Session A

Integrating Best Practices for Quality Improvement, Performance Improvement, and Participatory Learning and Action to Improve Health Services

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Essential Ideas to Convey

❑ Quality improvement (or QI) refers to efforts made by facilities to increase clients' satisfaction with services, improve their reproductive and overall health, and enhance clients' ability to achieve their reproductive intentions.

❑ Performance improvement (or PI) is a systematic and holistic step-by-step process for assessing the performance of health care providers and for identifying the root causes of any performance gaps that are identified.

❑ Participatory learning and action (or PLA) is an umbrella term that refers to a wide range of approaches and methodologies that incorporate the participation of community members in the processes of learning about their needs and identifying the actions required to address these needs.

❑ Blending these three approaches will help initiate and reinforce improvement in provider performance and service quality, while simultaneously improving clients' and communities' knowledge and awareness of reproductive health services. All of it will help to better meet clients' needs and achieve the ultimate results of increased access and use of reproductive health and family planning services.

❑ These approaches, while different, are complementary.

Objectives

By the end of this session, the participants will be able to:

• Describe QI, PI, and PLA approaches and tools

• Describe QI, PI, and PLA interventions

• List performance factors

• Describe the QI process

• Name the QI approaches and tools

• Explain the similarities in and differences between QI, PI, and PLA

Time

50 minutes

Appendix F

Materials
- PowerPoint presentation for Appendix F, Session A
- Flipchart paper
- Flipcharts detailing clients' rights and staff needs (from Session 2-1)

Advance Preparation
No advance preparation is needed.

Activity A: Guidance for Program Staff *(50 minutes)*

1. Tell the participants that different organizations have developed different approaches and tools that can help supervisors, program managers, and providers to assess the quality of services and providers' performance. We have already mentioned some of these approaches and tools when we discussed the role of supervisors as leaders or considered organizations as open systems and the use of a systems approach.

2. Ask the participants what approaches and tools they are aware of and which might be used to assess and improve quality of services. Write their responses on a piece of flipchart paper.

3. Tell the participants that The ACQUIRE Project developed a guidance document for program staff on quality assessment approaches (Integrating Best Practices for Performance Improvement, Quality Improvement, and Participatory Learning and Action to Improve Health Services).

4. Start the PowerPoint presentation. Reveal Slide 3 and ask the participants whether they know these approaches and whether they can name the tools associated with these approaches.

5. Show slides 4–5, which describe the PI process and factors. When presenting performance factors, reinforce the messages from earlier sessions and ask the participants to comment on performance factors and what supervisors' tasks and action need to be to address those factors.

6. Show slides 6–8, which describe PI tools and interventions. Refer the participants to pages XX–XX in their Participant Handbooks to find resources with more detailed information on PI.

7. Reveal Slide 9 and ask the participants to comment on the diagram. Discuss with them the sources that can be used to gather information, the techniques that can be used to analyze the root causes of problems, and how supervisors and providers can follow up and evaluate the changes in and quality of services.

8. Reveal Slide 10 and explain to the participants that all QI approaches and tools are based on the same underlying principles. Name those principles and explain their meaning. Remind the participants about the framework of clients' rights and staff needs. Point to the flipcharts showing clients' rights and staff needs, which were placed on the wall on the first day of the training, and reveal Slide 11. Ask the participants whether they remember how we have defined the quality of services.

9. Reveal Slide 12 and present the components of the QI package. Briefly describe the QI tools and interventions, using slides 13–24.

10. Use slides 25–28 to describe the PLA approach, tools, and interventions.

11. Reinforce the importance of the role of supervisors in involving staff and communities in quality and performance improvement and in bringing change to communities.

12. Explain what makes those three approaches "best practices" (Slide 29) and why it is beneficial for health care staff to integrate these approaches into their practices (Slide 30).

13. Analyze and explain the similarities, differences, and complementarities of these approaches, using slides 31–33.

14. Reveal slides 34–35 and comment on when and what might be used to have the greatest impact on the quality of services.

15. Lead the participants through slides 36–37 to demonstrate the complementary use of these approaches and tools.

16. Ask the participants to open the ACQUIRE guidance document and explain how it may be used by supervisors when they work on PI and QI activities.

Trainers' Resource

Guidance for Program Staff

**Integrating Best Practices for Performance Improvement,
Quality Improvement, and Participatory
Learning and Action to Improve Health Services**

The ACQUIRE Project
New York, NY
June 2005

Appendix F

ACRONYMS

ACQUIRE	Access, Quality, and Use in Reproductive Health
CDQ	Community-driven quality
COPE	Client-oriented, provider-efficient
BC	Breakthrough collaboratives
FP	Family planning
FS	Facilitative supervision
IBP	Implementing Best Practices
IUD	Intrauterine device
MAQ	Maximizing Access and Quality
MOH	Ministry of Health
MQI	Medical quality improvement
NGO	Nongovernmental organization
PI	Performance improvement
PLA	Participatory learning and action
PMTCT	Prevention of mother-to-child transmission of HIV
PNA	Performance needs assessment
PRA	Participatory rural appraisal
PVO	Private voluntary organization
QI	Quality improvement
QMT	Quality Measuring Tool
RH	Reproductive health
STI	Sexually transmitted infection
TOT	Training of trainers
USAID	U. S. Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization
WST	Whole-site training

The ACQUIRE Project brings together partners with proven, effective approaches to improve provider performance and quality of services and to mobilize communities to drive improvements in health care: performance improvement (PI), quality improvement (QI), and participatory learning and action (PLA). ACQUIRE programs are not limited to these three approaches, but PI, QI, and PLA are prominent features of the capacity reflected in our partnership and therefore are the focus of this guidance.

All of these approaches originated outside the health sector, but they are applied and recognized as "best" practices (i.e., evidence-based, replicable, transferable, and sustainable) in international health.[3] The ACQUIRE Project provides opportunities for the partners to further develop expertise and create synergies between the three approaches. Blending the approaches will help catalyze and reinforce improvements in provider performance and service quality, while simultaneously improving clients' and communities' knowledge and awareness of reproductive health (RH) services, all of which will help to better meet clients' needs and achieve the ultimate results of increased access and use of RH and family planning (FP) services. It is essential for ACQUIRE project staff to understand and be able to combine the PI, QI, and PLA approaches and tools that the partners bring to the project.

These approaches can be blended because they share key attributes and because their differences are complementary. All three approaches are participatory, all rely on a step-by-step process to identify gaps and solutions, all include root-cause analysis of gaps, and all promote stakeholder involvement and empowerment. The main difference is in where (and with whom) to focus the assessments and interventions to improve health and health services. PI emphasizes the provider's perspective (human performance); QI emphasizes the client's perspective (teamwork and team processes), and PLA focuses on the community perspective and addresses community empowerment broadly, beyond health needs (community development).

All three of these perspectives are important within ACQUIRE. There is some variation, however, in when and at what levels each approach should be applied:
- The PI approach refined by IntraHealth International, Inc., is most appropriate at the national, regional, and district levels, but it can also be applied to specific cadres of providers and even at the facility level. Specific job aids and tools support each stage of the PI process. The performance needs assessment (PNA), an essential part of PI, is a diagnostic process for identifying performance and programming needs. The data-gathering methods used to define desired performance and describe actual performance include interviews, observations, surveys, and reviews of performance data. A PNA is typically conducted prior to program design or as a first step in program implementation, so that subsequent interventions can be better targeted. The factors that ensure good performance are important inputs throughout program implementation.

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[3] See the Implementing Best Practices Initiative (www.ibpinitiative.org), USAID's Maximizing Access and Quality (www.maqweb.org), and Advance Africa's Compendium of Best Practices (www.advanceafrica.org/compendium).

- EngenderHealth's QI package includes approaches and tools to address supervision and medical monitoring, training, continuous problem solving, and direct costs of service delivery. The majority of the interventions focus on the facility level, particularly the clients, health care providers, and supervisors within facilities. Emphasizing clients' rights and staff needs, the QI processes and tools serve to continuously diagnose and address gaps in provider performance and service quality, exploring needs and practical solutions.

- The PLA approach, as implemented by CARE, is an ongoing process and long-term commitment to develop community capacity by identifying needs and planning and carrying out interventions to meet them. (Ideally, the community completely takes over the process.) PLA includes a wide array of tools and techniques, including mapping, Venn diagrams, transect walks, ranking and scoring, causal-impact analysis, trend analysis, matrix ranking, case studies, life histories, drama and role plays, and brainstorming, among others. In the ACQUIRE Project, PLA addresses community perceptions and priorities related to FP/RH, health behavior and use of services, access to services, and the quality of care provided in health services. PLA supports mobilization by communities to address health issues and link more effectively to health facilities. Although it is easier just to incorporate participatory methods in the needs assessment stage of a project, to achieve true community empowerment and sustainable change, PLA requires an iterative process throughout the life of the project, with community involvement in all project stages, including implementation, monitoring, and evaluation.

There are many ways in which the approaches can be integrated. All three approaches include steps for identifying needs and selecting interventions. At the data-gathering stage, consider the usefulness of borrowing and adapting tools from the other approaches (e.g., apply PLA methods or the Quality Measuring Tool within a PNA). When selecting and implementing interventions, consider the applicability of incorporating any of the other approaches (e.g., if a PNA identifies gaps in performance feedback and motivation, consider implementing facilitative supervision and COPE®[4]; conversely, when implementing facilitative supervision, reinforce the supervisor's role in ensuring that all PI factors are in place). The situation often determines which approach to use and how to initiate activities. It is important to use the approaches and tools in a flexible manner.

Purpose of This Guidance

This guidance was developed to help staff of the ACQUIRE Project understand and explain to counterparts and field partners the improvement approaches and tools used by ACQUIRE. ACQUIRE brings together partners with proven, effective approaches to improving provider performance and the quality of services and to mobilizing communities to drive improvements in health care: performance improvement (PI), quality improvement (QI), and participatory learning and action (PLA). Although many staff are already familiar with PI, QI, and/or PLA, they do not always recognize the similar purposes of these approaches and how the approaches are related. These approaches and tools can be used alone or in a complementary manner, depending on the situation and on the program level being addressed.

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[4]COPE, which stands for client-oriented, provider-efficient services, is a registered trademark of EngenderHealth.

This document includes:

- A brief overview of approaches and tools

- A discussion of similarities and differences

- An explanation of how these approaches and tools can be used together to maximize benefits

- A summary and recommendations

- A resource section, including references for materials containing in-depth information about the approaches and instructions for use and lessons learned about their use

Section 1:
A Brief Overview of the Approaches and Tools

The Performance Improvement Approach

Organizations seeking to solve provider performance problems frequently implement training and other interventions without fully understanding the nature of the performance gaps and whether the chosen interventions are appropriate for closing the gaps. The PI approach adapted by PRIME II (McCaffrey et al., 1999), which is in Figure 1, uses a systematic and holistic step-by-step process to assess providers' performance and identify the root causes of the performance gap.

Figure 1. The Performance Improvement Process
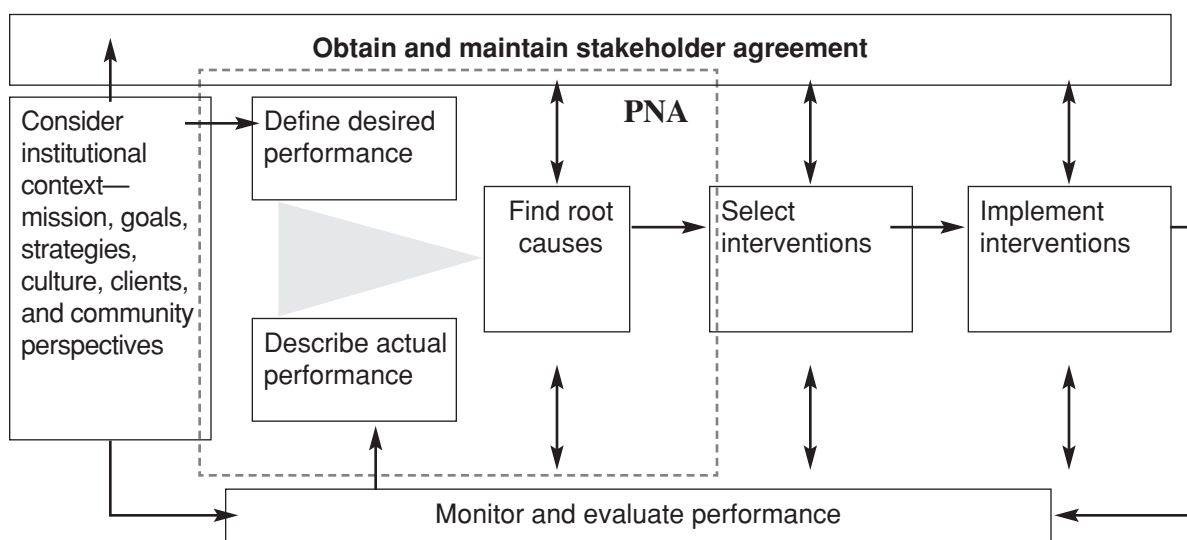
The **Performance needs assessment (PNA)** is a critical part of the PI process. Subsequent implementation follows usual program implementation guidelines, including monitoring and evaluation to ensure that the interventions have closed the performance gaps. The PNA (shown in Figure 1, outlined with dotted line) begins with consideration of the institutional context in which PI will occur and emphasizes the following stages and important elements:

- Establishing desired performance
- Collecting data related to a performance problem to assess actual performance and comparing it with desired performance to determine the gaps and their scale
- Analyzing the root causes guided by five performance factors to uncover the principal reasons behind the performance gaps (see box) (This helps the stakeholders select the most appropriate interventions to close the gaps.)

Performance Factors

Job Expectations: Do providers/staff know what is expected of them?

Performance Feedback: Do providers/staff know how well they are doing?

Physical Environment and Tools: Do providers/staff have what they need to perform?

Motivation: Do providers/staff have a reason to perform as they are asked to perform? Does anyone notice?

Skills and Knowledge to Do the Job: Do providers/staff know how to do the job? Are they able to do it?

