Volume Five 1997

Population Manager

PROGRAMME EXPERIENCES

- Ministry of Health, Kenya
- Kumudini Hospital, Bangladesh
- Catemaco Logistics Center, Mexico
- Taicang County, China
- Ministry of Health, Egypt
- Population Services, Zimbabwe
- ARCH, India
- Total Quality Management, Ministry of Health, Malaysia

Improving Quality of Care

Action Research

India

Sri Lanka

Vietnam

Editors
Maj-Britt Dohlie
Jay Satia

POPULATION MANAGER

VOLUME 5

Improving Quality of Care

International Council On Management of Population Programmes
(ICOMP)

FOREWORD

The International Conference on Population and Development (ICPD) in Cairo in 1994 provided all of us in the population field a great opportunity to reflect on the imminent challenges that will shape the contents, forms and structures of population programmes during this decade and into the next millennium.

The challenge now is how to go from the ICPD Programme of Action to its practical realization in the field.

It is our belief that the field-level managers, the "front line" translators and implementors of the programmes, need to be enabled and empowered for ICPD-envisaged, better and improved programme effectiveness and service delivery.

The concept for this new series of **Population Manager** by ICOMP is based on the above belief. The underlying premise is to learn from the ideas, approaches and practices of programmes that have achieved results and some measure of success. Each volume will identify and group a few of these experiences together under specific themes and present them in a way that is useful and practical to the field-level programme managers, the target audience of the **Population Manager**.

We as population programme managers and professionals want to be able to learn from each other. Therefore, I wish to thank UNFPA for providing support to this publication and hope that the readers of **Population Manager**, especially the field-level managers, will find it a useful vehicle for continuing learning and experience sharing.

Haryono Suyono, PhD
Minister of State for Population/Chairman
National Family Planning
Coordinating Board, Indonesia

PREFACE

The underlying premise of ICOMP's journal *Population Manager* is to learn from the ideas, approaches and practices of programmes that have achieved results and some measure of success. Our interest and concern are to identify and group some of these experiences together under specific themes and present them in a way that is useful and practical to field-level programme managers, the target audience of *Population Manager*.

ICOMP has revitalised an earlier series of *Population Manager* which was discontinued in 1991, but has re-focused it towards field-level population programme managers with a different purpose and format.

It is the field-level managers at the grassroots who implement population programmes and make a difference in people's lives. *Population Manager* will endeavour to bring ideas, experiences, approaches and practices from around the world to provide stimulation and learning to programme managers. Ultimately, new learning will enable them to perform their tasks well and even improve their performance. The journal will attempt to distill lessons where it can, spark debate when necessary, and raise questions and issues which managers confront in their daily activities. Experience sharing and information dissemination are important mechanisms in our continuing quest for improvement.

Population Manager has a thematic focus in each volume. For this fifth volume, the theme is *Improving Quality of Care*. The case studies and programme examples are from a number of countries. The case studies from India, Sri Lanka and Vietnam are the result of a UNFPA-supported action research project executed by ICOMP in collaboration with local institutions and government agencies that formed a quality improvement team in each country.

We are greatly indebted to UNFPA - both to the main office in New York providing financial support for the project activities and to each country office for its co-operation. The project would not have been possible without the hard work and commitment of the QI teams and other officials in each country. More specifically, we would like to thank the following institutions and agencies for their very important contribution to both the project. In India, Administrative Staff College of India, Indian Institute of Health and Family Welfare, Department of Health and Family Welfare, Academy for Nursing Studies, and the AIDS Control Programme (all in Andhra Pradesh) and Department of Health and Family Welfare, New Dehli; In Sri Lanka: Family Health Bureau, the STD/HIV Control Programme and the Cancer Programme (Colombo), and the MOH in both Eheliyagoda and Kuruwita; In Vietnam: the Centre for Population Studies and Information of the National Committee for Population and Family Planning (NCPFP) and the Ha Nam provincial and Duy Tien district population and health officials.

In addition, we would like to thank programme staff members in the project areas for their partnership in implementing the project. We also acknowledge the active involvement of people and community organisations – both existing and new ones - in the respective communities. Without their significant contribution, it would have been a very different and less successful project.

We are also grateful to the authors of the case studies which formed the basis for the programme examples provided in chapter 6 of this issue of the *Population Manager*. These case studies are drawn from different sources. The Kenya example has been documented with the support from the OPEC Fund. Other case studies were previously published in their entirety in *Innovations* Volume 1 or in ICOMP's latest international seminar report. The ARCH case study was developed for one of ICOMP's training manuals with UNFPA support. The case study on the Malaysian experience of TQM was written for a seminar on "Implementing Population Programmes: Quality of Reproductive Health Care as the Way Forward" held in Kuching, Sarawak, Malaysia in December 1995 and sponsored by the Economic Development Institute of the World Bank. All the case studies are available in full with ICOMP.

No particular preference is given in the order the case studies and programme examples are presented in this volume.

We are thankful to UNFPA for providing the support to publish *Population Manager* and also to Susan Tan, Aun Tin Lim, John Yap, Melinda Wong, Josephine Chong and Phang Choon Mee for assisting in publishing this issue.

Maj-Britt Dohlie
Jay Satia

Kuala Lumpur, November 1997

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante-natal Care
ANM	Auxiliary Nurse Midwife
ANS	Academy for Nursing Studies
ARCH	Action Research in Community Health and Development
ARI	Acute Respiratory Infection
ASCI	Administrative Staff College of India
AVSC	Association for Voluntary and Safe Contraception
CBD	Community-Based Distribution or Distributor
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
COPE	Client-Oriented, Provider-Efficient
CPR	Contraceptive Prevalence Rate
CPSI	Centre for Population Studies and Information
CQI	Continuous Quality Improvement
DHS	Demographic Health Survey
DOH	Department of Health
EC	Eligible Couples
EDI	Economic Development Institute
FGD	Focus Group Discussion
FHB	Family Health Bureau
FP	Family Planning
GOI	Government of India
GOK	Government of Kenya
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
IIHFW	Indian Institute of Health and Family Welfare
ICOMP	International Council on Management of Population Programmes
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
ICPFP	Inter-Commune Population and FP Centre
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device

MCH	Maternal Child Health
MOH	Ministry of Health, Medical Officer of Health
MR	Menstrual Regulation
MTP	Medical Termination of Pregnancy
MWRA	Married Women of Reproductive Age
NCPD	National Council for Population and Development
NCPFP	National Committee for Population and Family Planning
NGO	Non-Governmental Organization
OC	Oral Contraceptives
OPEC	The Opec Fund for International Development (Organization of Petroleum Exporting Countries)
ORT	Oral Rehydration Therapy (also ORS)
PCPFP	Provincial Committee on Population and Family Planning
PFA	Patient Flow Analysis
PHC	Primary Health Care
PHI	Public Health Inspector
PHM	Public Health Midwife
PHN	Public Health Nursing Sister
POA	Programme of Action
PNC	Post-Natal Care
QA	Quality Assurance
QCC	Quality Control Circle
QI	Quality Improvement
QOC	Quality of Care
RH	Reproductive Health
RTI	Reproductive Tract Infection
SDP	Service Delivery Point
SPHM	Supervisory Public Health Midwife
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TQM	Total Quality Management
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
WHC	Women's Health Committee
WHO	World Health Organization
WWC	Well Woman Clinic

1

Introduction

The International Conference on Population and Development Programme of Action[1] (ICPD-POA) set the agenda for family planning (FP) and population programmes to broaden their approach to meet clients' needs for comprehensive reproductive health (RH) care services. The POA states that FP programmes "must make significant efforts to improve quality of care"[2].

The *importance* of quality has received much attention in the 1990s and is no longer controversial. Although many programmes have committed themselves to improve quality, actual progress appears uneven.

After concentrating on coverage many FP programmes have concluded that they should focus on reducing unmet needs for contraception. This requires that the quality of the services they provide must be improved. It is argued that quality improvement (QI) will lead not only to meeting clients' needs so that they are able to achieve their reproductive goals but also to better health status overall. Finally, programmes adopt QI to achieve better use of resources. This last point is important in an era when programme managers must confront the fact that they are asked to provide more comprehensive services to current clients and to groups that previously were not considered clients. At the same time, they must also be prepared to meet the needs of an unprecedented number of young people about to enter their reproductive years.

While many FP programmes may have reached relatively high levels of coverage, this generally does not apply to other components of RH care services. The challenge in this area will be to provide *access to quality services*. Hence quality must be built into the services rather than come as an afterthought.

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[1] The conference took place in Cairo in September 1994.
[2] Chapter 7, paragraph 23.

WHAT IS QUALITY?

Quality is not an elusive and intangible concept but something that may be measured and quantified. However, there are multiple perspectives on what constitutes quality of care (QOC).

Above all, quality implies that the services must *meet customers' needs, add value, and perhaps even surpass their expectations*. Clients do not always have the same level of expectations, but often highlight similar issues related to the dimensions of QOC, for example, reliability and safety of contraceptive use, easy access to services, staff friendliness, cleanliness, good information, reliable supplies, and so on.

There is the concept of *customer value*. When a client receives medical services (or uses a product), there are both costs and benefits involved. Costs other than monetary ones must be considered. For example, visiting an STD clinic may cause embarrassment; the client may experience side effects related to the use of contraception; she may perceive a loss of control when using institutional delivery as opposed to a traditional birth attendant (TBA); or, there may be opposition of in-laws, husband or other family to the use of contraception. The perceived benefits of using the services must outweigh the costs to the client.

During the current period of transition from MCH/FP to comprehensive RH programmes, there is considerable need to educate clients on reproductive health; what their needs are; what constitutes good medical practices; and even what their expectations of the program should be.

Service providers usually have their own perspectives on quality. Often they may not be the same as the customers' perspectives. They tend to emphasise technical aspects and infrastructure while sometimes de-emphasising other dimensions of quality. On the other hand, a client-based definition of quality in RH programmes poses some difficulties. For example, users may not be able to assess the technical quality of the services.

Programmes may define quality as "conformance to specifications" (Crosby, 1982). Programme managers determine the level of quality of care to be provided and establish standards of care. Clinical and other standards, guidelines and protocols are developed. The QOC is assessed by comparing actual practices with the standards. Shortfalls are communicated to managers. Based on such assessments, managers at all levels take the steps necessary to improve the QOC.

Quality can be assessed in the process of service delivery, a programme's capability to provide services at a desired level, and its impact on clients' health. Both the information provided to clients and the actual technical services provided must be based on up-to-date scientific knowledge and technology to ensure an adequate level of quality.

Taking only the perspectives of the programme and service providers into consideration does not ensure quality because the services - even if the technical quality is excellent and the information correct - may be unacceptable to clients. The degree of match between the client's view of the performance of the services and the service provider's view determines client satisfaction (Ishikawa, 1985).

Moreover, RH programmes must consider the needs of society overall. In his *Seven Pillars of Quality* Donabedian (1990) includes the following: efficacy, effectiveness, efficiency, optimality, acceptability, *legitimacy* and *equity* (italics added). Very difficult issues such as concern for the individual versus responsibility to all, equitable access to care, and so on, are addressed in this framework. Such issues are clearly beyond the scope of this chapter, but must be seriously considered by health programmes. Human and reproductive rights as outlined in the ICPD-POA and other international charters represent a guide for programmes in doing so.

Programme managers may combine the multiple perspectives to establish or define the level of QOC in their programmes:

- identify through user surveys and qualitative research the dimensions of quality for different services most valued by the users and assess their level of expectations
- examine these through technical assessment and add dimensions which users may have neglected
- measure the current level of the dimensions provided by the service delivery system and establish standards

This process has to be repeated periodically as clients' expectations undergo change, the previous standards have been achieved and higher standards are desired, or new knowledge makes it imperative to change the standards.

As a guide to developing client sensitive services and measuring their success in doing so, programmes may use existing QOC frameworks and client's charters, but

programmes must ensure that clients participate in the process as opposed to thei making assumptions about the wants and needs of the clients.

QUALITY OF CARE FRAMEWORKS

QOC frameworks reflect the *aspects of services that clients experience as critical* (Bruce 1990). In the family planning field, the six elements of QOC proposed by Bruce ar widely accepted[3].

Choice of method refers to the range of contraceptive methods available in the programme. *Information* given to clients should include, among others, method characteristics, how appropriate the method is for specific users, details on how to use it, potential side effects and actions required to deal with side effects. Service providers need an adequate level of *technical competence* to provide safe services and they need skills to ensure satisfactory *interpersonal relations* and interactions with clients who must be treated with dignity and compassion. The programme also needs to ensure that there is *continuity* of care and that *follow-up* is provided. An *appropriate constellation of services* would vary from setting to setting but generally includes convenient and acceptable complementary health care services to FP users.

In this framework, the QOC provided to clients is viewed as the output of the programme effort, e.g., policy and political support, resources allocated, and programme management and structure. Higher levels of client satisfaction, knowledge and contraceptive use (acceptance and continuation) as well as better health are among the expected results or impacts of improving the QOC.

Another widely used framework is that developed by the International Planned Parenthood Federation (IPPF). It suggests that each FP client has the right to information, access, choice, safety, privacy, confidentiality, dignity, comfort, continuity, and an opinion on the services provided. It also states that service providers have needs that must be met to enable them to provide quality services with confidence while ensuring the rights of clients.[4]

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[3] According to Bruce, these six aspects are the following: choice of method; information given to clients; technical competence; interpersonal relations; follow-up/continuity mechanism; and appropriate constellation of services.

[4] According to IPPF these needs are the following: training, information, supplies, guidance, back-up, respect, encouragement, feedback, self expression, and infrastructure (Huezo and Diaz, 1992).

It has been suggested that the level of QOC provided by a programme is determined by the interface among users, the service delivery system and technology in a given socio-economic context (Simmons et al, 1997).

The ICPD-POA defines QOC and emphasises, among others, the following aspects:

- Recognition that clients have different contraceptive needs throughout their life cycle and depending on the individual situation. Access to and information on a wide range of methods is necessary to meet clients' needs and ensure informed consent. Hence information on the benefits and risks of the different methods, their possible side effects and effectiveness in preventing STD/HIV must be provided to clients.

- Services must be made safer, affordable, more convenient and accessible. Strengthened logistical systems must ensure sufficient and continuous supplies. Privacy and confidentiality must be safeguarded.

- Appropriate follow-up must be ensured including treatment for contraceptive side effects.

- Availability of related RH services must be ensured on-site or through effective referral.

- Qualitative as well as quantitative performance measures must be emphasised. The perspectives of both current and potential users must be sought through effective management systems and other survey techniques in order to evaluate services in a timely fashion.

- FP/RH programmes must emphasise breastfeeding education and support services which will simultaneously contribute to birth spacing, better maternal and child health as well as higher rates of child survival.

Emerging Framework for Quality of Care in Reproductive Health

QOC frameworks shift the attention to the client/service provider interaction or the process of care giving (Donabedian (1966, 1988; Bruce 1990). As programmes broaden their range of RH services offered, QOC frameworks need to evolve for several reasons:

- RH care involves both preventive and curative care as compared to mostly preventive care in FP programmes

- Referral plays an increasingly important role in RH care services

- Many social factors influence reproductive health. Therefore, gender issues and social aspects require attention

- Finally, there is the question of affordability. Most governments provide free FP services. It is not clear whether they will be able to provide comprehensive RH care services free of charge.

An analysis of the experiences of NGOs[5] that emphasise QOC and provide a more comprehensive range of RH care services leads to a discussion of the dimensions of QOC presented below.

An Emerging Reproductive Health Framework: Quality Dimensions

Service delivery attributes
- access to and availability of a wide range of RH care services
- effective referral linkages
- follow-up and continuity of care
- range and choice of contraceptive methods

Information
- comprehensive sexuality and RH education
- in-depth information on the service provided

Technical aspects
- technical skills of service providers
- infection prevention
- sound and appropriate medical practices

[5] ICOMP has documented the following experiences with the support of the Ford Foundation: Women's Health Care Foundation (WHCF), Philippines; Rural Women Social Education Centre (RUWSEC), India; Society for Education and Research in Community Health (SEARCH), India; and Bina Insani, Indonesia. With UNFPA support, a case study and video were developed on ARCH (Action Research in Community Health and Development), India.

Interpersonal aspects

- caring
- dignity, privacy and confidentiality
- individual acceptability
- appropriate counselling; listening

Social context

- social acceptability
- gender sensitivity
- empowerment of women
- male participation and responsible sexual behaviour

Economic dimension

- affordability

QUALITY TRANSFORMATION: APPROACHES TO IMPROVE QUALITY

Management theories and practices to improve quality often have different names and to some extent even different definitions, but they share the same intellectual roots and have many commonalties in their prescriptions for action. The use of a common term such as *quality transformation* has been suggested for the emerging paradigm (Kolarik, 1995). According to current thinking in management literature, client satisfaction and efficiency happen automatically when organisations focus on improvement in processes and systems to improve quality.

During this transformation, the approaches to quality improvement shift from being reactive to *proactive*. Rather than only inspecting and controlling, organisations build quality into the design of their services or products and into their work processes and systems. Through *strategic quality management* there is mobilisation of staff at all levels of the organisation to be responsible for quality and ensure its implementation instead of reliance on a quality department or programme (Garvin, 1988).

Quality improvement is a long-term process that requires commitment of both *time and resources*. Commitment to quality at the highest levels of the organisation is usually considered a prerequisite for quality to improve. Subsequently, the entire staff needs to "buy into" the concept. As suggested above, implementation of QI implies change in the organisation's structure and management systems to shift the focus to (internal and external) clients and to the work processes that enable staff members to

perform their tasks correctly and well and to solve problems. For many organisations, the initial outlays to improve quality pay for themselves - and more - because QI leads to more efficient use of resources and reduced waste.

There are different approaches to diagnose quality-related problems and to improve quality:

1. *Quality assurance approach* (QA). Organisations using this approach establish standards for structure, process and outcome. Actual results are compared to the standards. Outliers are investigated to find the causes of the deviations. The reasons for lack of compliance with standards may be common to all service delivery points (systemic cause) or unique to a specific service unit (special cause). The remedial actions required may differ accordingly.

2. *Systems improvement approach.* The tools for situation analysis were developed by the Population Council and are commonly used in the population field. However, any set of tools appropriate to the programme could be used. The assessment can be done by qualified researchers or as a rapid appraisal by managers. Once the weaknesses are identified, the programme would begin to improve systems.

3. *Teams and continuous quality improvement approaches.* Traditional QA approaches tend to be top-down and often ignore human factors. Such approaches may not be sufficiently proactive or lead to continuous improvement. Therefore, organisations have begun to involve staff in the problemsolving process. Quality control circles (QCC) and Malaysia's QI teams are examples of this approach. The COPE[6] approach should also be mentioned. This is a relatively simple and low-cost local problem-solving approach. However, in the absence of a stated programme-wide commitment to and policy of QI, a fair number of problems may remain unresolved.

4. *Total Quality Management* (TQM) is a relatively recent approach in FP and population programmes to create a *quality transformation.* When Malaysia adopted its "Q" programme[7] in 1989, it built on the approaches it had used previously and incorporated them. For example, the MOH had introduced a QA programme in 1985 with the stated purpose of improving health care and resource utilization as well as enhancing customer satisfaction (Satia and Dohlie, 1995). In the early 1990s, the government adopted "Corporate Culture" to encourage increased focus on clients and to develop its human resources. These steps reflected the gradual shift from inspection

[6] AVSC International developed COPE (Client-Oriented, Provider-Efficient).
[7] The "Q" Programme is another name for TQM.

and control to strategic quality management and to an organisational culture more conducive to customer satisfaction.

While incremental change may be the realistic option for FP/RH programmes, it can be argued that, from the very beginning, they should take a proactive stance to ensure that quality is built into the services they plan to provide, into the processes required to provide them and the systems needed to support them.

COSTS AND BENEFITS OF QI[8]

As suggested above, QI is expected to have a considerable impact on efficiency, client satisfaction, and utilisation rates. Yet, little is known about the economic costs involved, the rate of return on such investments, or the extent to which QI can be self-financing. These are important issues because advocacy for incremental QI almost always carries a price tag. Strategies to minimise costs and maximise benefits can help policy makers achieve greater "value for money" in a world of severe resource constraints. It should be noted that economic measurement has been hampered because of the confusion over the meaning and definition of quality itself and the techniques for measuring quality on a continuous basis.

The experience is that cost recovery and user fees must be accompanied by QI to avoid a significant drop in utilisation rates in the programme. The interdependence of QI and increased revenues is illustrated in Figure 1.

Benefits of Quality

Quality should be designed into the programme and services. The three components of quality design - structural requirements, process and procedures, and technical inputs - may be self-financing. For example, clients often complain of structural shortcomings such as irregular supplies and poorly maintained clinics. Experience shows that they are willing to pay for improvements in these areas. Such improvements often lead to increased demand.

Improvements in process and procedures imply attention to managerial and administrative issues. They reduce waste and inefficiencies and increase effectiveness in terms of discouraging, for example, contraceptive discontinuation. Research shows that there is considerable scope for cost-savings in this area.

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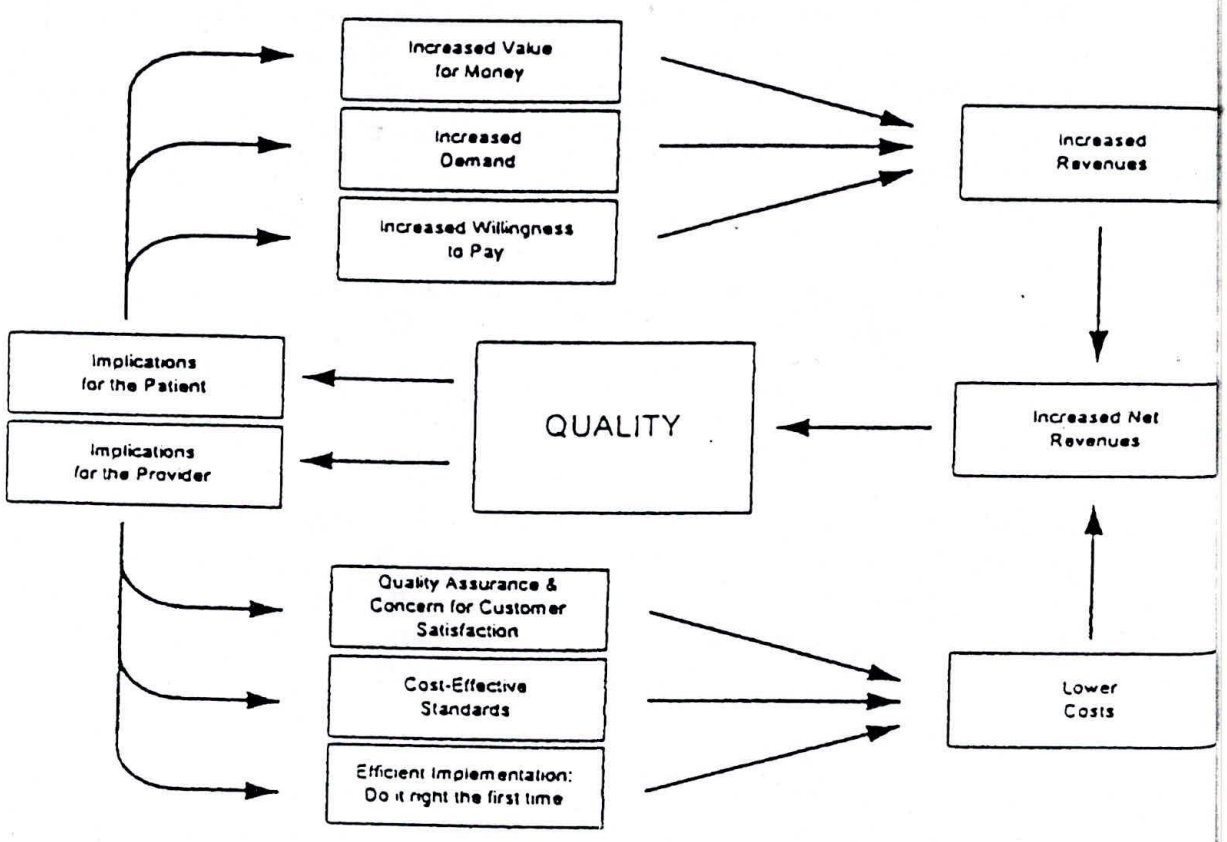
[8] ICOMP gratefully acknowledges the contribution of RP Shaw's paper to the discussion of costs and benefits.

Similarly, technical inputs can be self-financing. For example, as clients' expectations rise and their knowledge increases, they may be willing to pay (more) for new and improved technologies rather than settle for mediocre or inferior treatments. More and better alternatives generally attract more clients, contribute to continuous use, and encourage clients to stay with their service provider rather than switch to one that is perceived to be better.

Figure 1: Flowchart of Cost Recovery and Quality



Source: Adapted from HHRAA

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Costs of Low Quality

Low quality carries many costs both for the clients, service providers and programme. Some of the costs are reviewed briefly below:

- *Poor quality lower-level curative and preventive services are costly.* When clients by-pass lower level health care facilities in the referral system and seek care at higher levels, there are considerable economic costs and consequences for the efficacy of the health care system. Relatively simple services tend to be much more costly when provided at higher levels. For clients, obtaining services at higher levels often imply higher fees and opportunity costs of time to travel further, and so on.

- *Poor quality commodities and technologies may lead to adverse health outcomes for clients and damage the reputation of service providers / programmes.* For example, in China the use of a less effective and cheaper IUD as opposed to a more expensive and effective one saves the programme money at the time of insertion. Yet, the higher failure rate, the abortions resulting from contraceptive failure, and the lower continuation rate among women who use the less expensive and effective IUD result in higher programme costs. Moreover, there are economic and health costs for the women.

- *Poor quality staff and training can result in misdiagnosis and medical complications.* Interventions to remedy the complications and additional care are costly for the health care system. Both the programme and service providers may gain a bad reputation and clients may avoid seeking care. For clients, complications may have a considerable impact on their health and even lead to death. Clients may also face great economic costs.

- *Poor quality information, communication, education and outreach contribute to less knowledgeable clients, non-use and discontinuation of services and commodities.* In addition to less demand for services, incorrect use and non-compliance with treatment protocols may lead to inefficiency, waste, and complications for the clients.

Considering the benefits and costs discussed above, there are good reasons to believe that incremental improvements in the quality of RH care services can often be self-financing, and that failure to undertake quality improvements can result in serious losses due to errors, waste, and delays. It is also apparent that higher quality need not always cost money or, conversely, that reduced levels of funding need not necessarily be accompanied by lower levels of quality.

ISSUES RELATED TO QUALITY IMPROVEMENT

The QOC project and programme experiences described in this issue of *Population Manager* raise many issues that need to be addressed when programmes initiate quality improvement:

1. *Indicators of quality.* Both public and private sector programmes continue to use quantitative indicators as opposed to a desired mix of both qualitative and quantitative indicators to measure performance. Indicators may be described as the *driving force* behind programmes (Satia and Subramanian, 1996). They are measurable units derived from, among others, the various dimensions of quality. Appropriate indicators are selected for the process of care as well as for structure, output and outcome. In this context, it must be emphasised that the search for *qualitative* indicators for reproductive health is on-going as is the search for appropriate methodologies to measure quality.

2. *Learning from the private sector.* There is a need for FP and population managers in the developing countries to learn from the private sector, to reduce bureaucracy, and to motivate and involve people to perform well by removing barriers rather than giving incentives. It is also important to consider the use of non-monetary incentives in the motivation of staff.

