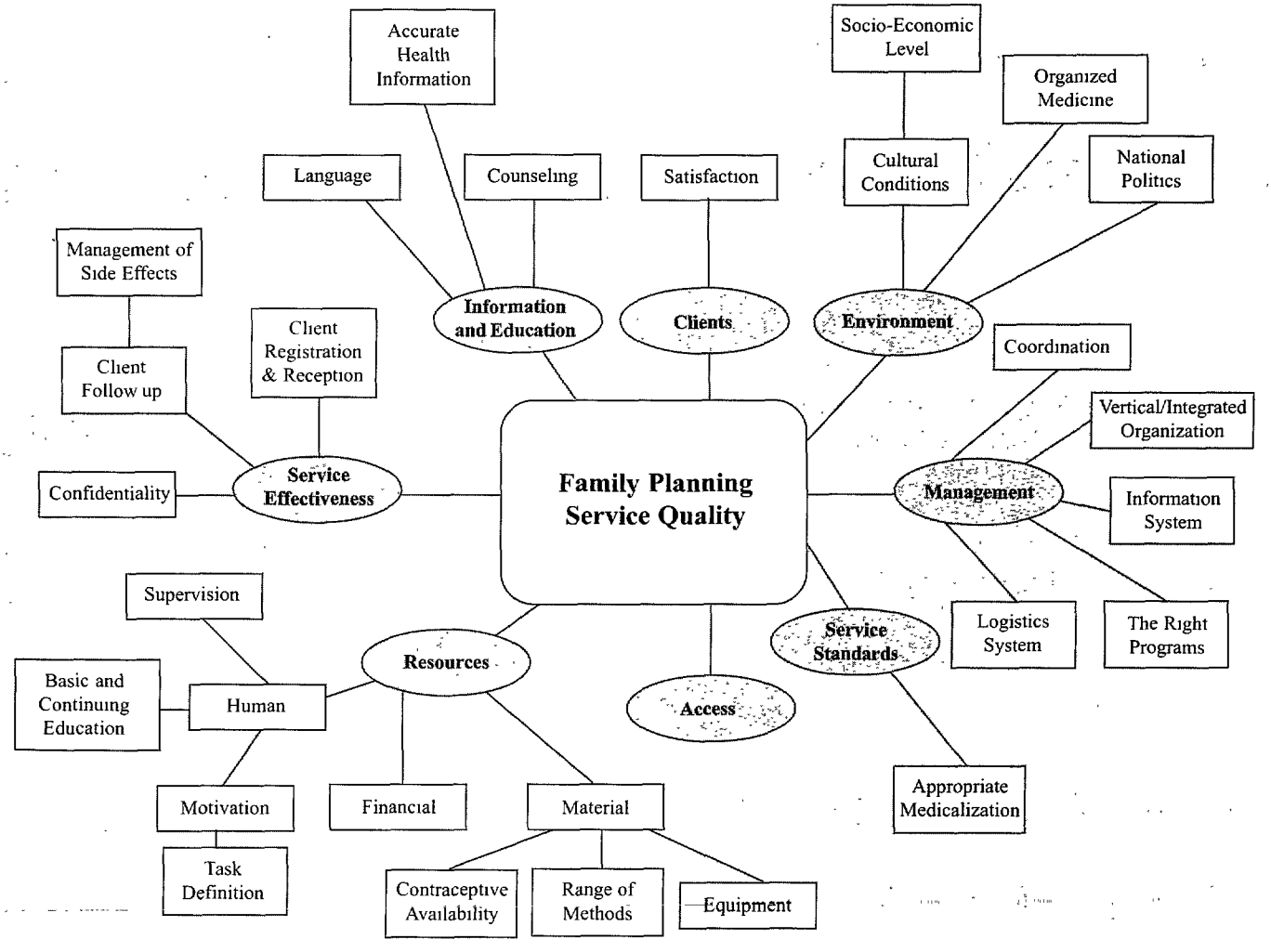
So that FPAK could learn from someone with direct experience in drawing and using maps, a Bangladeshi LIP staff member traveled to Kenya to train FPAK field-level staff to prepare and use ELCO maps. During the training, the FPAK staff renamed the maps MWORA maps (Men and Women Of Reproductive Age) to include all women and men of reproductive age, irrespective of their marital status. MWORA mapping has now been in use since April 1994. To demonstrate their enthusiasm for this technique, a number of FPAK volunteers have composed songs about mapping that they sing in the villages, which is a traditional means of spreading information. While the FPAK staff continue to shape the mapping tool to fit their program needs, it has greatly enhanced their work and allowed them to serve their clients more effectively.

Championing Quality Services

The ultimate goal of any family planning program is to provide safe and effective contraceptive methods and to continue to provide family planning services to an increasing number of satisfied clients. To turn family planning users into satisfied clients, managers need to continually think about ways to improve the quality of their programs. By developing and using systems to monitor client satisfaction and service effectiveness, managers are responding to signs of potential client dissatisfaction or poor program performance.

Family Planning Managers Identify Quality Issues

The Francophone Regional Advisory Committee (FRAC) is a network of senior family planning managers and policy makers from Haiti and French-speaking countries in Africa. Established in 1987 in response to an expressed need among Francophone family planning program managers to share experiences and learn from each other, FRAC members meet annually to discuss a specific management topic of common interest that is directly related to improving family planning program performance. One of their recent annual meetings focused on improving the quality of services in family planning programs. During this meeting, FRAC members analyzed the factors that influence the quality of family planning services. A graphic representation of the topics that they focused on in their discussions is presented below.



Many readers of *The Family Planning Manager* wrote to us about problems they have encountered in their efforts to provide high-quality services. Three of the most common problems they have worked to address are:

- Client waiting time;
- Education and counseling;
- Staff training and supervision.

Client waiting time. An increase in the number of clients attending a clinic often brings problems which, if not quickly addressed, can affect the quality of services and ultimately result in a loss of clients. The most common and obvious consequence of rapid growth is longer client waiting time. Improving client flow and reducing waiting time is one of the greatest challenges of a clinic manager. The following example from Ethiopia describes a number of ways to streamline clinic procedures.

Working Solutions—Ethiopia

Streamlining Clinic Procedures

The success of the Marie Stopes clinic in Addis Ababa, Ethiopia, resulted in greater and greater numbers of clients coming to the clinic for services. When more than 120 clients per day were visiting the clinic, waiting times became so long that clients often had to return home at the end of a day without being seen. Sometimes they would even be turned away the following day as well. The project's director, Getachew Bekele, mobilized his staff to resolve this problem and told us about their solutions.

To improve the client registration procedures and appointment system, they:

- Assigned an additional staff member (in addition to the receptionist-collector) to register clients;
- Registered new clients at any time of the day (instead of during fixed hours), and collected the registration fee at the same time;
- Made arrangements to screen continuing contraceptive users separately and to refer them directly to the dispensary without having to wait to be seen by a nurse;
- Gave clients using oral contraceptives a three-month supply of pills, instead of only a one-month supply.

To reduce the number of return trips a client needs to make to the clinic, they:

- Reviewed the protocols for ordering lab tests and then reduced the number of lab tests they ordered.

To make better use of waiting time, they:

- Provided information on family planning, maternal and child health, AIDS prevention, and population issues by playing pre-recorded radio programs in the waiting area.

Since these policies and procedures have been in place, waiting times have been reduced and clinic efficiency and client satisfaction have greatly improved. Mr. Bekele states that the clinic staff are pleased with the new procedures, which they themselves developed and carried out.

For more information on ways to reduce waiting time, please refer to Chapter Nine, "Reducing Client Waiting Time."

Education and counseling. To solve a potential problem caused by a change in the brands of pills available in his clinic, Joshua Arasomwan, State Manager with the Planned Parenthood Federation of Nigeria (PPFN) in Benin City, introduced client education and counseling to help clients deal with the brand changes. "Because we were unable to obtain our previous brand of oral contraceptive, our stocks ran low and we were forced to purchase another brand of the same oral contraceptive. But our clients were not willing to change to another brand. After exhausting all possibilities to obtain our previous brand of oral contraceptives we turned to client education and counseling to solve our problem." PPFN quickly devised an educational strategy so that they would not lose their clients. "First of all, we made sure no new client was provided with the brand whose supply was dwindling. Then we started a massive educational campaign to explain to our old clients the need to change to another available brand and to allay their fears that the new brand might not be good for them. As a result of this campaign, many women tried out the new brand and found no adverse side effects. They were satisfied with the switch and even helped us by talking to other women."

Staff training and supervision. To improve the performance of their CBD agents, the Family Planning Association of Kenya (FPAK), in collaboration with other agencies, developed a special program that allowed poor-performing CBD agents to learn from the experiences of high-performing CBD workers. Samuel Thuku Gachukia, Assistant Program Officer for CBD, wrote about how this innovative program works to help CBD agents who are having trouble meeting expectations to bring their work up to acceptable standards. FPAK supervisors selected their least effective agents—those who were serving few clients and who appeared to need more training about their job—and developed a training course for these agents to bring them together with their supervisors and a group of highly effective agents. The course focused on counseling, recruitment, and reporting. During the course, the trainers paired low- and high-performing CBD agents together and fostered an open dialogue about their problems and frustrations. In this setting, the less productive agents were able to express their concerns, improve their knowledge and skills, and benefit from the ideas of those who were working more effectively.

Before their return to the field, supervisors and their agents set challenging but realistic targets and developed personal action plans for reaching these targets. The workshop trainers helped supervisors recognize their responsibility to provide ongoing support and encouragement to their supervisees. Mr. Gachukia quotes one supervisor who expressed the spirit of the training: "If the agent I selected for this workshop isn't performing, then *I'm* not performing."

An important follow-up activity to the workshop was to bring visitors to the CBD agents' work sites. Mr. Gachukia recalls that this same supervisor enjoyed bringing visitors to see his agent at work because it gave the CBD agent the opportunity to explain her job and demonstrate her growing counseling skills. These follow-up site visits were critical to reinforcing the skills learned at the workshop. Mr. Gachukia notes that "CBD agents now consider it an honor to be visited."

Remarking on the results of this program, Mr. Gachukia concludes that a combination of well-designed training and creative supervision has improved CBD performance. As evidence, he cites the progress of one CBD agent: "She moved from the least productive to the third highest performer among the forty CBD agents at her work site."

