Quality of Care in Family Planning

A Catalog of Assessment and Improvement Tools

Karen Katz
Karen Hardee
Michele T. Villinski

Family Health International
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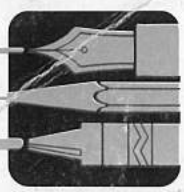

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NATIONAL FAMILY PLANNING BOARD
5 SYLVAN AVE., KINGSTON 5

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Family Health International
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1993

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Assessment Tools and Methods, continued

Improvement Tools

List of Acronyms Used in this Catalog

A.I.D.	United States Agency for International Development
APROFAM	FPA in Guatemala
AVSC	Association for Voluntary Surgical Contraception
CBD	Community-based distribution
CDC	Centers for Disease Control and Prevention
CEDPA	Center for Development and Population Activities
CEMOPLAF	FPA in Ecuador
CFA	Client Flow Analysis
CMS	Clinic Management System
COPE	Client-Oriented and Provider-Efficient
CQI	Continuous Quality Improvement
CSM	Contraceptive Social Marketing
DHS	Demographic and Health Survey
FP	Family planning
FPA	Family Planning Association
FPAK	Family Planning Association of Kenya
FPMD	Family Planning Management Development Project
FW	Field worker
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IPPF/WHR	IPPF, Western Hemisphere Region
JHU/PCS	Johns Hopkins University, Population Communication Services
MCH	Maternal and child health
MIS	Management information system
NFP	Natural family planning
OR	Operations research
PFA	Patient Flow Analysis
PQAT	Program Quality Assessment Tool
PROFAMILIA	FPA in Colombia
QA	Quality assurance
QOC	Quality of care
RTI	Reproductive tract infection
SDP	Service delivery point
SEATS	Family Planning Service Expansion and Technical Support Project
SOMARC	Social Marketing Project
SOP	Standard operating procedure
SQI	Service Quality Improvement
STD	Sexually transmitted disease
SWOT	Strengths, Weaknesses, Opportunities, Threats
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception

Acknowledgements

An endeavor such as this requires the time and cooperation of many people. The idea for this catalog came as a result of a survey conducted by Karen Hardee in collaboration with Maureen Norton and Cynthia Calla on the quality of care activities of A.I.D.'s family planning service delivery cooperating agencies. At FHI we would like to thank Theresa Burton, Jennifer Capps, Linda Francis, Lucy Harber, Lori Nicholson, and Cindy Waszak for their assistance on this catalog. We would also like to thank the EVALUATION Project's Working Group on Service Delivery and A.I.D. for endorsing the compilation of the catalog. We would especially like to thank the organizations and individuals who were enthusiastic about the need to gather these tools into one book and those who shared their tools--even those not published.

Introduction

Introduction

With the growing awareness of the significant role that quality of care plays in family planning service delivery, assessment of quality has emerged as an important issue in family planning programs. In order to measure quality of care, two fundamental questions need to be answered: What are the indicators which identify quality? How can these indicators be measured?

The quality of care (QOC) framework set forth by Judith Bruce in 1989 has helped programs focus attention on six elements of quality and has served as a starting point for assessing the quality of care received by clients from family planning programs. The six elements in the framework are: choice of methods, information to users, technical competence, client-provider interaction, continuity of care and appropriateness and acceptability of services (also known as constellation of services.)

Using the Bruce QOC framework as a base, work has continued to seek ways to apply the elements to program settings. The Subcommittee on Quality Indicators of the A.I.D. Task Force on Program Indicators, and more recently the Service Delivery Working Group of the A.I.D. EVALUATION Project and others, have drafted sets of indicators which can be used to measure quality elements (see the Quality of Care Indicators section of this catalog.) While these indicators provide guidance on what should be measured, they do not specify how.

Over the past few years, several tools have been developed to assess the quality of care programs offer. More recently some organizations have also designed tools which can be used to assess and improve quality. Most of these assessment and improvement tools have been developed by organizations for use in their own projects and while some of these tools have been field tested and results of the studies published, others have not. Consequently, program managers and providers who are seeking to assess and improve their services do not always have access to information about the tools which have been developed and used by other programs, and may not know what these tools can measure or how they can be used.

About the Catalog

The purpose of this catalog is to compile and present systematically the available tools to assess and improve the quality of services in family planning programs. The catalog is divided into three sections: quality of care indicators, assessment tools and improvement tools. Assessment tools refer to those methodologies which can be used to evaluate and monitor various aspects of quality of care; improvement tools define a process by which service delivery problems are identified and an improvement plan is designed and implemented. Examples of assessment tools are observation, patient flow analysis, focus group discussions, situation analysis and management information systems (MIS). Examples of improvement tools include COPE, Continuous Quality Improvement (CQI) and Service Quality Improvement (SQI).

For each tool, a descriptive summary is provided, including its advantages and disadvantages and examples of how the tool has been used. Attachments are provided when available to help clarify the use of the tool; citations are included for all examples used in summarizing each tool. While we have tried to make our descriptions as complete as possible, this catalog is meant to serve as a guideline, and we recommend that the source material be consulted for further information. For the assessment tools, we have also indicated which element(s) of quality of care the tool can measure. Those which measure all of the Bruce QOC elements are considered to be comprehensive tools.

Finally, we have provided a bibliography of all source material used, and an address list of the organizations whose work contributed to this catalog.

Studying Quality of Care

Deciding which tool or tools to use will depend on many factors, such as the specific research objectives, time and resources available and the skill level of personnel involved. From the examples given in the catalog it can been seen that many of the studies did not use just one methodology but a combination of them. Every assessment will have its own requirements and the methodologies will need to be adapted to the specific project.

This can be illustrated by the following example of an evaluation of service quality which was carried out by PROFAMILIA at eight clinics in Columbia.

> Quality was assessed on the basis of the six elements of the Bruce QOC framework. A variety of techniques were used, including focus group discussions, direct observation, interviews with current and former clients, and a review of medical histories or medical charts for clients who chose reversible methods or voluntary surgical contraception. The study found that quality varied according to clinic size in that large clinics were better at providing information to clients, while smaller clinics had better interpersonal relations and gave more of their clients complete physical examinations. According to clients, some important service qualities were good interpersonal relations, complete information on methods, clear instructions on how to proceed throughout the clinic visit and privacy. Providers stressed many of these same points, such as giving complete information, good interpersonal relations and privacy. Providers also noted the importance of an adequate number of personnel with well-defined roles and a surgery schedule that meets the needs of clients, not physicians.
>
> The study also concluded that, while focus group discussions with clients can often produce useful information on quality, sometimes budget and time constraints make focus groups impractical. The study also suggested that technical competence is better measured by professional supervision and monitoring than by client input. (Ojeda et al., 1992)

Other examples presented in this catalog also demonstrate the use of multiple methods to assess various dimensions of quality of care.

We have tried to gather as many examples of indicators and tools as possible for inclusion in this catalog. We recognize that numerous studies, including operations research studies, are currently being implemented using indicators or tools which we were not aware of when compiling material. We regret any such omissions but are confident that this catalog provides a good representation of studies in quality of care. We hope readers will find the catalog a useful resource and would appreciate receiving copies of tools and studies developed and implemented after this catalog is published.

Citations:

Bruce J. 1989. "Fundamental Elements of the Quality of Care: A Simple Framework." Population Council Programs Division. *Working Papers*, No. 1. May.

Ojeda G, E Prada, T Williams and LM Garzon. 1992. "Evaluation of Service Quality at Eight PROFAMILIA Clinics in Columbia." Presented at annual meeting of the American Public Health Association, Washington, DC. November.

Quality of Care Indicators

Quality of Care Indicators

The focus of this catalog is on the tools which can be used to assess and improve quality of care, but the importance of the indicators to measure quality cannot be overlooked. While the strength of the Bruce QOC Framework is that it focuses a program on key issues of quality for clients, the six elements are not mutually exclusive. Assigning operational definitions and compiling measurable indicators for each element is not an easy task. The validation of indicators which can adequately identify quality is critical to the development of measurement tools.

Four sets of indicators that were available for this catalog are included in this section. All of these lists are now being used in field assessments of quality of care in order to test their validity (Do they measure what they are supposed to measure?) and reliability (Do they yield the same results in repeated measures?). A summary of quality of care indicators for each of the Bruce QOC Framework elements, and the assessment tools in this catalog that can be used to measure them, is shown in Table 1.

The following sets of indicators are attached:

1. The A.I.D. Task Force on Program Indicators, Subcommittee on Quality Indicators produced a list of sample questions which can be used to assess each of the six elements of the Bruce QOC Framework. (A.I.D. Task Force, 1990)

2. The Quality Subcommittee of the EVALUATION Project Service Delivery Working Group not only provides indicators for each of the six elements but also identifies which indicators should be given highest priority and possible sources of data to measure each indicator (see Table 1 below). (EVALUATION Project, 1992)

3. García-Núñez developed a comprehensive guide for designing, implementing and analyzing an evaluation project. His book includes two field checklists of indicators to assess quality of care. His checklists include five of the six Bruce quality of care elements, omitting acceptability and appropriateness. He also adds two other elements: organization of services and service provider-donor interaction. (García-Núñez, 1992)

4. As part of a project designed to evaluate organizational development and management effectiveness in family planning organizations, the Family Planning Management Development Project (FPMD) developed a list of indicators to measure service quality. These indicators assess quality across three dimensions: service system, provider effectiveness and perceived quality. (FPMD, 1992)

Table 1: Quality of Care Indicators and Assessment Tools, by Element

Element	Indicators*	Methods and Tools in the Catalog
Choice of Methods	■ **number/range of methods available** ■ **provider refers clients elsewhere for methods unavailable at SDP** ■ **few restrictions placed on available methods** ■ **client receives chosen method** ■ number of methods approved for use at SDP ■ all methods appropriate to reproductive intentions offered to client by provider ■ client receives method appropriate to reproductive intentions	■ clinic management system ■ observation ■ focus group discussions ■ consumer intercept studies ■ structured interviews ■ MIS ■ simulated client studies
Information to Users	■ **provider gives in-depth information on method accepted** ■ **client correctly explains method chosen** ■ service providers trained in counseling skills ■ method-specific informational materials available ■ checklist available on information for provider to cover during counseling session ■ provider gives overview of all methods ■ privacy acceptable for counseling and exam ■ VSC consent form available and signed by client	■ observation ■ focus group discussions ■ structured interviews ■ panel studies ■ simulated client studies ■ DHS oversample ■ counselor training
Technical Competence	■ **existence of written guidelines on FP practice** ■ **provider can explain contraception: benefits, use, contraindications, side effects, management of side effects** ■ **provider demonstrates skill at clinical procedures** ■ **infection control procedures maintained** ■ **client receives an appropriate method** ■ existence of training criteria for service tasks, mechanism to screen potential service providers, and job descriptions ■ clinical provider has received relevant job training ■ new staff are trained in SDP guidelines ■ periodic refresher training for all staff ■ availability of appropriate basic items for delivering available methods ■ adequate frequency and content of supervision ■ capability for handling HIV, other STDs, and RTIs	■ clinic management system ■ observation ■ structured interviews ■ MIS ■ monitoring VSC procedures
Client-Provider Interaction	■ **provider established rapport for assessing client's personal situation** ■ **client reports feeling welcomed by staff, at ease asking questions, staff were polite** ■ service providers trained in interpersonal relations	■ observation ■ focus group discussions ■ structured interviews ■ simulated client studies ■ counselor training

Continuity of Care	■ **ease of resupply** ■ clients past due for follow-up are identified and contacted ■ reasons for non-return are identified ■ appropriateness of follow-up schedule ■ client encouraged to return as needed	■ clinic management system ■ MIS ■ panel studies ■ focus group discussions ■ observation
Acceptability and Appropriateness	■ **client perceptions of privacy for counseling and exam, waiting time, time with provider, clinic hours and days, staff (in terms of gender, ethnic group, age)** ■ **client perceptions of adequacy of waiting room, exam room, cleanliness/hygiene, water, toilet facilities**	■ client satisfaction studies ■ focus group discussions ■ panel studies ■ patient/client flow analysis ■ use and discontinuation studies
Comprehensive		■ matrix (CEDPA) ■ matrix (Enterprise) ■ operations research ■ Program Quality Assessment Tool ■ Quality Definition and Assessment ■ situation analysis ■ supervision tool (CARE) ■ SWOT analysis

Source of Indicators: The EVALUATION Project. 1992. Quality Subcommittee of the Service Delivery Working Group. "Indicators of Quality in Family Planning Programs." September 10.

* Indicators in bold are those judged by the EVALUATION Project Subcommittee to be "first priority" indicators for a shortlist. See page 15 of this catalog for the full text of these indicators.

Citations:

Agency for International Development (A.I.D.) Task Force on Standardization of Family Planning Program Performance Indicators. 1990. "Report of the Subcommittee on Quality Indicators in Family Planning Service Delivery." October.

The EVALUATION Project. 1992. Quality Subcommittee of the Service Delivery Working Group. "Indicators of Quality of Service in Family Planning Programs." September 10.

Family Planning Management Development Project. Evaluation and MIS Unit. 1992. *Evaluation Framework and Needs Assessment Guidelines for Family Planning Organizations.* MA: Management Sciences for Health. April 3.

García-Núñez J. 1992. *Improving Family Planning Evaluation: A Step-by-Step Guide for Managers and Evaluators.* CT: Kumarian Press.

Agency for International Development (A.I.D.) Task Force on Standardization of Family Planning Program Performance Indicators. 1990. "Report of the Subcommittee on Quality Indicators in Family Planning Service Delivery." October.

Appendix D

Sample Questions to Assess the Indicators

Element 1: Choice of Family Planning Methods

- To how many methods did the service providers have ready access? Were other methods available only under certain conditions (for example, locked away, with supervisor approval required)?
- How suitable were the methods for use (condition, expiration dates)?
- For clients: Did you get the method you wanted? Why or why not? Was your selection influenced by price? by the provider's recommendations?

Element 2: Technical Competence

- Were staff trained? How long ago?
- Were they certified if relevant?
- Do staff follow protocols? Do they know whether protocols are in accordance with accepted medical practices (national or international)?
- Are records kept on data such as morbidity and mortality information and numbers of failures? (Such data might include surgical complications, IUD perforations, and infection rates.) If so, these records can be reviewed to detect any problems related to lack of technical competence. Corrective actions can then be taken.
- Check supplies needed to maintain asepsis (e.g., disinfectants, gloves). Are sufficient supplies available? Are the most effective agents being used?
- Is equipment needed to maintain asepsis (e.g., autoclaves) in working order?

Element 3: Informing and Counseling Clients

Regarding quality of information given:

- Can the client accurately repeat the key information given?
- Is important information missing or misunderstood?

Regarding counseling:

- Did the client feel comfortable asking questions and bringing up concerns?
- Was the counselor responsive to the client's needs and feelings?
- Was sufficient information given to make a decision?

In observing counseling:

- Does the counselor ask open-ended questions that allow the client to provide information and ask questions?
- Were questions welcomed?
- Does the counselor recommend a contraceptive method, or is the client allowed to decide?
- Is there two-way communication, or does the counselor do most of the talking?
- Does the counselor present alternatives to the client?
- Does the counselor explore the client's feelings or fears?

Element 4: Interpersonal Relations

Regarding client-provider communications:

- Did the client perceive the opportunity to ask questions as real or pro forma?

- Were the client's questions and concerns heeded? Does the client have unanswered questions or remaining doubts?

Regarding client comfort:
- Are medical instruments at room temperature?

Regarding client time:
- Are appointments taken in order?

Regarding client/provider interactions:
- Are clients treated courteously?
- Do clients receive different treatment depending on their age, sex, social class, religion, or ethnicity?
- Do clients have an opportunity to ask questions and raise concerns?
- Are clients' values and feelings respected?

Element 5: Mechanisms to Encourage Continuity

- Is there a system in place for scheduling follow-up appointments at appropriate intervals for clients who accept new methods?
- Are those intervals realistic for use-defined testing periods for new methods (i.e., to counter the likelihood of a client's discontinuing a method after an initial trial period)?
- Are clients given information on what to expect from methods and warning signs of health risks?
- Do guidelines exist for CBD workers on follow-up and resupply?
- Do pharmacists and private outlets always maintain stocks of the same type of contraceptive? The same brand?
- Are clients encouraged to switch if they are having problems with their current method? Are they encouraged to resume after birth intervals?

Element 6: Appropriateness and Acceptability of Services

- Why did you come to *this* site for the service?
- Were you able to get the service you wanted? (Why not? What will you do next?)
- Are the times you can get services convenient for you? (What would be better days/hours?)
- Is the location convenient for you?
- How long did you have to wait before getting the service? Was this an acceptable amount of time?
- Was a sufficient amount of time spent with you? (Why not?)
- Did you feel you were treated courteously and with respect? (How so? Which category of staff did you find discourteous?)
- Do/did you have concerns about your privacy and confidentiality?

Regarding privacy:
- Are robes and/or drapes provided?
- Are exam rooms curtained?
- Do staff knock or ask permission before entering areas where clients are undressed?
- Do bathrooms have locks?
- Are confidential records maintained?
- Do you have questions or concerns that weren't addressed? (What are they? Why weren't these dealt with?)
- Do you plan to return to this site in the future? (Why not?) Would you recommend it to anyone? (Why not?)
- Are there other services you would like to see offered at this site?
- Do you have any other comments or suggestions for improving services?

INDICATORS OF QUALITY OF SERVICE IN FAMILY PLANNING PROGRAMS[1]

List Developed by Quality Subcommittee
Service Delivery Working Group
The EVALUATION Project
9/10/92

NOTES ON THE INDICATORS

The following list of indicators was developed and refined in light of the comments received with respect to an earlier list developed by the same Quality Subcommittee on June 17, 1992.

At the June 17th meeting the group agreed on the idea of limiting the number of indicators to arrive at a parsimonious list. Also, the group concurred that there are three levels for measuring indicators related to quality: (1) manager (referred to elsewhere as the "sub-systems" or "enabling systems"), (2) provider, and (3) client. These are interrelated, since certain inputs must be in place at the manager level (e.g., a full range of contraceptive methods in stock) to enable the provider to take the correct action (e.g., offer the client all methods that are medically appropriate), which can in turn be measured at the client level (e.g., by asking what methods were offered).

The rational for a short list of indicators was that it is not feasible for any one organization to measure 200 indicators on quality. Since a number of indicators could be measured at two or even three levels, it was decided to identify the level at which each indicator was most important and to include the item only once on the list. In most cases this was the client level. If results were satisfactory at the client level, one could assume adequate performance at the manager/provider levels. If deficiencies were found, one would then move back, first to the provider level, then to the manager level (or enabling systems) to identify the source of the deficiency in an effort to remedy the problem.

In the following list, the indicators are categorized according to the six elements of the Bruce Framework on Quality of Care. Those judged by the Subcommittee to be most important are shown by an asterisk and are presented in the chronological order in which they would be expected to happen in the service delivery setting.

Those not marked with an asterisk under the same element are presented in sequential order. In a number of instances, these consisted of indicators measuring the quality of the "enabling systems," which were considered to be of lower priority if only a short list of indicators could be measured. This is not to say that these are unimportant, but rather would not constitute the "first priority" indicators for a short list.

The right-hand column indicates the type(s) of data collection approach(es) that can be used to obtain data for each indicator. The codes are as follows:

AR = administrative (programs) records
CR = client record review
CS = client survey
FG = focus group
EI = exit interview with client
OB = observation (client-provider interaction, clinical procedure, etc.)
PS = provider survey

[1] The EVALUATION Project, Tulane University School of Public Health, minutes to the Quality Subcommittee meeting of The Service Delivery Working Group, September 10, 1992.

ELEMENT/INDICATOR		DATA COLLECTION APPROACH(ES)	
INTERPERSONAL RELATIONS			
1.	Provider establishes rapport for assessing personal situation (family circumstances, nature of sexual relationships)	OB, CS, EI, FG	*
2.	Client reports feeling:	CS, EI, FG	*
	a. welcomed by staff b. at ease/uncomfortable asking questions c. staff/providers were polite/rude		
3.	Service providers trained in interpersonal relations	AR, PS	
CHOICE OF METHOD			
4.	Number/range of methods available at SDP[2]	OB, AR	*
5.	Provider refers client for methods unavailable at SDP	PS, OB, AR	*
7.	Restrictions placed on available methods:[3]	PS, AR	*
	a. nonpermanent b. permanent (other than age 25+, parity 2+)		
8.	Client receives her/his method of choice[4]	CS, EI	*
9.	Number of methods approved (for use at the SDP)	AR	
10.	All methods appropriate to reproductive intentions[5] are offered to client by provider	OB, EI	
11.	Client receives method appropriate to reproductive intention	OB, EI, CS	

Note: a "*" indicates a priority indicator for the short list of indicators

[2] List of all methods physically available at the service delivery point (SDP) on the day of data collection. The indicator should be interpreted taking into account the number of methods approved for the country and appropriate to the type of SDP.

[3] For this indicator, more is not better.

[4] This indicator must be interpreted in connection with indicator # 24.

[5] Reproductive intentions refer to the desire for and preferred spacing of additional births.

INFORMING AND COUNSELING CLIENTS

12.	Provider gives in-depth information on method accepted: a. how it works b. how to use c. side effects d. complications e. managements of side effects f. followup g. resupply	OB	*
13.	Client correctly explains method chosen:[6] a. how to use b. what to do if side effects occur c. possible side effects d. when to return e. where to return	CS, EI	*
14.	Service providers trained in counseling skills (eliciting information, providing information)	AR, PS	
15.	Method-specific informational materials available (printed, model, sample, etc.)	OB	
16.	Checklist available on information for provider to cover during counseling session	OB, PS	
17.	Provider gives overview of all methods	OB, EI	
18.	Privacy acceptable for: a. counseling b. exam	OB	
19.	Consent form available and signed by client (VSC)	OB, CR	

TECHNICAL COMPETENCE

20.	Existence of written guidelines on FP practice	AR	*
21.	Provider can explain contraception:[7] a. benefits b. how to use/how it works c. contraindications d. side effects e. management of side effects and complications	PS	*

[6] Experience indicates that it may be difficult for interviewers to correctly record and assess the adequacy of responses given by clients. Although #12 and #13 are similar, a poor response on #13 does not necessaily mean that the providers' explanation was inadequate (#12), thus both are retained as indicators.

[7] "Can explain" refers to the ability to provide correct answers on a knowledge test. This is different from actually providing these explanations on the job (see indicator # 12, although #12 and #21 would be highly correlated).

22.	Provider demonstrates skill at clinical procedures (according to guidelines)	OB	*
23.	Infection control procedures maintained at SDP according to guidelines)	OB	*
24.	Client receives an appropriate method: a. not medically contraindicated b. appropriate for sexual lifestyle (including risk of STDs and HIV)	OB, CR	*
25.	Existence of education/training criteria for service tasks	AR	
26.	Existence of mechanism to review/screen potential service providers	AR	
27.	Existence of job descriptions for each position	AR	
28.	Clinical provider has received training relevant to the job	AR, PS	
29.	Training of new staff regarding institution's guidelines	AR, PS	
30.	Periodic refresher/in-service training of all staff	AR, PS	
31.	Availability of appropriate basic items for delivering available methods at SDP: a. sterilizing equipment b. gloves c. blood pressure d. specula e. adequate lighting	OB, PS	
32.	Adequacy of supervision: a. frequency b. content	PS, AR	
33.	Capability for handling HIV, other STDs, and reproductive tract infections (RTIs): a. diagnosis/identification b. treatment c. referral	AR, PS	

MECHANISMS TO ENSURE CONTINUITY[8]

34	Ease of resupply	OB, CS, EI	*
35.	Clients past-due for followup - identified	AR, CR	
36.	Clients past-due for followup - contacted	AR, CR	
37.	Reasons for non-return - identified	CS, FG	

38.	Appropriateness of followup/return schedule	CS, CR	
39.	Provider encourages client to return as needed	OB, EI, CS, FG	

APPROPRIATENESS AND ACCEPTABILITY OF SERVICES[9-10]

40.	Clients perceive that: a. privacy for counseling is acceptable/not b. privacy for exam is acceptable/not c. waiting time is acceptable/too long d. time with provider is acceptable/not e. hours/days are convenient/not f. staff is acceptable/not in terms of gender, ethnic group, age	CS, EI, FG	*
41.	Adequacy of facility (as perceived by client): a. waiting room b. exam room c. cleanliness/hygiene d. water e. toilet facilities f. _____ (other)	CS, EI, FG	*

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[8] Indicators #12-f, 12-g, 13-d, 13-e are also relevant to this element.

[9] Some would argue that "physical access" to the facility influences how acceptable it is to the client. However, under The EVALUATION Project, we have treated "access to services" as a separate (i.e. independent) dimension of the supply environment and thus have not included it on this list.

Another possible indicator of quality is affordability. However, this indicator has been excluded from this list on the grounds that the key dimension is not affordability per se, but value, which takes into account both quality and cost.

[10] Note: the client questionnaire should end with an open-ended question on other aspects of service that could be improved.

OUTCOMES:

Increase in number of new acceptors/users	CR
Complication rate for specific methods	CR,CS
Continuation rate (of any method)	CR,CS
New clients recommended by other users	CR
Users recommend service to someone else	CS
Clients achieves reproductive intentions	CS

García-Núñez J.1992.*Improving Family Planning Evaluation, A Step-by-Step Guide for Managers and Evaluators*. CT: Kumarian Press.

Table 12.5 Checklist to Assess Quality: Interview with and Observation of Service Provider

Quality of Care Elements	*Source of Data*		*Clinic/Health Post/ CBD Worker*	
	1. Interview Service Provider	*2. Observe Facilities*	*Name*	*Recommendations*
Choice of Family Planning Methods				
Which family planning methods does the clinic offer?	1. IS	1. OF		
Are other methods available under restricted conditions (for example, with written approval)?	1. IS			
Do service providers bias clients' selection of a method? How (limited offer of methods, preference for some methods)?		2. OF		
What methods are most often selected? Whey do clients choose those methods?	1. IS			
Information Given to Clients				
Does the clinic/CBD worker have posters, pamphlets? Does the clinic use audio visuals?	1. IS	2. OF		
Do the service providers spend time talking to clients before the service is provided?	1. IS	2. OF		
What are the conditions of client records? Does the clinic keep medical records? Does it send reports to supervisors (regularly)? Does it use records to order supplies?		2. OF		
During a counseling session: • Does the counselor respond to client's questions and concerns? • Is sufficient information given to client? • Are questions welcomed? • Is there two-way communication?		2. OF		
Technical Competence				
How many staff does this clinic have? (For CBD workers, put a "1" beside "CBD Workers.")	1. IS		____Doctors ____Asistants ____Nurses ____CBD Workers ____Other	
Are staff members (or CBD workers) trained? How long ago?	1. IS		No. of trainees Year ____Doctors ____ ____Nurses ____	
Do staff members have protocols? Do they use them?	1. IS	2. OF	____Assistants ____ ____CBD Workers ____	
Do staff members have job descriptions? Do they have a written work plan or scheduled FP activities?	1. IS			
What are the septic/aseptic conditions (cleanliness, physical appearance)?	1. IS	2. OF		

Table 12.5, continued

Quality of Care Elements	*Source of Data*		*Clinic/Health Post/ CBD Worker*	
	1. Interview Service Provider	*2. Observe Facilities*	*Name*	*Recommendations*
Interpersonal Relations				
How do staff members treat clients?		2. OF		
How long after a client's arrival does it take to complete a FP visit (average)?		2. OF		
Mechanisms to Encourage Continuity				
Is there a system in place to follow up clients?	1. IS	2. OF		
Do any staff go into the community to visit clients in their homes?	1. IS			
What is the client drop-out rate? What are the main reasons? Is this information in the files (check files)?	1. IS			
What is the staffing turnover? (For CBD workers, check at headquarters.)	1. IS			
Organization of Services				
Are all the facilities under one roof? Is electricity available in the room(s)? Is running water available?		2. OF		
Does this clinic offer MCH services?	1. IS			
What are the facilities to deal with side effects and problems? What is your assessment of these facilities?	1. IS			
Is the staff (or CBD worker) at work? Are they responsive to client needs? Do they attend clients promptly and properly?		2. OF		
Does this clinic have the equipment needed? Is the equipment in working condition (sterilizers, kidney dishes)?	1. IS	2. OF		
How many days per week are FP services available?	1. IS			
Do staff have some privacy when seeing clients?		2. OF		
Assess location of the clinic (or CBD worker): • What is the catchment area of the clinic or CBD worker (list districts, division)? • What is the main type of housing in the area? • What is the estimated population of the catchment area? • Is the clinic location (or CBD worker's site) safe; convenient?	1. IS			

Table 12.5, continued

Quality of Care Elements	*Source of Data* 1. *Interview Service Provider*	2. *Observe Facilities*	*Clinic/Health Post/ CBD Worker* *Name*	*Recommendations*
Organization of Services (continued)				
Assess supplies received at the clinic (or by CBD worker): • How many times in the last 6 months have you experienced a stock-out of contraceptives? • What suggestions do you have for managing commodities?	1. IS			
Assess technical assistance received at the clinic (or by CBD worker): • Did a supervisor come to observe FP work, inquire about problems, and provide suggestions during the past 3 months? • How many times? • What suggestions do you have to improve technical assistance?	1. IS			
Assess financial support received at the clinic (or by CBD worker): • Did the clinic receive the money it requested (or did you receive payment)? • Did it/you receive the funds on time?	1. IS			
Service Provider–Donor Interaction				
Assess supplies received at headquarters: • How many times in the last 6 months have you experienced a stock-out of contraceptives? • What suggestions do you have for managing commodities?	1. IS			
Assess technical assistance received at headquarters • Did a Pathfinder staff person come to observe FP work, inquire about problems, and provide suggestions during the past 3 months? • How many times? • What suggestions do you have for improving technical assistance from Pathfinder?	1. IS			
Assess financial support received at headquarters: • Did the clinic receive the money it requested? • Did it receive the funds on time?	1. IS			

Table 12.6 Checklist to Assess Quality: Interview of a Sample of Clients

Name of Interviewer/Observer	*Client*		
	1	*2*	*3*
Information and Counseling Given to Clients			
What IEC (posters, pamphlets) have you seen at the clinic (or were you given by a CBD worker)? Do you remember the main message?			
Did clinic staff (or CBD worker) explain the different FP options to you?			
Interpersonal Relations			
Client's perception of the services: • Did you come specifically for FP? • Did you get other services besides FP today? • Were you comfortable during exams? • Have you received the information and services you wanted? • Would you encourage a friend or a relative to use this clinic's services (or the services of this CBD worker)? • How satisfied are you with your visit today? • What suggestions do you have for improving FP services?			
Information and Counseling Given to Clients			
Client's perception of the waiting time at the service: • How long did it take you to complete your visit? • How many visits have you made in the last 12 months (include this one)?			
Mechanisms to Encourage Continuity			
Were you advised to return? Do you have a next appointment?			
In your previous 2 FP visits, were you attended by the same person?			
Organization of Services			
Are the clinic's (or CBD worker's) hours convenient for you; in what sense?			
What type of transportation did you use to come to the clinic (or CBD worker)? How long did it take you to reach the clinic (or CBD worker) from your house (in minutes)?			

Family Planning Management Development Project (FPMD). Evaluation and MIS Unit. 1992. *Evaluation Framework and Needs Assessment Guidelines for Family Planning Organizations.* MA: Management Science for Health. April 3.

