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QUALITY MANAGEMENT FOR FAMILY PLANNING SERVICES: PRACTICAL EXPERIENCE FROM AFRICA

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INTRODUCTION

Over the past five years, quality has rightfully emerged as a central concern for family planning programs. Much of the discussion has focused on defining what quality is in family planning programs and on how to measure and evaluate it (see, for example, Bruce, 1990; Bertrand et al., 1994; Jain et al., 1992). This paper is, however, concerned not so much with such matters as it is with the pragmatic concerns about quality management in developing countries by service providers who are on the front lines and by other key personnel, especially supervisors and trainers. These are the personnel who need to understand quality and translate it into action. Yet the challenges they face are enormous, especially in Africa where resources and infrastructure to support service delivery are so poor.

This paper describes some of the approaches and tools that AVSC International has been developing in Africa over the past decade to improve the quality of family planning service delivery. The paper includes examples of progress in helping service programs improve management and some intermediate outcomes. The longer term outcome—increased use of services—is evident in the nongovernmental sector but is still to come in the public sector.

OBSTACLES TO QUALITY SERVICES

Governmental support for family planning programs in Africa has changed dramatically in the past decade. After years of am-

bivalence or even hostility towards family planning, most governments in the region now favor and support ambitious programs to extend family planning services. Donors and technical agencies have responded with an infusion of financial and material resources and technical assistance. As a result, large numbers of personnel have been trained, information campaigns have been launched, contraceptive commodities systems have been created, and service delivery networks and channels have been established.

Yet the returns on this investment have been disappointing. Contraceptive prevalence has been increasing very slowly in countries like Nigeria, Tanzania, and Uganda. Yet in these countries, as well as in countries where prevalence has expanded more rapidly, like Kenya and Zimbabwe, results from the Demographic and Health Surveys suggest that there is nevertheless a large gap between the need for family planning services and the numbers of clients who use services (National Council for Population and Development et al., 1994; Bureau of Statistics and Macro Information, 1993). Situation analyses conducted in several African countries tell us that a small proportion of sites in each of the countries are serving the bulk of clients (Fisher, 1993). So why are the remaining sites underutilized? What are the obstacles?

We now believe that a major reason for underutilization of service capacity is the lack of attention given to systems operating

BEST AVAILABLE

The users of family planning services have seldom been asked for their ideas on quality

at institutional and local service site levels.¹ This belief is supported by what frontline service providers and supervisors have told us. In 1993, AVSC held workshops in Kenya and Uganda during which, among other activities, we asked supervisors and service providers to give us their views of the obstacles to quality services (AVSC International, 1993a, 1993b). In addition, in more than 10 African countries, we have helped to develop, introduce, and facilitate COPE exercises in which local service providers assess themselves and identify problems that have an impact on quality (see page 4). From these consultations and COPE self-assessments, as well as from our own observations over the past decade, we have developed a list of what we think are some of the important obstacles to effective utilization of services.

• **Quality remains an abstraction.**

Everyone talks about quality these days and agrees that it is important, but few really understand what it truly means. Various definitions of quality have appeared. Some are simple and intuitive, and others are detailed and complex. Donor agencies want to measure quality, but there is no agreement on how. Many staff—not only service

providers but also staff upon whom providers depend for support, like administrators, clinic aides, and receptionists—are not even aware of the discussion about quality. The users of family planning services, who have the biggest stake here, have seldom been asked for their ideas on quality services.

• **The client perspective is missing.**

Many staff in family planning services in Africa have come through the ranks of medical education, began their practice in public hospitals that serve sick patients, and have learned to deal with patients as captive audiences. They readily admit, for example, that family planning services are designed to fit hospital schedules or the convenience of providers. They are not accustomed to treating basically healthy family planning clients as “customers” whose needs should be understood and catered to. They do not know how to obtain customer

1. This paper focuses mainly on systems failures at local service delivery sites and at the institutional level. In addition, many fundamental obstacles to effective service utilization also operate at the “macro” program level; examples include uncommitted leadership, policy and cultural barriers, insufficient resources, poor infrastructures and logistics systems, and inadequate mass communications.

The purpose of *AVSC Working Papers* is to capture on paper AVSC's experience and to disseminate the results of AVSC-supported research. We welcome your comments and suggestions.