Working Solutions—Uganda

Improving Service Quality Through a Team Approach

When the Young Women's Christian Association (YWCA) of Uganda inaugurated its first family planning project in 1992, the staff and board of directors realized that the quality of services would depend to a great extent on how well family planning providers were trained and supervised. The YWCA/Uganda, with assistance from the Centre for Development and Population Activities (CEDPA), introduced an innovative package of training, follow-up, and supervision for field workers in two pilot sites, one urban and one rural. Mrs. Mary Kairu, Regional Program Coordinator for CEDPA's Nairobi Region Office, described the sequence and the rationale for it.

Community-based distribution workers and their supervisors were trained together in an initial six-day course that presented general family planning concepts and basic skills in communication, education, and motivation. For four months after the course, the newly-trained CBD workers worked in their communities. They had weekly meetings with the supervisors who had been in the course with them, and they and their supervisors met every two weeks with one or more of the trainers from the course. These meetings enabled the trainers to observe the application of course content in the field, to provide support for CBD workers and supervisors alike, and to establish a problem-solving approach to supervision.

The practice period was followed by a second course, lasting two weeks. During the first two days of the course, participants shared their field experience and reviewed what they had learned in the first course. During the rest of the course, the CBD workers and their supervisors learned and practiced skills in counseling, making referrals, and record-keeping.

Throughout this sequence, the trainers stressed the importance of adapting messages and counseling approaches to local ethnic and cultural norms, a central theme in all of the YWCA's community activities. Mrs. Kairu explained, "The participants were encouraged to begin a home visit by introducing themselves to the most respected person in the household. In some cases, this would be the oldest man in the family, in other cases the mother-in-law. Generally, the CBD worker would keep this person actively involved throughout the visit, with questions and comments directed to him or her. This approach ensured continued support from the head of the household and made the CBD worker's task easier in recruiting the eligible clients in that household."

The YWCA has been pleased with the enthusiastic reception of field workers, supervisors, and trainers alike and has shared their experience with other NGOs in Uganda in the hope that future family planning projects will incorporate the key features of their approach. These key features are:

- Training field workers and supervisors together, so they learn the same concepts and skills and begin working as a team;
- Providing a closely-supervised and supportive field experience immediately following basic training;
- Requiring trainers to make regular follow-up visits to participants at their service sites so they can clearly see the impact of their training, provide ongoing support to participants, and gather information that helps them to design future courses;
- Recognizing and adapting to ethnic and cultural differences.

Supervising staff in remote, rural areas is a challenge to managers even under the best circumstances. Because travel to these areas is expensive, time consuming, and difficult due to long distances and poor road conditions, supervisory visits are infrequent. One solution to this problem is a self-evaluation tool that service providers in remote areas can use to assess and improve their own performance. The following "Working Solution" from Angola describes the development and use of a self-assessment checklist in a situation in which regular supervisory visits were impossible. For more information about supervision and the use of self-evaluation checklists, please refer to Chapter Fifteen, "Improving Supervision: A Team Approach," and its accompanying supplement, the *Pocket Guide for Service Improvement.*

Working Solutions—Angola

Supervising Family Planning Service Delivery in a Country Torn by War

When war engulfs a country, it diverts energy and resources from the usual social support systems. Health and family planning programs cannot function as they did in peacetime, and managers must struggle to find alternative ways to maintain quality services in a chaotic context.

Over the last twenty years, Angola has been engaged in civil war with only intermittent periods of peace. Battles took place in the countryside, roads were mined, and transportation was almost non-existent, making regular supervision of rural family planning clinic nurses impossible. To confront this dilemma, the United Nations Population Fund (UNFPA) worked with Angolan family planning program staff to design a self-assessment checklist for clinic nurses working in isolated areas. Dr. J.W. Harnmeijer, Reproductive Health and Family Planning Advisor for UNFPA in southern Africa, told us how national family planning staff joined with provincial nurses to identify key indicators of quality (privacy, equipment, attitudes of nurses, etc.), and agree on a numerical rating scale for each indicator. This process helped to:

- Bring together staff who oversee rural programs and those who carry out the program's day-to-day activities;
- Promote thoughtful and often heated discussion of important issues, resulting in new understanding on the part of participants at all levels;
- Facilitate negotiation and compromise in areas of disagreement;
- Give credibility to the experience, knowledge, and concerns of those who would ultimately use the instrument.

Dr. Harnmeijer explained that the provincial nurses were enthusiastic about taking a checklist back with them and were motivated to use it because it was their own creation, rather than one that was developed by senior managers and imposed on them. This simple tool will support their efforts and help them to maintain a sense of direction and purpose under the most disruptive conditions.

Managing Resources

Today, managers are engaged in serious efforts to both improve the efficiency of their management systems and increase general revenues. Improving management systems allows an organization to do more with less, while increasing revenues provides opportunities for expanding services.

Strengthening management systems. Continuous quality improvement (CQI) is an effective system-wide approach used to strengthen management systems. Implementing a CQI program can help managers review work flow and systems in an organization, and to identify and make changes that will improve productivity and reduce costs.

Managers can also make more money available for service delivery by improving a specific management system. For example, managers can improve the procurement, distribution, and use of contraceptive commodities, medicines, and laboratory supplies. Dr. Emmanuel Nkodo Nkodo, Deputy Director of Family Health in the Cameroon Ministry of Public Health, writes that shortages in contraceptive supplies and poor distribution systems resulted in reduced clinic visits, poor service delivery, and higher drug costs. "To address these problems, we trained staff in logistics management, analyzed the contraceptive supply system, integrated contraceptives in the essential drug supply system, and organized a workshop for central level staff, other NGOs, and staff of international organizations to gain support for making changes to the logistics system. It has now been a year since these initiatives began and we have recently seen an increase in clinic attendance, the cost of drugs has been reduced, and clients are much happier with the services."

Generating Revenue. Many managers are facing decreases in donor funding with no indication that their local governments will be able to make up the difference. These managers are engaging in serious efforts to cover a greater proportion of their expenses with funds they generate themselves and to reduce costs by improving productivity and efficiency. The following example illustrates how PROFAMILIA, in Colombia, has successfully increased revenues without reducing coverage or putting an unacceptable burden on the poor and underserved people who need services.

Working Solutions—Colombia

Seeking Financial Self-Sufficiency

In working toward self-sufficiency, PROFAMILIA, the IPPF affiliate in Colombia, has been successful in raising 70 percent of its annual budget through local sources. The five components of PROFAMILIA's financial strategy are: charging fees for services; diversifying services; conducting social marketing; implementing assorted small income-generating initiatives; and cutting expenditures.

Charging Fees for Services

PROFAMILIA believes that even the very poor are willing to pay for services when the services are of high quality. This belief is based on the assumption that clients gain a sense of dignity and entitlement from paying what they can. Thus, PROFAMILIA charges for every service that it offers. Fees have been introduced cautiously, however, to maintain the delicate balance between raising needed income and providing services to all members of society. Service fees account for 16 percent of the money raised through local sources.

Diversifying Services

Recognizing that women have reproductive health needs that go beyond family planning services, PROFAMILIA has expanded the medical and surgical services it offers to women. By expanding the scope of reproductive health services, they have attracted new clients who can pay slightly more than the actual cost of providing the services. Payments received from these services account for 40 percent of the locally-generated income. Donors have been willing to fund this initiative, recognizing that the potential for generating additional revenue exceeds the initial expense.

Conducting Social Marketing

Twenty-five years ago, PROFAMILIA began distributing contraceptives through community-based programs. Since that time, the program has developed a strong commercial component. The present social marketing program involves selling contraceptives at a profit to pharmacies, supermarkets, drug stores, private physicians, and anyone else in the private sector who wishes to sell them. This component of the financial strategy accounts for about 10 percent of PROFAMILIA's locally-generated income and requires no additional financial investment.

Implementing Assorted Small Initiatives

There are a number of specific additional activities that produce another 10 percent of locally-generated revenue. These activities include investing money to obtain a return on the capital, renting out unused areas of PROFAMILIA clinics, raising local donations, and charging small fees for lectures and other educational activities.

Cutting Expenditures

The last strategy involves cutting expenditures as a way to increase net revenue, rather than increasing income from outside sources. By carefully determining which activities and supplies are essential to providing quality services and eliminating non-essential expenses from the budget, PROFAMILIA has been successful in reducing its operating costs.

Although financial self-sufficiency is only one aspect of sustainability, this is an excellent example of how one organization has achieved greater control over its financial resources, while continuing to expand its programs to serve those in need.

Reflecting on the Crucial Role of Managers

Family planning managers work with many people at different levels in the service delivery chain. Ultimately, they provide the foundation for delivering family planning services and facilitate the work of the many people involved in providing family planning services to clients. The result of the work of these many managers is a satisfied, continuing, and motivated family planning user. Although it sometimes seems that management is removed from the interaction between provider and client, the family planning manager plays a key role. It is the manager who develops the service delivery strategy, trains the provider, sets the program's standards for quality, ensures that services meet those standards, develops systems for keeping track of program data, and makes sure that the necessary supplies and money are available when needed for providing services to the client.

This chapter has focused on the important role that family planning managers play in the delivery of family planning services. The approaches and solutions to the problems described are relevant because they are real. As each "Working Solution" has illustrated, behind every management problem and every solution is the face of a client.

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Working Solutions Worldwide Contributors

Many readers contributed to the development of this chapter of *The Family Planning Manager*. Their names and affiliations are listed below. The editors greatly appreciate their willingness to share their management experiences so that other managers can learn from their experiences.

Kabir U. Ahmed, Urban EPI Technical Specialist, Bangladesh
Joshua O.E. Arasomwan, State Manager, Planned Parenthood Federation of Nigeria
Getachew Bekele, Project Director, Marie Stopes International, Ethiopia
Alpha Dieng, Director, SANFAM, Senegal
Desideria Priscilla Dlamini, Project Organizer, Holy Cross Clinic/Natural Family Planning Association of Southern Africa, South Africa
Samuel Thuku Gachukia, Assistant Program Officer (CBD), Family Planning Association of Kenya
J.W. Harnmeijer, Reproductive Health and Family Planning Advisor, UNFPA/Southern Africa, Zimbabwe
Ezekiel Ibrahim, Public Health Officer, Nigeria Police Force, Nigeria
Susan Igras, Project Coordinator, The RICHES Project, CARE/Haiti
Mary Kairu, Regional Program Coordinator, CEDPA/Nairobi Region Office, Kenya
Anna Eniya Mashiri, Provincial Nursing Officer, ZNFPC, Zimbabwe
Alphonse H. Mkini, Area Service Delivery Manager, Family Planning Association of Tanzania
Emmanuel Nkodo Nkodo, Deputy Director of Family Health, Ministry of Public Health, Cameroon
L.N. Patra, State MCH Officer, Administration of Dadra and Nagar Haveli, India
Jewel Quallo, Executive Director, Family Life Association, Belize
Elvia Salazar Antónez, Executive Coordinator, MEXFAM Sonora, Mexico
A.B. Sulaiman, Executive Director, Planned Parenthood Federation of Nigeria
Miguel Trías, Executive Director, PROFAMILIA, Colombia

Building a Common Vocabulary: A Glossary of Management Terms

This consolidated glossary of terms concludes *The Family Planning Manager* compendium. It provides managers with an easy reference to the management terms and definitions used in *The Family Planning Manager* series and helps to reinforce important management concepts presented in the series by relating the definitions to the context of managing a family planning program. This glossary is intended to build a common working vocabulary among managers around the world, whether they are directing or implementing programs in Asia, Africa, Latin America, the Near East, the Pacific, Europe, or North America.

