Family Planning Service Expansion and Technical Assistance Project

SEATS II

Strategy for Quality of Care in Family Planning and Reproductive Health

---

Li nda Ippolito
Nancy Pendarvis Harris
Don Lauro

JSI/Washington, D.C.
1616 N. Fort Myer Drive, 11th Floor
Arlington, VA 22209 USA
Tel. (703) 528-7474

USAID Contract Number CCP-3048-C-00-4004-00
July 1996

Acknowledgments

As is fitting with any document on quality, this strategy benefits from the knowledge and expertise of many team members. The approaches and practical experiences are based on the work of many SEATS colleagues and partner organizations involved in the development, implementation and refinement of activities to ensure quality of care and continuous quality improvement in family planning and reproductive health programs.

In addition to the cited authors, those directly involved in developing, reviewing and providing feedback on this document include: Laurie Cappa, SEATS Deputy Director; Elaine Rossi, Senior Technical Advisor for Quality under SEATS I and now Director of SEATS II Special Initiatives; Joan Haffey, PATH/SEATS Senior Technical Officer for IEC; Mona Khan, Program Associate for Reproductive Health, Virginia Hight-Laukaran, SEATS Senior Evaluation Officer; David O'Brien, SEATS Co-Regional Director for Asia/Near East/Europe; Carolyn Vogel, Technical Advisor for SEATS Urban Initiative; Paula Nersesian, SEATS Program Associate and Coordinator of the JSI/Reproductive Health for Refugees Project, Bill Brady, MotherCare Senior Advisor for Control of Infectious Diseases; Stephanie Kendall and Dana Gelfeld, SEATS Staff Associates; and Erika Pluhar, SEATS intern responsible for compiling information found in the SEATS II Guide to Tools and Resources for Quality of Care (Appendix A of this document). Other SEATS I & II team members whose work in quality and access is included though examples in this document include Martin Gorosh, Alain Damiba, Paul Sossa, Marc Okunnu, Melinda Ojermark, Ade Adelakun, Ismail Thioye, and Mary Lee Mantz.

JSI/SEATS wishes to acknowledge and thank its partners for their continuous contributions to high quality reproductive health and family planning service delivery provided through the SEATS project:

- AVSC International, which collaborated on the design of the SEATS II Medical Monitoring System and the *SEATS II Clinical Protocols for Family Planning Programs: A Resource Book*, sections of which are included in this document.
- The American College of Nurse-Midwives (ACNM).
- The Program for Appropriate Technology in Health (PATH).
- Planned Parenthood Federation of America (PPFA).
- Initiatives, Inc.
- World Education, Inc. (WEI).

SEATS gratefully acknowledges the financial support of the United States Agency for International Development for making preparation of this document possible.

Contents

List of Acronyms

ACNM	American College of Nurse-Midwives
AIDS	Aquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention
AJJDC	American Jewish Joint Distribution Committee
AMEG	American Manufactures Export Group
ASHMEI	Alumni Society of the Harvard Middle East Institute
AVSC International	Access to Voluntary and Safe Contraception, International
BCC	Behavior Change Communication
CA	Cooperating Agency
CAFS	Centre for African Family Studies
CBD	Community-Based Distribution
CCE	Client Capacity Estimator
CHS	Center for Health Services
COPE	Client-Oriented, Provider-Efficient
CPFH	Center for Population and Family Health (Columbia University)
CPI	Client-Provider Interaction
CPR	Contraceptive Prevalence Rate
CQI	Continuous Quality Improvement
CYP	Couple-Years of Protection
DHS	Demographic and Health Surveys
DTPS	District Team Problem Solving
ESARO	East and Southern Africa Regional Office
FGM	Female Genital Mutilation
FP	Family Planning
FPLM	Family Planning Logistics Management
FPMD	Family Planning Management Development
FPPMES	Family Planning Program Monitoring and Evaluation System
GTZ	German Technical Assistance Corporation
HARI	Helping Couples Achieve Reproductive Intentions
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IHI	Institute for Healthcare Improvement
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IRH	Institute for Reproductive Health (Georgetown University)
ISEPME	Institute for Social and Economic Policy in the Middle East
JDC	Joint Distribution Committee
JSI	John Snow, Inc.

LAM	Lactational Amenorrhea Method
MA	Medical Advisor
MAQ	Maximizing Access and Quality
MAPS	Midwifery Association Partnerships for Sustainability
MCH	Maternal and Child Health
MIS	Management Information System
MOH	Ministry of Health
MOPH	Ministry of Public Health
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OJT	On-the-Job-Training
OR	Operations Research
PATH	Program for Appropriate Technology in Health
PHNC	Population, Health and Nutrition Center
PPFA	Planned Parenthood Federation of America
PVO	Private Voluntary Organization
QA	Quality Assurance
QAP	Quality Assurance Project
QI	Quality Improvement
QOC	Quality of Care
QM	Quality Management
RH	Reproductive Health
SDP	Service Delivery Point
SEATS	Family Planning Service Expansion and Technical Support
SI	Special Initiatives
STD	Sexually Transmitted Disease
TA	Technical Assistance
TOT	Training of Trainers
TQM	Total Quality Management
UNAIDS	United Nations Program for Prevention and Treatment of
HIV/AIDSUSAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WARO	West Africa Regional Office
WEI	World Education, Inc.
WHO	World Health Organization

List of Figures

Executive Summary

The Family Planning Service Expansion and Technical Support Project's (SEATS II), *Strategy for Quality of Care in Family Planning and Reproductive Health* is central to the achievement of the Project's purpose and contribution to the overall goals and strategic objectives of the United States Agency for International Development's (USAID) Population, Health and Nutrition Center (PHNC).

In support of the USAID Program Result of "increased demand for, access to and quality of family planning and other selected reproductive health and information services," the SEATS II overall strategic approach seeks to enhance access to and quality of family planning and reproductive health services. In support of the USAID Program Result of "improved policy environment and increased global resources for family planning programs," the SEATS II overall strategic approach seeks to provide relevant and quality technical assistance and training in management, quality of care, sustainability, and other technical areas.

SEATS has long demonstrated its firm commitment to promoting and ensuring high quality services in the subprojects it supports and to advancing the field of quality improvement in family planning and reproductive health. This commitment is motivated in part by findings that quality has a positive effect on the most often cited desirable outcomes of family planning activities:

(1) Increasing the contraceptive prevalence rate (the percentage of women of reproductive age practicing contraception at a time), leading to reductions in fertility and improvements in maternal and child health (Jain, 1990).
(2) Meeting unmet demand for family planning services by providing services that are accessible, acceptable, appropriate, and provide an adequate selection for clients.
(3) Helping individuals to achieve their reproductive goals, thus producing a satisfied clientele of continuing users, which in the long term would also contribute to reductions in fertility (Bruce, 1990).

SEATS QOC Strategy offers practical guidance for operationalizing the aspects of the SEATS II strategic approach relevant to quality and to achieving the outcomes cited above. The strategy involves incorporating quality of care and continuous quality improvement strategies routinely into SEATS II subprojects. Guidance provided in this strategy is in accordance with SEATS contractual obligations, its overall program objectives, and its philosophy concerning quality, based on lessons learned from field experience and adapting current theoretical models and practical techniques for quality in health care and industry.

SEATS QOC Strategy has been developed in accordance with three important requirements:

< Address the needs of multiple constituencies including subprojects, country programs, SEATS regional and central management, USAID Missions and the USAID Health, Population and Nutrition Center in Washington.

- Build on the foundation of proven quality of care improvement approaches developed under SEATS I and elsewhere, adapted and improved for SEATS II.
- Meet the new requirements of performance-based contracting and respond to the changing needs of the field and the overall environment.

SEATS QOC Strategy presents:

- The intellectual framework for quality within which SEATS has actively made decisions concerning quality assessment and improvement.
- The essential elements of the SEATS approach to quality, based on proven strategies.
- Practical examples of successful quality initiatives from SEATS experiences and other sources.

- Recommended tools and resources to improve quality at various levels.
- Illustrative indicators to measure the outcome and impact of quality improvement efforts.

SEATS promotes use of quality models that are client-oriented. This involves balancing two interdependent components: *quality in perception*: the recognition of clients' needs, expectations and level of satisfaction in the organization and delivery of services; and *quality in fact:* performance according to up-to-date program guidelines, clinical protocols, and institutional and national policies that do not limit access or quality. At an operational level, this means the design of subprojects and selection of activities and indicators that address and measure both of these components.

Two key principles that guide application of the *SEATS QOC Strategy* are:

- "Quality" itself must be understood within the specific context of a given program. Quality of care components and improvement efforts therefore must be tailored for specific subprojects, respectively.
- Continuous quality improvement models recognize quality as a continuum, hence quality needs and improvement opportunities, supporting structures, activities and indicators will vary between subprojects and sometimes over the life of an individual subproject.

While the number of methods or models to achieve institutionalization of quality may vary, SEATS ensures that certain principles to promote quality are consistently applied. The SEATS approach stresses that quality should be conceptualized in concert with personnel at every level of host-institutions using key quality principles and models, with subsequent development of structure and skills.

Quality strategies, techniques and indicators will be integrated into the design, implementation and evaluation cycles of SEATS II subprojects. *SEATS QOC Strategy* provides guidance on doing so, and thus presents fundamental guidance for the promotion of quality improvement and the achievement of the next SEATS II quality milestone: quality monitoring in seventy-five percent of subprojects.

Introduction

The Family Planning Service Expansion and Technical Support Project (SEATS II), funded by the United States Agency for International Development (USAID), is implemented by John Snow, Inc. (JSI) and its partner organizations:

- The American College of Nurse-Midwives (ACNM)
- AVSC International
- The Program for Appropriate Technology in Health (PATH)
- Planned Parenthood Federation of America (PPFA)
- Initiatives, Inc.
- World Education, Inc. (WEI)
- American Manufactures Export Group (AMEG).

SEATS embodies a high level of commitment to quality of care (QOC) in reproductive health and family planning (RH/FP) programs. Issues related to quality in RH/FP are complex and rapidly evolving. This strategy document provides a summary of the evolution of the thinking in this area, including a description of SEATS' past experience and ways in which the Project has benefited from and contributed to the work of other groups in finding practical ways to promote quality. The strategy aims to present a brief background on the field of quality, an overview of the SEATS philosophy and approach to continuous improvement of quality, and practical guidance for staff as they promote quality in subprojects. The strategy also includes illustrative activities and indicators and recommended resources and tools for quality improvement.

Therefore, the various chapters of the document are interdependent in their underlying assumptions, yet distinct in their purposes:

Chapter I. Structure for Quality Within the SEATS Project
This chapter situates quality within the structure of USAID's strategic objectives and results framework, SEATS program objectives, and SEATS performance-based contract.

Chapter II. What is Quality?
Chapter II presents an intellectual framework for the discusion of quality based on a literature review. It is within this framework that SEATS has actively made decisions concerning its approach to quality.

Chapter III. Essential Elements of the SEATS Approach to Quality Improvement
In this chapter SEATS philosophy and approach to quality of care and quality improvement are described and illustrated with several examples from SEATS subprojects.

Chapter IV. Integrating Quality of Care into SEATS II Subprojects

This chapter provides technical and practical guidance on what subprojects can and should do to integrate continuous improvement of quality into design, implementation, and evaluation cycles.

Appendix A. SEATS II Suggested Tools and Resource Guide for Quality of Care

Appendix A presents contact information, descriptions, and uses for tools and resources that SEATS recommends to:

- Assess quality and quality needs.
- Improve client orientation.
- Improve clinical quality.
- Improve management.

Appendix B. USAID Draft Checklist for Maximizing Access to Quality (MAQ)

The checklist provides a quide to current issues and indicators in:

- Service delivery, including client-provider interaction (CPI) and technical competence.
- Support to services, including training, gender, Information, Education and Communication (IEC) tools and supervision.
- Framework for services, including policies, protocols and program strategy.

Appendix C. Useful Models Related to Quality of Care

Examples of models found to be useful for quality improvement including the SEATS improvement cycle, Plan-Do-Check-Act, FOCUS, and Juran's Journey.

The *SEATS II Strategy for Quality of Care in Family Planning and Reproductive Health* (*SEATS QOC Strategy*) is intended to offer practical as well as theoretical support for integrating QOC strategies and practices into new or ongoing programs.

I. Structure for Quality Within SEATS

This chapter situates quality within the structure of USAID's strategic objectives and results framework, SEATS program objectives, and SEATS performance-based contract.

I.A. USAID Strategic Objectives and Purpose of SEATS

The purpose of the SEATS II Project is "to expand the development of, access to and use of quality family planning and reproductive health services in currently underserved populations, and to ensure that unmet demand for these services is addressed through the provision of appropriate financial, technical and human resources" (JSI/SEATS, 1994). This purpose contributes directly to the USAID Population Health and Nutrition Center's (PHNC) strategic objective of "increased use by women and men of voluntary practices that continue to reduce fertility", and thus, the overall Agency's strategic objective of "sustainable reduction in unintended pregnancies" (USAID, 1996).

In support of the USAID program approach of "increasing the demand for, access to and quality of family planning and other selected reproductive health and information services", the SEATS II overall strategic approach seeks to enhance access to and quality of family planning and reproductive health services. This is accomplished by SEATS through the provision of resource support including Technical Assistance (TA) in quality of care, strategic planning, policy and management, sustainability, logistics and procurement, training, information, education and communication. SEATS performance-based milestones and strategic objectives are designed in accordance with USAID's strategic objectives and anticipated results (Figure 1).

Those elements with direct relevance to QOC are highlighted in bold within the table below.

Figure 1. Relationship of USAID's Strategic Objectives, Approaches and Results to SEATS II Strategic Objectives

USAID Goal 3: Stabilizing world population and protecting human health		
USAID PHNC Strategic Objective 1: Sustainable reduction of unintended pregnancies		
USAID Program Results	**SEATS II Program Objectives**	**Relevant Milestones**
1.1 New and improved technologies and approaches for contraceptive methods and family planning identified, developed, tested, evaluated, and disseminated	1. Develop comprehensive country strategic plans. 2. Support 50 multi-year family planning service delivery projects.	-Ten country strategic plans -MOUs for nine countries -Fifty subproject agreements -Two million CYP -Seven hundred new and improved service sites -SEATS has met Couple-Years Protection (CYP) objectives in target population
1.2. Improved policy environment and increased global resources for family planning programs	3. **Provide relevant and quality TA and training in management, quality of care, sustainability and other technical areas.** 4. Provide specialized assistance in commodity procurement and logistics.	**-Quality of care in family planning and reproductive health strategy** **-Clinical protocols for long-term methods**
1.3. Enhanced capacity for public, private, NGO, and community-based organizations to design, implement and evaluate sustainable family planning programs.	5. Design and implement subproject sustainability plans	-Sustainability plans in 50% of subprojects -Cost recovery in 40% of projects -Three dissemination seminars held -Three regional sustainability seminars held
1.4. **Demand for, access to and quality of family planning and other selected reproductive health information and services increased**.	6. Monitor and evaluate program and subproject inputs, outputs, and outcomes	-Monitoring and evaluation plan **-Quality of care monitoring in 75% of subprojects** -Self-evaluation mechanisms functional in 12 subprojects -Final report

I.B. Quality of Care within the Overall SEATS Performance-Based Structure

The SEATS mandate of strengthening and expanding access to quality family planning programs, together with the underlying assumption now generally shared in the population and reproductive health community that quality positively influences and impacts client satisfaction and contraceptive acceptance and continuation rates, demands that considerable effort be made to ensure the quality of family planning and reproductive services provided through SEATS subprojects. In accordance with its commitment to ensuring high quality service delivery, SEATS has three far-reaching milestones in its performance-based contract related to QOC:

SEATS QOC Milestone 1 Clinical protocols for long-term and permanent methods approved (project milestone 3-a: *SEATS II Clinical Protocols Resource Book* submitted and approved, 10/95).

SEATS QOC Milestone 2 Strategy for quality of care in family planning and reproductive health submitted (project milestone 6-b: due 7/96).

SEATS QOC Milestone 3 Quality of care monitoring in seventy-five percent of subprojects (project milestone 11-c: due 10/97).

Consequently, the *SEATS QOC Strategy* is central to the project's achievement of its purpose and to its contributions to the achievement of USAID's overall goal and strategic objectives.

I.C. Purpose of SEATS Strategy for Quality of Care in Family Planning and Reproductive Health

SEATS QOC Strategy provides guidance to SEATS staff and collaborating institutions on:

- The relationship between quality of care and achievement of strategic and program objectives.
- The promotion of quality of care and continuous quality improvement in family planning and reproductive health programs.
- The design for and monitoring of quality in SEATS subprojects, as required by SEATS II QOC Milestone 3: quality monitoring in seventy-five percent of subprojects.
- Issues related to integration of selected reproductive health interventions.

SEATS QOC Strategy provides guidance for country assessments, program planning, subproject implementation, management information systems (MIS) evaluation efforts and a framework for building QOC monitoring into subprojects. *SEATS QOC Strategy* continues the Project's commitment to ensuring that quality is adequately addressed in all country plans and subproject designs.

In addition to assistance aimed specifically at engendering continuous quality improvement processes and techniques, SEATS TA for quality will continue to emphasize strong counseling and client-centered approaches; promotion of wider choice of contraceptive methods and adequate referral systems; access to services by users and potential clients -- including underserved groups such as youth and postpartum/post-abortion women; and the establishment of functioning support systems such as MIS, logistics, training, follow-up and supervision.