3. *Resources.* Not all actions to improve quality require funds. It does not cost more to run a good training session than an inadequate one. However, it will take resources to improve current training programmes. Resources will be required to introduce new services, but it may not cost significantly more to provide quality services than inferior ones. Cost recovery is also an option to explore.

4. *Different perspectives on quality.* Programmes must take into account client and community perspectives on quality as opposed to its own and those of service providers which frequently prevail. There could well be divergent views on QOC among clients and service providers/programme.

5. *Community involvement.* The community must be in accord with the objectives of the programme all along the way in order to ensure convergence of client/community and service providers/programme perspectives on quality and to ensure use of the services provided.

6. *Securing commitment to QOC.* It is important to secure commitment to QOC among NGOs. This may be done by forming alliances and through other mechanisms.

7. *QOC must be part of the design of the services provided.* As new services are added, QOC must be designed into the services. This is important because inadequate quality leads to bad work habits. When providers accept low quality and clients have low expectations, it is very difficult to improve quality.

8. *Managerial practices must change.* Although much has been written on QI in FP programmes, it may not be sufficiently appreciated that most managerial practices need to be reoriented. With the shift from demographic achievements to enabling people to meet their reproductive intentions through quality RH care services there has been a realisation that current managerial practices are inadequate.

2

Background of Action Research

Despite growing recognition of the need for quality improvement, the level of action taken by government FP and population programmes remains uneven. There are many reasons. Programme managers often feel that the benefits of improving quality may not outweigh the costs; there is no clear roadmap to improve quality in large programmes; and quality improvement is difficult because it requires dealing with people and processes.

On this background, an action research project was implemented from 1995 to 1997 with funding from UNFPA at one site each in India, Sri Lanka and Vietnam to explore moderate cost approaches to improve the QOC. The programmes in the three countries are at different stages of maturity. The contraceptive prevalence rate in Sri Lanka is high. Although the Indian programme is the oldest, many questions remain as far as the level of quality of care is concerned. The contraceptive prevalence rate in Vietnam is relatively high but this is largely due to the use of one method - the IUD.

ICOMP executed the project with local partners in each country where they formed a QI team.[1] The objectives were the following:

1. Assist the participating programmes in developing measures of quality through understanding client perspectives and technical considerations, and in assessing current levels of quality through self-assessment.

2. Provide knowledge and skills to participants on how to improve the quality of care.

3. Formulate action plans to translate the acquired knowledge and skills based on diagnostic studies to improve quality.

[1] India: Hyderabad: Administrative Staff College of India (ASCI), Department of Family Welfare, Indian Institute of Health and Family Welfare (IIHFW), and Academy for Nursing Studies (ANS); New Delhi: Department of Family Welfare.
Sri Lanka: Family Health Bureau (FHB).
Vietnam: Center for Population Studies and Information/National Committee for Population and Family Planning (CPSI/NCPFP).

4. Provide financial support and technical assistance in implementing the action plans in areas with a population of around 100,000.
5. Disseminate more widely the learning from the implementation of the action plans and encourage participants to act as catalysts for institutionalising programme-wide quality improvement.

SELECTION OF PROGRAMMES AND SITES

Government service delivery points (SDP) were selected to participate in the project. It was understood that the teams would need to stay in continuous touch with the project areas, so relative proximity was considered important.

In India, Shamirpet Primary Health Center (PHC) in Ranga Reddy district in Andhra Pradesh was selected. The PHC provides services to a population of about 50-60,000 clients in 33 villages served by nine sub-centres. The whole area is considered backward compared to the coastal part of the state, which is also reflected in the quality of the health services provided.

In some ways, proximity to a big city (Hyderabad) may affect the health care services negatively in as much as staff members tend to live in the city and commute to their place of work. Given that transportation is difficult, this translates into less time available to the health care workers (HCW) for actual service provision.

In Sri Lanka, Eheliyagoda and Kuruwita in Ratnapura district were selected. The two areas combined have a population of more than 170,000. Again, relative proximity to the team was important. At the inception of the project, the services provided in the area were considered to be in need of improvement. The economy is based mainly on agriculture, but many are involved in the gem industry that is unique to the district. As there were many staff changes in Kuruwita, the activities were delayed. Therefore, we describe the quality improvement experiences in Eheliyagoda only.

In Vietnam, Duy Tien district in Ha Nam province with a population slightly over 135,000 was selected to participate in the project. The area is located about 50 km from Hanoi. The majority of the population is involved in agriculture. Although the area had previously received some financial support from international agencies, it was considered to be in need of quality improvement.

APPROACHES, ISSUES AND METHODOLOGY

At the beginning of the project, the QI teams and the programmes needed to enhance their *understanding* of quality although there was much *commitment* to quality improvement. The team in India wished to improve the quality of MCH/FP services whereas the Vietnamese team concentrated on family planning services. Sri Lanka's team expressed a wish to improve more than just FP services given the comprehensive nature of its program. Also, because of the Cairo-agenda, it was considered important to go beyond the traditional FP/MCH approach to the extent possible over two years.

Priority was given to review how existing services were provided and to make them more client-centered. The dimensions of QOC were to be the driving force. A second priority was to broaden the concept of "client" beyond married women of reproductive age and to introduce other reproductive health services, for example, primary STD/HIV prevention.

After a review of existing instruments available from several sources, ICOMP developed tools for the rapid and baseline assessments. Each team adapted the tools to the local context. In addition to assessing the current situation, carrying out the assessment was considered a learning process for the teams to prepare them for actual implementation. Moreover, the instruments were considered a suggested standard in some reproductive health areas where no standards had yet been set.

This was a project *for and by* managers. The teams would assess their own programmes, carry out interventions, and then evaluate the results themselves. From the beginning, a "new" approach to management was encouraged to involve staff in problemsolving and to set in motion a continuous quality improvement (CQI) process. The QOC project made a concerted effort to take a proactive approach to quality improvement rather than a traditional quality assurance (QA) approach.

As suggested above, clients' needs and perceptions of quality were to guide managers and staff in the QI process. In addition, the perspectives of managers/ programme, service providers and staff were considered important to shed valuable light on many issues.

Rapid Assessment and QOC Workshop for the Teams

After doing a rapid assessment in their respective countries, the three teams met in Kuala Lumpur, Malaysia, for an "immersion" in issues related to quality: QOC

frameworks and discussion on the various dimensions of quality; comprehensiv reproductive health; gender; indicators and assessment methodologies; QI approache including examples of programmes which have already adopted QI; management tools and visits to two different clinics (one NGO and one government SDP).[2] Based on th results from the rapid assessment, each team developed a tentative plan of action Finally, the instruments developed by ICOMP for the baseline research were discusse and modified. Each team subsequently adapted them to the respective country' settings.

Baseline Results

The baseline results in all three countries indicated shortcomings - to varying degrees - in all dimensions of QOC: insufficient, and sometimes incorrect, information giving; limited choice of contraceptive methods; inadequate technical skills and infection prevention; insufficient attention to privacy and sometimes other problems during the client/provider interaction; inadequate follow-up; inadequate availability of and access to comprehensive RH care services, sometimes also to contraceptive services; referral systems which were not functioning as they should; neglect of groups other than married women of reproductive age, and so on.

Data were collected through interviews with female clients (contraceptive users and non-users); men in the community; service providers; managers; and private medical doctors (PMD). There were also group discussions, observations of service provision of facilities using checklists. Using different methodologies allowed the teams to see issues from different perspectives.

Although courtesy bias and low expectations are very real issues, clients are definitely concerned about quality. As one team member stated:

> *"During the QOC project I came to realise that people are more concerned about quality than we providers tend to think. They may not voice their demand so often because they have few alternatives."*

The small group discussions added depth to many issues and the teams appeared to find them an effective tool both to obtain and impart information. One team member stated the following: *"After a while they (clients) forget themselves and are very open."*

[2] Selangor and Federal Territory Family Planning Association, and National Population & Family Development Board (LPPKN), Malaysia.

Building trust appears to be a very important aspect in the Asian context. As the community got to know and trust the teams, people became increasingly willing to talk. Therefore, as the project proceeded, people provided additional feedback and the teams continued to learn from and about the community.

The Plan of Action and Action Research Assumptions

Each country team agreed that its first intervention would be to sensitise staff to the importance of quality of care through training. Beyond awareness raising, training of staff was on the agenda to improve different types of technical skills and infection prevention as well as information giving and counseling skills. In addition, staff required new knowledge and skills to be able to address reproductive health issues beyond FP/MCH. Effective supervision conducive to quality was also considered important. This included creating a supportive environment to reinforce new behaviours and skills after the training.

Quality improvement requires a combination of "soft" and "hard" inputs. Therefore, the interventions included procurement of needed inputs such as supplies and new equipment as well as repairs and overall improvement of the structure. It is very easy to become too preoccupied with structural inputs - maybe because they are relatively easier to deal with than "people issues." *People are, however, the key to quality improvement.* Improved infrastructure, new equipment and adequate supplies are not likely to improve quality significantly unless the way staff think and act also changes. This is particularly true when staff morale and performance are low. The project, therefore, focused particularly on the development of human resources. Finally, community outreach was envisaged to reach groups not normally covered by the FP/MCH programme - men, youth, and women not generally seeking care (from the programme) - to address STD/HIV prevention and other issues related to RH.

It should be emphasised that, although the problems faced by each programme generally were the same, they often varied in severity. Therefore, the interventions required careful adaptation to the local context.

The action research project worked on the assumption that all the dimensions of quality are important and contribute to client satisfaction. There was no attempt to ascertain, for example, if the interventions to provide more effective choice of method were relatively more or less important than improving the information provided, convenience to clients, easier access, and so on. In actual service delivery, the quality dimensions and the interventions to improve quality are closely interdependent, frequently reinforcing each other.

Access to Quality Services

The three teams reported that access and availability are considerable problems - at some sites more so than at others. Discussions of access and availability versus quality are potentially very divisive but need to be addressed when quality is to be improved. The causes underlying deficiencies in these areas are often the result of faulty *processes* and *systems*. As discussed, both require serious attention when programmes initiate QI. QI implies using available resources more efficiently and that in itself may improve access and availability. The important point is that other QOC issues cannot and *should not wait until access is assured.*

Improving access does not always mean building new sites, providing new equipment, or employing additional staff. Although these actions might be desirable, the QOC project sought to reorganise work processes and undertake community outreach to increase access and availability. Systemic weaknesses became evident. The programmes began to examine both strengths and weaknesses.

Final Evaluation and Continuation of the QI Process

The teams have now completed their final evaluations. Although a separate report is available, each team's experience is presented in this issue of Population Manager from a management perspective for dissemination of learning.

The quality improvement *project* has made the transition to become a *continuing process* in each country. In India, the Andhra Pradesh government has decided to continue to fund some of the activities begun at Shamirpet. Some of the project outputs such as referral cards and protocol, client cards, and supervisory checklists are being reviewed for lessons to be applied to the overall programme. Moreover, UNFPA has shown interest in incorporating the lessons learnt through the action research in the country programmes.

In Sri Lanka, the lessons have been disseminated to selected officials. The initial project training for staff in QOC has already been replicated in other types of FHB training. The counselling component has also been replicated.

In Vietnam quality improvement has been included as one of the important areas of focus, and the National Committee for Population and Family Planning (NCPFP) has asked for a workshop to review in depth all the quality improvement experiences in the country.

3

India

Improving Quality of Care at Shamirpet Primary Health Centre, Andhra Pradesh[1]

BACKGROUND

This case study describes an action research project supported by UNFPA to improve the quality of care at Shamirpet Primary Health Centre (PHC), Andhra Pradesh, India during the period of 1995-97. Shamirpet PHC serves an area of 52,201 inhabitants (1981 census). The site is an upgraded PHC. It has three medical doctors when it is fully staffed. Each of the nine auxiliary nurse-midwives (ANMs) attached to the PHC is responsible for one sub-centre and also provides services to three or more villages with a total population of 5,000 and up. There are altogether 33 villages. The area has three male health care workers (HCWs) who have traditionally played a marginal role in the FP/MCH program.

A local QI team was formed comprising managers who were trained in a regional training program to sensitise and prepare them to undertake quality improvement. The team consisted of central and state level officials, two ASCI representatives, and a member from the Indian Institute of Health and Family Welfare (AP). Local institutions provided technical assistance with technical backstopping by ICOMP.

A rapid assessment of the level of quality provided was done in May 1995. A larger baseline survey followed in July/August 1995. The action plan prepared by the

[1]Contributed by: GNV Ramana, R Devi, M Prakasamma, S Ramidamy, MB Dohlie and J Satia. Other staff at ASCI, IIHFW and ANS also contributed. The project is indebted to R Chatterjee and I Pal for their help and support during the programme implementation.

team was implemented from September 1995 to February 1997. Interventions were evaluated in March 1997 and a dissemination workshop was held in April 1997.

The project not only demonstrated that quality of care can be improved even in somewhat constrained public sector health settings, but also identified and tested moderate cost interventions that were needed to improve quality. In the process, it enhanced the commitment of programme managers to improving quality and the national capacity to continue quality improvement.

BASELINE ASSESSMENT OF QOC

Shamirpet PHC has about 8,873 eligible couples (EC).[2] For the baseline survey, about five percent of the couples were interviewed from all the villages using population proportionate distribution. About half of the women interviewed were contraceptive users (220) and the rest non-users (244). In addition, a small number of men with spouses of reproductive age and service providers were interviewed. Antenatal care (ANC), immunization sessions, counselling and medical examinations during the first FP visit, and tubectomies were observed. In addition, there were group discussions with clients and service providers. Finally, the facilities were reviewed using checklists.

Level of Satisfaction among Clients

Clients were asked whether they were satisfied with the services provided by the programme. About 57 and 21 percent of users and non-users respectively stated that they were satisfied while the percentage of dissatisfied clients was 22 and 6 percent respectively for users and non-users. When interpreting this data, it is important to consider issues related to methodology such as courtesy bias and also the generally low level of expectations people may have of the services provided by the programme.

Another important element in rural India is *trust*. People may be relatively unwilling to speak to outsiders, or strangers, until they feel they can be trusted. This may be the reason why as many as 21 and 73 percent of users and non-users respectively responded that "they could not say" whether or not they were satisfied. Subsequent contact with the community also indicated that a large number of non-users saying so may not have been aware of the services provided by the ANM.

[2] Based on an estimate of 170 ECs per 1,000 population.

Both users and non-users were asked what they did and did not like about the services and what their suggestions were for improving them. It should be noted that, when asked, only 68 of the 220 users and 20 of the 245 non-users mentioned an aspect that they particularly liked. About the same number expressed reasons why they did not like the services. Generally, the respondents liked the monetary incentives given for sterilisation acceptors. They stated that their interactions with the service providers were good. They appreciated services being provided close to home and free of charge. Non-users mentioned the following positive service aspects: good interaction with the providers, and services provided close to home and free of charge.

Generally, the major reasons given for not liking the services were as follows: poor facilities at the PHC; lack of cleanliness, electricity and water; poor health after undergoing tubectomy; no follow-up services, and non-availability of or non-responsive providers at the PHC.

Relatively more clients were willing to make suggestions on how to improve the services rather than to state their likes and dislikes, an indication maybe that making suggestions is easier than criticising (Table 1). As suggested, courtesy bias or lack of trust must be considered. It is interesting to note that relatively more non-users than users gave suggestions for improvement. Shortcomings in many areas may possibly keep them from using the services. The suggestion most frequently made by both users and non-users was to increase the availability of staff at different levels of the system.

Table 1: Suggestions by Respondents for Improving FP Services

Suggestions for improvement	*Number of users*	*Number of non-users*
Availability of health staff: sub-centre, PHC, doctors and specialists.	66	94
Improvement of service delivery: emergency, follow-up, ANC and PNC.	17	-
Supply of good quality drugs and other supplies.	10	37
Proper maintenance of facilities.	10	12
Total respondents.	220	245

Note: Only major suggestions have been tabulated.

According to the baseline research, users appeared to consider the government programme a provider of FP, ANC, and immunisation services rather than of comprehensive RH or primary health care services. While more than 90 percent stated that ANC and immunisation services are available to them through the programme, a considerably smaller percentage mentioned other services, for example, care during childbirth (44); advice on the new-born and breastfeeding (63); referral of high-risk pregnancies and newborns (16); ORT (50); advice and prevention of acute respiratory infections (ARI 12); vitamin A supplements (57); RTIs (4); information on gynaecological problems and cancers (2); and medical termination of pregnancies (MTP, 1 percent).

Group Discussions with Clients

Group discussions confirmed many of the issues raised in the interviews and also added depth. Many seemed to have internalised a contraceptive pattern of bearing two or three children at an early age using no contraception before the first conception takes place. Childbearing is completed at an early age at which time a tubectomy is desired.

Temporary methods are not widely used although most women expressed that they consider a two- to three-year interval between pregnancies desirable; older women preferred four years. This contraceptive pattern may have developed as a result of the promotion of sterilisation in the programme combined with the importance attached to conception soon after a couple gets married.

Women were concerned about the health effects of contraceptive methods. For example, they worried that oral contraceptives (OCs) may cause infertility and cessation of milk production in lactating mothers while excessive bleeding, backache and white discharge were associated with IUD use. IUD use appeared to be considered the more convenient method, however, because one does not have to bother with it every day. Younger women in one village suggested that it would be convenient to have a reversible injectable contraceptive.

People still seemed to remember the forced vasectomies and complications attached to them during the Emergency in the 1970s. They expressed concern about the "loss of stamina and vigour" with this method. Moreover, there are good economic reasons why women prefer a post-delivery tubectomy. At that time, those who perform day-labour face loss of income anyway since they are supposed to rest for a month. A vasectomy, on the other hand, would cause additional loss of the husband's income. As far as tubectomies were concerned, many women worried about complications. Many

expressed that the "big operation" (hysterectomy) would be necessary a few years after a tubectomy. These statements are a cause of concern and require further investigation.

Subsequent interaction with the community provided the team with additional views on sterilisation. For example, both men and women stated that if a wife dies, the husband might want to remarry and have children with the new wife. This is, on the other hand, not a likely prospect for Indian women.

The Views of Service Providers

When the service providers (ANMs) were asked about their satisfaction with the services they provide, four stated that they were satisfied while the other five were not. The reasons for lack of satisfaction were inadequate basic facilities at the sub-centres, inadequate transport facilities, inadequate sterilisation facilities for IUDs, too many records to keep, and lack of drugs for post-natal care (PNC).

It should be noted that transportation presents difficulties for service providers (and that they are supposed to live in their area of work). In an area relatively close to a big city, service providers prefer to live in the city and commute to the service delivery point. This translates into short hours spent there and also in absence from work.

INTERVENTIONS TO IMPROVE QUALITY OF CARE

Interventions took place in many different areas. As indicated, the baseline survey revealed dissatisfaction with facilities and supplies among both clients and HCWs. Therefore, various structural inputs were provided early in the project to create enabling conditions for the workers to perform their tasks well. However, quality improvement is above all dependent on *people*. How HCWs and other staff perform their tasks, what they do, and how they behave are critical factors. Awareness raising and training were by far the more important, time-consuming and complex activities during this project.

Structural Inputs

One PHC, nine sub-centres and 14 clinic rooms in various villages were upgraded. After the PHC had received a thorough clean-up including unclogging of toilets, the beds and furniture in the patient ward were repaired and painted, and the mattresses were recovered. Benches for clients were procured as were lanterns and torchlights. The government ensured 24-hour water supply hook-up and carried out electrical repairs. A room was set aside to ensure privacy during counselling.

Observation during the baseline assessment revealed that blood pressure and weight were generally not checked at the sub-centres because many HCWs lacked either stethoscopes, blood pressure cuffs or both as well as scales (weighing machines). Examination tables, chairs for clients, storage facilities, cleaning aids, kerosene, and benches for waiting clients were frequently also unavailable. These items were procured.

Box 1: *Structural Inputs Provided in Shamirpet Project Area*

Villages (14)

- Clinic rooms and benches for clients.

Sub-centres (9)

- Stethoscopes, blood pressure cuffs and scales.
- Examination tables; tables and chairs for service providers; storage facilities.
- Chairs, benches and mats for clients.
- Curtains for privacy.
- Torchlights.
- Bags for carrying supplies.
- Uristix; disposable delivery kits.

Primary Health Centre (1)

- Hook-up to 24-hour water supply.
- Repair and painting of furniture; electrical repairs.
- Purchase of mattress covers, torchlights and lanterns.
- Benches for waiting clients; set-up of counselling area.
- Drugs for treatment of RTIs and minor ailments.
- Lab supplies for blood grouping and Rh typing; x-ray film.

The drugs for treatment of RTI and minor ailments as well as different types of laboratory supplies were provided by the project. Sterile delivery kits were procured. (They were not available in the area when the project began). The PHC and sub-centres received a small monthly contingency fund of respectively Rs 500 (US$14) and Rs 100 (US$3) in order to meet the need for some recurrent supplies. A partial list of the inputs provided is presented in Box 1.

Development of Human Resources

As suggested above, a minimal package of equipment, supplies and infrastructure is probably required to provide quality services, but it is *not* enough. It is critical to raise and maintain staff awareness of the importance of quality. Therefore, different kinds of training were carried out:

- A QOC workshop for staff was organised not merely to create awareness of quality but also to provide an opportunity for health care staff, programme managers, and the QI team to communicate and formulate an action plan.

- A two-day training in counselling skills.

- A two-week training for Child Survival and Safe Motherhood (CSSM) programme.

- Basic training in using new equipment. The availability of new equipment and the interventions to improve the services necessitated training. For example, the HCWs needed training on how to record blood pressure and weight, how to perform a urine test, and how to use the protocols that were developed.

- The national AIDS Programme provided the HCWs with training on HIV/AIDS and provided them with IEC materials for their outreach efforts.

It was considered critical to continue the training on-the-job. However, it was found that supervisors were not accustomed to provide *on-the-job training*. Moreover, their overall skills and attitudes also required improvement. A nurse from outside the program was hired for this task. She received an orientation on quality and the goals of the project. Subsequently, she spent time with the supervisors and each of the female HCWs to model new work behaviours and skills. A couple of motivational workshops were organised for the entire staff.

Checklists were developed for trainers/supervisors to assist them in their task of improving work processes. Reaching targets for tubectomy acceptors remained a main concern among the HCWs although recognition and prizes were introduced for those who performed well according to the checklists.

As mentioned above, protocols were developed for recording BP and weight, and for referring clients. Similarly, new client registers and cards were introduced. They were developed to be more user-friendly for the HCWs and to provide space to record more ANC visits, the results of urine tests, etc.

Access and Availability of Services

Both clients and staff identified access to and availability of services as major problem areas. Interventions to improve access and availability reflected the complex and diverse causes of the problem.

An early intervention was a request for a bus stop in front of the PHC. Vacant posts were filled in order to avoid the need for HCWs to cover more than their own sub-centre area. Steps were taken to create awareness in the community of its rights and of the availability of HCWs and services. For this purpose, signs indicating the days and hours of operation were displayed at each SDP. Moreover, inadequate supervision and lack of accountability compounded the problem of inadequate access and availability. Some of the interventions are discussed more in depth below.

Community Outreach

Because of the apparent mistrust and lack of knowledge in the community of the reproductive health care services available, education and outreach were considered essential to improve the access to and availability of quality services.

For this purpose, a total of 14 health camps were organised at the PHC - in the sub-centres and in other villages - with approximately 6,000 clients attending. The camps particularly emphasised problems related to reproductive health, but, not surprisingly, clients presented themselves with a variety of health problems reflecting the general unmet need for services. In the organisation of the camps, the QI team stressed qualitative aspects related to process such as health education for clients; use of

IEC materials such as inexpensive models of the reproductive system introduced by the project[3]; appropriate disposal of medical waste, and so on.

Street plays were also used to reach the community and create awareness about reproductive health and the services available. They were organised at night in 28 villages. It was estimated that 6,000 to 7,000 persons attended. The plays presented information on wide variety of reproductive health components including HIV/AIDS and STDs.

These were followed by health talks in the community. The supervisory team along with the female HCWs organized altogether 22 such health talks reaching almost 500 women. Almost half of the women attending admitted to suffering from a gynaecological problem. One third of the women were referred to government hospitals for further care.

The male HCWs were also trained to organise health talks with men in the community.

Community Mobilisation and Involving Men

However, to improve the quality of care, it is necessary to go beyond outreach to *mobilise* the community. This task was undertaken by a local NGO, the Academy for Nursing Studies (ANS). Village and Women's Health Committees (VHC and WHC) were established in 29 of Shamirpet's 33 villages. While the VHCs have both female and male members, they are mostly male reflecting the village power structure. Therefore, the QOC project prioritised the organisation of the WHCs. Considerable efforts were made to keep the WHCs apolitical and working for the common good. The establishment of the first committee took place in March 1996 and the final evaluation only a year after that.

A training curriculum (Box 2) and a participant manual were developed by IIHFW under the project for the training of the WHCs. The actual training or outreach effort itself was initially covered by a government grant. The QOC project subsequently supported these activities and expanded them to involve men to a larger extent. By June 1997, all the WHCs had met twice to share their experiences and to celebrate (each committee consists of approximately 15 women). The activities of the WHCs included, among others, providing health education including FP information to the community;

[3] An idea borrowed from the educational programme developed by ARCH which is discussed in Chapter 6.

being depot holders for pills, condoms and ORS; growing kitchen gardens; assisting community members in receiving health care services and referrals, and so on.

Box 2: Curriculum for the Training of Women's Health Committees

1. *Social Topics* (social status, literacy, child marriage, legal aspects).
2. *Adolescence* (menstruation, sexuality, reproductive physiology, menstrual hygiene, conception - sex determination, family size, family planning methods and care).
3. *Pregnancy* (care during pregnancy and risks, preparing for delivery, process of delivery, high risks, five cleans - use of DDK (sterile delivery kit), postnatal and neonatal care, perineal care).
4. *Reproductive Health* (white discharge/RTI, STDs, AIDS and care; chronic reproductive problems, cancers, uterine prolapse).
5. *Child Care* (birth weight and neonatal care, importance of breastfeeding, infant care, immunisation, respiratory infections, diarrhoea, scabies and skin care, worm infestations, growth and development, nutritional problems and corrections, weaning foods).
6. *General* (personal hygiene, environmental sanitation, nutrition, kitchen gardens).
7. *Group Activities* (registers, meetings, WOMAN project, division of work in the village among members, health camps, conducting women's health clinics, conducting child health programs, teaching the villagers, monitoring health services in the village).

The objectives of the intervention to mobilise the community were manifold:

- Educate and empower village women to become a positive force in their own and their family's health;
- Improve reproductive and overall health including health seeking behaviours; and
- Create bottom-up pressure on the health care system to improve the services provided.

The hope was that the VHCs would be sensitive to community needs and support the WHCs. Some were very supportive, but, from the experience of the team, community leaders do not always play such a positive role. As the project activities proceeded, it was felt that outreach to young men through the establishment of youth groups might increase the support needed by the WHCs. In addition, health education

including information on STD/HIV prevention and contraception - including male methods - was considered a priority in its own right for its impact on both women's and men's health.

The Issue of Access: Empowering Communities to Organize Quality Services

The QI team discussed whether the existing system, even *with* improvement, would be successful in providing adequate access. Based on other project experiences in the state, two of the most under-served villages in the project area were selected to establish two pilot clinics to be run by the WHCs. A local woman – chosen by the WHC- was trained to staff one clinic. For the second clinic, the WHC chose an already trained but unemployed ANM.