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Glossary of Terms

Acceptance Rate: The number of new users who have begun using any method of contraception, measured among a designated population (community, district, program area), covering a specific period of time (month, quarter, or year). An acceptance rate can be measured for all methods or for a single, specific method. *For example, in a clinic, the acceptance rate for oral contraceptives measured over the three-month period (January through March) could be expressed as 100 per 1000 clients, or 10 percent of visiting clients accepted an initial supply of oral contraceptives—a 10 percent acceptance rate during the first quarter of that year.*

Accounting System: A system for collecting, recording, processing, and reporting all financially related transactions. Two common systems are cash accounting and accrual accounting.

Accrual Accounting: An accounting system that records revenue when it is earned, expenses when they are incurred, and costs of using fixed assets such as buildings or equipment (as opposed to **Cash Accounting).**

Action Plan: Developed by a manager and his or her staff, an action plan lists program goals and objectives, and activities that will be implemented in order to achieve the objectives. An action plan often covers a time period of a year, indicates the person(s) responsible for implementing each activity, shows when each activity is due to be completed, and indicates the financial resources required. (See also **Operational Plan.**)

Activity Planning: The process of defining activities, planning the sequence of those activities, and identifying the resources (human, financial, and material) that will be used to carry out those activities to achieve the desired results.

Advisory Board: A group of external, experienced professionals who are charged with the responsibility of advising the senior management of an organization or program. An advisory board is usually structured more informally than a board of directors but may have similar responsibilities, such as helping senior management to formulate the organizational mission and policies, defining strategic directions, and providing general oversight of the financial health of the organization or program.

Appointment Card: A card provided to the family planning client showing the date and time of her next scheduled visit to the clinic, the address (and telephone number, if available) of the clinic, and often the name of a contact person. Using an appointment system helps clients remember when to return for a follow-upvisit, helps the clinic staff to plan and provide services more efficiently, and can help to reduce the time a client spends waiting for services.

Assessments: Studies used for analyzing a present situation against an ideal situation, identifying areas for improvement, or learning more about the situation in order to define a course of action. (See also **Situation Analysis.**)

Average Lead Time: The average length of time between placing an order for contraceptives or commodities and receiving the supplies ordered.

Average Monthly Consumption (AMC): The average number of units of a specific type or brand of contraceptive that are dispensed in a month. The average is usually based on quantities that have been dispensed over a period of six months.

Balance Sheet: The financial report that summarizes the value of the assets, liabilities, and reserves of an organization at a specific point in time.

Bar Chart: A graph that represents data or sets of data in vertical or horizontal bars so that the relationship between the data can be seen and interpreted more easily. Bar charts can be used to analyze most types of service data and help to show the differences between several different categories of data such as number of contraceptive users, non-users, and discontinuers.

Barriers to Services: National or local governmental laws or policies, professional practices and procedures, administrative regulations, or other official or unofficial rules that block people from receiving services because of age, gender, marital status, parity, financial ability, residence, etc.

Baseline Survey: A survey that is conducted at the start of a project to determine the level of key indicators against which future results are compared.

Benchmarking: A technique in which a set of indicators and sub-indicators are established, against which performance or progress towards obectives can be measured. Benchmarking can also be used to compare a service or process in one organization with similar services or processes in another similar organization for the purposes of improving the effectiveness and efficiency of a program.

Benchmarks: Established objectives or criteria that must be achieved over a specific period of time. Benchmarks are often set as incentives for a program to reach its short-term objectives which, when reached, qualify the program to receive additional funding or other forms of program support.

Bin Card: See **Stock Card.**

Board of Directors: Often a legal requirement for a nonprofit or for-profit organization, a board of directors is generally composed of a group of professionals with diverse skills and experience and is charged with the responsibility of overseeing the stability of the organization. Because board members are not employees of the organization and their membership is generally voluntary, boards can effectively and objectively guide an organization since no financial gain is involved. Areas of responsibility include: developing a strategic plan, supporting the leadership and growth of the organization,

providing financial oversight, maintaining community and government relations, ensuring that high-quality services are provided, and managing its own board activities.

Brainstorming: A group activity which allows people to quickly generate ideas, raise questions, and propose solutions on issues.

Business Plan: Often developed for the purposes of finding funding for a program or project, a business plan details the goals, activities, income sources, other financial resources, and expected revenue that will be generated from the business or activities.

Capital Costs: Costs of acquiring, constructing, or renovating fixed assets such as land, buildings, and large equipment (as opposed to **Operating Costs**).

Cash Accounting: An accounting system that records revenue when it is received and expenses when they are paid (as opposed to **Accrual Accounting**).

Cash Flow Projection Worksheet (also known as Cash Flow Statement): A projection of cash receipts and disbursements used to identify potential excess and shortages of cash funds.

Cause-and-Effect Diagram: A tool often used in a continuous quality improvement program to group people's ideas about the causes of a particular problem in an orderly way. This tool is also known as a "fishbone" diagram because of the shape that it takes when illustrating the primary and secondary causes of a problem.

Chronogram (also known as a Gantt Chart or Project Activity Timeline): A project planning tool that summarizes the major project activities listed in chronological sequence. It shows the month or quarter that each activity will be completed and the person or persons responsible for carrying out each activity. It helps managers to monitor activities and short-term results, keep a project on schedule, and manage project resources.

Client Characteristics: Information about client traits and needs that is used for analyzing a program's client base in order to provide high-quality client care based on clients' needs. Client characteristics include: age, marital status, number of pregnancies, presence of sexually transmitted diseases (STDs), literacy, preference for spacing births or ending reproduction, etc.

Client/Clinic Data: Summary information about the clients served by a clinic or community-based program. Types of clinic/client data typically include: types of contraceptive methods used by a program's clients (method mix), number of continuing users served by a clinic or program per month or year, number of new acceptors of a contraceptive method in a clinic or program, number of discontinuers of a method or clients who have dropped out of the program, and summary information on average age, marital status, and number of children of the clients.

Client Fees: Charges made to a client as payment for services provided to him or her, such as the provision of contraceptive supplies, counseling, clinical or laboratory services, and others. Client fees include registration fees collected at each visit, service fees collected for individual services provided, and membership fees collected on a yearly basis. Many programs charge clients a small fee to help cover some of the cost of providing services and to encourage clients to place a value on the services provided.

Client Flow Analysis (also known as Patient Flow Analysis): The process of determining the efficiency of service delivery operations in a health facility. It is based on observations made of the movement of clients through the health facility and tracks, in particular, the amount of time a client spends waiting to be seen by a provider and the amount of contact time a client has with each of the clinic's service providers.

Client Flow Chart: The chart that summarizes the information obtained from the client flow form. It shows the total time spent in the clinic, including time spent waiting and time spent with staff, as well as the percentage of the total time in the clinic that clients spent waiting for services.

Client Flow Form: The form used to record the information needed to perform a client flow analysis. The form records the client number, family planning method, type of visit, clinic arrival time, and the time and duration of each contact with staff.

Client Motivation: Information, education, discussion, or promotional activities that serve to encourage a client or potential client to use, or continue to use, contraceptives and reproductive health services on a regular basis.

Client Profile: A representation in numbers and/or percentages of the main characteristics of a program's clients. A client profile allows managers to gain a better understanding of the types of clients the program serves and (in some cases) the high-priority needs of those clients, so that the program can better serve its clients and potentially attract new clients who have similar needs.

Client Record (also known as Medical Record): The file or form completed for each client containing information on the client's medical and family planning history, health status, and physical exams. The file should include (at a minimum) the name, address, sex, age, parity, reproductive health history, and contraceptive method used by the client. The file is kept at the clinic and is updated by the staff each time a client returns for services.

Client Referral Card: A card given to a client or potential client by a community-based agent, outreach worker, or clinic provider that refers the client to another service facility for specific services that are not provided by the issuing agent or clinic. The referral card provides the name and location of the facility to which the client is being sent, the program or clinic

making the referral, the name of the client being referred, and the reason for referral.

Client Satisfaction: The benefits or value of the services (as perceived by the clients) provided by a program or clinic, often measured in terms of the quality of interpersonal interaction with providers, the range of contraceptive choice, and the efficiency and responsiveness to individual client needs.

Client Survey: A survey, often conducted through interviews, used to determine what clients' needs are, whether their needs are being met, what their perceptions are of the quality of care, their ability to pay for services, and other characteristics of a given client population.

Client Waiting Time: The time clients spend waiting to be seen by providers in a clinic. (See **Client Flow Analysis**.)

Clinic Management: All aspects of managing a clinic effectively, including planning activities and services, organizing the clinic space and work process for serving clients, managing financial and programmatic resources (including clinic and contraceptive supplies), managing information, monitoring progress toward objectives, and supervising clinical and non-clinical staff.

Clinic Performance: Clinic performance is often measured by counting the number of clients served by the clinic, and/or the number of new acceptors and continuing users served by the clinic over a specific period of time, and is evaluated relative to objectives set for the clinic.

Clinic Protocol: The list of medical standards that staff are expected to follow, which describes in detail the medical procedures and quality of care standards that ensure the safety and health of family planning clients.

Cluster Survey: A population-based survey technique that allows managers and evaluators to survey small population groupings and use the results to represent a larger portion of the overall population, thereby providing more rapid feedback on the impact of program activities. Stratified sampling techniques, by which the population is divided into different categories that are of interest to the program (such as age, parity, residence, and education), can be used in cluster surveys to improve the accuracy of the results.

Cold Chain Maintenance: The management of a system of freezers, refrigerators, dry ice carriers, and other devices used for maintaining the proper temperature for vaccines from the point of manufacture to the point of administration.

Community-Based Services (CBS): Health and family planning information and services provided to women and couples where they live or through locally-based depot holders. Services are organized through community-based activities where outreach workers, from a local clinic or the community, provide selected contraceptives (usually pills and condoms) to clients, follow up with clients who have questions, complaints, or side-effects, and make referrals to area clinics as appropriate.