In an effort to meet these goals, the *SEATS QOC Strategy* has been developed in accordance with three important requirements:

- Address the needs of multiple constituencies including subprojects, countries, SEATS regional and central management, USAID Missions and the USAID Health, Population and Nutrition Center in Washington.
- Build on the foundation of proven quality of care improvement approaches developed under SEATS I and elsewhere, adapted and improved for SEATS II.
- Meet the new requirements of performance-based contracting and respond to the changing needs of the field and the overall environment.

SEATS has, since its inception, maintained a firm commitment to results-oriented programming, which has taken on increased importance in the current environment. As stated in SEATS II Project Year Two Workplan:

> *Both USAID and JSI are strongly committed to managing for results and to performance-based contracting . . . Matching central level milestones with field-funded and field-generated benchmarks calls for new ways of looking at performance. Likewise, controlling the additional costs of monitoring and evaluation required by this contracting mechanism is essential if SEATS is to remain competitive regarding Field Support funding. SEATS continues to devote resources to meeting this challenge (SEATS, 1996).*

In accordance with these priorities, the *SEATS QOC Strategy* aims to integrate quality of care into the design, implementation, and evaluation cycles of subprojects in a manner that is both field-driven and based on the needs of individual projects as well as cost-effective. In this way *SEATS QOC Strategy* avoids additional or needless burdens on programs while simultaneously meeting the challenge of achieving central level performance-based milestones and contributing to the achievement of USAID's strategic objectives and results. The *SEATS QOC Strategy* also serves as both a reference and a guide for continuous quality improvement in subproject design, country programs, partner institutions, specific activities, and monitoring of programs.

II. What Is Quality?

This chapter presents an intellectual framework for the discusion of quality, based on a literature review. It is within this framework that SEATS actively makes decisions concerning its approach to quality.

II.A. How Do We Find Quality?

Efforts to define and measure quality are motivated by an interest in (1) identifying areas for improvement in a given family planning program and (2) determining whether the level of quality affects outcomes, such as continuation rates (Blaney, 1993).

Although it is sometimes rightly asserted that there is little consensus as to what constitutes high quality care (Hardee and Gould, 1992), and how to evaluate it (Brown, et al, 1995), the past decade has actually seen both an increased interest in these areas and significant program effort resulting in the development and adaptation of quality of care concepts, approaches, tools, and indicators for measurement -- many of which have been found to be useful for reproductive health professionals.

Moreover, the seeming lack of consensus, at least in terms of defining quality, may be a natural outgrowth of the current thinking that quality, while present in all programs, is best defined, promoted and measured within a particular program.

Donabedian, writing in 1988 on advances in defining and assessing quality, noted that "as we seek to define quality, we soon become aware of the fact that several formulations are both possible and legitimate..." (Donabedian, 1988).

Figure 2: Useful Definitions of Quality

Meeting the needs, expectations and requirements of clients and/or other customers . . .. with a minimum of effort, re-work, and waste (NDP on QI in Health Care, 1991).

Satisfaction of clients with services according to selected measures taken at the institutional and service delivery levels.

Doing the right thing, right, at the right time (adapted from Deming).

The way individuals and clients are treated by the system providing the service (Jain, 1992).

Definitions of quality and quality improvement found to be useful by SEATS place the client's perspective, including the client's expectations and level of satisfaction, in a central position, alongside clinical standards or other program guidelines and protocols (Figure 4). Previously, inspection of performance according to pre-set, external standards and protocols *alone* were traditionally relied on for quality assurance and assessment.

Figure 3: Contrasting the Traditional Approach to Quality Assurance with Total Quality and Continuous Improven

TRADITIONAL APPROACH TO QUALITY ASSURANCE	TOTAL QUALITY MANAGEMENT AND CONTINUOUS QUALITY IMPROVEMENT
Contrasting Perspectives	
Quality in health care consists of the proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society, and that have the ability to produce impact on mortality, morbidity, disability, and malnutrition. (Romer and Aquilar, WHO, 1988).	***High quality is client oriented and aims to help individuals achieve their reproductive intentions and goals (Bruce, 1990).*** ***The concept of continuous improvement strategy for quality implies that quality is a process rather than an outcome (Omachonu, 1992).***
Contrasting Characteristics	
Applies external "gold standard" of quality	Establishes quality concepts and processes based on client expectations and organizational resources with input by staff
Focuses on retrospectively identifying deviations from standards	Focuses on systems and processes as potential sources of error and stresses continuous improvement in performing an activity
Charges supervisors or inspectors with responsibility for quality	Puts every employee in charge of quality
Stresses "quality in fact" and treatment outcomes	Stresses "quality in perception" (meeting client expectations) as well as "quality in fact" (protocols and treatment outcomes)
Assumes the medical community and policy makers alone can define quality	Allows participation of customers to define quality according to their needs, wants and expectations
Judges quality during an announced visit by outside inspector or central level staff	Judges and improves quality on an ongoing basis with all staff involved (receptionists, secretaries, clinical providers, administrators, medical records clerks, drivers, etc)
Stresses administrative authority for inspection of standards	Emphasizes interdisciplinary teams working toward the objectives set by the customer

Although program-specific minimum standards can be valuable (Jain *et al.*, 1992), and SEATS has found that establishment and use of program-specific standards *contribute* to quality of care, the SEATS experience is in keeping with current models of quality suggesting there is no international or external "gold standard" of quality, as was sometimes previously assumed with "quality assurance" models. Rather, quality is specific to particular settings and can be improved on a continuing basis.

Quality itself is not a single standard, or as Bruce, writing on family planning programs and using Donabedian's concepts, indicates “quality is not a standard at all, though; rather, it is a property that all programs have... only a judgement can determine whether quality is good or bad, satisfactory or unsatisfactory." One of the recent watersheds in considering quality in health care systems in general, and family planning specifically, is to acknowledge and promote the client's role and even preeminence in the judgement of whether a program's quality is satisfactory or not. Figure 3 compares the traditional with the continuous approach.

II.B. Who Are Our Clients?

Client-centered quality improvement models and programs aim at increasing client satisfaction with services as well as adhering to clinical standards. Client-centered approaches stress identifying, knowing and listening to clients, responding to their input, and organizing services to meet their expectations and needs.

A *client* in family planning and reproductive health programs, or a *customer* in the lexicon of Total Quality Management (TQM), is the individual or group receiving a service that a supplier is providing. Customers/clients may be either *external* or *internal* to the organization which supplies the service.

- *External clients* are the final recipients, consumers, or beneficiaries of the service being offered. These include women and men who are the users or potential users of family planning and reproductive services, their families, friends and community members;
- *Internal clients* are “ those within the organization who rely on fellow workers for products and services that help them to fulfill their part in providing quality health care to the external client. Internal clients include front-line workers, supervisors, and other health team members” (Franco et al, 1994).

Other important customers of the services provided by reproductive health and family planning programs programs include donor organizations such as USAID and other third-party payers; referral groups; and to some extent other organizations who are involved in development and implementation of complementary programs, such as maternal mortality reduction or mother-child health programs.

Figure 4: Conceptual Framework for the Interdependence of Quality In Fact and Quality In Perception [2]

A useful conceptual framework for bringing into balance the traditional quality assurance stress on clinical standards and the recognition of the client's integral position in defining and judging quality is adapted from Omachonu (Figure 4) and summarized as follows:

> *Quality consists of two interdependent parts: quality in fact and quality in perception. The first involves meeting your own specifications (conformance to standards), the second part is meeting the expectations of your customer... Quality as perceived by the recipient of care is critical to the complete definition of quality... [a] definition would be considered inadequate and misguided [if] it fails to address an essential component -- the patient's viewpoint (Omachonu, 1991).*

Omachonu goes on to indicate that definitions of quality should focus on the future and be process oriented, rather than merely results oriented.

Text box
For figure 5

Thus, when answering the questions *"What is quality?"* and "*How do we find it?"* service providers, program planners, administrators, and evaluators should include from the outset the responses gained by asking and listening to clients, and should do so on a regular and continuing basis.

A summary of selected tools and resources that SEATS has found to be useful for improving "quality in fact," or clinical and managerial quality, and "quality in preception," or client orientation, is found in Appendix A.

II.C. Elements of Quality of Care in Family Planning Programs

A foundation for the elaboration of quality in family planning programs was provided by Donabedian's articulation of concepts which have proven pivotal to quality improvement efforts in health care. As early as 1966, he presented the now pervasive categorization of quality in health care according to structure, process and outcome.

Outcome refers to consequences or benefits of medical intervention; *process* refers to the activities of health care providers and others involved in providing services; *structure* refers to qualifications, certifications, standards, and other attributes of the resources employed. He later expanded on this to describe three domains or aspects: the *technical*, or the "application of science and technology;" the *interpersonal*, or the social and psychological aspects of the provider-client interaction; and later, the *amenities* of care, including elements of comfort, convenience, and attractiveness of facilities (Donabedian, 1980).

Building on this foundation, "Fundamental Elements of Quality of Care: A Simple Framework" (Bruce, 1990) applied these concepts to family planning programs. Considered a landmark contribution to the field, the "Bruce/Jain Framework", as it is now often called, describes six essential elements of quality of care in family planning while emphasizing the client's interaction with the service delivery system. Viewed as a whole, this framework encompasses not only the interpersonal dimensions required for client satisfaction but also the adherence to clinical standards (technical competence) and other aspects of infrastructure required for positive treatment outcomes (Figure 6).

Figure 6: Elements of Quality of Care
(Bruce/Jain QOC Framework)

- Choice of methods
- Information to users
- Technical competence of providers
- Client-provider interaction
- Continuity of care
- Constellation (or appropriateness and acceptability) of services

The Bruce/Jain framework provides guidance on which elements of a program to focus on during design, implementation and assessment. As Bruce indicated, it should be taken as a starting point and used in a flexible manner. However, program planners and managers wishing to apply the framework to their own programs in order to improve quality require practical tools and techniques which the framework itself does not provide (Rosenfield and Damiba, 1991).[3]

During its years of implementation, SEATS has both benefited from and contributed to the development, adaptation, and application of useful approaches and tools for quality improvement

in family planning. Many of these are described in subsequent sections of this strategy; in addition, Appendix A provides a description of resources and tools recommended by SEATS to assess quality needs, and improve client orientation, clinical quality and management.

In addition to the six elements listed in the Bruce/Jain framework, "access" is often cited as a critical element. Some definitions of access are highly compatible with "choice of methods" and "constellation of services." However, as indicated by the initiation of USAID's initiative to Maximize Access and Quality (MAQ), issues of providing and ensuring access to services deserve special consideration. As Bruce points out: "choice of methods is not possible without sufficient supply points" (Bruce, 1990).

II.D. Maximizing Access and Quality (MAQ)

USAID has consistently supported quality improvement through its own technical and policy initiatives and by support to and development of programs implemented by its Cooperating Agencies (CAs). *"MAQ"* is the USAID initiative that has grown out of USAID's efforts to provide a "cost-effective approach to family planning and reproductive health programs that increases client satisfaction through maximizing access to and quality of services" (USAID, 1996). The SEATS approach to quality is consistent with the USAID approach as represented by MAQ:

> *Although quality and access objectives may vary according to the service delivery context and resources available, MAQ stands behind several universal principles which can be applied regardless of the setting. These MAQ principles are:*
>
> < *Emphasize access with quality*
> < *Build a client orientation*
> < *Support quality from the top*
> < *Build quality from the bottom*
> < *Build in approaches to evaluate and improve (USAID, 1996).*

MAQ focuses on *access* in a manner that places it on equal footing with quality, not merely as a subcomponent thereof. (The other aspects of the MAQ principles, above, are dealt with in detail in subsequent sections of this Strategy).

The EVALUATION Project proposes indicators that are related to five dimensions of access and potential barriers which "should be addressed by FP program management in order to promote wide utilization of available services; that is: 'get clients to the door'"(Bertrand et al, 1994). These dimensions are summarized in Figure 7.

Figure 7: SEATS II Milestones and Activities to Improve Access to Family Planning Services[4]

Dimension of Accessibility	Description	Illustrative Indicator	*SEATS addresses by ...* (examples)
Geographic or Physical	the degree of difficulty/ease in reaching or obtaining FP services	number of service delivery points (SDPs) located within a fixed distance or travel time of a given community	*SEATS milestone*: - **Establishment of 700 new or improved service sites** *SEATS activity:* Urban Study and Initiative on service access (including mapping delivery point location and capacity), and quality
Economic	the extent to which the costs of obtaining services are within the economic means of a large majority of the target population	cost of one month's supply of contraceptives as a percentage of monthly wages	*SEATS milestones:* - **Sustainability and cost recovery plan** will look at both user fee systems and revenue generated from other sources besides user fees such as cross-subsidization - **Monitoring and evaluation strategy** tracks cost per client, cost per CYP (by method, by type of design), cost per new SDP, cost per improved SDP
Administrative	the extent to which unnecessary rules and regulation inhibit contraceptive choice	presence/removal of restrictive policies on choice	*SEATS milestone:* **Clinical Protocol Resource Book** includes WHO Eligibility Criteria for Contraceptive Method Provision *SEATS activity:* **Quality Improvement Activities** focus on various levels of the system to identify and remove barriers to services
Cognitive	the extent to which clients are aware of the location of service points and services available	percentage of the population who know of at least one source of contraceptive services	*SEATS activities:* **Information, Education and Communication (IEC)** uses formative research and is action-oriented, to ensure that message directing users and potential users to services are successfully delivered
Psycho-Social	the extent to which potential clients who desire to space or limit fertility are unconstrained by psychological, attitudinal or social factors	percentage of non-use related to psycho-social barriers	*SEATS activities:* **Counseling and information** IEC directed to clients, potential clients and the community. These include important secondary audiences such as men, youth, social and religious leaders SEATS Special Initiatives: -Reach special target populations such as: youth, illiterate women **Youth Initiative**: First Things First, Int'l. **Women's Literacy and FP Integration**

Figure 8: Improving Access and Quality: SEATS Urban Initiative

One of the primary objectives of the SEATS Urban Initiative is to assist programs to increase their service delivery capacity to meet a growing volume of clients due to rapid population growth in urban areas. An equally important objective of the Urban Initiative is to identify weaknesses in quality of services and design strategies for improvement. The SEATS Urban Initiative assists officials from local, municipal and national governments; and private sectors at all levels, to collect information and use research findings in their programming efforts to accomplish these objectives.

The Urban Initiative is founded on the SEATS I experience in the Sub-Saharan Africa Urban Family Planning Study and from urban service delivery subprojects in which an initial study by SEATS I found that the high rates of urban growth in Sub-Saharan Africa will certainly strain the ability of urban programs to maintain or increase contraceptive prevalence. In order to meet future demand and maintain or increase current CPR, it was seen through the SEATS Urban Study that service delivery must be enlarged, either by increasing the capacity for client volume or by increasing the number of service delivery points. Many urban clinics are not prepared for the expansion that will be required in the future. The creation of new service delivery points, training of an increased number of service providers, establishing alternative delivery systems and meeting the unmet demand for long-term and permanent method use are some appropriate strategies to address growth in clinic client capacity issues.

In keeping with SEATS approach, the Urban Initiative is designed to accommodate the special circumstances of each country involved. The SEATS I Urban Study research team developed an approach to evaluate service delivery capabilities of cities using a combination of new methods and adaptations of existing methods. These include the SEATS FPPMES (FP Program Monitoring and Evaluation System), which calculates CPR for a defined area; SEATS The Capacity Estimator, which evaluates future service delivery capabilities in light of population growth; the Population Council's Situation Analysis; Demographic and Health Surveys (DHS), and computer applications of mapping data which can reveal weaknesses in access to services.

USAID has developed a checklist to help operationalize MAQ. The checklist, now in final draft format, is intended to help assess, program or evaluate access and quality of care. It provides an excellent guide to current issues and indicators in the areas of:

- **Service delivery**, including provider-client interaction, technical competence, infrastructure, methods and commodities, privacy and infection prevention.
- **Support to services**, including training, IEC, gender, supervision, and management.
- **Services framework**, including policies, protocols and guidelines, constellation of services, participation, and program strategy.

The checklist is included in Appendix B and listed in *SEATS II Guide to Resources and Tools for Quality of Care*, Appendix A.

II.E. Why Does Quality of Care Matter?

A review of existing literature strongly suggests that the quality of services provided is an important determinant of acceptance and continuation rates, and therefore a major contributor to the level of contraceptive prevalence (Jain, 1989).

Quality of care is believed to have a positive effect on the most often cited desirable outcomes of family planning activities:

- Increasing the contraceptive prevalence rate (the percentage of women of reproductive age practicing contraception at a time) leading to reductions in fertility and improvements in maternal and child health (Jain, 1990).
- Meeting unmet demand for family planning services by providing services that are accessible, acceptable, appropriate, and provide an adequate selection for clients.
- Helping individuals to achieve their reproductive goals, thus producing a satisfied clientele of continuing users, which in the long term would contribute to reductions in fertility (Bruce, 1990).

While there is still limited research to directly support the latter, "studies have strongly suggested a positive association between several elements of quality and higher contraceptive acceptance, prevalence, and continuation of use, including choice of methods, information to clients, and provider-client interaction" (Hardee and Gould, 1992; Jain, 1989; Pariani, 1991; Prabhavathi and Sheshadri, 1988).

One recent study based on the analysis of data from a sample of 7800 women of reproductive age,

provides some of the strongest empirical evidence to date on the importance of quality of care for contraceptive acceptance and use. The results demonstrate that the perceptions of women regarding the quality of care provided by family planning field workers were significantly related to the probability of their subsequent adopting a family planning method, with non-contracepting women who scored high on an index of perceived quality of care 2.3 times more likely to subsequently adopt a method, compared with women with a low index score (Koeing et al, 1995).