Because of its involvement in the mobilisation activities, ANS had already established good rapport with the community. The organisation spent considerable time with the WHCs while guiding them in the development of a client charter, a fee scale, and so on. It was felt that these decisions must be made by the WHCs in order to ensure ownership - a critical element in making a sustainable intervention.

Different kinds of inputs were provided by the QOC project to establish the services, for example, simple equipment, funds to get the clinic started and to employ a retired female HCW to train the local woman and ANM selected to work in the two clinics. The WHC in one of the villages (Ponnal) managed to secure space for the clinic from the village head (sarpanch), transportation of equipment and supplies, and so on. With support from the community, it was similarly successful in persuading the sarpanch to have toilet facilities and a wall built in the front of the clinic.

Clients pay for the services provided by the trained local woman and for various supplies initially provided by the project. She is an employee of the WHC, and both her salary and future supplies depend on the income generated by her work. There is *no* charge to clients for services provided by the government HCW and doctor during their visits (once a week and once a month respectively). Neither visited the village on a regular basis before the project began.

After the establishment of the clinics, ANS continued its work to sensitise the WHCs and the community to issues related to reproductive health and to issues involved in running clinics. In collaboration, they updated family registers and identified women with gynaecological problems. They requested the female doctor at

the PHC to provide a special clinic session for the symptomatic women. More such visits may be organised as needed.

From the experience with the early camps, it was clear that there was considerable unmet need for services related to gynaecological problems. However, the QI team felt that these camps, or sessions, should be relatively small to keep the focus on the individual woman and to ensure the highest level of QOC possible.

Improving Quality of Private Sector Services

Registered medical practitioners (RMP) are a major source of care for many Indians because they do not have access to better trained health staff. Because of their inadequate knowledge, the RMPs may pose a health threat. For these reasons, the project contacted them to provide information and training on, for example, universal precautions and RTI/STD/AIDS. They also received correct information on FP and condoms for distribution. Moreover, they were encouraged to send clients with RTI/STD symptoms to the PHC for treatment.

ASSESSMENT OF CHANGES IN QOC

Increased Client Satisfaction

The final evaluation revealed that clients did indeed perceive that quality improvement had taken place in the government programme during the last couple of years. A total of 222 users and 243 non-users were interviewed. *Sixty-nine percent of the users interviewed stated that they observed change while almost 58 percent of the non-users did.* They mentioned better ANC, drugs, service availability and furniture, more time spent by HCWs at the SDPs, cleaner facilities, and better referrals (Table 2). Compared to the baseline survey, there was a significant increase in the number of clients who stated that they were satisfied with the services (Table 3). Methodological issues such as courtesy bias were discussed earlier, as were low expectations and the importance of establishing trust. Due to extensive contact with the population in the project area and the establishment of trust, the QI team speculates that people may have become more willing to communicate over time.

Table 2. Percent of Respondents Observing Changes in Services

Change Observed	*Percent of Users*	*Percent of Non users*
Observed change	69	58
Specific changes observed	-	-
Better AN care	59	50
Better drugs	50	38
Better availability of staff	48	31
Better furniture	38	29
More time with staff	26	11
Cleaner facilities	19	12
Better referral	8	3

Table 3: Percent of Clients Stating They Were Satisfied with the Services

Client Category	*Baseline*	*Final Evaluation*
Users	57	73
Non-users	21	42

The *group discussions* indicated that progress was uneven among the HCWs leading to varying levels of satisfaction or dissatisfaction among clients.[4] In eight of the ten villages where group discussions took place at the final evaluation, generally all or most of the participants stated that the services had definitely improved. Increased availability of the HCW and easier access to services; improved facilities; and better ANC were frequently mentioned as they were in the interviews. The discussions in a couple of sub-centre areas with relatively lower-performing HCWs reflected their low performance. In one village, for example, the group felt that no improvement had taken place. In a second village, the participants felt that only slight improvement had taken place.

The group discussions also indicated that with quality improvement taking place, new needs arose along with people's expectations. For example, during the baseline assessment, people complained of dirty facilities, clogged toilets at the PHC, and so on. At the time of the final evaluation, progress in these areas was praised, but people now saw a need for toilets at the sub-centres. However, the majority of the sub-

[4] Both users and non-users were represented in the group discussions carried out in ten villages.

centres still did not have toilets but some were shifted to better facilities during the project. Similarly, more villages provided a room for the HCW during her visit. These improvements were often the result of community pressure on local politicians once the QOC project began and the government health services received more attention.

Increased Satisfaction among Service Providers

At the final evaluation the service providers expressed increased satisfaction with the quality of the services they provide. Their statements suggested that the structural inputs, training and attention to work processes, including checklists, enabled them to perform their work better and with less difficulty. The resulting increase in client satisfaction appeared to have improved their relations with clients and the community and hence also their job satisfaction (Box 3).

Box 3: Statements of Health Workers Towards the End of the Project

"The project made the services provided at the sub-centres comparable to private clinics" (female HCW).

"The disposable delivery kits are being used extensively which made home deliveries safer" (female HCW).

"My work became more systematic after the project" (female HCW).

"Personally I gained by learning the practical concepts of how to identify high risk pregnant women" (female HCW).

"The project gave an identity to us. Now the community recognises us with the bag" (male HCW).

"Though we could certainly develop better rapport with the community through the project, our responsibilities have increased" (male HCW).

According to the HCWs, many areas still need improvement despite the progress seen. For instance, tubectomy services at the PHC continue to need further improvement. Observation during the final evaluation confirmed this, and it was brought to the attention of the physician-in-charge.

Increase in the Use of Services

The last statement by the male worker, see Box 3, alludes to the fact that the HCWs thought that they saw more clients and that their workload increased after the QOC project began. During the group discussion for service providers at the final evaluation, they stated that the demand for ANC had increased. As far as family planning was concerned, the providers stated that most people still prefer a tubectomy, but that there was a slight improvement in the acceptance of spacing methods. In some villages, the WHCs were, according to the providers, helpful in providing spacing methods to clients after they became depot holders for pills and condoms.

It is interesting to note that, towards the end of the project, service providers finally appeared to begin to accept the idea that, if they provide better services, clients will come to them, and they will no longer need to spend a considerable part of their time to reach their (tubectomy) targets. In the beginning, this concept was - and it probably still is - met with considerable mistrust and resistance.

According to the client interviews, the utilisation of antenatal services increased between the baseline and the final evaluation, thus supporting the HCWs contention. It must also be remembered that each antenatal visit would be expected to be more time-consuming due to the addition of tasks during the project.

The introduction of sterile delivery kits appeared to be successful (Table 4). It was already mentioned that the government program did not offer such kits when the project began, so only a small number of women used them at that time. (The question was not asked where they obtained the kit).

Table 4: Percentage Distribution of Respondents with the Most Recent Delivery at Home or at the Sub-Centre Using a Sterile Delivery Kit

Type of client	*Baseline*	*Final Evaluation*
User	17	80
Non-user	18	68

In this connection, it should be emphasised that the issue of *referral* went beyond pregnant women. Throughout the project, there was an effort to increase the scope of

the programme in spirit with the ICPD-POA and the new Reproductive and Child Health Programme in India. For example, the health talks for women described above led to a high number of (gynaecological and other) referrals. The camps organised under the QOC project had the same emphasis and included treatment or referrals as needed. Similarly, the increased awareness of the HCW to these issues led to an increase in referrals from the sub-centres (Table 5).

Before the project began, there was no consistent referral system so no comparison can be made in terms of numbers of referrals done then and later. However, it is likely that the majority of the women would have continued to ignore their problems because of the lack of attention to reproductive health problems.

Table 5: Number of Referrals

Origin of Referral	*No. of clients seen*	*No. of Clients with Gynaecological Problems*	*No. of Clients Referred to PHC or Government Hospitals for Gynaecological Problems*	*No. of General Referrals*
Health talks	436	216	69	-
Sub-centre	-	-	51 (to PHC) 57 (to hospital)	67 (to PHC) 39 (to hospital)

Overall, the PHC reported an increase in outpatients from 1995 to 1996 of about 23 percent, or, from a little more than 20,000 clients to almost 25,000. The increase was relatively highest among adult women (about 25 percent).[5] In this context, the effort to make services at the PHC more easily available to clients must be discussed. A new schedule was developed to ensure the availability of a doctor from 9 a.m. to 6 p.m. (as opposed to noon earlier) to see clients. There was still no doctor residing at the PHC, but a schedule was set up to ensure that one doctor remained the night following "operation day". Although the HCWs and clients recognised that improvements at the PHC had taken place, they also expressed that further improvements were needed.

[5] The increase among adult males and children was approximately 23 percent while it was lowest among female children. This is an area of concern which must continue to receive attention.

Choice of Method

The baseline revealed many weaknesses in the information giving process. For example, the HCWs did not routinely inform clients of all contraceptive methods available. Table 6 indicates that the relative emphasis on tubectomy decreased between the two surveys in as much as providers now inform clients more often of *all* available methods. Interviews with providers and group discussions confirmed this.

Table 6: Percentage of Users Offered Choice of Method*

	Condoms	*OCs*	*IUD*	*Tubectomy*	*Lap Tubectomy*	*Vasectomy*
Baseline	27	39	34	85	6	18
Final	34	77	59	84	2	14

*Rounded to nearest whole number

The users interviewed at the final evaluation were more aware of spacing methods than those in the baseline sample. According to users, the relative importance of health staff as the major source of information on contraceptive methods increased while that of friends, family, spouse and others decreased. It is interesting to note that the importance of health staff in providing information on contraception increased even more markedly among non-users.

Although fewer female contraceptive users received information on vasectomy at the final evaluation, it should be noted that after at least 2-3 years of *no* vasectomies, about twelve were performed in the project area from the end of 1996 to April 1997 according to the PHC's service statistics. This is an indication that the involvement of the male HCWs and their addressing men's need for information and services can quickly have the desired results.

Other Issues Related to Information and Protocol

During the interviews, clients were asked about the nature of the FP and other information they received from the HCWs. After the interventions, the workers appeared to provide information more frequently on the possibility of switching from one method to another; how to use the method; the scope for reversibility; method effectiveness; follow-up; re-supply; and appropriateness of the method. Moreover, the

HCWs appeared to discuss spouse's support and preferred family size to a larger extent than earlier.

However, further improvement is needed both in these and other areas. The HCWs remained resistant to the idea that side-effects must be discussed. They still appeared to be convinced that their clients are more likely to discontinue use if they are told about side-effects. Similarly, they tended not to discuss contraindications, and how the method works.

The HCWs were trained to provide information on RTI/STD/HIV. They expressed that they found the task of providing such information difficult, but according to clients they were an important source of information. Both female users (34 percent) and non-users (33 percent) indicated that health staff were a major source of information. Radio/TV served this role for 34 and 38 percent of users and non-users respectively. It should be noted that, among the women interviewed who stated that they had suffered from an RTI, 41 percent of the users and 35 percent of non-users sought care at the sub-centre.

The interviews with men revealed that for about 15 percent, health talks were their source of information. Radio and TV were relatively more important sources for the men interviewed than for the women. Men were more often aware of HIV/AIDS than women. Slightly more than half of the men interviewed stated they knew about HIV/AIDS while among women, 45 percent of the users and 35 percent of the non-users did. More men than women knew that HIV/AIDS spreads though sex and blood, while the knowledge that it spreads from mother to child was about the same.

It should also be mentioned that of the women and men who stated that they had experienced symptoms of RTI in the past, more women than men did nothing about it (users - 24 percent; non-users - 35 percent; and men - 17 percent). There was a slight increase in the number of women who stated that they had received a breast exam (6 percent at the final evaluation versus 3 percent at the baseline).

Issues Related to Client Convenience and Acceptability

According to interviews with clients, fewer mentioned long distance as an obstacle at the final evaluation (26 percent) that at the baseline (45 percent). This may be due to various interventions to improve access as discussed above. For example, more clinics were held in the villages after the project began.

Longer time for providing examinations and possibly more clients receiving services appeared to have had a negative impact on waiting times and possibly also on privacy despite the intervention to provide curtains and screens. Moreover, it is possible that the HCWs are still not sufficiently sensitive to clients' needs for privacy and must make efforts to use the inputs provided for this purpose.

Other Outcomes

Before the final evaluation, the community mobilisation intervention carried out self-assessment during the less than one year it was taking place. At the mid-term evaluation, the team felt that, of the 29 WHCs, five worked very well while four committees failed or malfunctioned, and the rest were deemed to be average.

Questions were asked about the WHCs in the client interviews at the final evaluation. More than 50 percent of those interviewed knew about their existence. Although fewer were aware of their exact activities, the respondents stated that the WHCs had led to better availability of the HCWs, and of OCs and condoms. They also gave the WHCs credit for better ANC.

Interviews with men showed that they also knew of the WHC's activities. Moreover, the HCWs appeared to consider the committees a positive force in the community. Considering the short time they had functioned and the level of difficulty involved in community organisation, these could be viewed as good results.

CONCLUSION

The above description shows that quality can be improved and that both clients and providers appreciate the improvements. However, two years is a very short time for QI which is a never-ending *process*. Quality itself is a dynamic concept, and what clients consider quality today, may not be considered so tomorrow. Quality must remain a top priority on the agenda of managers and supervisors at all levels to be sustainable.

Many lessons were learnt during the project about quality:

- The project showed the considerable extent to which *quality required a different way of thinking and of doing things* as well as the *critical role of management*: managers must change their approach when they aim to improve quality.

- Given the emphasis on reorientation in management approaches, work behaviour and processes, we found that quality improvement is both time consuming and labour intensive.

- As the benefits of improving quality were felt, staff morale improved and the community became more involved.

- Traditional evaluation measures need to be abandoned or complemented with new accountability measures that measure how well client needs are met. Until staff take these new indicators seriously because the system "tells" them to do so, quality improvement can only proceed to a certain point.

4

Sri Lanka

Focusing on Clients: Improving QOC at Eheliyagoda[1]

BACKGROUND

Eheliyagoda is a part of the Ratnapura district located 80 km from Sri Lanka's capital Colombo. Its population is slightly more than 65,000 according to the 1995 numbers of the Deputy Provincial Directorate of Health Services. Eheliyagoda covers 23 public health midwife (PHM) areas with a total number of 15 clinics holding about 26 sessions per month. The programme considered the services in the area in need of improvement when the project was initiated.

Baseline Survey: Strengths and Weaknesses Identified

Interviews with contraceptive users and non-users, men, and antenatal clients identified strengths and weaknesses in the programme. Users were selected from some midwife areas to represent a mix of contraceptive methods. Overall, client satisfaction expressed in the interviews was high. This may reflect genuine satisfaction with the services of a programme that has been successful in reducing infant and maternal mortality rates and reaching high levels of contraceptive use.

To understand what creates client satisfaction, clients were asked what positive or good things they had experienced or heard about the services provided (Table 1). Among the positive aspects mentioned by users were family planning information, no cost, usefulness of the services, and provision of services in the home.

[1] Contributed by: K. Wickramasuriya, V. Karunaratne, A. Fonseka, C. Gamage, C.D. Amarasekara, S.B. Abeyakoon, Maj-Britt Dohlie and Jay Satia.

The negative things heard or experienced by users, non-users and men in the community and their suggestions for improving quality were interpreted as *an indirect way of expressing dissatisfaction and pointing out shortcomings* (Table 2). A high percentage of non-users and men have neither heard nor experienced anything negative, but access may be an issue for non-users. Users mentioned inadequate access, facilities and supplies. Having used the services increased the chances that clients had heard or experienced something negative about them.

Clients had several suggestions for improving the services provided by the programme. Suggestions for improvement made by ANC clients are provided in Table 3.

Table 1: Percentage having experienced or heard positive or good things about the services *

Aspect experienced or heard	Male n=52	Non-user n=159	User n=250
Services are very useful	16	20	49
Free services	22	29	61
Services provided in the home	7	31	42
Services easy to obtain	-	13	39
Provide information on family planning	12	25	63
Kind staff	-	9	22
Don't know	45	21	17

*Each client could mention more than one item in Tables 1, 2 and 3

Table 2: Percentage of respondents having heard or experienced bad things about the services

Negative aspects heard or experienced	Men (n= 52)	Non-user (n=159)	Users (n=250)
Nothing negative	50	61	23
Not satisfactory	17	25	29
Not accessible	3	48	30
Method failure		6	2
Time consuming (waiting time)	19	12	17
No supplies sometimes	7	13	37
Lack of facilities	7	14	38

Table 3: Ante-natal clients – Suggestions for improvement of services

Suggestions made for improvement	*Percentage of ANC clients making the suggestion* (n=148)
Improve toilet facilities	25
Water to drink	18
Furniture (chairs and benches)	43
Syringes and needles – free of charge	55
Provide services according to arrival	13
Facilities for blood tests (referral for blood test was done but not systematically)	57
Regular issue of Thriposha[2]	49

Men frequently suggested that they need information, particularly on HIV/AIDS. Both men and female contraceptive users stated that children and youth should receive information related to sexuality – a request that was often heard during subsequent interaction with the community. Moreover, users suggested regular supplies of contraceptives, more facilities and drugs as well as facilities for LRT (female sterilisation). Some users felt embarrassed having the Depo-Provera injection administered in public.

The programme was interested in learning about the clients' knowledge on STD/HIV. The interviewers asked the respondents whether they had discussed the issue with anybody and with whom (Table 4). A surprisingly high number of users indicated that they had discussed STD/HIV with the public health midwife (PHM) or public health nursing sister (PHN). This was confirmed in interviews with service providers but some were concerned about the soundness of their own knowledge. The small group discussions described below indicated that the *quality* of the clients' knowledge of STD/HIV was poor suggesting that the information received may be very limited. Moreover, doctors played a small role in providing STD/HIV information. Particularly men, but also non-users, relied mostly on friends for such information.

[2] Thriposha is the food supplement given to pregnant and lactating women and children (6 months-5 years).

*Table 4: Source of information on STD/HIV for clients who discussed this issue with somebody (given as a percentage)**

Person with whom STD/HIV was discussed	Men n=30	Non-user n=76	User n=162
Friend	75	32	12
Doctor	7	1	3
PHN/PHM	1	29	79
PHI	-	1	-
Others	17	17	7
Cannot remember	12	29	-

* This table includes only clients who stated that they discussed STD/HIV with somebody. Each client could give more than one response.

Questions were included in the survey to assess clients' awareness of availability and knowledge of use of contraceptive methods. Not surprisingly, users were more aware of their availability than non-users. Men had least awareness about female methods and, of the three categories of clients, they had the highest awareness of the availability of male methods.

Nevertheless, the small group discussions indicated that there is a big gap between being able to *explain* how to use, for example, condoms and to *demonstrate* correct use (Box 1). Actual *use* would presumably be even more difficult. Similarly, superficial knowledge of AIDS may be better than no knowledge, but more in-depth information may be required for people both to perceive a need for behavioural change and to know exactly what to do to practise safe behaviours.

Box 1: Group discussions with clients in the baseline survey

In Eheliyagoda, altogether eight group discussions took place to explore in depth clients' views and knowledge of family planning and STD/HIV. Each group consisted of 15-20 clients totalling almost 200 people. Four groups consisted of married female users and non-users; one group of only non-users; and three groups of married and unmarried men. The following issues emerged:

- The majority of the women knew "something" about contraception. More than half of the women had at some time accepted a modern FP method. Those practising "safe period" often used the method incorrectly.
- Most of the non-users did not want a child within the next 2-3 years. They stated that they might have decided on a method earlier had they discussed the issue with the PHM. Some expressed that they could still select a method.
- Some users appeared to worry about a possibly negative health impact after accepting a method. This fear appeared to be behind non-use among some women. Some of the fears expressed included menstrual problems and cancer related to Depo-Provera; cancer related to oral contraceptives; complications, transmigration and cancer related to IUD use; impotence and lack of libido related to vasectomy; and lack of libido and difficulty with heavy work related to tubectomy.
- Many users mentioned that they had to obtain Depo-Provera from private service providers due to shortages at government sites. Most stated that the expense of RS 110 (about US$2) was difficult to bear.
- Some men mentioned that they obtained knowledge of FP from books and articles since there were no programmes for them. Some stated that they have more specific knowledge from these sources than their spouses who receive services and information from the clinics. They expressed interest in obtaining more information. It would appear that men could become involved relatively easily provided the intervention is well done.
- The majority of men had inadequate knowledge and negative attitudes towards male contraception and towards vasectomy in particular. Knowledge on *correct* use of condoms was poor, for example, the difference between explaining and demonstrating correct use.
- The majority of both male and female participants had heard about AIDS, but less than half knew that AIDS is incurable and that it is transmitted through sex, blood, and skin-piercing instruments.
- Further exploration revealed that clients have little in-depth knowledge. They did not understand how transmission of HIV occurs; what constitutes high-risk sexual behaviour; and how to practise safer sex. Moreover, they did not understand the HIV test and the "window" period; the difference between HIV and AIDS; the fact that AIDS is a syndrome; and what the symptoms are. The few clients who had previously attended HIV/AIDS programmes also expressed lack of specific and in-depth knowledge on these issues.

- Many clients expressed opinions that would be conducive to discrimination against HIV-infected persons and people living with AIDS. Examples include bathing in the same stream or river; allowing those who are HIV-infected to enter the barber saloon or the tea-kiosk; touching an HIV infected person; allowing one's children to play with the children of HIV-infected persons, etc. These misconceptions were discussed. Efforts were made to analyse concepts such as personal responsibility and choice.
- The majority of the participants, male and female, had no basic knowledge on STDs other than AIDS. The village term for STD is "dirty disease". There did not appear to be any distinction between STDs and other RTIs.
- Discussing FP and HIV/AIDS frequently led to discussion of other reproductive health issues and even overall health.
- A majority of clients expressed a wish for written health information including reproductive health in a booklet form for the home for people of all ages, even the very young.
- Both the baseline group discussions and the small group sessions subsequently organised to reinforce the skills of the newly trained staff often ended with a request from the community to cover the entire teenage and adult population in the village with the same information. There was appreciation among people that the seriousness of HIV makes it impossible to consider sex the taboo subject that it has been, and still is, considered according to cultural and traditional values. Clients were told that local health staff are available to continue to provide information, and that they themselves have a responsibility to help organise and request health staff to attend. The participants were also encouraged to discuss their new knowledge both with family and other community members. It was emphasised that STD/HIV can be brought up everywhere to spread the word among people.

Interviews with Providers and Managers

Ten service providers and two managers were interviewed. Group discussions were also held with providers. Staff were very open and willing to identify problems such as:

- Bias in discussing methods with clients
- Inadequate FP counselling and information on mode of action, side effects, risks and benefits, and how long the method is effective. Clients were often not told that method change is possible
- Inadequate screening for contraindications and no checklists used
- Problems with supplies and equipment
- Sometimes breakdown in referral system for family planning

written protocol. The service provider explained that they take medical history before providing a method, but felt that they did not know whether they perform this task adequately. Furthermore, they stated that a pelvic exam is done only for IUD clients (not for Depo-Provera and OC clients). They did not routinely ask IUD or other clients about possible RTI/STD symptoms.

While the providers stated that they provide STD/HIV information, they appeared to think that it is inadequate. Finally, four of the ten providers stated that they are not satisfied with the services they provide because of lack of facilities and supplies, and because of the heavy workload they have. The same issues were raised in the group discussions.

Observations and Facility Checklists

Only four family planning counselling sessions were observed. They were very time-consuming because the observer must be in the right place at the right time. The problem areas identified included:

- Contraceptive samples were not used
- IEC materials were not available
- No information was given on STD/HIV
- No checklists were used
- Sterilisation consent forms were not available

The observers of the five immunisation sessions noted that some refrigerators did not have a thermometer; the injection site was sometimes incorrect; recording was done before giving the injection; inadequate instructions were provided after immunization; unsafe handling of needles and syringes sometimes put providers at risk; and some providers were unsure of age-appropriate immunisation.

Observers of the four ANC clinics noted that clients received inadequate information. In addition, some equipment was not in working order, clients had to buy syringes and needles, and there was a lack of IEC materials.

The above description shows that the problem areas identified by each assessment tool for the most part were the same, so overall the results of the methodologies validated each other.

INTERVENTIONS TO IMPROVE QUALITY OF CARE

Interventions Begin: Creating Staff Awareness

At the inception of the project, QOC was a relatively new concept for both managers and staff in the FP/MCH programme. The QI team consisted of managers from different levels who were sensitised to QOC issues at a regional workshop early in the project. They felt that awareness raising of all staff to issues related to quality was a precondition for proceeding with the project.

The QI team focused on the Bruce elements of quality with the addition of a couple of other dimensions identified as problem areas in the rapid assessment (Box 2). During the training organised under the project, staff used these dimensions to analyse the baseline results and to develop their own action plan. The team felt that the staff needed to go through these steps in order to have ownership of the QI process.

Box 2: Elements guiding the project:

- Choice of methods.
- Information given to clients.
- Technical competence.
- Interpersonal relations.
- Follow-up mechanism.
- Appropriate constellation of services.
- Availability of essential supplies and equipment.
- Accessibility and availability of services.

The training stressed the critical role of service providers in each of the dimensions of quality and the extent to which their behaviour and actions determine whether clients choose to use the services provided by the programme. For example, they were encouraged to be very conscious of interpersonal relations during interactions with clients. More specifically, staff were told to be kind and polite also when clients make mistakes such as arriving late for appointments, forgetting to bring their appointment cards, and so on.

The importance of showing clients respect and considering their opinions was equally emphasised to staff as was ensuring that clients understand the information and instructions provided. Service providers were, among others, encouraged to use the same words as clients and to ask questions. Moreover, staff were requested to pay more attention to unmarried clients and to those with domestic problems. The importance of privacy and confidentiality was highlighted to create a safe environment for clients to discuss sensitive and difficult issues. As discussed below, subsequent supervisory activities have continued to focus on these dimensions.

The problems identified and the interventions are shown in Table 5.