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This paper grew out of AVSC's work with its counterparts in Africa, including governmental institutions, nongovernmental organizations, and the private sector, to improve the quality of family planning services. Our colleagues in these agencies are a constant source of inspiration, and their success demonstrates that improving quality is not only feasible but rewarding. Over the past two years, several AVSC International staff members provided useful comments on the many early drafts of this working paper. In particular, the authors wish to thank Ademola Adetunji, Lynn Bakamjian, Janet Bradley, John Githiari, Pamela Harper, Hugo Hoogenboom, Evelyn Landry, Pamela Lynam, Jan Neamatalla, Amy Pollack, Foluke Shobowale, Cynthia Steele Verme, and Grace Wambwa. Special thanks go to Karen Beattie whose advice and encouragement helped the authors deal with the reviewers' comments and give the paper its present shape. Pamela Harper edited the manuscript. Amy Van Hoogstraal and Stephanie Greig assisted with final production. A version of the paper was presented at the 21st Annual Conference of the National Council for International Health in Arlington, Virginia, June 28, 1994.

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input for designing services. They are often surprised to learn—as they do during COPE self-assessment exercises—how far clients have travelled, how long they have waited for services, or how late it will be when they reach home that night.

- **Services are isolated, fragmented, and vertical.** In many hospitals, temporary family planning methods are provided in a small, out-of-the-way or unmarked space. Sterilization services are tucked away in another corner or buried in the main surgical complex. Community-based distribution of contraceptives is often a separate program with its own staff and training, and may not even be housed with or close to clinic-based services.

Reproductive health services that are relevant to family planning are also separated. Gynecological care, including abortion or treatment of incomplete abortions, is set apart from maternity services. Obstetrics is often separate from maternal and child health clinics.

Given such fragmentation, it is hardly surprising that providers learn during COPE self-assessment exercises that clients often do not know that family planning services are available in these hospitals or, if they do know, where to find them.

There undoubtedly are many reasons for the development of fragmented, vertical services. But donor agencies and technical cooperating agencies (including AVSC) have been part of the problem. They have focused on discrete pieces of a comprehensive program, whether it be a particular contraceptive method, an essential input like training information and education, or a supporting subsystem like management information systems or logistics. They develop their narrow slices of the total picture at different times, in different ways, with different local counterparts, and often without reference to what other agencies have done or are planning to do. The result of this uncoordinated program development is a fragmented program at the top, and isolated and fragmented family planning services at the front lines.

- **Services do not adapt to growth.** In Africa, new service sites begin by serving very few clients, sometimes only 5 to 10 per week. There is no pressing need to pay at-

ention to the efficiency of such processes as client flow, record-keeping, commodities management, and scheduling. Some clinics in Africa, however, are now serving between 60 to 160 clients per day; yet the systems established at the beginning persist without review or revision. The results inevitably are frustrated clients, hassled providers, and breakdowns in service standards.

- **Training is inappropriate, narrowly focused, and unsupported.** Training is all too frequently carried out in central or regional training centers that bear little resemblance to the real-life conditions that trainees will face at their home institutions. Family planning training is often geared more to technical skills and not enough to management and supervisory skills. Key members of the local service delivery teams, including the administrators and matrons who have oversight and decision-making responsibilities, are often left out of family planning training; consequently, they often do not adequately support those who have been trained. Although trainee follow-up by trainers is often planned, it rarely happens because of inadequate resources and time.

- **Supervision is superficial or non-existent.** We have concluded that one of the biggest impediments to quality services is the lack of attention to supervision. Although money is devoted for start-up and capital investment costs—such as for centralized training or equipment—little money is set aside for supervision. Like trainee follow-up, it is given lip service, at best, in most programs in Africa.

Public sector supervisors have told us that they would like to visit service sites at least three or four times per year. However, a country like Tanzania has over 120 hospitals, 260 health centers, and over 2,000 dispensaries. In this kind of situation where resources for vehicles, fuel, and, most of all, time are scarce, the few supervisors are lucky to be able to visit just the major sites and a few of the smaller ones. And when supervisors do travel, they typically spend only an hour or two at each site, talking mainly with top-level hospital staff and devoting most of their time to collecting statistics.

Many supervisors do not have technical expertise in the services that they are super-

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Getting providers to develop more of an orientation toward the needs of customers is important

vising. Supervisors also say that they need training in helping sites to assess their own needs, in facilitating group discussions among local providers, in stimulating teamwork at local sites, and in guiding service site staff in solving some of their own problems.