This study also notes a significant relationship between quality of care and continued use of contraception.

Alongside the positive effects of quality, the relative costs of poor quality should also be noted. Studies conducted in industry and health care have shown that 20 - 50% of activities in the administrative and service provision processes are "non-real work", meaning that 10 - 25% of costs can be categorized as waste associated with poor quality (Omachonu, 1991). Non-real work and *re-work*, or re-performing the same task over one or more times in order to meet minimum standards or due to a general lack of quality, contribute to increased waste of resources such as time, money and staff motivation and expertise.

Other costs of poor quality include decreased safety and satisfaction for clients; decreased job satisfaction and motivation of staff; increased waiting times; decreased availability of contraceptive methods; increased drop-out (discontinuation) rates for family planning users; and possible contraceptive method failures due to poor quality counseling, resulting in unwanted pregnancies and abortions.

II.F. Importance of Choice, Counseling, and Access to a Range of Contraceptive Methods

Based on a number of studies and program experience, some key elements of the Bruce/Jain framework have been identified, including client counseling and information and choice from a range of contraceptive methods.

Client counseling and information have been found in some studies to have an apparent positive association with contraceptive method acceptance and continuation rates (Prabhavathi and Sheshadri, 1988). Other studies have shown that when a client, after counseling, receives the method that she or he has chosen, continuation rates are higher than when the provider chose the method for the client (Huezo, 1993; Pariani, 1991). Another large study has shown that providing too much information to clients adversely affects continuation rates (Huezo, 1993).

These are important findings for the provision of family planning counseling, client information, and for interpersonal relations as they place the client's choice in the center of method selection. It also reinforces that the client-provider interaction should be seen as a two-way communication, with information and guidance given by the provider in a respectful and flexible, not authoritarian, manner.

During counseling, the provider obtains information from the client on her or his reproductive needs and goals, and provides information on the methods in which the client is interested. If the client is undecided, or if the client's choice is unsafe or inappropriate (e.g., commercial sex worker's request for an IUD), the provider informs the client about the array of methods available and helps the client to choose the method appropriate for her or his needs, reproductive intentions and lifestyle (USAID, MAQ/CPI, 1996). Together, the client and provider seek a match between the client's preferences and safe contraceptive methods for a specific woman or man.

Free and informed choice means that the client's decision is made with full information about the nature, risks and benefits of the available FP methods, and without pressure or constraints. Providing *choice* also entails making a wide range of contraceptive methods available to clients on a regular basis. Choice "does not necessarily mean that all legal methods must be available at every service delivery point, but that the overall program effort on a geographic basis should be sufficient so that the prospective users have reasonable access to a variety of methods" (Bruce, 1990). It also means that referral systems are in place and functioning to ensure that the client can obtain the method of choice.

Providing a range of methods satisfies two important priorities:

- Enable clients to choose a method that meets their reproductive goals -- does the client want to delay childbirth, space pregnancies, or end child bearing? -- as well as her or his physical profile and lifestyle. (Providers and program planners

should also bear in mind that fertility intentions change over the course of individuals' and couples' reproductive life cycles.)

- Provide alternative methods for clients who wish to switch due to untolerated side effects, as a majority of discontinuation of contraceptive methods in the first year is attributed to such side effects.

Empirical support for these priorities is provided in a review and analysis of existing data from multiple country studies: "the addition of a contraceptive method yields a net increase in contraceptive prevalence; one-method programs are inadequate to meet individual fertility goals; the availability of multiple methods increases contraceptive use; and contraceptive prevalence depends upon the number of methods made available through multiple outlets in a country" (Jain, 1989).

When choosing the appropriate contraceptive method, clients, counselors, and service providers should consider age, gender, reproductive goals, lifestyle, lactational status, health profile, tolerance of side effects, re-supply, and cost. Programs should be able to provide quality service delivery in support of method selection and use.

II.G. Building on the Foundation of Quality of Care Under SEATS I

Since its inception, the SEATS Project has demonstrated commitment to promoting quality of care in family planning and reproductive health by designing, testing and implementing technically appropriate and cost-effective approaches.

Early in its first phase of funding, SEATS moved beyond the traditional "quality assurance" model with its reliance on episodic medical and managerial monitoring using a single, "gold standard" of quality. Instead, SEATS quality activities developed techniques for continuous assessment and improvement of quality at the point of service delivery, integrating quality concepts and initiatives into subproject designs and involving family planning and reproductive team members at all levels to define and ensure quality.

Early in the SEATS I project, the SEATS staff began exploring methods for applying a modified "Total Quality Management" approach, known as Continuous Quality Improvement, to health service delivery systems (Figure 9). Drawing on the considerable experience of US and European groups that have successfully used quality improvement techniques, SEATS I efforts proved to be pioneering in applying these models to developing country situations.

Support for the continuous improvement of quality of care in family planning programs was a major focal area for SEATS I, which included considerable QOC training, materials development and a pilot-study of the continuous quality improvement approach. Accomplishments under SEATS I included coordination of a major effort by the East and Southern African Regional Office (ESARO) to facilitate the development of quality improvement programs throughout that region.

In its West Africa Region (WARO), SEATS launched a pilot test of a new "grass roots" approach to quality assessment and improvement with eight service delivery sites in Togo. Technical and financial resources necessary to assist in developing and implementing site-specific action plans were provided by SEATS. In spite of various external barriers such as political upheavals, the Togo continuous quality improvement initiative demonstrated sustained positive outcomes, including increased client load and improved contraceptive method mix. Even within the first six months, before these gains became evident, clinic staff were empowered to identify problems and find appropriate solutions, making progress in areas related to client satisfaction and effective program processes.

Figure 9: Total Quality Management* and Continuous Quality Improvement**

Total Quality Management (TQM) refers to a management process and set of disciplines that are coordinated to ensure that the organization consistently meets and exceeds customer requirements.

TQM engages all divisions, departments and levels of the organization. Top management organizes its strategy and operations around customers' needs and develops an organizational culture with high employee participation. Managers lead their workforce to establish and commit to a vision of quality that incorporates client perspective. They should then train employees toward achieving the common mission.

To accomplish this, TQM companies are focussed on the systematic management of data in all processes and practices to eliminate waste and pursue continuous improvement.

TQM is a continuous journey toward excellence, with the goal to delivering the highest value for the customer.

Continuous Quality Improvement (CQI) recognizes that many organizational problems result from systems and processes rather than from individuals.

CQI enables staff at all levels to work as a team, to analyze systems and processus, to use information to identify the nature and size of each problem, and to design and implement activities to improve services. Cross-functional teams work on improvements that respond to customer requirements.

Staff themselves monitor the impact of their changes, and if the desired outcomes of the process are not achieved, staff can continue to make improvements until these results are achieved.

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

*Adapted from Capezie and Morehouse, 1993.
**Adapted from FP Manager, 1993.

In Morocco, SEATS took the lead in institutionalizing the inclusion of quality of care components into the Moroccan Ministry of Public Health's family planning program. Particular emphasis was given and successes achieved in incorporating client perspective, improving counseling and developing and using clinical standards. Over time, the components have broadened to include other related reproductive health efforts, most notably, maternal care. In addition, special interventions to promote the concept of continuous quality improvement have been taken, and helped pave the way for a successful quality initiative under the USAID Bilateral Project (Figure 10).

Figure 10: Decentralizing Data Analysis for Problem Solving in Morocco

An assessment of the quality of family planning services in selected provinces marked initiation of a sustained effort to improve quality of care in Morocco. Beginning in 1992 under SEATS and continued after 1994 under the USAID Bilateral Project, the Morocco Ministry of Health has emphasized the client perspective, use of data at all levels, and the team approach as key components for quality improvement. Among several quality improvement initiatives in Morocco in recent years, the Team Problem Solving Approach has proven especially useful, replicable, and resilient.

Adapted from the WHO District Team Problem Solving Approach, the Morocco Team Problem Solving Approach was applied initially in 1993 in Morocco in five provinces. Province-level teams were formulated and trained during a two week seminar in the principle elements of this approach: using data to analyze local level health delivery conditions and constraints, team interaction to prioritize and posit solutions among the various problems uncovered, implementation of the team solution, tracking indicators to measure progress in addressing the problem, and evaluation and presentation of the results to higher level MOPH managers. This first round of Problem Solving implemented over a one year period produced sufficiently positive results to lead to replication of the approach in an additional 21 sites during the subsequent two years.

Inexpensive in terms of external costs, subsequent iterations of the approach were funded from sources outside of SEATS, including the most recent applications which have been supported entirely through MOPH resources. In addition to specific gains achieved within particular aspects of service delivery or management, empowerment through data use was the most outstanding, and hopefully lasting, lesson demonstrated by this approach. In concert with increasing importance being placed upon decentralization in Moracco, the Team Problem Solving Approach has provided powerful and concrete experiences for involving personnel and using data at various levels to identify and solve concrete service delivery problems.

SEATS II builds on these achievements and on the finding that quality of care has been found to be an important, if sometimes neglected, determinant of contraceptive acceptance and continuation. These efforts are aimed at expanding and sustaining quality service delivery through helping to ensure client satisfaction, technical competence, and appropriate use of local resources.

Figure 11: Lessons Learned in QOC through SEATS I

Use Multiple Strategies: Use of one model (or efforts to develop one model) for improvement of QOC in all circumstances will not be as effective as more flexible approaches that reflect variations among service delivery conditions.

- use multiple strategies to impact on QOC at each level or site.
- consider multiple strategies when designing programs and projects.

Get Quality in the Agenda: In many countries, provinces, municipalities and clinics, quality is not a priority. It can take a concerted effort to make it one, but without such commitment, especially among decision-makers, a quality improvement program is unlikely to move very far or last very long.

- getting quality on the agenda is the first step to institutionalization.
- getting quality on the agenda in the public sector may mean getting over the perception that quality counts only in the private sector.

Build Coalitions for Quality at all Levels: Building coalitions for quality at all levels of authority is very important to the launch and continuation of quality improvement efforts.

- development and maintenance of coalitions, especially where supervisory structures are weak and quality of care actions will be district level or at service delivery points, is vital to the institutionalization of a culture of quality and application of resources.

Collaborate: Collaboration in the development and support of QOC improvements is critical, especially for long term impact.

- SEATS I and specialized CAs collaborated to increase the number of methods available.
- SEATS I and the German Technical Assistance Corporation (GTZ) produced community education materials together.

Use QOC as a Package: QOC presented as a package is often more appealing to most service providers than is focusing on just one aspect of it at a time.

- present QOC as a package, while empowering teams to choose and limit their efforts to which items they will work on at any given time.

Assess Systems and Service Delivery Points: National or regional systems that support service delivery points may have more influence on QOC than is commonly acknowledged.

- assessments need to look at larger systems as well as service delivery points.
- link indicators that reflect QOC at given service delivery points to those central or regional systems that also impact upon them, such as logistics systems to availability of methods at a SDP.

III. Essential Elements of the SEATS Approach to Quality Improvement

This chapter describes SEATS philosophy and approach to quality of care and quality improvement using several examples and illustrations from SEATS subprojects.

SEATS provides both project-wide structures and subproject-specific initiatives aimed at continuous improvement of quality. These include innovative service delivery approaches, training and TA for skills in service delivery, institutional development, establishment and use of clinical protocals and management and assessment.

While the number of methods or models to achieve institutionalization of quality and measurable quality improvements may vary, SEATS ensures that certain principles to promote quality are consistently applied in the design and implementation of subprojects and activities (Figure 12).

The SEATS approach stresses that quality should be conceptualized in concert with host-institutions and that key quality principles and techniques should be integrated into each subproject's design, implementation and evaluation cycle. This integration includes assessment of quality needs and resources, project design and structure to promote quality improvement activities, and emphasis on processes and outcomes consistent with key frameworks such as the six elements of the Bruce/Jain QOC framework, the principles of USAID's initiative for Maximizing Access and Quality, and appropriate quality improvement techniques and processes such as continuous quality improvement.

Figure 12: Essential Elements of SEATS Approach to Quality

- **T** Promotes institutionalization through:
  - ‘ Ownership
  - ‘ Peer exchange
  - ‘ Democratic team-approach
  - ‘ Establishing culture, structure and skills for quality
- **T** Process-oriented for continuous improvement
- **T** Information driven
- **T** Uses and adapts existing systems
- **T** Incorporates use of clinical protocals
- **T** Uses "best practices" and recognized tools as well as innovative approaches
- **T** Client oriented
- **T** Integrates family planning and reproductive health

III.A. Promotes Institutionalization

The SEATS approach to quality promotes institutionalization through stressing "ownership" by team members of the host institutions. The definition of quality, design of structures to promote continuous improvement of quality, and identification of specific quality improvement opportunities are thus conceptualized, planned and implemented jointly by team members within the host institution, taking into account the expectations and needs of the institution's potential client-base.

The issue of *ownership* of quality improvement efforts (and the program as a whole) is critical to the overall success of continuous quality improvement activities. Inherent in TQM and CQI are the involvement and a change in perspective of personnel at all levels of the organization: policy-makers, senior managers, service providers, technicians, clerks, drivers and receptionists (Figure 9).

The SEATS perspective is to pursue efforts in two directions simultaneously -- gaining support from the "top-down" and building skills and commitment from the "bottom-up." In order for quality improvement activities to take hold in a project, senior management and directors must be committed to the effort. At the same time, project staff from other levels must also be involved and dedicated. It is often useful to introduce these considerable changes in perception by starting quality efforts with a small select group that represents the systems from top to bottom. At the center of the effort should be consistent attention to client perspectives.

To promote ownership, SEATS encourages directors and top managers to involve their entire workforce in establishing and committing to a vision of quality and a mission statement with quality as a key component, and doing so in a *democratic* fashion, which includes equal input from all members of the workforce. SEATS provides support to top managers to ensure that employees have adequate training and support toward achieving the common mission. This furthers the democratic nature of the culture of quality being established by empowering personnel to act on quality and contribute their skills and perspective to the overall quality mission and agenda.

Ownership is also stimulated as CQI enables staff at all levels to work as a team, analyzing systems and processes as the cause of problems in quality. Staff work jointly to use information to identify the nature and size of each problem, to design and implement activities to improve services, to monitor the impact of their changes, and to make adjustments until the desired results are achieved. Training and support for structured, information-driven problem-solving and team work reinforce the team's ability to successfully take on these functions, and thereby increase ownership.

Other important pre-conditions or inputs to be agreed upon include resources and empowerment. SEATS program experience has found that as part of the democratic nature of quality improvement efforts, the provision of some resources directly to quality improvement teams, even in very small amounts, enables team members to test and implement solutions. This provides an important element of "empowerment" to team members and gives a vital boost to the initiation or continuation of quality improvement efforts.

SEATS supports exchange and activities that stress quality as the responsibility of every team member and that every staff person has important contributions to make toward quality improvement.

Part of achieving this involves organizing a team structure for quality, which may include one or more of the following:

- *Quality council,* comprised of management, department heads and supervisors, who lead the organization heads and workforce in establishing the quality mission statement, ensure the necessary training and support for integration of quality on a routine basis throughout the organization, and later, participate in the selection and final review of "quality improvement projects."
- *Quality teams,* comprised of voluntary workforce participants cooperating in the identification and clarification of problems or opportunities to improve quality, the collection of information about problems, and the design and implementation of solutions.

- *The workforce,* whose input helps shape the quality mission and agenda of the organization as well as establish quality in routine daily activities, and may at various times take part on specific quality teams and quality circles.
- *Quality circles,* which facilitate peer exchange on common problems, solutions, new techniques and resources among those involved in quality efforts at various levels of the organization or in different organizations.
- *Quality leaders, advocates, and change agents,* who place emphasis on the importance of quality and motivate the application of policies, skills and resources in its support at both the national and community levels.
- *Quality coaches,* who have received training in quality concepts and techniques and provide internal TA, reinforcement, and guidance for quality within organizations.

In a recent study of the role of tools for theory and data collection in quality improvement, researchers felt compelled to remark on their findings on the importance of structure and involvement as factors that "contribute substantially to team success: ...certainly the role of quality councils, the involvement of management at both the top and middle levels, and training in continuous quality improvement theory and practice are important" (Gilman and Lammers, 1995).

Catalytic Role of Outside Assistance

SEATS has found that the role of the Cooperating Agency (CA) or other external agency can be catalytic to quality improvement launch and implementation. The SEATS approach, based on proven experience dating from SEATS I and continuing in SEATS II, involves an infusion of TA at the outset of assessment, design, and/or activities, to be followed by active monitoring and periodic TA.

To promote ownership, peer exchange, and a democratic team approach to quality improvement, SEATS provides catalytic support, including TA, in areas including:

- Team building and skills development.
- Strategic planning.
- Definition of organizational quality concepts, visions and mission statements.
- Study tours to view quality of care improvement efforts.
- Establishment of quality councils and quality teams.
- Formative research on the client perspective, including focus group research, client intercept and exit interviews, and mini-surveys.
- Identification and prioritization of improvement opportunities.
- Data collection and analysis.
- Development of quality action plans.

In addition, SEATS supports and facilitates the peer exchange of best practices and lessons learned among both organizations with long-term commitment to quality improvement, and those just beginning their quality journey.

III.B. Process Oriented for Continuous Improvement

The SEATS approach uses a cyclic improvement model focused on improving work processes. This cycle describes a method of continuously identifying and analyzing problems and opportunities to improve work-processes, planning for solutions, and implementing and evaluating the solutions (Figure 13). Process orientation focuses on systems and processes, not individuals, as the cause of problems in quality.