Table 5: Problem Areas, Indicators Selected and Interventions Done

Problems identified in the baseline	*Interventions*
Lack of choice Irregular contraceptive supplies (Depo-Provera). Providers and managers state that some methods are promoted more than others. Local hospital does not provide sterilisation due to lack of trained providers. All sites do not provide all temporary methods.	Manager/staff meeting at the end of each clinic session to plan for adequate supplies for the next clinic session Sensitisation of staff (through training and subsequent support) to the importance of method choice; training to ensure all staff members have correct and sufficient knowledge about the methods Efforts to train doctors at local hospital in LRT and vasectomy Training of IUD service providers
Inadequate information: ANC clients do not receive information on warning signs. Clients receive little or no information on STD/HIV. Insufficient information provided on methods: side effects, risks and benefits, how long method is effective, possibility for method change. Lack of IEC materials or IEC materials not used.	Sensitisation of staff to importance of adequate information; review of correct information Training in various components of RH including STD/HIV, communication and counselling STD/HIV prevention message to be provided to all clients Method specific information introduced IEC provided to clinic sites and to PHMs for use at home visits (including bag for carrying IEC, contraceptive samples and penis model) One penis model provided to each field level staff and to every clinic site Sensitisation of need to use IEC materials
Inadequate privacy: Depo-Provera injections provided in public.	Sensitisation of staff through training (and subsequent support) to importance of privacy, confidentiality and good interpersonal relations with clients Procurement of screens/curtains

Problems identified in the baseline	*Interventions*
	ensure privacy during counselling, exam and provision of method
Inadequate technical skills and infection prevention: IUD providers state they do not feel confident about their skills and midwives state they are not sure they screen correctly for contraindications. IUD clients not routinely asked about RTI/STD symptoms. All supplies used for IUD insertions not sterile. Provider safety. Inadequate technique for administration of immunisation.	Training of service providers in IUD insertion, infection prevention and all contraceptive methods Training in maintenance of records; more systematic "flagging" of high-risk mothers Continuous training and supervision: all staff have to demonstrate correct use of steam steriliser ; other infection prevention measures taken to protect staff (and clients) Separate area for sterilisation to ensure supply of sterile supplies/equipment to sites with no electricity Sterilisation log in use Complication log introduced
Inadequate follow-up/ continuity on occasion. *Referral* system sometimes does not work.	Sensitisation of staff through training and continued support on-the-job to the importance of follow-up/continuity Development of referral system for well woman clinics Systematic referral of all high-risk mothers and follow-up by midwife Systematic review of ANC records to ensure timely PNC
Inadequate constellation of services: STD/HIV information not routinely provided. Men and youth do not receive FP and STD/HIV information	Training of staff on STD/HIV followed by on-the-job training & supervision to support new STD/HIV knowledge Well woman clinic introduced with attention to qualitative issues including information STD/HIV

Problems identified in the baseline	*Interventions*
Pregnant women not routinely referred for blood typing (first pregnancy) and VDRL.	Training of service providers in performing Pap smears Outreach sessions to men and women of all ages Blood testing of clients attending the ANC clinic reintroduced
Lack of supplies and equipment.	Adequate supplies planned ahead of next clinic session Needed furniture and equipment procured (Box 5)
Accessibility and availability of services.	Introduced FP services at two new sites and six clinic sessions added Saturday polyclinics for working mothers introduced Polyclinics rather than single service clinics offered to increase convenience for FP clients
Focusing on clients' perspectives.	Suggestion box installed Supervisor checklist developed to include interview with clients to assess their level of satisfaction Question included in the tools in the final evaluation

Training to Improve Skills and Knowledge

Many of the problems identified in the baseline were the result of inadequate knowledge and skills among service providers. Therefore, a comprehensive RH training lasting five days was among the first interventions (Box 3). It took place on weekends in order not to disrupt daily service delivery. Staff were *not* paid to attend because it would be impossible to replicate. Approximately 60 percent of the staff members attended the training. The training included some topics or sessions *not* routinely provided to staff such as communication and counselling. They were among the needs expressed in the interviews with service providers.

routinely provided to staff such as communication and counselling. They were among the needs expressed in the interviews with service providers.

Box 3: Topics Covered during the Staff Training:

- Components of reproductive health.
- Adolescent health.
- Temporary, permanent and natural FP methods
- STD/HIV.
- Communication and counselling (with special emphasis on FP and STD/HIV).
- Clinic management.
- Maintaining records and returns.
- Infection prevention.

In addition, some training took place on-the-job in the field. It was planned that staff would be trained 1) by observation 2) by performing the task themselves and 3) by continuous training and exchange of experiences, for example, at the monthly staff meetings.

The skills available in the STD/AIDS programme were utilised to train local staff in organising small group discussions to increase community awareness about FP and STD/HIV. This training/intervention is discussed in greater detail below. By the time the final evaluation began, 24 training sessions had been organised in Eheliyagoda. The PHI/PHM sessions organised independently numbered 15.

A hands-on training to improve their technical skills and aseptic techniques was provided to four service providers who perform IUD insertions. Two service providers were trained in taking Pap smears.

Although no systemic problems were found in the baseline, overall improvement in infection prevention was seen as important. An initial training session took place with continued on-the-job support as discussed below.

Strengthening Supervision to Focus on Quality

Strengthening supervision was considered a high priority when the QOC project began. Monthly staff meetings to discuss and review activities are **not** a new feature in Sri Lanka's FP/MCH program, but changes have taken place in the way the monthly meetings are conducted to encourage staff involvement and problem solving in terms of how to further improve the services:

- The meeting is used to reinforce and encourage continuous improvement of the new knowledge and skills introduced at the five-day training. This is done through lectures, discussions and demonstrations, or role-play, which is particularly important for practising newly acquired counselling skills. For example, staff have used the meetings for role playing condom demonstration and information giving. Each staff member has also had to demonstrate correct use of the steam steriliser.

- The monthly meeting is considered important in "keeping alive" staff awareness of QOC issues. While the word *quality* was rarely used previously, quality of care issues are now routinely discussed at the monthly meeting, during other supervisor/staff interactions, and during staff interactions. The team strongly feels that in order to sustain the QI undertaken, QOC must be internalised by staff.

- In addition to making changes to the monthly staff meeting, the Medical Officer of Health introduced weekly local conferences - meetings between the immediate supervisor and a small number of midwives - to strengthen supervision after the initiation of the project. All the midwives attend one such conference per month. The emphasis is on identifying problems both in the field and in the clinics. Clinic records and returns are reviewed to ensure that they are complete and correct and that they are done in a timely fashion.

- One-on-one supervisor/staff interactions have increased, or, perhaps more importantly, changed in nature, reflecting the emphasis on supporting staff and enabling them to perform their work better than before. In Eheliyagoda, the supervisory public health midwife (SPHM) has been completely released for the purpose of doing field supervision. Her reports are the basis for field supervision done by the MOH and the public health nursing sister (PHNS).

Overall, supervisory activities are done in a more systematic fashion than prior to the initiation of the QI efforts. Staff members have also become involved in the issue of systematic follow-up. For example, after each clinic session there are now reviews to:

The supervisory checklists developed have a provision that supervisors must talk directly to clients to assess their level of satisfaction with the services provided. Hence, the lists represent an additional mechanism for continuous feedback from clients.

Interventions Related to Structural Inputs

Box 5: Examples of Furniture and Equipment Provided

- Benches for waiting clients
- Curtains for screens
- Tables and chairs for providers
- Lockers
- Cupboards
- Test tube holders
- Examination bed stools
- Spot lamps
- Wooden racks to dry gloves
- Buckets for water storage
- Hot plates
- Bags for staff to carry supplies and IEC materials.

Common complaints among both clients and programme staff were related to inadequacies in structure. Staff at each clinic site helped identify shortcomings at the time of the sensitisation workshop. This included structural inadequacies. Some furniture and equipment were provided based on the plan of action and also as subsequent suggestions were made (see Box 5). Since many essential items were provided by a different UNFPA-supported project, the QOC project focused its interventions on many items which are very noticeable and make a big difference to clients and staff.

For example, screens to ensure privacy, benches for waiting clients, buckets for water storage, and so on were considered particularly important to ensure a high level of quality. However, the provision of the physical inputs was only a small part of the quality improvement interventions.

Improving Access and Availability

All the stakeholders - clients, service providers and managers - identified access and availability as a problem in the baseline survey. Several steps were taken to address this problem:

- There were two health facilities that provided no FP services and where expansion of such services was possible. The QOC project provided some physical inputs, and the time of existing staff was reorganised.

- The total number of clinic sessions per month was increased from 26 to 32.

- More clinics became polyclinics - simultaneously providing ANC, child welfare and FP services - rather than single-service clinics. FP clients appear to indicate that they appreciate this change as they can go directly from receiving services for their child to receiving FP services. Earlier these clients had to wait until the FP clinic opened in the afternoon.

- Clinic hours have been changed to cater to clients' needs. A special polyclinic for working mothers was introduced on Saturdays to make services more convenient for this group.

- Two well woman clinics (WWC) per month were introduced at the end of 1996. This was a modest start to address the needs of women who are neither pregnant nor in need of contraceptive services.

In addition, steps were taken to improve the client flow. Staff reorganised selected activities and clinic space. For example, pre-clinic preparations such as sterilisation of equipment and packaging of drugs now take place at the end of the workday before next day's clinic. According to staff this has improved the client flow because clinics start on time in the morning allowing more time for counselling, record keeping and service provision during the session. Because the preparations take place at the end of the workday, the field visits immediately following the clinic sessions are not neglected. Hence it appears that the change has led to better use of the time available during the workday.

The space available at each service delivery point (SDP) varies greatly. Within existing constraints, there has been an effort to use space better, and each activity now has a designated place. In some of the clinics, signboards have been put up to guide clients.

Moreover, a number system was introduced in the clinics to ensure that clients receive services strictly according to arrival. Staff themselves made the number tags which have health messages printed on the back.

A larger number of clients use the services after the quality improvement interventions began. Yet, staff state that the work is easier after the facilities were improved and changes were made in the workflow.

Well Woman Clinics: The First Step towards a Cradle-to-Grave Approach

The government is planning Well Woman Clinics (WWCs) for the entire country for women aged 35 and above. Some areas in the country have begun to offer these services while others have not. Well woman clients in Ehliyagoda receive a breast exam and are instructed in self breast exam; a urine test to screen for diabetes; a blood pressure check; a pelvic exam and visual inspection for possible abnormalities (cervix/vagina); an STD/HIV prevention message, and other information and referrals as needed. Although the focus is on women above 35 years, younger women are also encouraged to come for services if they do not already seek FP or antenatal services. For example, women in their early 20s have sought services for, among others, menstrual problems.

Among the issues emerging with the addition of WWCs are the effectiveness of the referral system and of client follow-up. Management and staff are currently in the process of exploring possible solutions. As discussed above, two service providers received training in doing Pap smears, but they have not yet been introduced. Other steps envisaged to improve the quality of the services provided include a client flow chart to be used as a simple standard, client cards, and a reproductive health leaflet.

Problems during Project Implementation

Although the provincial level staff was most co-operative and allowed the team much flexibility, a key member of the provincial staff - the medical officer/MCH - obtained a transfer soon after the QI team attended the training programme organised for the QI teams. This constrained province-level involvement and increased the burden on the other members of the team at the central level.

Some delays occurred in the implementation because of procurement procedures. Transport breakdowns affected the programme activities. For example, vehicle breakdowns made it difficult to reach the clinic sites to provide services; field staff lacked transportation facilities to reach the SDPs; and due to restrictions on the use of vehicles, it was difficult to perform supervisory duties on Saturdays.

EFFECT OF THE QUALITY IMPROVEMENT INTERVENTIONS

It is too early to evaluate the impact of quality improvement interventions. However, improvements are visible.

Privacy and Interpersonal Relations

Some clients in the baseline survey were concerned about privacy and disliked receiving Depo-Provera injections in front of others. Management and staff responded to this finding and reviewed this issue in relation to all services. Every clinic now has a separate room or area that allows privacy for IUD insertion, Depo-Provera, and other examinations. Screens and curtains are widely used. Only one client is seen at a time. Similarly, counselling takes place in a private area. Clients do appear to appreciate the efforts. During the final evaluation, 52 women seeking ANC gave the programme a high score on the issue of privacy. They also appeared to be satisfied with the kind and courteous service that they received.

Choice of Method and Comprehensive Reproductive Health Information

Several interventions were made to enhance method choice although no new method was introduced: problem solving and planning for adequate clinic supplies, improving overall knowledge of staff and motivating them to provide more comprehensive and correct information on reproductive health including FP methods, and introduction of method specific counselling. These measures altered the method-mix in Eheliyagoda and increased the number of new acceptors (Table 6).

Table 6: Number of New Acceptors and Method Mix in Eheliyagoda

Method	1995	1996
OC	236	176
Depo-Provera	255	319
IUD	161	267
LRT	78	68
Vasectomy	4	0
% increase over previous year	40	13.4

In the baseline survey, both staff and clients complained about Depo-Provera shortages. In the final evaluation, neither providers nor clients reported shortages of this or other methods. During the project period, the demand for Depo-Provera and IUD increased rapidly while the demand for pills declined. Relatively fewer acceptors selected tubectomy. This may be because of the inconvenience to clients of not being able to receive sterilisation services locally. The number of vasectomies remained unchanged despite the outreach to men. This issue requires further exploration.

Technical Services and Infection Prevention

Both service providers and managers state that this area improved as a result of the training, the equipment provided, and so on. Sometimes relatively small steps were taken by managers and supervisors to improve technical aspects. For example, to ensure that correct amounts of reagents are used for urine tests, the test tubes were marked to facilitate the task of running the test. Moreover, there is now a *system* in place to ensure that antenatal clients receive blood testing (typing and VDRL).

CONCLUSION

In conclusion, the quality improvement in Eheliyagoda focused on client needs. There is much evidence that the word *quality* has taken on a new meaning for both managers and service providers. The concept has been internalised and work behaviours have changed. The word *quality* is frequently overheard at monthly meetings, during staff interactions and supervisory activities. The following statements depict the changes taking place:

> "Quality improvement is more time-consuming and slower than I initially thought. I have seen a significant difference in the attitude of field staff. They are enthusiastic about the challenges implied in this kind of project. Change has also taken place in the way the team members think."
>
> Dr. K. Wickramasuriya, Director, FP/MCH, FHB, Ministry of Health, Colombo
> QI team leader

> "Quality matters! My attitude has changed. Now I start the different types of training I conduct with an introduction to quality of care. I talk in terms of the elements of quality and I take a more comprehensive view of reproductive health.
>
> I have also changed the way I interact with clients. For example, I discuss STD prevention with sterilisation clients because they often have a false sense of

security (after they become sterilised). I do not lecture to them, but ask them questions to see what they know and then give them the information they need."

Dr. V. Karunaratne, Principal Investigator, FHB, Ministry of Health, Colombo
QI team co-ordinator

"During this project I came to realise that people are more concerned about quality than we providers tend to think. They may not voice their demands as they have few alternatives in terms of receiving services. I feel that quality improvement needs the help of all types of staff starting with top level management to the grassroots level service provider."

Dr. A. Fonseka, FHB, Ministry of Health, Colombo
QI team member

"Staff are more active at the meetings than they were before. They ask more questions and bring up more problems."

Dr. C. Gamage, Medical Officer of Health, Eheliyagoda
QI team member

"This project was an opportunity to break barriers. When providing information on FP and STD/HIV to the community, we discuss many issues related to sexuality. For example, we discuss not only condom use, but also masturbation when we explain safe sex. We may discuss different sexual practices - what may be considered dirty - while also exploring the fact that different practices are acceptable as long as both parties agree and derive enjoyment. We use the same principles as for one-on-one counselling and we always ask permission. For example, we ask permission before we do a condom demonstration."

S.B. Abeyakoon
Counsellor and Trainer

Providers Speak

Service providers also had an opportunity to express their views on the changes taking place. Midwives at a monthly staff meeting in June 1997 made the following comments:

"The work is easier now because I can more easily refer clients to the MOH office (clinic) for family planning. Rather than being open until noon only, the clinic now stays open all day so clients can come at any time."

"The training made me understand the importance of access to services for clients."

"Because we have begun to do pre-clinic preparations at the end of the day after our field activities, we manage to start clinics on time the following morning. This is better for both the clients and us."

"Patients have told me that the clinic is really clean and nice and that they like to come here."

"All people benefited after we started to improve the services. Earlier we also understood that we should treat people well, but we did not take it as seriously. During this project, we learned to consider clients' opinions. We also began to provide family planning services in two remote areas."

"Before there was sometimes bias. Now we give information on all methods and emphasise no method in particular."

"The mothers come to me more often now - sometimes even in the evening."

"Now we cannot even show anger to clients when there is too much work because we were told in the training to always be kind."

Views of the Male Public Health Inspectors

"Earlier the PHIs were not involved in family planning and reproductive health. We learned a lot of new things during the project: to demonstrate condom use, and so on. We like to be involved in family planning because it makes it easier for the wives to make decisions when the men also have information."

"Maybe contraceptive use has gone up because we have removed fear of the methods among men."

"The workload is heavier because of the increase in the number of clinic sessions. It would be nice to be paid for increased workload."

When staff were asked about their preferences in terms of providing services - the "new" or the "old" way - they expressed that the advantages of the "new" approach outweigh the disadvantages, heavier work load, because of increased client satisfaction and interesting challenges.

The pilot project has begun to influence the training sessions provided by FHB. Gradually, the QOC component developed for the project is becoming part of its regular training. The counselling component developed for the staff training in the project area has subsequently been used for training of health staff in the plantation sector. FHB is also aiming to replicate other lessons learned in Eheliyagoda. For this purpose, a workshop was organised for central, province and district level officials. The Kandy district is beginning to explore the process of problem solving.

5

Vietnam

Improving Quality of Care in Duy Tien District[1]

Between 1995 and 1997, Duy Tien district in Ha Nam province, Vietnam implemented action research in improving the quality of care. The area has a population of approximately 136,000. After a description of the survey and plan of action follows a discussion of our experiences with the interventions tailored to solve the problems identified as well as the results of the interventions as measured in the final evaluation. Finally, the lessons from the action research are presented.

BASELINE ASSESSMENT OF QUALITY OF CARE

The quality of care was assessed according to the Bruce elements of quality using modified situation analysis instruments. The baseline study included interviews of various stakeholders (174 contraceptive users, 76 non-users, 10 married men, and 31 service providers); group discussions; observation of counselling sessions and medical exams; and use of a facility checklist. Managers in Duy Tien district and some antenatal clients were also interviewed. Since the Vietnamese programme promotes IUD and sterilisation in particular, an emphasis was made to reach users of other methods. While the respondents in the community were selected randomly, the exit interviews were steered towards clients using methods less widely offered and used in the programme.

[1] Contributed by HP Hoa, J Yap and J Satia. We would like to thank VQ Nhan and NQ Anh, past and present Directors, CPSI, for their guidance. We are also grateful to VA Dung, PD Vi, VD Doan for their contributions.

Contraceptive Users and Non-users, Men and Antenatal Clients

According to both users and non-users, there is relatively little choice of method in the programme. Condoms, IUD and tubectomy are available, but not always easily accessible, while oral contraceptives often are not. Although clients stated that the service providers explain how to use the methods, their knowledge of using them was lagging.

Observation of the client/provider interaction revealed weaknesses in this area: short time spent with the client; no separate area for counselling and information giving; insufficient information; and lack of IEC materials. The educational level of the clients is quite high so an important opportunity is missed to offer needed information through appropriate IEC materials to this literate population. A relatively high percentage of clients stated that the provider addressed issues such as follow up visit (64), sexual customs (63), contraceptive preference (84), method switching (67) and domestic violence (47). Overall, relations between client and provider appeared to be good.

Less than half the clients stated that they had privacy during the counselling session while the number was considerably higher during the exam. Box 1 indicates the medical services provided to clients and the extent to which universal precautions were taken. While 25 percent of the clients had symptoms of RTI, 21 percent received treatment. Eighty two percent of the clients stated they received information from the provider on STD prevention while 52 percent had received such information through mass media.

During the group discussion with users and non-users, several problem areas emerged. In practice, a client cannot easily receive an IUD because the method is not provided at the commune level in Duy Tien district. IUD insertions are the responsibility of a mobile team that visits the commune only once a month. Screening for the method appeared to be inadequate as was the information given. Health workers and commune collaborators seemed unable to provide correct information and to address clients' fears and concerns as a result of their own lack of knowledge.

Interviews with non-users indicated a high unmet need despite the fact that 95 percent stated that health centre staff motivated them to use contraception. (Seventy-one percent of the non-users did not want any more children. Ten percent of the women were pregnant and 32 percent were breastfeeding with varying levels of protection. The rest was at risk for pregnancy).

Box 1: Before providing the method, the provider:

	Percent
• Took medical history	88
• Did a pelvic examination	60
• Washed his/her hands	59
• Put on gloves	57
• Explained reasons for examination	63
• Did a Pap smear	7
• Took blood pressure	30
• Did breast examination	24
• Taught self breast examination	21
• Asked about history of STD	72
• Provided a user card	30

The number of men and antenatal clients interviewed was very small. Among the men interviewed, nine out of ten used some method of contraception (either the husband, or, in the majority of cases, the wife). Among the majority of users, non-users and men interviewed, contraceptive use or non-use was a joint decision by both husband and wife.

Most of the antenatal clients were satisfied with the services provided by the programme. Four of the six women interviewed sought ANC late, between the 6th and the 9th month. There appeared to be a lack of both information given to the clients and IEC materials. Overall, service providers did not encourage clients to ask questions. Observation revealed shortcomings in the following areas: lack of laboratory support for routine tests, inadequate facilities, and no antenatal cards for clients. Overall, there appeared to be insufficient capacity to care for all pregnant women.

The field visit by the QI team established for the project revealed the following:

a. There was an almost universal perception that quality improvement requires considerable financial resources. When asked the question "What can be done to improve quality?", the answer from managers and community leaders invariably was that technical training of providers, new equipment and facilities were needed. Other interventions, however, such as IEC or informed choice of methods were rarely mentioned.

b. There were no quality assurance mechanisms and supervisors did not check on quality.

c. Service providers generally treated clients well and provided the service requested. A large proportion of clients used an IUD, and there were concerns among clients about gynaecological problems related to its use.

d. The supply of pills and condoms at the health care facilities was inadequate (or stockouts occurred) because of lack of co-ordination between the Provincial Committee for Population and Family Planning (PCPFP) and the health system. There was an apparent division of labour; CPFP (Committee of Population and Family Planning) providing non-clinical methods of contraception and the health system providing clinical ones.

INTERVENTIONS TO IMPROVE QUALITY OF CARE

In November 1995, after the completion of the baseline survey and analysis of data, a QOC workshop was organised for various representatives from CPSI (Centre for Population Studies and Information); the District Committee for Population and Family Planning (DCPFP); the inter-communal and communal levels; the district health bureau, the general hospital and the Party. At the workshop, the results of the baseline assessment were discussed along with QOC frameworks. There appeared to be general support for improving quality as well as agreement that the assessment results reflect the real situation in Duy Tien district. Possible interventions were also discussed.

Appropriate interventions were designed to address the weaknesses identified in the areas of counselling and information giving, technical skills, universal precautions, IEC materials, infrastructure and equipment. Interventions were also required in the area of supplies/logistics.

Box 2: Topics Covered in the QOC/Counselling Training

- The importance of QOC
- The need for developing a protocol
- Counselling steps using the GATHER methodology
- Use of checklists and counselling for each method
- Recording and reporting skills
- User cards for improved follow-up
- Reproductive health and reproductive rights
- Brief overview of RTI/STD/HIV/AIDS

Training Related to Technical Aspects, Integration of Services, Follow-up and Continuity

This intervention began with a three-day QOC workshop, which also included training in counselling (Box 2). A total of 240 persons

(full time staff and community-based collaborators) were trained and received copies of a counselling guide. In addition to the above training, ten female assistant doctors and two midwives were trained in IUD insertion and menstrual regulation (MR) through a clinical training followed by three months of on-the job training to improve their technical skills. This intervention was also expected to provide easier access to and availability of these services. Moreover, two providers were trained in the provision of vasectomy services. However, clinical practice proved difficult because of the low number of acceptors for this method in the project area.

After the training, the participants were able to counsel according to the IUD and MR checklists developed under the project. Subsequently, a two-day training on monitoring and evaluation was organised for 40 managers and other individuals. Mass organisations -- the Youth Union, the Women's Union and the Peasant Association -- also participated. The major emphasis of the training was how to use the specially developed managers' checklist.

A two-day refresher training on counselling and QOC was also organised. In addition to full time staff and collaborators from communes and Inter-Commune Population and Family Planning (ICPFP) Centres, staff from the Department of Obstetrics and two mobile teams attended the training session. The training represented an opportunity to discuss the problems the service providers might have faced when practising their new counselling skills and utilising the new user cards developed under the project (Box 4).

Box 3: Convenience to Clients

Training of service providers in IUD insertion at the commune level improved access to services and client convenience. Clients comment that they are happy to have IUD insertion available in the community and that it is easier to understand the new user cards. A broader range of choices became available because of increased information.

Similarly, a one-day refresher training for managers was organised on monitoring and evaluation. Problems related to supervision, the introduction of key indicators for evaluating the QOC in the program, and the possible introduction of standards for the provision of IUD and MR at SDPs within the project area were discussed.

The QOC team used various resources for the training sessions including AVSC's *Family Planning Counselling Guide* and JHPIEGO's *Infection Prevention,* both of which were provided by the project. In addition, ICOMP publications such as *INNOVATIONS* and training modules already developed in Vietnam were also used.

A four-day refresher training in IUD insertion and MR was offered to all service providers. The FP mobile team from the District health office and the Department of Obstetrics at the district hospital were previously the only providers of these services. After the inception of the QOC project, trained service providers at selected commune health centres began to provide them. In other words, women began to receive IUD and MR services at the local level.

Box 4: From the Point of View of Service Providers

Service providers state that they feel more confident in doing their job as a result of the training provided in the project area and the improved supervision and support offered from the district hospital staff. They also indicate that they appreciate being able to share their experiences with other providers.

In addition to introducing the IUD and MR checklists, the QOC project introduced IUD and MR complication logs to improve the monitoring of these services. Use of the logs will assist programme managers in spotting possible areas in which service providers need additional training, or even individual providers who may need improvement. In this context, it should be mentioned that a log for pregnancy follow-up was also introduced. Clients in either logbook will receive a (follow-up) visit by the collaborator if they do not return for their follow-up appointment.

A six-day vasectomy refresher training was organised for two male medical doctors. The overall low demand for vasectomy was a problem when the initial training took place. Again, training of local providers has made vasectomy services more easily accessible for clients in as much as they no longer need to go to the district hospital or to a hospital in the neighbouring province.

Finally, several steps were taken to address reproductive health issues besides contraception and menstrual regulation. Two female staff members (one female medical doctor and one female assistant doctor) from Duy Tien district hospital were sent to the National Institute for Skin and Venereal Diseases in Hanoi to learn to diagnose RTIs and STDs. Subsequently, these doctors and two other service providers organised training for service providers on diagnosing STDs and RTIs at the community level (Box 5).

The participants' awareness and knowledge of STD/RTI/HIV have increased considerably as a result of the training. RTIs/STDs were previously treated at the province - or higher - levels although some RTIs could be treated at the commune and district levels by the MCH/FP mobile team or in the Department of Obstetrics at the district hospital. As a result of the training, 16 providers have screened 90 women to date and sent 72 specimens to the district hospital laboratory for diagnosis. Of the 72 specimens taken, 65 were positive for RTI while no STDs were reported.

Box 5: Training on RTI/STD diagnosis at the Commune Level

- STDs and RTIs.
- HIV and AIDS.
- How to diagnose STDs, RTIs and HIV/AIDS at the commune level.
- How to take laboratory specimen and transfer them to the district hospital.

Development of IEC materials and User Cards

Pamphlets were developed on oral contraceptives (OCs), IUD, female sterilisation, vasectomy, and on general information on all the methods as well as on HIV/AIDS. User cards for the various methods were also developed. Each client now receives both a pamphlet and a user card pertaining to the method selected. The interventions were done to ensure informed choice and better follow-up.

Structural Inputs

Five SDPs were identified by the QI team and received structural inputs. (The intervention took place at Mocbac health commune, Dongvan intercommunal family planning centre, Yen Bac and Tien Hiep health communes and also included two rooms used for family planning at the district hospital). Repairs, upgrading, and supply of various equipment were among the actions taken to improve the structure.

The inputs include linoleum for the floors, ceramic tiles, replacement of roof tiles, electrical wiring for lights, and replacement of ceiling boards. In the Department of Obstetrics, the family planning and counselling rooms were upgraded, and boards for guiding FP service providers in the counselling process were provided. In addition, the laboratory was upgraded. Equipment and supplies were also provided, for example, MR and vasectomy kits, electrical sterilisers, cupboards, microscopes, laboratory supplies, and so on.

The awareness of local leaders that they have responsibilities to the FP programme increased as a result of the QOC project. The increased awareness was translated into funds from the commune and district for facility upgrading such as procurement of a microscope, a new ceiling, a cupboard for storage, and so on.