Community Participation: A critical component of family planning programs, community participation can take many forms; it occurs when members of the community and local government play a significant role in managing the local family planning program including contributing money or materials, or volunteer time, thus deriving a sense of ownership of the program and accepting responsibility for achieving stated objectives.

Community Survey: A survey of a community that is the focus of a new program or an existing family planning program. In a community survey, interviewers/researchers often collect information on current knowledge, attitudes, and practices regarding contraception. Additional information can be collected as appropriate on the perception of a program's services (whether or not the respondents use those services), their source of services, income, and other socio-economic indicators that will help managers plan or improve the program.

Comparison Table: See **Matrix**.

Consolidation Stage: The third stage of organizational development during which the organization focuses on developing and refining its systems to increase management effectiveness, including its internal abilities to mobilize and control resources for organizational and program sustainability. (See **Stages of Organizational Development**.)

Contact Time: The amount of time that a client spends with clinic staff during a visit to a service facility. This is one of the elements that is analyzed in a client flow analysis.

Continuation Rate: The number of users who continue to use any method of contraception, measured among a designated population (community, district, program area), covering a specific period of time (month, quarter, or year). A continuation rate can also be measured for one specific method.

Continuing Users (also known as Active Users): Continuing users are contraceptive users who are practicing family planning on a given date. They are usually counted and reported on separately from new clients of a program and new users of a method.

Continuous Quality Improvement (CQI): A structured, cyclical process for improving systems and processes in an organization or program. It involves identifying an area where there is an opportunity for improvement, defining a problem within this area, outlining the sequence of activities (the process) that occurs in this area, establishing the desired outcomes of the process and the requirements needed to achieve them, selecting specific steps in the process to study, collecting and analyzing data about the process, taking corrective action, and monitoring the results of those actions. CQI is based on a team approach, and requires developing teams composed of staff from different functional areas and levels in the organization. It assumes that any system can always be improved and therefore emphasizes a process of

constant improvement, which requires long-term organizational commitment and effective teamwork.

Continuous (Perpetual) Review System (also known as Variable Order Interval System): A system of inventory control and resupply whereby stock levels are constantly reviewed and orders are placed when the stock reaches or falls below the predetermined reorder level. In this system, the reorders are usually for standard quantities but do not occur on a scheduled basis.

Contraceptive Data Analysis Chart: A worksheet used (for each method of contraception) to track the stock on hand and the amount of supplies ordered, received, and dispensed on a monthly basis. This worksheet helps managers to monitor changes in the quantities of stock on a month-by-month basis and provides a summary of the stock transactions over a one-year period.

Contraceptive Prevalence: The percentage of all women of reproductive age (WRA) or married women of reproductive age (MWRA), typically age 15 to 49, who are using a method of contraception. Contraceptive prevalence usually refers to the use of all methods, but may be given separately for modern methods (pills, IUDs, implants, injectables, condoms, diaphragms, cervical caps, and voluntary sterilization). It is calculated by dividing the number of WRA or MWRA who are using a method (numerator) by the total number of WRA or MWRA (denominator).

Contraceptive Product Cost: Used when determining the cost of services, the contraceptive product cost is the unit cost of a contraceptive product. If contraceptives are donated, then the contraceptive product cost will need to be estimated. The cost normally includes any expenditures on international and local transportation, customs, and taxes.

Contraceptive Supply Management (also known as Logistics Management): The management of all aspects of the supply cycle: product selection, forecasting, procurement, storage and inventory management, distribution, and use, so that a supply of unexpired contraceptives is available to clients in sufficient quantities when they need them.

Control Systems: All procedures and rules that guard against corruption, theft, and inappropriate utilization of funds or other resources.

Coordination: The planned collaboration of the different individuals, departments, and organizations concerned with achieving a common goal.

COPE (Client-Oriented, Provider Efficient): This is a low-technology technique to improve services for clients. COPE enables local service delivery teams to assess their own work in order to identify and find solutions to problems in their facility.

Cost Analysis: A study of the costs (personnel, products, equipment, etc.) associated with implementing a project, program, service, or other activities.

Cost-Effectiveness: A method of measuring the relative efficiency of a program by comparing the cost with the impact, using an indicator such as the contraceptive prevalence rate (CPR). One purpose of a cost-effectiveness study is to identify program strategies and operational modes that achieve the greatest impact for the least cost.

Cost per Year of Use (also known as Cost per Couple-Year of Protection): The cost of supplying an average client with a contraceptive for one year. The cost is calculated using the total cost per visit (personnel cost plus supplies), the average number of follow-up visits per year, and the average length of use of that method. The cost per year of use is a measure of output—the total cost of one couple-year of protection (CYP).

Cost Variance: The difference between the expected and actual expenditures for a product, service, or program.

Couple-Years of Protection (CYP): A measure representing the total number of years of contraceptive protection provided by a method. For each method, the CYP is calculated by taking the number units distributed and dividing that number by a factor representing the number of units (of that method) needed to protect a couple for one year.

CQI Core Group: Used in a continuous quality improvement (CQI) program, the core group is a group of people designated to lead the CQI process. The group is responsible for planning the implementation of the process, getting it started, developing training materials, organizing and providing training for all staff, and supporting it at all levels of the organization.

Cross-Functional Team: A group of individuals made up of people from different programs or departments, such as nursing, laboratory services, administration, and outreach who work together to achieve a common goal.

Cross-Subsidization/Cross-Subsidies: The system of using monies generated in one service to support the cost of another service within the same program. *For example, monies generated from sales of contraceptives in one clinic can be used to subsidize the cost of providing services to clients who are unable to pay for services or contraceptives in that same clinic or at other program sites.*

Cross-Tabulation: A table or chart used for simultaneously displaying summary data pertaining to two or more different sets of variables.

Cross-Training: Training staff to perform the functions of other staff members, so that when some staff are too busy or sick, other staff can help perform their job functions.

Daily Activity Register: The daily log of the number of client visits to a clinic, sub-divided into the types and quantities of contraceptives dispensed to each type of client (new or continuing user). The number of client visits and the number of each type and brand of contraceptive dispensed should be totaled daily.

Data Analysis: The process of examining data and finding patterns or trends. This provides managers with new information about their programs and services and helps them to make better management decisions.

Decentralization: A process of transferring responsibility, authority, control, and accountability for specific or broad management functions, to lower levels within a organization, system, or program. (See **Deconcentration, Delegation, Devolution**, and **Privatization**.)

Deconcentration: In program decentralization, deconcentration means that some management functions, such as developing program budgets, are transferred from the central level to *lower-level field units within the same agency or organization*, but the overall control of the program remains at the central level.

Delegation: In program decentralization, delegation means that the central level transfers the responsibility for specific managerial functions, such as developing and conducting management training, to *organizations or agencies that are outside the regular bureaucratic structure*, and thus these functions are only indirectly controlled by the central government.

Depot Services: A type of community-based service, this arrangement relies on having a person in a permanent location within the community who is available to provide information and contraceptive supplies (usually pills and condoms) to community members as needed. Because clients generally come to the depot for services, this approach reduces the number of people involved in delivering services at the community-level.

Devolution: In program decentralization, devolution refers to the transfer of power to newly created or strengthened *sub-national units of government*, the activities of which are outside the central government's direct control. In this approach, the responsibility, authority, and accountability for a program are usually transferred to a provincial or municipal government.

Direct Costs: Those costs that are directly associated with, or attributable to, a specific activity or department (such as training or tuition fees for a training program, seminar, or conference; contraceptive product costs; staff salaries and wages; costs of purchased services, etc.). Such budgeted costs should be clearly identifiable in an activity plan.

Discontinuation Rate: Discontinuation rates can be measured for each contraceptive method offered by a clinic, for several methods offered, or for all the methods offered by a clinic or program. The rate is calculated by dividing the number of discontinuers of a method or methods (for a specific period of time, such as a year) by the total number of users of that or those same methods, including those who discontinued the method(s), during the same time period. Multiplying the result by 100 provides the percent discontinuation of that or those methods for time period chosen.

Discontinuer (also known as Dropout): Someone who was formerly using a method of contraception but, for any of a variety of reasons, is no longer using contraception. A clinic/program discontinuer is someone who is no longer coming to the clinic for services. Although this may imply that the client is no longer using contraception, in some cases the client may be receiving services at another service facility. In order to track numbers of discontinuers, it is important for each program to define (for each type of method user) how long a client can be absent from the clinic after a scheduled appointment (or after the client was due for a resupply of contraceptives) before being considered a discontinuer. *For example, a pill user may be considered a discontinuer if three months have passed since she was due to pick up a resupply of pills. But an IUD user should not necessarily be considered a discontinuer if she doesn't visit the clinic even for an entire year, unless she had an appointment or was asked to return to the clinic for a check-up.*

"Doing the Right Things": A modern management motto which refers to the programmatic, strategic, and ethical soundness of a program. Managers who are concerned about "doing the right things" are concerned about the strategic direction of a program or organization and question the mission, goals, and objectives that underlie their decisions.

"Doing Things in the Right Way": A modern management motto which refers to whether activities are being carried out in the most effective and efficient way. Managers are concerned about "doing things in the right way" when they deal with day-to-day program operations.

Dropout: See **Discontinuer**.

Effectiveness: The extent to which a program has made desired changes or has met its objectives through the delivery of services.

Efficiency: The extent to which a program has used resources appropriately and completed activities in a timely manner.

ELCO Map: A graphic representation of the location in a community or village of **EL**igible **CO**uples (ELCOs—usually married couples of reproductive age, but the definition of eligible couple varies by country), showing where they live and the type of contraceptive method they are currently using. Generally used by fieldworkers, these maps keep track of each couple's reproductive status and any changes in the contraceptive method they use.

Emergency Order: An order for contraceptives or commodities that is placed out of the normal ordering schedule, usually when stocks have run dangerously low due to an unforeseen increase in demand. Emergency orders are usually placed for a quantity that will bring the stock levels up to a level that will last until the normal reorder time, taking into account the amount that will be dispensed in the interim.

Emergent Stage: The first stage of organizational development in which the primary goal is to start delivering services. This stage is characterized by an incomplete or unclear organizational mission, a simple organizational structure, basic programs and systems, and a high dependence on external financial support. (See **Stages of Organizational Development**.)

Endowment: A financial gift or gift with considerable financial value which may be sold or invested to produce additional income through interest, rent, or dividends and then used at a future time for institutional needs for purposes as stipulated by the donor.