- Selecting the most appropriate interventions for addressing the root causes identified through stakeholder analysis

- Involving stakeholders from different levels (A good mix of in-country or institutional stakeholders helps ensure representation of different perspectives and insights, as well as the ability to propose and act upon appropriate solutions during the process. Involving stakeholders from the outset of the process, including facility-level staff, increases the likelihood that selected interventions will be supported and will be sustainable.)

The PRIME II Project developed the following guides to support facilitation of the PI process and selection of interventions during a PNA:

- *Stages, Steps, and Tools for Performance Improvement: A Practical Guide to Facilitate Improved Performance of Healthcare Providers Worldwide* (PRIME II Project, 2000) gives instructions, job aids, and sample forms for facilitating the PI process.

- *Cost and Results Analysis, Volume 1: Strategy* (PRIME II Project, 2003a) is an approach for costing and analyzing the costs and results of activities designed to improve the performance of primary providers of FP/RH services.

- *Cost and Results Analysis, Volume 2: Toolkit* (PRIME II Project, 2003b) contains cost and results tools and analyses of program and policy options to complement training and non-training interventions for improving provider performance.

Within a typical PNA, the tools shown in the box below are developed or adapted to address the specific context.

**PI Tools for Assessing Desired and Actual Performance**

- Interviews with providers/staff (including supervisors and managers)
- Observation of client-provider interactions
- Facility audits/assessments
- Review of service statistics
- Client interviews
- Group discussions in the community

Interventions selected at the end of a PNA may range widely in size and scale, based on the needs identified. Typical interventions focus on strengthening the performance factors and may come from any source of knowledge, experience, and best practices.

Quality Improvement Approach

EngenderHealth's QI package has been developed and refined in collaboration with developing-country institutions since the 1980s (Dohlie et al., 1999). The goal of this integrated package is to help service-delivery programs and providers improve the quality of RH/FP services through a systematic and continuous process. Institutions continuously determine what needs improvement and implement needed interventions to move from actual to better practice, using a four-step process (see Figure 2, p. F-15).

Figure 2. The Continuous QI Process
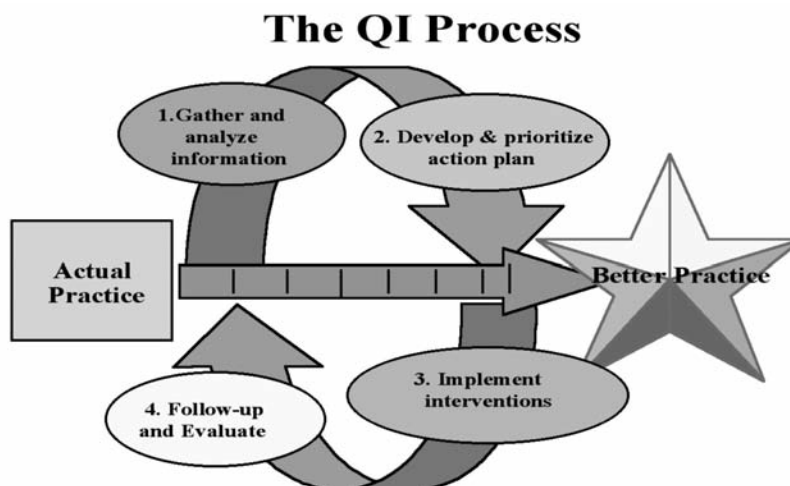
The QI Process

In addition to an overarching process, the QI package contains a set of approaches and tools based on the framework of clients' rights and staff needs (see box). These are most successful when used together, continuously reinforcing the same underlying values. Staff are able to focus on clients' rights when effective systems and processes are in place to meet their needs and support their performance.

EngenderHealth's QI approaches include:

- **Facilitative supervision (FS),** which is an approach to supervision that emphasizes mentoring, joint problem solving, and two-way communication between supervisors and staff. Supervisors lead staff in the QI process.

> **Framework of Clients' Rights and Staff Needs (AVSC International, 1995)**
>
> **Clients Have the Right to:**
>
> Information
> Access to services
> Informed choice
> Safe services
> Privacy and confidentiality
> Dignity, comfort, and expression of opinion
> Continuity of care
>
> **Health Care Staff Need:**
>
> Facilitative supervision and management
> Information, training, and development
> Supplies, equipment, and infrastructure

- **Whole-site training (WST)** and **inreach** form an approach to addressing the learning needs of a site. WST links training and supervision and includes orientations, updates, and skills trainings, which can take place either on-site or off-site but promote both on-the-job and on-site training. Inreach includes staff orientations, referrals, and signage to help staff ensure that clients get all of the services they need when attending a health facility.

- **Medical quality improvement (MQI)** represents an ongoing focus on the quality of medical services through medical monitoring, the development and revision of medical guidelines, standards, and job aids, the removal of detrimental practices and policies, the analysis of medical data, the monitoring of informed decision making and informed consent, and the enhancement of local capacity to carry on these processes.

The tools to help staff and supervisors practice the above approaches and to assess and improve the quality and efficiency of their services are shown in the following table:

Figure 3. QI Tools for Gathering and Analyzing Information

COPE	Community COPE
• Client interviews	• Individual interviews
• Provider self-assessment guides	• Focus-group discussions
• Record-review checklist	• Mapping exercises
• Client-flow analysis	• Site walk-throughs
Medical monitoring checklists	Quality Measuring Tool (a participatory type of facility audit)
Cost Analysis Tool	

Notably, the tools are based on international standards and practices and serve to remind or update staff about best practices in health care. They also help clarify performance expectations and program goals. The tools are tailored to FP and other RH services (see resource section for complete references). Together, the approaches and tools in the QI package serve as both tools to identify gaps in quality of care and also as interventions to close the gaps and support clients' rights and staff needs. Other interventions for improving care come from any source of knowledge, experience, and best practices, with an emphasis on using local resources to solve problems.

Participatory Learning and Action Approach

PLA is an umbrella term that refers to a wide range of approaches and methodologies that incorporate the *participation* of people in the processes of *learning* about their needs and the *actions* required to address them (IIED, 2000). It is important to note that the focus of PLA is community development (see box), so even when it is applied in health projects, it may result in community-led interventions outside the health sector

> **Definition of PLA**
>
> A long-term commitment to ongoing development of a community's capacity to identify its own needs and implement action plans to improve its own conditions.
>
> (CARE, 1999, p. F-1)

The four main steps of the continuous PLA process are shown in Figure 4.

Figure 4. The Continuous PLA Process

1. **Explore issues:**
   • Gather information
   • Analyze & prioritize problems

2. **Build support:**
   • Orientation to project objective & process
   • Identify community participants
   • Create linkages w/ other stakeholders

Apply relevant PLA tools in all steps

4. **Monitor progress:**
   • Were actions completed?
   • Were results satisfactory?
   • Are there new issues to address?

3. **Develop community action plans:**
   Solutions may be implemented by community members & Health workers

The first two steps of the PLA process (exploring issues and building support) tend to be inter-changeable, depending on the project, but a proper PLA begins with exploring issues. Within a health project context, the facilitator guides this exploration of issues according to the pro-ject's interests and/or limitations, to avoid raising expectations that cannot be addressed with project support. PLA offers a wide array of verbal and visual tools that are applied in all steps of the process. New methods continue to be designed to meet specific needs in particular con-texts. Figure 5 does not represent an exhaustive list of tools.

Figure 5. Tools for use in the PLA proces

• Social mapping	• Pocket chart (situational assessment/analysis)
• FP or sex census mapping	• Three-pile sorting
• Transect walks	• Picture stories/cartooning
• Venn diagrams (Human resource and community organization, Social networks and sources of information, Household relations/decision making)	• Drama (open-ended/closed-ended) and role plays
	• Critical incident analysis using visuals
	• Flexi-flans as creative materials
• Matrix ranking (e.g., choice of caregiver by type of maternal health and RH need)	• Unserialized posters
	• Carts and rocks (analysis of resources and constraints)
• Trend analysis (e.g., reproductive life-line)	• Two-circles exercise
• Ranking and scoring (e.g., contraceptive preference)	• Semi-structured interviews
	• Focus-group discussions
• Causal-impact analysis (flow diagrams)	• Case studies, stories, portraits

Note: This list shows selected PLA tools applicable to RH issues, adapted from CARE, 1999.

There are many levels of participation and different terms to refer to the processes applied. For the purposes of ACQUIRE, the two most important terms to distinguish are participatory learning and action (PLA) and participatory rural appraisal (PRA). The key difference between these is that in a true PLA process, the participatory methodologies are used in all phases of the project: assessment, project design, implementation, and monitoring and evalua-tion. This continuous process builds capacity and empowers communities to undertake ongo-ing self-development in a larger holistic environment and context. By contrast, in a PRA, the participatory methodologies are used only to extract information from communities for the purpose of an assessment and (usually) to inform project design. A PRA can be conducted in a few days, while PLA requires an ongoing commitment over many months or years.

Organizations can use PLA when they can commit to supporting community-planned and -led activities and can maintain relationships with the community over a long time. If a donor requires that a project be developed and designed by an outside agency, that agency can feasi-bly use PLA tools to get community input, participation, and buy-in during start-up and

implementation, but the "community" project is then categorized as being on the low end of the continuum of community participation and empowerment.

Origins of the Approaches and their Use in FP, RH, and Other Health Services

All of the approaches described here originated outside the health sector, and all have been successfully applied to international health. The PI approach originated in the for-profit field of human resources and instructional design, as a process to address performance gaps beyond training. Over nearly a decade, PI has been increasingly applied to health services in low-resource settings, particularly to identify performance gaps in numerous areas of RH and other services, such as integrated management of childhood illnesses (IMCI). During PRIME II, 28 PNAs were conducted in 18 countries (Luoma and Nelson, 2003). To promote wider use and understanding of the PI approach, the U.S. Agency for International Development (USAID) and several cooperating agencies formed the Performance Improvement Consultative Group. More recently, in international conferences, the World Health Organization (WHO), in its Implementing Best Practices (IBP) Initiative, has applied the PI framework to link the identification of program and performance gaps with the adaptation of best practices to address those gaps.

The QI approach originated in the engineering and manufacturing industries, but it has been applied to other sectors worldwide for decades. Since the late 1980s, EngenderHealth has developed its QI approaches and tools, which were originally for FP services but over time have been applied to other health services. FS, WST, and MQI interventions have been applied to hospital-wide practices (such as infection prevention), and COPE tools have been adapted for a range of services, including maternal care, child health, cervical cancer prevention, adolescent RH services, and prevention of mother-to-child transmission of HIV (PMTCT). New COPE tools are being adapted for voluntary counseling and testing for HIV (VCT), and sexually transmitted infection (STI) services. The COPE tools have been used by facilities in the public and private sectors—in the for-profit and nonprofit sectors, including mission hospitals. COPE is categorized as a best practice in Advance Africa's compendium of best practices, and USAID's MAQ initiative promotes the "supportive supervision" approach and defines it as synonymous with "facilitative supervision" (Marquez and Kean, 2002). The WST approach was included among the interventions promoted in a "Best Practices in Training" international conference held in Africa.

PLA, which originated as a community development process, particularly in the agricultural sector, has been used for and by the community at the community level and has been applied worldwide. CARE has used PLA in its development work, including RH efforts, for more than 10 years in both rural and urban settings. In CARE projects in Africa, Asia, and Latin America, PLA has proved to be crucial in involving the community in addressing family planning, maternal health, adolescent health, and prevention of STIs and HIV, as well as in establishing linkages between health, education, and economic opportunities. USAID's MAQ Initiative supported the implementation of PLA by promoting "Community-Driven Quality," defined as "a methodology to improve quality and accessibility of health care with greater involvement of the community in defining, implementing, and monitoring the quality improvement process" (MAQ Exchange, no date). Likewise, the IBP Initiative promotes wider use of PLA as a best practice by disseminating the approach through its conferences and global library.

Section 2:
Comparing the PI, QI, and PLA Approaches

PI, QI, and PLA all are effective approaches, and which one is selected depends on the problem to be addressed, the context or situation, and program level. However, familiarity with a given approach and personal preference may influence and actually limit the choice. ACQUIRE staff are encouraged to learn more about the different approaches and to seek opportunities to integrate and apply them, as appropriate.

This guidance has already alluded to similarities and differences between the approaches.

The PI, QI and PLA approaches and tools represented by the ACQUIRE partners' collective expertise share the following **similarities:**

- *The approaches all have common goals*. Within the ACQUIRE Project, all three approaches support the goal of improving performance and quality to increase access and use of RH services.

- *Active stakeholder participation is involved, to ensure a sense of ownership*. All three approaches are highly participatory in nature, involving in the improvement process a wide range of staff, stakeholders, counterparts, and community members.

- *The approaches use step-by-step processes to identify areas that can be strengthened or improved*. All three use such processes, including root-cause analysis.

- *All three approaches depend on facilitators to introduce the process*. However, the goal is always to build capacity among local stakeholders, in the health facility, the overall system, or the community, to take over as facilitators and ensure continuity and sustainability. Facilitators must invest time, effort, skills, and commitment to carry out their important role of ensuring that stakeholders remain motivated to participate.

- *Success ultimately depends on empowerment*. Unless the stakeholders—be they at the facility, community, or other levels—are genuinely empowered and consider the process to be their own, improvements and success are difficult to achieve.

Particular similarities between PI and QI

USAID established the Performance Improvement Consultative Group in January 2000 to promote processes and activities in health service delivery organizations to support and improve performance. The group was instrumental in creating agreement related to the PI process. The following is taken from the Frequently Asked Questions on the group's website, at www.pihealthcare.org/pi_faq.htm:

> "While their origins and orientation may be different, there are significant similarities between the QI and PI models. Both are cyclical problem-solving processes. Both advocate the establishment of standards and the continual quest to meet those standards. Both seek to establish the root causes of identified problems. Both identify and select appropriate actions that are intended to address performance problems. Both QI and PI seek the same ends:

high-quality products or services. Both models draw from the same toolbox, although the use of the tools may vary. The approaches are complementary and the strengths of each should be brought to bear in implementing reproductive health interventions."

The **differences** between PI, QI, and PLA create complementarities that make it worthwhile to blend the approaches. These differences include a different focus:

- *PI focuses on provider performance and the provider perspective.* Desired performance is defined for providers, and actual provider performance is determined through observations of providers and through interviews to understand their enabling environment. However, providers are certainly not the only stakeholders and participants in the process. Typical PNAs seek the client's perspective through interviews and seek the community's perspectives through group discussions.