B. QUALITY OF SERVICE INDICATORS

DIMENSION	COMPONENT	VARIABLE	INDICATORS
1. Service System	1. Accessibility	1. Cost of Access */	1. Time spent, means of transportation, cost of trip, distance.
		2. Fees	2. Amount paid
		3. Clinic Schedule	3. Days per week and hours per day services are provided for distribution of oral contraceptives.
	2. Supply	4. Inventory	4. Method in stock/ methods they should have
		5. Equipment	5. Examining table/ patient per day
	3. Environment	6. Hygiene	6. Provider washes hands between physical exam of clients.
		7. Provision of Privacy	7. Examination area: separate rooms; screen; none
		8. Basic Utilities	8. Running water (inside, outside, other), electricity, toilet
		9. Space	9. Patient flow/waiting, seating capacity.
	4. Staff	10. Clinical Staff	10. Clinicians per client per day
	5. Service Organization	11. Medical Records	11. System in place and accessible
		12. Service Statistic	12. New acceptors by methods
			13. Acceptance rates change
2. Provider Effectiveness	1. Technical Competence	1. Appropriate history, physical and therapy management	14. Age 15. Blood pressure 16. Smoking history 17. Treatment followed 18. Follow clinical protocol for contraceptive use
	2. Managerial Skills	2. Organization of time	19. Waiting time: difference between first visit and resupply of oral contraceptives

DIMENSION	COMPONENT	VARIABLE	INDICATORS
//	2. Managerial Skills	3. Management of system	20. Use of waiting time
		4. Accountability	21. Job description and performance review 22. Meeting performance standards
	3. Attitudes Toward Target Population	5. Cultural and ethnic tolerance 6. Sensitivity to women's issues	23. Caring 24. Respectful 25. Helpful
3. Perceived Quality	1. Clinical Service	7. Received appropriate information	26. Counseling 27. Methods described
		8. Decision making (client vs. provider)	28. Reasons for selecting the method
	2. Interaction With Providers		
	3. Result of Visit	9. Service received	29. Prescription of method 30. Obtained method 31. Scheduled appointment 32. Referral

Quality of Care Assessment Tools and Methods

NATIONAL FAMILY PLANNING BOARD
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Client Satisfaction Studies

QOC Element(s)

Acceptability and appropriateness

Description

Client satisfaction studies are used to gain the client's perspective on service delivery organizations, i.e., to find out what they like and what they don't like. Areas that can be examined include: choice of methods and method characteristics, accessibility and availability of services, clinic environment, client-provider interaction, involving clients in programs, and continuity of care. There is no single best method for measuring client satisfaction. A variety of methods have been used, including surveys, focus groups, direct observation and exit interviews.

Advantages

Most applicable methodologies are inexpensive, easy to use, and results can be quickly available. Evaluating client satisfaction is important since it can have significant impact on the success of a family planning program. Improving quality from the user's perspective could lead to increased numbers of new acceptors and improved continuation rates.

Disadvantages

Client satisfaction is difficult to measure. If a client is asked if she is satisfied, she will generally answer yes, whether she is or not. This answer can also indicate that expectations are low, not necessarily that quality is high. Therefore, direct questioning simply about "satisfaction" is seldom the best technique. Better measurement tools need to be developed to assess client needs and expectations.

Examples

1. In order to assess client satisfaction with NORPLANT provision in Bangladesh, a combination of interviews, focus group discussions and observation was used. Interviews were held with NORPLANT users and discontinuers, and with physicians and counselors. In addition, focus group discussions were held with counselors, and clinic activities were observed. The study found that about 90% of the clients were satisfied with the services they received and that their decision to accept NORPLANT had been made with a knowledge of other methods. Fewer clients than expected had heard negative rumors associated with NORPLANT. The 18-month continuation rate was found to be higher than the IUD continuation rate and more than half of current NORPLANT users said they would use it again. The survey found that some women who had side effects or complications were refused removal services by the clinics but that access to removal was not a widespread problem in the program. (Kamal et al., 1991)

Examples, cont.

2. IPPF/WHR affiliates in eight countries used a combination of exit interviews and focus group discussions to evaluate client satisfaction. Some of the problems identified were lack of privacy, long waiting times, inconvenient clinic hours and impersonal or unfriendly attitudes of some providers toward clients. (Helzner and Kopp, 1991)

Attachments

"Client Feedback" pp. 49-51. From Edmunds et al., 1987.

Citations

Edmunds M, D Strachan and S Vriesendorp. 1987. *Client-Responsive Family Planning: A Handbook for Providers*. MA: The Pathfinder Fund.

Helzner JF and SZ Kopp. 1991. "Quality of Care in Family Planning: Perspectives from IPPF/Western Hemisphere Region." Draft report. March 1.

Kamal GM, K Hardee-Cleaveland, and Barkat-e-Khuda. 1991. "The Quality of NORPLANT Services in Bangladesh." Final Report. Dhaka: ACPR. December.

Edmunds M, D Strachan and S Vriesendorp. 1987. *Client-Responsive Family Planning: A Handbook for Providers*. MA: The Pathfinder Fund.

Client Feedback

Qualitative information. The amount of qualitative information that can be collected is almost unlimited, and therefore requires some structure. Although the main question is whether the client is satisfied with the program, it is also necessary to determine the specific advantages and disadvantages of the program. It is useful to concentrate on program elements that can be changed, such as the behavior or performance of service providers, the physical appearance of the clinic or health center, or the hours that the clinic is open.

Here is a checklist of possible topics to discuss with clients (and dropouts):

Accessibility: Distance, location, transportation (availability, mode, cost, and time involved), hours of clinic or distribution post, cost of services and supplies

Availability and acceptability: Choice of methods, clinic procedures (waiting times, privacy, confidentiality, anonymity, special clinic routines), provider-related factors (technical knowledge, personality characteristics, similarity with clients, continuity), spousal involvement

Counseling: Counselor characteristics (knowledge, personality, skills), the counseling session, place of counseling, amount of information given, attention to rumors and fears

Follow-up: Frequency of follow-up contacts, nature of contacts (visit to or by service provider, type of assistance given)

The questions should determine how the client feels about the actual situation and what the client would like to see changed.

Methods to obtain qualitative information. The success of any family planning program is largely dependent on the clients' satisfaction with services. However, community leaders, traditional health providers such as healers and birth attendants, and the program staff also need to be satisfied with the services, the way they operate, and the effect they have on the community. It is therefore important to consult these people, in addition to individual clients, to get a complete picture of program effectiveness.

Individual interviews with clients: Several studies of in-depth interviews with small but representative samples of the client population have provided important information that revealed ways that programs were not client-responsive.[56] Individual interviews are time-consuming, and if done by highly trained experts, may be costly. For programs that serve large populations or large geographical areas, it may be better to use group interviews instead.

Centro de Pesquisas de Assistencia Integrada a Mulher a Crianca (CPAIMC), a family planning organization in Rio de Janeiro, Brazil, began a study in 1983 to examine the factors that affected approval for and follow-through of female voluntary sterilization. They wanted to identify possible problems and barriers that might keep women who were approved for surgery from undergoing the actual procedure. They interviewed clients individually and found that some of the requirements (such as obtaining necessary documentation) and the required use of effective contraception during the waiting period (between approval and actual surgery) did complicate the process, and caused some motivated women to drop out.[57]

This study shows how client feedback can be used to study clinic procedures and provide program managers with information from a client's perspective: it showed how routine requirements had become major obstacles for some clients. The results of the study will allow the staff to look closely at present procedures and requirements, and to examine which ones could be changed in order to make services more acceptable and accessible for the clients.

Group interviews with clients: One type of group interview is focus group research (See Appendix E). A lot of information about the program can be gathered in a short time from groups of people who have something in common (such as married women, married men, unmarried men or women, teenagers, pregnant or lactating women). Focus group research should show how the various groups feel about the services they received. Informal group interviews, such as discussions with members of an acceptors' club or clients in a waiting room, can also provide useful information.

Periodic reports: Periodic descriptive reports from fieldworkers, supervisors, counselors, or other service providers are also a way to gather information. A qualified person can be hired to visit field sites and talk to clients, staff, and community leaders, for a specific amount of time every year. Qualitative information can also be collected as part of the routine follow-up tasks of fieldworkers or clinic staff by supplying them with a shorter version of the checklist given earlier.

Interviews with community leaders or groups: Aside from formal or informal talks with community leaders about the way the program affects the community, it may also be a good idea to talk to groups like mothers' or acceptors' clubs. These groups can give important feedback about a program if clients are shy or not used to expressing negative concerns directly to the program staff. If these groups meet regularly, discussions may reveal the members' concerns. Staff members or fieldworkers who are trusted by, and preferably part of, the community should be encouraged to go to these meetings. They will stay informed (and will be able to inform the program management) about the program's performance, the peoples' needs and preferences, and how changes in the program are perceived.

Interviews with local traditional health providers: It is a good idea to talk with traditional healers and traditional midwives during evaluation, especially if they were not involved in program planning. Discussions with them can provide useful information about the community and their experience with locally-accepted health practices, and may reveal why a program is not as successful as predicted.

Traditional health providers usually have high social status and are trusted within the community. Their opinions about a program may mean more to a client than a program's education campaign or the words of a family planning counselor. Because traditional midwives may see family planning as a threat to their work, they may not support a family planning program, which is understandable. One program in Egypt failed completely because of the resistance of local midwives who saw the program as a threat to their income.[58] Interviewing traditional providers during evaluation may help explore what roles they could have played in the program, increasing the chances for program success while maintaining an active community role for the traditional providers.

Clinic Management System

QOC Element(s)	**Choice of methods, technical competence, continuity of care**
Description	Software developed by IPPF/WHR which includes modules for basic client history, voluntary surgical contraception, cash and inventory control, and report writing. The computerized clinic management system (CMS) enables managers to collect clinic statistics on clients, service providers and clinic services.
Advantages	While service statistics generally only provide an aggregate picture, CMS allows the analysis of individual client histories. System can track no-shows and can generate items such as appointment or pap smear reminders.
Disadvantages	Establishing a CMS system is a complicated undertaking. Requires substantial time and resources to develop system to a point where data are available and useful.
Examples	Used by three family planning associations of IPPF/WHR. APROFAM in Guatemala has noted several examples of how CMS has helped improve quality of care: 1. Can help detect provider bias by looking at method distribution by service provider. 2. Can monitor technical competence by linking complications related to a technical intervention (e.g., surgical procedures and IUD placement) with provider. 3. Can keep track of method switching patterns and continuation rates. 4. Estimated that CMS gives counselors 20% more time since some tasks are now done by data entry personnel. Believes this has helped improve staff and client interpersonal relations. 5. Can estimate future stock requirements through the CMS appointment system by identifying the methods needed for continuing clients and assessing new acceptor trends. This data is available through statistical reports. (Helzner and Kopp, 1991)
Attachments	Types of data collected by CMS, types of CMS reports. From IPPF.

Citations

Helzner JF and SZ Kopp. 1991. "Quality of Care in Family Planning: Perspectives from IPPF/Western Hemisphere Region." Draft report. March 1.

Kaufman J and C Marquette. 1992. "Report on the Meeting on Quality of Care and Clinic-Based MIS." NY: The Population Council. January 30. (Computerized Clinic MIS presented by Leslie Varkonyi, IPPF and Ricardo Rossal, APROFAM/Guatemala)

Kaufman J and C Marquette. 1992. "Report on the Meeting on Quality of Care and Clinic-Based MIS." NY: The Population Council. January 30.

Type of Voluntary Surgical Contraception Data Collected by CMS[1]

Field Categories	Standard, Pre-Defined Fields	User Defined Fields (in APROFAM/Guatemala)
System identification of clients	Client Identification No. Alternate System Code Last Name Middle Name First Name Date of Birth	Not applicable
Basic Client Data	Sex Age Address City Marital Status Telephone, if applicable Referred by Zone of Residence	Education Religion Traditional Indigenous Clothing Language Ethnic Group Official Id Number Place of Work/Occupation Monthly Income Amount of Client Contribution
Clinical Information	Date of 1st Family Planning Visit First Day of Last Menstruation Date of Last Delivery or Abortion Outcome of Last Pregnancy No. of Pregnancies No. of Living Children Do you want more children?	Permission to Contact via Mail No. of Living Male Children No. of Living Female Children No. of Total Living Children Knowledge of Other FP Methods Last Method Used No. of Months Last Method Used Side effects of Last Method Primary reason to accept VSC How long have you known about VSC? How long did it take to decide? Staff or private physician assigned
Surgical Information	Date of Surgery Date of Next Visit Surgeon Anesthesiologist Timing of Procedure (Post Partum) Surgical Technique Duration of Procedure Method of Occlusion	Complications Date of pap smears or sperm count

[1] Up to thirty fields maybe defined by the user within the Surgical Methods Feature. As many as twenty options or codes may be associated with each field through the use of tables.

Type of Reversible Family Planning Data Collected by CMS[1]

Pre-defined Fields	Standard, Pre-Defined Fields	User Defined Fields (in APROFAM/Guatemala)
System identification of clients	Client Identification No. Alternate System Code Last Name Middle Name First Name Date of Birth	Not Applicable
Basic Client Data	Sex Age Address City Marital Status Telephone, if applicable Referred by Zone of Residence	Education Ethnic Group Religion Type of Visit Age of Partner/Spouse
Clinical Information	Date of Last Delivery or Abortion Outcome of Last Pregnancy No. of Pregnancies No. of Living Children Do you want more children?	Not Applicable
First Visit	Date of First Visit Method Used Method Requested Attended by : Service Provider Method Adopted	Not Applicable
Last or Most Recent Visit	Date of Last Visit Method Adopted Date of next visit Reason for method change Date of method change Attended by : Service Provider Total No. of Visits	Not Applicable
DropOuts	Reason for Method termination Date of Termination	Not Applicable

[1] Up to thirty fields may be defined by the user within the Reversible Methods Feature of the system. As many as twenty options or codes may be associated with each field through the use of tables.

Type of CMS Reports

Module	Table Distribution		Pre-Defined Reports	The Report Generator (User Defined)
	REVERSIBLE METHODS	SURGICAL METHODS		
History Clinic	- Marital Status - Referred by - Zone of residence - Last pregnacy - Last method used - Method requested - Reason of method change - Reason of method termination	- Marital status - Referred by - Zone of Residence - Surgcal Technique - Type of Anesthesia - Method of occlusion	- Acceptors by method and age group - Acceptors by service provider - Acceptors per individual service provider - Service by type & age group - Couple year of protection by method & clinic.	With the selection of any field defined in the database, the user can define the report columns, the order of presentation and the conditions or criteria for data selection. Additionally, the system's parameter screen permits the definition of headings, report format (LOTUS, SPSS, Dbase), frecuency analysis and sub-total breaks.
Inventory Reports	Not Available		- Inventory Value - Expiration Date Control - Stock Balance - Minimum & maximum stock analysis - Supplier Control - Detailed listing of inventory deliveries, distributions and balance	
Income Reports	Not Available		- Comparative Income analysis by income type - Incomes for a specific period - Product and services by client type - Comparative analysis of income by clinic - Detailed income transaction listing for cashier's report	

Consumer/Client Intercept Studies

QOC Element(s)	**Choice of methods**
Description	An intercept study is a market research technique for gathering data on a sample of people who use a particular product (e.g. a specific contraceptive method) at the place where they obtain the product.
Advantages	A way of interviewing a population which would be hard to reach through traditional probability sample surveys. Selecting an intercept site enables the interviewer to quickly locate the designated sample population.
Disadvantages	Difficult to interview people in busy, public places. High rates of non-response. Results cannot be projected to population as a whole.
Examples	In the Dominican Republic, intercept interviews were used in combination with in-depth home interviews to evaluate the effectiveness of a social marketing program conducted by SOMARC and aimed at promoting low-cost oral contraceptives (Microgynon). Intercept interviews were performed at a sample of pharmacies in Santo Domingo. The pharmacies were selected based on their high levels of sales of Microgynon and because they represented a cross-section of socioeconomic groups in the city. Sales clerks at the selected pharmacies asked all those purchasing Microgynon if they would provide the following three pieces of information: the intended user of the product, prior contraceptive use and length of time of Microgynon use. They were also asked for their addresses, which most provided. A trained interviewer then made home visits, brought promised educational materials, and asked if the purchaser would answer some more questions. The survey found that the television marketing campaign was reaching its target audience of young, lower-middle class, low parity women. It also found that the marketing campaign was successful in attracting first-time contraceptive acceptors and was thereby expanding the contraceptive market. (Green, 1988)
Attachments	None.
Citations	Green EC. 1988. "A Consumer Intercept Study of Oral Contraceptive Users in the Dominican Republic." *Studies in Family Planning* 19,2:109-117.

Counselor Training Evaluation

QOC Element(s)	**Information to users, client-provider interaction**
Description	Measures the level of family planning counseling skills through the following indicators: **G**reeting the client, **A**sking about the client's needs or interests, **T**elling the client about family planning methods accurately and completely, **H**elping the client make a decision, **E**xplaining thoroughly about the method chosen, and **R**emembering to schedule a return appointment (**GATHER**). Also examines the availability of IEC materials and evaluates the extent to which they are used in counseling sessions.
Advantages	Can be used to assess proficiency in counseling skills to pinpoint areas for further training. Observation checklist provides a comprehensive look at client-provider interaction in a clinic or CBD setting.
Disadvantages	This tool assesses the quality of counseling skills, but training must be made available to providers to correct any weaknesses and to reinforce strengths.
Examples	Used in Kenya by the Family Planning Association of Kenya, with technical assistance from Johns Hopkins University, Population Communications Services as part of a long-term IEC project. A baseline survey to evaluate family planning counseling was carried out in 25 clinics or CBD sites. Providers were observed and an observation checklist completed, and exit interviews were conducted with new and continuing clients. The degree to which IEC materials were used was also examined. The results of the survey showed that the Kenyan providers performed adequately in greeting, helping, asking and remembering. They were found to be deficient in telling about the methods and in explaining how the method should be used. Some differences were also found between the clinic providers and CBD agents. For instance, CBD agents were more likely to discuss client concerns and partner attitudes, and clinic providers were more likely to encourage the client to participate in the decision-making process. Finally, though an inventory of IEC materials showed that materials existed, the providers did not make much use of them during consultation sessions. Another survey will be conducted upon completion of the project to evaluate the impact of providing counseling training. (Kim et al., 1992; JHU/PCS and FPAK, 1992)
Attachments	"Observation Checklist of Interaction Between New FP Client and Service Provider." From JHU/PCS and FPAK.

Citations

Johns Hopkins University Population Communications Services (JHU/PCS) and Family Planning Association of Kenya (FPAK.) 1992. "Quality of Family Planning Counseling for Community-Based Distribution Agents and Clinic Providers in Kenya." Presented at annual meeting of the American Public Health Association. Washington, DC. November.

Kim YM, L Gaffikin and E Landry. 1992. "Pilot Test using Training Evaluation Indicators in a Quality of Family Planning Counseling Study in Kenya." Presented at the Subcommittee Meeting, The Training Working Group, The EVALUATION Project. November.

Johns Hopkins University Population Communications Services (JHU/PCS) and Family Planning Association of Kenya (FPAK.) 1992. Quality of Family Planning Counseling for Community-Based Distribution Agents and Clinic Providers in Kenya. Presented at annual meeting of the American Public Health Association. Washington, DC. November.

KENYA
OBSERVATION
NEW CLIENT
CLINIC/CBD
Baseline study

(Do not fill in)
Serial Number ( ) _ _ _

INSTRUMENT A

OBSERVATION CHECKLIST FOR INTERACTION BETWEEN NEW FP CLIENT AND SERVICE PROVIDER

Instruction to the Research Assistant

For clinic provider;
ASK QUESTIONS 1 and 2 BEFORE YOU DECIDE TO OBSERVE

For CBD;
ASK QUESTION 2 BEFORE YOU DECIDE TO OBSERVE

1) Did the client attend this clinic for the first time today for modern family planning services? (circle)

1. Yes --- Ask question No. 2
2. No --- Do not observe this client with this instrument

2) Has the client ever used any modern contraceptive method ? (circle)

1. Yes --- Do not observe this client with this instrument
2. No --- Go ahead with the observation

3) Name of study site:_____Study site ID No.:_____

4) Name of Research Assistant:_____ RA ID No.:_____

5) Name of the Supervisor:(Do not fill)_____

5a) Review Date: Month_____/Date_____/1991

6) Observation No. (Circle): 1 2 3 4 5 6 7 8 9 10

NOTE: If there are two service providers interacting with the same client, circle the same observation number

7) Date of observation: Month_____/Date_____/1991

Source: The Johns Hopkins University Center for Communication Programs
Family Planning Association of Kenya

8) Starting time of the observed FP consultation session: _____

9) Ending time of the observed FP consultation session: _____

10) Duration of the consultation session: _____ Minutes

11) Language used: _____

12) Is the consultation session taped? (circle): 1. Yes 2. No

13) Name of the service provider observed:
_____

14) Service provider ID No.
(Do not fill in): _____

15) Sex of Service provider (Circle): 1. Male 2. Female

16) Type of service provider (Circle):

1. CBD
2. Registered Nurse
3. Enrolled Nurse
4. Counsellor
5. Medical Doctor
6. Other _____

17) Name of the Client_____

18) Sex of the client (circle): 1. Male 2. Female

19) Client clinic number (If any):_____

20) Client ID No. (Do not Fill in): _____

At the beginning of the consultation, did the service provider (Circle):

21) Greet the client? 1. Yes 2. No

22) Show friendly gestures? 1. Yes 2. No

During the consultation today, did the service provider ask (check) the client about his/her (Circle):

23) Medical history? 1. Yes 2. No

24) Previous family planning experience? 1. Yes 2. No

25) Knowledge about modern FP methods which he/she already know before he/she attended this session? 1. Yes 2. No

During the consultation today, did the service provider ask (check) the client about his/her (Circle):

26) Interest in a particular contraceptive method, for possible adoption? 1. Yes 2. No

27) Concerns about using a modern method? 1. Yes 2. No

28) Spouse/partner involvement with a modern FP method? 1. Yes 2. No

29) Ability to read the names of, and, instructions for FP methods? 1. Yes 2. No

During the consultation today, how did the service provider discuss each of the following?

WRITE 1, 2 , 3 or 4 IN EACH BOX:

1 represents "Discussed Correctly and Completely"
2 represents "Discussed Correctly but not Completely"
3 represents "Discussed Incorrectly"
4 represents "Not Discussed"

	30) Pills	31) Injec-table	32) IUCD	33) Foam	34) Diap-phram	35) Con-dom	36) Tubal lig.	37) Vase tomy	38) Nor plt
a) How it works									
b) How to use									
c) Advantages/ Benefits									
d) Contra indications									
e) Potential side effects									
f) Management of side effects									

39) Did the service provider give any misinformation, regarding contraceptives? 1. Yes 2. No

40) If yes, please specify:

_____

_____

_____

While the client was deciding to adopt an FP method, did the service provider (circle):

41) Discuss the client's present health condition? 1. Yes 2. No

42) Probe the client's reasons for seeking modern FP method? 1. Yes 2. No

43) Find out the attitude of the client's partner(s) about using FP method? 1. Yes 2. No

44) Communicate his/her understanding of the client's particular FP need? 1. Yes 2. No

45) Acknowledge and respond the client's concerns, if any? 1. Yes 2. No

46) Ask what concerned the client about using an FP method? 1. Yes 2. No

47) Give any opportunity for the client to express any misconceptions which he/she may have? 1. Yes 2. No

48) Clarify the client's FP misinformation or misconceptions, if any? 1. Yes 2. No

49) Explain the reasons why some methods may not be appropriate for the client? 1. Yes 2. No

50) Encourage the client to participate in choosing the method? 1. Yes 2. No

During the consultation session:

51) Did the service provider show any bias for or against FP method? (circle) 1. Yes 2. No

52) If yes, name the method(s) in which the provider showed bias:

_____

53) If a bias for a particular FP method was shown, was a reason given? 1. Yes 2. No

53a) If yes, what was the reason?

_____

_____

54) Did the client choose a method today? (circle): 1. Yes 2. No

55) Which method(s) did the client choose today?:

_____

_____

56) Was the chosen method given to the client? 1. Yes 2. No

If yes, which method(s) was given to the client today?:

_____

57) If no, what were the reasons explained for not giving:

_____

_____

After the client chose a modern FP method, did the service provider (Circle):

58) Explain how the chosen method works in detail? 1. Yes 2. No

59) Demonstrate how to use correctly the chosen method (in case of pills, condom, foam, diaph.)? 1. Yes 2. No

60) Explain how to deal with possible problems related to its use? 1. Yes 2. No

61) Use any printed/audio visual material? 1. Yes 2. No

62) Explain any possible side effects? 1. Yes 2. No

63) Give out booklets/leaflets to take home? 1. Yes 2. No

63a) If yes, specify the booklet/leaflets (Title and publisher):

_____

64) Ask the client to repeat important instructions? 1. Yes 2. No

65) Give a" back-up" FP method (If applicable)? 1. Yes 2. No

66) Give an appointment for service of the chosen method (in the case of IUCD,injectable TL, vasectomy, norplant), (if applicable)? 1. Yes 2. No

After the client chose a modern FP method, did the service provider (Circle):

67) Refer the client for a service other than FP services (if applicable)? 1. Yes 2. No

68) Give a follow-up appointment? 1. Yes 2. No

69) If yes, when is the next appointment? (Either put date or time period)_____

70) Tell the client to come back if he/she has any problem, even before the follow-up appointment? 1. Yes 2. No

During the consultation session today, did the service provider use (circle) (If yes, write down the name and description of the materials):

71) Leaflets/booklets on FP methods? 1. Yes 2. No

_____

72) Flip chart on FP methods? 1. Yes 2. No

_____

73) Posters on FP methods? 1. Yes 2. No

_____

74) Samples of contraceptives? 1. Yes 2. No

_____

75) Anatomical models? 1. Yes 2. No

_____

76) Others (Specify)? 1. Yes 2. No

_____

During the consultation, did the service provider? (circle):

77) Talk loud enough for the client to hear well? 1. Yes 2. No

78) Use language which the client understands easily? 1. Yes 2. No

79) Use simple words and expressions during the consultation? 1. Yes 2. No

80) Use a kind and pleasant tone of voice? 1. Yes 2. No

81) Was the service provider distracted or interrupted by noise or people walking in the room? 1. Yes 2. No

82) Arrange for privacy during consultation? (circle):

1. Yes, completely
2. Yes, but partially
3. No

During the consultation, did the service provider (circle): (If you can not observe find out whether the examination took place)

83) Check the blood pressure? 1. Yes 2. No

84) Measure weight? 1. Yes 2. No

85) Give breast examination? 1. Yes 2. No

86) Give pelvic examination? 1. Yes 2. No

87) Check urine sugar? 1. Yes 2. No

88) Pap Smear examination 1. Yes 2. No

89) Report back to the client the results of these physical examinations? 1. Yes 2. No

89a) Specify the results of the physical examinations which were explained? 1. Yes 2. No.

89b) Use the results to help the client choose a method ? 1. Yes 2. No

Demographic and Health Survey (DHS) Oversample

QOC Element(s)	**Information to users**
Description	Takes advantage of a country's DHS by adding questions to answer a particular study question. The expanded questionnaire is administered to a selected group by oversampling the survey population.
Advantages	Structure is already in place for the survey. Other information is already included in the DHS survey, such as sociodemographic data, so only questions pertaining to the specific research objective need to be asked.
Disadvantages	Requires the approval of the DHS.
Examples	Used by SOMARC in Bolivia. Twenty-three questions were added to the DHS to evaluate the effectiveness of their Contraceptive Social Marketing (CSM) campaign. Results indicated that the CSM-sponsored television campaign had improved the population's knowledge of maternal health and birth-spacing but not of oral contraceptives and their correct use. The results also demonstrated that the advertising material promoting a specific brand of oral contraceptives had not been effective. (Tipping and Allen, 1992)
Attachments	None.
Citations	Tipping S and H Allen. 1992. "Use of DHS-SOMARC Data in Decisionmaking: La Paz, Bolivia Oversample." SOMARC Occasional Papers, Number 14. March.

Focus Group Discussions

QOC Element(s)

Client-provider interaction, choice of methods, information to users, acceptability and appropriateness, continuity of care

Description

Focus group discussions are open discussions on a planned topic led by a facilitator. A guide for the discussion is developed on the basis of research objectives, though order is not rigidly fixed. Facilitator leads discussion to ensure all topics are covered and that everyone can participate. Group members are usually of similar age, sex, race and socioeconomic background. Groups should be small so that everyone has a chance to speak and so that facilitator can maintain focus. Discussions should be tape recorded to facilitate analysis. Focus group discussions can be used independently or in conjunction with survey research.

Advantages

Provides in-depth information about behavior and attitudes. Informal atmosphere can uncover information which may not be articulated within a more formal structure. Useful in questionnaire design by helping to formulate questions and develop vocabulary. Relatively inexpensive research tool. Can help clarify problems, add to information about a community's knowledge, attitudes and practices and help develop new research ideas for future studies.

Disadvantages

Some participants may be inhibited while others may be prone to exaggerate. Should not be considered a substitute for quantitative research. Facilitators should be trained in focus group research. Members are not necessarily representative of the larger population.

Examples

1. Focus group discussions were used in conjunction with quantitative methods to identify barriers to utilization of family planning and family health services in Burkina Faso. Focus groups were used to confirm the acceptability of survey questions and topics. Also, discussions found that although men and women generally have positive feelings toward family planning, men were concerned more for economic reasons whereas women were concerned about health issues. The women also pointed out that couples have a hard time communicating with each other on such topics. (McGinn, 1987)

2. Focus group discussions were used in Egypt to help explain findings from two previous studies of continuation, discontinuation and correct use of oral contraceptives. Discussions with women using oral contraceptives and discontinuers found women make numerous errors when taking the pill, including forgetting or running out of pills, not knowing how long to wait between pill packets, not taking

Examples, cont.

them because of side effects or believing they don't need to take them (e.g., if their husband is away). Some of these errors resulted from reliance on family, friends and neighbors for information, not receiving information from professional providers because they bought pills over the counter, and lack of confidence in physicians. Focus group discussions with providers confirmed that pill users do not receive the information, care or support they need to use oral contraceptives correctly and consistently. Providers did not have complete information on some topics, such as how long to wait between 21 and 28 day pill packs, how to compensate for 3 missed pills, when a back-up method is necessary and confusing the difference between side effects and contraindications.
(Loza et al., 1991)

Attachments

"Which to Use: Focus Groups or Individual depth interviews?," "Checklist for Setting Up Focus Groups" and "Summary of Key Steps in Conducting Focus Group Research". From Debus, 1988.

Citations

Debus M. 1988. *Methodological Review: A Handbook for Excellence in Focus Group Research.* Washington, DC: Academy for Education Development HEALTHCOM.

Folch-Lyon E and JF Trost. 1981. "Conducting Focus Group Discussions." *Studies in Family Planning* 12,12:443-447.

Loza S, H Sayed, and L Potter. 1991. "Oral Contraceptive Compliance and Continuation in Egypt: Complementary Findings of DHS and Focus Group Research." Presented at the annual meeting of the Population Association of America, Washington D.C. March 20-24.

McGinn T. 1987. "Pre Survey Focus Groups in Burkina Faso." Working Series Paper, Center for Population and Family Health, Columbia University, NY.

Schearer SB. 1981. "The Value of Focus Group Research for Social Action Programs." *Studies in Family Planning* 12,12:407-408.

Scrimshaw S and E Hurtado. 1989. "Focus Groups" in *Rapid Assessment Procedures.* Tokyo: UN University.

Debus M. 1988. *Methodological Review: A Handbook for Excellence in Focus Group Research.* Washington, DC: Academy for Education Development HEALTHCOM.

TABLE 2-1
WHICH TO USE: FOCUS GROUPS OR INDIVIDUAL DEPTH INTERVIEWS?

Issue to consider	Use focus groups when...	Use individual depth interviews when...
Group Interaction	interaction of respondents may stimulate a richer response or new and valuable thoughts.	group interaction is likely to be limited or nonproductive.
Group/Peer Pressure	group/peer pressure will be valuable in challenging the thinking of respondents and illuminating conflicting opinions.	group/peer pressure would inhibit responses and cloud the meaning of results.
Sensitivity of Subject Matter	subject matter is not so sensitive that respondents will temper responses or withhold information.	subject matter is so sensitive that respondents would be unwilling to talk openly in a group.
Depth of Individual Responses	the topic is such that most respondents can say all that is relevant or all that they know in less than ten minutes.	the topic is such that a greater depth of response per individual is desirable, as with complex subject matter and very knowledgeable respondents.
Interviewer Fatigue	it is desirable to have one interviewer conduct the research; several groups will not create interviewer fatigue or boredom.	it is desirable to have numerous interviews on the project. One interviewer would become fatigued or bored conducting the interviews.
Stimulus Materials	the volume of stimulus material is not extensive.	a larger amount of stimulus material must be evaluated.
Continuity of Information	a single subject area is being examined in depth and strings of behaviors are less relevant.	it is necessary to understand how attitudes and behaviors link together on an individual pattern basis.
Experimentation with Interview Guide	enough is known to establish a meaningful topic guide.	it may be necessary to develop the interview guide by altering it after each of the initial interviews.
Observation	it is possible and desirable for key decision makers to observe "first-hand" consumer information.	"first-hand" consumer information is not critical or observation is not logistically possible.
Logistics	an acceptable number of target respondents can be assembled in one location.	respondents are geographically dispersed or not easily assembled for other reasons.
Cost and Timing	quick turnaround is critical, and funds are limited.	quick turnaround is not critical, and budget will permit higher cost.