Checklists

Checklists for the different types of service providers and managers were developed to improve the service delivery of OCs, IUD and MR. Moreover, the lists should assist the supervisors in providing continuous on-the-job training and in supervising staff. The lists may be considered a first step towards the development of standards of care.

Efforts to Encourage Male Participation and Responsible Sexual Behaviour

Male doctors conducted the activities developed to address men's needs. In collaboration with the Peasant Association, PCPFP of Duy Tien, and the CPSI QI team, male group sessions were organised. From October through December 1996, a total of 16 sessions were held reaching a total of approximately 200 men. The men (or their partners) had either never used contraception or had discontinued use.

Box 6: Misconceptions among men related to reproductive health expressed at the sessions:

- Family planning is the responsibility of women.
- Vasectomy may cause both physical and psychological problems for men.
- Condom use is inconvenient.
- STDs and HIV/AIDS appear in urban areas and not in rural areas.

The main topics at the sessions were men's role in reproductive health including their responsibility for family planning and use of contraception, and in STD/HIV prevention. Misconceptions were discussed (Box 6). Men who had chosen vasectomy were invited to speak. Other topics were also discussed such as the benefits of the vaccination programme and the development of agricultural products. During each session, the facilitator would pose some questions to the participants and encourage them to share their experiences while answering the questions posed (Box 7).

As a result of the sessions, it appears that two men chose vasectomy while 45 chose condoms. Other men expressed interest in the IUD.

Box 7: One Man's Choice:
During a meeting in Tien Hiep commune, one man commented that he previously thought that women have the responsibility for family planning because men cannot use the IUD. After gaining increased contraceptive knowledge at the session for men, he stated that he now understands that the husband should share the responsibility for contraception with his wife. The man chose to have a vasectomy.

Outreach to Youth

Two assistant doctors (one male and one female) received training in youth counselling and conducted the youth outreach activities. They organised meetings in collaboration with the local youth union and a female medical doctor from CPSI. The groups were organised separately for boys and girls. At the time of the final evaluation, three meetings had been organised for each addressing a total of 59 girls and 64 boys.

Different reproductive health issues including youth sexuality, contraception and STD/HIV/AIDS were discussed at the sessions. The youth sessions followed the same methodology as those for men. The facilitators would pose various questions and encourage the participants to share their experiences while finding answers to the questions. The participants were also encouraged to discuss possible concerns and worries while the facilitators attempted to answer questions as needed.

Supporting the Radio Network to Provide RH Information

Different activities to support the local radio network in providing RH information were to have taken place during the first six months of the year, but were delayed to August 1996

A one-day information session on reproductive health and quality of care was organised with the purpose of raising awareness and educating the local network. The DCPFP of Duy

Box 8: Implementing the ICPD POA at the Grassroots
Mr. Le Co, head of the district radio broadcasting, stated that, after 1994, advocacy for the ICPD POA had been one of his concerns. However, neither he nor his colleagues felt that they understood the issues of comprehensive reproductive health and quality of care. According to Mr. Le Co, their hope was to provide better information as a result of the information session.

Tien, the district QOC team, and the Information and Cultural Office of Duy Tien joined forces to develop the session for the heads of the radio network in 22 communes and for 15 collaborators, four journalists and editors in the district broadcasting (Box 8).

After the training was organised, the radio network in Duy Tien District has featured 12 special programs on population, development and reproductive health, and 42 reports on the activities of the QOC project. In addition, a cassette tape on the QOC project was developed. It has been broadcast also on Ha Nam province radio station.

ACHIEVEMENTS OF THE QUALITY IMPROVEMENT PROJECT

Several process improvements have taken place since the inception of the QOC project. The additional 12 providers who underwent IUD insertion and MR training, for example, received intensive skills-based training. They inserted a total of 968 IUDs and performed 58 MR procedures with no serious complications during approximately nine months. Each room where FP services are provided is now equipped with a board containing step-by-step instructions on how to insert an IUD; how to perform menstrual regulation; and how to solve serious complications if they should occur.

There appears to be consensus among the district level managers that the training organised as part of the QOC project is better than that offered in the national programme. Therefore, these managers have decided that more service providers must receive the training introduced by the project. They have also decided to offer yearly refresher courses. It should be added that neighbouring provinces have expressed interest in the different types of training which took place in the project area.

Similarly, there is consensus that the level of co-ordination has improved among CPFP, the Ministry of Health, and the Ministry of Education and Information at the province and district levels. During the QOC project, a monthly planning meeting was introduced at each of the three levels (commune, district and province). The meeting aims to monitor the progress of the project and to continue the improvement process. This meeting will be institutionalised.

The IUD checklists discussed above are used at three different levels: by collaborators, service providers and managers. The lists would ensure that clients undergo thorough screening before they have an IUD inserted. Finally, the programme keeps track of possible complications in its newly introduced complication log facilitating systematic corrective action.

Although only a fraction of more than 300 collaborators in the district attended the counselling training, there appears to be an overall effort to provide information to clients on all methods available and to provide privacy (curtains were procured with community funds). Written information on the method selected is also provided. During the last six months of 1996, for example, providers and collaborators counselled approximately 3,000 clients; distributed 2,500 method information sheets; provided 1,985 user cards for IUD clients (of which 968 were new contraceptive clients); and seven, 41 and 80 user cards for respectively vasectomy, female sterilisation and oral contraceptive clients.

Final Evaluation

In order to evaluate the quality improvement interventions, 100 users, 15 providers and 16 managers were interviewed. In addition, selected facilities and the process of service delivery were observed. Below, the major findings are briefly described.

Almost all the respondents felt that quality had improved (Table 1). In addition, 66 percent of the users felt that the quality of counselling had improved. Fifty-seven percent felt that STD/RTI diagnosis and treatment had improved. However, it is interesting to note how some aspects appear to be more appreciated by clients than service providers/programme and vice versa, for example, in the area of convenience to clients (travel long distances to receive services).

Table 1. Percentage of Respondents having Observed Quality Improvements

Change Observed	*Users*	*Providers*	*Managers*	*Men*
IUDs are inserted at all commune health centres.	88	80	93	73
Better equipment and facilities.	72	40	33	27
Do not have to wait long or to travel long distances to receive services.	90	53	59	87
It is easy to find FP service rooms because there are sign boards.	32	93	47	27
Other	27	20	33	13

Contraceptive method choice also improved. At the baseline, only 41 percent of the users mentioned that pills were available. This proportion increased to 92 percent at the final evaluation, thus improving choice.

The interviews also indicated that clients received more comprehensive information after the inception of the project, particularly on how to use the methods, on follow-up, side effects and what actions to take should side effects occur. In this context, it should be mentioned that more than two-thirds of the respondents at the final evaluation mentioned these issues without prodding as compared to less than 15 percent at the baseline assessment.

The respondents also received more information on RTI/STD screening and treatment because of the project. More than 95 percent of the contraceptive users interviewed had heard about contraception, quality of care, reproductive health, STD/HIV, and male responsibility in reproductive health through radio broadcasts.

More than 75 percent of the managers felt that work methods had improved and that the efforts of various institutions were better co-ordinated for the benefit of clients. Moreover, better equipment became available as a result of the project.

LESSONS LEARNT

Several lessons have been learnt during the course of the QOC project. It is interesting to note that there may be congruence between the ICPD POA and the interests of the national FP/population programmes. In Duy Tien, for example, many demographic indicators have reached "good" levels. Hence the challenge for the programme in the future will be to maintain these levels. Leaders at both the commune and district levels understand that an adequate level of QOC may be both an effective and wise strategy for the programme at this stage.

To improve quality the following are required:

- Commitment from the leaders.
- Basic and relatively inexpensive equipment.
- Co-ordination among agencies.
- Effective training, supervision and monitoring.
- Follow-up and appropriate research on a continuing basis.

The action research project, along with other such projects, increased the interest of policymakers in QOC. QOC was incorporated in the recently issued executive instructions by the Prime Minister to the MOH and NCPFP. The instructions state that the conditions for providing all contraceptive methods must improve.

6

Review of Experiences in Improving Quality of Care

Below we briefly describe selected international experiences in improving the quality of care in population programmes. The experiences reflect the innovations taking place in some FP/RH programmes as well as the issues that become important when programmes make quality a priority.

IMPROVING QUALITY OF CARE: EXAMPLES[1]

1. Use of Situation Analysis in Kenya.
2. Introducing COPE in Asia: Kumudini Hospital in Bangladesh.
3. Continuous Quality Improvement Programme (CQI) at the Catemaco Logistics Center, Mexico.
4. Quality of Family Planning Services in Taicang County, China.
5. Quality Improvement Programme (QIP) by Ministry of Health, Egypt.
6. Effective Practices related to Human Resource Management, Population Services, Zimbabwe.
7. ARCH, India.
8. Total Quality Management in Malaysia's Government Health Services.

[1] The case studies are drawn from different sources. The Kenya example has been documented with support from the OPEC Fund. The other case studies were previously published in their entirety in *Innovations* volume 1 or in ICOMP's latest international seminar report. The ARCH case study was developed for one of ICOMP's training manuals with UNFPA support. The case study on the Malaysian experience of TQM was written for a seminar on "Implementing Population Programmes: Quality of Reproductive Health Care as the Way Forward" held in Kuching, Sarawak, Malaysia in December 1995.

IMPROVING QUALITY OF CARE IN KENYA USING SITUATION ANALYSIS[2]

BACKGROUND

Kenya's population has gradually increased from 5.4 million in 1948 to 21.4 million in 1989. It is currently estimated to be 29 million (Centre for Bureau of Statistics, 1996). The Government of Kenya formally accepted population and family planning (FP) as part of the National Planning Strategies in the Sessional Paper No.1 of 1965. Two years later, the National Family Planning Programme was established within the Ministry of Health. Family planning services were to be integrated into maternal and child health (MCH) services. At this early stage, however, the success of the programme was limited because of many deficiencies in the existing health infrastructure, human resources and quality related factors. This situation continued despite the high priority placed on family planning.

The Government of Kenya launched the National Council for Population and Development (NCPD) in 1982. The Council's mandate was to formulate population policies and strategies and to co-ordinate the activities of ministries, non-governmental organisations, the private sector and the donors involved in population and development. Two years later, NCPD launched Sessional Paper No.4 of 1984. It clearly stated the demographic, education and clinical services goals, and defined current and future population activities and the roles of the stakeholders.

The Ministry of Health continued to address the identified quality gaps in the service provision of the integrated MCH/FP Programme. Between 1978 and 1986 several reports rated the overall Family Planning Programme of Kenya as "weak" and "poor" (Ministry of Home Affairs, 1984; Henin, 1986; Lapham et al, 1984). However, the 1989 population census showed that the total fertility rate had declined to 6.9. The population growth rate had also declined to 3.3 percent per annum, and the contraceptive prevalence rate had increased to 27 percent for married women. In the same year, the Chogoria Report clearly suggested that a decline in the fertility rates was possible through the provision of high quality integrated services (Goldberg, 1989).

The Demographic and Health Survey of 1993 clearly indicated that Kenya was in a demographic transition. The contraceptive prevalence rate had increased to 33 percent and the total fertility rate had fallen to 5.4. Over this period of change, the

[2] Written by Achola Ominde, Ministry of Health, Kenya with support from the OPEC Fund.

population programme studies continued to provide key information that not only determined the progress made, but, more importantly, facilitated future planning over the last nearly one decade.

Kenya has conducted two situation analysis studies, one in 1989 and another in 1995. The findings of these studies have played an important role in reorganising and reorienting facility-based clinical services with an overall aim of improving the quality of MCH/FP services offered by the programme.

SITUATION ANALYSIS IN 1989

With the assistance of the USAID, the Ministry of Health conducted a situation analysis in 1989 with the aim of identifying the strengths and weaknesses of the service delivery programme (Miller et al, 1989). This study covered 99 randomly sampled MOH Service Delivery Points (SDPs). The information collected from these clinics provided a useful overview of the programme operations and gave many insights into possible areas for improvements. The study focused on two main areas: the functioning of subsystems and quality of care. A summary of the major outcomes of this study and the rating of the programme are as follows.

Operations of Subsystems

1. **Logistics and Supplies.** The logistics system was rated as "low to moderate", as there were inadequate supplies of oral contraceptives and Depo-Provera in many SDPs. Adequate supplies of condoms, foaming tablets and IUDs were available in less than half of the SDPs.

2. **IEC.** The clinic-based IEC programme was rated "low". This rating was given based on the limited availability of educational materials and the low proportion of SDPs holding health talks on the day of the research visit. Half of the SDPs did not have a single poster on the wall. Other pamphlets and educational materials were not available in 60 percent of the SDPs, one third of the SDPs had a health talk and only 16 percent had a health talk which included FP on the day of the visit. However, it was noted that the weakness in the educational programme was somewhat balanced by the one-on-one client counselling process.

3. **Management and Supervision.** These sub-systems were rated as "low" as 60 percent of the SDPs had two or fewer supervisory visits in the previous six months.

The recommended number of visits is one per month, which was reported by only 14 percent of the SDPs. Only half of the SDPs had a FP workplan or schedule of responsibilities even though all workers were trained to prepare these management aids. Record keeping was rated as "moderate" as 87 percent SDPs kept FP records even though there was a variety of record systems in use. Referrals of MCH clients for FP were rated as "high" as referrals took place in 81 percent of the SDPs. They did not take place in 13 percent of the SDPs, and the situation in the remaining six percent was unclear.

4. **Personnel and Training.** This system was rated as "moderate" with 92 percent of SDPs having at least one Kenya Enrolled Community Nurse. Fifty-six percent had a family health field educator and 45 percent had a midwife. Forty-five percent of the clinical nursing and nurse midwife staff available in the SDPs had ever received the seven-week training in FP, but continuing education in FP had been provided to 16 percent of the nursing and midwife staff.

5. **Number of Clients Served by Method.** Oral contraceptives were the most common method offered to the clients. Seventy-one percent received oral pills and 19 percent of the clients received Depo-Provera. Four percent of new clients received an IUD.

Situation Analysis in 1995

The ultimate objective of this 1995 situation analysis was to assist the MOH, NCPD, NGOs and donor agencies in planning the expansion and improvement of FP and other reproductive health services provided in Kenya (Ndlovu et al, 1997).

The situation analysis suggested that the Kenya programme was functioning better and the quality of care had improved since 1989 although there is still room for further development.

By 1995 the methodology used in the situation analysis study had undergone substantial revision, but there are several critical issues in the sub-systems and the quality of care that allowed the researchers to compare the study findings (Table 1).

Table 1. A Comparison of the Findings of Situation Analysis

Element of quality of care	Situation Analysis 1989	Situation Analysis 1995
Choice of Methods	Researchers reported that 94 percent of new clients observed received information on two or more FP methods and the mean number of methods clients received instructions was 3.8. Nearly all clients were told about orals and Depo-Provera. About three fourths of the clients were informed about IUDs. Fewer women were informed about condoms (60 percent and foaming tablets 50 percent) and very few clients were told about tubal ligation (17 percent) and vasectomy (4 percent).	Almost all facilities provided combined pill, the progesterone only pills and injectables while three-quarters offered the IUD. Most new clients were told about six methods on average. The most frequently imposed restriction on providing a method is requiring a client to have at least one child.
Interpersonal relations		Researchers observed that the vast majority of both family planning and MCH clients were satisfied overall with their visit and felt that they received the information and services that they wanted. Although most clients felt that the consultation time was satisfactory more than 20 percent of MCH clients and 11 percent of family planning clients felt it was too short.
Information exchange between clients and providers	Information given to clients was judged as "moderate" as 87 percent of clients were informed how to use FP methods. Benefits were discussed with 77 percent of the clients. Possible complications were discussed with 60 percent of the clients, contradictions with 50 percent and the management of complications with 44 percent.	The methodology and categories used to code the information provided to clients in this second situation analysis was very different from that of the 1989 situation analysis. Nevertheless, most new clients were asked about their reproductive intentions. In 75 percent of the consultations, clients were asked about their knowledge of and experience with family planning. In most cases the provider

		explained to the new client how to use the selected method. However, many women were not being properly informed about the side effects that they should expect or about switching method if they have a problem.
Clinical procedures performed	In terms of the technical competence, the study providers were relatively competent. This component was rated as "high". For example, 96 percent of the new clients observed had their gynaecological history taken. Blood pressure was checked for 85 percent while a pelvic examination was performed for 73 percent of clients. These findings had limitations, as an objective measure of the providers' skills was not carried out.	Most new and revisiting clients had their weight and blood pressure checked. A substantial proportion of new clients had breast and pelvic examinations. When providers were asked which procedures they should perform prior to offering combined pills, progesterone only pills, the injectable, and the IUD to new clients, more than 75 percent recommended a number of clinical procedures indicating that they knew which clinical procedures should be performed prior to offering various FP methods.
Mechanisms to encourage continuity and follow-up		Almost all family planning providers (98 percent) were told when to return for resupply or follow-up. In addition, over 90 percent were given a written reminder of when to return
Integration of services / constellation of services offered	Relatively little integration of other health care services was observed during visits by new FP clients. In 85 percent of the 49 new client-provider interactions observed, no other health issues were discussed at the time of FP service provision. Similarly, no other health topics were discussed in 85 percent of the 24 revisiting clients observed (although such discussions may have taken place prior to entering the FP service areas).	During 35 percent of the consultations with all clients there was some discussion of at least one or more health issues. This is a very encouraging result indicating a more integrated service delivery programme.

STEPS TAKEN TO IMPROVE QUALITY

At the policy level, the Sessional Paper No.4 of 1994 clearly recommended improvement of the quality of FP services offered. The situation analysis studies coupled with other documentation indicated the progress that the Kenyan Family Planning Programme has made towards this recommendation.

The first programme strategies and activities were reviewed in the context of the situation analysis and the 1989 Kenya Demographic and Health Survey findings to ascertain whether the programme was addressing service quality gaps. It is important to note that the existing programme strategies and interventions to address quality of care were basically already in place. They included the following:

- Improving the supply and distribution of contraceptives
- Providing extensive education through production of core materials, e.g., flip charts, posters and workshops specifically for the Ministry of Health
- Improving and strengthening MCH programme with the aim of improving the health of the mother and the child
- The Development of FP policy guidelines for service providers
- Monitoring and improving the quality of management, personnel and facilities

Despite assurance that the programme's course of action was right, programme managers realised that there were still major challenges in terms of meeting the ever-increasing FP needs while at the same time addressing the quality gaps identified.

Over the next five years, efforts to improve the Kenya FP programme were undertaken along several fronts and the progress made varied widely. The following are some of the key steps that were undertaken in four key areas: commodities management and contraceptive method mix; IEC; training of service providers and integration of services; strengthening management and supervision.

Commodities Management and the Contraceptive Method Mix

With support from USAID, the Family Planning Logistic Management Unit was established in 1988 within the Ministry of Health with the primary objective of addressing commodities management problems that were being encountered by the Kenyan FP Programme. Initially, the major tasks of this unit were to conduct a needs assessment; develop a curriculum to train programme managers and implementers in logistics; conduct training activities in selected pilot districts and thereafter expand

these training programmes. Over the five-year period, the Logistic Management Programme expanded rapidly in order to meet the ever-increasing programme needs for contraceptives and related commodities and supplies. Staff and supplies officers were trained and more frequent meetings were conducted between the Division of Primary Health Care and the donor agencies to address issues related to contraceptive supplies, contraceptive method mix and other related logistical issues.

Currently the programme addresses its contraceptive needs and distribution issues through a computerised system. An additional long-term method, the implant (Norplant) has been introduced into the programme and is currently available at the district level.

Information, Education and Communication

To facilitate the production of adequate IEC materials, the programme was to set up a media production centre within the Ministry of Health. The establishment of this unit was, however, hampered by a number of constraints and difficulties. Thus, the National Council for Population and Development in collaboration with the Ministry of Health undertook the same activity through the Family Planning Association of Kenya (a non-governmental organisation in Kenya) with the materials produced privately. The project includes IEC materials such as calendars, posters, T-shirts and pamphlets. In addition to materials produced by this project, other FP projects, i.e., the Family Planning Private Sector working in the field of MCH/FP, prepared additional IEC materials to supplement the above mentioned efforts.

In order to avoid unnecessary duplication - and therefore to maximise the impact - a National IEC committee was put in place under the chairmanship of the NCPD to discuss and plan the various IEC activities including the design, production, distribution, follow-up actions, etc. The Government and a number of multilateral and bilateral donors funded the activities. In addition to the IEC materials produced for use at the facility level, there was a number of channels/approaches that were implemented during this period.

Training Of Service Providers

As mentioned earlier, the Ministry of Health with support of a number of bilateral and multilateral donors was already implementing training activities that covered both the basic training and the in-service training of service providers. Again, interventions to

address the gaps in the basic training of service providers adopted a multi-pronged approach. The components of the approach include review of the existing curricula for various cadres of service providers to include practical management skills related to MCH/FP; strengthening and upgrading technical aspects of various issues in the curricula; upgrading the clinical area; supervision by supervisor in the area of MCH/FP; and logistic and managerial support to all existing medical training centres. Additional medical training centres were constructed and made functional to meet the ever increasing demand for trained service providers that was created by the expansion of service delivery outlets within the public and non-governmental organisation sectors.

Decentralised training centres (DTCs) were established specifically to address the in-service training needs and expanded ongoing in-service training further. This meant that more trainers must be trained to staff the newly established DTCs. The existing curriculum used for the in-service training was also reviewed to address various aspects on quality of care including counselling, technical competence, management and integration of services.

To make permanent methods more accessible, the Voluntary Surgical Contraception Programme expanded training of medical officers on these methods. Updates on counselling and the provision of quality surgical sterilisation methods were introduced and became part of the focus in the doctors' training programme. Newer concepts on quality of services were also piloted with the aim of adopting them for wider coverage. This included the Client-Oriented, Provider-Efficient (COPE) tool. As a result of the successful introduction and implementation of the trials, the expansion of the client-oriented services was undertaken with USAID funding.

At the national level the Division of Primary Health Care (formally the Division of Health) addressed managerial and supervisory gaps by training and updating all the programme managers at this level.

Management and Supervision

At the facility level, efforts to improve supervision were undertaken through the introduction of quality improvement techniques.

Planning and Voluntary Surgical Contraception Committees were created in selected hospital facilities in order to improve the provision of family planning services. Training and deployment of additional public health nurses at the district level

strengthened the supervision by the District Public Health Nurse of all the service delivery points within his or her catchment areas. However, the ongoing expansion added service delivery outlets as well as responsibilities and logistical difficulties that continued to be a major challenge to the improvement of supervision.

At the provincial or regional level, training aimed to develop facilitative supervisory skills of the regional supervisors. Logistics and materials support complemented their training and helped improve effective performance. The support to this initiative has continued through the Government of Kenya and USAID funding.

At regional level, the emphasis continues to be on the consistent monitoring of the following activities:

- Quality of counselling.
- Introducing client oriented services.
- Monitoring record-keeping and referral procedures.
- Ensuring that providers have up-to-date knowledge and skills.
- Helping providers address their service related problems effectively.

The Family Planning Policy Guidelines and standards for service providers were also developed and distributed to all service delivery outlets. However, the number of copies available could not keep up with the ever-increasing demand by service providers for this important document. The guidelines assisted both the service providers and their supervisors in meeting the needs of their clients with the provision of all the approved FP choices and with appropriate counselling/information.

LESSONS LEARNT

While the general quality of services offered continued to register significant improvements, there were several programme weaknesses at the facility level that will need improvement if the programme is to achieve its desired goals. For instance, the following are some of the weaknesses on interpersonal relationships:

- Revisiting clients felt the consultation time was inadequate.
- Service providers imposed restrictions on the provision of nearly all methods requiring the client to have at least one child. This was in keeping with the restrictions according to the Family Planning Policy Guidelines and standards for service providers that have since been revised.

- Most new FP clients were not asked about the nature of their sexual relationship; whether they had discussed family planning with their partners, or the presence of STI/HIV symptoms.
- Screening for cervical cancer seemed not undertaken on a routine basis for all clients visiting the FP clinic.
- Though the proportion of clients who hear about other health issues during their FP consultation increased from 15 to 35 percent, the numbers still indicate that full integration of services is an issue that has not been fully addressed.

Therefore, the situation analysis study, when conducted to assess quality of care, becomes an extremely important tool in the implementation of reproductive health programmes. It provides both programme managers and implementers insights about the changes unfolding within their programme performance.

FUTURE ACTIONS ENVISAGED

The results from the 1995 situation analysis study have been disseminated to all provincial and district teams countrywide with the primary objective of providing the essential feedback to regional and district supervisors as well as programme implementers at these levels. After discussions, the district teams then developed short-term plans that will address some of the quality gaps identified in the context of the National Implementation Plan for Family Planning Programme for the period 1995 to 2000. Over this period the Kenyan MCH/FP programme priorities are in the following areas:

- provision of reproductive health care
- the expansion of services
- improvement of the quality of care
- IEC and advocacy; and
- the financing of the Family Planning Programme.

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INTRODUCING COPE IN ASIA: KUMUDINI HOSPITAL IN BANGLADESH[3]

The assessment and implementation of strategies to improve QOC have remained in the hands of programme managers and senior level officials. The people ultimately responsible for the QOC provided to clients, the service providers, are not often afforded the opportunity to review and improve QOC even though they are the most knowledgeable about the services provided and the ones who interact with clients daily.

AVSC developed COPE (Client-Oriented, Provider-Efficient), a self-assessment and improvement tool to improve QOC. In 1993, it was introduced in Kumudini Hospital in Bangladesh. This is a private hospital located approximately 70 kilometers from Dhaka. It has 750 beds and is the largest private hospital in Bangladesh.

COPE is a relatively simple instrument administered at FP facilities. It aims to evaluate QOC also from the clients' perspectives and to use resources effectively. It requires the participation of clinic or hospital staff to evaluate the QOC using four tools: (1) the self-assessment guide (2) the client interview (3) the client flow analysis and (4) the action plan. The same staff members develop strategies to address the problems they identify and to implement the strategies.

The self-assessment guide is a ten-part list of questions. Each part addresses a specific right of the client based on IPPF's[4] framework for QOC. The staff may choose to use only some or all parts of the guidelines.

As a part of the COPE assessment, staff participants volunteer to interview about ten clients on (a) their opinion on the services provided by the facility (b) their knowledge about the services provided and (c) their suggestions for improvement. The client interview also encourages staff members to ask clients informally, on a regular basis, for feedback on the QOC they receive.

Client flow analysis is a low technology version of the patient flow technology developed by the Centers for Disease Control and Prevention (CDC) in the United States. The staff members are to chart the client flow through the clinic using client register forms. The clients are instructed to present the form to each provider with whom s/he has contact. The provider fills out the form with information on the type of

[3] Summary of a case study published in *Innovations*, written by AB Faisel, M Ahmed, KJ Beattie, BP Pati.

[4] International Planned Parenthood Federation.

visit, and the beginning and end of the contact. The information is analysed to identify problems and waiting times.

From the information collected with the hellp of the above three tools, staff members develop a plan of action to resolve the problems identified. The plan of action includes a statement of the problem, a plan for resolving the problem, assignment of responsibility for carrying out the planned actions to appropriate staff members, and a target date for completion of the planned action and resolution of the problem. The staff members also agree on a follow-up workshop about six months later.

After the head of Kumudini Hospital decided to introduce COPE, AVSC facilitators held a two-day introductory meeting. Staff members then used the COPE tools to identify problems. During the one-day follow-up meeting after the first round of using COPE, 14 of the original 25 problems identified were solved.