- *QI focuses on clients' rights and the client perspective.* Quality health services are defined as services that meet the clients' rights. Providers' needs are those that enable providers to ensure clients' rights. Even health care staff and supervisors are encouraged to see each other as "internal clients" within the health system. The QI approaches and tools address different stakeholders, but the majority of the tools focus on clients and providers within health facilities. FS is an intervention focused on building the capacity of supervisors (including supervisors within individual facilities and those who support multiple facilities), and Community COPE addresses community members in particular (and views community members as current, former, or potential clients, as well as agents in the process of improving health services).

- *PLA focuses on community empowerment and the community perspective.* With its broader goals of community development and primary health care, PLA focuses on community ownership of the process as well as the product, which can include improved health services. Although the process revolves around community member participation, it can relate to other stakeholders in several ways: by defining desired provider performance and quality of care, by providing feedback on existing health services, and by mobilizing resources (both financial and in-kind) to support health services.

The dual purpose of the QI approaches and tools

The QI package includes approaches and tools that serve a dual purpose: identifying gaps and serving as ongoing interventions to close those gaps. EngenderHealth's QI package includes approaches that constitute possible interventions to meet staff needs, close performance gaps, and improve quality. In PI, the PNA identifies performance problems and the most appropriate interventions to effectively address root causes and looks outside to select from the realm of possible interventions. The relevant solutions may include FS, WST, or MQI.

Particular similarities and differences between PLA and Community COPE

There are particular similarities and differences between PLA and Community COPE. Both emphasize the community perspective. Community COPE is a variation on the COPE process that applies the PLA approach and includes a subset of the PLA tools, focused on involving communities in improving facility-based health services. Community COPE requires the participation of both health care staff and community members. PLA includes more tools and

addresses community empowerment more broadly (e.g., even when PLA is focused on health issues, community participants typically raise needs related to economic or educational opportunities). PLA implies that control, ownership, facilitation, and maintenance of the process reside in the community.

In Community COPE, health care staff remain important stakeholders in the improvement of facilities and services. Although Community COPE could act as a catalyst for initiating overall community development, making a commitment to facilitating this process is probably too much to ask of health care providers, and it is not an effective use of their scarce and much-needed technical skills. Other organizations and community members are better positioned for this task. PLA facilitation requires people who are well-versed in this approach and who have practiced it. It also is intensive at first, although project involvement tapers off as facilitation roles are taken on by community facilitators. Recently, the ACQUIRE partners applied PLA methods to tailor information, marketing materials, and referral systems based on community perceptions of underutilized methods.

Section 3:
Recommended Ways to Integrate
the Approaches to Maximize Benefits

All three approaches—PI, QI, and PLA—have proved to be effective in various contexts and settings when they are implemented individually. The following guidance is based on lessons learned to date and developed for ACQUIRE Project staff who are expected to use the three approaches to help ensure more sustainable interventions. The most appropriate approach to apply depends on the **program level** where it will be used and the **context** or **situation**. You may choose to use either PI or QI or to blend the approaches, because they can stand alone or be used in a complementary manner. When used together, they represent a more comprehensive methodology. In this way, a country program, for example, could maximize the potential of each methodology to achieve an environment in which high-performing, effective providers are supported by their organizations or systems to provide high-quality services that meet the expressed needs of client populations, who participate actively along with Ministry of Health (MOH) stakeholders in these processes. Similarly, Community COPE and PLA complement each other and can strengthen both PI and QI.

Various field applications indicate that the three approaches are relatively easy to introduce and use, provided that motivation and support exist to do so. Staff and stakeholders can build local capacity to use the approaches and tools through training of trainers (TOT), orientation sessions, and hands-on application in the field. Once a person masters one approach, becoming adept at applying a second approach may not prove to be very difficult, due to their considerable similarities. All three approaches require a willingness to empower people.

The following are specific recommended ways to integrate the approaches:

- *Use PI and the PNA to identify needs at a higher programming level (national, regional, and district levels).* PI is a useful process for identifying systemic needs in health services, because it addresses the performance of institutions and of entire cadres of providers. Performance problems encountered in one facility are often common at facilities throughout the region and can only be addressed by working with higher levels in the health system. Key stakeholders include representatives from the national-level MOH, regional directors and supervisors, district-level directors, a sample of facility directors and department heads, providers and staff from selected health facilities, representatives of NGOs and private voluntary organizations (PVOs), donors, clients, and community members. It is important to include those who best know the issues and who can facilitate the implementation of interventions, as well as those who have decision-making authority. The sample of sites should be representative, not exhaustive, and existing data should be used as much as possible.

- *The QI tools address multiple levels, but they are mainly applied at the facility level.* This includes FS, MQI, WST and inreach, COPE, QMT, medical monitoring and the Cost Analysis Tool. FS is an approach for supervisors at any level (including those who supervise multiple facilities), and Community COPE is a process for linking service providers with community members, so it spans both levels.

- *Community COPE and PLA are complementary and are applied at the community level.* Thus, any of the PLA tools can be adapted for conducting Community COPE.

- *When implementing any of the approaches, at the data gathering stage, adapt tools from any of the other approaches, as appropriate.* For example, in a PNA, consider using the QMT, the COPE client interview guide, or any of the PLA tools. Within PLA, consider using some of the Community COPE tools.

- *At the stage of selecting and implementing interventions, consider the applicability of any of the other approaches or tools to meeting the needs that were identified.* For example, if a PNA reveals gaps in performance feedback, train supervisors in the FS approach. When implementing FS, reinforce the supervisor's role in ensuring all the PI factors are in place to enable good performance. Even if a formal PNA is not done, it is useful for supervisors to apply some form of the PI process as part of interactions and meetings among supervisors at different program levels (Mane et al., 2003).

  It is useful to link training in FS with the introduction of COPE, which provides supervisors with a tool for involving staff in improving performance and quality through teamwork. For example, if a PLA reveals poor client-provider interaction and long delays for services at a hospital, consider introducing COPE. On the other hand, if a facility has fewer clients than expected, use PLA or Community COPE to understand why people are not seeking services there and propose ways to improve the link between facilities and communities.

The following two descriptions and illustrations depict scenarios where the three approaches are successfully integrated.

Scenario I (Figure 6, p. F-25) presents an illustrative example of the complementary use of all three approaches to maximize improvements in performance and quality of service delivery, based on real programming experiences in West Africa. The MOH requested an exploration of performance problems in FP service delivery. Using the PI approach, a PNA was conducted in a selected sample of health facilities in different regions to identify performance gaps. At subsequent meetings, stakeholders discussed performance gaps identified by the PNA, analyzed root causes, and selected the most appropriate interventions. Root causes included staff's lack of skills and knowledge in FP and infection prevention, unclear expectations around FP, and minimal feedback on performance due to weak supervision. Stakeholders selected the following interventions:
- Update staff on contraceptive technology and infection prevention through WST

- Develop and disseminate standards and job expectations for providers in the area of FP

- Implement the FS approach, with an emphasis on MQI

These interventions were implemented, but monitoring revealed that some facilities needed additional assistance in improving their quality, so COPE was introduced. COPE client interviews revealed that community members were misinformed about FP and perceived health facilities to have poor quality of care. PLA exercises were then applied to involve the community in actively helping to define and improve the quality of service provision and become more informed about FP.

Figure 6. Scenario I:
Complementary Use of PI, QI, and PLA, Beginning at a National Programming Level

National stakeholder agreement meeting is held

MOH wants to explore performance problems

A PNA is conducted in the regions.

Stakeholders analyze gaps, select interventions.

Design, implement, monitor, evaluate

Whole-site training
(orient all staff on infection prevention and contraceptive technology)

Develop, disseminate job expectations, standards

Facilitative supervision for MQI
(for regional and district supervisors)

COPE" is conducted; an ongoing QI process is established

PLA is conducted to improve community awareness of FP

Continued monitoring and evaluation illustrated that using the approaches in this way improved FP service delivery at the facilities and regions involved in the PI and QI efforts.

Notably, the integration can begin with any approach at any level. For example, in Ethiopia (see **Scenario II**, Figure 7), EngenderHealth provided technical assistance to introduce QI approaches in health services in a CARE-supported community RH/HIV project that was working to improve RH information and services at the community and primary health care levels. In this effort, community extension and mobilization activities formed the basis upon which other participatory activities for improving RH were layered. One of the first activities of EngenderHealth was to provide training in FS and orient district/woreda and health facility supervisors in the QI approaches. Subsequently, the participating facilities introduced COPE. The facilities have experienced good results, and community feedback about services is being sought. Then, new issues can be addressed, including an identified need to improve the quality of and access to IUD services. To better understand specific performance gaps, root causes, and appropriate interventions, there are plans to conduct a PNA with providers in these and other facilities.

Similar scenarios can be developed starting with any of the approaches.

Figure 7. Scenario II:
Complementary Use of Approaches Beginning at the Community Level

Ongoing community health and development activities, based on PLA activities

FS is implemented at community health facilities

COPE is implemented in facilities

Plan:
Do a PNA to agree on and develop appropriate interventions to strengthen and improve access to IUD services

Results:
Numerous improvements at participating facilities
Continuous QI at participating facilities
Expected result: Increased IUD utilization

Appendix F

Figure 8 summarizes the levels at which we recommend the different approaches and tools be applied in health programs.

Figure 8. Approaches and Tools to Be Used at Selected Levels of the Health Care System and at Selected Types of Institutions

Level	Approaches and Tools		
	PI	QI	PLA
National	X		
Regional	X		
District/prefecture	X	X (FS)	
Institution	X	X (any approaches)	
Hospital		X (any approaches)	
Department or ward		X (any approaches)	
Community		X (Community COPE)	X

Where multiple approaches address the same levels, refer to the recommendations in Section 3 for advice on how to integrate them.

Section 4:
Conclusion

The ACQUIRE Project's mandate is to increase access to quality RH/FP services, improve the performance of service-delivery providers, and strengthen the environment for RH/FP service delivery. Our three strategies for achieving these results are:

- A focus on the fundamentals of clinical care (ensuring informed choice, assuring medical safety, and providing for quality assurance and management)

- A strong customer orientation to guide our work with host country counterparts, USAID, and other stakeholders

- The use of data and evidence-based programming for the strategic selection of interventions that address each program's particular context and stage of development

By integrating the three proven approaches (PI, QI, and PLA), we are putting into practice our use of data and participatory processes to drive strategic choices and develop relevant interventions. Whether we are planning at the national level, providing assistance at the institutional level, or working with clinic managers and staff at the site level, ACQUIRE's approach is strategic, relevant, evidence-based, and participatory. We work to enhance community involvement in RH/FP service provision by facilitating links between community members and facilities and by engaging community groups in exploring barriers to RH/FP services and solutions to the problems identified. With our package of tools and approaches, we are able to channel community input and expectations into other best practices for supporting provider and facility change to meet those needs.

The ACQUIRE Project partners' tools and approaches complement each other. Our aim is to encourage creativity and seek appropriate opportunities to create synergies between the approaches, all to maximize improvements in health. We do not simply recommend the use of all approaches in all places. We hope that this guidance contributes to a lasting ACQUIRE legacy of effective programming for strengthened provider performance and service quality. This document should be considered a starting point, based on the best practices and expertise the partners have brought to the project. As the ACQUIRE Project continues to unfold, we expect to adapt and apply additional best practices and approaches as the need arises. For example, we plan to apply Breakthrough Collaboratives to effectively address key FP service-delivery issues and to scale up improvements.

This guidance does not provide extensive information for the introduction and application of the tools discussed here. For that reason, we include two types of resources in Section 5; the first set contains guidance on implementing each of the approaches and tools, and the second provides descriptions of program experiences and lessons learned from the implementation of these approaches and tools.

Section 5:
Resource Materials

Guidance on How to Implement Each of the Approaches

AVSC International. 1995. *COPE: Client-oriented, provider-efficient services*. New York.

AVSC International. 1999. *COPE for child health: A process and tools for improving the quality of child health services*. New York.

Ben Salem, B., and Beattie, K. J. 1996. Facilitative supervision: A vital link in quality reproductive health service delivery. *AVSC Working Paper* No. 10. New York. AVSC International.

Bradley, J., et al. 1998. Whole-site training: A new approach to the organization of training. *AVSC Working Paper* No. 11. New York. AVSC International.

CARE. 1999. *Embracing participation in development*. *Wisdom from the field: Worldwide experiences from CARE's RH Program, with a step-by-step field guide to participatory tools and techniques*. Atlanta.

EngenderHealth. 2000. *Cost analysis tool: Simplifying cost analysis for managers and staff of health care services*. New York.

EngenderHealth. 2001. *COPE® for maternal health services: A process and tools for improving the quality of maternal health services*. New York.

EngenderHealth. 2001. *Facilitative supervision handbook*. New York.

EngenderHealth. 2001. *The Quality Measuring Tool for reproductive health services: A manual for using the Quality Measuring Tool for health care managers, supervisors, and providers*. New York.

EngenderHealth. 2002. *Community COPE®: Building partnership with the community to improve health services*. New York.

EngenderHealth. 2003. *COPE® handbook: A process for improving quality in health services*. New York.

EngenderHealth. 2003. *COPE® for reproductive health services: A toolbook to accompany the COPE® handbook*. New York.

EngenderHealth and Mailman School of Public Health, Columbia University. 2003. *Quality improvement for emergency obstetric care leadership manual: An adaptation of COPE® (client-oriented, provider-efficient services)*. New York. EngenderHealth.

EngenderHealth and Mailman School of Public Health, Columbia University. 2003. *Quality improvement for emergency obstetric care toolbook: An adaptation of COPE® (client-oriented, provider-efficient services)*. New York. EngenderHealth.

IIED. 2000. PLA Notes 37: *Sexual and reproductive health*.

Lynam, P. F., et al. 1994. Inreach: Reaching potential FP clients within health institutions. *AVSC Working Paper* No. 5. New York: AVSC International.

McCaffery, J., et al. 1999. *PRIME's reproductive health performance improvement approach: A source document*. Chapel Hill, NC. INTRAH.

PRIME II Project. 2000. *Participant manual for PI short course*. Chapel Hill, NC. INTRAH.