A SUMMARY OF KEY STEPS IN CONDUCTING FOCUS GROUP RESEARCH

1. ***Define the subject matter*** – the research question or problem – and specify the research objectives. Be sure the research findings are actionable and relevant to program planning or decision making.
2. ***Verify the method.*** Be sure that the objectives of the research are best met by conducting focus groups and not by some other type of research. Refer to the selection grids.
3. ***Define the qualifications of the research respondents.*** Be specific. List all of the factors that can influence the topic (number and age of children in the household, etc.), and then determine which ones are critical for the research.
4. ***Establish homogeneous groups.*** Determine which respondent variables will affect the research findings, and set up separate groups so that respondents are similar in terms of the key variables. It is advisable to conduct at least two group sessions for each different variable.
5. ***Develop the recruiting/screening questionnaire.*** In rural areas it may be necessary to have the village chief or another knowledgeable authority select the group respondents rather than to use a questionnaire screening. In such cases it is always advisable to have a member of the research team accompany the village leader on recruiting visits to be sure the respondents meet the group requirements and that the village leader does not bias them or reveal too much information about the subject matter.
6. ***Select the focus group moderator and the rest of the team.*** It may be necessary to have more than one moderator (male and female) and to have team members who are fluent in different languages, who have specific cultural knowledge, and who have specific technical knowledge (medical practitioners and/or communication specialists, for example).
7. ***Select supporting materials for the group discussion.*** It may be necessary to use stimulus materials to encourage the discussion. Use two tape recorders if possible – one as a back-up.
8. ***Select the focus group sites.*** Be realistic about accessibility and receptivity in certain regions. Choose sites where a comfortable, quiet, private group can be set up.
9. ***Select the date, time and length of each group.*** Be sure there are no conflicts with special days (holidays, market days) or with individual activities (household chores).
10. ***Develop the topic guide.*** Work with the moderator and the rest of the team to develop a carefully thought-out topic guide or guides. Be sure only questions that relate to the objectives of the study are addressed.
11. ***Conduct the focus group.*** Be sure that all logistics are handled in advance and that all members of the team – moderator, observer, recorder, etc. – are clear about their responsibilities.
12. ***Analyze and interpret the focus group findings.*** Reviewing the focus group tapes and constructing the report can be done by the moderator, alone or in conjunction with another team member. It is also advisable to formally present the conclusions, recommendations and key findings to program management.
13. ***Translate the research results into an action plan.*** Eliminate actions that are not realistic or feasible; pursue actions that are readily implemented and involve minimal risk; further research areas of uncertainty or major risk.

TABLE 3-1
CHECKLIST FOR SETTING UP FOCUS GROUPS

Determine the Number of Groups Needed

- Are there at least two groups for each relevant variable?
- Are there enough groups to rotate the stimulus materials?
- Were groups conducted until responses were showing similarities?
- Are groups needed in different geographic regions?

Determine the Composition of Each Group

- Are respondents of the same social class?
- Are respondents similar in terms of their "lifecycle" or "experience status" regarding the topic area?
- Can users and non-users (or practicers and non-practicers) be put together without stifling group interaction?
- Do respondents have similar levels of expertise on complex topics?
- Is it important to separate respondents by age and/or marital status?
- Are respondents of similar cultural background?
- Can males and females be mixed without inhibiting responses?

Determine the Length of the Group

- Can the information needs be met in one to two hours?
- If not, is another research technique more appropriate or should additional groups be set up?

Determine the Size of the Group

- Will respondents be able to say all they know in ten minutes? (eight-ten respondents)
- Is the subject complex enough for each respondent to give twenty minutes of relevant information? (five-seven respondents)
- Does the subject matter require a small, intimate group?

Determine the Group Setting

- Will respondents have sufficient privacy to talk freely?
- Can all respondents see and hear one another?
- Is the location accessible to respondents?
- Will respondents be threatened or intimidated by the location?

Management Information Systems (MIS)

QOC Element(s)

Choice of methods, technical competence, continuity of care

Description

Service statistics are routinely collected from the administrative records which exist in most service provider organizations. Statistics can provide various types of information, including the number of new and continuing clients served and number of methods used. Strengths and weaknesses can be revealed in patterns found in the service statistics. MIS can be more comprehensive in terms of data collected and can provide information on personnel, stocks/supplies, services provided, coverage attained and program quality and impact. Various indicators can be used to measure quality of care. For example, method choice can be evaluated by number and range of methods available at the service delivery point, evidence of provider bias, whether client receives method of choice, and whether informed consent is obtained before provision of a method.

Advantages

Generally available and easily obtained. Can provide information from the clinic up to the national level.

Disadvantages

Data must be interpreted. Can only identify areas which warrant further investigation. Although data are available, they are not always used in management decision-making. Quality of data is sometimes questionable. Development and operation of an MIS requires technical assistance and continued training. Once in place, there is no guarantee that the MIS functions as it should. System needs to be updated to ensure collection of only necessary data.

Examples

MIS systems incorporating quality of care elements have been developed by various organizations, including AVSC, Population Council, Georgetown University Institute of Reproductive Health and IPPF.

1. The Institute for Reproductive Health at Georgetown University has developed an MIS system to monitor follow-up and counseling of new acceptors of the Natural Family Planning (NFP) method. The MIS system was developed not to measure quality per se, but to enable providers to identify accomplishments and problem areas. The system is based on the Client-Based NFP Learning Model and makes use of the following data sources: a registration form, user registry, follow-up form and service statistics report. A form soliciting sociodemographic information and fertility intentions is completed at the client's first contact. The client is tracked as she moves through the learning process, first as a learning user, then as

Examples, cont.

an autonomous user (i.e. uses the method for three cycles and does not require follow-up) or as a discontinuer. The information collected can be used to monitor initial and subsequent client-provider relations, adequacy of information given, whether follow-up was sufficient, and client satisfaction (including reasons for discontinuation). Gaps in the MIS system include the need for information on potential users, referral, more details on autonomous users (since once they become autonomous they are not followed), and information on costs. (Institute for Reproductive Health, 1992; Kaufman and Marquette, 1992)

2. The Population Council developed an MIS system which will be used in Zambia for tracking clinic data that is collected on a routine basis. The system uses the existing clinic first-visit form and a new follow-up form which collects information on method switching, method and medical problems and method choice. Forms were also prepared to facilitate data entry. The nurse midwives who fill out the initial and follow-up forms also complete the data entry forms. The clinic registry is used to provide information on follow-up and continuity of care and a tally sheet keeps track of quantities of family planning methods dispensed. The system was designed to measure method choice, provider competence, information provision and counseling, and continuation and follow-up. Drawbacks are that women must return to the clinic or they are lost to follow-up, and that the system needs to constantly maintained to be of value. (Kaufman and Marquette, 1992)

3. See also in this catalog: Clinic Management System and AVSC example in Monitoring Voluntary Surgical Contraception Procedures.

Attachments

"Client Based NFP Learning Model," data collection instrument and instructions. From Institute for Reproductive Health, 1992.

Citations

Helzner JF and SZ Kopp. 1991. "Quality of Care in Family Planning: Perspectives from IPPF/Western Hemisphere Region." Draft report. March 1.

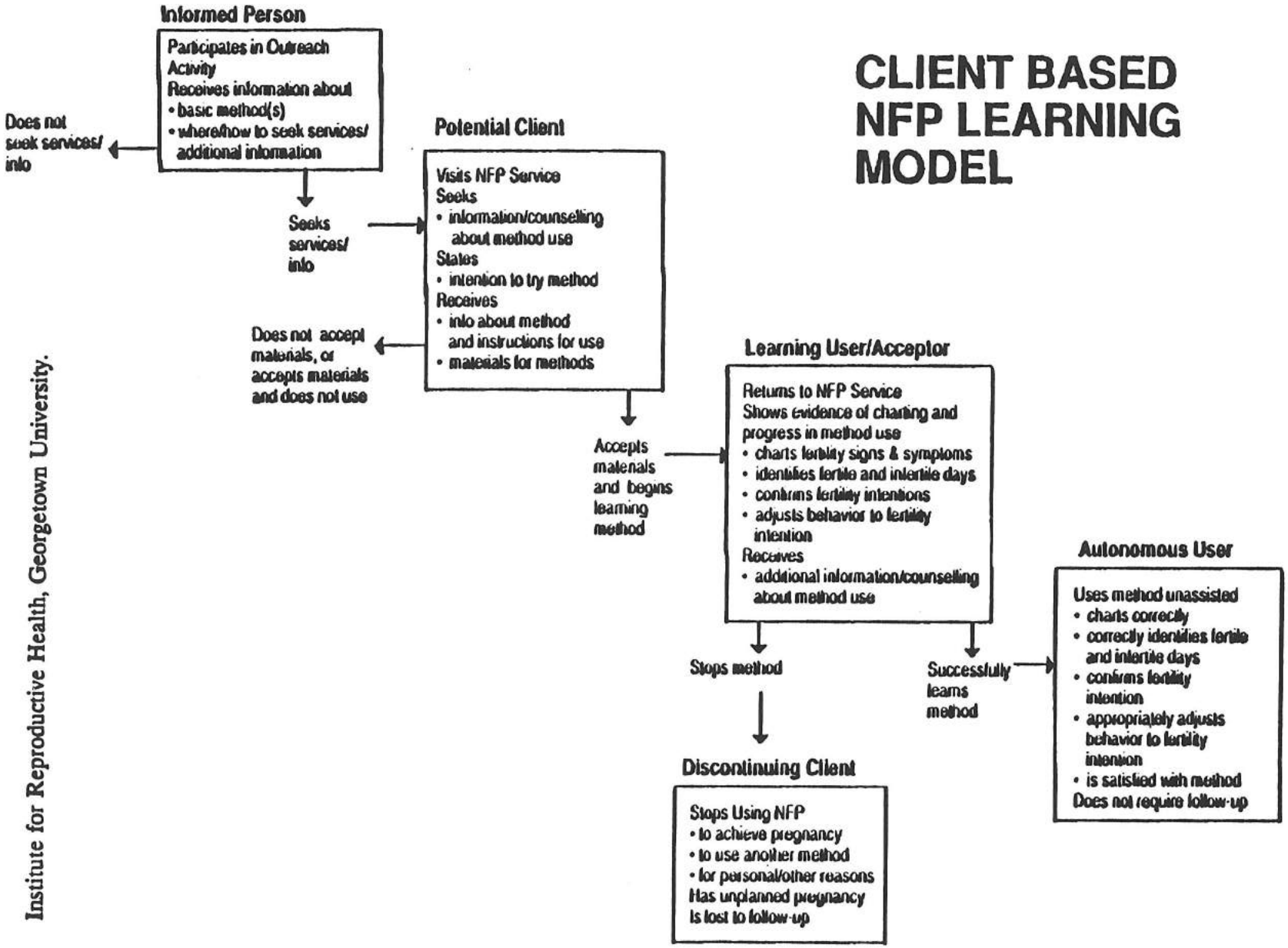
Institute for Reproductive Health. 1992. Client Based NFP Learning Model. Washington, DC: Georgetown University.

Kaufman J and C Marquette. 1992. "Report on the Meeting on Quality of Care and Clinic-Based MIS." NY: The Population Council.(Natural Family Planning presentation by Victoria Jennings, Georgetown University. Zambia model presentation by Joan Kaufman, Harvard School of Public Health). January 30.

Citations, cont.

Keller A. 1991. "Management Information Systems in Maternal and Child Health/Family Planning Programs: A Multi-Country Analysis." *Studies in Family Planning* 21,1:19-30.

CLIENT BASED NFP LEARNING MODEL



Kaufman J and C Marquette. 1992. "Report on the Meeting on Quality of Care and Clinic-Based MIS." NY: The Population Council.

Institute for Reproductive Health, Georgetown University.

GUIRH, 6/92

PROGRAM NAME _____

1. ZONE 1) Africa 2) America 3) Asia 4) Europe 1. [ ]

2. COUNTRY NAME _____ 2. [ ][ ][ ]
Code the first three letters of country

3. PROGRAM NUMBER within country (Assigned by IFFLP) 3. [ ]

4. LANGUAGE 1) English 2) French 3) Spanish 4) Other 4. [ ]

5. STAGE OF DEVELOPMENT (ASSIGNED BY IFFLP)
1) Beginning 2) Demonstration 3) Expansion 5. [ ]

6. QUARTER 1) Jan 01 TO March 31 2) Apr 01 TO June 30
3) Jul 01 TO Sept 30 4) Oct 01 TO Dec 31 6. [ ]

7. YEAR (Last two digits only) 7. [ ][ ]

8. ACTIVE TEACHERS - How many teachers or motivaters reported on a client related activity this quarter. 8. [ ][ ][ ]

9. INFORMED PERSONS - How many individuals were given information on NFP through a face to face contact (including outreach). 9. [ ][ ][ ][ ][ ]

10. OUTREACH ACTIVITY - List all activity other than face to face your program has done this quarter to inform the public about NFP. (Use the reverse side if necessary) Radio, TV, Health Fair, etc. _____ _____ _____ _____

11. POTENTIAL CLIENT/ INITIAL CONTACT - How many people have received information to help them to try NFP. 11. [ ][ ][ ][ ]

12. PREGNANCY AVOIDERS - How many avoiders began to use the method this last quarter. 12. [ ][ ][ ][ ]

13. ACHIEVERS AND FERTILITY AWARENESS - How many began to use the method this last quarter. 13. [ ][ ][ ][ ]

AVOIDERS ONLY FROM THIS POINT

14. AVOIDERS CARRIED OVER FROM LAST QUARTER 14. [ ][ ][ ][ ]

15. UNPLANNED PREGNANCIES - Number this quarter. 15. [ ][ ][ ][ ]

16. OTHER DISCONTINUATIONS - Besides unplanned pregnancies this quarter. 16. [ ][ ][ ][ ]

17. AUTONOMOUS - How many clients avoiding pregnancy reached autonomy this last quarter. 17. [ ][ ][ ][ ]

18. TOTAL LEARNING USERS THIS QUARTER =
(12 + 14 - (15 + 16 + 17)) 18. [ ][ ][ ][ ]

19. Person Completing _____ 20. Date Completed _____

21. Supervisor Review _____ 22. Date Reviewed _____

IFFLP05 08-07-92 Revised at Cameroon meeting

Instructions for completing the service statistics data form IFFLP05

Program Name - Provide the official program name.

Instructions - Fill in each box on the form with the required digits. If you do not know the answer, leave the boxes blank. Where indicated, IFFLP will provide the code.

1. Zone - code as indicated.
2. Country Name - Write the country name and then code the first three letters of it, for example - Canada - CAN Kenya - KEN, Peru - PER, Sri Lanka - SRI, USA - USA, etc.
3. Program Number within country - Do not complete. IFFLP will assign numbers to programs within countries.
4. Language - code the principal language.
5. Stage of Development - to be assigned by IFFLP.
6. Quarter - quarter of year during which the data were collected.
7. Year - year during which data were collected.
8. Active Teacher - a teacher or motivator reporting on any client related activity during this quarter. Client related activity includes all face to face outreach, teaching, and follow-up contacts with clients.
9. Informed Persons - the number of individuals informed about NFP and how to get services. They can be informed through group or individual meetings which involve face to face or personal contact with the NFP staff.
10. Outreach activity - list all activities, other than face to face contact, through which your program informs the public about NFP; for example, TV, radio, films, church bulletins, health fairs, etc.
11. Potential Clients - registered, the initial contact (first visit), after outreach, of a potential NFP user with the service, during which the individual receives information and/or materials for charting. Count only women.
12. Pregnancy Avoiders - clients who begin to chart or otherwise use NFP and state an intention not to become pregnant.
13. Achievers and Fertility Awareness - clients who begin to chart or otherwise use NFP for purposes other than avoiding pregnancy.

Beginning with question 14, report only on Pregnancy Avoiders

14. Avoiders Carried Over From Last Quarter - Item 18 from this report, last quarter.
15. Unplanned pregnancies - The number of pregnancies among pregnancy avoiders last quarter.
16. Discontinuing Client - an acceptor who stops using NFP for any reason other than unplanned pregnancy.
17. Autonomous - an acceptor who uses the method unassisted by the program and who does not require follow-up.
18. Total Learning Users This Quarter - New pregnancy avoiders (12), plus avoiders from last quarter (14), less unplanned pregnancies (15), discontinuing (16), and autonomous (17).
19. Person Completing - name of person filling out the form.
20. Date Completed - the actual date the form was completed.
21. Supervisor Review - if the supervisor did not complete the form they should review it.
22. Date Reviewed - the date the supervisor reviewed the form.

Matrix (CEDPA)

QOC Element(s)	**Comprehensive assessment tool**
Description	CEDPA has developed two matrices (or checklists) to be used as management tools for project monitoring. One matrix is for clinic use and one is for CBD projects. Each matrix assesses a modified version of the Bruce framework according to three levels of variables: the management system, provider level and the impact level. The purpose of the matrix is to enable subproject staff to develop a quality of care plan for each subproject, thereby linking quality to internal monitoring and planning activities. The plan may relate to the elements in the matrix, but this is not required. The matrix gives staff ideas for questions and indicators they might use in developing their quality of care plan.
Advantages	Quality of care is the responsibility of management and staff. Quality of care objectives will be integrated into the development of project plans.
Disadvantages	Management and staff must be committed to developing and carrying out quality of care plan. Difficult to measure indicators in the matrix.
Examples	Being field tested.
Attachments	"CEDPA Indicators for Quality of Care Assessment" Clinic Program and CBD Program. From Luke, 1991.
Citations	Hardee-Cleaveland K, M Norton and C Calla. 1992. "Quality of Care in Family Planning Service Delivery. A Survey of Cooperating Agencies of the Family Planning Services Division, Office of Population, A.I.D." Luke M. 1991. "CEDPA and Quality Assurance" in *The Quality of Family Planning Services in Field Projects: A Workshop Report*. SEATS. NY: Columbia University. June 18-20.

CEDPA

INDICATORS FOR QUALITY OF CARE ASSESSMENT: CLINIC PROGRAM

ELEMENTS	MANAGEMENT LEVEL	PROVIDER LEVEL	CLIENT LEVEL
1 CHOICE OF METHODS	1. Wide range of methods are available including IUD, referrals for sterilization, injectables (if available within country) 2. Adequate and continuous supplies of contraceptives is available 3. Management system projects method mix and tracks utilization data	1. All personnel, especially clinicians, nurses & counselors offer choices to clients 2. Referrals are made and follow-up provided for methods not offered 3. Providers discuss method preferences with managers if methods are not available.	1. Clients choose method and can explain why they chose a method 2. Clients can discuss at least one other method 3. Clients understand medical reasons why method may not be suitable
2 TECHNICAL COMPETENCE	1. Clinicians & medical staff receive technical updates once a year minimum 2. Observation of clinician performance done at least once 3. Written guidelines for FP practice are developed and approved 4. Training of clinicians & approval of skills is documented 5. A medical supervisor is designated to overview system 6. A supervision schedule with clinical observation is followed 7. Medical records are reviewed 8. Job descriptions are clear	1. Clinicians & medical staff demonstrate good knowledge of all meths, use, benefits, side effects 2. Clinicians and medical staff follow guidelines for FP practice 3. Clinicians and medical staff demonstrate good knowledge of infection control procedures 4. Clinicians demonstrate good clinical exam. skills 5. Clinicians perform simple lab tests as appropriate 6. Equipment is properly used and maintained 7. Infections and complications are properly handled 8. Referrals are made as appropriate 9. Proper screening is done for clinical methods	1. Clients experience minimal physical and emotional discomfort 2. Clients understand about other health problems 3. Clients can explain the benefits & risks of chosen method 4. Clients know about common side effects and how to manage them
3 INFORMING AND COUNSELING CLIENTS	1. Training on counseling is built into clinician training plan 2. Time is provided for clinician to do client counseling	1. Clinicians and medical staff demonstrate good communication and counseling skills 2. Clinicians and medical staff provide accurate & adequate info. for client decision making	1. Clients understand their method & how it works 2. Clients receive appropriate materials and instructions about side effects, contraindications
4 INTERPERSONAL RELATIONS	1. Selection of clinician and medical staff includes attention to interpersonal skills 2. Supervision includes review of interpersonal skills	1. Clinicians and medical staff develop trust and rapport with client 2. Clinician and medical staff listen to client & address their concerns	1. Client feels comfortable in talking with clinician and medical staff 2. Clients are satisfied with service 3. Good continuation rate
5 MECHANISMS TO ENCOURAGE CONTINUITY	1. Formal follow-up plan is written and clear 2. Referral system is developed and utilized 3. Record keeping system for follow-up visits is developed 4. Supervision system is in place to track follow-up cases	1. Clinicians follow the same clients if poss. 2. Clinician maintains good record keeping system 3. Manager ensures follow-up between clinic and outreach/CBD	1. Client continues using method or changes as needed 2. Client returns to clinic for follow-up care as needed
6 APPROPRIATENESS AND ACCEPTABILITY OF SERVICES	1. Clinic is located in accessible, convenient location 2. Clinic is personal, private, clean, attractive 3. Hours are convenient and varied as needed 4. Clinic has adequate exam. & supplies, equipment, running water, etc. 5. Client flow plan is organized and well supervised 6. Outreach, community edu. plan is well defined 7. Increased access to FP services	1. Clinician and staff have client orientation 2. Clinician and staff are well organized and clients are not made to wait for unusually long periods 3. Staff work in coordination as a team 4. Staff understand & work to achieve clinic goals	1. Clients are satisfied with services and return as needed 2. Clients tell others about clinic services 3. Community makes referrals to clinic 4. Increase in users

Luke M. 1991. "CEDPA and Quality Assurance" in *The Quality of Family Planning Services in Field Projects: A Workshop Report.* SEATS. NY: Columbia University. June 18-20.

CEDPA

INDICATORS FOR QUALITY OF CARE ASSESSMENT: CBD PROGRAM

ELEMENTS	MANAGEMENT LEVEL	PROVIDER LEVEL	IMPACT LEVEL
1. CHOICE OF METHODS	1. Methods are available & supply is continuous 2. Recordkeeping system tracks commodities distributed 3. Supervision system tracks FW goals & activities	1. FW offers choices to clients 2. Referrals are made for methods not available through CBD 3. Fieldworkers are motivated to recruit clients	1. Clients choose method & can explain why they chose their method 2. Clients can describe other methods
2. TECHNICAL COMPETENCE	1. Refresher training for FWs is provided at least annually 2. Consultation by medical person to discuss cases 3. Written guidelines are provided for screening & distribution of methods 4. FW receives training and supervision in record-keeping & follow-up 5. FW job descriptions are clear	1. FWs are knowledgeable about methods, proper use, side effects 2. FWs follow guidelines in follow-up methods 3. FWs complete record-keeping system 4. FWs know how to discuss and help clients manage side effects	1. Clients can explain the benefits and risks of their chosen method 2. Clients know about common side effects and how to manage them 3. Clients know where to go for serious complications
3 INFORMING AND COUNSELING CLIENTS	1. Training on edu. & counseling approaches are provided at least annually 2. Written material or pamphlets are given to FWs	1. Fieldworker is able to communicate clearly about methods and answer client questions 2. Fieldworker uses written materials appropriately	1. Clients feel their questions have been answered 2. Clients receive accurate information about methods
4 INTERPERSONAL RELATIONS	1. Staff selection is based on good interpersonal skills 2. Training includes interpersonal communications skills building 3. Supervision is based on periodic observation of client interaction	1. Fieldworker can build trust with clients & gain their respect 2. Fieldworker demonstrates good listening skills and sensitivity to clients	1. Clients feel comfortable in discussing FP and other health issues 2. Clients are satisfied with service
5 MECHANISMS TO ENCOURAGE CONTINUITY	1. Referral linkages and procedures are developed 2. Transportation plan is in place 3. Follow-up guidelines and system is clear and in writing	1. FW follows system for follow-up visits 2. Fieldworker maintains accurate records	1. Clients receive supplies as scheduled 2. Clients have opportunity to discuss and change methods 3. Good continuation rates
6 APPROPRIATENESS AND ACCEPTABILITY OF SERVICES	1. Community leaders and health agencies support CBD program 2. Informal and formal IEC plan promotes program 3. Increased access to services	1. FW provides services in an appropriate, private setting 2. FW understands and works toward goals of program 3. FW keeps community informed/involved in program	1. Clients are satisfied with service 2. Clients tell others about program 3. Community makes referrals to program 4. Increase in users

Matrix (Enterprise)

QOC Element(s)	**Comprehensive assessment tool**
Description	The Enterprise Program developed a matrix to be used by clinic managers to evaluate quality of care. The matrix looks at five quality of care areas: contraceptive method choice, information and education, technical competence of staff, accessibility, and physical facilities and equipment. Each of these areas is assessed across three dimensions: facilities/hardware, service delivery system, and client perceptions. There are questions within each of the 15 boxes with a choice of answers, and each answer has an associated numerical score. It is stressed, however, that although some sort of weighting scale is necessary, no cumulative score is given. The matrix is not for measuring performance against a standard, but rather for routine internal monitoring and problem solving.
Advantages	Management can use the matrix to understand and get involved in quality of care.
Disadvantages	Scoring for internal matrix elements has not been tested for validity. Matrix never published.
Examples	Not yet tested.
Attachments	Sample page from the matrix.
Citations	Hardee-Cleaveland K, M Norton and C Calla. 1992. "Quality of Care in Family Planning Service Delivery. A Survey of Cooperating Agencies of the Family Planning Services Division, Office of Population, A.I.D." Hart C. 1991. "Enterprise and QA", in *The Quality of Family Planning Services in Field Projects: A Workshop Report.* SEATS. NY: Columbia University. June 18-20.

I. CONTRACEPTIVE METHODS CHOICE

A. Facilities/Hardware	B. Service/Delivery System	C. Client Perceptions
1. How many contraceptive methods are offered by your program? ☐ Short-term reversibles (pill, barrier methods, spermicides, condoms) (1 point) ☐ Long-term reversibles (IUD, implants) (1 point) ☐ Irreversible (sterilization) (1 point) ☐ No family planning methods (0 points) Score	1. Which of the categories indicated at the left were distributed by you in your most recent 100 new family planning acceptors? ☐ all methods indicated at the left (3 points) ☐ two methods (2 points) ☐ only one method (1 point) ☐ no methods (0 points) Score	C. Client Perceptions 1. As far as you know, which methods are available at the facility? ☐ client identifies at least 75 percent of methods available in program (3 points) ☐ client identifies at least half of methods available in program (2 points) ☐ client identifies less than half of methods available in program (1 point) Score ☐ Client cannot identify any method (0 points)
2. Which of the following types of pills do you offer at your clinic? ☐ regular dose (1 point) ☐ low dose (1 point) ☐ mini-pills (1 point) ☐ no pills (0 points) Score	2. Of the types of pills indicated at left, which were distributed by you in your most recent 100 pill clients? ☐ all types indicated at left (3 points) ☐ two types (2 points) ☐ one type (1 point) ☐ no pills (0 points) Score	2. Have you ever changed a pill due to side effects or other changes in you personal circumstances? (i.e. breastfeeding) ☐ yes, OR no side effects or changes in circumstances have occurred (3 points) ☐ no alternative pill choice was available so method was changed altogether (2 points) ☐ no, no alternative pill/barriers method choice was available, but counseling on natural methods was provided (1 point) ☐ no, no alternative method was available or offered so client ceased contraception (0 point) Score
3. Of the contraceptive methods you offer in your clinic, how many do you have at least a 3-month supply of? ☐ all of them (3 points) ☐ more than half of them (2 points) ☐ less than half but at least one method (1 point) Score	3. Does the clinic maintain an inventory record system that ☐ measures current stock levels (1 point) ☐ ensures first-in, first-out procedures (that minimizes exp. dates) (1 point) ☐ provides for scheduled re-stocking of contraceptive supplies (1 point) ☐ none of above (0 points) Score	3. Is your preferred contraceptive method always available at the clinic? ☐ yes, method is always available (3 points) ☐ usually (with only minor exceptions) available (2 points) ☐ method discontinued (1 point) ☐ availability unpredictable (0 points) Score
4. Are any contraceptive methods not offered at your clinic available at other nearby facilities? ☐ more than one method (3 points) ☐ one method (2 points) ☐ none (1 point) ☐ not applicable, full range of methods is available at clinic Score	4. What kind of referral system do you have for methods not offered at your facility? ☐ formal referral system with client follow-up procedures (3 points) ☐ formal referral system with no follow-up procedures (2 points) ☐ informal referrals (1 point) ☐ no referral system exists (0 points) ☐ not applicable, full range of methods available at clinic Score	4. Have you ever been referred to another facility to obtain methods not available at you clinic? ☐ yes OR "no", have always been able to obtain desired method locally (3 points) ☐ no (alternative method choice was not available through existing referral system) (2 points) ☐ yes, but referral center is too difficult to reach or use (1 point) ☐ no (referral option was not mentioned or provided) (0 points) Score
5. Do you have at least one service provider trained to provide each method offered by your program? ☐ staff trained to provide all methods (3 points) ☐ one method not covered (2 points) ☐ more than one method not covered (1 point) Score	5. Is staff scheduled so that all reversible methods can be administered at any time the clinic is open? ☐ yes, all methods can be administered at all times (3 points) ☐ no, staff scheduled so that each method can be administered at least once a week (2 points) ☐ no, staff scheduling is not organized to ensure that method will be available at least once a week (1 point) ☐ scheduling of new methods dependent on availability and/or personal schedule of non-staff persons (0 points) Score	5. Were you ever unable to obtain a family planning method because the person trained to administer it was absent? ☐ have always been able to obtain method (3 points) ☐ only once was unable to obtain method (2 points) ☐ was unable to obtain method on more than one occasion (1 point) ☐ I am never sure whether I can obtain the method on any given day (0 points) ☐ more than 2 methods not covered (0 points) Score

Ninth Floor
1100 Wilson Boulevard
Arlington, VA 22209 USA
Tel: (703) 525-7474
Telex: 272896 JSIWUR

DRAFT

Monitoring Voluntary Surgical Contraception Procedures (VSC)

QOC Element(s)

Technical competence

Description

A system to collect data and monitor quality of care for clients requesting VSC. A client record form collects sociodemographic data, information on medical history and physical examination, medications and procedure, post-operative period, and follow-up visits. This reporting form can provide information on choice of methods, technical competence of providers, and mechanisms to ensure continuity. A monthly summary report aggregates information from the client records and provides information on timing of the procedure, anesthesia, type and length of surgery and complications. The summary form is designed so that problems can be readily identified.

Advantages

Clinical record and data collection instrument are easy to use and provide a rapid assessment of quality issues, especially on complications and follow-up. Analysis does not require a computer. The system is designed to make clinical staff more attentive to safety concerns and provide an efficient and effective means of supervision.

Disadvantages

To be successful, the system must be accepted by service providers, supervisors and administrators. Analysis can only indicate problems, staff must work to devise and implement solutions. Data on information and counseling of clients and interpersonal relations are not adequately captured and there is no way to determine the appropriateness and acceptability of services. Monitoring complications may require direct observation since complications are often underreported.

Examples

1. AVSC uses an MIS to identify trends related to safety and quality. The MIS can also be used to monitor new contraceptive services such as NORPLANT. The system is easy to use and has been applied in several settings. (Kaufman and Marquette, 1992)

2. A similar protocol has been used by IPPF affiliates in several countries including Venezuela, India, Sri Lanka and El Salvador. (Huezo, 1992)

Attachments

"Medical Record for Female Sterilization Procedure" and "Monthly Female VSC Report." From Kaufman et al., 1992.

"Clinic Record for Female VSC Procedure" and "Monthly Female VSC Report." From Huezo, 1992.

Citations

Huezo C. 1992. "Monitoring and Supervision of Voluntary Surgical Sterilization Procedures: A Model Protocol for Quality of Care." IPPF Medical Department. January.