Evaluation: A study of a program in which any number of different processes may be used to gather and analyze information to determine whether the program is carrying out the activities that it had planned and the extent to which the program is achieving its stated objectives (through these activities). Evaluation results can be used to learn in what areas the program is most effective and what modifications should be made to improve the program.

Exit Interview: An interview conducted with clients as they leave the family planning clinic to assess how they felt about the services they received. The interview can be an informal conversation or a more formal questionnaire that focuses on a particular aspect of service delivery.

Expenditures: Expense payments made in cash or checks.

Expenses: All the costs incurred in operating a program. In an accrual system, an expense is recorded in the accounting system when it is incurred, before cash is paid.

Expiration Date: The date determined by the manufacturer after which a contraceptive or other drug product should no longer be dispensed to or used by clients.

External Environment: The prevailing conditions in the country or region that affect the development and implementation of the family planning program including demographics, culture, policy, economy, health, market characteristics, and sources of funding and commodities.

Facilitative Supervision: An approach to supervision that emphasizes mentoring, joint problem solving, and two-way communications between the supervisor and the worker.

Facilitator: A person who assists, encourages, and supports a group of people in a participative way to work together, make decisions, and resolve conflict for the purpose of achieving a common goal.

Family Planning Activities Worksheet: A form sometimes used in busy clinics as an intermediary form between the Daily Activity Register and the Monthly Summary. The totals from the Daily Activity Register are transferred to the Worksheet each day, then totaled for the month and transferred to the Monthly Summary of Family Planning Activities.

Feedback: The process that allows for two-way communication between the field and the office or an employee and a supervisor, for the purpose of modifying, correcting, and strengthening performance and results.

Fee-For-Service Program: A program that charges a fee for individual services provided by the program or clinic. In a fee-for-service program a different fee is usually charged for each type of service provided, based on the actual cost of providing that service. In such a program, a new client receiving her first supply of pills will generally pay more than a continuing user who returns for a resupply. This is because the new client receives more comprehensive services on a first visit than a revisit client who is only picking up a resupply of pills.

Financial Audit: A formal periodic examination of accounts and financial records of an organization or program, generally performed for the purposes of verifying that funds were used as they were intended and in accordance with standard financial management practices.

Financial Management: A process of implementing and managing financial control systems, collecting financial data, analyzing financial reports, and making sound financial decisions based on the analyses. Financial management requires knowing how to read and interpret three key documents: a cash flow projection worksheet, a balance sheet, and an income statement.

Financial Position: The financial status of an organization at a particular point in time. The financial position indicates the organization's overall financial situation, taking into account current assets and liabilities, and projected income and expenses.

Financial Reporting: An established system for periodic reporting on financial transactions and financial status of an organization or program.

Financial Statement: The financial reports covering a period of time (month or year) that summarize the income and expenses for the period (Income and Expense Reports), and the assets and liabilities (Balance Sheet) at the end of the period.

First Consultation of a Client: See **New Client**.

First-to-Expire, First-Out (FEFO): A supply management system whereby contraceptives with the earliest expiration date are distributed first and contraceptives with later expiration dates are distributed only after the earlier-dated supplies have been issued.

Five-Table System: Often used in mobile, community-based approaches, the five-table system is a program that provides integrated maternal and child health and family planning services at one, temporary location. In this system, a table is set up for each of five services: registering the child; weighing the child; recording the results on a growth chart; providing health information (such as nutrition, oral rehydration, immunization,

breastfeeding, child spacing/family planning information); and providing any necessary medical treatment, contraceptives, or a referral to a fixed health facility as needed.

Flowchart: A chart used to analyze a process or activity that shows the sequence of activities, steps, and decision points that occur in a particular, discrete process, such as registering a client in a clinic. By defining a beginning and end point for the process and analyzing each step in the process, managers can identify problem areas and potential improvements in order to reach the desired outcome(s).

Focus Group: A planned and guided discussion among a group of participants for the purpose of examining a specific issue or issues. This is a qualitative method of gathering information. Results of focus group discussions are often complemented with or serve to further explain quantitative data collected through surveys or other quantitative methods.

Follow-up Visit: See **Revisit**.

Frequency Table: A chart used to record the number of times a particular event or occurrence takes place in a given time period, such as number of new acceptors and revisits during each month of the previous year, or for each reason cited for not using contraception, the number of people stating those reasons, etc.

Functional Responsibilities: The types of work responsibilities that a person or group is accountable for performing, such as planning, monitoring, evaluating, providing medical services, training, etc.

Fund Raising: The process of seeking financial support from community groups, local or central government units, local or international donor organizations or individuals, and others.

"Funnel" Approach: Used to describe an approach to delivering integrated services, the "funnel" approach depicts an agency or organization that separates its various programs vertically at the national and district levels, but integrates the programs and services at the clinic/community level. (See also **"Hourglass"Approach**.)

Gantt Chart: See **Chronogram**.

General Administration: Activities or, in the case of a budget, expenditures associated with the normal course of doing business, such as postage, freight, photocopying, telephone, utilities, bank charges, vehicle registration, and other usual and customary administrative costs (excluding personnel costs).

Goals: The proposed long-range benefits of the program to the selected population, defined in general terms.

Grants: Funds or donations given to an organization or program for the purpose of carrying out specific programs or services. Grants are usually provided by governments and local or international donors.

Graph: Used in data analysis, a graph illustrates in a picture the relationships or patterns that exist between numbers and sets of numbers, which would otherwise be difficult to see by looking at the raw data. (See **Line Graph**, **Bar Chart**, and **Pie Chart**.)

Growth Stage: The second stage of organizational development. At this stage, organizations develop a clear mission, define strategies for fulfilling the mission, have specific goals and objectives, and develop and use operational plans to achieve objectives. During this stage, as activities and services rapidly expand, the organization's reliance on external resources to support those programs and services also increases. (See **Stages of Organizational Development**.)

Histogram: A type of bar chart used to display data within a *single data category* such as age, which can be grouped as 20-24, 25-29, 30-34, etc. A normal bar chart is used to display data representing *different categories of data*, such as users of contraceptives, non-users of contraceptives, city or rural residence, etc. (For more information on Histograms and Bar Charts, please refer to Chapter Three, "Using CQI to Strengthen Family Planning Programs" and the supplement, *Manager's Toolbox for CQI*.)

Historical Data: Data collected from past reports, such as contraceptive distribution reports, daily activity registers, inventory cards, etc.

"Hourglass" Approach: Used to describe an approach to delivering integrated services, the "hourglass" approach depicts a combined vertical and integrated program in which staff at the national level are divided into separate divisions for family planning, immunization, infectious disease control, nutrition, and maternal health. At the regional or district level, however, programs are coordinated by one or two individuals, and at the service provider level staff are again assigned to separate programs. (See also **"Funnel" Approach**.)

Household Survey: A survey that collects information about the occupation(s) of a couple, the contraceptive method they use and/or have used in the past, whether the woman is pregnant or breastfeeding, recent births, total number of births and deaths, and other information concerning a couple's reproductive health and family planning history that is of interest to the program. Household surveys are used to establish the level or the indicator against which future results are compared.

Identification Codes: A series of numbers or letters used in a management information system to help differentiate specific locations of services (or clinic type), types of visits (first visit, revisit, procedure visit), types of services or contraceptives provided (IEC, IUD insertion, pill resupply), and other categories of data. To be useful, the same identification codes should be used consistently by all people who use the management information system.

Impact: In a family planning and reproductive health program, the extent to which the program has changed or improved the knowledge, attitudes, behavior, or health of the program participants.

Incentive Grants: Funds used to reward program performance, the achievement of objectives, or to motivate programs to launch new initiatives. Incentive grants are used to motivate programs and employees to (continue to) meet their objectives and maintain or improve program quality.

Income Statement (also known as Revenue and Expense Report, Income and Expense Report, and Profit and Loss Statement): A periodic summary report of income and expenses, showing a surplus (profit) or deficit (loss) for the period covered by the report.

Indicator: A certain condition, capability, or numerical measure which, when recorded, collected, and analyzed, makes complex concepts more readily measurable and allows managers and evaluators to compare actual program results with expected results.

Indirect Costs (also known as Overhead Costs): The operating costs of an organization which are shared by more than one activity or department (such as building maintenance and utility expenses).

Information System: A standardized system for collecting, recording, interpreting, analyzing, reporting, and disseminating data so that the data are available to be used for making critical management decisions. In a family planning clinic, this normally refers to collection and reporting of programmatic and financial information connected with providing client services and operating a facility. (See also **Two-Tier Information System**.)

In-Kind Contribution: A non-financial contribution or form compensation such as materials, goods, or services.

Inreach: In family planning, this involves using resources within a health facility to improve the understanding and knowledge of the facility's family services (as compared with **Outreach**). Inreach addresses missed opportunities to provide information about the facility's family planning services to staff, clients, and potential clients in all departments of the facility. Inreach activities include improving linkages and referrals between departments, posting signs about services throughout the facility, and orienting staff from other departments to the family planning services.

Insertion Visit: Generally used to describe a visit made by a client for the insertion of an IUD or contraceptive implant. Different types of visits are often designated by a program or clinic so that specific costs may be assigned or fees charged for each type of visit.

Institutionalization: The internalization by an organization or program of an activity, system, or practice, to the extent that the activity, system, or practice will continue to operate in spite of personnel turnover, and independently of external inputs or involvement.

Integration/Integrated Services: This refers to a program that combines family planning services with maternal and child health, nutrition, immunization, and other reproductive health services, such as control and treatment of sexually transmitted diseases.

Intermediate Outputs: Medium-term results that are critical to the achievement of long-term results. *For example, the number of workshops or courses held is a medium-term result that is critical to achieving the long-term result of having qualified providers.*

Internal Environment: Leadership, policies, systems, technology, financial capability, etc., that influence the effectiveness of an organization or program. Other factors in the internal environment include: management structure, management systems, staff capabilities, etc.

Internal Organization: The internal structure and arrangement of an organization or program as it pertains to the allocation of and relationship between different functional areas such as planning, budgeting, financial management, supervision, and others. The internal organization of a program is particularly important as programs become more decentralized and/or integrate several programs into a single program.

Inventory: The amount of stock (contraceptives, commodities, and other clinic supplies) that is on hand (for use by a program or clinic) at a given point in time.

Inventory Control Card: See **Stock Card**.

Job Description: A document that at a minimum states the job title and provides a description of the tasks and responsibilities of the position, the direct supervisory relationships with other staff, and the skills and qualifications required for the position.

Lead Time: The amount of time (usually expressed in months or weeks) that it takes for a shipment to arrive once an order has been placed.

Lead Time Quantity: Based on past records, the amount of contraceptive stock that will be dispensed during the time between placing an order and receiving new stock.