Several lessons have been learnt from the application of COPE in a large number of settings all over the world. First, in order for it to be successful, staff members must be willing to be involved in the process. They must see it as a problem solving process that focuses on work processes, and not on personal shortcomings or management deficiencies. Secondly, although the experiences suggest that several problems can be solved using the resources already available, some problems will require additional resources and/or higher level involvement for their resolution. Third, social and cultural factors will affect the implementation of COPE. In some cultures open criticism is considered inappropriate. Therefore, care should be taken to use it as an improvement rather than faultfinding tool. Finally, COPE is a continuous QI tool involving follow-up and periodic repetition of the activities.

CONTINUOUS QUALITY IMPROVEMENT PROGRAMME (CQI) AT THE CATEMACO LOGISTICS CENTER, MEXICO[5]

The continuous quality improvement approach has been used by MEXFAM (Fundacion Mexicana para la Plaeacion Familiar, A.C.) of Mexico since 1991. MEXFAM was concerned with the quality of the delivery of medical services to the rural population, but realised that the lack of resources and remoteness of many communities hampered the delivery of comprehensive service provision to them. Therefore, a programme of CQI was initiated and the Catemaco Logistics Center (CLC) was chosen as a pilot.

The objectives were to continuously improve the quality of the medical care provided to the target population, to prevent and control possible mistakes and to assure client satisfaction. The strategy comprised two steps: (a) establishing a functioning service delivery system with well defined tasks at the four levels: community health assistants, community health technicians, medical brigade, and clinic/hospital staff; and (b) setting in motion a process to achieve desired standards of service delivery.

For each of the levels, factors to control and results to expect were identified. (See Box 1 for an example at the field level). Operation and quality standards were set by a majority vote. Monthly general meetings and extraordinary meetings were convened to resolve problems. The different departments instituted internal cross-supervision. A book containing minutes of all agreements and solutions was maintained.

To adapt the approach to MEXFAM's particular needs, a training manual was developed. This resulted in widespread acceptance of the approach. The implementation of CQI led to an increase in the number of consultations taking place at various service delivery centres, indicating that the target population has not only been reached but has been sufficiently motivated to use its services.

[5] Summary of a case study published in *Innovations*, written by AL Juarez.

Box 1: Level Field Attention: Community Health Assistants (CHA)

Factors to be controlled:

The CHA should have the correct and recognised profile. She detects the problems and identifies the relevant individuals, and has the contraceptives and materials necessary including leaflets and documents.

The CHA should be ready to receive training and can conduct talks. She should also have all the manuals necessary to handle medication and medical procedures. She should be able to determine the appropriate time to request the services of technicians or the brigade.

The expected results:

The FP methods and medication suggested by the CHA are appropriate for the client. And she has, available and ready, the outlets where the technicians or the brigade can work safely. Her referrals should be correct.

The talks given by CHA have an impact. There is a feedback on the training she has received from the community health technicians. All the potential users of the medical brigade services are attended to. Last but not least; the CHA is self-financing.

The CQI approach is a departure from traditional management improvement techniques in that it seeks improvement in the performance at all levels of the organisation and not just at those that are not functioning well. Each level has its own set of standards to which is must adhere. A continuous cycle of measuring current performance against the set standards takes place. Once achieved, the standards can be revised upwards. Because it is a continuous process of improvement, it requires long-term commitment and teamwork.

QUALITY OF FAMILY PLANNING SERVICES IN TAICANG COUNTY, CHINA[6]

Using the Bruce elements of quality as a basis for strategic interventions, Taicang County in China has adopted a series of programme-wide management actions to improve the QOC. Taicang County is located in the southeastern part of Jiangsu province in southern China. In 1993 the natural growth rate was 0.92 per thousand, very close to zero increase, and the total fertility rate was 1.2. At the end of the year the total population of Taicang County was 448,784. The contraceptive prevalence rate was 92.75 percent.

Choice of methods. According to the national FP policy, married couples are free to choose their preferred method of contraception. The following methods are provided: IUDs, pills, condoms, vasectomy, tubal ligation, injection, spermicide, rhythm and withdrawal methods, diaphragms, cervical caps, and Norplant. The programme minimises unwanted pregnancies by providing specific guidance to newlyweds, lactating women, couples who have only one child, couples who have two children, and women experiencing climacteric.

Information and counselling. IEC has played an important role in changing couples' reproductive behaviour. Various types of media are used to disseminate information. Most women of childbearing age have an MCH handbook. Counselling is conducted both individually and in groups, and the communication process has progressed from a one-way (provider to client) to a two-way approach. Consequently, a survey found that the people in the area knew seven methods of contraception on average.

Technical competence. The medical personnel providing FP clinic services must follow two regulations. First, they must adhere to the *General Clinical Standards of Various Contraceptive Methods* formulated in 1989 by the State Family Planning Commission (SFPC) to provide the principles for standard management of FP services. Secondly, the *Birth Control Operation Clinic Routine Standard* laid down by the Ministry of Public Health and SFPC must be strictly followed. All facilities are well equipped and supplied in order to provide quality services. Doctors and nurses must be certified and pass a clinical examination before they are allowed to provide services. The programme keeps important data on, for example, contraceptive acceptance and failure rates, the incidence of abortion and side effects.

[6] Summary of a case study published in *Innovations*, written by X Sun.

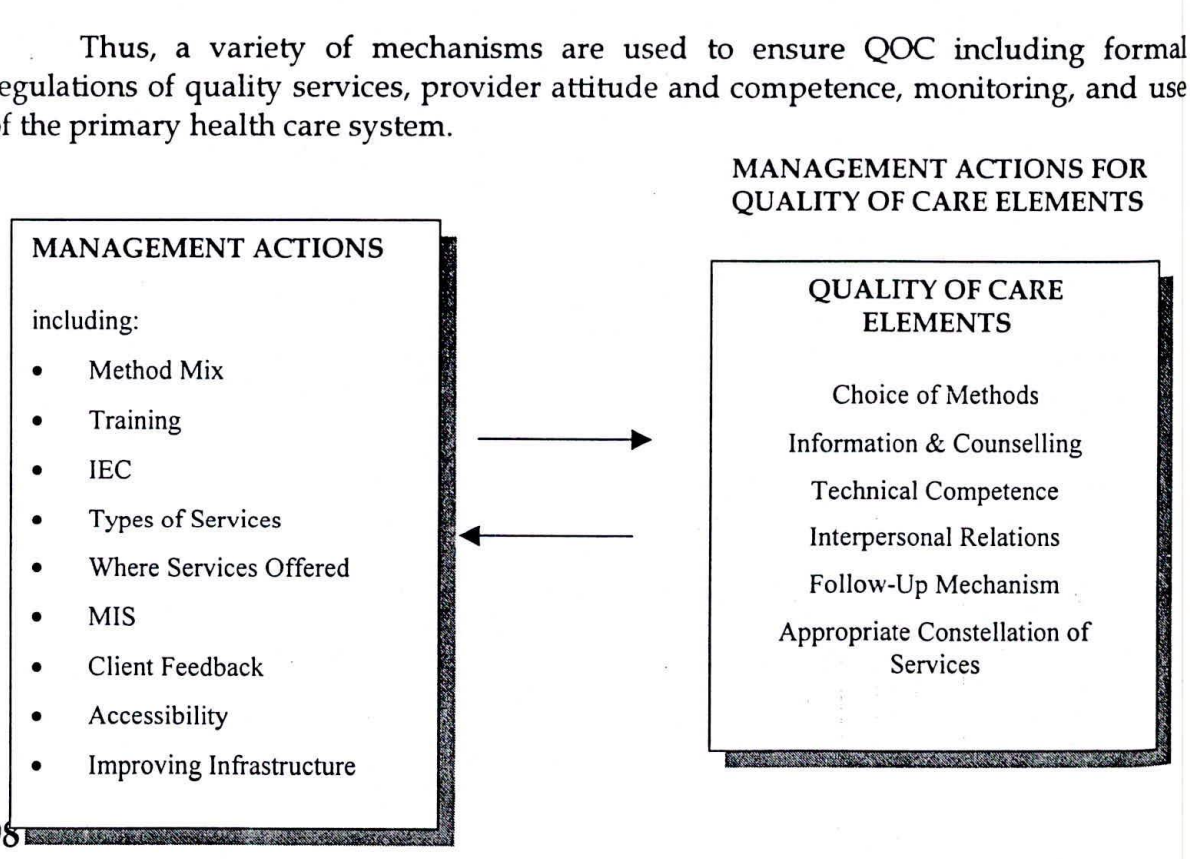
Interpersonal relations. In the course of providing FP services, the relationship between providers and acceptors has improved. The FP workers have continued to deliver services during home visits. They are concerned not only with the acceptors' contraceptive choices but their general health. Therefore, the acceptors like to see the doctors and FP workers when they have problems hoping to obtain advice.

Follow-up mechanisms. Traditionally, the reporting system is done by collecting data on women's reproductive history such as the number of children, current contraceptive methods, continuation of contraceptive use, and so on. A computer-based MIS was set up in 1993 to improve follow-up by providing HCWs better data.

Appropriateness and acceptability. The FP services are provided by well-equipped county and township hospitals. There are strict regulations concerning the clients' rights to privacy and confidentiality. Clients face short waiting time to receive FP services.

Appropriate constellation of services. In Taicang County, FP is integrated with the MCH programmes. In 1993, the Taicang County decided to establish a new service network for health promotion called *Family Health Service Center* from cities to every township and village. The services will cover three groups -- children, couples and the aged.

Thus, a variety of mechanisms are used to ensure QOC including formal regulations of quality services, provider attitude and competence, monitoring, and use of the primary health care system.



QUALITY IMPROVEMENT PROGRAMME (QIP) BY THE MINISTRY OF HEALTH, EGYPT[7]

In 1993, the Egyptian Ministry of Health System Development Project began a two-governorate, nine-district study to improve the quality of the FP services provided. This was the beginning of the Quality Improvement Programme (QIP). It emphasises teamwork and leadership and tries to inculcate positive organisational attributes that will promote quality of care.

The most important feature of the programme is the formation and maintenance of the supervisory team at the governorate and district levels. At each level the team comprises a FP director, a clinical supervisor and a nurse supervisor. All the supervisors must pass a supervisor orientation course designed to provide awareness and understanding of their supervisory skills and responsibilities in applying the QIP monitoring system. The supervisors must make extra efforts to ensure that the clients are properly informed and satisfied with the services they receive.

Each unit receives the *Clinic Procedures Manual* and the *Service Delivery Resources Manual* so that they know the indicators according to which their performance will be judged. The indicators selected cover twelve technical and administrative categories:

1. Clinic equipment/furniture.
2. Clinic facilities.
3. Contraceptive commodities.
4. Infection prevention.
5. Client registration, FP information, history.
6. Method specific counselling, physical examination, method provision.
7. IEC activities.
8. Home visiting/Dropout follow-up.
9. Records/reports.
10. Clinic operations.
11. Targets.
12. Client satisfaction.

Each QIP category comprises a number of individual indicators that the service units should achieve. Using a checklist, the supervisory team awards a mark of "1" where the standard is met and a zero otherwise. The supervisory team visits a service delivery site once every quarter and spends about three days conducting the assessment through observation, interview, role-play and demonstration. At the end of

[7] Summary of a case study published in *Innovations*, written by EH Gebaly, C Brancich, ME Shaffie.

the visit, the team discusses the score with the clinic staff as a whole and sets targets for performance improvement.

The monitoring system has resulted in considerable improvement in the QOC provided. At the beginning of the QIP, in one governorate with 102 units, 42 units received scores below 70 percent, only four units received 90 percent and more, and no unit met the minimum standards of 100 percent. After three-quarters of QIP activities, five units met the 100 percent required, and 31 units achieved 90 percent or more. Only 24 units remained below 70 percent.

The providers complied with the standards of practice and the indicators for the facilities and equipment are improving. The QIP uses an external, pre-determined set of standards as a reference point on which reviews and recommendations are based. Establishing clear standards and assisting clinics in achieving them through effective supervision is pivotal to the success of the QIP in improving the quality of the FP services. It is expected that continued problem solving, decentralisation and teamwork would lead to further improvement over time. In view of the positive results of the pilot project, the QIP is gradually being expanded to cover all service delivery sites throughout the country.

EFFECTIVE PRACTICES RELATED TO HUMAN RESOURCE MANAGEMENT[8]

Not only the service delivery system but also the people who provide services deserve attention if the QOC is to improve. Population Services in Zimbabwe pays attention to managerial practices in the area of human resources, for example, staff recruitment, induction period, training to enhance competence, commitment to team work, frequent feedback, two-way appraisal and adequate incentives. The organisation involves staff members in the planning process and encourages them to continuously learn and innovate.

Recruitment

Effective practices that promote QOC:

- Staff recruitment.
- Induction.
- Training to enhance competence and commitment to team work .
- Frequent feedback.
- Two-way appraisal.
- Adequate incentives.
- Involvement of staff in planning.
- Encouraging staff to continuously learn and innovate.

Sustenance of motivation begins with staff recruitment. It must be carried out professionally and efficiently. Various selection skills are required to make good recruitment decisions. Job applicants can be quite deceptive resulting in bad selections. A thorough, unrushed job interview conducted two to four times as needed with each candidate is important, and it must be combined with an induction period.

The interview may reveal inconsistencies. It also represents a good opportunity to become acquainted with the candidate. It is important to find out why the applicant wants to work for the organisation. How much does the applicant know about it? Is there commitment to its goals, or does the candidate just want a job? Conversely, it is important to brief applicants on the organisation's mission, goals and objectives so that they make an informed decision.

The interview should discuss remuneration including the organisation's performance-related incentive scheme, and so on. It should closely examine the candidate's education and qualifications to ensure that they fit the position. References by phone or in writing should be sought from past employers. Refusal to give written references may indicate a possible problem. Length of time in the previous position is also

[8] Taken from ICOMP's seminar report, contributed by A Rugara, Population Services, Zimbabwe.

important. The induction/probation period should be at least three months, six for key posts, in order to provide ample opportunity for interaction, training, exposure to the organisation, and to determine whether the person can deliver.

The role of appraisal

The candidate and line manager must agree on appraisals throughout the induction period. Weaknesses and strengths may be discovered to assist in the final hiring decision. If the candidate has many strengths, but is lacking in some ways, the induction period may be extended, but this may also cause problems. Appraisals should continue after the candidate is permanently employed. A two-way appraisal was at first controversial in Population Services, but is now well accepted and has improved staff/manager relationships. It is important to capitalise on the strengths of employees and improve on the weaknesses.

Training and other issues

Training is also very important in enhancing commitment to teamwork and QOC. Both in-house and formal training is provided, for example, FP and STI updates are done and contribute to staff motivation. Training needs are assessed on a continuous basis. Staff members are always involved when change is taking place. They must own the change which, after all, they will be responsible for implementing.

Similarly, Population Services has a GAP (good action planning) process which provides staff with an opportunity to do a SWOT analysis, consider the organisational environment, and participate in the planning process. This has increased motivation through increased knowledge and organisational transparency. Other important factors contributing to staff motivation include two-way motivation, staff meetings, frequent feedback, adequate incentives, staff setting their own objectives, and continuous learning and innovation to avoid stagnation.

ACTION RESEARCH IN COMMUNITY HEALTH AND DEVELOPMENT[9]

Action Research in Community Health and Development (ARCH), founded in 1982, serves a rural community near Baroda in the state of Gujarat, India. Founded by, among others, a husband and wife team, Dr. Anil and Daxa Patel, ARCH began its activities by studying the problems and diseases most prevalent in the area. It explored the needs and wants of the community as well as its beliefs and misconceptions -- efforts that enabled the organisation to develop effective service, counselling and health education programmes. It is also interesting to note that the founders acquired much of their knowledge of the area as a result of their informal relations with the community health workers (CHWs), their emphasis on two-way communication, and the continuous learning/training process to which they committed themselves.

Since ARCH's inception, each and every intervention developed is based on research and a carefully developed plan of action. This process continues also after the intervention has been launched. ARCH offers comprehensive primary health care services to a project area with approximately 12,000 population. Over the years, the services of ARCH have grown from meeting community's needs in the areas of acute illnesses and maternal health to those in reproductive health, including diagnosis and treatment of RTI/STD.

The use of the CHWs in providing services has proved to be effective because the organisation provides adequate training, supervision and technical back-up to the workers. This programme also offers a strong educational programme aimed both at particular target groups and the community at large.

ARCH attributes its success in ensuring a high level of QOC to the CHWs who are the core service providers. Specific approaches to staff management, or more specifically to the CHWs, are considered essential in developing their potential. The CHWs are particularly effective in performing some tasks because they are rooted in the community. Some of their tasks are as follows:

- bridge the gap between tradition and medical science.
- provide culturally acceptable and low cost health care services.
- encourage women's participation.
- help evolve a tentative body of knowledge about women's concerns, their wants, and their apprehensions.

[9] Taken from ICOMP's QOC training manual, summary of a paper written by MB Dohlie et al. The summary is also based on a video on ARCH. Funded by UNFPA.

- help prepare acceptable health education materials and conduct health education to the community.

ARCH has currently fourteen full-time and six part-time health care workers in addition to two doctors.

Selection of CHWs

ARCH prefers to recruit women from either the project villages or the village of Mangrol where the clinic is located. The selection of a worker is largely based on her communication skills, her willingness to learn new things, and her ability to interact with all women irrespective of caste or community. All the current CHWs started as part-time workers. Many outstanding workers were selected to work full time.

Training of the CHWs

"As we worked with women in an atmosphere of friendly informality, we learnt a lot about the worries of the women, what they really wanted, what they were apprehensive about and what were their hidden, unspoken shames," says Dr. Daxa Patel. It is from this understanding that a tentative body of knowledge was developed. It was further checked and tested in large, formalised and structured meetings. The training materials were a result of these experiences.

Training at ARCH is a slow and ongoing process. The relatively low levels of education of the CHWs presented a challenge. Not only did the health care workers need to learn the complicated and unfamiliar concepts of modern medicine, they also had to overcome their own traditional beliefs. All the new concepts had to be internalised and accepted.

The process of teaching the CHWs new concepts and about illnesses, developing their skills in diagnosing, making correct interventions and providing appropriate treatment took a long time. The following methods and factors facilitated the training of the CHWS:

1. CHWs learned on the job by examining the patients with the doctor. In this way, they learned to take the medical history, to diagnose, to explain the disease and treatment to the patient, to administer treatment, and to document and keep records.

2. Currently, the CHWs can manage 70-80 percent of the cases on their own. With the remainder, they need assistance from the doctors. Clients have gradually come to accept care from the CHWs. Working alongside the doctors at the dispensary established their credibility in the eyes of the villagers who are no longer apprehensive of receiving care from them in their homes.

3. The categories of illnesses were introduced to the CHWs in an incremental manner.

4. Weekly meetings and case discussions have contributed to the training process.

5. The training of the CHWs in various laboratory procedures further increased their diagnostic skills.

The relatively slow process of training the CHWs allowed them to move from a point at which they were supplying drugs, but understood little of the reasoning behind it all, to a point at which they understood the concepts of modern medicine and internalised this knowledge. Firmly rooted in the community, they had at the same time a thorough understanding of the cultural beliefs existing there. For this reason, they are exceedingly effective educators and also constitute an important link between the community and the doctors at ARCH who continuously strive to understand the community and respond to its needs. After the training, the CHWs worked alongside Dr. Patel until they were confident enough to treat minor illnesses. It took another 1-2 years for them to gain confidence to treat more complicated diseases.

In addition to the dispensary work, all CHWs are responsible for health care in their individual villages. They also collect vital data, conduct health education to the community, distribute iron folic tablets, and immunise children who have not been covered by the (government) ANM. The health workers do not do door-to-door visits unless required but rather diagnose and dispense medicines from their own house in the village.

Management of staff

Dr. Anil Patel, one of the founders of ARCH, says, "*ARCH values a democratic organisation in which communication flows freely up and down. It may indeed be a misnomer to call it up and down as there is little hierarchy; it is expected that socio-economic and caste differences play no role in any interactions.*" These as well as other expectations are clearly articulated.

Employees have much flexibility in terms of how, and, to some extent, when to perform their tasks, but tasks are expected to be performed correctly and well. On the other hand, it is also accepted that mistakes are part of the learning process. The precondition is that staff must own up to their mistakes and learn from them.

All ARCH employees participate in the decision-making process. At weekly meetings attended by all full-time staff members, issues and decisions related to the organisation as well as client cases are discussed. Thus, the meetings constitute an important part of the continuous learning/training process of the CHWs.

Supervision is supportive and positive feedback is frequent. Part-time staff in the villages are supervised by senior CHWs as well as by the doctors who visit the villages regularly. Part-time staff also attend meetings and training sessions at ARCH on a regular basis.

When enquired about their motivation to perform, a worker said, "*there is an open and friendly atmosphere here and we like the opportunity to learn and develop skills.*" Another mentioned, "*I like to work at ARCH because I know what is expected of me and we can work on our own without somebody looking over our shoulders or scolding us.*" The workers feel that they want to give back to the community because they have had an opportunity to learn and develop. In addition, the CHWs tend to emphasise the fact that the community appreciates their services and that clients often express gratitude. The friendly atmosphere observed among staff carries over to client/provider interactions.

While many factors have contributed to the success of ARCH, three deserve particular emphasis: (1) the strong groundwork, research, and intensive planning before starting an intervention (2) ARCH's ability to learn from the community and (3) the critical role of the CHW's in providing RH care services to a traditional, poor society through their dissemination of ideas, information, and knowledge.

TOTAL QUALITY MANAGEMENT IN MALAYSIA'S GOVERNMENT HEALTH SERVICES[10]

Quality is the most important item on the agenda for the health care system in Malaysia. This is reflected in the following comment made by Dr. Abu Bakar Suleiman, Director General of Health, Malaysia, in his recent address at the World Congress on Quality of Health Care:

> *"Quality, as perceived by consumers must be the number one priority for any health care system that strives to excel."*

In 1989, the Malaysian Government introduced the "Q" program into all its agencies. The program is a Total Quality Management (TQM) approach which relies on seven strategies, the 7-'Q's:

- quality day.
- quality slogan.
- quality information system.
- quality feedback system.
- quality suggestion system.
- quality process system.
- quality assurance system.

The Quality Assurance Program

By 1985, the Malaysian Ministry of Health (MOH) felt that it had succeeded in providing extensive coverage of health care services to the population. Therefore, the Quality Assurance Program (QAP) was initiated to achieve the optimal benefits from the resources available to the programme. The QAP had three objectives: (1) to improve health care (2) to increase resource utilisation and (3) to enhance customer satisfaction.

Initially the National Indicator Approach (NIA) was used to set standards for optimum achievable levels of quality of care and to assess the quality of care in all government hospitals. By 1992, the approach covered all the MOH activities. As this approach created an awareness of quality, hospitals and districts were increasingly encouraged to set their own standards (with hospital and district specific indicators).

[10] Summary of a case study written by J Satia and MB Dohlie, ICOMP 1995.

The QA process is envisaged to comprise eight steps: problem identification, prioritisation of the problem, assessment of quality of care, problem analysis, investigation, identification of remedial actions, implementation of remedial actions and evaluation of quality of care.

The program is organised by the steering committees specially established for this purpose at the ministry level, at the divisional level and state levels. This approach led to considerable improvement in quality as indicators continued to improve over time.

Quality Control Circles

Quality Control Circles (QCC) have been a feature in Malaysian government agencies since the early 1980s. These activities focused on solving many day-to-day problems or those that cause customer dissatisfaction. The groups are decentralised and each facility has its own QCC.

TQM: Building a Corporate Culture

The Malaysian Government introduced TQM in all its government agencies to make public services more responsive to people's needs while also improving their efficiency and effectiveness. While the Malaysian approach includes the QAP and the activities of the QCCs, the "Q" programme takes a more comprehensive view of quality resulting in a relatively stronger focus on clients, on the development of human resources, and on the creation of an enabling environment.

To create a philosophical foundation and an enabling environment for the programme, both a vision and a mission statement were formulated after consultation with key stakeholders. To further develop the organisation and its focus on clients, the programme adopted a "Corporate Culture" in the early 1990s. It has the following three core values: (1) caring services (2) team work and (3) professionalism.

Awards are used to motivate employees to improve the QOC. Priority is given to communication with all staff on issues related to quality through talks, guidelines, and other means. There is visible evidence of the enthusiasm that exists at the local level when exhibitions are organized on quality day. For example, one official states: "Formerly the frontline workers obeyed the instructions issued from the top. Now we see that they want to tell us what they have done. They are proud of themselves."

The client's charter developed is used to empower clients and institutionalise quality. It enables the public to evaluate the service performance against the charter. It has led to increased expectations on behalf of clients in terms of what they should expect and can demand. The client's charter defines the responsibilities of the health care facilities and service providers as well as the client's obligations.

In conjunction with higher per capita income, better socio-economic conditions, and rising expectations among clients, prioritising quality of care has led to considerable improvement in the health status of the population.

7

What Would Managers Need to Do?

The importance of improving QOC is widely recognised. Now the major issue is not why *quality* but *how to improve quality*. As the action research and other examples documented in this issue of *Population Manager* show, quality improvement (QI) is not an autonomous process. On the contrary, it requires well-planned proactive actions. Based on these experiences, Chapter 7 discusses the lessons learnt and QI approaches used. The role of leaders and managers in QI is also discussed along with actions required to initiate and sustain this process.

LESSONS FROM ACTION RESEARCH

Many lessons were learnt in all three countries since the inception of the project. Moreover, several issues arose in the move towards comprehensive RH care services.

Quality can be improved, even in constrained settings. The cases demonstrate that quality could be improved despite the many constraints faced in the public sector. At the project sites in the three countries, clients perceived that improvement took place in the services provided. However, quality improvement is a slow, time consuming and labour intensive process that must be allowed the amount of time required by the individual programme depending on the cultural, social and organisational context as well as the maturity of the programme.

Rapid assessment appears to be an effective tool for managers to assess the QOC of their programmes in a relatively easy and inexpensive way. The action research in the three countries - India, Sri Lanka and Vietnam - showed that involving managers in carrying out a rapid assessment in their area quickly sensitised them to address some of the problems identified. Once the problems are identified, managers and staff may explore ways to correct them. However, a rapid assessment will only uncover the nature of problems and not their scope.

Although there are many similarities in the quality-related problems identified, their extent and nature may differ from one programme context to another. Therefore, many actions taken to improve the quality of care were common to the three action research sites. These activities included sensitisation of staff to quality of care, training to improve counselling, information giving and technical skills, and the use of supervisory checklists to assure quality. They also encompassed relatively modest investments to improve the infrastructure and to establish new community outreach arrangements both to improve access and availability and to address broader RH care needs. Improving quality of care requires attention to mundane issues such as cleanliness, availability of water, functioning toilets, curtains to ensure privacy, and overall maintenance of facilities.

Box 1: Possible Interventions

Common Interventions:

- Training in QOC, counselling and technical skills
- Supervisory check lists
- Modest investment in infrastructure
- Community outreach
- Attention to mundane details

Context Specific Interventions:

- India: Community mobilisation through women's health committees and village health committees
- Vietnam: RTI screening and treatment, IUD insertion at commune health centres
- Sri Lanka: Organising quality well woman clinics, improved organisation of community clinics, group counselling on sexual and reproductive health

However, activities to improve the quality of care also differed at the three sites. In India, for example, there was considerable emphasis on forming women's and village health committees and on educating them on reproductive and child health. In Vietnam, providers were trained in IUD insertion at selected commune health centers, RTI/STD screening was introduced at two sites, and selected providers were trained to do group education for youth and men. In Sri Lanka, several changes were made to better organise community clinics. Service providers were trained to do group counselling sessions on sexuality and reproductive health in the community. Moreover, quality-related issues in relation to the planned well woman clinics received attention.