Kaufman J and C Marquette. 1992. "Report on the Meeting on Quality of Care and Clinic-Based MIS." NY: The Population Council. (AVSC presentation by Evie Landry). January 30.

Kaufman J and C Marquette. 1992. "Report on the Meeting on Quality of Care and Clinic-Based MIS." NY: The Population Council. (AVSC presentation by Evie Landry). January 30.

MEDICAL RECORD FOR FEMALE STERILIZATION PROCEDURE

CONSEJO NACIONAL DE POBLACION Y FAMILIA
(DOMINICAN REPUBLIC)

1. Date of procedure ☐☐ Day ☐☐ Mo ☐☐ Yr
2. Name of client _____ 3. Client # ..... ☐☐☐ A
4. Address:

5. Client's age in completed years ..... ☐☐ B
6. Marital status: 1. Single 3. Living in union 5. Divorced/Separated
   2. Married 4. Widowed
7. Education: 0. None 2. Intermediate 4. University
   1. Primary 3. Secondary 5. Other (specify)
8. Number of living children _____ ☐☐ C
9. Contraceptive method mainly used in past 3 months _____ ☐ D
   (before conception for postabortion and postpartum cases)
   0. None 2. IUD 4. Injectables 6. Spermicides
   1. Pills 3. Subdermal implants 5. Condoms 7. Other (specify)
10. Primary reason for requesting VSC procedure
    1. Desires no more children 3. Economic
    2. Medical 4. Other (specify)

PREOPERATIVE CLINICAL INFORMATION

Medical History

	Yes	No		Yes	No		Yes	No
Heart disease			Psychiatric conditions			Allergy to medication		
Hypertension			Active tuberculosis			PID		
Anemia			Vaginal disorders			Pelvic/abdominal surgery		
Diabetes			Bladder disorders					
Convulsive disorders			Bleeding disorders					

Drugs presently taking _____
Comments:

Obstetric History gravida ____ para ____ abortions ____
Date of last menses (month/day/year) _____
Date last pregnancy completed (month/day/year) _____

Physical Examination
Blood pressure ____/____ Pulse ____ Weight ____
Nutritional status: 1. Normal 2. Abnormal (describe)
Cardiorespiratory system: 1. Normal 2. Abnormal (describe)
Abdomen: 1. Normal 2. Abnormal (describe)

Pelvic Examination
External genitalia, vagina, cervix: 1. Normal 2. Abnormal (describe)
Uterine position: 1. Antéverted 2. Retroverted 3. Midline
Uterine size: 1. Normal 2. Enlarged or abnormal (describe)
Adnexa: 1. Normal 2. Abnormal (describe)
Uterine mobility: 1. Mobile 2. Fixed
Additional notes:

INTRAOPERATIVE INFORMATION

11. Timing of surgical contraception ☐ E
    1. Immediate postpartum
    2. Late postpartum
    3. Postabortion
    4. With cesarean section
    5. Interval

12. Bladder emptied:
    1. Voided before surgery
    2. Catheterized
    3. Bladder not emptied

Vital signs during surgery:

	Time	Pulse	B.P.	Respiratory rate
Preoperative				
During the operation				
Immediately postoperatively				

13. Anesthesia ☐ F
    1. Local only
    2. Local with analgesia and/or sedation
    3. Regional only (spinal, epidural, caudal)
    4. Regional with analgesia and sedation
    5. General - not intubated
    6. General - intubated

	Drug name	Dosage	Duration time	Route
Anesthesia				
Analgesia				

14. Surgical approach ☐ G
    1. Laparotomy
    2. Minilaparotomy
    3. Laparoscopy
    4. Other (specify)

15. Method of tubal occlusion ☐ H
    1. Ring
    2. Ligation with resection
    3. Ligation without resection
    4. Fimbriectomy
    5. Salpingectomy
    6. Clip
    7. Other (specify)

16. Size of incision (cm) ☐☐ I

17. Duration of procedure
    Time of incision _____ Time of closure _____
    Total in minutes _____ ☐☐ J

18. Procedure-associated complications and events ☐ K_1 ☐ K_2
    0. None
    1. Uterine perforation
    2. Perforation or other injury to bladder
    3. Perforation or other injury to intestine
    4. Other organ injury
    5. Major blood vessel injury
    6. Life-threatening cardiorespiratory event
    7. Other (specify)

    (Identify more than one if necessary; however, code only the two most important.)

    Comments and details:

19. Surgical events ..... ☐☐

0. Incomplete procedure
1. Difficulty finding tubes
2. Adhesions
3. Ovarian cysts
4. Inflamed tubes
5. Pregnancy
6. Difficulty penetrating peritoneal cavity
7. Other (specify)

(Identify more than one if necessary; however, code only the two most important.)

Comments and details:

POSTOPERATIVE INFORMATION

Vital signs after surgery:

Time	Pulse	B.P.	Respiratory rate

20. Postoperative complications detected before discharge ..... ☐☐

0. None
1. Pelvic infection
2. Wound infection and/or hematoma
3. Urinary tract infection
4. Fever
5. Hemorrhage or abnormal bleeding
6. Life-threatening cardiorespiratory event
7. Severe abdominal pain
8. Other (specify)

(Identify more than one if necessary; however, code only the two most important.)

If there are no complications, go to question 21.

Comments and details:

Treatment of complications:

Blood or plasma transfusion — Yes No

Unintended surgery — Yes No

Comments and details (describe other relevant treatment; for example, antibiotics):

21. Date of discharge _____

Number of nights client spent at facility postoperative ..... ☐☐

22. Discharge status ..... ☐☐

1. Discharged well
2. Discharged with home treatment
3. Referred to another facility for management of complications
4. Deceased

If patient transferred, give name of institution and state reason for transfer.

Other postoperative notes (include name of person recording information):

FOLLOW-UP INFORMATION

23. Source of follow-up information ..... ☐ P

1. Clinic visit (spontaneous)
2. Clinic visit (after home visit)
3. Home visit
4. Other clinic/hospital report
5. Other (specify)

Date of follow-up _____

24. Complications after discharge ..... ☐ Q_1 ☐ Q_2

0. None
1. Pelvic infection
2. Wound infection and/or hematoma
3. Urinary tract infection
4. Fever not associated with above complications (38°C or more for 3 or more days)
5. Hemorrhage or abnormal bleeding
6. Life-threatening cardiorespiratory event
7. Severe abdominal pain not associated with above complications
8. Other (specify)

(Identify more than one if necessary; however, code only the two most important.)

If no complications are recorded, go to question 25.

Comments and details:

Treatment of complications:

Blood or plasma transfusion	Yes	No
Surgery	Yes	No
Hospitalization	Yes	No

Comments and details (describe other relevant treatment; for example, antibiotics):

Date this information recorded _____

25. Current condition of client ..... ☐ R

1. Complete recovery
2. Still receiving treatment
3. Referred to another facility for management of complications
4. Deceased

If patient referred to another health care facility, give name of institution and state reason for referral.

Other notes:

MONTHLY FEMALE VSC REPORT
(DOMINICAN REPUBLIC)

Name of Institution ______________________________

Reporting Period [_][_] MONTH [_][_] YEAR [_] R [_][_] PROV [_][_] MUN

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Client number	Age	Living children	Contraceptive method	Timing of procedure	Anesthesia	Approach	Method of occlusion	Incision length (cm)	Duration of procedure (mins)	Procedure-associated complications	Surgical events	Postoperative complications	# nights hospitalized	Discharge status	Source of follow-up	Complications after discharge	Current condition	COMMENTS

FORM A

CLINICAL RECORD FOR FEMALE VSC PROCEDURE

NAME OF CLIENT_____

ADDRESS_____

Ask the client how best to contact her. For example: if visiting her at home, what is the most convenient time_____

1. Date of procedure..... Day ☐☐ Month ☐☐ Year ☐☐

2. Client number..... ☐☐☐ A

PERSONAL INFORMATION Date recorded_____ (day / month / year)

3. Client's age in completed years ..... ☐☐ B

4. Marital status: 1-single 2-married 3-living in union 4-widowed 5-divorced/separated

5. Number of living children ..... ☐☐ C

6. Primary reason for requesting VSC procedure: 1-Personal 2-Medical 3-Other (specify)

PREOPERATIVE CLINICAL INFORMATION

7. Medical History

	YES	NO		YES	NO
Heart disease			Vaginal disorders		
Hypertension			Bladder disorders		
Anaemia			Bleeding disorders		
Diabetes			Allergy to medication		
Convulsive disorders			PID		
Psychiatric conditions			Abdominal surgery		
Active tuberculosis			Other		

If any of the answers is "yes", please explain:_____

Drugs presently taken:_____

8. Obstetric History: gravida___ para___ abortions___ C. sections___
Date of last menses (day/mth/yr)_____
Date of completion of last pregnancy completed (day/mth/yr)_____

9. Physical Examination. Date recorded_____
B.P_____ Pulse_____ Weight_____ Temp_____
Nutritional status: 1-normal 2-abnormal (describe)
Cardiorespiratory system: 1-normal 2-abnormal (describe)
Abdomen: 1-normal 2-abnormal (describe)

10. Pelvic Examination
Post Partum Cases: Describe contraction and size of the uterus, and characteristics of the uterine discharge (lochia):

For All Other Cases:
Vaginal, cervix: 1-normal 2-abnormal (describe)
Uterine position: 1-anteverted 2-retroverted 3-midline
Uterine size: 1-normal 2-enlarged (describe)
Adnexa: 1-normal 2-abnormal (describe)
Uterine mobility: 1-mobile 2-fixed

11. Laboratory Examination Hb (grams)_____ HCT% _____
Other (explain positive results):

INTRAOPERATIVE INFORMATION (in Surgical Room)

12. Timing of Surgical Contraception ..... ☐
1-Interval 2-Immediate Post partum 3-Late Post partum
4-With C. Section 5- Post abortion

13. Bladder Emptied? 1-Voided before surgery 2-Catheterized 3-No

14.

Vital Signs	Time	Pulse	B.P.	Resp. Rate
Preoperative				
During the Operation				
Post Operative				

15. Duration of Procedure in minutes ☐☐
Time of incision _____ Time of closure _____ Duration ....

16. Anaesthesia: 1-Local 2-Regional (spinal, epidural, caudal) ☐
3-General - not intubated 4-General - intubated

	Drug	Dosage	Route	Duration
Anaesthesia				
Analgesia				

Huezo C. 1992. "Monitoring and Supervision of Voluntary Surgical Sterilization Procedures: A Model Protocol for Quality of Care." IPPF Medical Department. January.

17. **Surgical Approach** . . . . . G
1-Laparoscopy 2-Minilaparotomy 3-Laparotomy 4-Other (specify)

18. **Length of incision (in cm)** . . . . . H

19. **Method of Tubal Occlusion** I
0-Not completed, explain
1-Ligation with Resection
2-Ligation without Resection
3-Salpingectomy
4-Fimbriectomy
5-Ring
6-Clip
7-Other

20. **Other procedure performed concurrently with VSC**
0-None 1-Uterine Curretage
2-Removal of IUD 3-Other (specify)

21. **Intra-operative complications and events** J_1 J_2
0-None
1-Uterine Perforation
2-Perforation/Injury to Bladder
3-Perforation/Injury to Intestine
4-Other Organ Injury
5-Major Blood Vessel Injury
6-Life Threatening Cardio-respiratory event
7-Adhesions found
8-Other (specify)
(Can mark more than one but, only code the two most important)
Comments and details:

POSTOPERATIVE INFORMATION (in Recovery Room)

22. **Client's Vital Signs:**

TIME	PULSE	B.P.	RESP. RATE

23. **Postoperative complication Detected Before Discharge** K_1 K_2
0-None
1-Pelvic Infection
2-Wound Infection/Haematoma
3-Urinary Tract Infection
4-Fever
5-Haemorrhage/Abnormal Bleeding
6-Life threatening Cardio-resp. event
7-Severe Abdominal Pain
8-Other (specify)
(Can mark more than one but, only code the two most important)
Comments and details:

If no complications in questions 21 and 23 go to question 25

24. **Treatment of complications**
Blood or Plasma Transfusion 1=Yes 2=No
Unintended surgery 1=Yes 2=No
Details (describe other relevant treatment, for example antibiotics):

25. **Date of Discharge**_____ L
Number of nights postoperative, client spent at facility . . . . . .

26. **Discharge Status** . . . . . M
1-Discharged Well 2-With Home Treatment
3-Referred to another Facility 4-Dead

(If referred, give reason and name of referral institution)

FOLLOW UP INFORMATION

27. **Source of follow up information** . . . . . N
1-Clinic Visit 3-Other Clinic/Hospital Report
2-Home Visit 4-Other (specify)

28. **Complications after Discharge** O_1 O_2
0-None
1-Pelvic Infection
2-Wound Infection/Haematoma
3-Urinary Tract Infection
4-Fever
5-Haemorrhage/Abnormal Bleeding
6-Life Threatening Cardio-resp. event
7-Severe Abdominal Pain
8-Other (specify)
(Can mark more than one but, only code the two most important)
Comments and details:

If no complications are recorded go to question 30.

29. **Treatment of complications**
Blood or plasma transfusion 1=Yes 2=No
Hospitalization 1=Yes 2=No
Surgery 1=Yes 2=No
Details (describe other relevant treatment, for example, antibiotics):

30. **Current condition of the client (in case of hospitalization this information should be completed at the time of discharge)** P
1-Complete Recovery 2-Still receiving Treatment
3-Referred to another Facility 4-Dead
(If referred, give reason and name of referral institution)

Date this information recorded:_____

Other Notes (enter here information on any additional follow-up):

REVIEWING FORM B

This is an example of how the data recorded in Forms B can be reviewed and interpreted. For preparing the completed Form B used in the example given in the next page, problems identified in several forms have been compiled in a single form.

When we glance down *Column B* we can quickly identify what can be a problem with Client No. 014 - the recorded age is 16; if we go down the next column which concerns the number of living children we can also find that the same client had no living children. the identification of this problem obviously will require contacting the clinic for more information.

If we glance down *Column D*, timing of the procedure, we can find that for Client No. 016 the code 3 was written, which corresponds to late post-partum. In this case, reviewing Form A will be required to determine when the operation was actually performed. It is possible that the wrong code was entered in Form A and/or Form B, or that the service provider did not know the definition of "late post-partum" or that the guidelines recommending that the VSC should not be performed late post-partum (seven days after delivery) were ignored. In any case, corrective actions would be required.

By reviewing the information in *Column E* which corresponds to duration of the surgical procedure, we can identify excessive time for performing some of the operations. In some cases this excessive time may be satisfactorily explained, for example, if the operation was done in conjunction with another operation such as a caesarean section (Client No. 018), but in other cases it may identify an operator who needs additional training.

By reviewing *Column F*, which corresponds to anaesthesia, we can see that Clients 013, 014 and 015 had code 3 which means general anaesthesia without innubation. Local anaesthesia is recommended as the first choice, general anaesthesia may be required in exceptional cases, such as cases of extreme obesity. If general anaesthesia is used too often it may reflect a problem in the quality of services.

In *Column G* which corresponds to surgical approach we can also identify clients who require special attention, such as those who have code 3 which corresponds to laparotomy. We know that laparotomy is no longer required for performing surgical sterilization alone.

Any complication recorded in *Columns J, K, and Q* will obviously require special attention. In these cases the codes recorded will give us an idea of whether or not this is a major complication. A close review of these cases should be carried out, starting by studying Form A.

Note that no complications were reported for case 015. However, the operation lasted 90 minutes, the incision length was 6 cm and the client stayed in the clinic for six nights. A supervisor may become suspicious that a major complication was not reported and decide to undertake a review of this case.

Note that two clients did not have follow up.

In the same way every column in Form B can be quickly reviewed and problems identified.

FORM B

MONTHLY FEMALE VSC REPORT

Name of service delivery site ..... Region .....

Reporting period ☐☐ MONTH ☐☐ YEAR

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Client Number	Age	Living Children	Timing of Procedure	Duration	Anaesthesia	Surgical Approach	Incision Length	Method of Occlusion	Intra-operative Complications	Post-operative Complications	# Nights Hospitalized	Discharge Status	Source of Follow up	Complications after Discharge	Current Condition
001	23	0	2	0	1	2	0	6	0	0	0	1	2	0	1
002	34	1	2	0	1	2	1	6	0	0	0	1	2	0	1
003	23	0	2	3	3	2	2	6	0	0	0	1	2	0	1
004	30	0	2	0	3	2	2	6	0	0	0	1	2	0	1
005	29	0	2	0	3	2	2	6	0	0	0	1	2	0	1
006	26	1	2	0	3	2	2	6	0	0	0	1	2	0	1
007	33	0	2	0	3	2	2	6	0	0	0	1	2	0	1
008	24	0	2	0	3	2	2	6	0	0	0	1	2	0	1
009	29	0	2	0	3	2	2	6	0	0	0	1	2	0	1
010	23	0	2	0	3	2	2	6	0	0	0	1	2	0	1
011	24	0	2	0	3	2	2	6	0	0	0	1	2	0	1
012	26	0	2	0	3	2	2	6	0	0	0	1	2	0	1
013	24	0	2	0	3	2	2	6	0	0	0	1	2	0	1
014	16	0	2	0	3	2	2	6	0	0	0	1	2	0	1
015	25	1	2	0	3	2	2	6	0	0	0	1	2	0	1
016	24	0	3	0	3	2	2	6	0	0	0	1	2	0	1
017	23	0	2	0	3	2	2	6	0	0	0	1	2	0	1
018	24	0	2	0	3	2	2	6	0	0	0	1	2	0	1
019	25	0	2	0	3	2	2	6	0	0	0	1	2	0	1
020	24	0	2	0	3	2	2	6	0	0	0	1	2	0	1

TABLE 1

RATE OF COMPLICATIONS BY MONTH

	A	B	C
Month	**No. of Operations**	**No. of Clients with Complications**	**Rate of Complications**
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			
TOTAL			

Calculation of the Rate of Complications - (%)

$$C = \frac{B}{A} \times 100$$

Divide the number of clients who had any complications (clients who have a code other than 0 in any of the columns J, K or O of Form B) by the total number of sterilizations performed in the reporting period and then multiply by 100.

TABLE 2

RATE OF POST-OPERATIVE FOLLOW-UP BY MONTH

	A	B	C
Month	**No. of Operations**	**No. of Clients with Follow up**	**Rate of Follow up**
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			
TOTAL			

Calculation of the Rate of Follow-up - (%)

$$C = \frac{B}{A} \times 100$$

Divide the number of clients who had post operative follow up (clients who have code 1, 2, 3, or 4 in column N of Form B) by the total number of sterilizations performed in the reporting period and then multiply by 100.

Observation

QOC Element(s)

Client-provider interaction, technical competence, information to users, choice of methods, continuity of care

Description

A qualitative research methodology which can be used alone or in conjunction with other methodologies. Useful for examining clinic operations, process of service delivery and clients themselves. An observation guide or checklist should be developed beforehand based on research objectives.

Advantages

A good tool to assess service delivery context and behavior.

Disadvantages

Can produce bias. If staff is aware they are being observed they will be on their "best behavior." If period of observation is short, may be difficult to make an accurate assessment. Requires skilled observers and analysts. Results my be influenced by interobserver variability and observer bias.

Examples

1. IPPF uses direct observation in combination with a quality of care site visit list to assess the service delivery process. The list incorporates the six quality of care elements and requires observation as well as interviews with the staff. (Helzner and Kopp, 1991)

2. Direct observation was one of the methodologies used in Nigeria to assess the impact that a nurse training program in family planning counseling skills had on the quality of service delivery and on client compliance with follow-up appointments. A specialist in counseling skills and interpersonal relations observed counseling sessions conducted by nurses who had participated in the training program and nurses who hadn't. Information from the observer supported data gained by the exit interviews and provided a different perspective. The study found that the trained nurses performed better than the untrained nurses in the areas of interpersonal relations, counseling and information giving. Also, client compliance was greater with trained nurses. Specifically, direct observation noted that trained nurses were more relaxed than untrained nurses, listened more attentively, helped clarify method choice, gave feedback, and managed their time more efficiently. (Kim et al., 1992)

Attachments

Portions of observation checklist, from Fisher et al., 1992.

Citations

Fisher A, B Mensch, R Miller, I Askew, A Jain, C Ndoti, L Ndhloru and P Tapsoba. 1992. *Guidelines and Instruments for a Family Planning Situation Analysis Study*. NY:The Population Council.

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Section I. To Be Completed During the Observation

INSTRUCTIONS TO OBSERVER: For each of the questions listed below, enter the code that represents your observation of what happened during the interaction.

1. Did provider give client a respectful and/or friendly greeting?

   0 = NO
   1 = YES

2. What was the purpose of the visit as initially indicated by the client?

   1 = RESUPPLY/CHECK UP (Continuing user) (Go to question 3)
   2 = CONSULT ABOUT PROBLEM/DOUBT WITH CURRENT METHOD (Go to question 3)
   3 = SWITCH METHODS (Current user) (Go to question 8)
   4 = OBTAIN METHOD FOR THE FIRST TIME (New user) (Go to question 8)
   5 = OBTAIN METHOD (Old user, not currently using) (Go to question 8)
   6 = DISCONTINUE METHOD (Go to question 3)
   7 = OTHER _____ (Go to question 8)
   8 = PURPOSE NOT INDICATED (Go to question 8)

3. Did the provider enquire whether the client's reproductive goals and plans (number and timing of children) have changed since the last visit?

   0 = NO
   1 = YES

4. Did the provider enquire whether the client was breastfeeding?

   0 = NO
   1 = YES
   2 = CLIENT WAS BREASTFEEDING DURING CONSULTATION

5. Did the provider enquire whether the client had any problems with the method currently being used?

   0 = NO (Go to question 6)
   1 = YES

5a. If YES: Did the provider discuss how to manage the problems with the method?

   0 = NO
   1 = YES
   8 = CLIENT HAD NO PROBLEMS

6. Did the provider enquire whether the client wanted to switch methods?

   0 = NO
   1 = YES

7. Did the client decide to switch methods?

   0 = NO (Go to question 23)
   1 = YES (Go to question 11)

8. Did the provider enquire about the client's reproductive goals and plans (number and timing of children)?

   0 = NO
   1 = YES

9. Did the provider enquire whether the client is currently breastfeeding?

   0 = NO
   1 = YES
   2 = CLIENT WAS BREASTFEEDING DURING CONSULTATION

Fisher A, B Mensch, R Miller, I Askew, A Jain, C Ndoti, L Ndhlovu and P Tapsoba. 1992. *Guidelines and Instruments for a Family Planning Situation Analysis Study*. NY: The Population Council.

10. At the beginning of the consultation did the client indicate that she wanted to use (or switch to) a particular method?

    0 = NO
    1 = YES (Go to question 10b.)

10a. At the beginning of the consultation did the provider inquire whether the client wanted to use (or switch to) a particular method?

    0 = NO (Go to question 11)
    1 = YES

10b. If YES to question 10 or question 10a: What was the method?

    1 = PILL NOT SPECIFIED
    2 = PROGESTERONE-ONLY PILL
    3 = COMBINED PILL
    4 = CONDOM
    5 = IUD
    6 = INJECTABLE
    7 = FEMALE STERILIZATION
    8 = VASECTOMY
    9 = SPERMICIDE
    10 = NATURAL FAMILY PLANNING
    11 = NORPLANT®
    12 = OTHER _____

11. Tick if any of the following were discussed when the provider talked about family planning methods. (Tick all that are discussed)

DISCUSSED?	PILL ANY TYPE	COMB. PILL	PROG. ONLY PILL	CON. DOM	IUD	INJECT. ABLE	FEM. STER.	VASEC. TOMY	NOR. PLANT®	SPERM. ICIDE	OTHER
1. METHOD MENTIONED											
2. HOW IT WORKS											
3. EFFECTIVENESS											
4. HOW TO USE IT											
5. CONTRA-INDICATIONS											
6. SIDE EFFECTS											
7. MANAGEMENT OF SIDE EFFECTS											

12. When discussing family planning methods, did the provider use any of the following IEC materials? (Tick all that were used)

IEC MATERIAL USED	TICK IF USED
1. FLIPCHART	
2. BROCHURE/PAMPHLETS	
3. INSTRUCTION SHEET	
4. EXAMPLES OF CONTRACEPTIVES	
5. OTHER (Specify) _____	
6. OTHER (Specify) _____	
7. OTHER (Specify) _____	
8. OTHER (Specify) _____	

13. Was the client's medical history taken?

0 = NO
1 = YES

14. Did the provider ask the date of the last menstrual period?

0 = NO
1 = YES

15. Did the provider ask about unusual vaginal bleeding?

0 = NO (Go to question 16)
1 = YES

15a. If YES: Does she have unusual vaginal bleeding?

0 = NO
1 = YES

16. Did the provider ask about unusual discharge?

0 = NO (Go to question 17)
1 = YES

16a. If YES: Does she have unusual discharge?

0 = NO
1 = YES

17. Did the provider ask about pelvic pain?

0 = NO (Go to question 18)
1 = YES

17a. If YES: Does she have pelvic pain?

0 = NO
1 = YES

18. Was weight taken?

0 = NO
1 = YES

19. Was blood pressure taken?

0 = NO (Go to question 20)
1 = YES

19a. If YES: Was it high?

0 = NO
1 = YES
9 = DON'T KNOW

20. Was lab screening done for STDs?

0 = NO
1 = YES

21. Was a physical exam performed?

0 = NO
1 = YES, PARTIALLY
2 = YES, FULLY

22. Was a pelvic exam performed?

0 = NO (Go to question 23)
1 = YES

22a. If YES: Did the provider use a sterile speculum?

0 = NO
1 = YES
9 = DON'T KNOW

22b. Prior to the exam, was the client informed what is involved in a pelvic examination?

0 = NO
1 = YES

22c. Was anything abnormal discovered during the pelvic exam?

0 = NO
1 = YES
9 = DON'T KNOW

22d. Did the provider wash his/her hands before the exam?

0 = NO
1 = YES

22e. Did the provider use gloves to perform the exam?

0 = NO
1 = YES, STERILE GLOVES
2 = YES, NONSTERILE GLOVES
9 = DON'T KNOW

NOTE: The remaining questions should be completed for *all clients*.

23. What was the outcome of the visit?

0 = NO METHOD WAS ACCEPTED
1 = COMBINED PILL ACCEPTED
2 = PROGESTERONE-ONLY PILL ACCEPTED
3 = CONDOMS ACCEPTED
4 = FOAM ACCEPTED
5 = IUD ACCEPTED
6 = INJECTION ACCEPTED
7 = FEMALE STERILIZATION ACCEPTED
8 = VASECTOMY ACCEPTED
9 = NORPLANT® ACCEPTED
10 = COMBINED PILL RESUPPLIED
11 = PROGESTERONE-ONLY PILL RESUPPLIED
12 = CONDOMS RESUPPLIED
13 = FOAM RESUPPLIED
14 = INJECTION RESUPPLIED
15 = CLIENT DECIDED TO CONTINUE WITH FP METHOD
16 = CLIENT DECIDED TO DISCONTINUE METHOD
17 = OTHER _____

24. Was the method accepted an appropriate choice given what you found out about the client's age, parity, reproductive goals, health, and attitudes?

0 = NO
1 = YES
9 = CAN'T DETERMINE

25. If the method desired was not available at the SDP, did the provider inform the client where to get it?

0 = NO
1 = YES
2 = METHOD AVAILABLE AT SDP
3 = NO METHOD ACCEPTED

26. Did the provider inform the client when to return for a follow-up visit?

0 = NO (Go to question 27)
1 = YES

26a. If YES: Did the provider use cards or other memory props?

0 = NO
1 = YES

27. Was the client told what to do if she experienced problems before the next visit?

0 = NO
1 = YES
9 = NOT APPLICABLE, NO METHOD ACCEPTED

28. Did the provider inform new acceptors where to go for resupplies?

0 = NO
1 = YES
8 = CURRENT VISIT FOR RESUPPLY
9 = NO METHOD ACCEPTED

29. Were any other health issues discussed during the interaction?

0 = NO (Go to question 30)
1 = YES

Operations Research

QOC Element(s)

Comprehensive assessment and improvement

Description

Operations Research (OR) is a problem solving process that comprises five steps: 1) problem identification and definition; 2) strategy or intervention selection; 3) strategy experimentation and evaluation; 4) information dissemination; and 5) utilization of study findings. Operations research is used to increase the efficiency and effectiveness of services and to improve the quality of services. It is also used to increase access to family planning and to improve the acceptability of services. OR studies can be diagnostic or exploratory, field intervention studies, or evaluation studies.

Advantages

The OR methodology focuses on practical ways to solve operational problems in service delivery. Impediments to quality can be identified through diagnostic studies and various approaches to problem solving can be compared through intervention studies.

Disadvantages

The research design can be complicated and require outside assistance or highly trained research staff. Strategies for intervention are not always implemented because they are often identified by researchers and outsiders rather than by staff involved in the work processes. Actions taken can be perceived as imposed from outside.

Examples

1. Fisher et al. (1991) provides a detailed guide to OR processes and objectives.

2. An OR study was conducted in Burkina Faso by the Ministry of Health and Columbia University to determine if integrating maternal and child health services within family planning services would be more effective than the existing system which offered these services on alternating days. Each center was allowed to make its own decisions about reorganizing staff and physical resources. The study found that overall the integration of services had a positive impact on the quality and quantity of services provided, staff effectiveness and client satisfaction. (Direction de la Santé de la Famille and Columbia University, 1990)

Examples, cont.

3. Conversely, an OR study in Peru showed that it was more effective in this case to separate family planning services from reproductive health services. Although in Peru these services were typically integrated, the Ministry of Health suspected that in hospital-based clinics the demand for other services left little time or resources for family planning. Further, because of staff rotations, there was no guarantee that the staff member providing family planning had the necessary training. The study compared single-purpose family planning clinics in hospitals with the integrated clinics and found that the new single-purpose clinics not only attracted greater numbers of new family planning clients, but also attracted more men, a group previously thought to be underserved. (Solari et al., 1989)

4. Several other examples of OR studies are described elsewhere in this catalog. For example, see consumer intercept studies (Green, 1988), panel studies (Allen et al., 1991; Stover 1991), observation (Kim et al., 1992), simulated/mystery clients (Huntington et al., 1990; Schuler et al., 1985) and situation analysis (Miller et al., 1991).

Attachments

"Illustrative Topics for OR Studies" from Fisher et al., 1991.

Citations

The Africa Operations Research and Technical Assistance Project. 1992. *Eighth Semi-Annual Report Excerpts*. NY: The Population Council. October.

Bruce J and A Jain. 1991. "Improving the Quality of Care Through Operations Research," in Seidman M and M Horn. 1991. *Operations Research: Helping Programs Work Better*. NY: Wiley-Liss.

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Solari A and R Maurtua, E Huaita, J Rosen and J Foreit. 1989. "Operations Research to Improve the Ministry of Health Family Planning Services in the Departments of Ayacucho and Huancavelica, Peru." Final Technical Report, Vecinos Peru (VECINOS) and The Population Council. As cited in Way A, N Murray and MC Horn. 1991. "Quality of Care: What OR projects have learned." Presented at the annual meeting of Operations Research for Health and Development. June 27.

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Illustrative Topics for OR Studies

Hundreds of health and family planning OR studies have been completed in Asia, Africa, and Latin America. For the purpose of illustration only, we list below nine general areas that often are the focus of operations research studies.

1 **Training Programs**. Countless health and family planning workers have received training throughout the world. Frequently, OR studies are conducted to examine the content and methods of training, or to compare one type of training approach against another in terms of field-worker knowledge and performance.

2 **Information, Education, and Communication (IEC)**. Providing information to people is a major activity of most health and family planning programs. OR studies are often designed to compare different communication approaches in terms of message understanding, message retention, cost-effectiveness, and the ability to reach specific target audiences.

3 **Management Information Systems**. All health and family planning programs collect information on clients and services delivered. Sometimes, however, the information is inaccurate or simply not used for any administrative purposes. OR studies can be designed to experiment with new data collection systems and to test new procedures for using the information collected to improve services.

4 **Program Impact**. OR studies frequently test prospectively and in field settings the impact of different approaches to service delivery, such as the use of community-based distributors (CBDs) or traditional birth attendants (TBAs). Impact can be measured in many different ways by examining, for example, contraceptive prevalence, contraceptive continuation rates, client satisfaction with services, or increased availability and accessibility of services.