Line Graph: A graph that represents data or sets of data that have been collected over a period of time. The data are plotted on a graph corresponding to standard intervals of time and a line is drawn connecting the data points. The line in the graph allows managers to see trends in the data (an increase, decrease, or no change) over a period of time. Line graphs are often used to analyze trends in new acceptors, continuing clients, dropouts, new acceptors using a particular method, and

others. Line graphs (updated regularly) help managers to follow a trend over a period of time and take actions to manage the trend.

Logistics Management: See **Contraceptive Supply Management**.

Long-Acting Methods (or Long-Term Methods): Contraceptive methods that remain effective for a relatively long period of time. Experts may differ in the methods they include under this term. Some experts include only IUDs, implants, and injectables, some also include oral contraceptive pills, and some include voluntary sterilization.

Maintenance Cost: Generally refers to the cost of maintaining a facility and may include repairs, cleaning, rent, taxes, insurance, etc.

Management Accounting: Collecting information from the financial accounting system and other financial data (such as budgets) and combining this information with statistical data (such as service outputs) to produce information which is useful for making managerial decisions.

Management Components: The basic elements used to analyze the way an organization functions. The four basic management components are mission, strategy, structure, and systems. (See also **Mission Statement**, **Strategy**, **Organizational Structure**, and **Management Functions/ Systems**.)

Management Functions/Systems: The basic management functions of program planning, budgeting, determining staff roles and responsibilities, training, supervising staff, managing resources (including money, contraceptive and commodities supplies, and other program equipment or services), monitoring program activities, evaluating program achievements, and managing the provision of client services.

Managing Board: A formal group of advisors who provide general strategic and financial oversight to an organization and are responsible for maintaining and promoting the stability and sustainability of the organization.

Mapping: A process by which information or data are laid out on a diagram or representation of a community, village, or other defined territory for the purposes of tracking changes in the data.

Market Analysis: An examination of the environment in which an organization or program provides or sells goods or services. A market analysis typically includes conducting a survey of a program's current clients (their needs, satisfaction with services, socio-economic status, etc.), a survey of the community (to learn more about potential clients and the existing demand for services), and a survey of the other family planning service providers in the area (the types of services they provide, the cost and quality of services, etc.). This information provides a program or organization with critical information about underserved populations in their area, the level of access to services, feedback on clients' satisfaction with services, the ability of clients to pay or the amount they can pay for services, and other information about the role the program should play in relation to other service providers in order to maintain a competitive edge. Having the ability to address these factors serves to strengthen program sustainability.

Marketing: The activities related to designing and pricing goods and services so that they are bought or used by the public, informing the public of the available services and their prices, and promoting the value of those goods and services for the purpose of generating demand.

Matrix (also known as a Comparison Table): A chart used for analyzing two or more sets or types of information (such as the number of users of each contraceptive method by type of client, such as new acceptor or revisit). A comparison table can also be used for comparing organizational processes or activities against a set of criteria that reflect organizational priorities, resources, and constraints to help managers prioritize areas for improvement.

Mature Stage: The fourth and last stage of organizational development, during which an organization develops its ability to effectively manage the organization and adjust its mission, strategy, structure, and systems in response to internal and external challenges in order to increase sustainability. (See **Stages of Organizational Development**.)

Maximum Quantity: The maximum quantity is the largest amount of stock (of each contraceptive item) that a facility should ever have in inventory. The quantity should be set high enough to maintain adequate stock between orders and low enough to prevent overstocking and wastage due to expiration. It is calculated separately for each contraceptive item and consists of the minimum quantity of stock plus the amount that is used between regular orders. (A formula for calculating maximum and minimum stock levels and quantities can be found on pages 317-319 of Chapter Thirteen, "Improving Contraceptive Supply Management.")

Max/Min (Maximum-Minimum) Stock Level: Assigned minimum and maximum stock levels designed to ensure that a program doesn't run out of contraceptive supplies and also doesn't become overstocked. Minimum and maximum levels are expressed in terms of a certain number of months' worth of supply.

Medical Record: See **Client Record**.

Membership Fees: Fixed fees charged to clients or members of an organization, usually on a yearly basis, entitling them to a range of services.

Method Mix: A summary, usually represented in percentages, showing the proportion of all users (of a general or specific population) that are using each contraceptive method.

Micro-Manage: The practice of providing unnecessary and excessive oversight in the management of staff and staff activities.

Minimum Quantity: The minimum quantity is the least amount of stock (of each contraceptive item) that a facility should ever have in inventory. The minimum quantity should be set high enough to prevent shortages and stock-outs, even if deliveries are late or demand unexpectedly increases. The minimum quantity is the safety stock quantity plus the amount of stock used between placing and receiving an order. (A formula for calculating maximum and minimum stock levels and quantities can be found on pages 317-319 of Chapter Thirteen, "Improving Contraceptive Supply Management.")

Missed Opportunity: An occasion that offered a chance for a beneficial activity to occur (service provision, employee feedback, etc.) but was overlooked.

Missing Client: See **No-Show Client**.

Mission Statement (also known as Organizational Mission): A brief general statement describing the type of organization, its main purpose, and its values. The mission of an organization provides the rationale for defining goals and objectives.

Monitoring: The process of periodically checking the status of a program, by observing whether activities are being conducted as planned.

Monthly Summary of Family Planning Activities: The form used to record the monthly totals for all the data collected on the Daily Family Planning Activity Records. Generally, the clinic manager keeps one copy and another copy is sent to the program supervisor who aggregates the monthly data for all the clinics in the region or district.

Months of Supply (also known as Months' Worth of Supply): This term is used to express the amount of asupply on hand (of a specific contraceptive or commodity) in terms of the number of months that quantity would last if it is dispensed at current (average) rates. It is the quantity on hand (of the specific contraceptive or commodity) divided by the average monthly consumption (AMC) of that item.

Mutually Accountable: A situation in which multiple parties or individuals are jointly responsible for the outcome(s) of an activity or activities.

New Acceptor (also known as New User): Someone who accepts a contraceptive method for the first time. Programs differ in their definition of new acceptors/new users. Some include only those persons who are using contraception for the first time and have never used any form of contraception before. Some also include those persons who are using a particular contraceptive method for the first time (even though they have used a different method before). Still others may include those persons who are accepting a method from (an agent of) that particular program for the first time (even though they may have used a method provided by another program before). Whatever definitions your program uses, it is critical that the definitions be clear and understood by all staff, so that service data in all the service facilities will be collected and reported on in the same way.

New Client (also known as First Visit or First Consultation of a Client): Someone who receives services from (an agent of) a family planning program who has not received services from that program before. Programs differ in their definitions of a new clients. Some programs include persons who receive any type of service (including counseling) who have not received services from that program before. Other programs include only persons who are accepting a family planning method for the first time and have never used contraceptives before from any program. Still other programs distinguish new clients (of a program) from new acceptors/users (of a method). Whatever definitions your program uses, it is critical that the definitions be clear and understood by all staff, so that service data in all the service facilities will be collected and reported on in the same way.

No-Show Client (also known as a Missing Client): A client who does not come for a scheduled visit or has not returned to the clinic for services for a long period of time.

No-Show Rate: Often expressed as a percentage, the no-show rate can be calculated most easily in a clinic that uses an appointment system, in which it is known when and how many clients are due to return to the clinic for services. The no-show rate is calculated by taking the total number of clients who came to the clinic for services (during a specific period of time) divided by the number of clients who were due to come to the clinic for services during the same period of time. Multiplying the result by 100 gives the percent of no shows for the designated period of time. Such an analysis can also be done for a specific contraceptive method or age group of clients. (For more information on measuring no-show rates, please refer to Chapter Fourteen, "Reducing Discontinuation in Family Planning Programs".

Objectives: The anticipated results or outcomes of a program, representing changes in the knowledge, attitudes, and behavior of the program's clients, described in measurable terms and indicating a specific period of time during which these results will be achieved. Objectives should be **S**pecific, **M**easurable, **A**ppropriate, **R**ealistic, and **T**ime bound (SMART).

Observation-Study Visits: An organized series of visits to other program sites or organizations for the purpose of studying and learning about the other program and sharing successful experiences for replication or adaptation.

Operating Costs (also known as Recurrent Costs): Regular expenses of running programs and providing services which are incurred year after year (as opposed to **Capital Costs**).

Operational Plan: Different from a strategic plan (which sets forth the general strategies a program will use or initiatives it will undertake to achieve its objectives), an operational plan sets forth the specific projects or activities (consistent with the strategic plan) that will be conducted, and the timetable and resources needed for completing those projects or activities. (See also **Action Plan**.)

Order Interval: An established and regular number of months between placing orders for contraceptive supplies. The order interval should be set individually for each method of contraception to correspond to the desired maximum and minimum inventory levels.

Organization Type: The structural or legal definition an organization, such as private commercial organization, private non-profit, public agency, non-governmental organization, or affiliate or subsidiary of a larger organization.

Organizational Chart (also known as an Organogram): A chart showing the working relationships of all staff positions within an organization or program and the formal supervisory structure and reporting relationships between different functions and positions of the management and staff.

Organizational Stability: The ability of an organization to effectively use management controls and systems to prevent any major disruptions in services in spite of unexpected changes in the external environment or turnover of personnel, especially senior personnel.

Organizational Structure: The internal lines of authority and communication within an organization which define how programs and departments are managed, which types of activities are carried out by which programs or departments, and the functional and supervisory relationships between the staff and the manager of those departments. (See also **Organizational Chart**.)

Organogram: See **Organizational Chart**.

Output Information: Information concerning the products or accomplishments (in numerical terms) of the activities of an individual or program over a specific period of time.

Outreach: Activities related to providing information and services to the community outside of the clinic facility, usually by working with community groups or volunteers.

Overhead Costs: See **Indirect Costs**.

Pareto Analysis: Based on the principle set forth by an Italian economist Vilfredo Pareto, which states that only a few factors are responsible for producing most of the results (positive or negative), a Pareto Analysis helps to identify the "vital few" factors that need to be improved in order to achieve the desired results. Performing this analysis helps managers to concentrate their efforts on a few activities and thereby use their scarce resources efficiently and effectively to achieve results. (For instructions on how to perform a Pareto Analysis, please refer to Chapter Three, "Using CQI to Strengthen Family Planning Programs" and the supplement, *Manager's Toolbox for CQI.*)

Participative Style: A style of management in which the supervisor or manager actively works with his or her staff and listens to their ideas, acknowledges their points of view and accomplishments, encourages joint discussions of issues, and finds solutions together.

Patient Flow Analysis: See **Client Flow Analysis**.