PRIME II Project. 2002. *Stages, steps, and tools for performance improvement, A practical guide to facilitate improved performance of healthcare providers worldwide,* CD-ROM or www.prime2.org/sst Chapel Hill, NC. INTRAH.

PRIME II Project. 2003a. *Cost and results analysis, volume 1: Strategy*. Chapel Hill, NC. INTRAH.

PRIME II Project. 2003b. *Cost and results analysis, volume 2: Toolkit*. Chapel Hill, NC. INTRAH.

Schoonmaker Freudenberger, K. *Rapid rural appraisal and participatory rural appraisal, a manual for CRS field workers and partners*. Catholic Relief Services. http://www.catholicrelief.org/about_us/newsroom/publications/RRA_Manual.pdf

Srinivasan, L. 1990. T*ools for community participation: A manual for training trainers in participatory techniques*. New York: PROWWESS/UNDP.

Materials that Describe Experiences and Lessons Learned

Each resource is listed, with a brief description to guide readers.

Askew, I. 1989. Organizing community participation in family planning projects in South Asia. *Studies in Family Planning* 20(4):185–202. Describes PLA experiences in FP projects.

Beattie, K. et al. 1994. Introducing COPE in Asia: A quality management tool for FP services in Bangladesh *Innovations* 1:16–29. Describes early results of using COPE in Bangladesh.

Bradley, J., et al. 1998. Using COPE to improve quality of care: The experience of the Family Planning Association of Kenya. *Quality/Calidad/Qualité*. No 9. New York: Population Council. Description of use of COPE in the NGO sector.

Bradley, J., et al. 2002. *COPE® for child health in Kenya and Guinea: An analysis of service quality*. New York: EngenderHealth. Report on a two-year study of the introduction and results of the COPE process in a non-FP area of health in the public sector.

Bradley, J., et al. 1998. *Quality of care in family planning services: An assessment of change in Tanzania 1995/6–1996/7* New York. AVSC International. Presents early results of changes in quality (according to clients' rights and providers' needs) as measured with the QMT, and describes other QI interventions that were implemented to achieve those improvements.

Bradley, J., et al. 2000. *Family planning services in Tanzania: Results from a project to improve quality, 1996-1999*. New York. AVSC International. Presents changes in quality as measured with the QMT, and describes the other QI interventions that were implemented to achieve those improvements.

Bradley, J., et al. 2002. Participatory evaluation of reproductive health care quality in developing countries. *Social Science and Medicine* 55(2):269–282. Describes the use of the Quality Measuring Tool as a key intervention to improve quality of care in RH services in Tanzania.

Butta, P. 1995. US and Canadian clinics learn to "COPE," *Focus,* Vol. 2, No. 2. New York: AVSC International. Describes the experience of both U.S. and Canadian health facilities in implementing COPE to improve FP services.

CARE. 1999. *Embracing participation in development. Wisdom from the field: Worldwide experiences from CARE's RH program with a step-by-step field guide to participatory tools and techniques*. Atlanta. In addition to explaining the PLA process, this reference also describes lessons and results from the use of PLA in projects (including health projects) in many countries.

Dohlie, M. B., et al. 1999. Using practical quality improvement approaches and tools in reproductive health services in East Africa. *Joint Commission Journal on Quality Improvement* 25(11):574–587. Description of the EngenderHealth QI package, including FS, WST, COPE, and the QMT.

Dohlie, M. B., et al. 2000. COPE, a model for building community partnerships that improve care in East Africa. *Journal for Healthcare Quality* Vol. 22, No. 5. Description of the EngenderHealth QI package, including an early Community COPE experience in a mission hospital.

Dohlie, M. B., et al. 2002. Empowering frontline staff to improve the quality of FP services: A case study in Tanzania. In *Responding to Cairo: Case studies of changing practice in reproductive health and family planning,* ed. by N. Haberland and D. Measham. New York: Population Council. Description of QI package and results of use, including early use in the area of maternity services, in the public sector.

Dwyer, J., et al. 1991. COPE: A self-assessment technique for family planning services. *AVSC Working Paper* No. 1. New York. AVSC International. Describes the self-assessment process and the earliest experiences with the use of COPE in Kenya and Nigeria.

Dwyer, J., and Jezowski, T. 1995. Quality management for family planning services: Practical experience from Africa. *AVSC Working Paper* No. 7. New York. AVSC International. Describes early experience with COPE and FS in Africa.

EngenderHealth. 2002. Improving provider performance: Results from Guinea and Kenya. *Compass,* No. 1. Describes a quasi-experimental study of improvements in provider performance, client satisfaction, and caregiver knowledge related to child health services as a result of implementation of COPE for Child Health Services in two countries.

International Society for Performance Improvement. 2003. *Performance Improvement.* Volume 42, No. 8, September 2003. Examples of PI used in international settings.

Jaskiewicz, W. 2000. *PI approach raises reproductive health to a new level.* PRIME Pages: PI-2. Results of use of PI in the Dominican Republic.

Jezowski, T., et al. 1995. A successful national program for expanding vasectomy services: The experience of the Instituto Mexicano del Seguro Social. *AVSC Working Paper* No. 8. New York. AVSC International. Describes how no-scalpel vasectomy services were expanded in Mexico, in part due to the WST approach for training providers.

Kaim, B., and Ndlovu, R. 2000. Lessons from 'Auntie Stella': Using PRA to promote reproductive health education in Zimbabwe secondary schools. *PLA Notes 37* (February). Describes use of PRA to understand effective sources of health information for adolescents.

Kaniauskene, A., Mielke, E., and Beattie, K. Improving reproductive health services through whole-site training. Paper presented at the annual meeting of the Global Health Council, May–June 2001, Washington, D.C. Summarizes the WST approach and provides data on training results from Moldova and Tanzania.

Luoma, M., et al. 2000. Dominican Republic performance improvement project evaluation. *Technical Report* No. 19. Chapel Hill, NC. INTRAH.

Luoma, M, and Nelson, D. 2003. *Lessons learned in improving provider performance.* PRIME Pages: RR-28. Brief review of the lessons learned and recommendations for introducing and implementing successful PI around the world.

Lynam, P., et al. 1992. The use of self-assessment in improving the quality of family planning clinic operations: The experience with COPE in Africa. *AVSC Working Paper No. 2.* New York. AVSC International. Describes follow-up evaluation of COPE in 11 African clinics.

Lynam, P., et al. 1993. Using self-assessment to improve the quality of FP services. *Studies in Family Planning* 24(4):252–260. Description of early experiences and results from the use the COPE process.

Lynam, P., Smith, T., and Dwyer, J. 1994. Client flow analysis: A practical management technique for outpatient clinic settings. *International Journal for Quality in Health Care* 6(2):179–186. Describes results from use of the Client Flow Analysis tool to reduce client waiting time for services (part of COPE).

Mane, B., et al. 2003. *Final evaluation of the supervision intervention in Kebemer District. Final project report*. Dakar, Senegal. IntraHealth. Describes how PI was introduced as part of an FS intervention after the interventions had been selected.

Marquez, L., and Kean, L. 2002. *Making supervision supportive and sustainable: New approaches to old problems*. USAID MAQ Paper, Vol. 1, No. 4. Describes the supportive/facilitative approach to supervision, benefits of the approach, and lessons from its use in international low-resource settings.

Mielke, E., and Beattie, K. 2001. COPE: A process and tools for healthcare. *QA Brief,* Vol. 9, No. 1. Provides a brief overview of COPE process, purpose, results, and new adaptations of the materials.

Mielke, E., Bradley, J, and Becker, J. 2001. Improving maternal and child health services through COPE®. *QA Brief,* Vol. 9, No. 2. Provides a review of experience and tools for COPE for Maternal Health Services and COPE for Child Health Services.

PRIME II. 2002. Measuring provider performance: Challenges and definitions. *PRIME II Better Practices* No. 1. Summary of a technical meeting sponsored by PRIME II and MEASURE Evaluation to shape and advance the dialogue on performance measurement among family planning and reproductive health professionals and organizations.

RACHA (Reproductive and Child Health Alliance). 2000. The COPE process: Improving the quality of services in Cambodia's public health facilities. *RACHA Photobook No. 2.* – Describes site-level improvements (e.g., for infection prevention) as a result of COPE in Cambodia.

Stanley, H., et al. 2001. The quality of care management center in Nepal: Improving services with limited resources. *AVSC Working Paper* No. 13. New York: AVSC International. Describes a comprehensive approach to quality of care, addressing management, flow of funds to clinics, maintenance of facilities and equipment, training, supervision, and monitoring, all leading to improvements in care. Interventions included COPE, FS, and WST.

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Dohlie, M. B., et al. 1999. Using practical quality improvement approaches and tools in reproductive health services in East Africa. *Joint Commission Journal on Quality Improvement* 25(11):574–587.

IIED. 2000. *PLA Notes 37: Sexual and reproductive health.*

Luoma, M, and Nelson, D. 2003. *Lessons learned in improving provider performance.* PRIME Pages: RR-28.

Mane, B., et al. 2003. *Final evaluation of the supervision intervention in Kebemer District. Final project report.* Dakar, Senegal. IntraHealth.

MAQ Exchange. No date. *Community defined quality (CDQ): Creating partnerships for improving quality.* Accessed at www.maqweb.org/maqslides/powerpoint/New_Mods/CDQ/CDQ.pdf.

Marquez, L., and Kean, L. 2002. *Making supervision supportive and sustainable: New approaches to old problems.* USAID MAQ Paper, Vol. 1, No. 4.

McCaffery, J., et al. 1999. *PRIME's reproductive health performance improvement approach: A source document.* Chapel Hill, NC. INTRAH.

PRIME II Project. 2002. *Stages, steps, and tools for performance improvement, A practical guide to facilitate improved performance of healthcare providers worldwide,* CD-ROM or www.prime2.org/sst. Chapel Hill, NC. INTRAH.

PRIME II Project. 2003a. *Cost and results analysis, volume 1: Strategy.* Chapel Hill, NC. INTRAH.

PRIME II Project. 2003b. *Cost and results analysis, volume 2: Toolkit.* Chapel Hill, NC. INTRAH.

Session B

Involving Staff in the QI Process: COPE®

Essential Ideas to Convey

❑ COPE® fits within a continuous QI process.

❑ COPE® is both a process and a set of tools designed to help health care staff at a service-delivery site continuously assess and improve the quality of their services.

❑ COPE® stands for "client-oriented, provider-efficient services."

❑ COPE® is built on a framework of clients' rights and staff needs.

❑ The COPE® tools consist of:

1) Self-assessment guides, including a client record review checklist

2) A client interview guide

3) A client-flow analysis (CFA)

4) An action plan

❑ The self-assessment guides contain key questions based on international clinical and service standards and follow the clients' rights and staff needs framework.

❑ COPE®:

• Develops a customer focus among the staff

• Provides a forum for staff to interact

• Focuses on systems and processes, not on blaming individuals for mistakes

• Empowers staff at all levels, builds teamwork, and creates ownership of the QI process by involving all levels of staff

• Provides tools for local problem identification and problem solving

• Presents concrete and immediate opportunities for action

• Helps to communicate standards and improve performance

Objectives

By the end of this session, the participants will be able to:

• Explain what COPE® stands for

• Describe the COPE® tools and process

• Use COPE® tools

• Teach staff to use COPE® tools

Time

1 hour, 40 minutes

Appendix F

Materials

- PowerPoint presentation for Appendix F, Session B
- *COPE® Handbook: A Process for Improving Quality in Health Services*
- *COPE® for Reproductive Health Services: A Toolbook to Accompany the COPE® Handbook*
- Participant Handout B-1: Client Record Review Checklist
- Flipchart paper, markers, pencils

Advance Preparation

1. Make one copy of Participant Handout B-1.
2. Have enough copies of the PowerPoint presentation and of the *COPE® Handbook* and *COPE® for Reproductive Health Services* to distribute to all participants.
3. Prepare a flipchart showing sample action plans with unclear and clear problem statements:

Flipchart B-1				
Sample COPE Action Plan (Unclear Problem Statement)				
Problem	**Cause(s)**	**Recommendation**	**By Whom**	**By When**
HIV-positive pregnant women are lost to follow up	Clients are not interested in services	Make clients more interested in services	All staff	Immediately
Sample COPE Action Plan (Clear Problem Statement)				
Problem	**Cause(s)**	**Recommendation**	**By Whom**	**By When**
Pregnant clients testing positive for HIV do not return for follow-up services	1) Staff not trained to discuss the range of services available	1) Conduct site orientation on clinical, counseling, and support services available to prevent MTCT and support HIV-positive clients using whole-site training	L. Karisa (clinic nurse)	July 1, 2008
	2) Clients feel unwelcome and stigmatized by staff	2) Conduct HIV and stigma awareness/ sensitivity training for all staff	J. Samanda (nurse supervisors)	July 30, 2008
	3) HIV-positive clients are afraid others will find out their status and harm them	3a) Review/revise protocols on client confidentiality and orient all staff	Dr. Ware (clinic director)	August 30, 2008
		3b) Provide counseling training for providers on how to assist clients in making decisions about disclosure	R. Minja (HIV counselor)	September 5, 2008

Training Steps

1. Start a PowerPoint presentation. Reveal slides 2–3 and remind the participants of the steps in the QI process.

2. Ask the participants to recall the definition of quality services and to list QI approaches and tools (the QI Package). Use slides 4–5.

3. Reveal Slide 6 and briefly remind the participants of the QI principles.

4. If the participants are familiar with the clients' rights and staff needs framework, reveal slides 7–8 and remind them that it is a framework for quality services. If the participants do not know about clients' rights and staff needs, conduct the exercise to define quality.

5. Continue the PowerPoint presentation, slides 9–12. Explain what COPE® stands for and list the COPE® tools and the health topic areas for which there are COPE® toolbooks.

6. Reveal slides 13–15. Explain the format of the self-assessment guides and how to use them.

7. Ask the participants to open the *COPE for Reproductive Health Services* toolbook and read a few questions from the different parts of the guides to demonstrate how to use them.

➻ **Training Tip**

Emphasize that COPE is not a test, and that staff should focus on gaps in the system and in processes, not on individuals. Remind the participants of the QI principles.

Tell the participants that all COPE tools are adaptable and adjustable.