5 **Administration and Management**. Qualitative assessments of program administration and management are sometimes the focus of OR diagnostic studies.

6 **Quality of Care**. Increasingly OR studies have been directed at evaluating the quality and acceptability of services offered to clients. These studies can provide an analysis of the current situation of health and family planning services.

7 **Commercial Channels of Distribution**. Many family planning programs use commercial outlets such as pharmacies to distribute nonprescription contraceptives. OR studies can be designed to compare commercial against noncommercial service delivery systems.

8 **AIDS (HIV) and Family Planning**. In many countries program administrators are concerned about the potential impact AIDS (HIV) may have on family planning activities. In Africa and Latin America, a number of OR studies have been conducted to test the effect of integrating AIDS (HIV) information and education into on-going family planning programs.

9 **Male Involvement in Family Planning**. In some national family planning programs, attention has been directed almost exclusively at females and most services are available only at MCH centers. Testing mechanisms for involving males in family planning programs and providing them with appropriate services either at the work place or elsewhere has been a focus of many OR studies.

Obviously there are many other topics that could become the focus of an operations research study. Whatever the topic selected, it is important to remember that the primary goal of operations research is not merely to collect information and discover the reason for a problem situation. It is to use the information collected to solve the problem. Designing and conducting an OR study is only one part of the entire operations research process. Disseminating the results from the study and then utilizing these results to improve service delivery constitutes the other essential part of the OR process.

Panel Studies

QOC Element(s)

Continuity of care, acceptability and appropriateness, information to users

Description

Panel studies consist of a series of interviews with the same individuals over time and are used to measure behavioral changes.

Advantages

These long-term studies can give answers to questions which are otherwise hard to obtain (e.g., on access, side-effects, switching and stopping). Can be used to examine service delivery as an individual's reproductive intentions change over time.

Disadvantages

Panel studies are very expensive. Following individuals over long periods of time can be difficult and many may be lost to follow-up. Attempts to track those who are lost can take considerable time and resources.

Examples

Used by SOMARC in Egypt.

1. SOMARC used a panel study to evaluate whether a social marketing program could rely on commercial outlets to provide high quality services comparable to family planning clinics. The Egyptian social marketing program tracked nearly 1,500 women for 2 years and analyzed the experiences of over 700 who reported using the pill. Half who obtained pills from pharmacies were still using the pill compared to just over one-third who obtained pills from clinics. However, women who used both clinics and pharmacies had the highest continuation rates (two-thirds). The study showed that commercial outlets can provide good quality family planning services for oral contraceptive users. (Stover, 1991)

2. The Egypt panel study also examined knowledge of correct oral contraceptive use among women who obtained their products from a pharmacy, and continuation with the CSM orals brand compared with other brands. Between the first and second interviews, 9.4% of the sample dropped out of the study. The study found no significant difference in knowledge between CSM brand users and non-CSM users, while continuation rates were higher among those using the CSM brand. The concern that women who obtained their products through CSM projects would have higher discontinuation rates was not supported by the results. (Allen et al., 1991)

Attachments

"Objectives of the Study" and "Research Methodology," pp. 5-7, from Fateem, 1986.

Citations

Allen H, S Tipping and S Maher. 1991. "Norminest in Egypt: Comparing the CSM Brand to Other Oral Contraceptives." *SOMARC Occasional Papers*, Number 12. January.

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(A) MANAGEMENT NEEDS OF MARKETING INFORMATION

A family planning decision-maker needs basic information on which to base his daily decisions. This information generally revolves around the characteristics of the public he is dealing with, its attitudes toward family planning methods as well as actual behaviours.

The importance of this information corresponds to the increasingly complex and expanding market. This fact is especially applicable to the contraceptive market in Egypt. This market is characterized by contradictory attitudes and conventions, and a variety of organizations that are responsible for distributing contraceptives: in the public and private sectors. The multiplicity includes another set of objectives and approaches.

Moreover, there are different kinds of contraceptives for each spouse, some of which are acceptable while others are not. On the other hand, marketing of contraceptives involves a substantial market of a large age span; i.e., from 15 to 49 years of age. This market is also varied socio-economically, spanning nearly all social categories, as well as geographic regions. This means a lot of cultural and intellectual differences.

B.OBJECTIVES OF THE STUDY

1. To Explore the most important demographic charcteristics of contraceptive users in urban areas in Egypt: that is to explore the charcteristics of users and non-users.

2. To Find out the attitudes of contraceptive users concerning family planning, as well as the sources of and reasons behind these attitudes.

3. To Know the use experience of each brand of contraceptive, sources of this experience as well as problems, side-effects and ways of dealing with them.

4. To Explore the changes in attitudes and practices over a certain period of time, as well as the aspects, trends and expalanations of these changes.

-Achieving these objectives will enable the managemetn to make the following marketing decisions:

1. To Rapidly respond to changes occuring in the contraceptive market.

2. To Design marketing strategies in accordance with available data.

3. To Formulate policies for the expansion of family planning services based on the actual needs of the market.

C. RESEARCH METHODOLOGY

1. Definition of the study

The longitudinal study is the "repeated measuring of the same variables, for the same individuals, during a certain period of time."* This kind of study is considered to be a prinicpal source of marketing information that deals with the purchasing behaviour on a continuour basis

2. Stages of the study:

FIRST: Determining the study objectives and method of data collection: A committee of Experts in the population field was formed.

These experts represent different specifications that deal with the issue at hand (statistics, demography, anthropology, sociology, psychology, research, medicine, pharmacology). This committee has determined the study objectives as well as topics to be researched. It has also been agreed that the tool of study would be the "structural interview through a questionaire" for the following reasons:

a. The large sample size for which the treatment and analysis of data from the structured interview are easier than those of the open-ended interview.

b. Using a large number of researchers necessitates the following of a limited number of steps. Only the structured interview fulfills this requirement.

c. Diversity of topics in the interview and multiplicity of details necessitate using the structured interview.

SECOND: Determining the frequency of measuring and the time span. It has been decided that the time span for this study will be 2 years. Respondents will be visited 6 times. Intervals between visits will be 4 months so that an experience related to contraceptives may be accumulated during that period.

(FN) *Parfitt "Panel Research" In: R.M. Warchester, Consumer Market Research Handbook, MC. Grow Hill, London 1972 pp 43-177.

THIRD: Designing the questionaire: The Committee of Experts has seen that although the usual procedure in different surveys is to start an interview with talking about knowledge, then attitudes and finally practice (K.A.P)-the nature of the current study necessitates the reverse. Therefore, the interview will start by asking questions about practice, then attitudes and finally knowledge (P.A.K.). The reason for this switch is the importance of actual practice in this current study. Moreover, starting an interview through a discussion of knowledge and attitudes may affect responses.

FOURTH: Frame Sample Data Collection Card:
A data collection card has been designed to be used in data collection at large, out of which the sample will be drawn. This card includes basic data about husband and wife, use or non-use of contraceptives, number of children.etc... It also includes whether this individual agrees to participate in the study, and suitable visiting times.

FIFTH: Pretesting the tool of the study: The questionaire has been pretested on categories of the public that represent the study sample in characteristics. This was done in order to assure clarity and consistency of the phraseology.

SIXTH: Training of Researchers: Forty (40) researchers have been trained to interviews and to administer the questionaire. Ten (10) researchers have been trained to check and code the questionaire. This intensive training also facilitated maximum agreement among researchers.

At this stage of the study, the work plan was formulated into the following segments:

a. Data collection of the entire sample frame: February to May, 1985. (collecting data for about 12940 families).
b. Data collection of the first wave of the study : August - September, 1985.
c. Data analysis, and the final report writing: October to December, 1985.

Patient Flow Analysis/Client Flow Analysis

QOC Element(s)

Acceptability and appropriateness

Description

Patient Flow Analysis (PFA) is a computerized system developed by the CDC to perform a time and motion study during one clinic session. It documents utilization of staff time and patient flow and can be used to identify problems in patient flow, determine personnel and space needs, and document personnel costs per patient visit. The results are presented in a graphical representation of the clinic session and a statistical report which includes a summary and six tables. These provide information on how patient and staff time are used and a cost-analysis of services provided. In addition, there is a simulation program which can be used to manipulate the data and illustrate the effects of proposed solutions to the problems highlighted by PFA.

Advantages

Can help clinic run more efficiently by using staff more effectively, by decreasing client waiting time and by reducing personnel costs. PFA is rapid, inexpensive and easily learned. Data collection takes one day, and results can be prepared in one to two days. Costs are minimal; the software is free. Collection and analysis of data is easily learned and training can be done in one week.

Disadvantages

Doesn't directly address quality of care, just identifies problems. Clinic must then work to develop and implement improvements. If an outside agency without "line authority" performs PFA, clinics may elect not to make any changes (this is what happened in Costa Rica- see example below). Difficult to implement without a computer though it has been modified by AVSC for use without a computer (see COPE).

Examples

1. Has been used in family planning clinics throughout the U.S. and internationally. Used extensively by IPPF/WHR (referred to as Client Flow Analysis (CFA)). (Helzner and Kopp, 1991)

2. PFA has been carried out in seven Latin American countries. Commonly observed problems include: inappropriate arrival patterns for patients, improper sequencing of patients through the clinic, late staff arrival and disruptions caused by closing of the clinic for lunch. In response to PFA results, a clinic in Quito increased staff by 25%, staggered work schedules so the clinic would not close for lunch, and remodeled the clinic to improve patient privacy. An analysis 11 months later showed average waiting time decreased from 62 to 32 minutes, average patient time in clinic decreased by 31 minutes and number of clients served increased by 32%. (Berrio et al., 1990)

Examples, cont.

3. PFA was implemented in 52 out of 55 family planning clinics in Costa Rica in 1985. Problems found included inefficiencies in the appointment system which resulted in longer patient waiting times, long waits for pharmacy services, extremely early arrival of clients, services slow in starting, and under- or over- utilization of staff. These findings led to improvements in many clinics, though 52% of the clinics decided not to make any changes. Changes included improving or implementing an appointment system, reassigning tasks among clinic staff or altering working hours, and making it easier for patients to pick up oral contraceptives from the pharmacies. Average patient waiting time decreased by 65 minutes in clinics that made changes and increased by 17 minutes in clinics that didn't. Clinics that changed their appointment systems showed a decreased waiting time of over 1½ hours. Reasons why so many clinics did not make any changes included a general reluctance to change and, as stated by 26 clinics, because the agency which conducted the PFA did not have any "line authority." (Hudgins and Merino, 1988)

Attachments

Study Coordinator's Checklist, from CDC.

See also: Attachments for COPE, in the improvement tools portion of this catalog.

Citations, cont.

Berrio DE, A Hudgins and M Quevedo. 1990. "Issues in Family Planning Clinic Management in Seven Latin American Countries." Paper presented at the annual meeting of the Population Association of American, Toronto, Canada, May.

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Citations

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Hudgins AA and L Merino. 1988. "Computerized Patient Flow Analysis in Costa Rica." Paper presented at the annual meeting of the Population Association of America, New Orleans, LA. April 21-23.

Centers for Disease Control. 1992. "Patient Flow Analysis in General Outpatient Clinics: Instructions for Collecting Data." Public Health Service, Department of Health and Human Services.

Study Coordinator's Checklist

PLANNING AND ORGANIZING THE STUDY

- ☐ Determine the Data Set Number (State, County, Site and Session Codes).
- ☐ Decide on the date of the study session.
- ☐ Decide the way in which Patient Registers will move through the clinic.
- ☐ Decide which staff members will participate in the study session.

COLLECTING DATA

☐ PREPARE FORMS

Personnel Worksheet (Form 5)

- ☐ List staff for clinic
- ☐ Assign Personal Identification Codes
- ☐ Complete Personnel Worksheet (optional)

Personnel Register (Form 2)

- ☐ Enter Personal Identification Codes on Personnel Registers (one for each staff member).

Patient Register (Form 3)

- ☐ Determine how Patient Registers will move through the clinic.
- ☐ Hold orientation for staff

☐ INSTRUCTION SESSION

- ☐ Give general instructions: Fill empty boxes to the left of single digit (or double digit) numbers with zeros; use pencil and block letters, write legibly, use one number or letter per box.
- ☐ Give time-out and time-in instructions.
- ☐ Give CALL instructions.
- ☐ Explain how to record patient contacts on Patient Registers.
- ☐ Identify staff who change jobs and instruct them about what to do.
- ☐ Explain that overlapping staff contacts and multiple encounters are all right.
- ☐ Synchronize clocks and watches.
- ☐ Distribute Personnel Registers, note staff arrival times.
- ☐ Place Patient Sign-In Sheet and supply of Patient Registers at reception desk.
- ☐ Instruct receptionist.

☐ COORDINATE STUDY AND RETRIEVE FORMS

- ☐ Keep log of events that are not recorded on forms but influence patient flow.
- ☐ Be available for questions.
- ☐ Help staff members who switch jobs to complete new Personnel Registers.
- ☐ Collect Personnel Registers at end of clinic session.
- ☐ Check against Personnel Worksheet to be sure all are accounted for.
- ☐ Collect Patient Registers.
- ☐ Check against Patient Sign-In Sheet to be sure all are accounted for.

☐ COMPLETE FORMS

Clinic Register (Form 1)

☐ Complete Lines 1-9.

Personnel Register (Form 2)

☐ Complete Lines 2 and 3.

☐ Complete Lines 7-12.

Patient Register (Form 3)

☐ Complete Lines 2 and 3 from information on the medical chart.

☐ Complete Lines 4 and 5 from information on Patient Sign-In Sheet and appointment book.

WRAPPING UP THE STUDY

☐ Conduct visual edit.

☐ Put forms in order and check for completeness.

☐ Send batched forms to data processor with instructions and include your *address and phone number.*

☐ File Personnel Worksheet (Form 5), Patient Sign-In Sheet (Form 4), Code List (Form 6) and log for use in error correction and data interpretation.

NOTES

Program Quality Assessment Tool (PQAT)

QOC Element(s)	**Comprehensive assessment**
Description	Uses fifteen indicators to evaluate program quality in the service delivery organization. Though it makes use of the Bruce framework, it focuses on the service delivery organization, rather than the client. Integrates key design issues (e.g., technical and administrative management and client access), inputs (resources and technical support), and program outcomes (continuation). Should provide all information to identify changes necessary to meet PQAT standards.
Advantages	Becoming more user-friendly. Designed as a practical tool for managers to evaluate program performance.
Disadvantages	The tool is still being developed. Successful use of PQAT depends on use of trained assessors. Assessors must develop good rapport during assessment so that the tool is viewed not as punitive or threatening, but rather as educational. Summary tally sheet uses negative terminology (e.g. comments on negative assessment).
Examples	Has been used in six countries. Used by Pathfinder to evaluate all eight clinics of the Jordanian Association of Family Planning and Protection. Three to four hours were spent at each clinic. The doctor in charge of the clinic was oriented to PQAT. After the doctors and nurses in the clinic were observed, the doctor in charge and the assessor independently completed the evaluation. They jointly completed Pathfinder's Non-VSC site visit checklist. Evaluation findings were: all but one of the clinics had adequate accessibility, IEC outreach was poor, the MIS system was poor, supervision was generally adequate, and in some clinics there were concerns about safety, technical competence and poor facilities. A series of recommendations were made. (Raghavan-Gilbert and García-Núñez, 1990)
Attachments	"Analysis of Program Quality Variables" and "PQAT Template," from Raghavan-Gilbert, 1991.

Citations

Raghavan-Gilbert P. 1989. "Closing the Implementation Gap: Jointly Developed Standards as Ethical Tools." MA: The Pathfinder Fund.

Raghavan-Gilbert P. 1991. "A Program Quality Implementation Assessment Tool." Paper presented at the annual meeting of the American Public Health Association, Atlanta, GA. November 10-14.

Raghavan-Gilbert P and J García-Núñez. 1990. "Quality of Care." Final report. MA: Pathfinder Fund.

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ANALYSIS OF PROGRAM QUALITY VARIABLES

Program quality variables	Treatment specification	Link to quality	Link to action
Competence	Training SOP use Knowledge Interpersonal	Imported technologies Technology transfer and integration	Case mgt Practice Communication Supervision
Choice	Range available Method mix	Options Coercion Paternalism	Commodities acquisition Provider training Supervision
Safety	Infection control Commodities storage	Invasive procedures Method failure	Training Management support Supervision
Medical back up	Technical back up	Emergency protocols	Organizational routines
Adequacy of commodities	Written inventory	Unbroken supply	Training Org: routines
Adequacy of expendables	Written inventory	SOP application	Training Org: routines
Adequacy of equipment	Written inventory	Safe practice	Training Org: routines
Physical facilities	Appearance Privacy Ventilation Water available Toilet/WC Signs & directions Client flow	Consumer preferences Client satisfaction	Upgrade facilities Management training Supervision

Raghavan-Gilbert P.1991."A Program Quality Implementation Assessment Tool". Paper presented at the annual meeting of the American Public Health Association, Atlanta, GA. November 10-14.

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Program quality variables	Treatment specification	Link to quality	Link to action
SOP & protocols (Guidelines)	Clinical SOP IC SOP Admin/Mgt. SOP Current literature	Specify current standard Technical and mgt practice	Management support Training Supervision
IEC	Hospital outreach Community outreach Teaching aids Information mat'ls	Parallel activity Communication	Program policy Organizational routines
MIS	Record forms Service statistics	Reliable client data Reliable program data	Program policy Training Supervision
Supervision	Project supervision Clinic supervision Supervisory tools Supervisory workplan	Supportive close supervision at all levels Structured supervision	Management support Training Supervision
Monitoring	Program performance Program feedback	Intrinsic rewards Motivation	Linkage of field to management and trainers
Client follow up system	Defaulter tracing Appointment system	Program and method continuity	Program policy changes
Accessibility	Cost Distance Waiting time Cultural barriers Functional access	Program use Program non-use Program discontinuation	Program design Program redesign

Exhibit B: Program Quality Assessment Tool Template

Indicators of Program Quality	good to adequate	less-than adequate	Cause of negative ** assessment	Recommended Improvements	Additional Notes
Competence Technical competence Use of cl. guidelines Counselling content Interpersonal process					
Adequacy of choice Range of methods available Actual method mix					
Safety of services Infection control Commodities storage					
Medical back up					
Adequacy of commodities Written inventory					
Adequacy of Expendables Written inventory					
Adequacy of Equipment Written inventory					

** EVERY NEGATIVE ASSESSMENT MUST HAVE A COMMENT OR EXPLANATION THIS MUST BE FOLLOWED BY SPECIFIC RECOMMENDATIONS FOR IMPROVEMENT.

Indicators of Program Quality	good to adequate	less-than adequate	Cause of negative ** assessment	Recommended Improvements	Additional Notes
<u>Physical facilities</u> Appearance Water Ventilation Privacy Toilet/W.C. Client flow Signs/Directions					
<u>Guidelines&protocols</u> Clinical guidelines IC guidelines Admin/Mgt guidelines Current literature					
<u>IEC</u> Hospital outreach Community outreach Teaching aids Informational material					
<u>MIS</u> Client record forms Service statistics					

** EVERY NEGATIVE ASSESSMENT <u>MUST</u> HAVE A COMMENT OR EXPLANATION THIS <u>MUST</u> BE FOLLOWED BY SPECIFIC RECOMMENDATIONS FOR IMPROVEMENT.

Exhibit B, cont.

Indicators of Program Quality	good to adequate	less-than adequate	Cause of negative ** assessment	Recommended Improvements	Additional Notes
<u>Supervision</u> Project supervision Clinic supervision Supervisory Tools Supervisory workplans					
<u>Monitoring</u> Program performance Program feedback					
<u>Client follow up</u> Defaulter tracing Appointment system					
<u>Accessibility</u> Cost Distance Waiting time Cultural barriers Functional access					
OTHER COMMENTS:					

** EVERY NEGATIVE ASSESSMENT <u>MUST</u> HAVE A COMMENT OR EXPLANATION THIS <u>MUST</u> BE FOLLOWED BY SPECIFIC RECOMMENDATIONS FOR IMPROVEMENT.

Quality Definition and Assessment

QOC Element(s)	**Comprehensive assessment**
Description	Defines a standard of quality as a set of attributes. Requires managers and providers to assess the ideal and actual levels of quality for each attribute within their family planning organization.
Advantages	Takes into account that the definition of high quality will vary among settings and is dependent on political realities and resource constraints.
Disadvantages	Evaluation is subjective and should not replace direct assessments. This is the first stage in the process to define and improve quality.
Examples	To be field tested by the Population Council.
Attachments	"Quality of Care: Definition and Assessment." From Jain et al., 1992.
Citations	Jain AK, B Mensch and J Bruce. 1992. "Quality Definition and Assessment." Population Council.

Jain AK, B Mensch and J Bruce. September 18, 1992. "Quality Definition and Assessment." Population Council.

The Population Council

Quality of Care: Definition and Assessment

Family planning program managers in most countries do intend to provide services of adequate quality. We understand that political realities and resource constraints must be considered while implementing their desire to provide services of high quality and to plan improvements in a logical sequence. The definition of high quality may itself vary from setting to setting. We would like your assistance in identifying important attributes of high quality programs that are relevant in most developing countries.

To achieve this objective, we have identified a set of attributes that may be used to define a program of high quality. Two questions are asked for each attribute. The first question refers to the emphasis or importance a program should place and the second question refers to the emphasis your program actually places on a particular attribute. Please feel free to circle 0 if a particular attribute is not relevant in your setting or if your program places no emphasis on it. Please circle 3 if a particular attribute is most important or if your program places most emphasis on it. Please feel free to add any other attributes(s) that you think are most important for a high quality family planning program.

A. How much emphasis should family planning programs place on the attributes included in the enclosed table.

0. No emphasis
1. Minor emphasis
2. Moderate emphasis
3. Considerable emphasis

B. How much emphasis does your program actually place on the attributes included in the enclosed table.

0. No emphasis
1. Minor emphasis
2. Moderate emphasis
3. Considerable emphasis

Attributes of Family Planning Programs of High Quality	Ideal emphasis	Actual emphasis
1. a. Providing an appropriate choice of methods to a significant proportion of clients	0 1 2 3	0 1 2 3
b. Not promoting any particular method	0 1 2 3	0 1 2 3
c. Not restricting any particular method	0 1 2 3	0 1 2 3
2. Ensuring that providers are technically competent in:		
a. Screening clients for contraindications	0 1 2 3	0 1 2 3
b. Supplying 'clinical' methods	0 1 2 3	0 1 2 3
c. Applying effective aseptic techniques	0 1 2 3	0 1 2 3
3. Ensuring that clients receive information about:		
a. Method options appropriate to client needs	0 1 2 3	0 1 2 3
b. Contraindications of method selected	0 1 2 3	0 1 2 3
c. Common side effects of method selected	0 1 2 3	0 1 2 3
d. Follow up requirements of method selected	0 1 2 3	0 1 2 3
e. Duration of effective use of method selected	0 1 2 3	0 1 2 3
f. Possibility of switching the method if it turns out to be not suitable	0 1 2 3	0 1 2 3
g. Possibility of switching the source of supply	0 1 2 3	0 1 2 3
4. Ensuring that providers assist client's choice process by soliciting information from clients about client's:		
a. Background (age, number of children)	0 1 2 3	0 1 2 3
b. Reproductive goals (timing of next desired child)	0 1 2 3	0 1 2 3
c. Attitudes and preferences for contraceptive methods	0 1 2 3	0 1 2 3
d. Prior experience with contraceptive methods	0 1 2 3	0 1 2 3
5. Ensuring that clients make a specific appointment for a follow up visit or a specific plan for resupply with providers	0 1 2 3	0 1 2 3
6. Ensuring that clients receive visual and physical privacy for:		
a. Information sharing and personal interviews	0 1 2 3	0 1 2 3
b. Physical examination/method provision	0 1 2 3	0 1 2 3
7. Ensuring that providers treat clients with dignity and respect	0 1 2 3	0 1 2 3
8. Other (please specify)_____	0 1 2 3	0 1 2 3

Simulated/Mystery Client Studies

QOC Element(s)

Client-provider interaction, information to users, choice of methods

Description

In these studies, individuals and/or couples are trained to pose as actual clients at a family planning clinic in order to examine the user's perspective. It is best to select clients who represent a cross-section of the clinic's actual client-base, and also to select those who are actually interested in family planning so they can be themselves and not have to act. After the clinic visit, mystery clients are debriefed by a trained interviewer to solicit the clients' observations. Debriefings are generally tape-recorded. Interviews can be used to develop a questionnaire or guidelines for later use in interviewing clinic staff themselves.

Advantages

This is a relatively quick, low-cost technique which enables the direct observation of the clinic staff without their knowledge, so that staff won't be biased or on their "best behavior." Gives user's, not observer's, perspective.

Disadvantages

Clients will not be able to accurately recall all details in the debriefing session, nor be able to judge the technical competence of the service providers or assess if provider gave complete and accurate information. Information recalled will be distorted by client's own understanding and perspective. Must ensure clients remain anonymous or results will be biased.

Examples

1. Used in Nepal to determine why family planning services were underutilized and, in particular, if providers themselves contributed to underutilization. Couples and individual women of different socioeconomic backgrounds were trained as simulated clients. The study found that information provided is often incorrect or presented in a way which drives clients away, and that the quality of services is positively related to the socioeconomic status of the client. Interviews with clinic staff confirmed that they feel it is difficult to work with uneducated people and that uneducated people cannot understand the information presented. Therefore the staff must try to influence them "for their own good." In effect, staff feels that they must make the appropriate contraceptive choice for the clients since clients are not capable of making it for themselves. (Schuler et al., 1985)

Examples, cont.

2. Used in Ghana to evaluate counseling training programs. Women of different ages, martial status, education level and parity acted as mystery clients. Each mystery client was sent to one clinic with a trained counselor, and one with an untrained counselor. After both visits, the women were debriefed by trained interviewers. Clients noticed differences between trained and untrained counselors; trained counselors tended to provide more complete information about all available methods. However, counselors from both groups treated younger clients in a disrespectful manner and refused to give them information. Led the training program to incorporate a section on the treatment of young, single women. (Huntington et al., 1990)

3. Used by IPPF/WHR in Haiti. Local people were trained as mystery clients. After a clinic visit, they filled out a simple form recording their observations. Results showed that staff often had "inappropriate attitudes;" side effects and contraindications were not always explained and a full range of methods were not always offered. Service delivery organizations were then informed of deficiencies along with recommendations for improvement. (Helzner and Kopp, 1991)

4. SOMARC used mystery clients in Ghana to evaluate the effectiveness of the contraceptive social marketing training program for pharmacists and chemical sellers who were distributing oral contraceptives, condoms and vaginal foaming tablets. The study used a combination of observation and direct questioning. A female interviewer initially posed as a customer who wanted to purchase contraceptives, to determine what information was normally provided. Later, the same woman returned and requested additional information to share with her "association," and proceeded to ask direct questions about different family planning methods, their use and side effects. The study found that while knowledge of contraindications, side effects and method use was higher for trained than for untrained retailers, this knowledge was often not passed on to the customers. In addition, most of the retailers, whether trained or untrained, were negligent in asking screening questions for pill use. This study led SOMARC to conclude that their training course needed to better emphasize the counseling component. SOMARC now uses mystery client studies to evaluate all of their CSM retailer training programs. (Tipping and Adamchak, 1990)

Attachments

Ecuador Questionnaire Mystery Shopper Interview. From SOMARC.

Citations

Helzner JF and SZ Kopp. 1991. "Quality of Care in Family Planning: Perspectives from IPPF/Western Hemisphere Region." Draft report. March 1.

Huntington D, C Lettenmaier and I Obeng-Quaidoo. 1990. "User's Perspective of Counseling Training in Ghana: The 'Mystery Client' Trial." *Studies in Family Planning* 21,3:171-177.

Schuler SR, EN McIntoch MC Goldstein and BR Pande. 1985. "Barriers to Effective Family Planning in Nepal." *Studies in Family Planning* 16,5:260-270.

Tipping S and S Adamchak. 1990. "A Mystery Shopper Study: Evaluation of the retailer training component of the Ghana Contraceptive Social Marketing Program." SOMARC Occasional Papers, Number 10. July.

From SOMARC.

ECUADOR QUESTIONNAIRE MYSTERY SHOPPER INTERVIEW

Identification and Interview Result

A. Identification

CODE

1. Type of outlet: ☐ Pharm. ☐ Chem. Store
2. Name and address of outlet: ☐☐☐☐

_____

_____

_____

3. Description of person interviewed:

_____

_____

B. Pill Purchases

Brand: _____ ☐

Price: _____ ☐☐☐☐☐

C. Date and Time of Visit and Interview

Date: _____

Time: _____

Section 1. Mystery Shopper Information

(This section should be completed when you leave the shop--that is, outside of the shop after the first visit.)

1. Were you asked questions relating to your medical history or type of women who can safely take the pill? ☐ Yes ☐ No
2. If "yes" to (1):
   What questions were you asked?

   _____

   _____
3. Were you given any instructions about how to take the pill? ☐ Yes ☐ No
4. If "yes" to (3):
   What instructions were you given?

   _____

   _____
5. Were you given any information or any advice regarding any side effects you may experience when you take the pill? ☐ Yes ☐ No
6. If "yes" to (5):
   What information or advice were you given about pill side effects?

   _____

   _____

   _____
7. Were you told or advised to come back with questions? ☐ Yes ☐ No

General Report of First Visit

Please narrate what took place during your visit to the shop and during your interaction with the person who sold the product.

1. Did the retailer appear embarrassed when bringing out the product?

2. How interested was he/she in you and in providing information on products?

3. How knowledgeable or confident in methods/products did he/she seem?

4. Was the retailer in a rush or seem to have time for questions?

5. If you were a consumer, what degree of confidence would you have felt in this retailer?

Section 2. Direct Interview: Knowledge of Screening Questions and Instructions for Method Use

Approach the same pharmacist or clerk interviewed by the "mystery shopper" and say you are with MARKOP, a research firm, and you are conducting a survey about the birth control pill. You must interview the same person that the "mystery shopper" did. No substitutions can be allowed. Continue with the interview.

A. Screening questions:

1. Please, are the pills suitable for a woman who is 30 years old? ☐ Yes ☐ No
2. So, at what ages are the pills recommended to be taken?
3. If a woman is breastfeeding a three-month-old baby, can she take the pill? ☐ Yes ☐ No
4. Some people say if a woman has some health conditions she should not take the pill. Please, what are these conditions?

   Any others?

B. How to take the pill:

1. How should the pill be taken the first time I use it?
2. How often should I take it?

3. After I finish the first pack, on what day do I begin the next pack?

_____

4. If I forget to take the pill for one day, what should I do?

_____

_____

5. What about if I forget or something prevents me from taking the pill for two or more days? What should I do?

_____

_____

C. Pill types:

1. What is the difference between 21- and 28-day pills?

_____

_____

2. Which type of pill is best, low dose or high dose? Why?

_____

_____

D. Side effects:

1. Some people say if you take the pill for a long time you may be unable to become pregnant in future, when you want to have a child. Is this true? ☐ Yes ☐ No
2. So, does the pill have any (other) side effects at all? ☐ Yes ☐ No
3. If "yes" to (2):
   What are the side effects?

_____

_____

4. How long do the side effects last?

_____

5. What should I do if I have side effects?

_____

6. Can I start on the pill any time? When can I start on the pill?

_____

7. Does the pill cause cancer? ☐ Yes ☐ No
8. If I want to have a baby, what do I do with the pill?

_____

9. Is it true the pill causes sterility? ☐ Yes ☐ No
10. How often should I stop the pill to give my body a rest?

_____

11. How many years can I take the pill?

_____

12. Is the pill more or less safe compared to other methods? Why?

_____

_____

E. Training in family planning methods:

1. I understand some of the people from pharmacies and drugstores have attended training courses in family planning and contraceptive methods organized by Schering. Did you attend any of the courses? ☐ Yes ☐ No
2. What did you think of the courses?

_____

_____

3. Did the sessions make a difference in how comfortable you feel in advising consumers on family planning methods? ☐ Yes ☐ No

4. What difference?

_____

_____

5. How many persons from this shop have attended any of the courses? Number: _____

6. Please, may I know your name and position in this shop?

Name: _____

Position: _____

Section 3. Product Display and Advertising

A. Interviewer: Please look around for display of contraceptives, particularly pills and condoms.

Product	Samples of Products on Display				No Samples on Display
	Conspicuously and Exclusively on/in Display Box	Conspicuously on/in Display Box	Conspicuously Elsewhere	Not Conspicuously Elsewhere	
Pills					
Condoms					

B. Interviewer: Please look around for a display of posters/publicity materials on family planning, AIDS, pills, or condoms.