Payables: See **Accounts Payable**.

Performance Targets and Objectives: The end results that are expected to be achieved by an organization or an individual employee by the end of a specific time period. Performance targets generally relate to a shorter time period (several months) and pertain to very specific tasks. Performance objectives relate to longer time periods (one year) and determine the type and scope of activities that an organization, program, or staff member will undertake for the purpose of achieving the desired results.

Perquisites: A reward in cash or in kind, which is in addition to or in place of one's salary, such as health benefits, club membership, free meals, or parking.

Personnel Category: The different types of personnel. In a family planning program personnel categories include doctor, nurse, pharmacist, pharmacy assistant, counselor, outreach worker, registration clerk, etc. Personnel categories are often defined for the purpose of establishing consistent salary levels and are useful when determining personnel costs associated with the types of services provided.

Personnel Committee: Usually a sub-committee of a larger group such as a board of directors, which focuses on personnel issues, concerns, and trends, and advises the larger group, board, or organization of necessary changes.

Personnel Cost (or Total Personnel Cost): The cost of paying personnel (including allowances) for their time in performing a specific service, combination of services, or set of services over a specific period of time.

Personnel Cost Per Visit-Type: The cost of a single type of visit, such as a visit to insert an IUD, taking into account only the cost of the various personnel involved in providing that service.

Personnel Management: Responsibilities related to hiring and firing staff, supervising, promoting, organizing, motivating staff, and developing their professional capabilities. Personnel management requires strong interpersonal communication skills and skills in group facilitation, conflict resolution, and problem solving.

Pie Chart: A graph that represents summary data or percentages as wedges in a circle, or pie shape, so that the relationship between the data can be seen and analyzed more easily. Pie charts can be used to analyze the method mix of any type of client or for all clients in a program or clinic. Pie charts allow managers to compare proportions and represent summary data for a specific period of time, such as one month, quarter, or year.

Plateau Effect or "Plateauing": A situation in which a program's performance—number of people served and actively practicing family planning—has leveled off. In many cases, a program that has plateaued has already achieved a contraceptive prevalence rate (CPR) of 40 to 50 percent, has the capability to serve more clients, and must consider new ways to attract and retain clients, reduce barriers to services, reorganize programs and systems that provide services, and make other types of strategic decisions that will increase program performance.

Population-Based Survey: A survey in which information is obtained directly from a representative sample of the population or population group of interest to the program, such as women of reproductive age. Information is typically obtained through interviews, rather than from service records or other indirect sources. (See also **Cluster Survey**.)

Population Density: The total number of people living in a defined area such as a community, district, capital city, country, region, or square kilometer or square mile.

Population Distribution: The arrangement of population geographically as it is spread over a defined area such as community, district, capital city, country, region, etc. Knowing the distribution of population is important to managers as they plan new programs and the locations of service facilities.

Potential Client: Any person of reproductive age who is sexually active, not currently using the services of a clinic or community-based family planning program, and does not intend to have children at the current time. Potential clients also include couples who have problems with infertility, but want to have children. Programs should seek to attract such persons to the program and provide them with appropriate services.

Privatization: Privatization refers to the transfer of specific management functions, such as contraceptive procurement, logistics, and training, to *private non-profit or commercial organizations* outside the government structure. Although often used to describe a form of decentralization, some experts believe that privatization is not a means of decentralization because, in privatizing, a government relinquishes responsibility, rather than transfers power to lower levels.

Problem Solving: A critical management skill that involves objectively identifying the causes of a problem and proposing potential, often creative, solutions to the problem, which will be agreeable to multiple parties or individuals.

Procedure Visit: Generally used to describe a visit made by a client for a specific medical procedure, such as voluntary sterilization or the insertion or removal of an IUD or contraceptive implants. Different types of visits are often designated by a program or clinic so that specific costs may be assigned or fees charged for each type of visit.

Process Analysis: Any type of analysis in which a process, processes, or a sequence of activities is studied. Examples of process analyses are: flowcharting, decision-tree analysis, and client flow analysis.

Process Information: Different from output information which identifies products, outcomes, or accomplishments (in numerical terms), process information is qualitative, providing information about the ways that people and materials are used to produce specific outputs. *For example, by using process information, managers can determine the cause of a contraceptive stockout (a negative output) by analyzing each (process) step in the logistics system.*

Professional Development (also known as Staff Development): The process of increasing the professional capabilities of staff by providing (or providing access to) training and educational opportunities. This can include on-the-job training, outside training, or observation of the work of others. Professional development is widely recognized as a way to maintain staff morale, build the institutional capacity of a program, and attract and maintain high quality staff.

Professional Fees: Costs generally incurred through contractual agreements with *individuals* for specialized services such as lectures, training, and evaluation, as opposed to costs incurred through long-term contractual agreements with outside *institutions* for services such as vehicle maintenance, janitorial services, advertising, or promotion services, which are referred to as purchased services. (See **Purchased Services**.)

Profit and Loss Statement: See **Income Statement**.

Programmatic Reporting: An established system or process for reporting detailed information on the activities undertaken during a specific period of time. Programmatic reports are usually in narrative form and generally only report non-financial information about activities and progress made toward achieving objectives.

Project Activity Timeline: See **Chronogram**.

Public Affairs: Activities that promote an organization's program, services, and image to the public.

Purchased Services: Long-term contractual services or agreements with outside *institutions* for services such as vehicle maintenance, janitorial services, advertising or promotion services. Although similar, contractual agreements with *individuals* are often for a specialized service such as lectures, training, and evaluation, in which case the service is referred to as a fee-based service. (See **Professional Fees**.)

Quality Management: Quality management involves monitoring products or services to ensure that suppliers and providers are following accepted standards to meet desired outcomes and, if problems are observed, are taking the actions necessary to improve the products or services.

Quality Management System: In family planning, a system that brings together in a harmonizing and reinforcing manner the various activities that help to assure and continuously improve the quality of family planning services throughout a service-delivery network. In an effective quality management system, supervisors at all levels must have updated knowledge and skills in both service delivery and management areas.

Quarterly Reporting Form: A form used for reporting quarterly summary information such as the number and types of clients served (new acceptors and revisit clients), the quantities of contraceptives (each type and brand) on hand at the beginning of the quarter, the quantities received and dispensed over a three-month period, the quantities requested for resupply for the next quarter, any adjustments or losses, and ending balances.

Random Variations: Non-systematic inconsistencies or irregularities in data. When analyzing data, small (non-systematic) irregularities are often insignificant and can be disregarded.

Rapid Assessment: A quick, economical, sample-based study conducted to determine the extent or causes of a problem or to determine specific client or program needs that were identified through service statistics or other large studies.

Rate: A measure of an event (numerator) within a specific population (denominator) covering a specific period of time. *For example, the infant mortality rate is the number of infants that die in the first year of life (numerator) among all live births (denominator) in a specific one-year period. Infant mortality rates are usually expressed as the number of deaths per 1000 live births.*

Ratio: A proportion obtained by dividing one quantity by another quantity. *For example, eighteen family planning nurses (numerator) divided by six clinics (denominator) is a ratio of three nurses to one clinic.*

Recurrent Costs: See **Operating Costs**.

Referral System: An established system that defines when a client should be referred to another facility for services (often for treating medical complications or providing clinical methods or surgical procedures), how the client will get to the clinic (for instance, whether an outreach worker will accompany the client to the clinic), who the client should contact at the referral site, and what documentation should be presented by or given to the client at the referral site. Effective referral systems help to expand access to services and long-term clinical methods and serve to enhance the quality of services provided by a smaller satellite clinic.

Registration Fees: A fixed fee collected from clients at each visit regardless of the types of services provided.

Reporting Channels: An established system within a supervisory structure for reporting information and data. Appropriate reporting channels are critical, particularly as the provision of different types of services becomes more integrated and/or program management becomes more decentralized.

Requisition and Issue Voucher: The form used by the clinic manager to request new supplies, by the warehouse manager to fill the order and record the quantities sent, and again by the clinic manager to check that the clinic received the correct quantities and types of supplies ordered. More than simply an order form, this form summarizes the average monthly consumption of each contraceptive ordered, the clinic's desired maximum quantity, and the quantity on hand at the time of the order, and therefore serves to justify the quantity ordered.

Resource Management: The work of managing and controlling the limited resources needed to run a program such as people, money, and equipment. (Some people also consider time a resource.)

Revenue and Expense Report: See **Income Statement**.

Revenue Report: A daily, monthly, or quarterly report of monies or the equivalent received from sales, services, or fees. In accrual systems, revenues are recorded when they are earned, not when the actual cash or goods are received.

Revisit (also known as Follow-up Visit): A visit made by a client to a clinic often for the purposes of checking up on the client's success or comfort with a contraceptive method or to address medical complications or side-effects. The term is also used to describe a visit for the resupply of a contraceptive.

Safety Stock: The amount of stock (number of months' supply) below the minimum level which serves as a cushion or buffer against major fluctuations in contraceptive demands or unexpected shipment delays.

Satellite Services: Services that are provided to a community or several communities at a specific time (usually once a month) and at a designated location. Satellite services often provide integrated health, maternal and child health, and family planning services. (See also **Five-Table System**.)

Self-Evaluation Guidelines (also known as Self-Assessment Tool or Checklist): Guidelines or a series of checklists that pose specific questions for evaluating the abilities of staff or the performance or functioning of a program.

Self-Sufficiency: The level of organizational development that is reached when the organization is able to function independently of outside (donor) assistance. Self-sufficient organizations are capable of mobilizing a wide range of resources to avoid dependence on a single financial resource and have the management and leadership capability to adapt

their programs to a changing environment. (See also **Sustainability**.)

Service Delivery Approach: Designed to reach and attract different client groups, service delivery approaches include community-based services, clinic-based services, employer-based services, hospital-based services, in-home or depot services, and community gatherings for information, education, communication (IEC) about family planning.

Service Fees: Fees charged to a client for each service provided, such as counseling, examination, laboratory testing, and contraceptive supplies. Some programs set a standard charge for an initial visit and a revisit. An initial visit might include the cost of an examination, counseling, and a contraceptive method, whereas the revisit might cover the cost of a resupply of contraceptives and consultation.

Service Marketplace: The target area or region that a program intends to reach in delivering its services to a population.

Service Quality: Service quality refers to a number of inter-related factors including the way in which individuals are treated by providers, the scope of services and contraceptives available to clients, the quality of the information provided to the clients and quality of the counseling skills, the promotion of individual choice, the technical competence of providers, and the accessibility and continuity of services.