A *process* is a set of activities or steps that results in an outcome, such as providing an output for clients. Types of processes in health care include those related to client flow, information flow, material flow, or multiple flows. For every process, there are one or more identifiable inputs, suppliers, outputs, customers (clients), and, in health and family planning, potential outcomes.

Text box for Figure 13

Problems in quality often arise from overly complex processes, problems with execution of a step or several steps within the process, problems with hand-offs between steps of a process, and/or problems when multiple processes are involved. "Non-real work" or "re-work" occurs due to additional tasks we must perform because the process itself is not perfect (Institute for Healthcare Improvement, 1992).

The SEATS model of continuous quality improvement is consistent with the scientific method and leading models used in quality improvement efforts,[5] such as the "Shewhart Cycle" of Plan-Do-Check-Act, and the FOCUS model, often linked with the Shewhart Cycle, that includes: *F*ind an opportunity for improvement; *O*rganize the team; *C*larify the process; *U*ncover possible causes; and *S*elect the improvement.

The SEATS model is also consistent with "Juran's Journey," which focuses on establishing an organizational structure that supports continuous quality improvement on an on-going basis, and uses a problem-solving approach in "quality improvement projects" to institute changes based on identification and analysis of individual weaknesses in the system. A valuable element of Juran's Journey is its focus on "holding the gains," an explicit phase in the quality improvement process.[6] (Appendix C includes diagrams and descriptions of the Shewhart Cycle, FOCUS and Juran's Journey.)

Within the SEATS approach, "Continuous Improvement" results from:

- **Applying the principles of quality to daily work and monitoring selected indicators**.
  Indicators of quality of care to track as part of routine program operations are incorporated into SEATS subproject design and listed in detail in each SEATS subproject's monitoring and evaluation plan. In this way, planning for quality is incorporated from the outset of the subproject, and therefore not viewed as an "add-on" activity or additional burden in implementation, monitoring and reporting. Indicators are tailored to the specific needs and situation of the individual subproject, and are consistent with USAID indicators for quality as suggested by the EVALUATION Project. For illustrative indicators, see Chapter IV.

- **Implementing process-oriented "quality improvement projects."**
  These efforts focus on specific problems, issues, or processes. Topics for quality improvement projects are identified by various organization team members including an established quality council, quality teams, and other members of the workforce. They are frequently based on feedback given by clients concerning their level of satisfaction with services (for example, complaints about long waits could stimulate focus on processes and steps related to client-flow). Staff must be aware of the quality agenda, reach consensus and take responsibility at their own levels while participating voluntarily in the quality improvement project.

III.C. Information Driven

One of the keys to improving quality is to support and strengthen use of qualitative and quantitative data at all program levels. Though intuition and subjective assertion certainly play roles in the various stages of quality improvement, tangible data -- both qualitative and quantitative -- provide a level of objectivity that is essential to the process.

A variety of tools, such as brainstorming, flow-charts, and cause-effect diagrams are useful to identify and clarify processes and problems related to quality improvement. Such tools are usefully applied within the cycle of problem identification, determination of cause, and planning, implementing and evaluating proposed solutions. However, data, and not just unsubstantiated hunches and theories, should be used throughout, particularly in situations where analysts are both part of both the problem and the solution.

Using data and analytic tools to produce programmatic insights helps base decisions on "facts" and avoids arbitrary "tampering" with the existing system which could exacerbate problems. It also invests participants in a measurement mentality so that the results of changes may be objectively evaluated. Information-based decision making assists both newcomers and seasoned professionals to approach quality problems and potential solutions in a scientifically sound, measurable, and innovative manner.

Following Bertrand Russell's dictum that "thinking that you know when in fact you don't is a fatal mistake, to which we are all prone" (Russell, 1950), data used within an objective analytical process helps us break the mold and posit bold solutions. As pointed out in a recent study of 168 process action teams which correlated frequency of tool use with net perceived improvement, use of analytic tools was "necessary but not sufficient; data must be collected in order to ensure that the quality improvement process is most likely to succeed" (Gilman and Lammers, 1995).[7]

SEATS approach to quality is information-driven in a variety of respects:

- Country assessments for priority setting, strategy development and subproject design are based on analysis of existing data -- special though focused data collection is often undertaken; special studies to generate critical new information are occasionally required.
- Tracking progress toward outcomes in a given subproject's monitoring and evaluation plan is data specific -- plans specify data sources in advance.
- Particular work-processes, such as service delivery integration or triaging, may present special opportunities for quality improvement -- these may entail special studies, and possibly applications of operations research.

Teamwork is an essential component of quality improvement and teams must collect and use information to identify the nature and size of each problem, to design and implement activities to improve services, to monitor the impact of their changes, and to make adjustments so that the desired results are achieved. To accomplish this, teams must have the skills and support to use data at every step of the process.

Formation and timely involvement of teams at various levels is based on the assumption that those who do the work know it best, and those working in teams are more successful than those working alone. Data gives teams a measure of objectivity -- they reflect upon the work they do from a more distant perspective to determine how it may be improved. Data, displayed graphically as histograms, bar charts, scatter diagrams, pareto diagrams, and control charts in order to assist with analysis, decision making and dissemination, makes the objectivity explicit. (Appendix A includes a description)

To assist all levels of staff and team members in planning and quality improvement, SEATS utilizes both existing and special sources of data. Important among these are: focus group research; checklists for observation and data collection; Demographic and Health Surveys (Macro International); Situation Analysis for Family Planning Programs (Population Council); Situation Analysis for maternal health (JSI/MotherCare); client-exit interviews, and mystery client technique (Appendix A).

Where such data does not exist but is needed for a particular problem-solving purpose, SEATS may support their collection. Two examples of information use for quality improvement in SEATS subprojects come from the Togo Continuous Improvement initiative, and the Morocco District Team Problem Solving initiative (Figure 10 and 14).

Figure 14: Using Information and Team Work for Continuous Assessment and Quality Improvement In Togo

The SEATS I Togo subproject used team work to analyze information on a regular basis for continuous assessment and improvement. Beginning in 1990, nine pilot sites participated in the testing of a continuous assessment methodology which demonstrated results such as increased client load and improved contraceptive method mix.

The SEATS continuous assessment methodology means that quality of care interventions are constantly being identified, implemented and monitored. The phases of the cycle are represented in Figure 13. The approach used by SEATS involved the entire team of staff from every level at each service delivery point in each phase of the cycle.

Initially, the team reviewed information collected through situation analysis, DHS and other outside sources to help identify possible problems. Data collection aimed at providing enough information on which to base problem-identification and decision-making included focus group discussions with users, non-users and clinic personnel; in-depth interviews with personnel at each site; community mini-surveys; observation of organization and functioning of services; and analysis of service statistics.

Based on this information, team members would select one problem and assign a team member to collect information to measure the extent of the problem using data agreed to by the group. Staff meetings were used to report back on findings. The team would then identify the possible cause of the problem indicating whether more data was needed. Recommendations and an action plan would be constructed by the team including indicators to measure effectiveness of proposed solutions. Some time after the action plan's implementation, the results would be measured to determine whether improvements had occurred. Once the team was satisfied with the result, they would focus on another problem, thus beginning the cycle again.

Inputs and activities in action plans varied from clinic to clinic, and included:

- < Improved access through changes in clinic hours and community outreach.
- < Increased privacy to respond to clients' expectations and perceptions
- < Improved record keeping, supervision, and use of data collected
- < Improved referral system; integration of FP with MCH at several sites.

Impact included increased new clients, higher continuation rates, improved method mix. Comparison of pilot sites with control sites showed that during 1991-92, while new clients and return visits declined at control sites, both increased markedly at pilot sites. Follow up data collection is now in process.

III.D. Uses and Adapts Existing Systems

SEATS QOC Strategy is consistent with the overall SEATS strategic approach of using and integrating existing systems whenever possible, including monitoring, supervision and training systems in host-institutions and national programs. This stresses that improvement of quality of care is not a vertical program, but is integrated into other technical and managerial functions such as monitoring and training. SEATS aims to accomplish this in a manner that is cost-effective and upgrades existing systems when necessary, while not adding an extra burden or a parallel system for quality improvement.

SEATS I support in Burkina Faso is an excellent example of use and adaptation of existing systems. In a quality improvement program that focused on integration of family planning and reproductive health services to improve client satisfaction, use and continuation rates, integration of FP/RH/MCH service delivery led to integration of various family planning and reproductive health management functions, including supervision. The result in many districts and at many sites was increased and improved supervision (Figure 15).

At the central project level, SEATS has developed a variety of systems and specialized tools to assist with the analysis of data and use of information by SEATS staff. To the extent that these have been decentralized, made user friendly, and provide needed information on a timely basis, they can contribute substantially to quality improvement efforts.

A summary of these systems and tools is provided below; a full description can be found in the *SEATS II Monitoring and Evaluation Strategy*.

Database Management System (DBMS)

The DBMS provides the following on all active subprojects: financial information and subproject objectives; tracks accomplishments of project objectives; records delivery service outputs; coverage information; as well as other information from the subproject quarterly reports that is essential to project management.

In keeping with the SEATS II objective of improving utilization of information for management at all levels, SEATS II has consciously and systematically increased the accessibility and utility of DBMS information by staff at all levels, particularly subprojects. During the first three quarters of the current project, the SEATS I DBMS was revised and updated to encompass the milestones for SEATS II and to improve the reports and graphs that are produced by the program. In order to utilize the DBMS effectively, project staff are being trained in use of Paradox, the DBMS programming software.

Subproject Monitoring System

Regular monitoring of quarterly subproject and subcontractor reports ensures integration of financial and technical project monitoring. Results from subprojects are entered into the DBMS and used to identify problems or issues that might effect or impact on quality, which can then be addressed by subproject staff.

Technical Assistance Database

The TA database maintains an easily accessible record of TA for ongoing project management purposes and also facilitates mid- and end-of-project TA assessments. Each TA visit is recorded by project quarter, individuals providing the TA, subproject(s) duration, country, and type of TA. Brief summaries of objectives, accomplishments, contacts and follow-up needed for the TA is entered in each

record. To assess TA, an evaluation form has been developed to obtain feedback from recipients of TA for purposes of evaluating satisfaction with TA among recipient organizations and USAID Missions.

Family Planning Program Monitoring and Evaluation System (FPPMES)

The FPPMES converts quarterly contraceptive supply data into estimates of contraceptive prevalence rates (CPR) and couple-years of protection (CYP) for contraceptive methods; can also be used to forecast the impact of changes in method mix on CYP, CPR, and service delivery. Under SEATS II the FPPMES has been incorporated into the DBMS in order to allow the fuller utilization of subproject service statistics information. A next step in this effort will be to link the output from FPPMES to reproductive health outcomes such as births averted, abortions averted, and maternal and infant deaths averted.

III.E. Incorporates the Use of Clinical Protocols[8]

The development and implementation of service delivery guidelines and clinical protocols are fundamental in the effort to standardize practices and improve the quality of family planning services. Guidelines and clinical protocols provide a foundation and ready guide for program planners, trainers, service providers, supervisors, evaluators, and policy makers--helping each to approach service delivery practices from a common understanding. [9]

Protocols and guidelines, as well as policies and administration, are part of the "*quality in fact*" component of the conceptual framework for quality in health systems presented by Omachonu (Figure 4), and is thus concerned with the structure, process, and outcome of the service provided especially the "clinical outcomes." Properly designed and implemented clinical protocols can improve quality by helping to ensure that every client-provider interaction meets established standards in client eligibility, use of various contraceptive methods, provision of up-to-date information and counseling, method provision, infection prevention practices, referral and follow-up.

Moreover, developing and implementing clinical protocols affects broader systems and processes supporting service providers that enable clients to become continuing users of family planning services. These systems and processes include logistics and procurement, service provider training and supervision, monitoring, and evaluation.

Within each system, the existence of and adherence to clinical protocols will help to standardize and strengthen the service delivery processes and streamline functions, leading ultimately to increased staff motivation and client satisfaction, as well as greater efficiency. In order to promote the development, up-dating and use of clinical protocols, SEATS II, in collaboration with AVSC International, developed and disseminated the *SEATS II Clinical Protocols for Family Planning Programs: A Resource Book* during Project Year 1. Often, the identification of the need for protocol development or strengthening is expressed in terms of a problem or series of problems that arise from a lack of standardized practices. Recognizing this need may begin with clients, service providers, clinic directors, policy makers, or other organizational team members. It is important that input and support from these groups be gained at the appropriate time in order to successfully develop or implement protocols. As described in the *SEATS II Clinical Protocols Resource Book*, the development and implementation of clinical protocols is a *team*

activity, one requiring the commitment and input of a variety of family planning professionals and clients.

The *SEATS II Clinical Protocols Resource Book* highlights both the importance of functioning clinical protocols for quality of services and the process for developing or revising these clinical protocols. Clinical protocols should incorporate information on up-to-date practices and new approaches and technologies which develop rapidly in the fields of reproductive health and family planning. Therefore this resource tool contains the latest information on all temporary and permanent contraceptive methods, along with special reference materials on counseling, infection prevention practices, post-abortion family planning service delivery, and the integration of reproductive health interventions such as breastfeeding and the prevention and treatment of sexually transmitted diseases and human immunodeficiency virus (STD/HIV).

As additional references, the *SEATS II Clinical Protocols Resource Book* provides a case study illustrating the development of clinical protocols at the national level as well as an extensive bibliography. Also provided is a prototype document for family planning program protocols, although it is stressed that successful development of country or institution-specific protocols cannot be accomplished by simply copying a prototype, because protocols must be well suited to country- and/or institution-specific conditions.

The *SEATS II Clinical Protocols Resource Book* is designed to present technically correct information and an overview of the process of protocol development so that this end may be achieved. This approach is preferable to disseminating a generic document that may be programmatically inappropriate in some countries and may become out-of-date relatively quickly.

The *SEATS II Clinical Protocols Resource Book* thus presents:

- Up-to-date references such as:
  - *Recommendations for Updating Selected Practices in Contraceptive Use* (USAID).
  - *Medical Eligibility Criteria for Initiating and Continuing Use of Contraceptive Methods,* World Health Organization (WHO).
- An overview of the process of protocol development.
- A representative case study in protocol development.
- Method-specific materials containing the necessary information for guidelines and protocols.
- Reference documents containing up-to-date information on the criteria and practices needed to reduce barriers to access while improving the quality of services.

The SEATS II Project will ensure that the technical information presented in the contraceptive method-specific chapters, the bibliography and the list of potential prototypes are updated on a regular basis for SEATS staff and partner institutions. In turn, national or institutional family planning clinical protocols and guidelines should include the commitment both to review and update them on a regular basis and to

ensure that the protocols receive appropriate dissemination and supporting activities, such as training of service providers and supervision.

It is critical that the development of protocols not be viewed as an isolated activity. Incorporating clinical protocols into a quality-improvement model and designing and implementing training and managerial strategies to enable providers to learn, follow and critique the protocols is essential. Moreover, the protocols themselves are subject to the quality improvement cycle, as the model presented in Appendix C illustrates: "Steps in the Development and/or Revision of Clinical Protocols." For a detailed discussion of the development, implementation and evaluation of clinical protocols and of performance according to clinical protocols, see the *SEATS II Clinical Protocols Resource Book*.

Medical Monitoring Systems for Voluntary Surgical Contraception (VSC) and NORPLANT®

Monitoring medical quality of family planning programs is an integral component of a systematic approach to provision of quality services. Medical monitoring also provides a basis for improvement of medical quality. Family planning services should be based on international, national or organizational service delivery standards or guidelines which provide a framework for staff as well as standards necessary for monitoring.

Traditional medical monitoring, while important, has not been found to be completely effective. It is often driven by short, medically-focused site visits conducted by outside medical personnel from funding agencies and frequently from other countries. Findings reports are often submitted only to the funding agency. This type of monitoring contributes little toward institutionalization of the system and the building of skills. In addition, staff often view oversight as policing and visitors as a threat. They are not always receptive to monitoring from outsiders who spend little time at the facility and may lack an understanding of issues affecting the daily functioning of the clinic. Travel, time, and financial constraints may also limit effectiveness of this strategy.

By developing the capacity of an institution, whether it be a Ministry of Health or NGO, to carry-out its own monitoring, the process becomes more effective and sustainable. While each country must design and develop a system that is adapted to its own particular circumstances, innovative approaches developed by SEATS II partner, AVSC International, such as decentralized monitoring systems and self-assessment strategies, have shown early signs of success in a number of programs. These strategies will be employed by SEATS in conjunction with facilitative supervision focused on problem-solving and support as well as other complimentary QOC improvement techniques.

SEATS, together with AVSC International, is establishing a medical monitoring system for SEATS II subprojects that deliver NORPLANT® and VSC services. SEATS II and partner AVSC International will also provide medical monitoring and supervision to improve the quality of VSC and NORPLANT® services. The SEATS II Medical Monitoring System will be a required component of all subprojects providing training and/or delivery sources for these methods. The system focuses on identification, management, follow-up and reporting of complications related to delivery of NORPLANT® or VSC, and investigation and follow-up of any mortality suspected to be related to the provision of these services.

The System involves establishment of sub-project level supervisory systems based on the approach outlined in Chapter IV, "Integrating QOC into SEATS II Subproject", which AVSC has successfully implemented in other countries.

III.F. Uses “Best Practices” and Recognized Tools

A central aspect of the SEATS approach to quality is ensuring the identification, dissemination, and use of “best practices” in family planning and reproductive health. For example, working from years of experience in RH\FP program design and utilizing targeted TA and support, SEATS has been successful in taking such proven modes of service delivery as community-based distribution (CBD) and introducing them to countries where they were formerly unknown but critically needed.