Product	Posters/Publicity Materials Available			No Samples on Display
	Conspicuously and Exclusively on/in Display Box	Conspicuously Inside Shop	Displayed/ Kept Elsewhere	
Family Planning				
Pill				
Condoms				
AIDS				

C. General comment on interview:

Please report and give any details on the interview.

_____

_____

_____

_____

Situation Analysis

QOC Element(s)	**Comprehensive assessment**
Description	Situation analysis is an approach which looks at service delivery points in a defined geographic area in order to describe the availability, functions and quality of health and family planning activities. On a more complex level it can analyze the relationship between performance and the quality of services provided and received. Finally, it can be used to determine whether improvements in quality will have an impact on contraceptive acceptance and continuation. One day is spent evaluating each study site on seven subsystems, or areas: logistics/supplies, facilities, staffing, training, supervision, IEC, and record keeping. Information is collected through direct observation and interviewing service providers and clients. There are four data collection instruments; obtaining this information takes from 4-6 hours/site. There are also three optional collection instruments. Research teams should include at least one person with a clinical background and one with a social science background and field interview experience. Each supervisor should be responsible for three or fewer research teams. Training generally takes at least eight days.
Advantages	Provides a comprehensive look at service delivery in a specified region. Identifies areas which need strengthening. Data can be easily and quickly collected, analyzed and made available to decision-makers.
Disadvantages	Results will be somewhat biased since staff members will be at their best during the analysis. (This bias could be lessened by spending more time at each site, though this may mean visiting fewer sites. As staff become used to the observer's presence, they might return to their usual behavior). Assessment will not be completely accurate if only spend one day at each site. Difficult to gain client perspective in a one-day visit.
Examples	Has been undertaken in several countries in Africa.

Examples, cont.

1. First tested in Kenya. Situation analysis was conducted at 100 of 775 Ministry of Health Service Delivery Points. Direct observation was used as much as possible, otherwise questionnaires were used. Three research teams of two members each conducted the analysis. Training took six days and the field work six weeks. Findings included complaints about long waiting times, that new clients were usually informed about at least two contraceptive methods though most clients were not informed about permanent methods, and that clients were usually told about the use and benefits of methods, but not about side effects and contraindications. Clients appeared to be generally satisfied (though this was difficult to measure) and providers appeared to be competent. (Miller et al., 1991)

2. Used in 53 of 91 service delivery points in Burkina Faso. A three-person team (social worker, social scientist and nurse/midwife) spent one day at each site. The team looked at the inventory of administrative sub-systems and service statistics, and observed all consultations with new clients, interviewed all service providers and all clients attending clinic for other than family planning and conducted exit interviews with all new clients. Also used a self-administered questionnaire for program managers at national and provincial levels. Epi Info was used for data entry and analysis. The most significant results were presented immediately to senior program and donor agency staff. Quality was found to be generally good. Weaknesses identified included a need for IEC materials and counseling training so that more information on a wider range of methods can be provided in a manner which can be understood by clients. Analysis was not able to measure client satisfaction though the impression was that it was high. (Ouédraogo et al., 1991)

3. The EVALUATION Project designed a set of situation analysis data collection modules to examine elements of quality of care. A local research group in Morocco administered the questionnaires to a sample of clinic clients and women who were not clients. Clinic supervisors were also actively involved in implementing the study. A preliminary analysis has been published by the local researchers and the Ministry of Health. Further analysis will link study items with the Bruce framework. English versions of the data collection instruments are available from the EVALUATION Project. (Bertrand, 1993)

Examples, cont.

4. A study in Côte D'Ivoire used situation analysis to derive a quality of care score for each delivery site, thereby enabling comparisons between clinics. Eleven indicators of quality of care were identified and linked to questions from four situation analysis questionnaires. Responses to the questionnaires were converted to percentages (and recoded when necessary for consistent scoring) and a mean score calculated. Although some methodological weaknesses were identified, it was felt that these scores provide useful information for illustrating differences in quality among the clinics. (Huntington et al., 1992)

Attachments

List of appendices, from Fisher et al., 1992.

"Analysis Plan for Quality of Care Component." From Ouédraogo et al., 1991.

"Indicators of Quality of Family Planning Services in an Ongoing Study in Morocco." From Bertrand, 1993.

Citations

Bertrand J. 1992. Presentation made at the EVALUATION Project Service Delivery Working Group meeting, December 9-10 and personal communication to K Hardee February 8, 1993.

Fisher A, B Mensch, R Miller, I Askew, A Jain, C Ndoti, L Ndhloru and P Tapsoba. 1992. *Guidelines and Instruments for a Family Planning Situation Analysis Study*. NY:The Population Council.

Huntington D, A Damiba, K Koffi and L Kouakou-Kouassi. 1992. "Assessing the Relation Between the Quality of Care and the Utilization of Family Planning Services in Côte d'Ivoire." Paper presented at annual meeting of the American Public Health Association, Washington, DC. November.

Miller R, L Ndhlovu, MM Gachara and A Fisher. 1991. "The Situation Analysis Study of the Family Planning Program in Kenya." *Studies in Family Planning* 22,3:131-143.

Ouédraogo Y, P Tapsoba, I Askew, D Bakouan and P Sebgo. 1991. "Quality of Care in the National Family Planning of Burkina Faso." Paper presented at the annual meeting of the American Public Health Association, Atlanta, GA. November 10-14.

Fisher A et al.1992. *Guidelines and Instruments for a Family Planning Situation Analysis Study*. New York:The Population Council.

LIST OF APPENDIXES

The questionnaires need to be adapted to reflect the local family planning program. For each study which has been undertaken thus far, the questionnaires were modified to suit the needs and interests of the program administrators and the organizational features of the specific program.

Appendix A: Inventory for Facilities Available at the Service Delivery Point and Summary of Service Statistics

Appendix B: Observation Guide for Interaction Between Consenting Family Planning Clients and Service Providers

Appendix C: Exit Questionnaire for Family Planning Clients Attending the Service Delivery Point

Appendix D: Interview Schedule for Staff Providing Family Planning at the Service Delivery Point

Appendix E: Questionnaire for Non-Family Planning Female Clients Attending the Service Delivery Point

Appendix F1: CBD Interview Schedule

Appendix F2: Observation Guide for Interaction Between Consenting Family Planning Client and CBD

Appendix F3: Exit Questionnaire for Family Planning Clients Attending the Service Delivery Points

Appendix G: Program Manager Questionnaire (Self-Administered)

Ouédraogo Y et al.1991. "Quality of Care in the National Family Planning of Burkina Faso." Paper presented at the annual meeting of the American Public Health Association, Atlanta, GA. November 10-14.

TABLE 1 **ANALYSIS PLAN FOR QUALITY OF CARE COMPONENT IN THE BURKINA FASO SITUATION ANALYSIS STUDY**

INDICATOR	Data Collection Instrument					
	Inventory (n = 53)	Staff Interviews (n = 93)	Observations (n = 66)	FP client interv. (n = 193)	Non-FP clients (n = 344)	Policymaker (n = 14)
1. Method choice a) legal restrictions						prescriptions necessary
b) logistical restrictions	method availability					perceived availability
c) provider bias		methods most recommended	emphasis on certain method(s)	reported method(s) discouraged		methods recommended
d) accessibility				travel time to clinic	travel time to clinic	
2. Information to clients a) type	content of clinic IEC materials		information given during consultation			instructions abo counselling inf
b) adequacy			appropriate choice discussed	ability to describe method chosen		instructions abo benefits/risks
3. Provider competence		method during breastfeeding	questions/technique during consultation			
4. Interpersonal relations a) understanding clients needs			needs and previous experience asked	perceived that felt needs met		instructions abo assessing needs
b) provider's interpersonal skills			two-way communication	perceived provider courtesy		instructions abo communicating
c) time spent on interaction			duration in minutes	waiting time		
d) client satisfaction			perception of client's feelings	expressions of satisfaction	expressions of satisfaction	
5. Continuity and follow-up	mechanism exists	action if referral	action for referral			follow-up proce
6. Constellation of services	MCH/FP services availability					perceived level integration

Bertrand J. 1992. Presentation made at the EVALUATION Project Service Delivery Working Group meeting, December 9-10 and personal communication to K Hardee February 8, 1993.

INDICATORS OF QUALITY OF FAMILY PLANNING SERVICES IN AN ONGOING STUDY IN MOROCCO [1]

MINISTRY OF HEALTH, SEATS, THE EVALUATION PROJECT

ELEMENT/INDICATOR	MODULE A INVENTORY OF FACILITIES	MODULE B PROVIDER/ CLIENT OBSERVATION	MODULE C EXIT INTERVIEW	MODULE D INTERVIEW WITH PROVIDERS
INTERPERSONAL RELATIONS				
1. Rapport established for assessing personal situation (family circumstances, nature of sexual relationships)		101, 106, 107.	101, 101a, 102, 103, 103a, 104, 105, 106, 107, 107a, 401, 402, 403, 404.	
2. Client reports feeling: a)welcomed by staff, b) at ease/uncomfortable asking questions, c) providers were rude/polite.		101.	110, 301, 302, 303, 306.	
3. Personel trained in interpersonal relations	403.			103a.
CHOICE OF METHOD				
4. Number /range of methods available at the SDP	602.	201, 401.		
5. Referrals for methods not available		401a.		205.
7. Restrictions placed on available methods - nonpermanent, permanent.				201, 203
8. Client receives her/his method of choice.		206	205a-c, 206, 206a, 207a,b, 208,209, 210.	
9. Number of methods approved for use at the SDP				
10. All methods appropriate to reproductive intentions are offered to the client		201, 202.	213a.	201, 202, 203.
11. Client receives method appropriate to reproductive intention		102, 203, 404.	212, 213, 405, 406a, 406b, 407, 408.	
INFORMING AND COUNSELING CLIENTS				
12. Provider gives in-depth information on method accepted: a) how it works; b) how to use; c) side effects; d) complications; e) management of side effects; f) followup; g) resupply		201, 207.	213, 304.	
13. Client correctly explains method chosen: a) how to use; b) what to do about side effects; c) possible side effects; d) when to return; e) where to return			211, 211a, 211b, 211c.	

[1] *The numbers in the column refer to items on the data collection instrument. They are listed here to give an idea of the indicators for which multiple questions were used in the Morocco Study*

ELEMENT /INDICATOR	MODULE A INVENTORY OF FACILITIES	MODULE B PROVIDER/ CLIENT OBSERVATION	MODULE C EXIT INTERVIEW	MODULE D INTERVIEW WITH PROVIDERS
INFORMING AND COUNSELING (CONT'D)				
14. Service providers trained in counseling skills (eliciting and providing information)		103, 104, 105, 108, 109, 110, 205.		103a.
15. Method specific informational materials available	301, 302, 303.	204.		303.
16. Checklist available on information for provider to cover during counseling session		111.		304
17. Provider gives overview of all methods		201.		201-203
18. Privacy acceptable for counseling and exams	501, 502	112, 305b.		
19. Consent form available and signed by client for VSC		appendix		
TECHNICAL COMPETENCE				
20. Existence of written guidelines on FP practices	201			304, 306
21. Provider can explain contraception: benefits, how to use, contraindications, side effects, management of side effects				102, 103, 103a, 105, 204.
22. Provider demonstrates skill at clinical procedures (according to guidelines)		301-305		
23. Infection control procedures maintained at SDP according to guidelines	504	305a		
24. Client receives appropriate method: not medically contraindicated, and appropriate for sexual lifestyle		103, 104.		204
25. Existence of education/training criteria for service tasks	702			
26. Existence of mechanism to review/ screen potential service providers	702a			
27. Existence of job description for each position	701			
28. Clinical provider has received training relevant to the job				102, 103, 103a, 105, 106.

ELEMENT /INDICATOR	MODULE A INVENTORY OF FACILITIES	MODULE B PROVIDER/ CLIENT OBSERVATION	MODULE C EXIT INTERVIEW	MODULE D INTERVIEW WITH PROVIDERS
TECHNICAL COMPETANCE (Cont'd)				
29. Training of new staff regarding institu tion's guidelines				103a.
30. Periodic refresher/in-service training of all staff				104, 107.
31. Availability of appropriate basic items for delivering available methods at SDP: sterilizing equipment, gloves, blood pressure, specula, adequate lighting	505, 601.	304		302.
32. Adequacy of supervision: frequency and content	805.			305.
33. Capability to handle reproductive tract infections - RTI, STDs, and HIV: a) diagnosis, b) treatment, c) referral	706, 706a.			
MECHANISMS TO ENSURE CONTINUITY				
34. Ease of resupply		401		
35. Clients past-due for follow-up identified	703			
36. Clients past-due for follow-up contacted	704			
37. Reasons for non-return identified				
38. Appropriateness of follow-up/return schedule			211d, 211e.	
39. Clients encouraged to return as needed		402, 403.		
APPROPRIATENESS AND ACCEPTABILITY OF SERVICES				
40. Client's perceive that: privacy for exam and counseling is acceptable/not, waiting time is acceptable/not, time with provider is acceptable/not, hours/days are conven ient/not, staff is acceptable/not in terms of gender, age, ethnic group	402, 1001.	501-503	108, 301, 301a, 302, 305, 307,	
41. Adequacy of the facility (as perceived by the client): waiting room, exam room, hygiene, water, toilet facilities, other	202-204, 506		109, 307.	

Structured Interviews/Surveys

QOC Element(s)	**Choice of methods, information to users, technical competence, client-provider interaction**
Description	Structured interviews, or surveys, are a common data collection method. A questionnaire is developed and administered to all people in the sample. To ensure usefulness of data, the survey must be designed, administered and analyzed correctly. Questionnaires should be kept simple, unambiguous, and focused on the research objectives. Interviewers must be carefully trained so that they understand the meaning and intent of the questions. Structured interviews are often a main component of client satisfaction studies, intercept studies, panel studies and use and discontinuation studies.
Advantages	A good measure of behavior and practices of family planning clients and service providers. Relatively easy tool to use. Provides quantitative data that can be, depending on the sample size, representative of the study population. Data analysis is relatively straightforward.
Disadvantages	It is important to have skilled interviewers; survey results are largely dependent on them. Interviewers must be trained together to ensure that they all interpret the questions correctly and in the same way. Otherwise, interviewers can produce bias by asking questions in different ways and inconsistently selecting portions of responses to record on the questionnaire. Structured interviews tend to produce data on what is happening without explaining why.
Examples	García-Núñez, 1992 and Fisher, 1991, both contain guidelines on interviewing and questionnaire development. The Bangladesh project described in the Client Satisfaction Studies section of this catalog used structured interviews to assess the quality of care provided to Norplant acceptors, and to collect information on client knowledge, decision-making, and satisfaction. (Kamal et al., 1991)
Attachments	Selected portions of "Questionnaire for Survey of Acceptors." From Kamal et al., 1991.

Citations

Fisher A et al. 1991. *Handbook for Family Planning Operations Research Design*. Second Edition. NY: The Population Council.

García-Núñez J. 1992. *Improving Family Planning Evaluation, A Step-by-Step Guide for Managers and Evaluators*. CT: Kumarian Press.

Kamal GM, K Hardee-Cleaveland, and Barkat-e-Khuda. 1991. "The Quality of NORPLANT Services in Bangladesh." Final Report. Dhaka: ACPR. December.

Kamal GM, K Hardee-Cleaveland, and Barkat-e-Khuda. 1991. "The Quality of NORPLANT Services in Bangladesh." Final Report. Dhaka: ACPR. December.

Section-3

INFORMATION AND ACCEPTANCE OF NORPLANT

	RESPONSE		SKIP TO
301. Please tell me where or from whom you **first** heard about NORPLANT ? Was it at the clinic or the home ? **(SINGLE ANSWER)**	Worker, in clinic	1	
	Worker, in Home	2	
	NORPLANT user, in clinic	3	
	NORPLANT user, in home	4	
	Other _____ (Specify)	5	
302. Where else have you heard about NORPLANT ?**(MULTIPLE ANSWERS)**	No body else	0	
	Husband	1	
	Relative _____ (Specify)	2	
	Friend/ Neighbour	3	
	FP worker	4	
	Dai/TBA	5	
	Radio/TV/ newspaper	6	
	NORPLANT user	7	
	Other _____ (Specify)	8	
303. Before getting the NORPLANT implanted, who are the persons you discussed NORPLANT with ? (PROBE, anyone else ?) **(MULTIPLE ANSWERS)**	Husband	1	
	Relative _____ (Specify)	2	
	Friend/neighbor	3	
	FP worker	4	
	DAI/TBA	5	
	NORPLANT user	6	
	Other _____ (Specify)	7	
	None	7	-->305
304. What did you discuss with him/ her/them about the NORPLANT ? Verbatim: _____ _____ _____			
INTERVIEWER: CHECK 303, IF CODE 6 IS NOT CIRCLED, ASK 305; OR ELSE SKIP TO 308			
305. Before you had NORPLANT inserted, did you know anyone who had accepted the NORPLANT ?	Yes	1	
	No	0	--> 308

	RESPONSE		SKIP TO
306. Did you discuss NORPLANT with any NORPLANT users before you accepted NORPLANT ?	Yes No	1 0	 --> 308
307. What did you discuss with her about NORPLANT ? Verbatim: _____ _____			
308. Does your husband know that you have had NORPLANT implanted ?	Yes No Not currently married	1 0 2	 --> 311
309. Did he know before or after the implantation ?	Knew before implantation Knew after implantation He does not know	1 2 3	 --> 311
310. Did your husband suggest that you accept NORPLANT or did you suggest it to him ?	I suggested to him He suggested to me	1 2	
311. Among all the FP methods why did you choose NORPLANT ? Verbatim: _____ _____			

Supervision Tool (CARE)

QOC Element(s)	**Comprehensive assessment**
Description	This tool is being developed by CARE so that quality of care can be evaluated during supervisory visits. It incorporates indicators for assessing clinic management, providers and client satisfaction so that problems can be identified and a plan of action developed.
Advantages	Will provide guidelines to enable supervisors to quickly and easily evaluate quality, identify problems and develop solutions. Is supposed to be a collaborative tool so that supervisors and staff can work together to decide how to solve problems and who will be responsible.
Disadvantages	Is in the process of being developed and a number of issues still need to be resolved: Should there be a built-in ratings scheme? How should elements and indicators be weighed? What sources of information should be used? What methods of gathering data should be used? Can the same tool be used for clinics and CBD sites? How can indicators and scores be validated?
Examples	Is now being tested in CARE projects.
Attachments	Draft protocol. From CARE, 1992.
Citations	CARE. 1992. "Draft quality of care protocol for use during supervision visits." Revised October. Presentation made by T McGinn at the EVALUATION Project Service Delivery Working Group meeting, December 9-10.

CARE. 1992. "Draft quality of care protocol for use during supervision visits." Revised October. Presentation made by T McGinn at the EVALUATION Project Service Delivery Working Group meeting, December 9-10.

Draft Quality of Care Protocol for Use During Supervision Visits (Revised October 1992)

Supervisor ____________________

Site ____________________

Date of this visit ____________________

Date of last visit ____________________

Planned date of next visit ____________________

Score Summary

	Score		Percent (Visit score divided by maximum possible score)
	This visit	Maximum possible	
Clinic Management Component			
Provider Component			
Client Component			
Total			

\>>>

URGENT ACTIONS REQUIRED

ACTION	PERSON RESPONSIBLE	BY WHEN?

CLINIC MANAGEMENT COMPONENT		
Indicator	**Scale and Points**	**Comments**
Percent approved methods in stock (Calculation: Number of methods in stock divided by number of approved methods for site; in stock = unexpired and at least 1 month's supply)	100% 2 points 60-99% 1 point <60% 0 points	
Written guidelines for family planning education and practice visible	Yes 1 point No 0 points	
Necessary equipment and materials in stock and working to deliver safe services: • (to be filled in) • • (It is recommended that a list be developed based on country protocols. Only those items relevant to the site being assessed should be considered in the scoring.)	All 2 points Most 1 point Little or none 0 points	
Percent approved methods for which educational materials are in stock (in stock = at least 1 month's supply)	100% 2 points 60-99% 1 point <60% 0 points	
Privacy available	Yes 1 point No 0 points	
System exists for follow-up: • to <u>identify</u> clients past due for follow-up • to <u>contact</u> clients past due for follow-up	Yes 1 point No 0 points Yes 1 point No 0 points	
SCORE ON CLINIC MANAGEMENT COMPONENT	MAXIMUM 10 THIS VISIT _____	

PROVIDER COMPONENT		
Indicator	**Scale and Points**	**Actions to be taken by Supervisor**
Did provider give overview of all methods during contact?	Yes 1 No 0	
Did provider offer all available, medically appropriate methods?	Yes 1 No 0	
Was in-depth information provided on method accepted: • how it works • how to use it • side effects • warning signs • management of side effects and warning signs • follow-up and resupply: place, time	 Yes 1 No 0 Yes 1 No 0 Yes 1 No 0 Yes 1 No 0 Yes 1 No 0 Yes 1 No 0	
Were available educational materials used appropriately?	Yes 1 No 0	
Did provider elicit questions from client?	Yes 1 No 0	
Was client offered the option of referral for unavailable methods?	Yes 1 No 0	
Was the VSC consent form explained and signed?	Yes 1 No 0	

PROVIDER COMPONENT (Cont.)		
Indicator	**Scale and Points**	**Comments**
Did the provider demonstrate skill in clinical procedure: • (to be filled in) • • (It is recommended that a detailed list be developed based on country protocols.)	Yes 1 No 0 Yes 1 No 0 Yes 1 No 0	
Did provider encourage client to return as needed?	Yes 1 No 0	
SCORE ON PROVIDER COMPONENT	MAXIMUM POSSIBLE FOR THIS SITE _____ THIS VISIT _____	NOTE: The maximum score will differ by site since some items, such as VSC forms or IUD technique, will not be applicable to all sites. Only items which are relevant for the site being assessed should be included in the MAXIMUM POSSIBLE score.

CLIENT COMPONENT		
Indicator	**Scale and Points**	**Comments**
Did you receive a contraceptive method today? Was it the method you wanted? Are you satisfied with the method?	All Yes 3 points 2 Yes 2 points 1 Yes 1 point 0 Yes 0 points	
(For referred clients) Where will you go to get the method you want?	Knows referral site 1 point Does not know 0 points	
Please explain to me /show me how to use your method?	Covers all important info 2 points Covers most imp. info 1 point Does not know imp. info 0 points	
Regarding the service site: Was location convenient? Were hours/days convenient? Was facility clean? Was service too expensive? Did you have privacy? Did you have to wait too long?	 Yes 1 No 0 Yes 1 No 0 Yes 1 No 0 Yes 1 No 0 Yes 1 No 0 Yes 1 No 0	
Regarding the staff: Were they polite or rude? Could you ask questions easily? Did you have enough time with them? Were you comfortable or uncomfortable? Were they patient or too rushed?	 Polite 1 Rude 0 Yes 1 No 0 Yes 1 No 0 Yes 1 No 0 Patient 1 Rushed 0	
SCORE ON CLIENT COMPONENT	MAXIMUM POSSIBLE FOR THIS CLIENT _____ SCORE _____	When several clients are interviewed, their scores can be added, then divided by the total maximum possible. (Individual scores may be averaged if the maximum possible for each client is the same.)

NOTE: The wording of the questions to clients is particularly important, as is the method of data collection. This is presented as an interview questionnaire, but focus groups or in-depth interviews may well be more appropriate. Scoring may not be suitable and another way of tracking changes over time may be required.

PROBLEMS DISCUSSED AND ACTION PLAN
(Leave carbon copy at site)

Problem Description	Steps Required to Resolve Problem	Person Responsible For Each Step	By When?

NOTES AND GENERAL COMMENTS

Staff interviewed/observed during this visit:

Name	Title

Other

SWOT Analysis

QOC Element(s)

Comprehensive assessment

Description

A SWOT analysis identifies and analyzes the Strengths, Weaknesses, Opportunities and Threats of an organization. To identify the strengths and weaknesses, the planning team examines the management, programming and financing capabilities of the organization. It is often helpful for the planning team to interview different levels of staff members to gather information. Next the team assesses the external (or environmental) factors perceived as opportunities or threats to the organization. Generally, opportunities and threats can be identified in brainstorming sessions by the planning team. The results of the SWOT analysis can help define program-related and organizational goals.

Advantages

SWOT analysis can help the planning team set realistic goals and plan strategies for reaching these goals. Identifies and acknowledges outside factors that help determine program effectiveness.

Disadvantages

Must use caution in setting goals. Goals should not exceed available resources nor should the organization over-extend itself. It is better to accomplish one goal than to set out to do too much and not accomplish anything.

Examples

A SWOT analysis was done by CEMOPLAF, a private family planning organization in Ecuador. Some of the identified strengths at CEMOPLAF included highly trained and motivated staff and conveniently located service centers which had the capacity to expand, while some of the weaknesses included lack of quality controls, financial dependence on donors, and an administrative inability to expand. The government's population policy, international donations and greater awareness in the community were some of the perceived opportunities while competition, fewer types of contraceptives donated to CEMOPLAF and the increase in inflation were a few of the perceived threats. The review of the SWOT analysis led CEMOPLAF to establish two goals: to increase access to family planning services in both urban and rural communities, and to become self-sufficient in family planning activities while still relying on donated contraceptives. A set of specific objectives were drawn up to meet these goals including: publicizing new services on the radio and in local newspapers, designing and developing promotional material, training personnel to provide new services as well as preparing courses on client-provider relations, hiring additional staff, selecting new distribution locations and expanding the contraceptive mix and reserve supply. (Wolff et al., 1991)

Attachments

"How to analyze internal strengths and weaknesses." From Wolff et al., 1991.

Citations

Wolff JA, LJ Suttenfield and SB Binzen eds., Management Sciences for Health. 1991. *The Family Planning Manager's Handbook.* CT: Kumarian Press.

How to ...

Analyze internal strengths and weaknesses

Management Capabilities

Analyze your organization's strengths and weaknesses in the following management areas:

- **Organizational Structure:** Does the organizational structure and culture lend itself to a free flow of information, both from the bottom levels up and from the top down? Does the organizational structure hinder or facilitate efficient and client-responsive implementation of activities? Do all staff, including volunteers, have clearly defined roles?
- **Planning:** Have feasible long-term and short-term plans been made, involving all of the staff and the community to be served in the process? Do these plans guide the work of the organization? Have they led to success in achieving goals?
- **Coordination:** How well do different departments or divisions within your organization cooperate and coordinate with each other? Are any groups (formal or informal) or departments in a chronic state of conflict, and if so, why? How well does the organization coordinate with other family planning and health organizations?
- **Staffing:** Do you hire people with the appropriate skills and attitudes for their positions? Does each staff person have a job description with a clear delineation of roles and duties? Are there staff whose job descriptions overlap, so that the division of responsibilities is unclear? Are on-going training and on-the-job feedback provided consistently to ensure high performance?
- **Supervision:** Do all staff at every level have regular personal contact with a supervisor? Do all staff (including the supervisors themselves) view the supervisor's role as one of guidance, assistance, and support? Do supervisors help set performance objectives for those they supervise and check progress toward these objectives? Do the supervisors effectively solve performance problems through their interventions? Does each supervisor have a supervisory schedule and a supervisory session plan?
- **Training:** In what areas does each type of staff need training? In what areas is each type well-trained? Will training resolve the problem? Do some staff people have unused potential or skills that could be useful to the program? Do you regularly assess training needs of new staff and of existing staff who have performance problems or who are assuming new responsibilities? Are the training goals and content closely linked to these assessments? Does the evaluation of your training examine trainee satisfaction, increases in knowledge, changes in on-the-job performance, and the impact of training on service delivery? Are all providers trained in counseling and communication skills?
- **Management Information System:** Do managers have accurate information on the progress made toward the objectives of the program and on whether or not activities are happening as scheduled? Do supervision reports provide information on the reasons for a lack of progress in any given area? In the areas of finance, supplies, and planning, do managers have sufficient information to forecast trends and make decisions? Does the management information system also provide information on non-quantifiable issues such as quality of care and user satisfaction?

Continued

Continued

- **Commodities Management:** Are there stockouts at any level of the supply system in any essential commodity? Does the central warehouse conduct an inventory at least once a year? Do all warehouses and supply depots employ the "first to expire/first out" (FEFO) system? Is forecasting accurate enough to prevent both stockouts and wastage from expired contraceptives? Do conditions at all storage points prevent damage to or loss of supplies and contraceptives? Are there any contraceptive methods that would improve the client's choice but are not currently offered? Are clinics or community posts adequately equipped? If not, list what is missing or in disrepair.

Programming Capabilities

What is the potential capacity of the program to provide services, train, and/or educate? Does the current level of client/trainee/educational activities match this capacity? Is the program able to expand simply by increasing its efficiency, without requiring a significant new source of revenue? If so, how can this expansion be implemented? What is your assessment of the quality of care in your program? What can be done to improve it? What is the current user discontinuation rate? What is the level of client satisfaction? Is the transportation that is available adequate for program needs? If not, describe what is needed for which type of personnel and in which areas. (Transportation could be inadequate for a certain level of staff, such as community promoters, or for a geographical region.) What are the weak points in your programs? What are the reasons for these weak points? What are the strong points? What expertise exists among your staff that gives you the ability to run your programs? Is this expertise under-utilized? Are existing staff overworked and unable to undertake new activities? Are they under-utilized, with free time on their hands? Are there any activities that would enhance your current program but that you can't carry out for lack of human or financial resources?

Financing Capabilities

What is your current level of self-financing? What are your current sources of financing? How stable are they? Are they likely to increase, decrease, or remain the same in the near future? In the distant future? What would have to change in the external environment or within your organization in order to secure additional funding or generate more revenues? Which of these changes are feasible? Where can you cut costs in your program? What level of community support does the program enjoy? Are there community boards? Community-level fund-raising programs? Volunteers? Donations of materials or supplies?

Use and Discontinuation Studies

QOC Element(s)

Acceptability and appropriateness

Description

Like client satisfaction studies, use and discontinuation studies attempt to obtain the client's perspective on quality of care in service delivery organizations. A client's satisfaction with services is often linked to contraceptive use and subsequent continuation.

Advantages

This method gives the researcher the ability to study the client directly. Use and discontinuation may be one of the most important issues in family planning provision.

Disadvantages

Use and discontinuation are hard to measure. It is difficult to track discontinuers. Use and discontinuation studies can be very time consuming and expensive depending on the size of the study.

Examples

1. IPPF conducted a one year prospective study at six family planning associations to evaluate the factors affecting acceptability and continuation of family planning methods and services. Over 10,000 new acceptors were interviewed several times over the course of the year. Clients were interviewed upon entering the clinic and upon completion of the first visit, and then three, six, and twelve months later. Clients who did not come back to the clinic were followed-up at home to determine why they hadn't returned to the clinic and whether they were still using their method. Recommendations made as a result of the study included: training staff in inter-personal relations, contraceptive technology and time management; increasing staff sensitivity to the needs of individual clients; making the clinics more accessible by making scheduling changes; and implementing systems to track and motivate drop-outs. (Helzner and Kopp, 1991)

2. Baseline and special cross-sectional surveys were used in Bangladesh to assess quality from the client's perspective and its bearing on acceptance and continuation of contraceptive use. The study found that the quality of the interaction between fieldworker and client had a significant impact on the client's subsequent decision to accept contraceptives and on continued use of that method. (Koenig et al., 1992)

Attachments

None.

Citations

Helzner JF and SZ Kopp. 1991. "Quality of Care in Family Planning: Perspectives from IPPF/Western Hemisphere Region." Draft report. March 1.

Koenig M, MB Hossain and M Whittaker. 1992. "The Influence of Fieldworker Quality of Care upon Contraceptive Adoption in Rural Bangladesh." Paper presented at the annual meeting of the Population Association of America, Denver, CO. April 30-May 2.