DEVELOPMENT OF QUALITY MANAGEMENT APPROACHES

The list of obstacles to quality services is daunting, especially given the scarce resources and weak infrastructures that characterize health services throughout Africa. But there has been progress. With our country partners, AVSC is developing tools and approaches that get service providers, trainers, and supervisors to take the first steps in the quality improvement journey.

Perhaps the most effective approach is the COPE self-assessment methodology that AVSC and our partners in Kenya and Nigeria have developed and refined over the past six years (see Dwyer et al., 1991, and Lynam et al., 1993, for a more detailed discussion). COPE is an acronym that stands for client-oriented and provider-efficient. The essence of COPE is a facilitated process that gives service providers some simple techniques by which they can self-assess their own services, identify problems, and devise solutions to the problems. The methods described below have grown out of our initial work developing COPE; either they are incorporated into the COPE self-assessment package, or they are used in addition to, or as next steps after using, COPE.

The Quality Definition Exercise

One of the most important first steps is to get the staff themselves to define quality services and the conditions that are necessary for quality to exist. When staff are involved in defining quality, they are more likely to get beyond the abstractions and jargon, to know what quality means, and to be able to measure their progress.

We now include a quality definition exercise at the beginning of a COPE self-assessment. It begins with the facilitator asking local staff what they see as a quality service. The staff envision themselves, or their family members, coming to the site for service and describe the kind of service that they would like to receive.

Only *after* staff have developed their personal vision of a good service do we help them to develop and gain a comprehensive picture of quality. We do this by orienting them to the Rights of Clients and Needs of Providers, as developed by the International Planned Parenthood Federation (IPPF) and by giving them checklists of questions that are organized according to these rights and needs (Huezo and Briggs, 1992; Huezo and Diaz, 1993).² These checklists are given as a guide to help staff look at their services. Completing them is one of the primary components of COPE self-assessment exercises. We encourage clinic staff to add their own questions and to make the guide their own.

Customer Interviews

Getting providers to develop more of an orientation toward the needs of customers is important. Customers of providers include not only family planning clients but also fellow providers, managers, and other personnel who rely on the providers in order to do their work well. The COPE tools include a guide for conducting client interviews to help providers "break the ice" in getting client feedback. In many sites, providers have found the clients' views so interesting that they continue the practice, adding their own questions each time they conduct COPE. A second, very important part of customer interviews is setting a forum where supervisors ask the staff what they need to provide quality services. Supervisors say that thinking of the staff they supervise as their customers is a major breakthrough in seeing their role as facilitators, rather than as inspectors.

COPE Workplan Development

Once staff of a site have completed a COPE self-assessment, they take the findings and develop a workplan. The simple format for the workplan consists of four columns under which staff list the problems, pro-

2. The 10 IPPF Rights of Clients are the rights to information, to access, of choice, to safety, to privacy, to confidentiality, to dignity, to comfort, of continuity, and of opinion. The 10 IPPF Needs of Providers are the needs for training, information, infrastructure, supplies, guidance, back-up, respect, encouragement, feedback, and self-expression.

posed solutions or recommendations, persons responsible, and target completion dates. This workplan, including the identification of problems and solutions, is developed by group discussion among team members who participated in the self-assessment exercise. The facilitator guides the discussions and helps staff agree on the problems and practical solutions.

Some obstacles have been obvious to staff for a long time, and some solutions require simple, clear-cut problem-solving and more teamwork. Very often few additional resources are needed to solve problems.

Some problems require additional resources from the hospital or clinic administrator, and some need resources from headquarters. Involving site administrators and senior matrons in COPE helps in releasing resources to solve problems. Likewise, involving supervisors from headquarters when introducing COPE helps pave the way for more resources from the central level.

Some problems will keep recurring and will seem intractable. This is because the initial problem identified was a symptom of deeper problems. We believe this is natural and that staff can learn to address deeper problems as they gain more experience with COPE.

Although the management science of Total Quality Management (TQM) has developed many powerful tools and methods that can be useful for improving health care systems,³ it is important to keep the COPE tools simple in the initial stages so that staff at all levels can identify more easily with the process of self-assessment and with the issues that they themselves put in their follow-up workplans. As facilitators and supervisors gain more experience with COPE, we help them learn more sophisticated techniques to identify problems and solve their root causes.