Service Stops: Different stages or locations within a clinic where a client receives specific types of services. Service stops often include: registering with the registration clerk, being weighed, having blood pressure taken, seeing a counselor, being examined by a nurse or doctor, and checking out at the registration desk.

Shelf Life: The length of time a contraceptive can be stored under normal circumstances without losing its efficacy. Poor storage conditions (such as extremes in temperature) can reduce the shelf life of a product.

Short-Term Methods: Contraceptive methods that remain effective for a relatively short period of time. Experts differ in the methods they include under this term. Some experts include only spermicides, diaphragms, and condoms; others also include oral contraceptive pills.

Site Training: An integrated approach to training that views the service-delivery site as a system and treats staff as members of the team that makes the system work. The goal of site training is to improve systems at a local site through effective teamwork and by ensuring that all members of the team have the knowledge and skills they need to fulfill their respective roles on the team.

Situation Analysis: A systematic process for analyzing the internal environment and capabilities of an organization and the external political, social, economic, and programmatic environment in which a program works. Such an analysis is performed for the purposes of comparing a present situation against an ideal situation in order to determine a course of action for improving program management, performance, and sustainability.

Sliding Fee Scale: A system of charging clients for services based on household income and family size, allowing clients to pay what they can afford.

Social Marketing: A strategy modeled after commercial product marketing in which contraceptives and other products related to sexual and reproductive health are promoted, distributed, and sold at relatively low prices through existing commercial outlets. Social marketing advertises reproductive health and family planning to different segments of the population by using such commercial outlets as radio, newspaper advertisements, and television to provide family planning information, education, and communication.

Staff Development: See **Professional Development**.

Staff Motivation: The personnel activities of an organization or supervisor that are designed to reaffirm the importance of the staff's jobs to the achievements of the program and to improve the skills, motivation, and qualifications of employees. Such actions or activities include providing training, giving positive and constructive feedback on a regular basis, showing appreciation for their work, and engaging them in problem solving.

Staff Responsibilities: The specific responsibilities or set of responsibilities of different staff positions for which staff can be held accountable. Such responsibilities can usually be quantified, such as providing counseling to an average number of clients over a specific period of time, or providing medical services to a district clinic three days a week.

Staff Roles: The broad responsibilities attached to different staff positions. *For example, the roles of managers include leadership, understanding, problem solving, advice, and encouragement.*

Stages of Organizational Development: The four stages that characterize the development of an organization: Emergence, Growth, Consolidation, and Mature. These stages are based on the principle that organizations develop in a systematic way over time and portray distinct characteristics during each stage in relation to mission, strategy, structure, and systems. (See **Emergent Stage**, **Growth Stage**, **Consolidation Stage**, and **Mature Stage**.)

Start-Up Organization: Usually a small organization in the early years of its development. Many start-up organizations are characterized by highly creative leadership, highly innovative initiatives, and a small, highly committed and motivated staff.

Status of Supplies Chart: A worksheet for calculating the average monthly consumption (AMC) and the maximum and minimum stock quantities. The status of supplies chart allows

managers to record on a single chart information about the desired minimum and maximum stock quantities for all types of contraceptives based on recent consumption patterns.

Stock Card (also known as Inventory Control Card or Bin Card): The form used to record all stock transactions (contraceptives received or dispensed) and the quantities of contraceptive currently in stock and on order. A separate stock card should be maintained for each type and brand of contraceptive.

Stock on Hand (also known as Balance on Hand): The quantity of each contraceptive or commodity in stock at any given time.

Stock on Order: The quantity of stock of each contraceptive that has been ordered but has not yet been received (by the clinic or facility).

Stockout: A situation in which a program or clinic runs out of supplies of one or more contraceptive methods (or other drug or equipment supplies) and does not have any supplies on hand to serve the client.

Stock Position: The number of months of supply that you have available at any given time for a single type and brand of contraceptive or commodity. The stock position is calculated by dividing the quantity of stock on hand by the average monthly consumption of that contraceptive or item.

Strategic Management: A way of managing the direction of a program by identifying the specific services that the organization is best suited to deliver and the population groups the organization can most effectively serve, and by making a realistic assessment of available resources for carrying out the work. Strategic management requires managers to think strategically, ask questions such as "Is the program doing the right things?" and consider and anticipate trends in the external environment that will affect the achievement of organizational goals.

Strategic Plan: The document that is the result of long-range (strategic) planning. It usually covers a period of three to five years, sets forth the mission and goals of the program, prioritizes strategies, and formulates the financial basis for achieving the goals.

Strategic Thinking: A critical management skill that requires having the ability to assess a program in relation to its mission, its future goals, and the external environment in which it works. Strategic thinking requires managers to examine whether their programs are "doing the right things" in order to achieve their mission.

Strategy: The approach or approaches that serve to fulfill the mission and that will be used to achieve organizational or programmatic goals.

Subsidizing Program Costs: See **Cross-Subsidization**.

Supervisor's Visit Plan (also known as a Session Plan): A statement or checklist used by supervisors that outlines the items, skills, and statistics to be monitored during each supervisory session. This plan should also include program support activities, such as collecting reporting forms and replenishing supplies, and any post-session activities to be completed by the supervisor.

Supervisory Protocol: An established system for supervising staff (clinical and non-clinical). A supervisory protocol should clearly describe supervisory procedures and schedules, organizational philosophy on supervision, tools for effective supervision (such as job descriptions and performance objectives), criteria for promotion, and techniques for motivating and supporting staff.

Supervisory Schedule: A written plan of supervisory sessions showing the name of the employee involved and the date, time, and content of upcoming supervisory sessions. A supervisory schedule is used for planning purposes and for communicating to employees such upcoming supervisory activities.

Supervisory Structure: The formal structure of reporting relationships between different functions and positions of the management and staff.

Survey of Family Planning Providers: A study of other family planning providers, usually those that work in the same area as the program conducting the study. The information is used to compare the types and quality of services offered by the other providers and to determine areas for coordination, referral, or new service opportunities.

Sustainability: The ability of a program to provide quality services to its clients, expand its scope of services and client base, increase or maintain demand for services, and generate income from the program and through local funding mechanisms, while decreasing its dependence on funds derived from external donors. (See also **Self-Sufficiency**.)

Tally Sheet: A chart designed to easily collect and organize data. Tally sheets are used to list the types of data that will be collected and to record the number of occurrences or observations that are counted in each category.

Target Group: The specific population group or groups intended as beneficiaries of a program. This will be either all or a subset of potential users such as adolescents, pregnant women, rural residents, or the residents of a particular geographic area.

Task Analysis: An examination of all the duties and activities that are carried out by an individual employee or position, for the purpose of determining the required skills, knowledge, attitudes, resources, and risks involved with each task.

Task Definition: The duties and activities that are specified as the responsibility of a particular employee or staff position.

Team Approach: A philosophy and a technique that relies on developing and working with a group of people with different skills and perspectives to identify and discuss issues, define causes of problems (or successes), and find and implement solutions in order to achieve a common goal.

Team Supervision Process: Any established process for supervising staff using a participative, team approach that involves supervisors and staff in the entire process.

Third-Party Payments: A system whereby a third party (such as an employer, an insurance company, or health plan) pays for services provided to the client. There may also be co-payments, whereby the client pays part of the fees.

Total Visit Cost: The cost of providing services for different types of visits (for example, first pill visit, IUD insertion visit, counseling visit), including direct personnel costs and contraceptive supplies, and a proportion of overhead costs. Used for comparing cost effectiveness and efficiency of services and in setting fees.

Trend Analysis: The representation of data to show an increasing, decreasing, or unchanging pattern of data over a period of time. A trend analysis is often performed by creating a line graph from a set of data.

Two-Tier Information System: An information system that is designed to collect output information on a routine basis, and asks managers to also collect process information to help them determine where a problem may have occurred so that it can be corrected.

Underserved Populations: Groups of people that are not normally served or not well-served by established service delivery programs. In family planning, some examples of underserved populations are adolescents, men, low-parity women, the urban poor, unmarried people, and people who live in remote rural areas.

Unit Cost (of Contraceptive Products): The total cost of a single contraceptive product unit, such as a cycle of pills, a set of surgical gloves, a Norplant kit, a single condom, etc., including transport costs, customs, taxes, and other costs.

Unmet Demand or Unmet Need: This term is used to describe the number of people or the percentage of the population who desire to use contraceptives to space or limit births but for a variety of reasons, including lack of access to information or services, are not currently using contraceptives.

User Fees: See **Client Fees**.

Variable Order Interval System: See **Continuous (Perpetual) Review System**.

Vertical Services/Approach: An approach in which services, such as family planning, maternal and child health, nutrition, immunization, and other reproductive health services are provided through separate facilities with separate staff managed at the central level by separate divisions or ministries that operate independently from one another.

Visit-Type: A individual type of visit made by a client to a clinic such as a first or initial visit, insertion visit, removal visit, resupply visit, complications visit, education or counseling visit, etc. Visit-types are usually defined for the purposes of determining the average cost of providing each type of service.

Volunteer Services: An approach used to support a local public- or private-sector program in which members of the community assist government workers, or fieldworkers employed by non-governmental organizations (NGOs), to carry out functions related to motivation, contraceptive resupply, and follow up. Workers may receive a small honorarium, reimbursement for travel expenses, or other tangible rewards but are not paid a regular wage.

Waivers/Waiver System: A system used to determine under what conditions a client will not be charged for services or when a portion of the client fee will be drawn from a reserve fund to pay part of the fee for the client. A waiver system uses a standard set of criteria to determine which clients are eligible for such financial support.

Work Plan: A document developed by the manager and the staff, covering a specified period of time, that lists all planned activities, the date by which they will be accomplished, the resources that they will require, and the people responsible for carrying them out.

Work Process: The process or sequence of activities that is carried out in order to complete a piece of work. *For example, the work process for registering a client in a clinic might consist of greeting the client, taking his or her name, checking to see if the client is a new or returning client, opening a new client record and having the client fill out the necessary forms, or pulling the existing client record, collecting any registration fees (if appropriate), asking the client to be seated until she or he can be seen by a service provider, and notifying the service provider that the client is ready to be seen.*

Working Capital: The amount of short-term funds available for operations, or the excess of current assets over current liabilities.

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The Family Planning Manager's Handbook: Basic Skills and Tools for Managing Family Planning Programs (Available in English, French, Spanish, Bangla, and Arabic)

"*Initiatives*," a 15-minute video describing the successful community-managed family planning program in Bangladesh, the Local Initiatives Program. (Available in English [NTSC format], Bangla [PAL], and French [SECAM])

Beyond the Clinic Walls: Case Studies in Community-Based Distribution
(Available in English)

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