In addition, SEATS II has designed and is currently implementing exciting new initiatives based on replication of successful models, such as the Midwifery Association Partnerships for Sustainability (MAPS) Special Initiative, focusing on strengthening private sector networks. MAPS is based on successful models found in Ghana and Uganda integrating FP/RH, STD/HIV/AIDS, and MCH and Life Saving Skills (LSS).

III.G. Client Oriented

As described in detail in Chapter II, a client-centered approach to reproductive health and family planning is a key feature of the SEATS approach to quality. This orientation guides service providers, planners and managers, trainers, and other staff in ensuring informed choice and contributing to overall client satisfaction and continuation rates. In practical terms, this means that the client's expectations and level of satisfaction are placed in a central position along with clinical standards or other program guidelines and protocols. Level of satisfaction provides an important indicator of our level of success and areas for potential improvement (Figure 5).

As is appropriate with the SEATS approach to quality, ensuring client-oriented subprojects and services needs to be planned and implemented within the particular context of a given situation. SEATS’ experience in doing so varies as widely in content as its particular country programs and the clients served would dictate. Despite this variation, however, several characteristics will remain constant, including:

- Identification of clients and use of information regarding their needs, expectations and level of satisfaction.
- Organization of service delivery and provision of support to meet the expectations of clients and ensure their satisfaction.
- Monitoring of indicators for subprojects that reflect a strong client-orientation, such as:
  - Client receives method she/he has chosen.
  - Client perception of privacy and confidentiality for counseling and exams are accommodated.
  - Client perception of acceptable waiting time is accommodated.
  - Client perception of acceptable amount of time with provider is accommodated.

- C Clinic days and hours are convenient and acceptable.
- C Provision is made for clients with family and/or children who must attend the visit with them.
- C Client perception of waiting room, exam room, cleanliness/hygiene, water, and toilet facilities are positive.
- C Client's ability and willingness to pay for services is known.
- C The cost of services is acceptable to clients.

For a complete list of illustrative indicators for QOC on SEATS II subprojects, see "Integrating QOC into SEATS Subprojects" in Chapter IV.

III.H. Integrates Family Planning and Reproductive Health

Reproductive Health can be defined in a number of ways. According to Germaine and colleagues, comprehensive reproductive health programs should provide services for women of all ages, including adolescents and women beyond the childbearing age, with a focus on sexual health beyond pregnancy, contraception and abortion, to include treatment of reproductive tract infections, gynecologic services and child health care (Germaine, 1994).

SEATS I was one of the first CAs to include a focus on integrating selected reproductive health interventions into family planning. SEATS I experience in the integration of reproductive health and its links with quality present a firm foundation for further work in this area (Figure 15).

The SEATS II mandate is to strengthen and expand FP services by addressing unmet needs and increasing demand. However, subprojects are designed and implemented within a broad quality and reproductive health framework. This will continue as future subprojects are developed in the target countries in which SEATS II operates. SEATS II will also continue to participate on USAID's task force on reproductive health.

III.H.1. SEATS II Priorities in Reproductive Health

In terms of operationalizing reproductive health interventions, SEATS efforts are consistent with the six programmatic priorities identified as a framework for USAID's Office of Population RH activities:[10]

- < Maximizing access and quality of care.
- < Reducing unmet need and increasing demand.
- < Addressing the needs of adolescents.
- < Reducing unsafe abortion through post-abortion treatment and contraception.
- < Adding other selected reproductive health interventions including STD/HIV prevention; breastfeeding; increasing linkages with safe motherhood and STD management; and reduction of harmful practices such as female genital mutilation (FGM)
- < Strengthening linkages with other related areas such as child survival, female literacy and education, women's employment and status, environment, and democracy.

SEATS II reproductive health framework is defined first and foremost by the primary target population of women of reproductive age (WRA) in countries with high fertility, high female illiteracy, increasing rates of HIV infections, and high maternal and child mortality. To the furthest extent possible, SEATS II approaches RH issues with an emphasis on responding to the articulated needs of women and their partners.

SEATS II will continue to design and develop activities in its subprojects that help women and men exercise their fertility preferences, experience safe pregnancy and childbirth, and protect themselves from the transmission of STD/HIV. SEATS continues to incorporate gender and cultural considerations into all levels of the design, implementation and monitoring and evaluation phases of its subprojects. All of SEATS II approved subprojects now incorporate reproductive health components, ranging from STD detection and management within existing FP services to promotion of rooming-in of newborns to LAM as a transitional FP method to efforts to eradicate FGM.

In order to operate within its mandate and resource/milestone structure, SEATS II must focus on key interventions within the RH arena that are clearly linked to expanded and/or improved FP service delivery and are within its scope of work. Reproductive health assessments, such as those conducted by SEATS in Albania and Russia,[11] indicate a real unmet need for services, local interest in integrated FP/RH activities, and support for RH activities by USAID in various target countries.

Figure 15: Quality Improvement and Integration of Reproductive Health in Burkina Faso

When family planning (FP) services began in selected government clinics in the capital city of Ouagadougou in 1985, early surveys confirmed that FP was considered a low priority by clinical personnel. A managerial strategy was designed to address this perception and improve service delivery through integration of family planning and reproductive health services. The result was increased client and provider satisfaction, increased use and continuation rates, and improved efficiencies in other areas, such as supervision and MIS.

The Ministry of Health and Social Action, with the support of agencies such as Columbia University and later JSI/SEATS, conducted initial assessments -- including surveys, focus groups and operations research -- followed by a national conference to review results and plan the strategy. Staff at various levels and service delivery points became involved in the decision-making process -- defining objectives and strategy, creating an action plan, and analyzing results. The strategy identified the integration of FP and RH into daily services
-- all services, all day, every day.

An increase in use of both FP and MCH services was achieved and maintained. The number of services received per client increased, as did the number of visits and clients' requests for services.

Clients indicated they were pleased with the integrated service because it saved time per visit and reduced the number of visits they needed to schedule. Staff also reported that they were more satisfied -- citing a more evenly distributed client load and a less stressful working environment.

The integration of family planning and reproductive health in Burkina Faso maintained or decreased the management burden in each clinic while increasing the quality and quantity of services and continuation rates in both FP and MCH.

In addition to the prevention of unwanted pregnancies among women of reproductive age, the priority program components of reproductive health under SEATS II are presented in Figure 16, along with the relevant USAID Strategic Objectives.

Figure 16: SEATS II Priorities in Reproductive Health

SEATS RH Interventions	USAID Strategic Objectives
Post-partum and post abortion family planning and care	Sustainable Reduction in Unintended Pregnancies Sustainable Reduction in Child Mortality Sustainable Reduction in Maternal Mortality
Support For LAM/ Breastfeeding	Sustainable Reduction in Unintended Pregnancies Sustainable Reduction in Maternal Mortality Sustainable Reduction in Child Mortality
Prevention of HIV/STDs	Sustainable Reduction in STD/HIV Transmission Among Key Populations
RH services for youth	Sustainable Reduction in Unintended Pregnancies
Efforts to Eradicate Female Genital Mutilation	Sustainable Reduction in Maternal Mortality Sustainable Reduction in STD/HIV Transmission Among Key Populations

In addition, SEATS II will collaborate where possible with JSI/MotherCare initiatives and programs focused on safe pregnancy and motherhood. SEATS also actively collaborates with its partners ACNM, PATH, Initiatives Inc., PPFA, WEI, AVSC International, and other USAID Cooperating Agencies to maximize the RH technical expertise available to subprojects and share resources. SEATS II will thus design subprojects to coordinate and/or link with other reproductive health services that will result in synergistic and cohesive programs.

The infrastructure of existing FP services provides a strategic venue for the incorporation of basic RH services. SEATS II continues to seek opportunities to integrate and/or improve RH services into existing systems already operating in a given setting. This approach makes the most efficient and effective use of scarce resources by utilizing and building upon the skills and training of existing personnel and the corresponding resources of service delivery systems (Ashford, 1995). It also supports USAID's approach to reproductive health in terms of integrating health and population activities to best meet the reproductive health needs of the target population of women and men.

III.H.2. Post-Partum/Post-Abortion Family Planning

SEATS recognizes that post-partum and/or post-abortion services can be instrumental in achieving both FP and MCH objectives. They can offer a low-cost means of extending FP services to much of the active childbearing population as well as to those who wish to delay childbearing. They can avert unwanted conceptions by providing counseling and contraceptives promptly after birth or abortion -- since most fecund couples tend to conceive again quickly. This applies especially to women who breastfeed partially or not at all.

Many facilities that offer post-partum or post-abortion contraception have experienced a decline in the number of septic abortions. For example, a study conducted in six hospitals in the United States showed a 22% decline in the abortion rate. Post-partum programs have also been shown to advance health objectives by raising attendance at the six-week check-up, increasing infant immunization, reducing the frequency of short birth intervals, low-birth weight and the associated risks to infant mortality, reducing the frequency of repeat abortions and unwanted births (Ross, 1993).

A full post-partum or post-abortion program requires coordination among several departments and/or units, including pre-natal, delivery, abortion care, surgery (for voluntary surgical contraception), and multiple outpatient departments, especially if FP and MCH are delivered separately.

SEATS provides TA and resource support to establish the necessary linkages for provision to eligible women and men immediate or subsequent post-partum/post-abortion IUD insertion and voluntary sterilization, barrier methods, LAM (as a transitional method with support of exclusive breastfeeding), and appropriate hormonal methods. SEATS collaborates with partners such as AVSC International and ACNM and other JSI projects such as MotherCare for the design and delivery of such services, as needed.

An example of a current SEATS post-partum program is the Zimbabwean subproject, "Chitungwiza Family Planning Services: Comprehensive Training for Quality Improvement." The objectives of this program are to:

- Increase counseling services for postpartum women.
- Increase utilization of family planning among post-partum women.
- Increase utilization of LAM.
- Improve breast-feeding practices.
- Increase referrals for long-term and permanent methods.

SEATS has developed recommended indicators for the evaluation of a "typical" postpartum program (S*EATS II Monitoring and Evaluation Strategy*). For each indicator, the table presents the subproject objective, baseline and/or target information, and possible data sources.

III.H.3. Support for LAM/Breastfeeding

The Lactational Amenorrhea Method (LAM) of contraception contributes to reduced fertility, reduced child mortality and improved women's nutrition, and serves as a successful entry point for introduction of an appropriate FP method. LAM attracts women who are distrustful of contraceptive methods, and facilitates earlier acceptance of longer term family planning methods. As Theresa de Vargas, Executive Director of CEMOPLAF, notes, "LAM is the only family planning method that benefits directly both mother and baby while improving the service delivery system by promoting the development and integration of family planning and health."

SEATS is committed to increasing access to quality family planning services, and as such, recognizes the potential of incorporating LAM and breastfeeding activities into family planning projects for promoting reproductive and child health. In order to increase and promote the health of mother and child, SEATS facilitates LAM's addition to subproject activities.

Under a Memorandum of Understanding (MOU) signed in 1995 between SEATS and the Institute for Reproductive Health (IRH) at Georgetown University, LAM activities will be incorporated into SEATS subprojects through the following activities:

- Materials dissemination, development, and adaptation.
- Training.
- Strategy development for integrated activities.
- Technical Assistance for integrated activities.
- Possible small studies/research.

Figure 17: LAM/Breastfeeding Activities in Zimbabwe

Subprojects in Zimbabwe provide examples of LAM/breastfeeding activities under SEATS II. In collaboration with the Zimbabwe National Family Planning Council (ZNFPC) and the city health departments of Chitungwiza and Gweru, SEATS completed a study on the use of LAM as a component of FP/MCH programs in Zimbabwe. The study responds to MOH and ZNFPC efforts to expand the FP method mix, to support the aims of Baby Friendly Initiatives, and to promote resource-efficient service delivery.

A workshop on the implementation of LAM in FP programs is scheduled to take place in Zimbabwe for key ZNFPC and other local health officials and service providers, as well as for representatives from USAID and the MOH. SEATS will cover a range of issues, including international research on LAM and the SEATS experience in Burkina Faso. The participants will assist in interpreting data from the SEATS LAM study in Zimbabwe and developing strategy and action plans for LAM. SEATS will also hold a Training of Trainers (TOT) workshop for trainers of the Chitungwiza, Bulawayo, and Gweru subprojects.

III.H.4. Prevention of STD/HIV

The high incidence of STDs in several countries in which SEATS II works, and the expressed needs of clients, service providers and governments, led SEATS to target STD/HIV prevention as a key reproductive health component. STD/HIV activities are and will continue to be integrated into appropriate subprojects. Specific activities include:

- Inclusion of "doubling methods" messages into IEC and counseling to encourage use of condoms for STD/HIV prevention.
- Infection prevention as a focal area for training.
- Upgrading of clinical practices, standards and training modules.
- Integration of STD/HIV prevention information and counseling skills into basic FP training curriculum of SEATS II training materials.

Appropriate activities will be selected that encompass both policy and service delivery considerations. Referral systems for FP clients to access existing STD/HIV services and vice-versa will be developed and implemented as needed. Linkages between services will be developed or improved in appropriate SEATS II subproject sites.

A special focus will be placed on youth under SEATS II subprojects activities, particularly through SEATS First Things First International/Youth Initiative under the Special Initiatives portfolio. SEATS II will address issues such as access to information, privacy, quality counseling and service delivery, as well as participation by youth in program design and implementation where possible, and involvement of peer counselors in the provision of FP/RH and STD/HIV services.

In addition, depending on subproject needs, design and available resources, SEATS II will identify and develop innovative approaches such as:

- < Cross-training of STD and FP service providers where separate facilities and/or units exist.
- < Social marketing of female barrier methods and STD treatment kits as well as condoms where feasible.
- < Policy reform to expand distribution of STD treatment drugs beyond STD clinics. (Availability of treatment drugs in FP and MCH clinics can improve access to treatment for adolescents and women.)
- < Pilot studies to introduce diagnosis and treatment into the FP/MCH clinics that serve high STD-prevalence communities, including cost-benefit studies.
- < IEC activities for both post-partum and post-abortion treatment wards through STD and FP/RH information, service provision, and referrals.

III.H.5. Efforts to Eradicate Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is a widespread harmful traditional practice in much of Africa, and is estimated to affect a subtantial number of women and girls. FGM's health risks include severe blood loss, bladder and urethra infection and/or mutilation, menstrual problems, and pregnancy and childbirth complications. According to the World Health Organization, FGM significantly increases the likelihood of maternal mortality and still-births. Therefore, both women and infants are seriously at risk of serious complications as a result of this long-held practice.

Currently, the primary FGM activity under SEATS II will take place in Eritrea in collaboration with the MotherCare Project and PATH (aa partner of both SEATS and MotherCare). The FGM eradication component of the SEATS FP/RH program in Eritrea has resulted from the health and psychological problems which women and girls undergo from such a practice. SEATS support for FGM eradication was requested by several senior Eritrean health officials.

SEATS TA constitutes a less visible role than in other family planning programs due, in part, to the sensitive nature of FGM, but primarily because TA will be provided where requested or where SEATS II can support local efforts. For instance, SEATS TA in Eritrea will originate with a needs assessment component to identify the capabilities and on-going FGM eradication efforts of national and international

agencies and groups in Eritrea, assess the existing resource materials on FGM in Eritrea, and select project sites in collaboration with prospective partner organizations. This needs assessment will be followed by research on FGM by the Eritrean partner groups in order to guide interventions and workshops addressing this practice and its implications.

III.H.6. Special Initiatives Activities

The Special Initiatives (SI) portfolio responds to all four Agency Strategic Objectives, and reflects a two-pronged rationale:

- Focus on strengthening family planning service delivery through a cost-effective, outcome-oriented approach, particularly through reproductive health interventions.
- Respond to key epidemiological and demographic indicators of the illustrative SEATS II country list, namely STD/HIV/AIDS, high maternal mortality, and low contraceptive prevalence rates.

Two of the Special Initiatives that directly address RH concerns, in addition to the Youth Initiative discussed under prevention of STD/HIV, are the Midwifery Association for Partnerships in Sustainability (MAPS), in collaboration with the American College of Nurse-Midwives (ACNM), and the Women's Literacy Initiative (WLI), in collaboration with World Education, Inc. (WEI).

Through MAPS, SEATS supports institutional development of midwifery associations to promote service expansion within a solid RH context that addresses both maternal health and STD/HIV/AIDS prevention and treatment where appropriate while maintaining high standards of QOC. WLI acknowledges the strong connection between women's education and positive RH/FP and QOC indicators. Through WLI, SEATS is integrating FP/RH into existing NGO literacy programs for women while developing linkages to service delivery, including referral systems.

IV. Integrating Quality of Care into SEATS II Subprojects

This chapter provides technical and practical guidance on what subprojects can and should do to integrate continuous improvement of quality into design, implementation, and evaluation cycles.

The SEATS approach to quality stresses the importance of *building in* quality of care from the start of individual subprojects. Every program has its own level of quality, and it requires on-going assessment to determine which areas program managers and service providers would like to improve in order to meet clients' expectations and ensure their satisfaction using the resources at hand. Therefore, the promotion of quality of care in family planning is highly contextual, and needs to be organized and assessed according to the situation of the specific program and clients in question. Also, continuous quality improvement models recognize quality as a continuum; therefore, quality needs, improvement opportunities, supporting structures, activities and indicators will vary between subprojects and sometimes over the life of an individual subproject.