Facilitative Supervision: The Missing Link

We have found in observing COPE done in many different sites that the workplans often produce similar lists of problems and recommendations. COPE uncovers two broad classes of needs: those that can be addressed by the local staff themselves with available resources and ingenuity, and those that require help from headquarters

or outside technical agencies. Included in the latter group are the need for improving the knowledge and skills of staff at *all* levels; the need for more financial, logistical, technical, and moral support from the service sites and their headquarters institution or government agency; and the need for more time and resources for supervisors so that they can give the necessary guidance to local sites and strengthen the links between service sites and central headquarters.

One of the most important contributions that donors and technical assistance agencies can now make is to help family planning institutions and governments to devote more resources to improving supervision, and to help supervisors learn the skills of facilitation, mentoring, and on-site training.

AVSC is working with its partners to improve supervision in several ways:

- We are encouraging and supporting programs so that there are more supervisors, fewer sites to cover per supervisor, adequate transport, and the time to spend two to five days at a service site during visits, rather than only a few hours.
- We are developing workshops where supervisors and trainers can improve their technical knowledge and skills and learn to become facilitators and mentors.
- We are encouraging family planning institutions and governments to select trainees who have the interest and capability to share new skills with their colleagues at the local site.
- We are working with donors and our partners to reprogram or augment some of the funds now earmarked for centralized training courses for trainee follow-up so that all trainees can receive supportive supervision at their service sites.
- We are working with our partners to design site training and to develop materials that support site training.

Site Training

COPE self-assessments have revealed several needs that cannot be solved independently by local providers and that must be

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3. Berwick et al. (1990) provide a good summary of the TQM techniques that can be used to improve the processes that are typical in health care systems.

addressed with the assistance of the headquarters of the national family planning institutions. COPE has shown that most staff at a local service delivery site need to improve their knowledge and skills to deliver or support family planning services. COPE has also uncovered the need to develop better local teamwork and to initiate or strengthen the linkages between the separated, but related, services at a site. Improving the knowledge and skills of all staff is not something that most sites can manage on their own. Yet it is not feasible to send everyone to central training sites, which, in any case, are often not oriented to field realities.

Thus, with our partners in several countries, we have begun to evolve the framework and methodologies for conducting what we call *site training*. As the name implies, site training carries with it the notion of reorienting the entire local service delivery site. Site training views the entire service delivery site as a system and treats staff as members of a team that make the system function. Thus, site training is a comprehensive intervention. It involves conducting at the service site itself a series of staff development activities for all or different categories of staff according to their needs. (These needs are usually identified during the COPE self-assessments or by supervisors.)

In the early stages, site trainings have been organized with the facilitation of AVSC staff and consultants working with headquarters supervisors and trainers from the umbrella institution and with the key providers and administrators of the local service sites. Eventually we envision that site training will become an essential function that supervisors and trainers will manage independently.

A site training may include a basic orientation to the family planning services for all staff at the site, contraceptive technology updates for service providers, skills training for counselors, and skills training for clinicians in IUDs, Norplant implants, and surgical sterilization skills. Supervisors who possess facilitative and training skills play a catalyst role in the training, using the talents and interests of site staff as much as possible. In Kenya, Uganda, and Tanzania, supervisors are already linking trained colleagues at the site level with untrained colleagues. The supervisor plays a key role in maintain-

ing standards by certifying surgical skills before trainees practice solo. To ensure that standards are maintained, the supervisors and trainers who are conducting site training rely on technical guidelines and instructional curricula that are available for family planning methods, surgery, counseling, infection prevention, and other skills.

RESULTS TO DATE

The verdict is still out as to whether the quality management approaches discussed in this paper will translate into service delivery systems that are reaching their full potential in serving the unmet demand that exists. As we have already suggested, installing quality management systems and improving quality is a long-haul process. Nevertheless, there have been many encouraging results and small victories that suggest we are probably on the right track.

- Staff at different levels in the institutions using COPE tell us that they now have a clearer idea of what quality means, especially in relation to their own jobs. We have witnessed frustrated service providers become excited and eager to do a better job in serving their customers.
- Staff also report that the COPE tools are useful, that they frequently use or refer to them, and that they refer to and update the workplans that they developed from the self-assessment exercises.
- The COPE methodology is effective in helping site providers to solve problems they identify. In one follow-up study, sites solved an average of 78% of identified problems. Client waiting times, a problem frequently identified by COPE, have been reduced by an average of 50% (Lynam et al., 1993).
- Many providers have told us that they like viewing their family planning patients as customers. They have found their talks with customers rewarding and in some cases, these talks have led to quick and inexpensive actions to respond to customer needs.
- Likewise, some supervisors report that they like thinking about local service providers as their customers. They report that helping providers to solve problems gives them satisfaction.