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8. Explain in details how to use the self-assessment guides. Explain that during the second half of the session, the participants will have an opportunity to use the COPE tools in a mock exercise.

9. Reveal Slide 16 and tell the participants about the Client Record Review Checklist. Distribute Participant Handout B-1 (or ask the participants to open their *COPE for Reproductive Health Services* toolbook to page XX) and explain how to use the checklists.

10. Discuss with the participants why it is important to have complete client records.

11. Ask the participants why staff should conduct client interviews.

12. Reveal Slide 17 and comment on it. Explain the instructions on how staff should conduct client interviews. Allow the participants a few minutes to read the client interview form. Emphasize that staff's good communication skills are very important when they conduct client interviews.

13. Tell the participants that the interview form should be adjusted to reflect services that are provided at a site.

14. Present slides 18–20 and explain how to organize that specific activity and how to use the forms presented in the *COPE for Reproductive Health Services* toolbook.

> ➤➤ **Training Tip**
>
> Emphasize that client-flow analysis (CFA) is not used in the first COPE exercise.
>
> Refer to the *COPE Handbook*, Chapter 7, Figure 7-3, to explain what CFA can and cannot do.

15. Tell the participants that staff use all of the COPE tools to identify problems, analyze the root causes of these problems, and develop solutions.

16. Use slides 21–24 to explain how to develop an action plan and how to use the "multiple whys" technique to develop a clear problem statement.

17. Reveal Slide 25, which shows the action plan format. Explain how staff should use that format to record the results of the use of the COPE tools.

18. Reveal Flipchart B-1 and analyze the sample action plans shown on it.

> ➤➤ **Training Tip**
>
> Emphasize that in developing solutions, staff first of all should look for internal resources—what they can accomplish without external help. In a case where external help is crucial, the staff will need to plan concrete steps for how to get that help.

19. Use slides 26–28 to explain the schedule of the introductory COPE exercise and how all of its activities should be organized.

20. Describe an action plan meeting and present the tasks of the QI committee. Use slides 29–30.

> ➤➤ **Training Tip**
>
> Emphasize that being a member of the QI committee does not require too much time and that all tasks are very simple. When you explain it to the staff, people usually volunteer to become committee members.

21. Reveal Slide 31 and explain what it means to have an ongoing COPE process.

22. List the COPE toolbooks that are available (see also Slide 32).

23. Discuss with the participants the benefits of COPE, and give examples of COPE success stories, using Slide 33.

24. Use slides 34–36 to explain what happens after the introductory COPE exercise, in terms of implementing interventions and evaluating changes.

25. Reveal Slide 37 and remind the participants about the QI process. Tell them that COPE is one of the ways to gather information that supervisors and staff can use to improve the quality of services.

26. Tell the participants that you will now start a mock COPE exercise to demonstrate more clearly how to use the COPE tools.

27. Divide the participants into groups in the following way: Designate four trainees to work together in two pairs, select one participant to work individually, and divide the rest of the group into three (or four) groups. Those participants who are in pairs will be practicing conducting client interviews. One person will work on the Client Record-Review Checklists. The small groups will use selected self-assessment guides.

� **Training Tip**

Explain the tasks for each group. Ask the participants to think about their own facility when they use the COPE tools. The goal for each group is to identify problems, to develop solutions, and to record them using the action plan format.

The participants in pairs should decide who will play the role of a client and who will be a service provider. Those who are to play the role of a client should be creative and suggest some improvements to "the site" (or should complain about the services), so the pairs can come up with an action plan using the results of the client interviews. Use the *COPE for Reproductive Health Services* toolbook.

The person who is assigned to work with Client Record Review Checklists should use a copy of Participant Handout B-1. She or he should read the checklists carefully and recollect (or imagine) what usually is missing in the client records. That participant also should come up with an action plan for how to solve the problems she or he has identified.

Explain to the participants from the three groups how they should work using the self-assessment guides. For the purpose of the exercise, it would be sufficient to have each group to focus on one set of the questionnaires. For example, the sets on clients' rights to information, on clients' rights to privacy and confidentiality, and on staff needs for facilitative supervision and management might be used for the exercise. Ask the participants to imagine that they are clinic supervisors and staff and to use their experience and imagination when they answer the questions. Ask them to identify at least two issues to be improved and to think about causes and solutions that the staff might develop to solve those problems.

The participants should use flipchart paper to record the action plans that they develop.

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28. Tell the participants that they have 20 minutes to work on using the COPE tools and developing an action plan.

29. Ask each group to present one identified problem only. Lead a discussion and connect it to real situations.

➳ **Training Tip**

When leading an action plan meeting, pay attention to whether the participants are:

❑ Using the "multiple whys" technique

❑ Being specific and concrete in identifying problems and in developing solutions

❑ Always asking the same person to implement the solutions

❑ Allowing a realistic amount of time for implementation

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30. Mention again the further steps that need to be taken after the introductory COPE exercise: monitoring and evaluation. Discuss the roles of an external and an internal facilitator in introducing COPE to the sites and in helping to implement solutions.

31. Remind the participants that at the beginning of the course, they participated in an exercise in which they discussed a definition of quality services and came up with a framework of clients' rights and staff needs. Repeat a description of this exercise within this particular module for those who will introduce COPE to their staff or to other supervisors.

Participant Handout B-1: Client Record Review Checklist

Note: This checklist can be used to review the records for clients of any reproductive health services. For surgical procedures, please also use the **Surgical Record Review Checklist.**

Site: _____ Date: _____

Reviewer:_____

(select 10 records at random)

Checklist Item	1	2	3	4	5	6	7	8	9	10	Total
1. Client identification information recorded											
2. Date of visit is recorded											
3. Client's reason for visit is recorded											
4. Client's medical history is recorded											
5. Clients' reproductive health history is recorded											
6. General physical examination was conducted											
7. Client's signs and symptoms are recorded											
8. Any prescriptions or treatment are recorded											
9. Follow-up plans are recorded											
10. Staff signatures are present											
11. Entries are legible											

Comments on records reviewed: _____

_____

_____

_____

Appendix F

Surgical Record-Review Checklist

(See the *COPE for Reproductive Health Services* toolbook for the Record-Review Checklist for family planning and reproductive health services.)

Checklist Item	1	2	3	4	5	6	7	8	9	10	Total
1. Client identification information is recorded											
2. Physical examination was completed											
3. Informed consent form was signed and attached											
4. Information on intraoperative medications is recorded: • Time of administration • Names of medications • Dosage of medications											
5. Intraoperative vital signs are recorded											
6. Procedure notes are recorded in detail (e.g. type of incision, findings, type of surgery, type of suture).											
7. Postoperative vital signs are recorded											
Complications (Note cases where a complication occurred)											
8. Complication described in detail (e.g. type of incision, findings, type of surgery, type of suture).											
9. Treatment procedure is described in detail											
10. Medication given is recorded											
11. Discharge status recorded											

Comments on records reviewed: _____

_____

_____

_____

Session C

Involving Staff in the QI Process:
The Whole-Site Training Approach

Essential Ideas to Convey

❏ Whole-site training (WST) is an approach focused on meeting the learning needs of staff at a site by linking supervision and training, emphasizing teamwork and sustainability, and applying a range of training strategies.

❏ The WST approach includes different types of training at different locations:

❏ WST includes Inreach within a facility—the sharing of knowledge learned through training with others at the site, on-site orientations about services provided, linkages between departments and a referral system within a facility, and adequate signage—to ensure that clients do not miss opportunities to access information and services for all of their health needs when they come to the site.

❏ The six elements of the WST approach are:

○ Linking the supervisory and training systems to involve both on-site and off-site supervisors in assessing training needs and in planning, developing, and conducting the training.

○ Assessing site training needs and planning to meet them, beginning at the site level and gathering information through COPE, medical monitoring, or other processes

○ Focusing on teams, not only on individuals

○ Tailoring the level of training to the needs of different employees

○ Expanding the locales where training occurs

○ Building sustainable capacity

Objectives

By the end of this session, the participants will be able to:

• Explain the WST approach

• List the types of training and locations

• Describe the six elements of the WST approach

• Explain the roles of supervisors in assessing and meeting learning needs through the WST approach

• Teach staff to apply the WST approach

Time

35 minutes

Appendix F

Materials

- PowerPoint presentation for Appendix F, Session C
- Participant Handout C-1: Case Study: Dr. Gonzáles
- Participant Handout C-2: Sample Plan
- Participant Handout C-3: Is Training the Answer?
- Resource: AVSC Working Paper #5, Inreach
- Resource: AVSC Working Paper #11, Whole-Site Training: A New Approach
- Resource: *Improving Reproductive Health Services through Whole-Site Training*
- Flipchart paper, markers, and pencils

Advance Preparation

Make enough copies of the handouts for distribution to all participants.

Training Steps

1. Start the PowerPoint presentation by revealing Slide 2 and reminding the participants of the needs that staff have.

2. Distribute Participant Handout C-1 and ask for a volunteer to read it.

3. Discuss with the group what weaknesses they see in the traditional/centralized approach to training illustrated by that case study.

4. Reveal Slide 3 to summarize the discussion.

5. Reveal slides 4–11 and explain the WST approach, its elements, the changes in the roles of supervisors, how it helps in assessing and meeting learning needs, and any additional benefits.

6. Reveal slides 12–14 and explain Inreach.

7. Distribute Participant Handout C-2 and allow the participants three minutes to analyze it.

8. Ask the participants to analyze one more time the case study of Dr. Gonzáles and to think about how they would use WST to plan training and other related activities to get more effective results. Allow the participants five minutes to work individually.

9. Ask for a volunteer to present the results.

10. Ask the participants to think about the functions of off-site supervisors in terms of helping on-site supervisors and staff meet their learning needs. Tell the participants that on-site supervisors can use the WST approach and Inreach. Off-site supervisors can teach on-site supervisors how to use these approaches.

11. Tell the participants about additional reference materials included on this CD-ROM (such as *Improving Reproductive Health Services through Whole-Site Training* and AVSC Working Papers No. 5 and No. 11).

Participant Handout C-1: Case Study: Dr. Gonzáles

A decision is made at higher levels that no-scalpel vasectomy should be introduced at all of the clinics in a certain region. Dr. Gonzáles is chosen to go to the capital city for technical training in this procedure. He goes away for a week, is trained, and returns to his clinic.

Months go by and he does not use his new skills. Why?

❏   Mainly because there is no demand for the service.

❏   This is because there has been no effort to provide information on no-scalpel vasectomy to the community

❏   There are no educational materials on no-scalpel vasectomy in the clinic itself.

❏   In addition, few staff in the clinic have been informed that this service is now available, so they do not refer potential clients.

Consequently, when the supervisor arrives six months after the training, she finds that not only is Dr.Gonzáles not using his new skills, but also that he has lost some of his proficiency in the technique.

Appendix F

Participant Handout C-2: Sample Plan

Problem and cause	Recommendations	Type of training	Where	By whom	By when	Materials needed
Reusable instruments and other items used in clinical procedures are not always decontaminated in a 0.5% chlorine solution before processing because of staff turnover and a lack of training	Provide training in infection prevention (IP) to the staff responsible for processing instruments and other reusable items	Refresher training on IP	At the trainees' site	Dr. Y (trained in conducting IP course)	June 2008	IP guides Chlorine
		Skills training in preparing 0.5% chlorine solution	At the trainees' site	Nurse Z	June 2008	IP guides Chlorine
						IP guides Chlorine
		Refresher training on IP	At the trainees' site	Dr. Y	For all newly hired nurses and cleaning staff	
						IP guides Chlorine
	Provide training to all newly hired staff responsible for processing reusable instruments	Skills training in preparing 0.5% chlorine solution	At the trainees' site	Nurse Z	For all newly hired nurses and cleaning staff	
Practitioner lacks Norplant implant removal skills; never received training	Provide training in Norplant implant removal	Skills training in removal of implants	At the Dr.'s X site (nearby clinic)	Dr. X (from nearby clinic)	June 15	Norplant implant operator's manual; removal instru-ments; Norplant training arm

Trainer's Resource: Improving Reproductive Health Services through Whole-Site Training

(*Note:* This is an adaptation of the following: Kaniauskene, A., Mielke, E., and Beattie, K. 2001. Improving reproductive health services through whole-site training. Presentation at the 28th Annual Global Health Council Conference, Washington, D.C., May 29–June 1.)

Whole-site training is an integral approach among the range of quality improvement (QI) approaches and tools that EngenderHealth (formerly AVSC International) has developed since the late 1980s to assure the quality of reproductive health services. All of these approaches and tools are based on a framework of clients' rights and staff needs, which guides site managers, supervisors, and staff in their efforts to improve quality, increase their customer orientation, and increase their own job satisfaction and motivation. Acknowledging that clients have a right to expect certain things when they come for services is a powerful concept, one that has implications for staff behavior and performance. Moreover, recognizing that service providers and other staff have needs that must be met in order to provide quality services is a motivating force among staff and supervisors.

EngenderHealth's Quality Improvement Package

QI Approaches	QI Tools
• Facilitative supervision • Medical quality improvement • Whole-site training	• COPE® • Community COPE® • Quality measuring tool • Cost analysis tool • Medical monitoring

The six principles underlying all of EngenderHealth's QI approaches are:

❑ Customer mindset	❑ Focus on systems and processes
❑ Staff involvement and ownership	❑ Staff development and capacity building
❑ Cost consciousness and efficiency	❑ Continuous quality improvement

These approaches are most successful when used together continuously.

Approaches: EngenderHealth's approaches for continuously improving the quality of services include:
• **Facilitative supervision.** This approach to supervision emphasizes the supervisor's role in facilitating quality improvement among a team of staff. It emphasizes mentoring, joint problem solving, and two-way communication between a supervisor and those being supervised. To facilitate change and improvement and to encourage staff to solve problems, supervisors must have the solid technical knowledge and skills needed to perform tasks, know how to access additional support as needed, and have time to meet with the staff they supervise.

- **Medical quality improvement.** This ongoing approach focuses on the quality of medical services, and includes several processes: medical monitoring; developing and/or updating and implementing written medical guidelines, standards, and job aids; analyzing and rectifying detrimental written and "unwritten" medical policies and practices; analyzing relevant medical data and reports for service improvement; monitoring and assuring informed decision making and informed consent; and building the capacity of institutions and sites to continue to improve medical quality.