The challenge for SEATS is to provide guidance to its staff to develop appropriate and meaningful quality of care improvement efforts in its subprojects, and do so in a way that is field driven and which monitors and documents achievements in a fashion that contributes to overall SEATS milestones, especially new and improved service sites, quality of care monitoring in 75% of subprojects, and accumulation of CYP.

IV.A. Resources and Tools for QOC

As part of the SEATS II approach to quality, staff should assess and plan for quality of care and continuous quality improvement at every step of the subproject cycle. These steps include:

- Country assessment.
- Institutional assessment.
- Strategic planning.
- Subproject design.
- Implementation.
- Monitoring and evaluation.

Resources and tools that SEATS recommends for improving QOC efforts are described in detail in Appendix A. Included are contact information, descriptions and uses for these tools and resources that SEATS recommends to:

- Assess quality and quality needs.
- Improve client orientation.
- Improve clinical quality.
- Improve management.

Figure 18 presents some general principles staff can refer to when selecting among priorities, tools and indicators for quality improvement.

Figure 18: Selecting Quality Improvements that Matter

Key to quality improvement is *selection* -- from a universe of problems, which should be selected, and from a range of possible solutions, which should be implemented. While there is no simple formula for selecting from among problems and solutions those which will be most likely to make a major difference, some general principles and criteria are given below to guide this selection.

- Be clear about what is to be improved: the process of management itself, or the product of service delivery. While there are often combined agendas, to the extent that there is clarity of foucs for a particular quality improvment effort, the following may be applied:
  - if *process* is the priority, quality improvement efforts may begin by focusing on areas where there is high probability of success. This will gain support and build skills for more complex improvements later on.
  - if *product* is the priority, ensure that service providers are involved in the process, and that the client's perspective is a part of problem identification as well as solution implementation.
- Ask whether the data support theories concerning the problem and/or solutions; gather more data if necessary, especially to enable the team to measure the relative success of solutions being tested.
- Select the most important problems and key quality improvements based on objective criteria and tangible data.*

  Problem-selection criteria include:
  - Overall importance of the work-process and/or output of the work-process to subproject objectives.
  - Potential impact on clients.
  - Extent of internal support for doing something about the problem.
  - Extent to which designing and implementing solutions is within the teams' control.
  - Relation to overall subproject objectives and/or anticipated outcomes.

  Solution-selection criteria include:
  - Financial cost;
  - Opportunity cost (will the program have to give up something else?)
  - Technical difficulties;
  - Extent of management burden eased or added;
  - Potential side effects;
  - Resistance to change;
  - Time required to implement.

*Criteria adapted from Institute for HealthCare Improvement, 1994.

IV.B. Illustrative Key Indicators for QOC in SEATS II Subprojects

"The specific outcomes chosen as indicators of quality will vary to some degree depending on the aspect of quality being assessed, but the role of outcomes in assessment will be fundamentally the same in all cases" (Donabedian, 1992).

As part of its overall project, SEATS II has developed illustrative or prototypic indicators to match objectives typically found in subprojects that can be used for strategic planning, subproject design, monitoring and evaluation. This includes prototypic indicators for monitoring various types of subproject components, including specialized technical areas such as postpartum FP/RH programs, program sustainability, community-based distribution programs, and youth initiatives. For each indicator, tables present subproject objectives, baseline and/or target information and possible data sources. (For a full list of these indicators and their use, see the *SEATS II Monitoring and Evaluation Strategy*.)

SEATS II illustrative indicators for Quality of Care are based on and consistent with those recommended by the USAID-funded EVALUATION Project. They are incorporated into the monitoring and evaluation plan of SEATS II subprojects.

- Number of contraceptive methods available at a specified service delivery point.
- Percentage of counseling sessions with new acceptors in which a client receives the method she/he has chosen.
- Percentage of clients counseled on potential side-effects and their management.
- Percentage of client visits during which a provider demonstrates skill at clinical procedures, including asepsis.
- Percentage of clients reporting sufficient time with provider.
- Percentage of time clients informed of timing and source of resupply/ revisits.
- Presence of a quality improvement plan, reviewed at least quarterly and updated at least yearly.
- Organization and provision of services based on clients' needs and expectations.
- Percentage of clients reporting satisfaction with services.
- Decrease in drop-out rates.
- Increase in utilization rates.
- Increase in continuation rates.
- CYP.

These indicators reflect the collective contribution of multiple functional areas, not just quality.

In order to aid staff in their selection of indicators, this strategy document provides quality indicators in two additional formats:

- **Routine Monitoring**
  Indicators are presented according to the components of the Bruce/Jain Framework for Quality of Care (Figure 19).
- **Intermediate Process Indicators for QOC**
  Indicators are presented together with a summary list of QOC activities that can be referred to when designing and monitoring quality improvement initiatives in an organization (Figure 20).

Indicators and activities are selected by SEATS field staff and consultants responsible for its design. The SEATS Washington-based team members for quality of care, reproductive health and evaluation participate in planning and implementing quality monitoring and evaluation by serving as consultants to provide input for the selection of appropriate indicators during the subproject design process. They also participate in the planning and development of strategies for measurement and assessment through MIS systems, routine reporting and special studies.

Figure 19: Illustrative Indicators for Routine Monitoring Presented According to the Bruce/Jain Framework for Quality of Care in Family Planning Programs
(key indicators are presented in bold)

ELEMENT	ILLUSTRATIVE INDICATORS
CHOICE OF METHODS	**-Client receives chosen method** **-Number/range of methods available** **-Methods offered are available** **-Providers refer clients to another SDP for methods unavailable at that SDP** **-Few restrictions placed on available methods** -Service provider does not inappropriately limit choice of method -All methods appropriate to reproductive intentions offered to client by provider -Client receives method appropriate for reproductive intentions -Contraceptives are well stored
COUNSELING AND CLIENT INFORMATION	**-Provider gives an overview of all available methods (first-time/undecided clients)** **-Provider gives in-depth information on method asked for and/or accepted, including management of possible side-effects** **-Client correctly explains method chosen to provider** -IEC material is available and complete -Waiting rooms have IEC materials available -IEC materials are available for clients -Method specific information available -Service provider trained in counseling skills -Service provider gives information in a complete, concise and non-biased manner that accurately reflect clients' lifestyle and needs -Checklist available on information for provider to cover during counseling session -Service provider has the client repeat the key points concerning the method she/he has chosen -Privacy acceptable for counseling and examination -VSC consent form available and signed by client
TECHNICAL COMPETENCE	-**Existence of written guidelines on FP practice** **-Providers informed and knowledgeable about written guidelines** **-Provider can explain contraception: benefits, use, contraindications, side effects, management of side effects** **-Provider demonstrates skills in clinical procedures** **-Provider performs in accordance with written guidelines** **-Client receives an appropriate method** -Proper infection prevention procedures are followed by all staff in all cases -There is a description of the tasks for each post -Existence of training criteria for service tasks, mechanisms to screen potential service providers, and job descriptions -Clinical provider has received relevant job training -New staff are trained in service guidelines -There is periodic refresher training for all staff -Availability of appropriate basic items for delivering all available methods -Adequate style, frequency and content of supervision -Capability of handling HIV, STDs, GTIs, etc.

ELEMENT	ILLUSTRATIVE INDICATORS
CLIENT-PROVIDER INTERACTION	-**Provider establishes a rapport for assessing client's personal situation** **-Client reports feeling welcomed by staff, at ease in asking question, staff is polite** -Service provider respects the privacy of the client during exams and procedures -Service providers trained in interpersonal relations
MECHANISMS TO PROMOTE CONTINUATION OF SERVICES	**-Provider/client knowledgeable about management of possible side effects** **-Ease of resupply of contraceptive method** **-Provider encourages client to return as needed** -Services are available at all times -Provider establishes an appropriate schedule for return visits -Provider identifies those who do not return for their visits -Client who does not return for follow-up visit is contacted -Reasons for missed-visits are identified -Client encouraged according to follow-up schedule
ACCEPTABILITY AND APPROPRIATENESS OF SERVICES	**-Services are organized according to clients' expectations** **-Client expectations of quality and satisfaction with level of quality are measured and acted on; examples:** **-Clients perceptions of privacy and confidentiality for counseling and exams are accommodated** **-Client perception of acceptable waiting time is accommodated** **-Client perception of acceptable amount of time with provider is accommodated** **-Clinic days and hours are convenient and acceptable** **-Provision is made for clients with family and/or children who must attend the visit with them** **-Client perception of waiting room, exam room, cleanliness/hygiene, water, toilet facilities are positive** **-Client's ability and willingness to pay for services is known** **-The cost of services is acceptable to clients**

Figure 20 presents a summary list of activities and indicators that can be used to further and support specific quality improvement initiatives (Ippolito, 1996).

Figure 20: Intermediate Process Indicators for Quality of Care

QOC Illustrative Activities	Illustrative (Intermediate) Indicators
Establish an organizational quality council	-Existence of written membership list and charter of quality council -Council meets regularly -Council generates ideas for quality improvements -Council identifies and removes institutional barriers (policies, regulations) pertaining to access and QOC -Council reviews and approves QOC improvement activities of workforce
Establish quality teams or circles	-Existence of quality teams -Members trained on quality concepts and skills -Teams meet regularly or as necessary to work on quality improvement projects -Teams have access to resources for quality improvement activities
Gather and incorporate information on clients' expectations and needs	-Focus group research on client expectations conducted and utilized in program design and/or quality improvement activities -Program outcomes reviewed in light of client needs and expectations
Define key organizational quality concepts, including a quality mission statement	-Existence of a written quality mission statement and customer identification, constructed with input by all personnel, approved by senior staff, and readily available/known.
Train staff in continuous quality improvement processes and problem-solving	-Number of trained staff initially trained (first generation) -Number of staff subsequently trained in QOC concepts and skills by first generation trained staff (that is: number of second generation trained staff) -percent of trained staff who apply quality concepts and skills to their work -Number of QOC problems identified and solved -Number of QOC opportunities for improvement identified and acted upon
Conduct quality assessments	-Participation/representation of members of the workforce from every level in quality assessments -Assessment conducted; existence of written report or materials -Existence of a quality improvement action plan resulting from the assessment -Recommendation/quality action plan reviewed and implemented by quality council

QOC Illustrative Activities	Illustrative (Intermediate) Indicators
Develop a structure for continuous quality improvement	-Existence of active quality council and quality teams -Data on QOC gathered, analyzed and used on a routine basis -Specific quality improvement projects identified and implemented based on information gathered -Specific resources within the organization committed: money: percent of overall budget spent on quality staff: number of full/part time equivalents dedicated to QOC and/or with QOC responsibilities and tasks indicated in their job descriptions
Train quality coaches	-Number of trained quality coaches -Quality coaches providing TA on a regular basis
Develop/adapt specific guidelines and/or clinical protocols	-Existence of up-to-date clinical protocols -Functioning clinical protocols (see section on clinical protocols)
Utilize clinical protocols/ perform according to clinical protocols	-Performance according to clinical protocols (*percent of protocol-supported provider-client encounters)* -Providers are aware of the protocols -Providers have received a copy -Providers can produce a copy on request -Providers can recall the essence of the protocols -Providers have received training in the implementation of the protocols -Providers ever attempted to implement the protocol -Providers are currently attempting to implement the protocols, and/or have received any post-training supervision
Develop quality improvement action plan	-Existence of written quality improvement action plan -Number of quality improvement improvements implemented in accordance with action plans
Utilize quality coaches	-TA provided by coaches to staff

QOC Illustrative Activities	Illustrative (Intermediate) Indicators
Implement and assess improvements according to action plan	-Specific quality improvements identified, clarified, tested and implemented -Existing institutional processes and systems streamlined, upgraded or otherwise improved to meet quality expectations of customers, solve problems, or disseminate up-to-date quality concepts, tools and information
Conduct periodic meetings on quality improvement measures according to action plans	-Meetings conducted; progress assessed (progress according to action plans assessed)
Develop storyboards on quality improvement activities	-Storyboards displayed
Disseminate information of successes in continuous quality improvement	-Information dissemination through: written reports, staff presentations, storyboards, on the job training

IV.C. Summary of SEATS II Medical Monitoring System for VSC and NORPLANT®

SEATS II, in collaboration with partner AVSC, International is establishing a medical monitoring system for all SEATS programs that deliver services for voluntary surgical contraception and/or NORPLANT.® In order to include VSC or NORPLANT® services in SEATS II subprojects, the SEATS II Medical Monitoring system must be in place, or the subcontracting institution must demonstrate in advance of initiation of SEATS II support their internal capacity to perform the functions of medical monitoring adhering to the requirements of the SEATS II system. Such would be the case only if a comparable medical monitoring system has been previously established meeting the requirement of the SEATS II Medical Monitoring System. (Institutions which have previously or are currently collaborating with groups such as AVSC may have such functioning systems in place).

A detailed guidelines document is in process that SEATS II staff will refer to during proposal and design phases of such subprojects. Currently, SEATS staff based in Washington, D.C., including the Senior Technical Advisor assigned to Quality of Care and/or the SEATS Deputy Director, provide input and technical oversight to subproject proposals that include components related to the delivery of NORPLANT® and VSC. They will continue to function in this capacity when the guidelines document is disseminated.

A description of the subproject specific system and its relation to quality monitoring and improvement is specified in (a) the SEATS II subproject proposal text under "Quality of Care" (b) the subproject monitoring and evaluation plan.

IV.C.1. Outline of the Process of Establishing Activities and Reporting under the SEATS II Medical Monitoring System

IV.C.I.a. Activities to establish and support services:

- < Performance of initial assessment (including assessing and providing for suitability of service and training sites).
- < Follow-up medical site visits.
- < Provision of TA aimed at service establishment, internal monitoring and self-assessment, and problem solving.
- < Workshops on QOC.
- < On-site training.
- < Provision of training activities and teaching materials.
- < Follow up and evaluation of ongoing activities.
- < Follow up of trainees to assess their activities and competence.

IV.C.1.b. Reporting Complications

Complication reporting helps monitor the safety and quality of clinical contraception programs according to SEATS II/AVSC standards. It aims at identifying problems in service delivery and training and determines measures to take to improve programs.

Process for reporting complications:

1. Written Quarterly Complication Reports (QCR) from subgrantees to SEATS Regional Director and/or AVSC, as designated.
2. Medical Advisor (MA) reviews QCRs and provides appropriate follow-up.
3. MA sends reviewed reports with written indication on the report that it has been reviewed to Medical Division AVSC/NY. Written indication of follow-up action taken submitted to SEATS II.
4. Medical Division AVSC/NY reviews each report. If further action is needed, SEATS II is informed. If not, report is stamped reviewed and sent to data processing.
5. Data files on complications organized according to the subagreement number on each complication form.
6. Annual Summary Statistical Reports prepared by AVSC/NY and submitted to SEATS II Project Director.
7. Medical Director may send notes to the Field Operations Division or Regional Offices on recommended follow-up actions.

IV.C.1.c. Reporting and Investigation of Mortality

The designated Medical Advisor must report all deaths that occur among VSC or NORPLANT® clients within 42 days of the procedure and are related or suspected to be related in any way to the procedure or anesthesia.

Process for reporting and investigating mortality:

1. Initial reporting within 24 hours of death made to SEATS II Project Director.
2. Written report after investigation made to SEATS II.
3. Further investigation if necessary.

IV.C.2. Summary Description of SEATS II Medical Monitoring System

Initial subproject assessment: In each subproject, an initial subproject assessment to evaluate the current level of quality and the current system for monitoring and supervision within that country and/or subproject institution(s) will be conducted. The subproject medical monitoring and supervision system will depend largely on the organization of the institution involved, its current method of providing supervision if one exists and the types of services offered in the program. Typically, a doctor/nurse team will be trained for each subdivision within the system. An overall supervisor will need to be selected whose responsibility it is to monitor reports and to work with the supervisory teams on a periodic basis to provide supervision and TA to them. Depending on the size of the system involved, it may be necessary to have a three or four-tiered system.

In addition to the medical oversight system, SEATS will design and carry out specific training or updates to meet needs identified in the initial subproject assessment that will have an impact on the quality of services being offered. This will be done with the recommendations made in the initial assessment and in collaboration with SEATS II partners as necessary, and specified in individual subprojects and related task orders.

Quality of care training and supervision: Once the system is designed, a draft supervision plan will be developed and an initial quality of care workshop will be held for all high level managers of the institutions involved as well as those individuals responsible for monitoring quality of care. During this workshop, the system will be reviewed and fine-tuned, and a course for implementation agreed upon.

Next, a workshop for designated supervisors will be conducted which will include the components of quality of care, how to conduct medical site visits, facilitative supervision skills, contraceptive technology updates (as needed), an update on infection prevention practices and an overview of specific quality improvement techniques. Also, instruments to be used for the collection of service statistics, complications and mortality within the subproject will be reviewed. (The SEATS II Medical Monitoring System uses forms adapted from AVSC International.)

Ongoing TA and oversight: The SEATS II staff member, AVSC staff member or consultant responsible for providing ongoing TA to the subproject supervisory team will schedule periodic medical site visits with the subproject supervisors. The Deputy Director of Medical Services at AVSC will review quarterly reports for possible problems in quality services, and will schedule twice-yearly supervisors meetings to orient any new supervisors and review pertinent issues that have arisen in the previous six months as requested by SEATS.

Endnotes

1. Characteristics adapted, in part, from Kaluzney, 1991.

2. Adapted from Omachonu, 1991.

3. As noted at the SEATS sponsored meeting on "The Quality of Family Planning Services in Field Projects", (Rosenfield and Damiba, 1991).