Site training carries with it the notion of reinventing the entire local service delivery site

- One of the most frequently reported benefits of COPE is the team-building that it generates within a service site, and the development of “inreach” linkages between different services that have been separated from one another—for instance, between the clinic that provides temporary methods and the sterilization service, or between the family planning clinics and postpartum or postabortion services (Lynam et al., 1994).
- Two major family planning institutions in Kenya—the Family Planning Association of Kenya and the Christian Health Association of Kenya—have restructured their quality assurance systems and adopted facilitative supervision and COPE self-assessment as cornerstones of their new systems.
- Finally, missions of the U.S. Agency for International Development in Kenya and Tanzania have recently expressed an interest in helping governments to improve supervision by providing support for more supervision teams, decentralization of supervisory teams, and a shift to on-site training.

CONCLUDING REFLECTIONS

We conclude this paper with a few reflections and caveats. We are now convinced that it is possible to install quality management practices that are based on simple technology and on practical approaches that work, and that busy providers and supervisors can master and will use. But the steps described in this paper are merely the first in a long journey.

When embarking on this journey, the entire institution, from top to bottom, must be committed to quality. We have not yet found easy ways for stimulating this total commitment by our partners. Technical assistance organizations like AVSC can only be a catalyst in helping interested agencies to find their own way. Certainly, AVSC cannot do it alone. It will help to develop this commitment if donors and technical agencies work together.

It merits repeating, yet again, that more supervision—and supervision that is supportive and facilitative rather than inspective—is critical. We emphasize this point in the national quality improvement work-

shops that we hold when discussing the cost of poor quality. As participants begin to realize the costs of dissatisfied clients, wasted staff skills due to lack of problem solving at the site level, errors in the management information reporting systems due to poor training and no supervision, and frequent stock-outs of commodities and essential expendable supplies, they agree that the cost of improving quality will be less than the resources now being wasted by poor quality and the absence of a functional supervisory support system.

We also must be prepared for some very hard work and investment in staff development. The development of facilitative supervisory capacities will be very hands-on, staff-intensive work for in-country institutions and technical assistance agencies. Likewise, doing effective facilitative supervision will require supervisors who have strong technical and interpersonal skills, who have patience and perseverance, and who are willing to spend time in the field.

A shift in the mindset of donors is also needed. The hope that donors could fund only up-front, short-term costs and avoid recurrent costs is being dashed by the reality that sustainable development will require sustained support for the critical elements of supervision and management. Such support will, however, leverage better use of the substantial local contributions and human resources that are now poorly used.

A shift in training models is also required. In the evolution of family planning programs in Africa, training has become divorced from supervision. In many programs, most training is done in central or regional training courses that often are conducted in ways and in settings that have little relevance to the local field conditions of service providers. We think that more, if not most, orientation and skills training should take place at the service delivery site, preferably focusing on local service delivery teams, rather than on individuals. In this vision of the future, facilitative supervisors and site staff with skills are the key trainers. Historically, much of medical training was colleague to colleague. It is time to return to this mentoring base and to put supervisors back into the picture.

Finally, we need to stop fragmented program development and to start focusing on

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We need to develop the comprehensive systems for service delivery that meet client needs

developing the comprehensive systems for service delivery that meet client needs. This will not be accomplished quickly, but the things we have talked about will foster a more holistic "systems approach." It will include moving away from centralized technical training for particular cadres of personnel to facilitative supervision and site training for the entire local service delivery team. It will also mean moving away from a project-centered mentality that has been driven by the separate and specialized agendas of donors and technical agencies; instead country counterparts, donors, and technical agencies will sit and plan together for a single comprehensive national program. Because the goal of all this work remains quality services that meet the needs of clients and that are used by them, the guiding principle for comprehensive national programs should be that whatever is done will make it possible for front-line service delivery sites to do their jobs better.

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* On October 1, 1994, the Association for Voluntary Surgical Contraception changed its name to AVSC International.