Hence some interventions were common whereas others were specific to the programme and cultural context.

When improving quality, the issues of access and availability often must be addressed. At all the three sites, issues of access and availability arose and had to be addressed. Additional facilities and staff are often thought to be necessary to improve access and availability. However, the action research shows that reorganisation of the work and of staff time can play an important role in improving access and availability.

Many of the structural inputs required to improve the quality of care are very basic and relatively inexpensive. Some of the examples include curtains to ensure privacy, benches for waiting clients, stethoscopes and/or cuffs to enable providers to record clients' blood pressure, scales for babies or adults, follow-up cards, IEC materials, and so on. Even if many of these inputs are relatively inexpensive, it may under normal circumstances be difficult for managers and staff at the service delivery level to procure such items. Centralised procurement processes often do not include the items and make little allowance for possibly varying needs at different sites.

Change in work behaviours and improvement in staff morale must take place in order to make the improvements in infrastructure, equipment and supplies sustainable. The female HCWs were provided with various equipment and supplies at Shamirpet PHC in India that made it possible for them to provide better services. The interventions appear to have improved their relations with clients and community and to some extent boosted their morale. Given the fact that the female HCW is the manager and provider at her sub-centre, it is possible to make her personally responsible for the equipment and supplies provided. This has been more complicated at the primary health centre (PHC) where different types of staff must learn to work together as a team and to take joint responsibility.

Overall, these are extremely complicated issues in *all* organisations and perhaps particularly in large government programmes. The issues also highlight the importance of managerial skills and practices. Authoritarian management styles are quite common while success in improving the quality of care will require programmes to adopt a more participatory style that allows for involving staff at all levels to tap their creativity and ability.

Staff sensitisation, training and monitoring become major interventions when programmes confront quality improvement. The QI teams at the three sites identified these interventions among their major activities. The training needs were diverse and addressed counselling skills, knowledge in the areas of family planning, STD/HIV and other reproductive health issues and sometimes also primary health care, technical skills, infection prevention, clinic management, and recording/reporting. However, a

one-time training is not enough. New skills need to be practised on-the-job under close supportive supervision.

There is a need for reviewing training modules to ensure that they are conducive to a high level of quality of care. At the same time, it is important not to forget the basics. At the project site in India, the team found it necessary to train the HCWs in using the scales, stethoscopes and blood pressure cuffs provided by the project. In Vietnam, improving technical skills in IUD insertion, MR and vasectomy was an important issue that was addressed along with improved counselling and information giving. However, it is not necessarily easy. Bottlenecks emerged in the vasectomy training in both Sri Lanka and Vietnam because an insufficient number of men wanted the service.

The earlier comments of the HCW worker in Sri Lanka may guide programmes in their quest for better training programmes ("Now we are told to be kind"). It is not enough to take for granted that staff will exhibit good work habits. Programmes must introduce their expectations in their training programmes and provide subsequent on-the-job reinforcement of good work behaviours.

Programmes need to consider community education in their efforts to improve and increase the information and prevention messages clients receive. Many HCWs already carry a heavy workload. Much of the information which programmes need to communicate could be given in a group setting rather than to the individual client coming for services. Traditional FP programmes generally do not reach non-users, men, youth of both sexes, and women past reproductive age. New innovative approaches are required for this to happen. If, indeed, programmes offered comprehensive community education programmes, more target groups would be reached, and HCWs might have more time to focus on the individual client requesting services at the clinic for her/his problems.

The community outreach interventions at the Indian project site contained FP and other reproductive health information (in addition to primary and public health information). In the context of Sri Lanka, the public health midwives themselves came up with ideas for new subjects in their information sessions for the community after they had been sensitised and trained.

The QI team in Sri Lanka used the male public health inspectors to communicate with and involve men. Similarly, the Indian team increased the role of the male HCWs in the areas of FP/RH.

Both the skills level of the HCW doing the outreach and the socio-cultural context probably determine the speed with which a programme may proceed with its RH education and outreach efforts. These factors may influence the type of sessions the programme chooses to provide. In Sri Lanka, for example, mixed groups were possible whereas in India and Vietnam the groups were either male or female with information generally provided by someone of the same sex.

The action research project shows the considerable extent to which quality requires a different way of thinking and of doing things. Managers and supervisors must change their approach when they aim to improve quality. The action research also highlights the critical role of management and leadership.

Managerial Styles and Systems Conducive to Quality. An important task of managers at all levels becomes that of mentor and of enabling staff (and lower-level managers) to perform their work better than before. Problemsolving with staff is important. This requires open two-way communication. It is interesting to note that the concept of quality with its implications for systems and managers seems to be much easier to inculcate in a less autocratic context or system. Managers and staff at all levels may already be more used to relatively more openness and equality in dealing with each other as well as with clients. In this context, it appears easier to encourage staff to be frank about problems they encounter while in a more autocratic context staff are sometimes more concerned with cover-up. Lack of accountability may further compound the problem. If there is no faith that appropriate action can or will be taken at higher levels, staff at lower levels will not bother, maybe not even dare, to raise issues.

Commitment to Improving Quality. Unless there is genuine commitment to quality at the *top* levels of the organisation, it may not be possible to achieve truly sustainable quality improvement. In addition, this commitment must also permeate all levels down throughout the system. Unless there is accountability and transparency in the programme, however, appropriate actions by management cannot and will not take place to change work behaviours sufficiently. In such situations, one can, in other words, create enabling conditions for those who want to work while those who do not perform their duties may continue to do so with impunity. The latter will generally have a demoralising impact on all staff. If, in addition, the efforts to improve quality take place in a setting where there is relatively little accountability to the *community*, the situation becomes even more difficult.

Role of Supervisors. Current supervision is often inadequate or insufficient for the on the-job coaching and monitoring that need to take place after initial training. In line with the new management approaches described above, supervisory behaviours need

to change. The COPE programme example highlighted the fact that criticising is more difficult to do in some cultural contexts than others, and that a positive rather than a negative approach - problemsolving, rather than fault-finding – is essential to success. Similarly, the example from Zimbabwe emphasised the importance of building on employees' strengths while improving weaknesses. The CHW at ARCH also indicated that a positive enabling approach works better than a negative approach such as "scolding."

The QOC project encouraged supervisors to go beyond their customary inspection and monitoring of, for example, targets. The project developed different types of checklists that were adapted to the local context by each team. The lists are training tools that might eventually serve the workers directly as an aid to remember tasks and to do them correctly. They can be used as a basis for discussion and problem-solving between supervisor and supervisee or among co-workers. Moreover, the checklists are a useful aid for supervisors who often perform their tasks inadequately prepared.

Given the emphasis on reorientation in management approaches, work behaviours and processes, we found that quality improvement is both time consuming and labour intensive. It may be tempting to fall into the trap of spending too much time on structural inputs because they are so much easier to deal with than issues related to people and management. In addition, some settings require relatively more input than others do. Some programme contexts also will have more difficulty in dealing with the implications of the concept of quality. As emphasised above, the mere existence of brooms, waste containers, and so on will not alone ensure a cleaner site unless staff begin to think differently and change their work behaviours accordingly. Even under the best of circumstances, however, re-orientation does not come easily.

In addition, most FP/RH programmes are already involved in many activities and some may find it difficult to spend the amount of time and effort required to improve quality, or they appear to need to spread the effort over a longer time.

Considerable investment of time is required to sensitise staff and provide appropriate skills-based training. Both are critical to bring about sufficient change to improve quality. As discussed above, the QI teams at the action research sites spent considerable effort on staff sensitisation and training - or retraining - to improve staff's skills and level of knowledge.

The extent of sensitisation required to improve the QOC may be under-estimated. The effort must be on-going until new behaviours are internalised. Similarly,

the QI teams themselves required both time and sensitisation to become prepared to break away from "old" ways of thinking and performing tasks.

The very heavy emphasis on or promotion of some methods in the Indian and Vietnamese programmes illustrates well the need for reorientation and change in work behaviours.

As the benefits of improving quality are felt, staff morale improves, the community becomes more involved and local managers take many actions to improve quality on their own initiative. In the action research project areas, the early indications are that staff respond to the new circumstances enabling them to do a better job. (This transformation has already taken place in many of the NGO experiences described in Chapter 6). This applies to better physical work environment, improved skills and knowledge, and a different and more supportive approach on behalf of supervisors/managers. In both India and Vietnam, the community/commune also responded to the perceived improvement by providing funds, better space for the clinic, and so on. Both programmes were very proactive in encouraging this to happen. The local involvement will presumably have a positive impact not only on the programme but, ultimately, also on the health status.

The perceptions of quality - perhaps particularly in terms of interpersonal dimensions - vary considerably among countries and among providers within a country. Although the various quality frameworks developed contain dimensions of quality that have universal application, their interpretation may vary greatly in different contexts. The issue of privacy is interesting in this respect.

The potential for pilot projects to play an important role in terms of advocacy for quality improvement may sometimes be overlooked. Moreover, aiming to provide quality services implies advocating for other RH services to meet clients needs effectively. Overall, the pilot projects played an important role in sensitising the top managers to quality issues. Improving quality of care became a priority for the programme managers in all three project sites.

Quality efforts are generally driven from the top, but the efforts are truly successful when quality becomes everyone's value and responsibility. Some middle level and field level supervisors are more effective in inculcating this value in staff than others, so within a programme quality will vary. Similarly individual staff members are receptive - or not receptive - to varying degrees. This makes it difficult to compare sites A and B in a particular programme. When evaluating their progress in quality improvement, they should, above all, compare their current performance against their

past performance while using better performing sites as a *benchmark*. There may also be external factors that make it more difficult to improve quality at site A than at site B.

Sometimes site B's reaction to quality improvement at site A is *"we are already doing that"*. This is not an approach or attitude conducive to QI. The point is that site A - and maybe the majority of other sites in the programme - may *not* be, and they need to improve their performance. Instead site B could pick the same or another area to improve *against its own higher standard*. That is continuous quality improvement as opposed to meeting a set standard.

LESSONS FOR THE SHIFT TOWARDS COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES

Current QI efforts must deal with the improvement of existing services as well as the difficult transition to more comprehensive RH care services. The project worked on the premise that current services should be improved with a gradual addition of new activities and services depending on the programme's ability to introduce them adequately and safely.

The experience to date shows that if comprehensive quality RH care services are to be introduced, then the knowledge and skills of staff and service providers must improve greatly in many settings. Staff in all three programmes required considerable training to perform tasks that their programmes have normally not addressed such as STD/HIV prevention. Inadequate technical skills may represent a problem area even for existing services.

Given the fact that both medical doctors and different types of HCWs sometimes appeared unprepared to perform, for example, pelvic exams, it is important to examine the curricula of medical and nursing schools along with those of training programmes for HCWs. With a view to the services implied in the ICPD-POA, are existing training programmes sufficiently *skills based, relevant and up-to-date?*

There is, and will probably continue to be, a considerable demand for service providers who can perform different types of procedures related to RH. This is due to the heavy burden of disease related to this area of health and its relatively large impact on overall health. Moreover, many clients may currently not even seek care for such problems because of their low awareness of RH. On this background, the question must be asked whether general practitioners are sufficiently and adequately trained to perform many of the most common procedures. These include pelvic exams, treatment

of RTI/STD, follow-up of abnormal Pap smears, and various procedures related to pregnancy such as obstetric complications, menstrual regulation, medical termination of pregnancy, treatment of post-abortion complications, and so on.

At all three sites, the project made use of the skills, knowledge and staff of the respective STD or STD/AIDS control programmes. There was considerable willingness among FP/MCH and STD/AIDS programme personnel to cooperate. It is interesting to note that the STD/HIV programmes and their staff may be very positive role models for staff in traditional FP/MCH programmes because they are already used to asking some of the questions that often cause quite a bit of embarrassment among other service providers.

In most countries, there should be much room for cooperation (or preferably integration) between these services. STD/HIV programmes tend to be relatively understaffed and mainly focus on high-risk groups while FP/MCH staff have access to the mainstream population. The inherent conflict between these services, i.e., the emphasis on protection against pregnancy versus disease, could be overcome with a strong message about dual method use. Cooperation between the two programmes does, however, raise many different issues.

The first issue may be one of coordination. How can STD/HIV programme activities be closely coordinated or integrated with FP/MCH activities with no disruption of daily activities/service provision? How can other programme activities with an impact on reproductive health be better coordinated with these activities? Do HCWs have enough time to provide the services required in the programme that we want to see evolve? What are the implications for managers at all levels of the bureaucracy? Are the structures developed for the delivery of FP programmes appropriate for the delivery of more comprehensive reproductive health care services?

The question needs to be raised whether the barriers to discuss difficult issues with clients may be among staff rather than clients. Family planning and even more so other issues related to reproductive health tend to be considered sensitive to varying degrees in most countries. Adding information about STD/HIV did not appear to present significant problems at the sites in either India, Sri Lanka or Vietnam. Outreach activities to both men and women were overall met with interest. Clients sometimes expressed appreciation that they were able to ask questions related to this area - for most it appeared to be the first opportunity they ever had to do so. Staff were overall willing to discuss the above issues with different types of target groups. Asking individual clients questions about their sexual history during the client/provider interaction appeared to be more difficult. It should also be added that it was not easy to find individuals with good counselling skills. This complicates the issue of staff (counselling) training.

The difficulty staff may have in discussing various issues with clients reflects the fact the traditional FP/MCH programmes have shied away from issues of sexuality. As programmes aim to implement the ICPD-POA, however, it will become increasingly difficult to continue to do so. Secondly, sexuality and gender are inextricably linked. Women's roles are socially constructed and only partly a result of biology. Effective programmes must take into consideration not only of women's biology but also of their overall low status.

How to operationalise gender sensitivity at the field level remains to some degree an open question. In the project, the Women's Health Committees in India are very much based on the concept of empowerment. The community outreach activities in all three project areas aimed to encourage responsible male sexual behavior and male method use. Men appeared very interested in the opportunity to gain information.

Introduction of new RH services will increase the pressure on referral points. The critical question is to what extent they are prepared: Are already overcrowded hospitals prepared for new waves of clients who earlier had an unmet need? For instance, as RH services are added, the programmes must face issues such as cancer screening, services for infertility and for older women. Some will require interventions at higher levels. Many difficult questions must be considered in this context: To what extent should and can governments pay for such services? What priority should new activities be as opposed to improving the quality of other important prevention activities?

The introduction of new services will challenge programme capacity not only to provide more services at higher levels or in terms of providing continuity of care. How should the process of referral be managed in an orderly fashion? Referral will need to take place both within and outside programmes. How do programmes follow-up on these clients? These are some of the issues that received attention in all three project areas.

There is a need for developing adequate standards and guidelines for all RH services. Most of the services which programmes have committed themselves to making more generally available after Cairo are provided in some fragmented form or another in most countries. However, adequate standards and guidelines were generally not available.

In this connection, it should be emphasised that the private sector plays a considerable role in providing medical services in many countries. Clients often appear to prefer these services because they are perceived to be of better quality, more easily

accessible and so on. While client/provider interactions may be more cordial in the private sector and the amenities better, this does not necessarily guarantee better technical skills or that the medical practices are appropriate. Government must initiate, encourage and facilitate efforts to improve these areas also in the private sector.

QUALITY IMPROVEMENT APPROACHES

The QI experiences discussed in Chapter 6 demonstrate four approaches to improve quality:

1. *Quality Assurance Approach (QA).* In this approach, standards are established for structure, process and outcome of quality of care. The actual functioning is compared to existing standards, and outliers are investigated for the causes of the deviations. The reason for lack of compliance with standards may be common to all service units (*systemic* cause) or *special* to one service unit or service provider. The remedial actions required may differ accordingly. The quality improvement approach used by the Ministry of Health in Egypt illustrates this approach. Supervisory checklists were used to assess the quality of care provided at the SDPs and scores were assigned based on the checklists. The individual units were encouraged and assisted to improve their score and thus improve quality on a continuing basis.

2. *Systems Improvement Approach.* Both the Kenya and Taicang County (China) examples illustrate this approach. In this approach, tools such as situation analysis developed by the Population Council are used to assess the elements of quality of care. Managers could also carry out a rapid assessment of the quality of care the programme is providing. Based on the assessment findings, various systems - logistics, IEC, training, supervision and so on - are strengthened. The Population Services (Zimbabwe) and ARCH (India) examples illustrate how NGOs often pay attention to their practices related to human resource management to improve quality. Besides effective human resource management, ARCH uses a variety of other mechanisms such as listening to the community and staff to ensure a high level of quality of care.

3. *Quality Improvement Approach.* Considering the possible disadvantages of the traditional QA approaches because they may be top-down and ignore human elements, many organisations have begun to involve staff in the problem solving process. COPE developed by AVSC and QI teams in Malaysia are examples of this approach. COPE is a relatively simple low-cost localised problem solving approach that relies on the use of the programme's existing approach. However, in the absence of a stated programme-wide policy for quality improvement, a fair number of

problems may remain unsolved. The continuous quality improvement (CQI) example in Mexico illustrates an approach where the results to be expected and the factors to be controlled are established. Standards for operation and quality are set using a participative approach. Local teams subsequently utilise the standards to institute a continuous cycle of performance improvement.

4. Malaysia's *Total Quality Management* approach utilises all of the above approaches and, in addition, aims to develop an organisational culture conducive to quality by paying particular attention to issues related to the management of human resources. The programme determines clients' needs and plans for quality.

Programmes may wish to gradually move towards a quality transformation similar to TQM/CQI. However, as the Malaysian example indicates, it may take more than a decade of effort to reach that stage, and at that point, the process still needs to continue.

A Blueprint for Action

Many actions are required to influence the organisational culture to make it conducive to quality and QI. Various roadmaps have been developed for this purpose and include a combination of *quality planning, quality control* and *continuing quality improvement.* Below we describe the steps adapted from Juran's trilogy of quality management.

Quality Planning

1. Review or create a vision for the programme and raise the awareness of quality throughout the organisation
2. Determine who the clients are and determine their needs
3. Develop standards considering both the client, provider and programme perspectives of quality
4. Select indicators for measuring quality of care
5. Design the service and develop the processes needed to produce or deliver the service
6. Transfer the service to a site as a pilot project, implement and utilise evaluation results
7. Plan for up-scaling
8. Review systems and structures
9. Upscale

Quality Control

1. Evaluate services actually provided
2. Compare with standards and goals
3. Act on the difference
4. Review standards and goals
5. Redo the above cycle

Continuous Quality Improvement

1. Establish improvement teams, motivate and train them
2. Review training and development for staff
3. Provide training
4. Establish the infrastructure and provide resources
5. Follow a continuous improvement cycle to diagnose and solve problems
6. Do a pilot project, evaluate and upscale
7. Repeat steps 2 through 6.

Role of Leadership and Managers in Quality Transformation

This section will focus on the role of leadership in creating and sustaining organisational commitment to quality RH care services. Various characteristics of organisational culture conducive to quality are discussed such as client-orientation; focus on processes and systems as well as overall performance; continuous QI and a proactive approach to QA; human development; and openness to learning, experimentation and innovation.

The quality transformation puts the spotlight particularly on leadership and management and the critical role they play in accepting and interpreting the new management paradigm correctly and in creating an organisational culture conducive to quality. Leadership has been defined as *the process of influencing a group toward the achievement of a goal or purpose* (Reitz 1977). In other words, it creates a vision and sustains motivation. Management, on the other hand, is responsible for making resources available and creating enabling conditions for employees. It is argued that, in excellent organisations, managers are both effective leaders and managers.

Quality is not a separate issue or programme. In many client-oriented organisations, the leaders/managers have made quality *a way of life* in the organisation

through its focus on meeting clients' needs and creating enabling conditions for staff to perform at optimum levels (see the example of ARCH in Box 2).

Box 2 - Making Quality a Way of Life: Leaders as Role Models and Facilitators

Action Research and Development in Community Health (ARCH)

ARCH (discussed in Chapter 6) invested considerable time in the development of staff, CHWs, with relatively low educational levels. They were rooted in the community and received intensive on-the-job training working side-by-side with the founders who were their role models and mentors. The leadership greatly facilitated the tasks that staff were to perform by creating enabling work conditions. Adequate infrastructure, equipment and supplies were available. There was timely feedback and effective supervision. The CHWs had a sense of control over their work situation; and, above all, a sense of purpose and meaning. The organisation has always had high expectations of staff, but accepts mistakes as part of learning.
(Information taken from a paper written by Dohlie et al, 1995)

The issue of leadership *style* has received much attention. The terms used to describe the styles generally reflect the relative level of direction and support provided to employees.[1] Gradually, the concept of *situational leadership* has emerged, i.e., the leader must use *different styles adapting to the particular situation*. This situation depends on the employee(s), the task(s) to be accomplished, and so on. Variables include, among others, the employees' experience, background, age, gender, education, skills level, maturity, etc., and their response to the leader; the task to be accomplished such as level of complexity and the degree to which it is structured; the personality of the leader; and the context including the leader's own superiors and peers, the organisational culture, policies and so on (Reitz 1977).

Quality implies focusing on *people, process* and *product/service*. The emphasis on people is not limited to (external) clients and leadership, but also includes employees. Waterman (1994), for example, suggests that excellent companies have *organised to meet the needs of their people*. They have created a culture that nurtures quality. The Malaysian example provides an example of how a programme may go about doing that.

[1] Examples of such terms include *authoritarian, democratic* and *laissez-faire*.

Box 3 – Artifacts
Unless the inward view of culture is challenged to change, new artifacts have no meaning. For example, "quality" symbols and celebrations are empty gestures unless values, beliefs and underlying assumptions also change. This often happens in a crisis situation, e.g., when a company is falling on hard times, or, in some RH programmes, when facing the HIV pandemic.

Organisations that prioritise quality tend to develop similar organisational cultures.[2] Culture is usually defined at three different levels: 1) artifacts, 2) values and beliefs, and 3) underlying assumptions (Schein, 1985). Artifacts can be easily observed – they are the "outward view" of culture – but their meanings depend on the other two levels (or the 'inward view' of culture). Artifacts comprise, among others, management practices, behaviour, norms, symbols, communications, etc. (Box 3).

Values and beliefs guide decision making and behaviour. They include vision, philosophy, purpose, commitment, ideologies, and cognitive processes (Box 4). Underlying assumptions emerge when fundamental values and beliefs are taken for granted to the extent that they are considered 'truth' and not even questioned. People are generally not conscious of them as they influence decision making and behaviour.

The three levels of culture are closely interrelated and *change must take place at all levels*. During the quality transformation, it becomes a major leadership/management activity to challenge and influence the existing organisational culture to introduce change if it is counter-productive to quality improvement.

Different characteristics desirable in an organisational culture are discussed below. They reflect the statement above that quality improvement implies a focus on people, process, and product.

[2] Organisational culture is defined as the ways members of a particular organisation tend to think and act.

Box 3 – Vision and Underlying Philosophies and Beliefs

Women's Health Care Foundation (WHCF)

WHCF was founded in the Philippines in 1980 by men and women who felt that the definition of women's health must be expanded to include all aspects of their life cycle from birth to death. From its inception, many beliefs, among others, that quality health care should be available, affordable, safe, acceptable, comprehensive, appropriate and gender-sensitive, guided the organisation.

The WHCF developed objectives reflecting underlying beliefs, namely to establish and effectively operate quality and affordable clinical and laboratory facilities that meet the reproductive health needs of women, particularly disadvantaged women, their partners and children.

The organisation currently runs three clinics in Metropolitan Manila in addition to outreach clinics offering a wide variety of health services such as physical exams; FP services; RTI/STD screening and treatment, prenatal and postnatal care; birthing facilities at one site; services related to menstrual and post-menopausal problems; and basic laboratory services including blood count, gram stain, Pap smears, pregnancy testing, urinalysis, Hepatitis B testing, stool exam, and semen analysis.

Finally, the WHCF focuses on various target groups for reproductive health education in addition to its advocacy efforts in the area of women's health and rights.
(Information taken from a paper written by Tadiar et. al. 1996)

Clients' values, perceptions and needs must be understood and prioritised ahead of organisational goals

Quality is customer-driven and implies that clients' needs, perceptions and values are put ahead of internal organisational goals. For example, demographic targets have been the driving force behind many traditional FP programmes, often with the result that quality has suffered and clients have become alienated from the programme.

Programmes must *know* and *understand* their clients' needs. Research and surveys are major activities in industry to anticipate customers' needs. Rather than just

assuming they know what their needs are, the health sector, including FP/RH programmes, is beginning to ask clients what services should be provided and how they should be provided to be acceptable.

Reorienting programmes from organisational goals to meeting clients' needs requires a major effort, but it also presents programmes with an opportunity to review their vision, values, and beliefs. Quality - meeting clients' needs - may be a more compelling vision than meeting targets which often works against a good client/provider interaction. Hence a new vision could act as a highly motivating factor by providing employees with *meaning and pride* in their work.

Focus on improving processes and systems rather than the results themselves

Good results such as client satisfaction, efficiency, functional outputs, and so on, are generally the by-product of effective work processes and systems. The strategic issue for organisations is to ensure that all processes and systems function in such a way that they are conducive to quality services. This includes not only service providers and the process of care giving, but all processes and systems supporting them. Planning processes; systems and processes related to human resources; logistics; MIS; health education, etc. must also be considered.

It was mentioned above that quantitative goals might compromise quality. It is therefore important to consider *what to measure and reward.* For example, if an organisation decides to prioritise quality but continues to reward staff for reaching targets while offering no rewards for providing client-sensitive services, cynicism among employees is frequently the result. *New visions and goals are easily defeated if old systems and processes counteract them.*

Overall performance is more important than maximising various functional results

Sometimes different functional objectives may work against each other and be counterproductive to the optimal performance of the entire programme. For example, the health education programme may be very successful in raising awareness and creating demand for a newly introduced reproductive health care service while the service delivery system cannot cope with the demand for lack of adequately trained personnel, lack of equipment, supplies, etc. Client dissatisfaction may result because there is no holistic view of programme performance.

The "functional mindset" is hard to overcome also in organisations that have taken the big step to reengineer to be "process organisations" rather than based on functions. Majchrzak and Wang (1996) emphasise the importance of managers creating

a collaborative culture, which cultivates *shared responsibility* for quality. This causes functional sub-cultures to blend while meeting customers' or clients' needs becomes the overriding goal for all and no longer the responsibility of a quality department, inspector or programme.

Quality improvement is a continuous and never-ending process

CQI does not stop with conformance to existing standards. Standards, or the status quo, are not considered the limits of performance, but something that may be improved upon. CQI is contrary to the saying "if it ain't broke, don't fix it" because it goes beyond fixing defects and problems to *find the root causes* of problems. And these are generally found in processes and systems rather than in people.

Programmes can never consider the process of improvement as complete because *surpassing* clients' expectations has become the goal of excellent companies. Clients' perceptions and needs are dynamic and change over time with rising incomes and new knowledge. For example, rising expectations were one of the reasons stated for adopting the "Q" programme in Malaysia. In addition, scientific knowledge and technology change rapidly indicating a new for continuous review of standards and medical practices.

It must be remembered that clients' knowledge about reproductive health issues and their expectations of the programme are often low. The onus of initiating QI is therefore on programme managers, planners and service providers.