4. Dimensions, description and indicators for access proposed by Bertrand, et al, 1994.

5. Scientific Method: a systematic approach to understanding complex systems comprised of the following steps: gather information or observe; look for unifying themes or patterns; propose a theory to explain the observations; test the theory (IHI, 1994).

6. Stages of Juran's Journey are: Project Definition and Organization; Diagnostic Journey; Remedial Journey; and Holding the Gains (Institute for HealthCare Improvement, 1995).

7. This study also found that "other factors contribute substantially to team success. Certainly the role of quality councils, the involvement of management at both the top and middle levels, and training in continuous quality improvement theory and practice are important" (Gilman and Lammers, 1995).

8. This document, *SEATS QOC Strategy*, will provide a summary discussion of the importance of clinical protocols and their assessment. For a more detailed discussion, including steps for development and revision, see *SEATS II Clinical Protocols for Family Planning Programs: A Resource Book*, (JSI/SEATS and AVSC International, 1995).

9. Protocols help to direct the step-by-step processes and decision-making steps required to deliver a service. Guidelines address broader issues such as what services will be provided, by whom and in what setting (*SEATS II Clinical Protocols for Family Planning Programs: A Resource Book*, 1995).

10. Maguire, Elizabeth S. (1994) "Changing Paradigms and Lessons for the Public Health Sector in Population and Reproductive Health". Presentation at the 21st Annual NCIH International Health Conference, June 26-29, pp. 5-6.

11. SEATS FP/RH assessment in Russia was conducted in collaboration with the JSI/MotherCare project. Subsequently, complementary FP/RH activities are included in both project implementation plans.

Summary Table: Guide to Tools and Resources for Quality of Care

To Assess Quality and Quality Needs

- Bruce Framework
- Qualitative Methods:
  - Observation
  - Client Exit-Interview
  - Focus Group Discussion
- SEATS Urban Initiative
  - Modified Situation Analysis
  - Mapping SDPs and Population
  - Client Capacity Estimator
  - FPPMES
  - DHS Secondary Analysis
  - Focus Group Discussion
- Situation Analysis
- DHS Secondary Analysis
- STD/HIV Protocols
- MAQ Services and Policy Checklist
- Training to Maximize Access and Quality Brochure
- SEATS II Quality of Care Strategy for FP/RH Programs

To Improve Client Orientation

- Rights of the Client
- Counseling:
  - USAID/MAQ Guidance
  - CLIENT Method
  - GATHER Method
  - AVSC Training Package
- CAFS/SEATS CBD Training Manual
- Mystery Client Interview Technique
- HARI Index
- Information, Education and Communication: Guides for Behavior Change Communication Campaigns

To Improve Clinical Quality

- On-the-Job Training
- SEATS List of Standard Equipment and Materials
- MotherCare Quality Indicators
- SEATS II Clinical Protocols
- Client Flow Analysis
- COPE
- (AVSC) SEATS II Medical Monitoring System
- JHPIEGO Competency-Based Training Modules, Checklists, Reference Guides, and *PocketGuide for Family Planning Service Providers*

To Improve Management

- Family Planning Manager's Handbook
- CYP Target Model
- Quality of Care Tools Catalog
- Quality Assurance Project
- The Forecasting Cookbook (Logistics)
- Quality Awards
- Total Quality Management Techniques:
  - Flow Chart
  - Check Sheet
  - Pareto Diagram
  - Cause and Effect Diagram
  - Scatter Diagram
  - Control Chart
  - Histogram
  - Project Selection Matrix
- Supervision Checklists
  - CARE Quality of Care Supervisory Tool
  - ZNFPC Guidelines and Checklists
- Family Planning Monitoring and Evaluation System

To Assess Quality and Quality Needs

Name and Contact	Description	Uses
Bruce Framework • Bruce, Judith. 1990. "Fundamental Elements of the Quality of Care: A Simple Framework." *Studies in Family Planning*, Vol. 21, No. 2: 61-91.	Theoretical framework for assessing quality from the clients' perspective. Identifies six essential elements of quality for FP programs: choice of methods, information given to clients, technical competence, interpersonal relations, follow-up and continuity mechanisms, and appropriateness and acceptability of services.	Ž A starting point for evaluation of program quality Ž Helpful when designing subprojects Ž A framework within which quality assessment and improvement tools and indicators can be designed and applied
Observation Examples: • 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. • McGinn, T. 1992. "Draft Quality of Care Protocol for Use During Supervision Visits." Atlanta: CARE.	A qualitative research methodology which can be used alone or in conjunction with other methodologies such as key informant interviews. An observation guide or checklist should be developed beforehand based on research objectives to be used by a trained observer at a service delivery point (Katz et al., 1993).	Ž Evaluating clinic procedures to ensure adherence to protocols/guidelines Ž Examining service delivery process
Client Exit-Interview Examples: • Williams, T. (International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHI)). 1996. *Client Satisfaction Survey: Questionnaire, Reporting Form for Evaluation, and Instructions for Use*. • For an example of how a client exit interview was used to assess the quality of service, see: Green, E.C. 1988. "A Consumer Intercept Study of Oral Contraceptive Users in the Dominican Republic." *Studies in Family Planning*, Vol. 19, No. 2: 109-117.	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 (Katz et al., 1993). **Client Satisfaction Survey** - One page questionnaire to assess client satisfaction with family planning services (or other services offered within the same clinic) upon exit of a clinic. Simple enough to be self-administered by most clinical clients and left confidentially in a covered box. An outside interviewer may be necessary in the case of a clinic serving a population with low-literacy rates.	Ž To assess level of client satisfaction with service offered Ž To assess level of client knowledge regarding contraceptive methods Use *Client Satisfaction Survey* to: Ž Assess elements of quality in a quick, easy and practical way without a significant financial or technical burden Ž Results can be used to identify problem areas and quickly take action to improve the shortcoming

To Assess Quality and Quality Needs

Name and Contact	Description	Uses
Focus Group Discussions Examples: • Debus, M. 1988. *Methodological Review: A Handbook for Excellence in Focus Group Research*. Washington, DC: Academy for Education Development HEALTHCOM. • Folch-Lyon E. And J.F. Trost. 1981. "Conducting Focus Group Discussions." *Studies in Family Planning*, Vol. 12, No. 12: 443-447.	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 (Katz et al., 1993).	Ž Use in assessing client expectations and/or level of satisfaction Ž Use in assessing client attitudes toward FP/RH issues (especially effective in initiating discussion about sensitive topics) Ž Use as a supplement to quantitative research
SEATS Urban Initiative • JSI, CAFS, and CPFH (Columbia University). March 1995. "Findings from the Sub-Saharan Africa Urban Family Planning Study: Overview." • Fisher, A., B. Mensch, 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. • For examples of mapping, see: SEATS, CAFS, and CPFH. 1995. "Findings from the Sub-Saharan Africa Urban Family Planning Study: Blantyre, Bulawo, Mumbasa City Reports." • Miller, K. March 1995. "Client Contact Estimator Manual." • Miller, K., M. Gorosh, M. Ojermark, and P. Wondergem. April 1996. "Family Planning Program Monitoring and Evaluation System, Version 2.0: User's Manual." • The EVALUATION Project. February 1994. *EASEVAL: A Computer Program for Easy Analysis of DHS Data for Evaluation*.	SEATS special initiative which uses a data-driven approach to program design in urban areas. The following tools have been designed, tested, and/or used within the Urban Initiative: **Modified Situation Analysis -** A version of The Population Council's Situation Analysis (see page xx) adapted to urban service delivery sub-systems. **Mapping SDPs and population -** Maps of urban area are generated through computer software to display information about the number and type of SDPs existing, overlaid with population density. **Client Capacity Estimator (CCE) -** Computer software that provides an estimate of the number of client contacts an urban family planning program will have to support in the future given population growth. It works with the current CPR and method mix, and calculates future client loads through both automatic and user-directed projection. It is especially designed for urban programs, but can be used for any region (Miller, 1995). **FPPMES -** Customized spread sheet designed to be used in Lotus 123 Release for Windows that converts quarterly supply data into estimates of CPR and CYP. The output consists of several tables displaying each statistic by method and by quarter, as well as automatically generated graphs that can be designed by the user (Miller et al., 1996). **DHS Secondary Analysis -** Analysis of the urban sub-samples from existing DHS data conducted using EASEVAL, computer software developed specifically for DHS analysis. The program employs a user-friendly menu system that allows the user to investigate DHS data sets beyond the information available in the final reports (The EVALUATION Project, 1994). **Focus Group Discussion -** See description above.	Ž Comprehensive methodology for use in assessing quality in metropolitan areas across a region Ž Data-driven approach to program design Ž Supplies information for policy and decision makers Ž Analyzes changes in CPR, CYP and method mix of regions defined

To Assess Quality and Quality Needs

Name and Contact	Description	Uses
Situation Analysis Examples: • 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. • Zimbabwe National Family Planning Council, The Population Council's Africa Operations Research/Technical Assistance (OR/TA) Project and JSI/SEATS. March 1992. *Zimbabwe: A Situation Analysis of the Family Planning Programme*. • MotherCare. 1996. "Safe Motherhood Needs Assessment (draft)."	A tool that can be used to evaluate the strengths and weaknesses of FP subsuystems and quality of care at a representative sample of service delivery points. 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 (Katz et al., 1993). **Safe Motherhood Needs Assessment** - Designed specifically for analysis of integrated maternal and child health (MCH) programs. Has been field tested in Malawi, Uganda, and Ethiopia. The package includes guidelines, model forms, a trainer's manual, a surveyor's manual, dummy tables and suggestions for analysis and interpretation, and maternal death review guidelines.	Ž Describe availability, functioning, and quality of health and FP activities for a representative sample of SDPs Ž Analyze the relationship between subsystem functioning and the quality of services provided and received Ž Evaluate the programmatic impact quality service has on client satisfaction, contraceptive use dynamics, fulfillment of reproductive intentions, and ultimately, fertility Use *Safe Motherhood Needs Assessment*: Ž For assessing the needs and quality of integrated MCH programs
DHS Secondary Analysis Tools Examples: • The EVALUATION Project. February 1994. *EASEVAL: A Computer Program for Easy Analysis of DHS Data for Evaluation*. • The Futures Group. 1995. *Policy and Programmatic Use of DHS Data: A Tool for Family Planning Program Managers and Analysts*.	**EASEVAL -** Computer **s**oftware developed specifically for DHS analysis. The program employs a user-friendly menu system that allows the user to investigate DHS data sets beyond the information available in the final reports (The EVALUATION Project, 1994). **Policy and Programmatic Manual -** Focuses on the use of DHS data to help program managers make wise decisions about program directions. Three analytical chapters address priority issues confronting national family planning programs that can be examined using DHS data. The priority issues are: designing and appropriate method mix, understanding why women o not use contraception, and identifying and appropriate source mix. Each chapter presents and analytic approach to the issue, guides the reader through a simple process of how to tabulate the data, and suggests possible programmatic options and solutions based on the results. The final section contains a glossary of technical terms (The Futures Group, 1995).	Use DHS Analysis to: Ž Assess country/regional family planning needs and/or prevalence for use as a framework in program design or improvement Use DHS Analysis Tools to: Ž Increase the accuracy, efficiency, and applicability of DHS data analysis Ž Guide the user through a step-by-step process of DHS data analysis

To Assess Quality and Quality Needs

Name and Contact	Description	Uses
STD/HIV Protocols For more information on each of the tools listed in italics under the "Description" heading, contact the respective organization in paratheses (see organization contact list, or request information through SEATS Washington, DC office).	**Prevalence and risk factor assessment methodologies -** Quantitative methods include cross-sectional prevalence surveys. Qualitative methods include: Ž *Assessment and Monitoring of Behavior Change Communication Intervention Research* (AIDS Control and Prevention (AIDSCAP)) Ž *Rapid Evaluation Method Guidelines for Maternal and Child Health, Family Planning, and Other Health Services* (World Health Organization (WHO)) Ž *Targeted Intervention Research* (AIDSCAP). **Prevention -** Tools include: Ž *Rapid Assessment Protocol for Planning:Condom Component of AIDS/STD Prevention Program* (WHO) Ž *Guidelines for HIV Interventions in Emergency Settings* (UNAIDS) Ž *National AIDS Programme Management: Training Course Series* (WHO)	Ž Use prevalence and risk factor assessment methodologies to assess STD/HIV prevalence rates and/or to assess the level of risk in a given population Ž Use prevention tools to design and implement interventions (social marketing of condoms, clinical guidelines to improve the quality of STD/HIV clinics, and training courses to improve management of STD/HIV programs) around the goal of STD/HIV prevention
Maximizing Access and Quality Checklist • USAID. April 1996. "Maximizing Access and Quality: Checklist for Family Planning Service Delivery, With Selected Linkages to Reproductive Health."	Checklist designed to help operationalize the basic principles of MAQ: (1) emphasize access with quality; (2) build a client orientation; (3) support quality from the top; (4) build quality from the bottom; and (5) build in approaches to evaluate and improve. The checklist is NOT intended to be an encyclopedia; it assumes knowledge on the part of the user.	Ž Intended for Joint Programming Teams and others to assess, program or evaluate access and quality of care in family planning and related reproductive health programs. Ž Sections may be used independently according to user needs
Training to Maximize Access and Quality: Considerations for Family Planning and Reproductive Health Programs (Checklist) • USAID/MAQ, Communication, Management and Training Division Office of Population. 1995. (Brochure).	A working checklist to assist in thinking about training for family planning and reproductive health programs.	Ž To assist management staff in thinking more fully and systematically about the training and human resource development component of national FP and RH programs Ž **NOT** intended to replace more detailed assessment needed for design of specific activities
SEATS II Quality of Care Strategy for FP/RH Programs • Ippolito, L., N. Harris, and D. Lauro. (JSI/SEATS). 1996. "SEATS II Quality of Care Strategy for FP/RH Programs (draft)."	Outlines SEATS II strategic approach for integrating quality of care into its subprojects. Provides guidance to SEATS staff and collaborating institutions on the relationship between quality of care and achievement of strategic and program objectives, the promotion of quality of care and continuous quality improvement in FP/RH programs, quality issues related to integration of selected RH interventions, and design for monitoring quality in SEATS subprojects.	Ž As a strategic guide for SEATS field staff in assessing quality needs and designing and implementing quality improvement initiatives for subprojects

To Improve Client Orientation

Name and reference	Description	Uses
Tools for Improving Counseling Examples: • USAID/MAQ and E. Murphy (PATH). July 1996. "Draft Summary of Revised Guidance for Client-Provider Interactions (CPI) in Family Planning/Reproductive Health (FP/RH) Programs." • Lettenmaier, C. and M. Gallen. 1987. "Why Counseling Counts!" *Population Reports, Series J* No. 36. Baltimore: Population Information Program, Johns Hopkins University. • AVSC International. 1995. *Family Planning Counseling: A Curriculum Prototype (Trainer's Manual and Participant's Handbook).* New York.	**USAID/MAQ Guidance for CPI -** Summary of most recent findings and recommendations for family planning counseling. Includes discussion of "Dynamic Interaction," a new model for counseling that emphasizes the importance of good information-giving, informed choice and respect for the client. **CLIENT Method -** An acronym similar to the GATHER method that is included in the "Summary of USAID/MAQ Guidance for CPI." "C" is for: **c**lient-centered services; the **c**lient's contraceptive choice; **c**ouple communication; and **c**ourtesy**.** "L" is for: **l**istening to client's concerns and asking about; **l**ifecycle stage; **l**ife situation; and **l**earning about client's HIV/STD risk. "I" is for: **i**nteraction rather than recitation; **i**nquiry regarding method preference; **i**ntentions regarding future childbearing; **i**nviting clients to ask questions and raise issues; **i**nformation (brief and practical regarding method); and **i**nstructions (find out if clear to client). "E" is for: **e**nvironment of comfort, privacy and confidentiality; **e**xploring sexuality and gender aspects of FP; **e**xplaining side effects and how to manage or outlast them; **e**ncouraging return for follow-up support or to change methods; and **e**mergency contraception. "N" is for: **n**o scolding or disrespect; **n**o pushing methods of disparaging methods; and **n**o refusals regarding changing methods. "T" is for: **t**rust, which keeps clients coming back;and **t**elling others: **T**ry it, you'll like it! **GATHER Method -** An acronym containing indicators for essential elements of family planning counseling: **G**reeting the client, **A**sking about the client's need 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 follow-up appointment. **AVSC Training Package -** Includes manual for trainers and participant's workbook to be used as the prototype for a training course for family planning counseling. Training is estimated to last five or six days and includes 14 modules, each of which focuses on an aspect of counseling. Appendices to the trainer's manual include evaluation instruments, guidelines for how to conduct a counseling practicum, and instructions on how to arrange observations of clinical procedure. Participant's handbook contains handouts and exercises that are used by participants during the course. Curriculum also includes a basic review of family planning methods, common sexually transmitted diseases, including HIV infection, and reproductive anatomy and physiology (AVSC International, 1995).	GATHER method can be used: Ž In the form of a checklist for assessing the quality of counseling received by clients or as a format within which counseling training Ž As a framework within which counseling training can be designed and implemented The cited (as well as other) PATH Information can be used: Ž As a source for the most up-to-date research, recommendations, and future direction for family planning counseling AVSC Training Package can be used: Ž To conduct a training session to develop or improve counseling skills among health and family planning workers who interact with clients