- **Whole-site training (WST).** WST is an approach focused on meeting the learning needs of a site by linking supervision and training, emphasizing teamwork and sustainability, and applying a range of training strategies. To be more sustainable and have a greater impact on service quality than earlier centralized training approaches, the WST approach includes different types of trainings at different locations. The types of training include orientations to new services or concepts, knowledge updates, and skills training. The locations for training can be on-the-job, on-site, and regional or central trainings. The emphasis is on conducting the training at or as close to the site level as possible. WST includes Inreach within a facility (sharing of knowledge learned through training with others at the site, on-site orientations about services provided, linkages between departments and a referral system within a facility, and adequate signage) to ensure clients do not miss opportunities to access information and services for all of their reproductive health needs when they come to the site.

Tools: To help implement these approaches, EngenderHealth has developed the following simple and practical tools designed to help supervisors and staff improve the quality of services:

- **COPE®.** This is a process and set of tools for health care staff to use to continuously assess and improve the quality of their services. COPE, which stands for "client-oriented, provider-efficient services," is a built on a framework of clients' rights and staff needs. COPE consists of four tools: self-assessment guides (one for each of the clients' rights and staff needs); a client interview guide; client-flow analysis; and an action plan. The self-assessment guides encourage staff to review the way they perform their daily tasks and serve as a catalyst for analyzing the problems they identify. The guides contain key questions based on international clinical and service standards, and the safety guide includes a medical record review. The tools also highlight client-provider interactions and other areas of concern to clients. Toolbooks for specific health services include:

  - ❏ *COPE for Reproductive Health Services*
  - ❏ *COPE for Cervical Cancer Prevention Services*
  - ❏ *COPE for Services to Prevent Mother-to-Child Transmission of HIV*
  - ❏ *COPE for HIV Care and Treatment Services*
  - ❏ *COPE for HIV Counseling and Testing Services*
  - ❏ *COPE for Maternal Health Services*
  - ❏ *COPE for Child Health*

- **Quality Measuring Tool (QMT).** Based on the self-assessment tool used in COPE, the QMT is used annually to measure QI over time. Site staff and supervisors use the QMT together to determine whether clients' rights are being upheld and staff needs are being met. Any new problems identified are then incorporated into the site's ongoing Action Plan.

- **Cost Analysis Tool.** Health care staff use this tool to measure the direct costs of providing specific health services. The tool measures the cost of staff time spent directly providing a service or clinical procedure and the costs of the commodities, expendable supplies, and medications used to provide that particular service or procedure. The information can be used to improve the efficiency of staffing and the use of staff time and supplies at a site, as well as to set user fees for different services that reflect the actual direct costs.

- **Community COPE®.** This participatory process and tools, an extension of COPE, is for health care staff to learn how to build partnerships with community members to improve local health services, making them more responsive to local needs. It can also have the result of increasing community "ownership" of health facilities and services and community advocacy for resources for health. It is particularly useful to site administrators in areas undergoing health reform as a means of engaging the community in defining and supporting the quality of services they want. The range of activities for learning about local needs and suggestions for improvement include individual interviews, group discussions, community meetings, site walk-throughs, and participatory mapping. Like COPE, the process includes identifying and analyzing problems, developing an Action Plan, and prioritizing solutions. Community members select representatives to join the health care facility's QI Committee and facilitate ongoing communication between the community and the facility's staff.

- **Medical Monitoring:** This medical QI intervention entails the objective and ongoing assessment of the *readiness of* and *processes for* service delivery. It is conducted to identify gaps between best and actual practices and leads to recommendations for improvement To accomplish medical monitoring, a variety of observation, record review, case review, and facility audits are available and need to be adapted to the local situation, as well as for use either by internal or external supervisors.

Typically, the application of any combination of the approaches and tools described above leads to the identification of some training needs for site staff. When training is needed to close the gap in service quality, staff and supervisors implement the WST approach.

The Six Elements of the Whole-Site Training Approach

❏ *Linking the supervisory and training systems to involve both internal and external supervisors in assessing training needs and in planning, developing, and conducting the training.* External supervisors assist the site staff in accessing training resources outside the site. The WST approach encourages supervisors to provide follow-up and support trainees, regardless of where they were trained. Supervisors also orient the staff who do not participate in off-site training, to build their support for the returning trainees to apply their new knowledge and skills. The WST approach enables mentoring between supervisors and staff and among staff. Supervisors also ensure the site has appropriate supplies and equipment for practicing new skills and providing new services. The training and supervisory systems complement each other, leading to sustained improvement.

❏ *Assessing site training needs and planning to meet them.* Assessment begins at the site level, and information can be gathered through COPE®, medical monitoring, or other processes. Site staff know the facility best and can best identify gaps in quality of care, plan, prioritize, and take action as a team to make training fit their needs. Centralized

training remains an important element of WST for meeting particular needs—for example, when a new contraceptive method is introduced or when particular skills are needed.

❏ *Focusing on teams, not only individuals*. Working as a team, staff understand better the role and the value of each staff member in providing quality services, and they identify the training needs that fulfill their team responsibilities.

❏ *Tailoring the level of training to the needs of different employees*. The WST approach is more flexible than centralized training because it includes different types of training. The site decides what level of the training is needed for each level of service providers: skills training, service orientation, or updates.

❏ *Expanding the locales where training occurs*. Skills training, updates, and orientation can all be done on-site, allowing the transfer of knowledge and skills to larger numbers of staff. Training may be adjusted more easily to meet the specific needs of the site and its staff.

❏ *Building sustainable capacity*. Trained and certified (as required) individuals become part of the local pool of skilled individuals who train others. The overall capacity is built as skills are transferred. Information sharing and training become part of daily work, thus promoting sustainability. Problem solving becomes part of performance improvement.

Whole-Site Training in Tanzania

EngenderHealth has been working to improve family planning services in Tanzania since 1988, in collaboration with the Ministry of Health of Tanzania, UMATI (the Family Planning Association of Tanzania), and Marie Stopes International and with support from the U.S. Agency for International Development (USAID). Starting in 1995, collaborative efforts focused on improving supervision and enhancing coordination between the public, non-governmental, and private sectors. Program activities were aimed at addressing providers' needs for training, management and supervision, and supplies by building human resource capacity, improving problem solving and team-building, and providing equipment and information, education, and communication materials.

From 1994 to 1999, service providers and supervisors from regional and district hospitals in Tanzania were trained through the WST approach in skills including family planning counseling, surgical contraception (minilaparotomy, no-scalpel vasectomy, and Norplant insertion and removal), postabortion treatment and counseling, proper infection prevention (IP), and management skills. In the early years of the program, many staff were trained at a central or regional level in surgical skills and in the counseling for those surgical procedures. In later years, as more sites had at least one trained provider, the on-the-job training approach, combined with medical monitoring and supervision by external supervisors, was used to train many more service providers at the site. Through on-the-job training, surgical assistants were trained in minilaparotomy under local anesthesia, doctors and nurses were trained in Norplant insertion and removal, and many staff were trained in family planning counseling skills, COPE® facilitation, and IP practices. External supervisors routinely oriented and provided updates (or trained) for site staff to concepts and practices during site visits, depending on the needs identified through COPE®, facilitative supervision, and medical monitoring. These included such topics as

expanding men's access to family planning, services for preventing sexually transmitted infections (STIs), and improvement of IP through proper handwashing, decontamination, sterilization, and waste disposal. To reinforce the improved practices, supervisors provided posters reminding staff of IP procedures and helped staff establish IP stations in each ward.

For some training activities, it was essential to hold the training at a centralized training facility to ensure sufficient client load. These include services such as manual vacuum aspiration (MVA) and minilaparotomy under local anesthesia. Once clinicians were trained centrally in services such as MVA treatment for postabortion complications, supervisors oriented site staff about the new services being offered and trained cleaning staff to process the MVA equipment. Both staff and area supervisors recognized more efficient service delivery and supervision as a result of the decentralized training.

**Expanding Training Opportunities at
Maswa District Hospital**

Legend:
- ☐ Clinical Skills (CS)
- ■ CS Update
- ☐ Supervisory & Training (S&T) Skills
- ▨ S&T Update
- ▦ Orientations
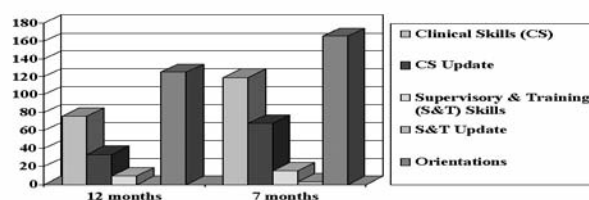
The above graph shows the increase in the numbers of staff trained in various skills at one district hospital through the WST approach, compared with the earlier centralized approach. Through the centralized approach, 243 individual staff skills trainings took place in a 12-month period (1996–1997). In the following seven-month period (July, 1997–January 1998), a total of 370 individual staff skills trainings took place—an increase of 127 skills trainings in just over half the time. In a national program assessment for the period 1994–1999, the program exceeded the goal for training by conducting 1,700 skills trainings (the goal was 1,400). Current studies showed that the quality of family planning services, as measured by the Quality Measuring Tool described above, improved at both local and national levels in the same period (see Bradley J. et al., 1998 and 2000).

Whole-Site Training in Moldova

EngenderHealth's objectives in Moldova were to improve reproductive health within the government system of countrywide family planning rooms. In the first phase of activities, from 1995–1997, EngenderHealth conducted contraceptive technology updates for doctors and midwives, training courses to improve counseling, clinical and management skills, and training of trainer activities for counseling and management courses. Through training and technical assistance to the Women's Health Center "Dalila," EngenderHealth helped to institutionalize counseling training nationally. This center was later licensed by the Ministry of Health to provide certificates equivalent to those provided by refresher training institutes. In the second phase of activities, during 1997–1999, teams of doctors and midwives from each of the country's 60 family planning facilities were trained in counseling and management of the family planning services. The courses aimed to improve the quality of care at the sites, by giving teams the tools to make their services client-oriented.

Appendix F

The WST approach was broadly used at the program sites. Overall, 550 service providers were trained, and quality services were established at 60 sites. The sites continue using different types of training (i.e., orientation, knowledge updates, and skills training) at different locations. For example, at the Women's Health Center "Dalila," which had a staff of 14 (including the receptionist and cleaning staff), during the period January 1997–November 1999, different members of the center's staff attended 19 centralized courses for a total of 78 individual staff skills trainings. (Several staff attended different courses.) The courses covered a range of topics: antenatal care, primary care, prevention of STIs/HIV, domestic violence, clinical protocols, and medical skills (e.g., colposcopy, sonography, laboratory evaluation, etc.).

In regular monthly meetings, staff at the Women's Health Center "Dalila" discussed what knowledge and skills they needed to provide better or additional services. To respond to the needs identified by staff and to build teamwork and empower staff, the supervisor and the staff members who had been trained centrally conducted eight skills training courses on-site, providing 74 staff skills trainings. The staff established the rule that everybody who had returning from a centralized course or who had attended an on-site training must provide an orientation or update for their colleagues. For example, one doctor attended a training course on colposcopy and then trained other gynecologists at the center. As a result, all doctors learned how to use a colposcope. Overall, the "Dalila" staff conducted 14 orientations. The management of the site followed up on the implementation of the skills gained and, for example, provided a colposcope and ultrasound equipment, enabling the staff to provide the new services. The demand for those services had been identified through the client interviews conducted as a part of COPE® exercises. The average number of trainings for each member of staff was 10.9 (skills), 7.4 (updates), and one (orientation) for the period.

As a result of all of the trainings, many new services became available at the Women's Health Center "Dalila", such as ultrasound, colposcopy, reproductive health services and counseling for adolescents, educational classes for adolescents, counseling for couples, and counseling on domestic violence. One example of the impact of the changes in quality of services may be the significant decrease in the rate of abortions for Chisinau City, the area where the Center's clients came from. During the time that the Center's reproductive health services expanded and improved, the number of abortions per 1,000 women of reproductive age decreased by more than half, from 47.7 abortions in 1995 to 21.4 in the year 2000. The Center staff also conduct many outreach activities and are transferring their knowledge and skills to their colleagues from other facilities, in both the city and the country as well as internationally. The "Dalila" staff also helped the neighboring Romanian Ministry of Health to establish a Women's Health Center using the same model.

A similar example of implementation of the impact of the WST approach, combined with other QI approaches, is the Women's Health Center in Drochia, which is located in the northern part of Moldova and provides reproductive health services for the whole district. In the period January 1997–November 1999, the center's five staff received on average 8.4 skills trainings and 4.4 updates in STI counseling, counseling for adolescents, and family planning methods. Following the training, staff introduced educational sessions for adolescents and provided training to their colleagues in other district facilities in counseling for family planning and STI prevention, contraceptive technology updates, and reproductive health services for adolescents. Similar to the Chisinau case, the abortion rate among women of reproductive age in the

Drochia district decreased from 118 abortions per 1,000 women in 1988 to only 0.13 abortions per 1,000 women of reproductive age in 1999.

Due to their improved performance, both centers in Moldova became known nationally as centers of excellence. More importantly, the results of client interviews have confirmed that the services provided by the staff at the "Dalila" and Drochia Centers are client-oriented and meet clients' needs.

WST works to build sustainable capacity by involving many staff in training and by developing a role for supervisors as part of the day-to-day system, in which the sharing of knowledge and expertise is encouraged and follow-up becomes routine. Staff continue to use problem-solving processes to reinforce their performance improvement mindset. Assuring the quality of WST requires well-trained supervisors to conduct effective monitoring of training and post-training performance; adequate training reference materials and evaluation tools; and, where certification of clinical skills is required, assessment of skills by regional supervisors to ensure the assessment is according to standards. In summary, the approach demystifies training and builds a foundation for the sustainability of quality services.

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Participant Handout C-3: Is Training the Answer? (Optional)

What is the performance problem?

Is it important?
(If so, continue)

Are the performance expectations clear?
(If not, clarify them)

Does the individual have the knowledge and skills to perform the task?

— No → Has the person done the task in the past?

— Yes → Is there a disadvantage to doing this task well?

Has the person done the task in the past?
- No → Arrange for an update and practice.
- Yes → Has person used this knowledge and skill often?