Quality of Care Improvement Tools

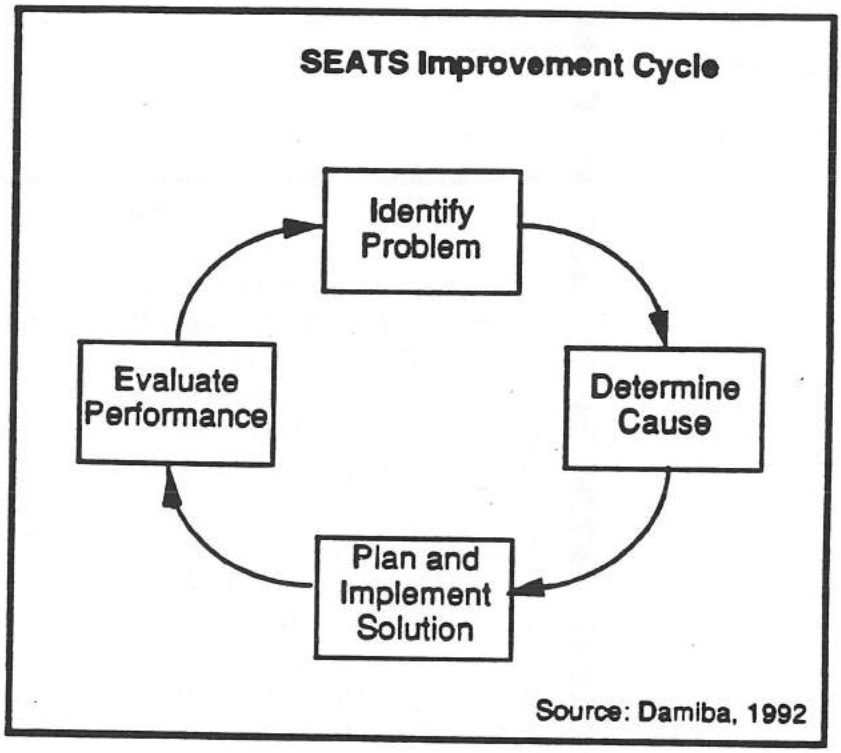
Continuous Assessment (SEATS)

QOC Element(s)

Comprehensive assessment and improvement

Description

All staff at a service delivery site meet periodically to identify quality of care problems and select one to address. Staff decide what data should be collected to document the problem and choose a staff member to proceed with data collection, to examine reasons for occurrence, and to report back. Staff then make recommendations for improvement and decide on a plan of action. When a satisfactory level of achievement is reached, a new quality of care problem is selected.



Advantages

Problem identification and resolution are provider-generated. "Outsiders" are used only for initial and periodic training, and in providing support materials. Makes all staff aware of quality of care problems and allows everyone to contribute to the process. It is a practical approach which can show results quickly.

Disadvantages

Requires staff at all levels to communicate with each other, something which may be difficult in some cultures. Staff must understand that the process is for improving quality of care, and not for placing blame on someone. Support of upper management is crucial. Sometimes relies on people's impressions rather than formal data collection for decision-making on quality improvement. Since it is difficult to assess clients needs and expectations, the client is generally neglected in selecting a problem to focus on (though client-exit surveys have been used to try to assess client attitudes towards services).

Examples

Used by SEATS in Togo, Burkina Faso and Côte d'Ivoire. Improvements in Togo have included putting a sign on the door of a clinic, adding a door between two rooms, putting curtains on the windows for privacy, cleaning the waiting area, fixing a leaking roof and procuring equipment and supplies. (Rosenfeld and Damiba, 1991)

Attachments

None.

Citations

Damiba A. 1992. Presentation at the meeting on "Assessing Quality of Care in International Family Planning Programs," sponsored by The EVALUATION Project and A.I.D. June 3.

The EVALUATION Project. 1992. "Service Delivery Working Group Minutes of Meeting." Chapel Hill: Carolina Population Center, University of North Carolina. June 3-4.

Hardee K and B Gould. 1992. "A Process for Service Quality Improvement in Family Planning." Family Health International. December.

Hardee-Cleaveland K, M Norton and C Calla. 1992. "Quality of Care in Family Planning Service Delivery. A Survey of Cooperating Agencies of the Family Planning Services Division, Office of Population, A.I.D."

Rosenfeld A and A Damiba, workshop coordinators. 1991. "The Quality of Family Planning Services in Field Projects: A Workshop Report." SEATS. NY: Columbia University. June 18-20.

Continuous Quality Improvement (CQI)

QOC Element(s)

Comprehensive assessment and improvement

Description

CQI, also known as Total Quality Management, is an ongoing management approach that strives to improve quality of services. CQI is guided by principles of client orientation, involvement of all levels of staff, and problem prevention. The stages of CQI focus on improving service delivery processes, instead of examining individual staff performance.

Advantages

Uses collected data as the basis for decision-making. Assumes problems in service delivery are due to ineffective processes, rather than poor staff. CQI is a cyclical process.

Disadvantages

Requires strong commitment and willingness to change on the part of managers. May be difficult in some programs to foster an environment that enables all staff to contribute. Staff members must be convinced of the organization's long-term commitment to quality and must be trained in CQI methods and tools.

Examples

1. MEXFAM began implementing CQI in 1990 in response to more demanding clients, the need to improve cost effectiveness and the need for standardized service guidelines and practices. MEXFAM is being assisted in their improvement process by the Population Council and Management Sciences for Health. Key activities undertaken by MEXFAM thus far have included: fostering a commitment among management for quality improvement, training all staff in quality management techniques, recognition and reward, staff empowerment, systems to measure and analyze change, and implementation of solutions. The first year of MEXFAM's CQI endeavor required numerous meetings to convince staff that the quality improvement process was not a passing phase at the organization. MEXFAM learned that implementing team suggestions for improvement was vital for the credibility of the quality improvement process. MEXFAM also discovered that not all solutions are difficult to implement, for instance, simply putting more chairs in a clinic waiting room solves the problem of clients having to stand while they wait. (Lopez Juarez et al., 1992 and MEXFAM, 1992)

2. The January/February 1993 issue of *The Family Planning Manager* introduces the concepts of Continuous Quality Improvement. The issue also provides examples of quality improvement activities and tools, including a description of MEXFAM's experience improving their computer services department.

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 Word Perfect 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

Checklist for Using CQI to Strengthen Family Planning Programs

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.

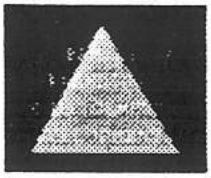
For Clinic Managers and Supervisors

- ☐ 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.

The Family Planning Manager is designed to help managers develop and support the delivery of high-quality family planning services. The editors welcome any comments, queries, or requests for free subscriptions. Please send to:



The Family Planning Manager
Family Planning Management Development
Management Sciences for Health
400 Centre Street
Newton, Massachusetts 02158, U.S.A.
Phone number: (617) 527-9202
Fax number: (617) 965-2208
Telex : 4990154 MSHUI

The FPMD project is funded by the U.S. Agency for International Development. This project provides management assistance to national family planning programs and organizations to improve the effectiveness of service delivery.

Examples, cont.

3. The Ministry of Health of Guatemala, with technical assistance from INOPAL II, has adapted the COPE methodology and developed self-evaluation forms to be used for continuous quality improvement in their Family Planning Units. Since supervisors only have a limited amount of time to spend in each health unit, a meeting is held in each health district with all the area service providers. The providers complete a self-evaluation form to identify quality issues and propose solutions to those problems which they feel are feasible to resolve and for which they have the resources. The workplans include the actions which need to be taken, person(s) who should be responsible and a time frame for implementation. The service providers then present the workplan to their staff and together they agree upon which problems to try and solve. Supervisors provide technical assistance during their visits. A sample of health areas were chosen to test the strategy. Subsequent supervision visits found that of the 316 actions proposed, 120 (38%) had been completed and 41 (13%) had begun. Some of the solutions to the more common problems which were identified included developing materials to provide information on methods, making posters and promoting family planning services to inform the public about available services and schedules, and making house visits and giving talks at the district center in order to follow-up discontinuers. (The Ministry of Health, Guatemala, 1992)

Attachments

"Checklist for Using CQI to Strengthen Family Planning Programs" and "Working Solutions-Mexico." From *Family Planning Manager*, January/February 1993.

Sample questions from the self-evaluation guides. From the Ministry of Health, Guatemala.

Citations

Buxbaum A, N Murray and R Vernon. 1993. "Strengthening Services Using the Continuous Quality Improvement Approach." *Family Planning Manager* II,1.

Hardee K and B Gould. 1992. "A Process for Service Quality Improvement in Family Planning." Family Health International.

Hardee K and S Kleefield. 1993. "Manager's Toolbox for Continuous Quality Improvement." *Family Planning Manager* II,1. MA:FPMD, Management Sciences for Health. January/February.

Lopez Juarez A 1990. *Quality in Family Planning. A Business Management Approach.* Mexico City: MEXFAM.

Citations, cont.

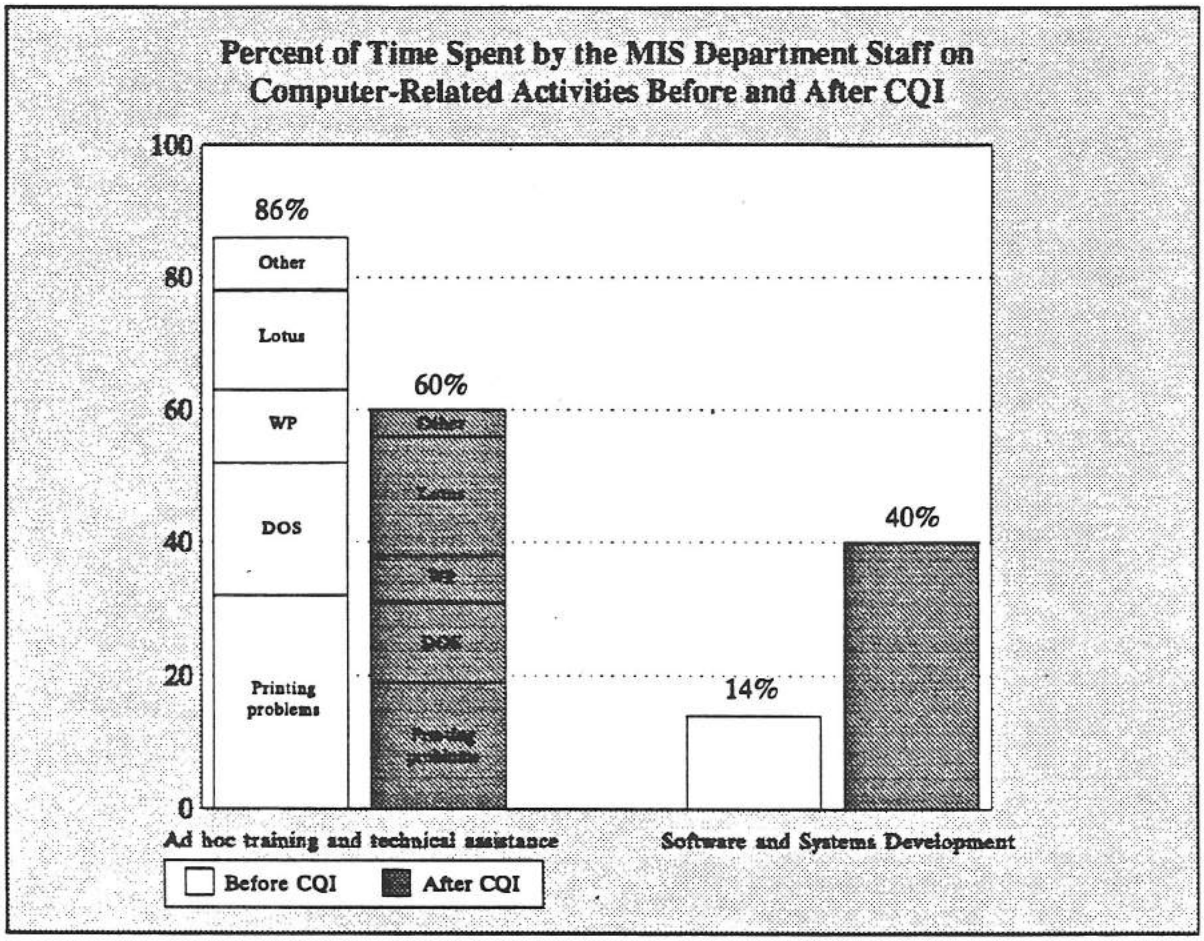
Lopez Juarez A, G Rodriquez, H Carrizo, I Beltran, R Ramirez, E Rico and PA Costa. 1992. *Mejora Continua en MEXFAM* [Quality Improvement in MEXFAM]. Mexico City: MEXFAM.

MEXFAM. 1992. Staff member presentation at A.I.D. April 8.

The Ministry of Health, Guatemala. "WORKING SOLUTIONS." Guatemala. 1992.

continued from previous 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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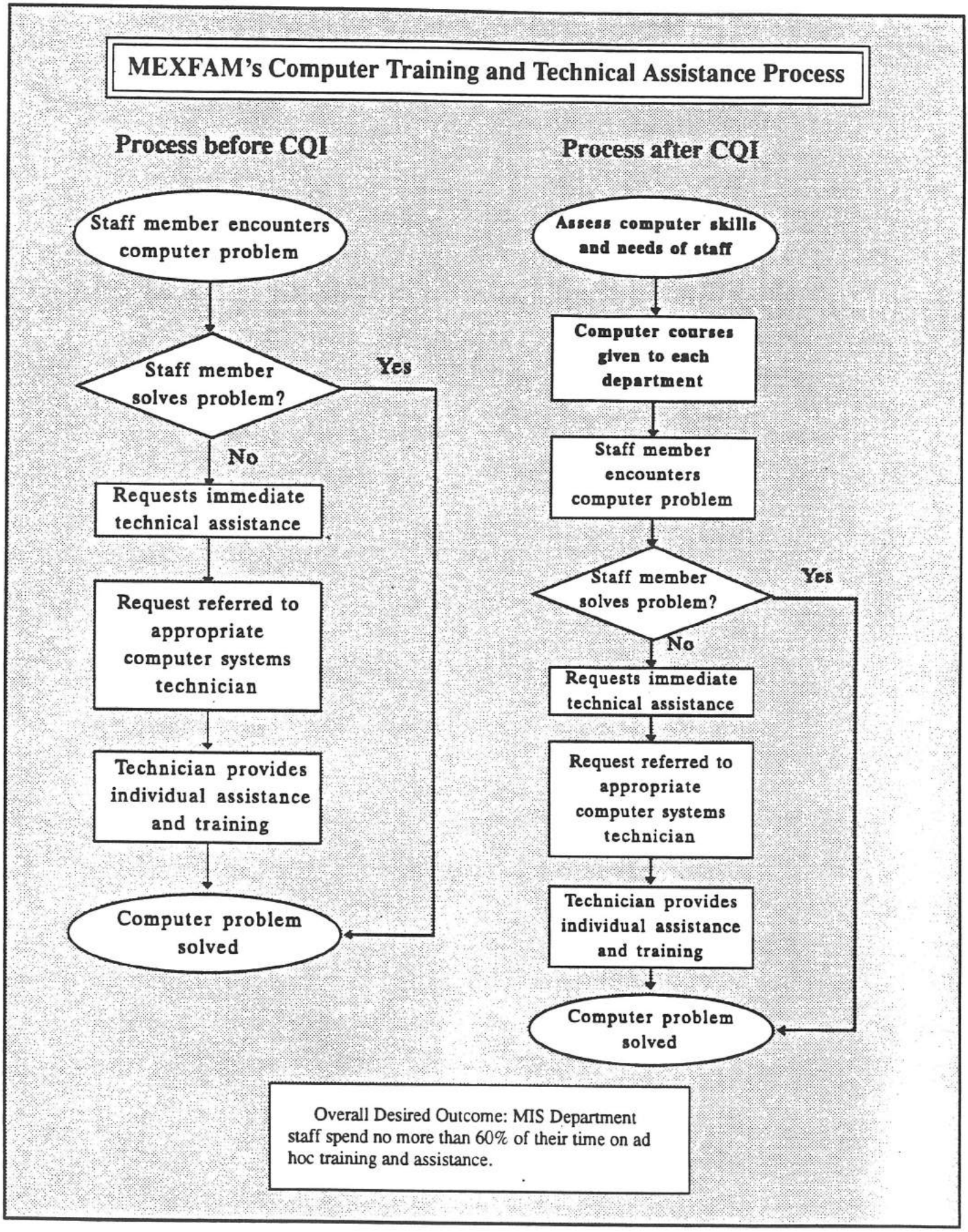


Information supplied courtesy of Lic. Alfonso Lopez Juarez, Executive Director of MEXFAM, and Dr. Pedro Manuel Acosta and Lic. Jesus Vertiz, of MEXFAM's Evaluation Department.

SELF-EVALUATION GUIDES

CATEGORIES OF QUALITY OF CARE

I. CHOICE OF METHODS
II. TECHNICAL CAPACITY
III. EDUCATION/OUTREACH-IEC
IV. STAFF/CLIENT RELATIONS
V. CONTINUITY OF CARE
VI. CONSTELLATION AND ORGANIZATION OF SERVICES
VII. EVALUATION/SUPERVISION AND USE OF DATA

SAMPLE QUESTIONS: CATEGORY III

TRANSLATED FROM SPANISH

III. EDUCATION/INFORMATION/OUTREACH

A. Information provided to client:

1. ONLY FOR HEALTH CENTERS: Do you explain to the client what procedures you will be doing in the physical exam in order to make him/her more comfortable?	Circle the X if THIS CAN BE IMPROVED YES/NA NO --> X
2. Do you give information to the client about all methods available and offered at the health service?	YES NO --> X
3. Do you give information to the client about methods which are not offered at this service (e.g. sterilization)	YES NO --> X
4. Do you explain to women at higher risk the advantages of family planning for their health?	YES NO --> X
5. Do you explain adequately how to use the selected method?	YES NO --> X

COMMENTS:

6. Do you explain the advantages, disadvantages, contraindications, risks, and side effects of each method?	CIRCLE THE X IF This can be improved Yes NO --> X

B. Information to potential users in the Community:

		CIRCLE THE X IF	
1. Do you develop frequent community health education activities about FP and reproductive risk?	YES	NO -->	X
2. In the last 15 days have you given orientation talks about FP and reproductive risk?	YES	NO -->	X
3. Do you try to give information to men about Family Planning?	YES	NO -->	X
4. Are FP activities coordinated regularly with that of rurual health workers, volunteers, and midwives?	YES	NO -->	X
5. Do the Rural Health Workers (RHW), Health promotors, volunteers, and midwives refer clients to the centers and health posts?	YES	NO -->	X

COMMENTS:

C. Educating/Counseling Clients about Family Planning

1. When you are interacting with clients, do you use techniques like:			
Listening	Yes	No -->	X
Clarifying doubts or rumors	YES	NO -->	X
Asking questions	YES	NO -->	X
Illustrating with examples	YES	NO -->	X
Discussion	YES	NO -->	X
Using appropriate language	YES	NO -->	X
Sharing information	YES	NO -->	X
Paraphrasing	YES	NO -->	X
2. When you are educating the client, do you allow time to clarify his/her doubts about sexuality, health, STD's and AIDS, etc?	YES	NO -->	X
3. When you are counseling the client, do you guarantee your support to monitor the side effects or recommend another if the client is not satisfied?	YES	NO -->	X

D. Educational Materials:

1. Are the following educational materials and information available, in view, and used?			
-posters on the wall	YES	NO -->	X
-Samples of methods	YES	NO -->	X
-Notice showing FP clinic services which are available daily?	YES	NO -->	X

COMMENTS:

COPE

QOC Element(s)

Comprehensive assessment and improvement

Description

This assessment and improvement tool was developed by AVSC to make family planning services more Client-Oriented and Provider-Efficient (COPE). There are three stages in the assessment: client flow analysis, self-assessment for staff and a follow-up plan. The assessment is completed by an outside COPE facilitator and clinic staff. The initial evaluation takes up to three days. CDC's computerized client flow analysis or a non-computerized adaptation is used to chart how clients and staff spend their time in the clinic. Then staff and the facilitator complete a self-assessment checklist which looks at all aspects of service provision. The results are then reviewed and the staff meet and develop a follow-up plan. The plan is written out and includes the identified problem, recommended solution, person responsible for implementing solution, and date by which implementation should be accomplished. The plan is posted so that progress can be checked and staff can see what still needs to be done. After several months, the COPE facilitator returns to the site to assess progress and provide technical assistance. COPE has evolved since it was initially used and continues to be adapted to take into account lessons learned from past COPE exercises.

Advantages

An efficient, cost-effective way to analyze a clinic. Involves all staff. Identifies problems and bottlenecks. Is oriented to the client.

Disadvantages

COPE is not a substitute for judgment, expertise and staff experience. The process sometimes relies on people's impressions rather than formal data collection for decision-making on quality improvement. COPE identifies problems but staff must develop explanations and solutions. It is unclear whether improvements will result in increasing the number of clients at a clinic. The client assessment aspect of COPE is the weakest part of the process.

Examples

Used by AVSC at numerous sites in Sub-Saharan Africa.

In 1990, COPE was tested at eight sites in Kenya and Nigeria. Each site had a unique set of strengths and weaknesses, but two findings were common to all. First, client waiting time is much too long. Recommended solutions for decreasing waiting time included changing staff working hours and having auxiliary staff perform tasks which do not require nursing skills. Second, clinic staff is interested in improving family planning services. Family planning service providers have been enthusiastic about COPE and its use is expanding to other departments and organizations. Providers are acting quickly to implement follow-up plans. Some facilities have noted increases in numbers of clients receiving family planning methods and sterilization after making improvements. (Dwyer et al., 1991)

Attachments

Sample forms and charts (Figures 1-7) from Dwyer et al., 1991.

Citations

Dwyer J, J Haws, G Wambwa, M Babawale, F Way and P Lynam. 1991. "COPE: A Self-Assessment Technique for Improving Family Planning Services." AVSC Working Paper.

Dwyer J et al.1991."COPE: A Self-Assessment Technique for Improving Family Planning Services." AVSC Working Paper.

Figure 1
Client-Flow Analysis: Sample Client Register Form, Partially Completed

Client Register

1. Client Number 01
2. Type of Visit ..... REVISIT
3. Family Planning Method ..... PILL
4. Time of Client's Arrival in Clinic — Hour: 08 Min: 00
5. Client Service Time:

	Initial of staff responsible	Time service started Hour	Min		Time service completed Hour	Min	Total contact time (Mins)
First contact	N	08	10	til	08	50	40
Second contact				til			
Third contact				til			
Fourth contact				til			
Fifth contact				til			

Figure 2
Client-Flow Analysis: Sample Client Flow Chart, Completed

Client No.	Time In	Time Out	Total Minutes	Contact Minutes	Waiting Minutes	Percent Waiting	Visit Code	Method Code	Comments
01	8:00	8:50	50	40	10	20%	R	P	
02	8:10	9:20	70	11	59	84%	R	I	
03	8:15	9:23	68	14	54	79%	R	I	
04	8:15	9:25	70	6	64	91%	R	I	
05	8:15	9:26	71	3	68	96%	R	I	
06	8:15	11:00	165	57	108	65%	F	C	
07	8:20	1:30	310	74	236	76%	R	T	
08	8:20	11:00	160	17	143	89%	F	C	
09	8:20	10:22	122	8	114	93%	R	I	
10	8:28	12:55	267	193	74	28%	R	T	
11	8:30	9:34	64	8	56	88%	R	I	
12	8:30	9:40	70	7	63	90%	R	I	
13	8:30	10:08	98	24	74	76%	R	I	
14	8:30	10:15	105	6	99	94%	R	I	
15	9:00	1:20	260	52	208	80%	R	T	
16	9:00	2:10	310	111	199	64%	R	T	
17	9:00	10:05	65	16	49	75%	R	I	
18	9:00	10:05	65	6	59	91%	R	N	
19	9:00	10:30	90	6	84	93%	R	I	
20	9:30	10:11	41	6	35	85%	R	I	
	ALL USERS		2521	665	1856	74%			
	NONSURGERY		1374	235	1139	83%			

Method Codes
- C Counseling
- J Injectable
- N No method being used (this code is used for all non-family planning clients, including women who come for prenatal care)
- P Pill
- T Tubal occlusion (this code is used whether the client is coming for counseling, surgery, or follow-up)

Visit Codes
- F First visit
- R Revisit

Nonsurgery Clients: N=16

Avg. Time in Clinic: 1374÷16 = 86

Avg. Waiting Time: 1139÷16 = 71

Avg. Contact Time: 235÷16 = 15

Figure 3
Client Flow Analysis: Sample Client Flow Chart, Completed

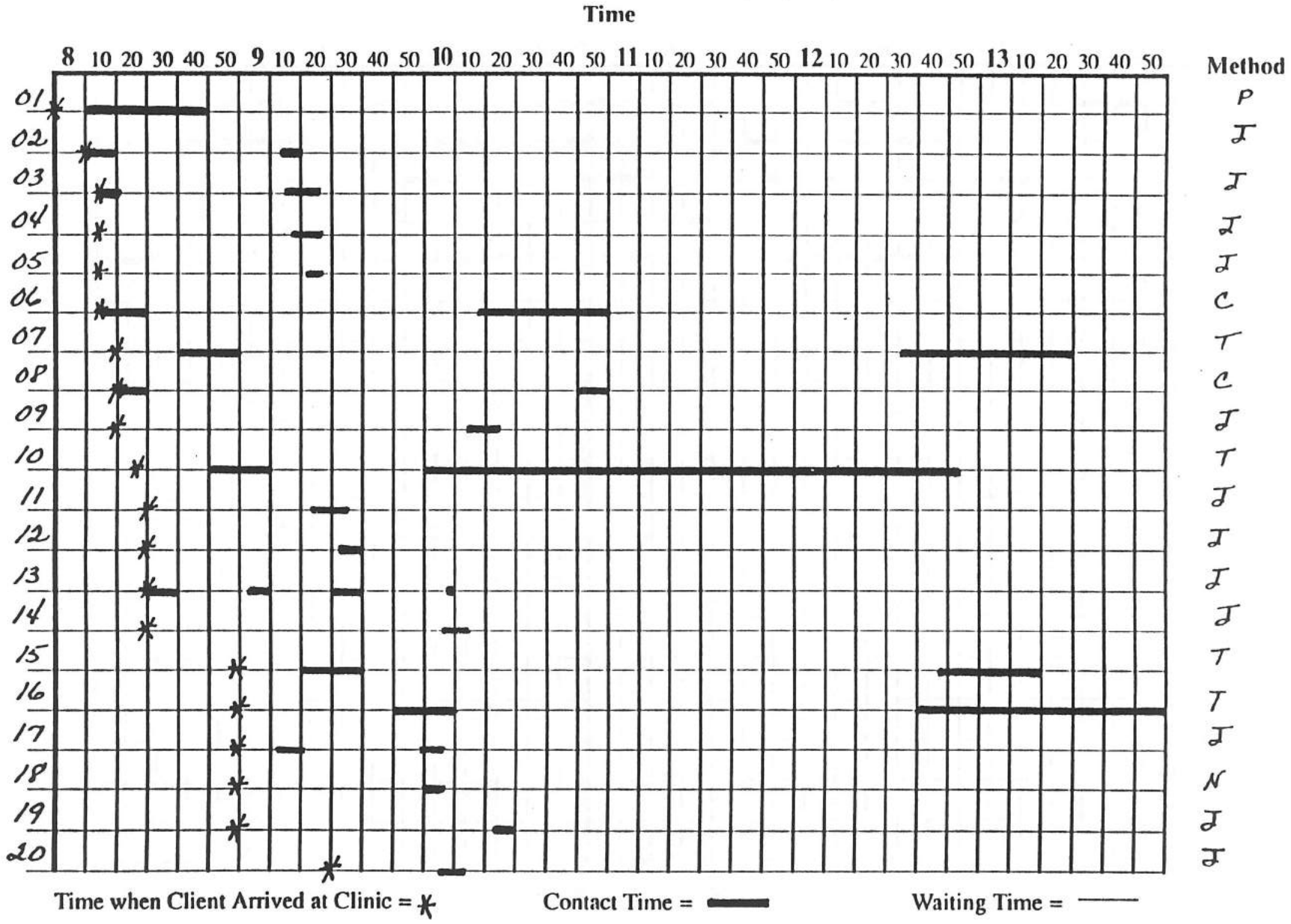


Figure 4
Client Flow Analysis: Sample Staff Utilization Graph, Completed

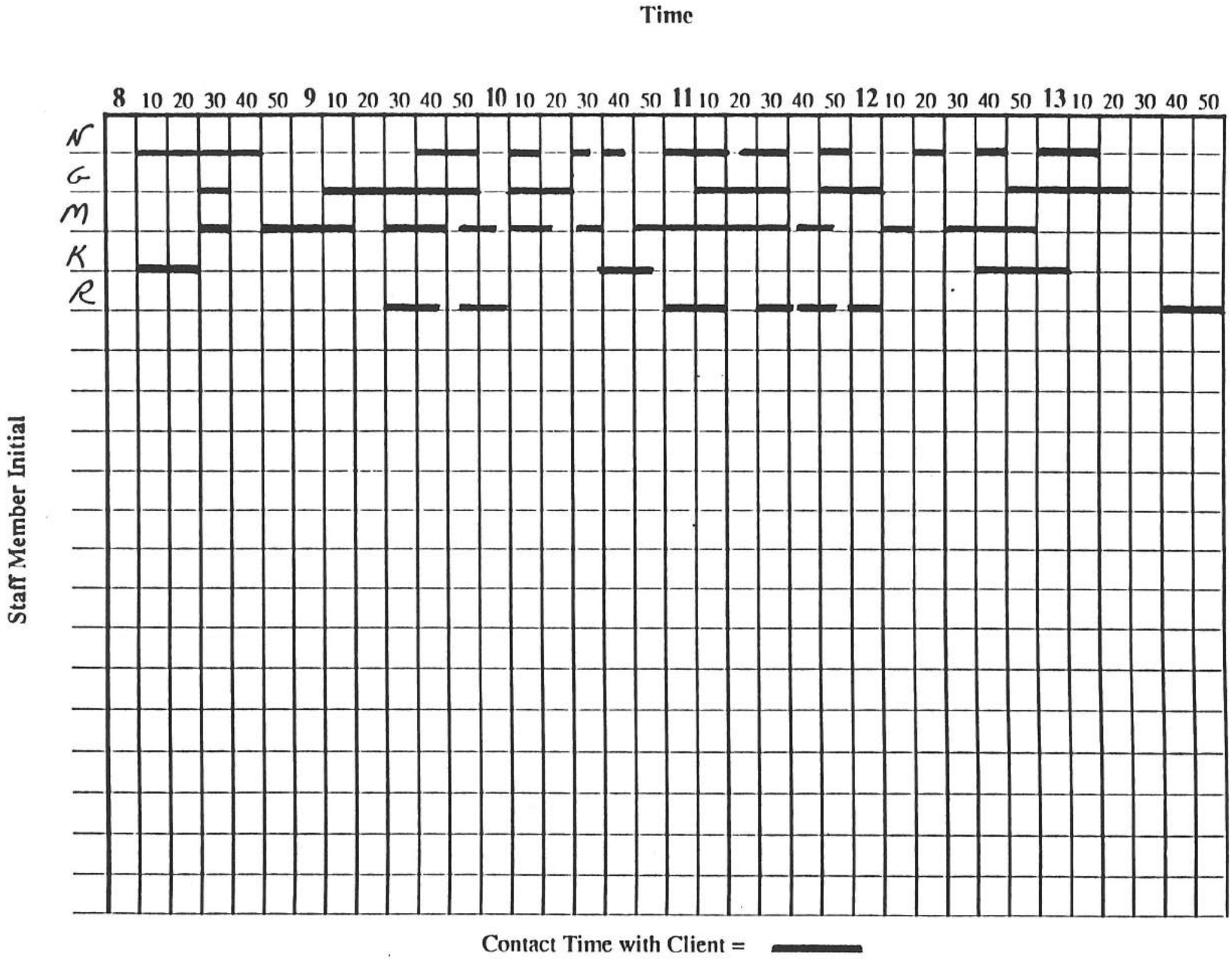


Figure 5
Self-Assessment Checklist: Selected Questions, Completed

Please mark an X in the box ☐ if there is a problem. If no problem exists, leave the box blank. Include comments on the line.