Proactive as opposed to reactive approaches to quality

One of the major reasons for prioritising quality in industry is the issue of efficiency and savings. Preventing problems and defects is more cost-effective than fixing them afterwards. Defects are costly because defective goods are discarded and may lead to loss of customers and market share. Besides, when systems and processes do not function smoothly, there is inefficient use of resources leading to waste. Although there are initial costs involved in adopting a proactive approach to quality assurance, industry has discovered that there are considerable long-term, sometimes even immediate, savings.

Mistakes and inadequate systems and processes in the health care sector are equally costly. Incorrectly performed medical procedures and treatments may lead to more advanced and expensive treatment. Lawsuits may follow. Clients may choose not

to use the services for lack of trust. Last, but not least, medical malpractice adds to morbidity and mortality. Moreover, procuring the wrong equipment or supplies may lead to non-use and waste as well as inadequate treatment of clients.

As discussed above, total mobilisation of staff at all levels is required for proactive approaches to quality assurance to work.

People must be improved along with systems and processes

Because the quality transformation relies on mobilisation of employees at all levels of the organisation, people are of critical importance. Unless behaviours and ways of thinking change from top-level management and down, it is, in fact, difficult to see how QI can take place. While strong leadership and commitment are essential to QI, new knowledge, skills, behaviours and ways of thinking must spread throughout the organisation to ensure that staff are able to do undertake the responsibility for assuring quality (Box 5).

Box 5 – Developing human resources and creating enabling conditions
Integrating HIV testing in Thailand's FP/MCH programme

When Thailand's FP/MCH programme integrated HIV services, i.e., HIV counselling and testing, the intervention relied on the use of existing staff who received training. The programme realised that a one-time training is not enough, and most hospitals have established in-service training. Some provincial health offices also organise regular conferences for counsellors so that they may share experiences and discuss common problems. In addition, it was realised that staff had to be made aware of the importance of QOC. Therefore, the training developed emphasises this component.

Supervision and monitoring at different levels also take place. In order to ensure that quality services are provided, the programme measures, among others, the technical competence of providers; the adequacy of client-provider interactions including privacy; and client comfort, convenience and access.

When staff seek technical or other assistance, it is made available. The programme has also developed guidelines for staff. Last, but not least, the programme recognised that staff – despite training and other assistance - need the support of their supervisors. Therefore, the programme began to systematically involve administrators in a dialogue to raise their awareness and gain their cooperation in supporting staff in setting up counselling clinics.
(Information taken from paper written by Auamkul et. al, 1996)

However, training and development are not a panacea and cannot substitute for required actions to create an *enabling environment*, for example, adequate supervision and support; adequate resource allocation; hiring practices and reward systems supportive of qualitative goals, etc.

Although all staff must be mobilised to improve quality, top management cannot delegate the responsibility for quality. Many of the actions that must be taken to enable staff to provide quality services are beyond their authority. However, they must have sufficient autonomy to make day-to-day decisions related to their work.

Openness to learning, experimentation and innovation

Organisations that prioritise quality must ensure openness to learning and create a safe environment for experimentation and innovation. Factors ensuring this include, among others, open communication throughout the organisation and considering mistakes as part of the learning process as opposed to an occasion for assigning personal blame (Box 6). These issues have universal relevance, but are maybe particularly important as reproductive health programmes undergo thorough transformation and search for viable courses of action.

Box 6 – The overall importance of open communication to quality

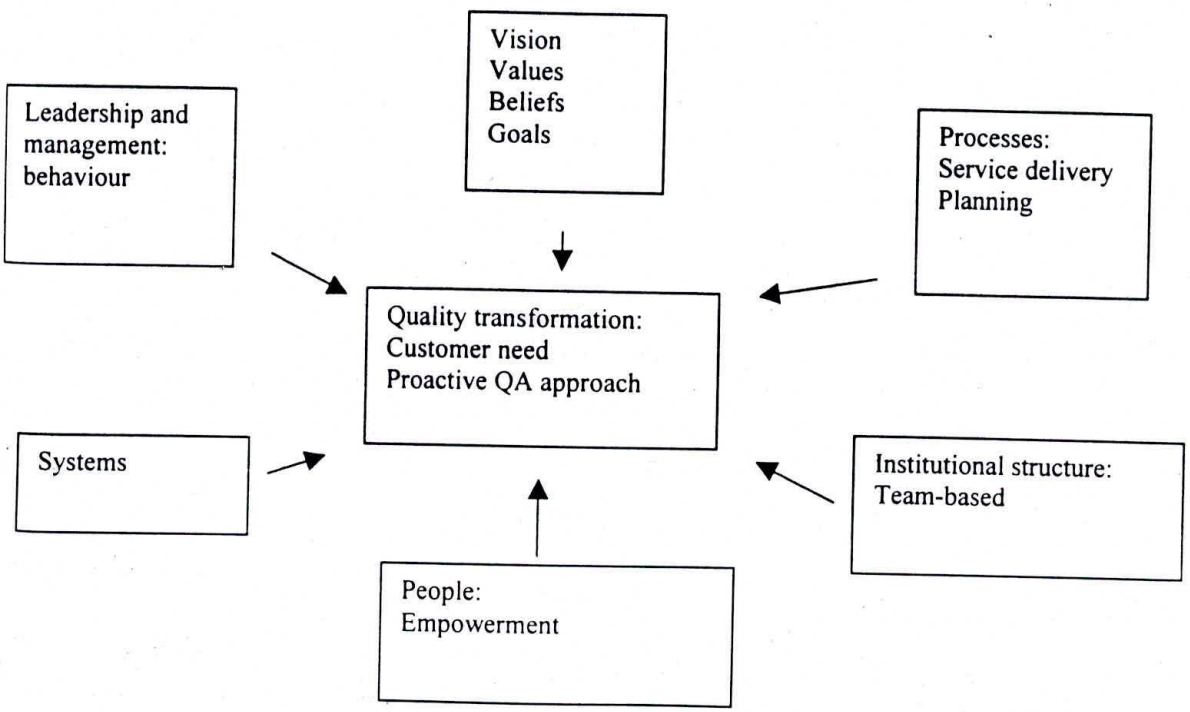
- Poor communication is at the base of many quality problems and may take many forms.
- Poor communication between health care worker and patient: a) inadequate information gathering during consultation leading to incorrect diagnosis b) inadequate explanation to patient and c) inadequate instruction to patient.
- Poor communication within the health system: a) health worker unaware of health system's goals and directions b) health worker does not receive feed-back on service information forwarded to headquarters and c) management unaware what is really happening in own health system.
- Poor communications - health system to users: a) important health messages not communicated b) messages poorly communicated – unintended messages received, and c) existing services underutilised increasing inefficiency of health system d) health system fails to monitor health concerns of the population and address these through effective communication.

(Kaijuka, 1996)

Programmes must *experiment* to find innovative and appropriate solutions for their particular context. Some experiments will be less successful, or they may outright fail, but they provide an opportunity for learning – either to prevent similar mistakes, or, better yet, how to improve. Unless people feel safe to discuss and learn from their mistakes, they will cover them up instead. Moreover, a safe environment is conducive to finding the root causes of problems rather than focusing on the problems resulting from them which leads to *ineffective solutions* and *quick fixes*.

In addition to increased awareness and systematic building of knowledge and skills, people must be encouraged to use analytical skills and tools to continuously improve themselves, systems and processes as well as the services they provide.

Figure 1 – Quality transformation



WHAT WOULD MANAGERS NEED TO DO?

Both the action research and programme experiences reviewed in earlier chapters show that managers made a variety of interventions to improve the quality of care. Table 1 summarises these interventions. Similarly the discussion of the role of leadership/management in this chapter indicates the broad areas requiring particular attention. Figure 1 illustrates the quality transformation and categorises the different areas of concern where interventions are required. On this background, several possible QI interventions are proposed below (see also Box 7).

Interventions to Improve Quality

Establishing organisational arrangements to catalyse QI efforts. First, top managers must be sensitised to quality issues and to the importance of their commitment to sustained quality improvement. Then organisational arrangements would need to be established to provide and/or mobilise technical and financial assistance for QI. This may comprise of a cell and an advisory committee. Some financial allocations are needed.

Orienting programmes' management systems of training, logistics, MIS, supervision, monitoring and evaluation towards QI. Various management systems would need to be reoriented towards QI. For example, training must include sensitisation of staff to QOC and meeting clients' needs, up-date on technical skills for comprehensive RH care services, special training for counselling, and on-the job training.

Often supplies are available in the system but not where and when they are needed. Therefore, the logistics system needs to be strengthened.

Box 7: Actions Needed to Improve QOC

- Establish organisational arrangements
- Orient programme management systems: Training, logistics, MIS, supervision and monitoring/ evaluation
- Set QA standards
- Develop supervisory checklists
- Provide necessary infrastructure
- Institutionalise CQI (a) at middle management and (b) through local teams
- Institute community actions
- Continue advocacy for QOC
- Celebrate QI

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Table 1. Interventions to Improve Quality of Care

Interventions	Kenya	COPE, Bangladesh	CQI, Mexico	Taichang County, China	MOH, Egypt	Population Services, Zimbabwe	ARCH, India	TQM, Malaysia
Establish organisational arrangements			X		X			X
Orient programme management systems: Training, IEC, logistics, MIS, supervision and monitoring/evaluation	X			X				
QA standards			X		X			X
Supervisory check lists					X			
Institutionalise CQI								
Middle management					X			X
Local teams		X						X
Institute community actions							X	
Continuing advocacy for QOC		X	X		X			X
Celebrate QI					X			X

Effective supervisory systems are a key intervention to facilitating quality improvement. They generally need to be reoriented for this purpose. Prioritising quality requires reliance on qualitative indicators. However, MIS systems frequently do not measure QOC. Programmes would have to rely on supervisory checklists, client feedback surveys, and observation of facilities and service provision, and perhaps specially commissioned studies. More work is required to explore how MIS and monitoring systems should be modified.

Introducing quality assurance through the establishment of standards and use of supervisory systems to enable implementation of the standards. Clear standards should be established for service provision and counselling, technical competence of staff, and so on. Adherence to the standards requires an effective supervisory system and increased accountability through the establishment of QA teams.

Provide necessary infrastructure. Inputs required for quality improvement are often inexpensive, but not available, for example, water containers, curtains, brooms, benches for waiting clients, and so on. Therefore programmes need to ensure that these are available at the SDPs. This may involve review of procurement processes.

Institutionalising continuous QI through the development of capability at middle management levels. Key middle level managers in the system must be identified, sensitised to QOC, and trained in QI approaches and techniques.

Mobilising initiatives at the local level through team efforts. Middle level managers would need to initiate and sustain QI/problem solving teams at the local level. These teams could use the COPE approach.

Instituting community actions. The accountability of the health care system/ programme to the community would need to enhanced through the formation of women's health or village committees and similar groups. They must receive education and support to sustain their commitment.

Continuing advocacy and support for QI through mechanisms such as Quality Day and rewards for successful QI teams. These efforts would need to be supported by continuing advocacy as well as *demonstrated commitment* by top management. Such actions include celebration of a quality day, rewards for effective QI teams, and awards for excellent facilities.

The above list comprises a set of QI interventions and organisational arrangements to implement them. However, all the interventions need not be implemented at the same time. A sequential plan of action would need to be developed in consultation with managers at different levels. As increasingly more of the above actions are implemented, the QOC will continue to improve and the quality transformation would ultimately incorporate all of the above measures.

Clearly top-level management commitment and an explicit policy on quality will facilitate quality improvement. However, middle or clinic level managers can act and accomplish much even if there is no explicit policy on quality or expressed top level commitment at the national level. The above list shows that the local teams can do many actions. Middle managers can advocate for quality, improve systems, provide necessary infrastructure and institutionalise quality improvement at their level. Local level managers can use supervisory checklists, form local QI teams, institute community actions and seek client feedback

Conclusion

The vision was developed by the ICPD-POA. The challenge is to communicate it effectively to staff, community and networks outside the organisation which may assist in achieving the goals of the POA . It is important not to underestimate the need for involving people: staff should be challenged, consulted and involved at each step. Clients - people in the community - must also participate.

QI takes place in a context that may be more or less resistant to change. It is about challenging and breaking down barriers, and, as suggested, it is a long-term process rather than a separate programme or short-term project.

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ANNEX

USEFUL QUALITY IMPROVEMENT TOOLS AND AIDS

The following tools may be used when programmes aim to improve the quality of care they provide:

1. List of methodologies and tools to assess and/or improve quality
2. Checklist for mobilising community groups
3. Training checklist for QI
4. Supervisory checklists
   - Checklist for FP/well woman clinic (female HCW)
   - Checklist for RH care services (male HCW)
5. The referral system
   - Example of referral protocol
   - Example of referral card

Assessing Quality

A large number of methodologies and instruments may be utilised to assess quality. Among others, the following three methodologies may be mentioned:

- Aga Khan Foundation: *The Primary Health Care Management Advancement Programme,* Modules 1-9
- AVSC International: *COPE*
- The Population Council: *Guidelines and Instruments for a Family Planning Situation Analysis Study.*

The action research project to improve the quality of care at sites in three different countries described in Chapters 2, 3, 4 and 5 used the following tools. They were borrowed and adapted from several sources:

- **Interviews with**: current or ever user, non-user, male with spouse of reproductive age, antenatal care client, immunisation (observation, client and provider interviews all in one instrument), service providers, manager and supervisor, private medical doctor (PMD), community based distributor (CBD)
- **Group discussions with**: users, non-users, men, service providers, managers
- **Observation of**: counselling session, medical examination, antenatal care, CBD
- **Facility checklist**

Katz et al. (1993) provide a list and description of tools which have been used by programmes to assess quality. However, it should be remembered that more than one perspective on quality should be considered when programmes assess

Assessment and/or Improvement Tools:

- ☑ Client Satisfaction Studies
- ☑ Clinic Management System (CMS)
- ☑ Consumer/Client Intercept Studies
- ☑ Counselor Training Evaluation
- ☑ Demographic and Health Survey (DHS) Oversample
- ☑ Focus Group Discussions
- ☑ Management Information Systems (MIS)
- ☑ Matrix (CEDPA)
- ☑ Matrix (Enterprise)
- ☑ Monitoring Voluntary Surgical Contraception Procedures (VSC)
- ☑ Observation
- ☑ Operations Research
- ☑ Panel Studies
- ☑ Patient/Client Flow Analysis
- ☑ Program Quality Assessment Tool (PQAT)
- ☑ Quality Definition and Assessment
- ☑ Simulated/Mystery Client Studies
- ☑ Situation Analysis
- ☑ Continuous Assessment (SEATS)
- ☑ Continuous Quality Improvement (CQI)
- ☑ COPE
- ☑ Service Quality Improvement (SQI)

(Taken from Katz et al, 1993)

Mobilising Community Groups

Mobilising community groups is a key intervention to assure and sustain improved quality of care in the area of reproductive health. A checklist is provided to systematise the efforts or steps in such mobilisation

Checklist:

- ☑ Select a group, team or organisation that can undertake the mobilisation effort
- ☑ Establish trust in the community while providing RH education to raise its awareness of needs in this area
- ☑ Do a needs assessment in consultation with the community and ensure that all perspectives are taken into consideration (programme context and goals, technology available, community and service providers' needs, and so on)
- ☑ Develop a plan of action *with* the community and other stakeholders based on the results of the needs assessment
- ☑ Procure needed physical inputs after taking all stakeholders' perspectives into consideration
- ☑ Provide appropriate training to staff
- ☑ Provide health education in the community
- ☑ Continue to sensitise staff and community to the need for *quality* RH services
- ☑ Establish institutional linkages and structures to ensure that the effort becomes self-sustainable
- ☑ Monitor and review the efforts and make corrections as needed

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Always consider:

☑ Community participation:

- Is the community an equal participant?

☑ Community responsibility:

- Do the efforts inculcate this value to the community?
- Do the programme's actions reinforce this value?

☑ Community ownership:

- Does the community feel that it "owns" the plan of action and the activities to improve quality?

☑ Gender sensitivity - Different groups have different needs:

- Does the programme aim to meet the needs of all groups?
- Does the programme aim to meet the different needs of women and men?
- Does the programme address the needs of youth - female and male?

Supervisory checklists

Training must be accompanied by appropriate support on-the-job after the trainee returns to work, and supervisors can do a better job if they have tools to assist them. Supervisory checklists may be used for this purpose. The QOC project developed several generic checklists which were subsequently adapted to each country context. Attached as examples are the checklists developed for the female and male HCWs. In Vietnam, checklists were also developed for managers to assess themselves.

The supervisor and supervisee should use the checklist together. The checklists may be used for sensitisation, training and problem-solving. Ultimately, it would be desirable to have service providers (as well as supervisors and managers) assess themselves continuously against the checklists.

The checklists must be up-dated on a regular basis to allow for rising expectations of clients, new medical knowledge and improved technology.

The following checklists were developed during the QOC project:

- ☑ FP/well woman visit (female HCW)
- ☑ Antenatal care (female HCW)
- ☑ PNC (female HCW)
- ☑ RH care services (male HCW)
- ☑ IUD (service provider, manager, and collaborator (screening only))
- ☑ MR (service provider and manager)

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SUPERVISORY/TRAINING CHECKLIST

(female health care worker)

Name:_____ Area:_____

FAMILY PLANNING/WELL WOMAN VISIT: SKILLS AND PRACTICES OBSERVED	YES		NO	AREA OF IMPROVEMENT/ COMMENTS
	Correct	Incorrect		
Communication Did the provider a. try to ensure that the client knows about all available methods..... b. encourage the client to select a method..... c. try to assess the needs of the client (sexual practices, coital frequency, number of children wanted and domestic violence).....				Specify:
Did the provider explain how the methods work?..... (If the method selected is tubectomy/vasectomy, did the provider stress that this method is irreversible?).....				
Did the provider discuss side effects?				
Did the provider explain necessary follow-up?				
Did the provider enquire about possible gynecological problems such as symptoms of RTI?.....				

FAMILY PLANNING/WELL WOMAN VISIT: SKILLS AND PRACTICES OBSERVED	YES		NO	AREA OF IMPROVEMENT/ COMMENTS
	Correct	Incorrect		
Did the provider explain: a. menstrual and other hygiene.... b. self breast exam.....				
Did the provider explain the importance of doing a Pap smear (if applicable)?				
Did the provider: a. take the medical and reproductive history..... b. refer according to protocol.....				
Exam and universal precautions Did the provider wash his/her hands with soap?				
Did the provider change gloves after seeing the previous client?				
Was the speculum and other instruments sterilized according to WHO standards				
Was the exam table wiped with disinfectant/bleach between clients?				
Did the provider perform a pelvic exam?				
Did the provider: a. check for signs of RTI/STD?... b. treat RTI/STD..... c. discuss need for partner treatment.....				
Was blood pressure taken?				
Did the provider do a breast exam?				
Did the provider do a Pap smear?				

FAMILY PLANNING/WELL WOMAN VISIT: SKILLS AND PRACTICES OBSERVED	YES		NO	AREA OF IMPROVEMENT/ COMMENTS
	Correct	Incorrect		
FAMILY PLANNING/WELL WOMAN VISIT: SKILLS AND PRACTICES OBSERVED	YES		NO	AREA OF IMPROVEMENT/ COMMENTS
	Correct	Incorrect		
<u>Overall impression</u>: The provider ensured privacy: a. during the counseling..... b. during the exam and provision of a method.....				
The provider: a. was friendly and supportive..... b. encouraged client to ask questions and made an effort to ensure that client understood information..... c. used IEC materials/ models/samples..... d. encouraged client to communicate with husband about FP..... e. counseled the couple.....				
The client's record was accurate and complete				

SUPERVISORY/TRAINING CHECKLIST

(male health care worker)

Name:_____ Area:_____

REPRODUCTIVE HEALTH CARE SERVICES : SKILLS AND PRACTICES	YES		NO	AREA OF IMPROVEMENT/ COMMENTS
	Correct	Incorrect		
Family planning Provider explained all methods available: a. condoms..... b. OCs..... c. Depo- Provera..... d. IUD..... e. Norplant..... f. tubectomy..... g. vasectomy..... h. NFP..... i. other.....				
Provider explained how the methods work.and stressed the lack of reversibility for vasectomy and tubectomy)				
Provider explained side effects				
Provider explained necessary follow-up and resupply				
Provider: a. encouraged husband to communicate with wife regarding FP..... b. discussed FP with the couple..... c. discussed FP with a group				
Provider distributed a contraceptive method				Which method:

REPRODUC... /R
CARE SERVI...ES
AND PRACTI...E

Other RH issu...s

Provider:

a. enquired ... o symptoms of
b. gave an S...)/ preventio... m (monogamy, condom u ...).
c. Demonstrate...
d. answered h... related to ...x...
e. gave treatme... for possibl ...S
f. discussed dor... violence...

Overall impre...ic RH services.

Provider:

a. was friendly a... supportive ...
b. encourage ...q tried to ensure understoo... ...h
c. used IEC mate...
d. ensured pr... a... counseling ...f

Immunization

Number of im... u... sessions done wit... to date:____ (T... r... supervisory/ ... in...

Minor ailments

Malaria

Sanitation

Other

Number of RH outr...

REPRODUCTIVE HEALTH CARE SERVICES : SKILLS AND PRACTICES	YES		NO	AREA OF IMPROVEMENT/ COMMENTS
Other RH issues Provider: a. enquired about possible symptoms of STD.... b. gave an STD/HIV prevention message (monogamy, abstinence, condom use).... c. Demonstrated condom use. d. answered other questions related to sexual health..... e. gave treatment or referred for possible STD..... f. discussed domestic violence....				Specify:
Overall impression related to RH services. Provider: a. was friendly and supportive... b. encouraged questions and tried to ensure that client(s) understood the information. c. used IEC materials /models. d. ensured privacy during counseling of individuals....				
Immunization Number of immunization sessions done with female HCW to date:____ (For skills use supervisory/ training checklist)				
Minor ailments				
Malaria				
Sanitation				
Other				

Number of RH outreach sessions done year-to-date? _____

The Referral System

An effective referral system is essential for FP programmes and becomes even more important and more complicated when they begin to offer comprehensive RH care services. For a programme focusing on mainly preventive services such as FP referral may take place mainly within the programme. Comprehensive RH care services require extensive referral also outside the programme which may involve more contact with the part of the health care system providing *curative* services. Potentially life-threatening diseases such as reproductive cancers will require referral to hospitals.

Effective follow-up also becomes a major concern with comprehensive RH services. STD treatment and abnormal Pap smears are good examples.

The three country QI teams described in earlier chapters (Chapters 2-5) began to take actions to improve their referral system and follow-up of referred and other clients. Attached is the referral protocol and cards developed by the Indian QI team.

Training was provided to staff in using the new protocol and cards. It also proved imperative to stay in contact with the different referral institutions.

Beneficiar
Pregnant women

Referral Protocol						
Beneficiary	Period	High Risk	PHC	Sub district	District hospital	Teaching hospital
Pregnant women	Ante-natal	Bad Obstetric History: Abortions, Still Birth			#	
		Previous Caesarean			#	
		Previous third stage Complications: Post partum haemorrhage			#	
		Pregnant with low birth	#			
		Abnormal position (before 32 weeks)	#			
		Abnormal position (after 32 weeks)			#	
		Multiple pregnancies			#	
		Severe anemia			#	
		Rh incompatibility				#
		Hydroaminos			#	
		Pregnancy Induced		#		
		Eclampsia			#	
		Antepartum haemorrhage			#	
		Cardiac disease				#
		Diabetes complications				#
		Grand multipara			#	
		Previous uterine surgeries			#	

Referral Protocol						
Beneficiary	Period	High Risk	PHC	Sub district	District hospital	Teaching hospital
	During Labour	Prolonged labour (>24 hrs in primi and 18)			#	
		Obstructed labour			#	
		Cephalo pelvic disproportion/ Contracted			#	
		Mal-presentations			#	
		Hydrocephalus			#	
		Retained placenta			#	
		Post partum haemorrhage			#	
		Ruptured Uterus			#	
	Post natal	Puerperal pyrixa	#			
		Secondary PPH			#	
Infants & children	New born	Low birth weight: 2000-2500	#			
		Low birth weight: 1500- 2000			#	
		Low birth weight: 1500				#
		Birth Asphyxia				#
		Neonatal Jaundice within 24 hrs				#
		Neonatal Jaundice after 24 hrs	#			
		Neonatal sepsis			#	
		Neonatal tetanus			#	#
		Respiratory Infections			#	
		Diarrhoea			#	
		Other infections of new-born Oral	#			
		Bleeding disorders			#	

Referral Protocol						
Beneficiary	Period	High Risk	PHC	Sub district	District hospital	Teaching hospital
		Congenital anomalies involving the vital				#
		Other congenital anomalies				#
		Convulsions			#	
		Precious babies				
		Cyanosis			#	
	All infants & children up to 5 years	Severe ARI/Pneumonia			#	
		Severe diarrhoea			#	
		Convulsions			#	
		Measles	#			
		Polio			#	
		Childhood Tuberculosis-Pulmonary			#	
		Childhood Tuberculosis-Meningitis				#
		Whooping Cough	#			
		Diphtheria				#
		Tetanus			#	
		Fevers lasting more than one week			#	
		Fractures			#	
		Head injuries				#
		Burns:			#	
		Nephritis			#	
		Rheumatic Heart Disease			#	
		Growth retardation				#
		Marasmus/ Kwashiorkar			#	
		Childhood malignancies			#	

Diagnosis:

Investigations (if any):

Treatment given:

Surgical procedures (if any):

Follow-up services:

Date of review if necessary:

Signature of the Medical Officer: _____

Name of the Institution: _____

Place: _____

Referral Card*

Name (with surname) : _____

Age: _____ **Sex:** _____

Husband/Father's Name: _____

Address: **House No.:** **Village:**

Mandal: **District:**

Referred from: _____

Referred to: PHC ☐ Sub-Dist.Hosp. ☐ Dist.Hosp. ☐ Teaching

Reasons for referral:

Complicated pregnancy	☐	Fever for more than one v
Complicated delivery	☐	Injuries
Low Birth Weight/Pregnancy	☐	Hypertension
Convulsions	☐	Chest Pain
ARI	☐	Unconsciousness
Diarrhoea	☐	Others (specify)_____

Descriptive Note:

Investigations (If any):

Treatment given:

Signature of the Health Worker: _____

Date:

Discharge Summary from Place of Referral*

OP/IP No.:

Date of receiving the patient/admission:

Date of discharge:

Name (with surname): _____

Age: _____ Sex: _____

Husband/Father's Name: _____

Address:

House No.: Village:

Mandal: District:

ICOMP - the International Council on Management of Population Programmes - was established in 1973 by a number of top third world population/family planning programme managers and heads of management institutes as well as representatives of donor agencies.

The initiative, twenty-four years ago, was taken in response to expressed concerns that management of population programmes was becoming increasingly demanding as more and more programmes were taken up on a national scale. There was a felt need to have a forum for exchange of experiences among population programme managers and between them and the academic community in the field of population-related management. ICOMP was to serve this function, within a South-South context.

For the past twenty-four years, ICOMP has assisted in sensitizing the top managers to professional management, trained middle-level managers, created a network of management-related institutes in this field, promoted women's programmes and disseminated state-of-art knowledge and experiences in the field of population programme management.

Much remains to be done. Current programmes and those of the early next century would need to provide comprehensive reproductive health services, respond to people's needs, focus on quality of care with a balanced emphasis on women and men, promote government-NGO partnership and be financially more self-reliant. Reaffirming its mission of improving population programme management, ICOMP has refocused its activities to meet the emerging challenges of the 1990s and beyond.

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