Has person used this knowledge and skill often?
- No → Arrange for the person to receive training in the knowledge or skill
- Yes → Arrange for the person to get constructive feedback

Is there a disadvantage to doing this task well?
- Yes → Remove the disadvantage.
- No → Is there an advantage to doing this task poorly?

Is there an advantage to doing this task poorly?
- Yes → Arrange a positive consequence for doing the job well.
- No → Can the task be made easier? (If so, simplify task.)

Can the task be made easier?
- No → Are there any other obstacles to performance (e.g., resources)?

Are there any other obstacles to performance (e.g., resources)?
- Yes → Remove obstacles.
- No → Does the performance matter to the employee?

Does the performance matter to the employee?
- No → Make it matter.

[5]Adapted from: Mager, R. F. and Pipe, P. 1984.
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Session D

Involving Staff in the QI Process:
The Quality Measuring Tool

Essential Ideas to Convey

❑ The quality measuring tool (QMT) is a simple, action-based rapid assessment tool.

❑ The QMT gives health care supervisors and staff a way to measure changes in the quality of their services and to assess their compliance with service delivery standards.

❑ The QMT can be used by on-site and off-site supervisors and by the staff of a site. The role of supervisors in this process is facilitative rather than directive.

❑ The QMT is similar to COPE® in several ways. It is also a participatory, team-led self-assessment exercise based on the same framework of clients' right and staff needs.

❑ The QMT indicators are based on the self-assessment guides in COPE and focus on family planning, maternal care, gynecology, and sexually transmitted infection (STI) and HIV services, as well as emergency care and infection prevention practices.

❑ The QMT process is not a punitive inspection of services and should not be used for evaluating individual performance.

❑ The QMT data should be used by staff to identify strengths and weaknesses in their services and to take action to address the problems they identify.

Objectives

By the end of this session, the participants will be able to:

• Describe the purpose of the tool

• Explain the format of the QMT

• Describe how to use the QMT

• Explain the ways to communicate successes

• Teach staff to use the QMT

Time

40 minutes

Materials

• PowerPoint presentation for Appendix F, Session D

• The QMT

• Participant Handout D-1: Facility Summary Sheet

• Participant Handout D-2: Communicating about Your Successes

• Resource: Communicating about Your Successes—answer sheet

• Calculators and pencils

Appendix F

Advance Preparation

Make enough copies of the handouts and have copies of the QMT for distribution to all of the participants.

Training Steps

1. Start a PowerPoint presentation by revealing Slide 2 and reminding the participants about EngenderHealth's QI package.

2. Reveal Slide 3 and present the QMT. Distribute copies of the QMT to the participants.

> ➥ **Training Tip**
>
> Emphasize the QMT's similarities with and differences from COPE.

3. Explain the format of the QMT and how staff and supervisors can use it to monitor and evaluate changes in the quality of services.

4. Reveal slides 4–5 and comment on them.

5. Tell the participants that their next activity will be a mock exercise on how to use the QMT.

6. Divide the participants into pairs.

7. Assign the sections of the QMT to each pair to work on it.

8. Tell the participants that they will have 10 minutes to complete a task using the QMT—to answer the questions, identify problems, calculate data, and develop solutions.

9. Distribute Participant Handout D-1 and explain how to complete it.

10. After 10 minutes, halt the activity and invite each pair to read their results.

11. Reveal Slide 6 to demonstrate how site staff can use the data obtained from the QMT.

12. Tell the participants that before using the tool, they need to adapt the questions to match the site's protocols.

13. Tell them that staff and internal supervisors should try to administer the QMT once a year.

14. Remind the participants that the QMT provides a quantitative measurement of the quality of services and is meant to complement other, more qualitative tools available to assess reproductive health services.

15. Tell the participants that the next exercise will help them to think about how to use information collected using different assessment tools, including the QMT.

16. Divide the participants into five groups and distribute blank copies of Participant Handout D-2.

17. Tell them that each group should work on one type of audience. Assign a task for each group. Allow them 5–7 minutes to work in small groups.

18. When they have finished, invite each small group to present its results.

Participant Handout D-1: Facility Summary Sheet

Name of facility: _____

Date of QMT survey (Month and Year): _____

1. In Column A, write the total number of times you answered "yes" to all of the QMT sections. (The total for each guide should be written in Row A at the bottom of the guide.)

2. In Column B, write the total number of times you answered "no" in all of the sections. (The total for each section should be written in Row B at the end of the section.)

3. In Column C, add the totals from columns A and B (A + B).

4. In Column D, divide the Column A total by the Column C total and multiply the result by 100 (A/C x 100).

QMT SECTION (Client Right or Staff Need)	A Total Yes	B Total No	C Total Yes+ No (A+B)	D Score (% Yes) A/C x 100
I. Information				
II. Access				
III. Informed Choice				
IV. Safe Services				
V. Privacy and Confidentiality				
VI. Dignity, Comfort, and Expression of Opinion				
VII. Continuity of Care				
VIII. Facilitative Supervision and Management				
IX Information, Training, and Development				
X. Supplies, Equipment, and Infrastructure				

Participant Handout D-2: Exercise: Communicating about Your Successes

Audience	Messages	Ways to Communicate
Clients and community members		
Site staff		
Upper management		
Other sites and organizations		
Donors and other founders		

Trainer's Resource: Communicating about Your Successes—Answers

Audience	Messages	Ways to Communicate
Clients and community members	• We listen to your suggestions. • What changes/improvements staff have made • Why certain changes have been made (especially related to location or organization of services and any changes in costs of services) • Recognize community inputs to service improvements!	• Interpersonal communication • Posters • Bulletin board • Community meetings
Site staff	• Where we are with our current action plan. • What we ave achieved in the last year/since we began the process • What clients are saying about services • Recognize the importance of teamwork! • There is always room for improvement!	• Providing copies of the COPE action plan for staff/posting the action plan for staff to see • Updates in staff meetings • Interpersonal communication
Upper management	• What accomplishments have been made • What clients say about services • What problems are recurring or system-wide and require support from higher levels	• Meetings • Site visits by upper managers • Reports
Other sites and organizations	• Examples of creative solutions to common problems • Opportunities for working together to solve problems (with community members, local organizations, etc.)	• Meetings • Site visits • Reports
Donors and other founders	• What accomplishments the site has made • Examples of what clients say about services at the site • How their support has helped • Any areas where further support could help resolve recurring/ongoing problems	• Reports • Meetings • Site visits

Session E

Involving Staff in the QI Process:
The Cost Analysis Tool (CAT)

Essential Ideas to Convey

❏ The Cost Analysis Tool (CAT) is a simplified tool that involves site supervisors and staff in measuring the direct costs of providing services.

❏ Measuring, understanding, and documenting the direct costs of services can make it easier to improve the cost-efficiency of services, demonstrate funding needs to government and donors, and set fees for clients based on the realistic costs of the services.

❏ Direct costs are those directly related to a particular service or clinical procedure:

1) Costs of the staff time spent directly providing the service or clinical procedure, including the time spent preparing to provide procedures and the time spent cleaning up after procedures

2) Costs of commodities, expendable supplies, and medications

❏ The CAT requires the cooperation of different kinds and levels of staff.

❏ The CAT might be used one or two times a year, when there are changes in:

➤ Costs of supplies (because of inflation, availability, etc.)

➤ Staff salaries (due to salary increases, changes in staffing, etc.)

➤ Services offered (because services were reorganized or new services offered)

➤ Client load

❏ The CAT does not automatically interpret the quality of services provided. Thus, it is important to use CAT together with other QI approaches and tools.

❏ While introducing the CAT:

➤ Create an environment of trust

➤ Adapt the tools to the site

➤ Ensure that the service or clinical procedure reflects appropriate, safe medical practices

➤ Cut costs by eliminating unnecessary effort and preventing rework and waste

❏ CAT can complement and feed into more comprehensive and complex cost analysis tools available.

Objectives

By the end of this session, the participants will be able to:

• Describe the CAT tools

• Apply the CAT to the calculation and analysis of the direct costs of services

• Teach staff how to use the CAT tools

Time

45 minutes

Materials

- PowerPoint presentation for Appendix F, Session E
- Cost Analysis Tool Handbook
- Participant Handout E-1: Cost Analysis Forms
- Resource: CAT, completed forms
- Flipchart paper, calculators, and markers

Advance Preparation

Make enough copies of the handouts for distribution to all participants.

Training Steps

1. Ask the participants whether they know the cost of the services and clinical procedures that are provided at their sites. Tell them that very often, health care organizations do not know what their costs are and have no a simple way of assessing costs on a regular basis.

2. Tell the participants that you will introduce one more QI tool that involves a site's supervisors and staff in calculating the direct costs of services provided.

3. Start the PowerPoint presentation on the CAT. Follow the slides to explain what the CAT measures, what the CAT can be used for, who benefits from using CAT tools, how often they can be used, and how to use the results.

4. Distribute the CAT handbooks.

5. Explain the format of the handbook and the forms that staff use when apply the CAT tools.

6. Tell the participants that the next exercise will help them learn how to use the CAT tools.

7. Divide the participants into four groups. All of these groups will be working on the same tasks.

8. Distribute calculators and copies of Participant Handout E-1.

➤➤ Training Tip

Completed forms for the trainer are presented in the resource part of the Participant Handbook.

You can suggest to the participants that when they work on Worksheet One Part Two, Worksheet Two, and Worksheet Three, they cane trade off while filling in the lines, so that everybody will be involved in the process.

---

9. Ask the groups to follow instructions given in the handout.

10. Allow 20 minutes for the participants to work on the forms.

➡➡ **Training Tip**

Optional: Participants can work individually, with the lead trainer rechecking the results of each step.

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11. Summarize a session making a connection to the steps in the QI process.

12. Ask the participants whether they think that the tool might be useful for them.

Appendix F

Participant Handout E-1: Using Data to Evaluate the Quality of Services: The Cost-Analysis Tool (CAT)

Analysis of Direct Costs per Procedure: Tubal Ligation at Hospital M**

Instructions:

1) Review Worskheet 1:Part 1, which shows information from Hospital M in Country X. The information refers to the number of minutes spent by different personnel in each step of providing tubal ligation services to a client.

2) Complete Worksheet 1: Part 2, adding the total time spent by each staff member in providing the services.

3) Review Worksheet 2. Complete the following calculations

   Column D—Cost per day (divide Column B by Column C)

   Column F—Number of working minutes per day (multiply Column E by 60)

   Column G—Cost per minute (divide Column D by Column F)

4) Review Worksheet 3: Part 1. Complete the columns in the following way:

   Column A—Copy the results from Worksheet 1: Part 2

   Column B—Copy the results from Worksheet 2

   Column C—Multiply Column A by Column B

5) Review Worksheet 3: Part 2. The information refers to the supplies used in providing tubal ligation services to one client.

6) Complete Worksheet 3: Part 3 with the information from the previous worksheets. Add the Total Direct Variable Costs for providing a tubal ligation at Hospital M.

Worksheet 1: Part 1
Calculation of Staff Time for Services or Clinical Procedures
Steps of Service Provision

Location	Activity	Individual responsible	Time (minutes)
Service or Clinical Procedure: __Laparotomy__			
Staff Time—Admission, Counseling, and Examination			
	Register client	Receptionist	3
	Collect payment	Cashier	2
	Take medical history	Nurse	
		Physician	5
	Prepare room and client	Support staff	5
		Nurse	2
	Conduct physical examination	Physician*	5
		Nurse	
	Laboratory: Register client	Receptionist	
		Cashier	2
	Laboratory: Conduct test(s)	Lab technician	10
	Provide preprocedure information and counseling	Nurse	3
		Support staff	
	Prepare examination room after each client	Nurse	
		Support staff	5
	Schedule procedure (this may be scheduled for the same day or for another day)	Receptionist	
		Nurse	
Daily Tasks in Procedure Room			
	Prepare procedure room at beginning of day (60 minutes for 10 clients)	Support staff	6
		Nurse	
	Clean and prepare examination equipment (120 minutes for 10 clients)	Support staff	
		Nurse	12
	Clean room at the end of the day (120 minutes for 10 clients)	Support staff	12
		Nurse	
	Overall staff supervision	Supervisor	30

*Actual involvement by a physician in this activity varies according to national and local protocols

Appendix F

Worksheet 1: Part 1
Calculation of Staff Time for Clinical Procedures

Service or Clinical Procedure _____			
Staff Time—Surgical/Medical Procedure			
Location	**Activity**	**Individual responsible**	**Time (minutes)**
	Register client	Receptionist	
	Prepare client and take vital signs	Physician	
		Nurse	3
	Provide preoperative drugs	Anesthetist	2
		Physician	
		Nurse	
	Repeat examination, review laboratory tests, and obtain informed consent	Physician	5
		Nurse	3
Surgical teams generally carry out a number of procedures in one session. The times listed should be divided by the number of procedures to obtain the time per procedure per client			
Preprocedure			
	Prepare equipment and materials (__20__ minutes for __10__ clients) Perform scrub (surgical team)	Nurse	2
		Support staff	3
		Physician	3
		OR nurse	
During Procedure			
	Give anesthesia (general and/or local)	Anesthetist	5
		Physician	
	Clinical procedure __60__ minutes each procedure and __5__ minutes between clients for cleaning and preparation (total __5__ minutes)	Physician	65
		OR nurse	65
		Runner nurse	65
		Support staff	65
	Clean up procedure room (__480__ minutes weekly for __40__ clients)	Support staff	12
		Nurse	12
Postprocedure Care			
	Rest in recovery room (__300__ minutes for __10__ clients)	Nurse	30
		Support staff	
	Provide post-procedure instructions	Physician	
		Nurse	5
	Schedule follow-up visit	Receptionist	
	Discharge patient	Physician/ anesthetist	2
	Clean up recovery room and equipment (__10__ minutes daily for __10__ clients)	Nurse	
		Supervisor	1
	Overall staff supervision	Support staff	30

Worksheet 1: Part 1
Calculation of Staff Time for Clinical Procedures

Service or Clinical Procedure _____			
Staff Time—First Follow-Up Visit			
Location	**Activity**	**Individual responsible**	**Time (minutes)**
	Register client	Receptionist	2
	Review records	Physician	5
		Nurse	2
	Remove stitches or check postprocedure condition	Physician	3
		Nurse	5
	Clean up review room and equipment (__10__ minutes daily for __10__ clients)	Support staff	1
		Nurse	
	Overall staff supervision	Supervisor	30