To Improve Client Orientation

Name and reference	Description	Uses
Rights of the Client • International Planned Parenthood Federation. 1992. *Rights of the Client.* London.	List of fundamental client rights compiled by the International Planned Parenthood Federation: 1. **Information -** To learn about the benefits and availability of family planning. 2. **Access -** To obtain services regardless of gender, creed, color, marital status, or location. 3. **Choice -** To decide freely whether to practice family planning and which method to use. 4. **Safety -** To be able to practice safe and effective family planning. 5. **Privacy -** To have a private environment during counseling or services. 6. **Confidentiality -** To be assured that personal information will remain confidential. 7. **Dignity -** To be treated with courtesy, consideration, and attentiveness. 8. **Comfort -** To feel comfortable when receiving services. 9. **Continuity -** To receive contraceptive services and supplies for as long as needed. 10. **Opinion -** To express views on the services offered (AVSC International, 1995.)	Ž A set of principles upon which to base family planning program design and service delivery with focus on the client Ž A checklist to assist in the development of evaluation methodologies (e.g. checklists) in order to assess and improve the quality of service and focus on client orientation

To Improve Client Orientation

Name and reference	Description	Uses
Information, Education and Communication: Guides for Behavior Change Communication (BCC) Programs Examples: • World Bank Guides for IEC Campaign Design: **Part I** - Verzosa, C. 1996. *Health Communication for Behavioral Change: A Guide for Task Managers*. Washington DC: The World Bank. **Part II** - Hornick, R. 1996. *Communication Research Approaches for Bank Projects*. Washington DC: The World Bank. • Kim, Young Mi, P.M. Kumah, P.T. Piotrow, W.B. Morgan, M. Kotei, J.K. Ofori, G. Osae, I. Obeng-Quaidoo, and D. Blumhagen. 1992. "Family Planning IEC Project in Ghana: Impact on Ghanian Males." Paper presented at the 120th APHA Annual Meeting, Washington DC. • Hindin, M.J., D.L. Kincaid, O.M. Kumah, W. Morgan, Y.M. Kim, and J.K. Ofori. 1994. "Gender Differences in Media Exposure and Action During A Family Planning Campaign in Ghana." *Health Communication*, Vol *6*, No. 2: 117-135.	**World Bank References -** The listed references are guides for the design of BCC campaigns within reproductive health programs. They offer simple methods and techniques to aid program designers and managers which cover aspects of BCC ranging from counseling, efficacy and efficiency of mass media use, cost savings and recovery, and evaluation. Special emphasis is given to formative and evaluative research methods and approaches. **IEC Project in Ghana -** The two listed papers discuss the results of a two-phase multimedia campaign to improve CPRs implemented by the Health Educaiton Division of the Ministry of Helath in Ghana and launched in 1990. The first phase of the campaign targeted women and the second phase targeted men. The campaign won the Population Institute's Global Media Award for Best Combined Media Effort in support of population. Because the campaign targeted both men and women, it is useful to see how gender differences could affect exposure and interpretation of FP messages (Hindin et al., 1994).	Ž To help RH program managers plan, implement and supervise BCC campaigns Ž Contains examples of successful campaigns that can be used as models for program design and implementation Ž Written from a realistic, "lessons-learned" perspective with an emphasis on overcoming barriers in BCC campaign implementation, efficacy and sustainment
Mystery Client Interview Technique Examples: • Huntington D., C. Lettenmaier and I. Obeng-Quaidoo. 1990. "User's Perspective of Counseling Trianing in Ghana: The 'Mystery Client' Trial." *Studies in Family Planning*, Vol. 21, No. 3: 171-177. • Schuler, S.R., E.N. McIntoch, M.C. Goldstein and B.R. Pande. 1985. "Barriers to Effective Family Planning In Nepal." *Studies in Family Planning*, Vol. 16, No. 5: 260-270.	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 (Katz et al., 1992).	Ž A method for obtaining the user's perspective on the quality of service received without the bias that may be involved in observation studies Ž Interviews with mystery clients can be used to develop a questionnaire or guidelines for later use in interviewing clinic staff themselves (Katz et al., 1992)

To Improve Client Orientation

Name and reference	Description	Uses
Helping Couples Achieve Reproductive Attentions (HARI) Index Examples: • Jain, A. and J. Bruce. 1995. "Implications of Reproductive Health for Objectives and Efficacy of Family Planning Programs." Working Paper #8. NY: Population Council, Programs Division. • The Population Council. "Reconsidering the Rationale, Scope, and Quality of Family Planning Programs." NY: The Population Council. • Jain, A. And J. Bruce. 1994. "A Reproductive Health Approach to the Objectives and Assessment of Family Planning Programs," in *Population Policies Reconsidered: Health, Empowerment, and Rights*. G. Sen, A. Germain, and L.C. Chen, eds. Harvard University Press, pp. 193-209.	An evaluation tool to assess the impact of family planning programs in terms of the quality of services provided; their success in helping individuals avoid unwanted and unplanned childbearing safely; and their impact on reproductive health. HARI approaches these aspects of evaluation from the perspective of the client rather than looking at a particular contraceptive method or supply source. It links the client's reproductive goals, which are stated explicitly at a point in time during service, with her or his subsequent fertility behavior and health status. The HARI Index measures this approach to family planning and reproductive health by counting as a success a client who has avoided unwanted pregnancy, regardless of the number of services and strategies she has used. If a family planning program fails to empower a client sufficiently to avoid unwanted pregnancy, the program is counted as a failure, not the client (The Population Council).	Ž To evaluate and improve program efforts to orient service toward the client Ž To focus program efforts on the concept of client-empowerment with the ultimate goal of service being to empower clients in order that they may make conscientious family planning and reproductive health choices based on knowledge of all available (and appropriate) methods, and benefits and costs of each Ž To assist in the process of integrating family planning programs with reproductive health services
CAFS/SEATS CBD Training Manual • CAFS/SEATS. 1994. *Management of Community-Based (CBD) Family Planning Programmes: Manual for Trainers*.	A manual containing standardized curriculum guidelines for teaching program management skills specific to community-based distribution programs. The training materials, visuals and reference materials reflect the way in which CAFS has delivered the training course. Other users may choose to reorganize the course by adding, modifying, deleting or replacing curriculaum units with their own training material to reflect their particular orientation to management of CBD programs. The modules contained int he curriculum make up a course of four weeks duration (CAFS/SEATS, 1994).	Ž For mid-level managers who wish to improve the management of their programs Ž For the manager who does not have a CBD program but wishes to start one

To Improve Clinical Quality

Name and Reference	Description	Possible Uses
On-the-Job Training (OJT) Examples: • *Pipeline: Issues in Logistics for Global Family Planning and AIDS Prevention*. Family Planning Logistics Management Project (FPLM)/John Snow, Inc. For more information on OJT through FPLM, contact Daniel Thompson, FPLM/JSI. • Jacobs, R.L. and M. J. Jones. 1995. *Structured On-the-Job Training: Unleashing Employee Expertise in the Workplace*. San Fransico: Berrett-Koehler Publishers. • Rothwell, W.J. and H.C. Kazanas. 1994. *Improving On-the-Job Training: How to Establish and Operate a Comprehensive OJT Program.* San Fransico: Jossey-Bass Publishers. • Salisbury, Frank S. 1994. *Developing Managers As Coaches: A Trainer's Guide*. London: McGraw-Hill Book Company.	**The Family Planning Logistics Management Project (FPLM) -** Subproject within John Snow, Inc. that provides training in contraceptive supply logistics to developing country family planning and AIDS prevention programs. FPLM has developed a general training model that is adaptable to meet specific country needs and includes OJT, training that takes place in the actual work setting. The articles in *Pipeline* outline this model and discuss some of the specific tools used in On-the-Job Training such as Job Aids, mechanisms for storing and conveying information to guide the performance of work with are then incorporated into OJT (FPLM, 1995). **OJT Literature -** The first two books listed contain detailed explanations of the structure and function of OJT and offer practical step-by-step advice on how to implement successful training programs. The material is not specific to health systems or family planning programs, as is the training within FPLM, but it contains useful information about the fundamental aspects of OJT that is applicable to any industry. The third book is a guide for trainers and managers and is based on the concept that managers and trainers are coaches. The author focuses on the coaching model "POWER"(*P*urpose, *O*bjectives, *W*hat is happening now?, *E*mpowering and *R*eview) and combines coaching strategies from athletics with managerial approaches to motivation. The book offers: guidance on teaching managers how to release latent employee skills and talent; research-based advice; and real-life illustrations (Salisbury, 1994).	Ž To maximize employee potential through training in the actual job setting Ž To improve employee job performance through one-on-one interaction
SEATS Clinical Protocols • SEATS/John Snow, Inc. and AVSC. October 1995. *SEATS II Clinical Protocols for Family Planning Programs: A Resource Book*.	Purpose is to provide documents that can serve as up-to-date resources on technical and programmatic issues in the development and/or revision of clinical protocols and guidelines for family planning programs. The method-specific materials presented contain the necessary information for guidelines and protocols, while the reference documents contain up-to-date information on the criteria and practices needed to reduce barriers to access while improving the quality of services (SEATS/JSI and AVSC International, 1995).	To assist the developers and implementors of family planning service delivery protocols in: Ž Assessing the need for protocols and/or protocol revision Ž Identifying the end-users of any protocol development Ž Agreeing to achievable tasks and deadlines toguide the protocol development and/or revision process Ž Planning for the dissemination, implementation and evaluation of the protocols developed

To Improve Clinical Quality

Name and Reference	Description	Possible Uses
(AVSC) SEATS II Medical Monitoring System • SEATS/AVSC. June 1995. "Medical Monitoring and Supervision Under the SEATS II Project (draft)."	AVSC International, in collaboration with SEATS II, provides medical monitoring and supervision for family planning services, particularly those that offer long-term and permanent methods. This is accomplished through establishing subproject level supervisory systems based on the approach used by AVSC. Components of the system include: initial subproject needs assessment, quality of care workshop, supervisory training, and ongoing technical assistance and oversight.	Ž Establishing a baseline to which data from a subsequent assessment using the same instrument can be compared Ž Understanding how services are organized, what equipment and supplies are needed to improve services, and how the quality supervision of the service is carried out Ž Disseminating and reviewing findings from assessment to all high level managers and planning a course of action for improvement Ž Providing training to the designated supervisors on how to implement and conduct a medical monitoring system
List of standard equipment and materials • SEATS. 1995. *SEATS II Commodity Procurement Reference Guide*.	An official reference guide for commodity procurement on behalf of SEATS subproject organizations. Includes an overview of and guidelines for the procurement process and a section on post procurement management.	To assist SEATS regional and field ofice staff: Ž In establishing and maintaing adequate project commodity procurement procedures in accordance with the standards of USAID and JSI Ž As a reference or resource document in the procurement process Ž In determining whether to procure through SEATS/Washington, locally, or a third country
Client Flow Analysis Examples: • Lynam, Pamela F., T. Smith, and J. Dwyer. 1994. "Client Flow Analysis: A Practical Management Technique for Outpatient Clinic Settings." *International Journal for Quality in Health Care*, Vol. 6, No. 2: 179-186. • Graves, J.L., A.A. Hudgins, J. DeLung, C.A. Burnett, P. Scanlon, and D. Orentlicher. 1981. "Computerized Patient-Flow Analysis of Local Family Planning Clinics." *Family Planning Perspectives*, Vol. 13, No. 4: 164-170.	A practical technique to help address one of the most frequently cited causes of patient dissatisfaction with quality of FP/RH services--waiting times. Computerized software (called "Patient Flow Analysis) can be used or analysis can be conducted by hand using a spreadsheet format. Analysis allows clinic managers and workers to look at the way that clients and patients move through the clinic. It gives information on waiting times, time spent in contact with different service providers, bottleneck areas in service and staff utilization patterns. The software is simple, quickly performed, cost-effective, easy to learn and easily transferrable (Lynam et al., 1994).	Ž To assess client flow through the clinic at different aspects of the service delivery process Ž To improve the quality of specific aspects in the service delivery process such as waiting time and staff allocation

To Improve Clinical Quality

Name and Reference	Description	Possible Uses
Client-Oriented, Provider-Efficient (COPE) Examples: • 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. • Lynam, P., L. McNeil Rabinovitz, and M. Shobowale. 1992. "The Use of Self-Assessment in Improving the Quality of Family Planning Clinic Operations: The Experience with COPE in Africa." AVSC Working Paper.	Assessment and improvement tool developed by AVSC to make family planning programs more Client-Oriented and Provider-Efficient (COPE). The three stages in assessment include: 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. Computer software or a non-computerized adaptation is used to chart how clients and staff spend their time in th clinic. Then staff and facilitator complete a self-assessment checklist which looks at all aspects of service provision. The results are 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 assess progress and provide technical assistance (Katz et al., 1993).	Ž To help family planning service providers improve the quality of clinic operations by making them more oriented toward clients' needs and more efficiently organized for the number of clients seeking services (Lynam et al., 1992).
MotherCare Quality of Care Indicators • MotherCare. 1996. "Quality of Care for Integrated Reproductive Health Programs (draft)."	Summary of indicators for quality of care within MotherCare subprojects. MotherCare is a subproject of John Snow, Inc. that carries out work in the area of maternal and neonatal health and nutrition.	Ž To assist in assessing and improving the quality of individual MCH programs or MCH programs integrated with RH programs
JHPIEGO Compentecy-Based Training Modules, Checklists and Reference Guides For more information or to order materials, contact JHPIEGO (see organization contact list, or request information through SEATS Washington, DC office). • Blumenthal, P.D. and N. McIntosh. 1995. *PocketGuide for Family Planning Service Providers*. Baltimore: JHPIEGO.	Compentency-based training modules, checklists and reference guides for the following clinical processes: Ž IUD insertion and removal Ž Norplant insertion and removal Ž Infection prevention Ž Genital Tract Infection (GTI) treatment and prevention Ž Postabortion care **PocketGuide** - Designed to provide clinicians with easily accessible, clinically-oriented information for use in FP service provision.	Ž To standardize the training of service providers in the clinical activities listed under the description heading Ž As reference materials for consultation regarding correct clinical procedure *PocketGuide* - for clinician use when: Ž Faced with a client with special needs, such as a woman with a medical problem (e.g. diabetes) or who may need emergency contraception (includes guidance for common as well as rare medical problems) Ž Information about a specific contraceptive method is required (includes mechanism of action, benefits, limitations, instructions and side effects)

Organization Contact Information

Academy for Educational Development (AED)/HEALTHCOM
1255 23rd Street, NW
Suite 400
Washington, DC 20037
PH: (202) 862-1900
FAX: (202) 884-8710

AIDS Control and Prevention (AIDSCAP)
2101 Wilson Blvd.
Suite 700
Arlington, VA 22201
PH: (703) 516-9779
FAX: (703) 516-9781

Access to Voluntary and Safe Contraception, (AVSC) International
79 Madison Ave., 7th Floor
New York, NY 10016
PH: (212) 561-8000
FAX: (212) 779-9439

CARE
Population Unit
151 Ellis Street
Atlanta, GA 30303
PH: (404) 681-2552

Center for Population and Family Health (CPFH)
Columbia University
60 Haven Ave. B-3
New York, NY 10032
PH: (212) 304-5210
FAX: (212) 305-7024

Centre for African Family Health (CAFS)
Pamstech House Westland
Woodvale Grove
P.O. Box 60054
Nairobi, KENYA
PH: 011-254-2-448-618/619/620
FAX: 011-254-2-448-621

The EVALUATION Project
Carolina Population Center
University of North Carolina at Chapel Hill
CB# 8120 University Square
Chapel Hill, NC 27516
PH: (919) 966-7482
FAX: (919) 966-2391

Family Health International (FHI)
P.O. Box 13950
Research Triangle Park, NC 27709
PH: (919) 544-7040
FAX: (919) 544-7261

The Futures Group
1050 17th Sreet, NW
Suite 1000
Washington, DC 20036
PH: (202) 775-9680
FAX: (202) 775-9694

International Planned Parenthood Federation
Western Hemisphere Region (IPPF/WHR)
902 Broadway
New York, NY 10010
PH: (212) 995-8800
FAX: (212) 995-8853

Institute for Social and Economic Policy in the Middle East (ISEPME)
John F. Kennedy School of Government
Harvard University
att. Tamar Miller
79 John F. Kennedy Street
Cambridge, MA 02138
PH: (617) 495-3666
FAX: (617) 495-4188

Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO)
1615 Thames Street
Suite 200
Baltimore, MD 21231
PH: (410) 955-8558
FAX: (410) 955-6199

Joint Distribution Committee (JDC)-Brookdale Institute
att. Meira Aboulafia
Joint Hill, P.O. Box 13087
Jerusalem, Israel 91130
PH: 972-2-6557445
FAX: 972-2-635851

Management Sciences for Health (MSH)
400 Centre Street
Newton, MA 02158
PH: (617) 527-9202
FAX: (617) 965-2208

Program for Appropriate Technology in Health (PATH)
4 Nickerson Street
Seattle, WA 98109-1699
PH: (206) 285-3500

The Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
PH: (212) 339-0500
FAX: (212) 755-6052

Quality Assurance Project (QAP)
University Research Corporation (URC)
7200 Wisconsin Ave.
Suite 600
Bethesda, MD 20814
PH: (301) 654-8338
FAX: (301) 654-5976

United States Agency for International Development (USAID)
Office of Population
1801 N. Kent Street
Arlington, VA 22209
PH: (703) 875-4505
FAX: (703) 875-4413

World Bank
Headquarters
1818 H Street, NW
Washington, DC 20433
PH: (202) 477-1234
FAX: (202) 477-6391

World Health Organization (WHO)
Headquarters
CH-1211 Geneva 27
Switzerland
PH: 41-22-791-2111
FAX: 41-22-791-0746