Space and Facilities for Tubal Ligation Staff responsible AB

1. Is adequate space provided for the following activities:
   - a. Registration ☐ yes
   - b. Counseling ☐ yes
   - c. Examination/Follow-up ☐ yes
   - d. Operating theatre ☐ yes
   - e. Recovery ☐ yes
   - f. Records ☒ no - too many records
   - g. Sterilization/Autoclaving ☐ yes

2. Are the above facilities well marked with signs? ☒ no

3. Does the space used for tubal ligation fulfill the following:
   - a. Well organized? ☐ yes
   - b. Fully utilized? ☐ yes
   - c. Clean? ☐ yes
   - d. Well maintained? ☐ yes

Figure 6
Clinic Activities Reviewed in Self-Assessment Checklist

The self-assessment checklist focuses on sterilization services and examines the following activities:

Clinic administration
Availability and training of staff
Evaluation activities
Space and facilities
Equipment
Supplies
Record keeping
Communication and reporting
Organization of services
Counseling
Postpartum services
Follow-up of clients after counseling
Medical screening and preoperative assessment
Preoperative care
Surgical procedures
Postoperative care
Postoperative follow-up
Information and education
Delivery of temporary methods of contraception

Figure 7
Follow-Up Plan of Action, Completed

PROBLEM	RECOMMENDATIONS	STAFF RESPONSIBLE	BY WHEN
RECORDS - NOT ENOUGH ROOM	CLEAR OUT OBSOLETE RECORDS	RECORDS CLERK	1 MONTH
NO SIGNS TO FP CLINIC	MAKE SIGNS AND PUT UP FOR PEOPLE TO SEE	ADMINISTRATOR	2 WEEKS

Service Quality Improvement

QOC Element(s)	**Comprehensive assessment and improvement**
Description	Service Quality Improvement (SQI) integrates the Bruce Framework for quality of care and the principles of Total Quality Management and Continuous Quality Improvement, quality philosophies used in industrial and health care settings. Managers can use SQI to assess and improve the quality of their programs. SQI helps staff examine the process of service delivery and systematically and scientifically identify, analyze, and solve problems in these processes.
Advantages	Uses a set of relatively simple tools. Does not replace existing management practices, but provides the environment to achieve improvements in record keeping systems, supervision, logistics, information programs, training and all other components of programs. Flexible enough to be used in a variety of settings. Includes program staff in the process. Uses data for decision-making. Focuses on client perspective.
Disadvantages	To be successful, SQI cannot be simply added to the existing structure of a program, but requires a commitment by top leadership to create an environment conducive to change. Requires training for staff to be able to participate in quality improvement projects. Allowing staff to become more involved in suggesting improvements can be threatening to management. Some staff may require assistance from a statistician or researcher to use tools.
Examples	To be field tested by FHI.
Attachments	"Appendix 1: Example of the Quality Improvement Process." From Hardee and Gould, 1992.
Citations	Hardee K and B Gould. 1992. "A Process for Service Quality Improvement in Family Planning." Family Health International. December.

Hardee K and B Gould. 1992. "A Process for Service Quality Improvement in Family Planning." Family Health International. December.

Appendix 1: Example of the Quality Improvement Process

The approach to quality improvement activities is perhaps most easily understood within the context of a case study. The following hypothetical example uses some of the quality improvement tools discussed in Section 3 to work through the FOCUS-PDCA cycle to analyze an opportunity for improvement.

"F": Find an opportunity for improvement

Data from the MIS of five urban family planning clinics revealed that the number of removals of IUDs performed by clinicians is much higher than desired. Early IUD removal diverts staff time and may indicate the client has previously received poor quality service. The head supervisor of the five clinics wants to reduce the removal rate at her clinics.

"O": Organize the Team

The head supervisor selects the head nurse from Clinic A to lead the team. The head nurse is familiar with both the counseling procedures and the IUD insertion procedures, and is qualified to insert IUDs. The head supervisor and Clinic A head nurse then select persons so as to obtain a representative sample of all staff levels involved (nurses, receptionist, counselor, and physician). A person from the head office will act as a team facilitator at the initial team meetings for support with the quality improvement tools.

"C": Clarify the Process

The team is informed of the head supervisor's desire to reduce the IUD removal rates and the team agrees that improvement in this area will reduce the workload for all of the clinics. This problem, however, is not limited to one clinic process, since the team knows that many factors contribute to a person's decision to have an IUD removed. The team decides to proceed to the next step to uncover possible causes and then return to this step when they have defined a process on which they wish to proceed with improvements.

"U" : Uncover Possible Causes

The team brainstorms over possible reasons the clients choose to have their IUDs removed. Although the discussion is helpful in discovering possible causes, the team decides it needs to obtain the clients' reasons for discontinuing use of the IUD. Making use of the reasons mentioned in the brainstorming section, the team develops a checksheet that the receptionist or counselor will use to collect data on the clients' reasons for removal (see Figure A.1).

After a month of data collection, the team reconvenes. The team decides to use a Pareto chart to combine the data from the five clinics and display it so that the "vital few" causes of IUD removal can be easily recognized. The Pareto chart constructed clearly shows that three reasons, side effects, method expiration, and desire for more children account for more than 80 percent of the reasons clients give for removal (see Figure A.2).

"C" Clarify the Process

The team agrees that IUD removals for planned pregnancy or method expiration are acceptable, yet some removals due to side effects may be preventable. The team then returns to the "C" step to clarify the processes at the clinic that lead to the client's decision to choose an IUD, the counseling and the insertion procedures. The team constructs a flowchart to indicate visually the steps involved in the process (see Figure A.3). Through the creation of the flowchart, the team members begin to see several possible areas for improvement, yet they are not sure which are most important.

"U": Uncover Possible Causes

The group brainstorms again to expand their thinking beyond the process in the flowchart to include all dimensions of the problem. The list developed by the team (see Figure A.4) is then used to construct a cause and effect diagram. The team chooses the categories of client, clinic staff, and procedures to classify the items on the brainstorm list. In the construction of the cause and effect diagram, the team realizes it must consider some items not mentioned during the brainstorming session. The completed cause and effect diagram (Figure A.5) has not generated answers to why clients have their IUDs removed, yet has generated some theories that need to be examined. Furthermore, the team must consider all possible causes so that they do not jump to one conclusion based on intuition alone.

The next step is to determine which of the possible causes may have the most impact on the problem and is most amenable to change, considering staff and resource constraints. The team decides to conduct a small survey of women discontinuing to determine what aspects of service delivery may be changed to reduce the likelihood of IUD removal.

After six weeks, the team meets again to examine the short survey results. The team constricts another Pareto diagram to visually display the data (Figure A.6). The first three categories, clients not given sufficient information, clients scared of side effects, and side effects more severe than expected, account for more than 80 percent of the reasons given by clients. All of these factors may be better addressed in the counseling sessions provided by the counselors and nurses.

"S" Select an Improvement

The information in the Pareto chart generated a theory that the clients were not receiving adequate information on the possible side effects of the IUD before choosing to have the method inserted. The task for the team now is to develop improvements in their service delivery process to improve the amount and quality of information the clients receive. The solutions are not always evident, and the team looks at the flowchart, brainstorms again, and conducts an informal survey with nurses and counselors at the five clinics to gather information to select an improvement (Figure A.7). The team also considers benchmarking a clinic run by another program to investigate what information these clinics provide their clients on IUDs.

After reviewing the data collected, the team presents their suggestions to the head supervisor. The team suggests that a brief training session be conducted with all the counselors on how to counsel about side effects. The procedure is changed so that the nurse, prior to insertion of the IUD, also reviews the advantages and disadvantages of the method with the client. Thirdly, one of the team members found a pamphlet on the IUD in another clinic during the benchmarking activities, and suggested to the head supervisor that the pamphlet be obtained in sufficient quantities to give to all clients interested in the IUD.

"D" Do the Improvement

The head supervisor works with the team leader to set up the brief training sessions with the counselors. Another session is set-up to talk with the nurses about pre-insertion counseling. The IUD pamphlet is obtained in sufficient quantities, but the head supervisor will pursue the possibility of the creation of a pamphlet specifically for their program. In addition, data will continue to be collected on IUD removals through the MIS, but the group will continue to use the initial checksheet to stratify the data on removals by category.

"C" Check the Improvement

After six months, the team reconvenes to review the data collected. The run chart demonstrates that the removal rate has gone down (see Figure A.8).

"A" Act to Maintain the Gains

The head supervisor works to have the side effect training for nurses and counselors included in the training received by all the employees. A new pamphlet has been drawn up and seems to have been received well by the clients. The supervisor will continue to monitor the IUD removal rate with data collected with the MIS to assure that the gains achieved to not dissipate over time.

Figure A.1: **Checksheet to Tally Reasons for Removal**

Checksheet for IUD Removals

Date Started __ __/__ __/__ __

Date Completed __ __/__ __/__ __

Clinic Name _____

District Name _____

Staff Completing Form _____

Remarks _____

_____

_____

Reasons	Checks	Frequency
Planned pregnancy	𝍸 𝍸 II	12
Removal medically indicated	𝍸	5
Side effects	𝍸 𝍸 𝍸 𝍸 II	22
Method expiration	𝍸 𝍸 I	11
Desire different method (unrelated to side effects)	III	3
Fear harmful effects	II	2
Other	IIII	4

Figure A.2: **Pareto Diagram**

Reasons Given by 59 Clients for Their Request for IUD Removal

Category	# of Responses	Percent of Total Responses	Cumulative Percent
1. Side effects	22	37.3	37.3
2. Planned pregnancy	12	20.3	57.6
3. Method expiration	11	18.6	76.2
4. Removal medically indicated	5	8.5	84.7
5. Other	4	6.8	91.5
6. Desire different method (unrelated to side effects)	3	5.1	96.6
7. Fear harmful effects	2	3.4	100.0
Total	**59**	**100.0**	**100.0**

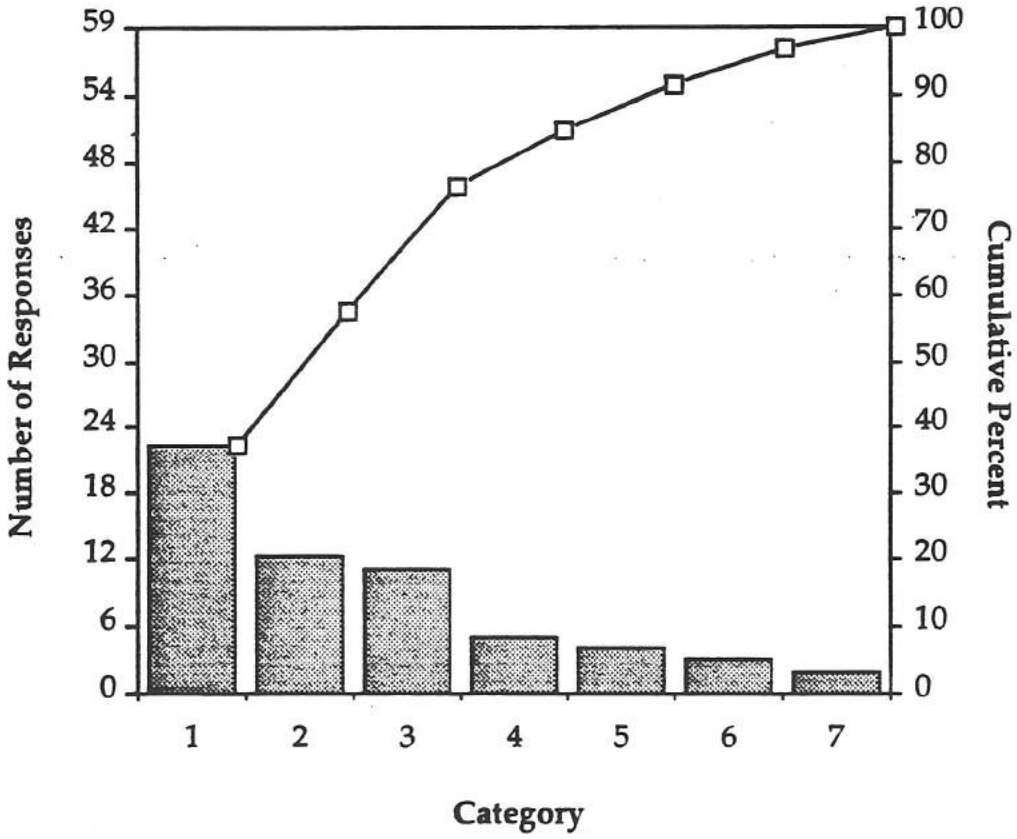


Figure A.3: Flowchart of Counseling and Service Delivery Process for New IUD Acceptors

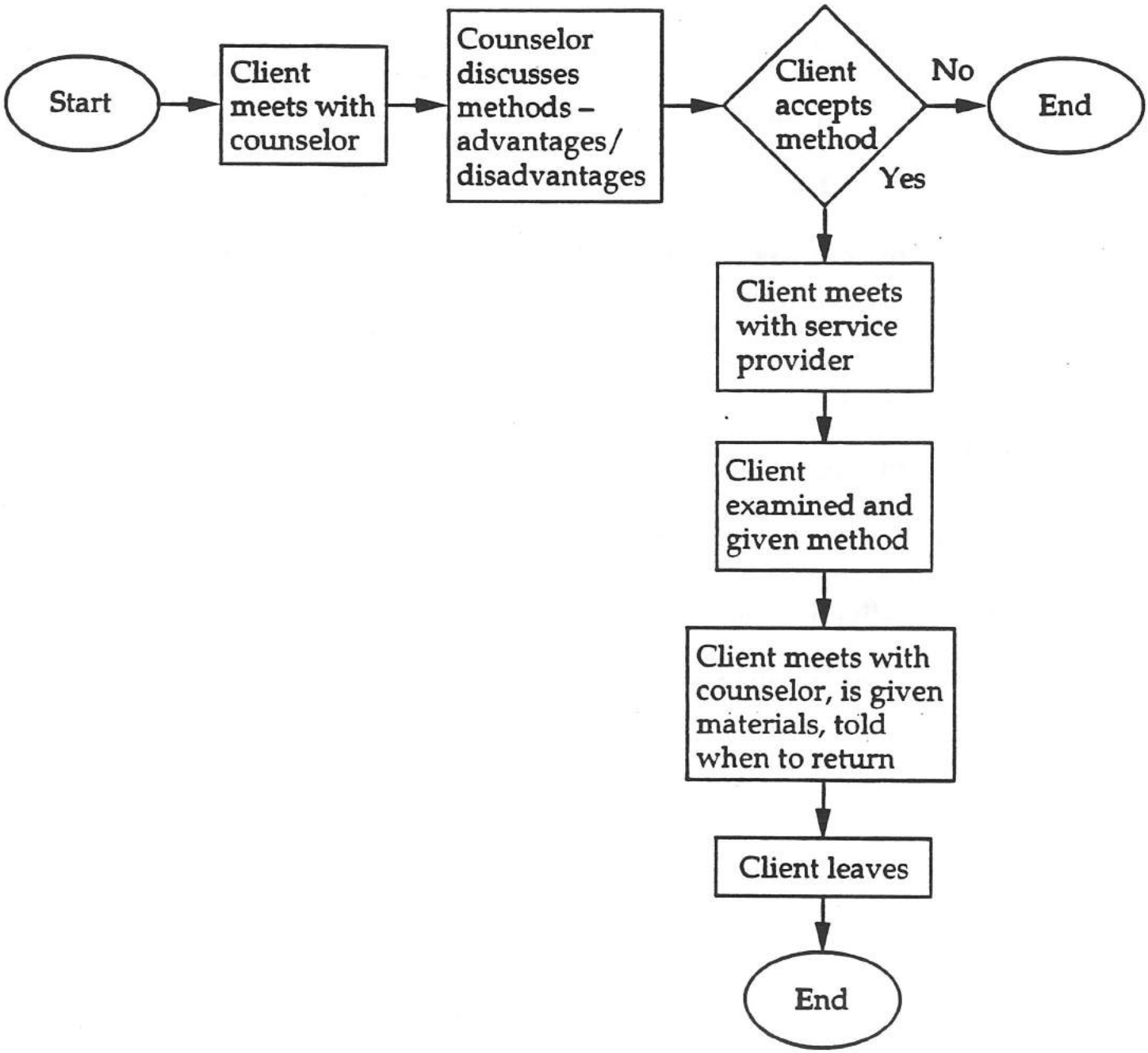


Figure A.4: **Brainstorm List**

PROBLEM: Why clients are discontinuing IUD use due to side effects

- Side effects are severe
- Removal medically indicated
- Client scared about side effects
- Client not given adequate information about side effects
- Client not given written materials about side effects
- Infection
- Client cannot tolerate side effects
- Husband doesn't like side effects
- Side effects inconvenient
- Client heard rumors from friends/relatives

Figure A.5: Cause and Effect Diagram

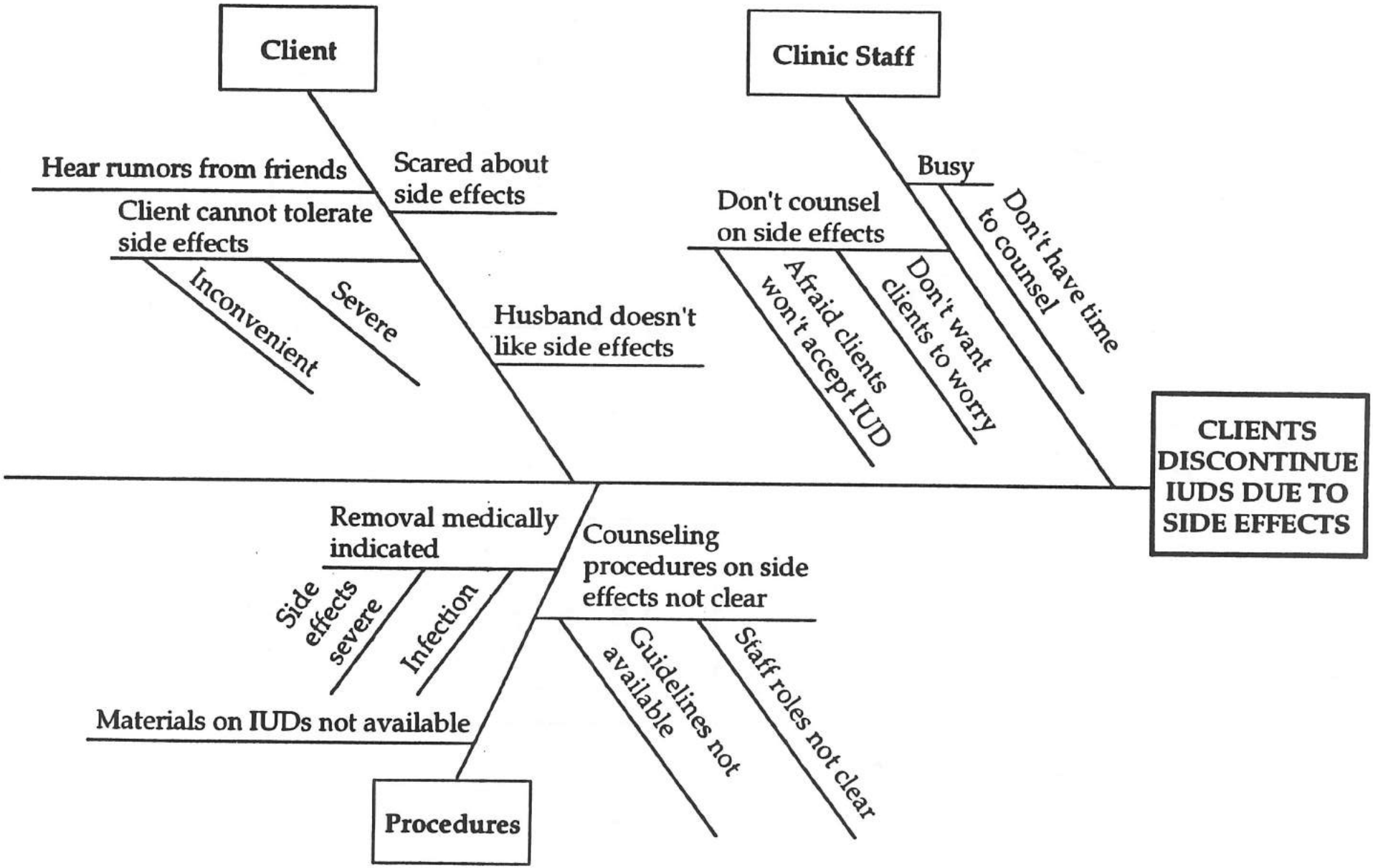


Figure A.6: **Pareto Diagram**

Reasons Given by 40 Clients for Discontinuing IUD Use Due to Side Effects

Category	# of Responses	Percent of Total Responses	Cumulative Percent
1. Were not given sufficient information	30	32.6	32.6
2. Scared of side effects	25	27.2	59.8
3. Side effects more severe than expected	20	21.7	81.5
4. Inconvenience of excess bleeding	6	6.5	88.0
5. Husband complaints	5	5.4	93.4
6. Other	4	4.3	97.7
7. Discontinuation medically indicated	2	2.3	100.0
Total	**92**	**100.0**	**100.0**

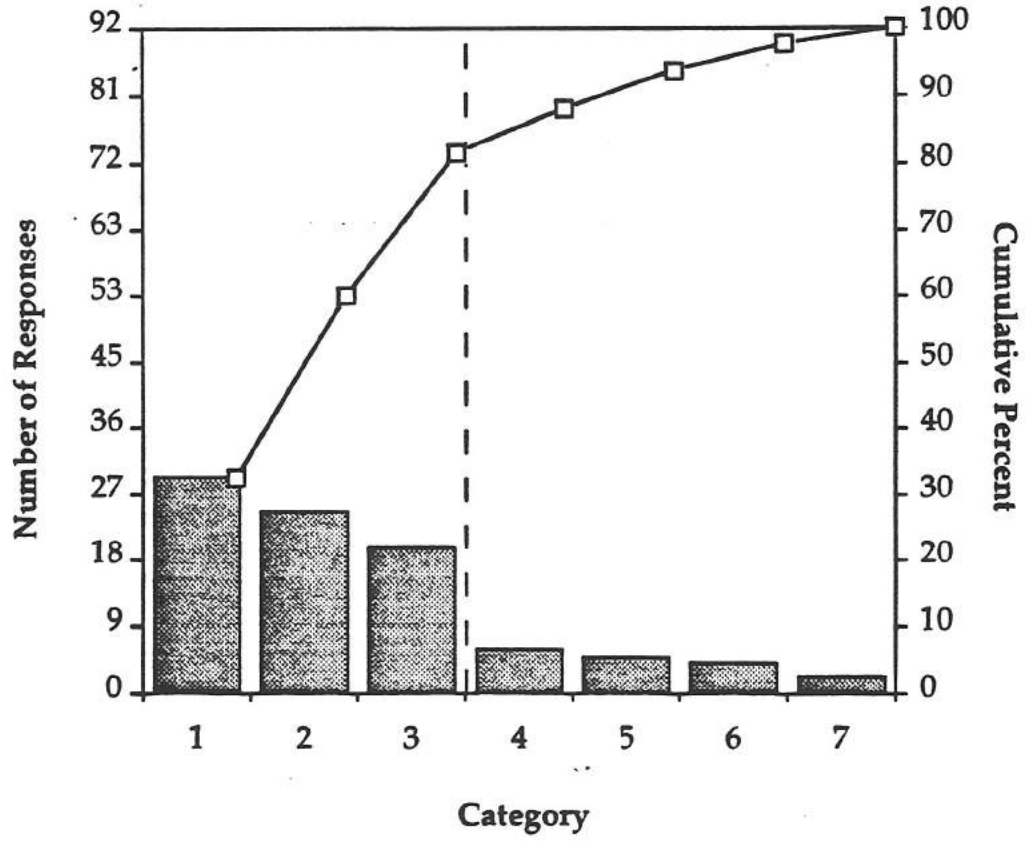


Figure A.7: Sample Questions for Informal Survey of Service Providers and Counselors to Help Select and Improvement

1. How much time do you spend, on average, with IUD clients?

2. What information do you provide to the client on side effects and what they should expect using an IUD?

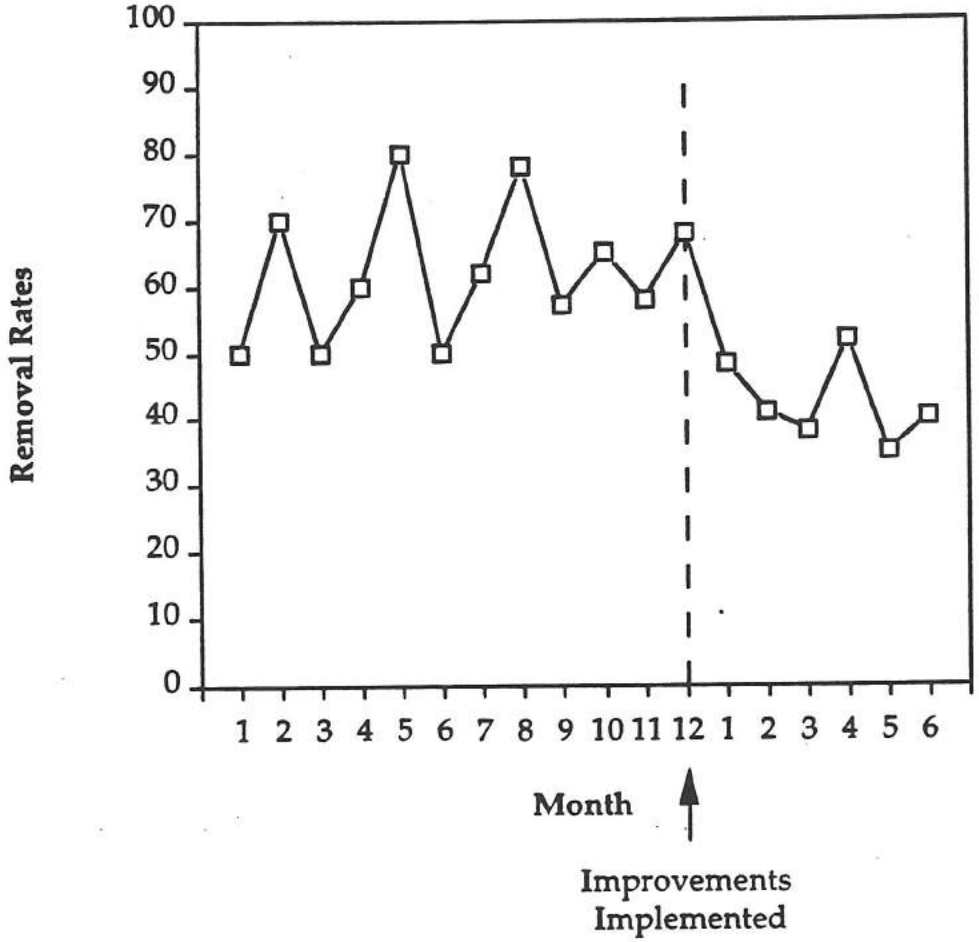
3. What is the role of a counselor in counseling the client on IUDs, including side effects?

4. What is the role of the service provider in counseling the client on IUDs, including side effects?

5. Do clients ask questions about what they should expect when using an IUD?

6. In you opinion, what information does an IUD user require to use an IUD?

Figure A.8: **Run Chart of Removal Rates of IUDs, by Month, After Improved Counseling (5 Clinics)**



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List of Contact Organizations

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Organization	Tools Cited in this catalog
Association for Voluntary Surgical Contraception (AVSC) 79 Madison Avenue New York, NY 10016 (212) 561-8000 FAX: (212) 779-9439	*COPE* *MIS* *Monitoring VSC Procedures*
CARE 660 First Avenue New York, NY 10016 (212) 686-3110 FAX: (212) 686-4005	*Supervision Tool*
CEMOPLAF Esmeraldas 712 y Guayaguil Ed. Pichincha 2do. piso Casilla 3459 Quito, Ecuador 593-2-518122 FAX: 593-2-582435	*SWOT*
Center for Development and Population Activities (CEDPA) 1717 Massachusetts Avenue, NW Suite 202 Washington, DC 20036 (202) 667-1142 FAX: (202) 332-4496	*Matrix (CEDPA)*
Centers for Disease Control and Prevention (CDC) Atlanta, GA 30333 (404) 488-5612 FAX: (404) 488-5628	*Patient Flow Analysis*

Organization	Tools Cited in this catalog
Columbia University **Center for Population and Family Health** 60 Haven Avenue New York, NY 10032 (212) 305-6960 FAX: 305-7024	*Focus Group Discussions* *Operations Research*
The EVALUATION Project Carolina Population Center University of North Carolina 8120 University Square Chapel Hill, NC 27516-3997 (919) 966-7482 FAX: (919) 966-2391	*Indicators* *Situation Analysis*
Family Health International (FHI) P.O. Box 13950 Research Triangle Park, NC 27709 (919) 544-7040 FAX: (919) 544-7261	*Client Satisfaction Studies* *Focus Group Discussions* *Observation* *Operations Research* *SQI* *Structured Interviews*
Family Planning Association of Kenya (FPAK) P.O. Box 30581 Nairobi, Kenya 254-2-215676	*Counselor Training Evaluation*
Family Planning Management and Development (FPMD) **Management Sciences for Health** 400 Centre Street Newton Corner, MA 02158 (617) 527-9202 FAX: (617) 965-2208	*CQI* *Indicators* *SWOT*
INOPAL (See Population Council)	

Organization	Tools Cited in this catalog
Institute of Reproductive Health Georgetown University 3800 Reservoir Road NW Washington, DC 20007 (202) 687-1392 FAX: (202) 687-6846	*MIS*
International Planned Parenthood Federation (IPPF) Regent's College, Inner Circle Regent's Park London NW1 4NS 071-486-0741 FAX: 071-487-7950	*Monitoring VSC Procedures*
International Planned Parenthood Federation (IPPF) **Western Hemisphere Region** 902 Broadway New York, NY 10010 (212) 995-8800 FAX: (212) 995-8853	*Client Satisfaction Studies* *Clinic Management System* *MIS* *Observation* *Patient/Client Flow Analysis* *Simulated Client Studies* *Use and Discontinuation Studies*
MEXFAM (Fundacion Mexicana Para La Planeacion Familiar, AC) Juárez 208 Tlalpan C.P. 14000 Mexico D.F. MEXICO 525-655-1265 FAX: 525-573-7100	*CQI*
Pathfinder Fund 9 Galen Street Watertown, MA 02172 (617) 924-9202 FAX: (617) 924-3833	*Client Satisfaction Studies* *Program Quality Assessment Tool*

Organization	Tools Cited in this catalog
Population Communication Services (PCS) Center for Communication Programs Johns Hopkins University 527 St. Paul Place Baltimore, MD 21202 (410) 659-6300 FAX: (410) 659-6266	*Counselor Training Evaluation* *Observation*
Population Council One Dag Hammarskjold Plaza New York, NY 10017 (212) 339-0500 FAX: (212) 755-6052	*CQI (INOPAL)* *MIS* *Observation* *Operations Research* *Quality Definition and Assessment* *Simulated Client Studies* *Situation Analysis* *Structured Interviews* *Use and Discontinuation Studies*
INOPAL Population Council Regional Office for Latin America and Caribbean Alejandro Dumas No 50 Apartado Postal 105-152 11560 Mexico, D.F. MEXICO 525-280-1725 FAX: 525-281-0702	
Population Council **Africa Operations Research Project** P.O. Box 17643 Nairobi, KENYA 254-2-449003 FAX: 254-2-499074	

Organization	Tools Cited in this catalog
Population Council **Asia and Near East Operations Research Project** House No. 55, Street No.1 Sector F 6/3 Islamabad, PAKISTAN 92-51-814066 FAX: 92-51-822401	
PROFAMILIA Calle 34 No. 14-52 Bogota, Columbia 571-287-2100	*Quality of Care Evaluation*
SEATS (Family Planning Service Expansion and Technical Support) John Snow Incorporated 110 Wilson Boulevard, 9th Floor Arlington, VA 22209 (703) 528-7474 FAX: (703) 528-7480	*Matrix (Enterprise)*(JSI) *Continuous Assessment*
SOMARC The Futures Group 1101 14th Street NW, 3rd Floor Washington, DC 20005 (202) 775-9680 FAX: (202) 775-9694	*Consumer/Client Intercept Studies* *DHS Oversample* *Panel Studies* *Simulated Client Studies*