Staff Time—Second Follow-Up Visit			
Location	**Activity**	**Individual responsible**	**Time (minutes)**
	Register client	Receptionist	
	Review records	Physician	
		Nurse	
	Remove stitches or check postprocedure condition	Physician	
		Nurse	
	Clean up review room and equipment (____ minutes daily for ____ clients)	Support staff	
		Nurse	
	Overall staff supervision	Supervisor	

Worksheet 1: Part 2
Total Staff Time for a Service or Clinical Procedure _____

Staff	Total Time
Physician	
Nurse	
Receptionist	
Support staff	
OR nurse	
Runner nurse	
Lab technician	
Supervisor	
Cashier	
Other (1)	
Other (2)	
Other (3)	

Worksheet 2
Calculation of Cost per Minute of Clinic Staff Time

A	B	C	D	E	F	G
Staff position	Annual salary with fringe benefits	Number of working days per year	Cost per day (B/C)	Number of working hours per day	Number of working minutes per day (E x 60)	Cost per minute (D/F)
Physician	2,400,000	240		8		
Nurse	600,000	240		8		
Receptionist	420,000	240		8		
Support staff	420,000	240		8		
OR nurse	600,000	240		8		
Runner nurse	420,000	240		8		
Lab technician	600,000	240		8		
Supervisor	600,000	240		8		
Cashier	480,000	240		8		
Other (1)						
Other (2)						
Other (3)						

Worksheet 3: Part 1
Calculation of Service- or Clinical Procedure–Specific Costs

Name of Service or Clinical Procedure _____
Part 1: Direct Cost of Staff Time

Staff Position	A	B	C
	Time spent per client	Cost per minute	Total cost per client (A x B)
Physician			
Nurse			
Receptionist			
Support staff			
OR nurse			
Runner nurse			
Lab technician			
Supervisor			
Cashier			
Other (1)			
Other (2)			
Other (3)			
Total cost of staff time			

Worksheet 3: Part 2
Procedure-/Method-Specific Supplies

Item	A Amount in unit	B Unit cost	C Amount used per client	D Cost per client (C/A) x B
Chromic catgut **1 or 2**	12	700	3	175.00
Plain catgut				
Silk No. 2 or No. 0	12	500	1	416.00
Cotton wool	500	2500	20	100.00
Absorbent cotton gauze (plain)	100	9800	5	490.00
Strapping (tape)	5	2100	0.2	84.00
Disposable syringes: 2 cc				
Disposable syringes: 5 cc	40	1	6	0.15
Disposable syringes: 10 cc				
Disposable syringes: 20 cc				
Disposable needles				
Nondisposable surgeon's gloves	1	150	10	1500.00
Disposable gloves	100	2700	10	270.00
1% Xylocain w/o epinephrine				
Atropine injection (0.5 mg dose)	1	190	1	190.00
Tincture of iodine	1000	1500	20	30.00
Glove powder	5	13380	0	0.00
Autoclaving tape				
Surgical spirit (methylated spirit)	5000	5600	20	22.40
Antiseptic solution				
Urine dipstick	100	13000	1	130.00
Paracetamol (acetaminophen)				
Surgical blades	12	3900	2	650.00
Soap				
Bleach/chlorine solution	1000	1350	135	182.25
Diazepam (5 mg dose)				
Fallope rings				
Disinfectant solution				
Microscope slides				
Condoms				
Silk sutures 2.0				
Intrauterine device				

(continued)

Worksheet 3: Part 2 (*cont.*)
Procedure-/Method-Specific Supplies

Item	A Amount in unit	B Unit cost	C Amount used per client	D Cost per client (C/A) x B
Sanitary pad				
Injectable (DMPA or Net-En)				
Alcohol				
Norplant implants				
Trocar	1	290	1	290.00
Hand towel				
IV fluid (5% dextrose)	1	450	4	1800.00
Adrenaline injection	1	60	1	60.00
Hydrocortisone injection	1	240	1	1800.00
Sofra-Tule (Vaseline gauze)				
Oxygen gas				
Halothane gas				
Nitrous oxide gas				
IV ketamine	10	560	3	168.00
Thiopentine				
Ethyl alcohol	500	5000	250	2500.00
Methonium	1	90	1	90.00
Giving set (fluid administration apparatus)	1	200	1	200.00
Nasal gastric tube (for suction)	1	720	1	720.00
Urinary bag	1	248	1	248.00
Catheter	1	140	1	140.00
Total cost of supplies				**12255.80**

Worksheet 3: Part 3
Total Direct Variable Costs

Total cost of staff time	
Total cost of supplies	
Total cost of laboratory tests (add only costs that are not already included above)	
Total daily inpatient costs (staff time, food for patients, etc.) (Cost per day __x__ number of days)	
Other (describe):	
TOTAL DIRECT VARIABLE COSTS	

Exercise: Using Data to Evaluate the Quality of Services: Cost-Analysis Tool (CAT): Completed Forms

Conduct exercise in groups. Total time: 20 minutes

Analysis of Direct Costs per Procedure: Tubal Ligation in Hospital M

Instructions:

1. Review Worskheet 1: Part 1, which shows information from Hospital M in Country X. The information refers to the minutes that different personnel spend in each step of providing tubal ligation services to a client.

2. Complete Worksheet 1: Part 2, adding the total time for each staff member spent in providing the service.

3. Review Worksheet 2. Complete the following calculations

    Column D—Cost per day (divide Column B by Column C)

    Column F—Number of working minutes per day (multiply Column E by 60)

    Column G—Cost per minute (divide Column D by Column F)

4. Review Worksheet 3: Part 1. Complete the columns in the following way:

    Column A—Copy the results from Worksheet 1: Part 2

    Column B—Copy the results from Worksheet 2

    Column C—Multiply Column A by Column B

5. Review Worksheet 3: Part 2. The information refers to the supplies used in providing the service to one client.

6. Complete Worksheet 3: Part 3 with the information from the previous worksheets and add the measures together to calculate the Total Direct Variable Costs for providing a tubal ligation in Hospital M.

Worksheet 1: Part 1
Calculation of Staff Time for Services or Clinical Procedures
Steps of Service Provision

Service or Clinical Procedure: **Laparotomy**			
Staff Time—Admission, Counseling, and Examination			
Location	**Activity**	**Individual responsible**	**Time (minutes)**
	Register client	Receptionist	3
	Collect payment	Cashier	2
	Take medical history	Nurse	
		Physician	5
	Prepare room and client	Support staff	5
		Nurse	2
	Conduct physical examination	Physician*	5
		Nurse	
	Laboratory: Register client	Receptionist	
		Cashier	2
	Laboratory: Conduct test(s)	Lab technician	10
	Provide preprocedure information and counseling	Nurse	3
		Support staff	
	Prepare examination room after each client	Nurse	
		Support staff	5
	Schedule procedure (this may be scheduled for the same day or for another day)	Receptionist	
		Nurse	
Daily Tasks in Procedure Room			
	Prepare procedure room at beginning of day (__10__ minutes for __10__ clients)	Support staff	6
		Nurse	
	Clean and prepare examination equipment (__120__ minutes for __10__ clients)	Support staff	
		Nurse	12
	Clean room at the end of the day (__120__ minutes for __10__ clients)	Support staff	12
		Nurse	
	Overall staff supervision	Supervisor	30

*Actual involvement by a physician in this activity varies according to national and local protocols

Appendix F

Worksheet One, Part I
Calculation of Staff Time for Clinical Procedures

Service or Clinical Procedure _____			
Staff Time—Surgical/Medical Procedure			
Location	**Activity**	**Individual responsible**	**Time (minutes)**
	Register client	Receptionist	
	Prepare client and take vital signs	Physician	
		Nurse	3
	Provide preoperative drugs	Anesthetist	2
		Physician	
		Nurse	
	Repeat examination, review laboratory tests, and obtain informed consent	Physician	5
		Nurse	3
Surgical teams generally carry out a number of procedures in one session. The times listed should be divided by the number of procedures to obtain the time per procedure per client			
Preprocedure			
	Prepare equipment and materials (__20__ minutes for __10__ clients) Perform scrub (surgical team)	Nurse	2
		Support staff	3
		Physician	3
		OR nurse	
During Procedure			
	Give anesthesia (general and/or local)	Anesthetist	5
		Physician	
	Clinical procedure __60__ minutes each procedure and __5__ minutes between clients for cleaning and preparation (total __5__ minutes)	Physician	65
		OR nurse	65
		Runner nurse	65
		Support staff	65
	Clean up procedure room (__480__ minutes weekly for __40__ clients)	Support staff	12
		Nurse	12
Postprocedure Care			
	Rest in recovery room (__300__ minutes for __10__ clients)	Nurse	30
		Support staff	
	Provide post-procedure instructions	Physician	
		Nurse	5
	Schedule follow-up visit	Receptionist	
	Discharge patient	Physician/ anesthetist	2
	Clean up recovery room and equipment (__10__ minutes daily for __10__ clients)	Nurse	
		Supervisor	1
	Overall staff supervision	Support staff	30

Worksheet One, Part I
Calculation of Staff Time for Clinical Procedures

Service or Clinical Procedure _____			
Staff Time—First Follow-Up Visit			
Location	**Activity**	**Individual responsible**	**Time (minutes)**
	Register client	Receptionist	2
	Review records	Physician	5
		Nurse	2
	Remove stitches or check postprocedure condition	Physician	3
		Nurse	5
	Clean up review room and equipment (__10__ minutes daily for __10__ clients)	Support staff	1
		Nurse	
	Overall staff supervision	Supervisor	30

Staff Time—Second Follow-Up Visit			
Location	**Activity**	**Individual responsible**	**Time (minutes)**
	Register client	Receptionist	
	Review records	Physician	
		Nurse	
	Remove stitches or check postprocedure condition	Physician	
		Nurse	
	Clean up review room and equipment (____ minutes daily for ____ clients)	Support staff	
		Nurse	
	Overall staff supervision	Supervisor	

Worksheet One, Part II
Total Amount of Staff Time for a Service or Clinical Procedure

Staff	Total Time
Physician	93
Nurse	79
Receptionist	5
Support staff	110
OR nurse	65
Runner nurse	65
Lab technician	10
Supervisor	90
Cashier	4
Other (1)	
Other (2)	
Other (3)	

Worksheet Two
Calculation of Cost Per Minute of Clinic Staff Time

A	B	C	D	E	F	G
Staff position	Annual salary with fringe benefits	Number of working days per year	Cost per day (B/C)	Number of working hours per day	Number of working minutes per day (E x 60)	Cost per minute (D/F)
Physician	2,400,000	240	10000	8	480	20.83
Nurse	600,000	240	2500	8	480	5.21
Receptionist	420,000	240	1750	8	480	3.65
Support staff	420,000	240	1750	8	480	3.65
OR nurse	600,000	240	2500	8	480	5.21
Runner nurse	420,000	240	1750	8	480	3.65
Lab technician	600,000	240	2500	8	480	5.21
Supervisor	600,000	240	2500	8	480	5.21
Cashier	480,000	240	2000	8	480	4.17
Other (1)						
Other (2)						
Other (3)						

Worksheet Three, Part I
Calculation of Service- or Clinical Procedure–Specific Costs

Name of Service or Clinical Procedure _____

Part One: Direct Cost of Staff Time

Staff Position	A Time spent per client	B Cost per minute	C Total cost per client (A x B)
Physician	93	20.83	1937.50
Nurse	79	5.21	411.46
Receptionist	5	3.65	18.23
Support staff	110	3.65	401.04
OR nurse	65	5.21	338.54
Runner nurse	65	3.65	236.98
Lab technician	10	5.21	52.08
Supervisor	90	5.21	468.75
Cashier	4	4.17	16.67
Other (1)			
Other (2)			
Other (3)			
Total cost of staff time			3395.83

Worksheet 3, Part II
Procedure-/Method-Specific Supplies

Item	A Amount in unit	B Unit cost	C Amount used per client	D Cost per client (C/A) x B
Chromic catgut **1 or 2**	12	700	3	175.00
Plain catgut				
Silk No. 2 or No. 0	12	500	1	416.00
Cotton wool	500	2500	20	100.00
Absorbent cotton gauze (plain)	100	9800	5	490.00
Strapping (tape)	5	2100	0.2	84.00
Disposable syringes: 2 cc				
Disposable syringes: 5 cc	40	1	6	0.15
Disposable syringes: 10 cc				
Disposable syringes: 20 cc				
Disposable needles				
Nondisposable surgeon's gloves	1	150	10	1500.00
Disposable gloves	100	2700	10	270.00
1% Xylocain w/o epinephrine				
Atropine injection (0.5 mg dose)	1	190	1	190.00
Tincture of iodine	1000	1500	20	30.00
Glove powder	5	13380	0	0.00
Autoclaving tape				
Surgical spirit (methylated spirit)	5000	5600	20	22.40
Antiseptic solution				
Urine dipstick	100	13000	1	130.00
Paracetamol (acetaminophen)				
Surgical blades	12	3900	2	650.00
Soap				
Bleach/chlorine solution	1000	1350	135	182.25
Diazepam (5 mg dose)				
Fallope rings				
Disinfectant solution				
Microscope slides				
Condoms				
Silk sutures 2.0				
Intrauterine device				

(continued)

Appendix F

Worksheet 3: Part 2 (*cont.*)
Procedure-/Method-Specific Supplies

Item	A Amount in unit	B Unit cost	C Amount used per client	D Cost per client (C/A) x B
Sanitary pad				
Injectable (DMPA or Net-En)				
Alcohol				
Norplant implants				
Trocar	1	290	1	290.00
Hand towel				
IV fluid (5% dextrose)	1	450	4	1800.00
Adrenaline injection	1	60	1	60.00
Hydrocortisone injection	1	240	1	1800.00
Sofra-Tule (Vaseline gauze)				
Oxygen gas				
Halothane gas				
Nitrous oxide gas				
IV ketamine	10	560	3	168.00
Thiopentine				
Ethyl alcohol	500	5000	250	2500.00
Methonium	1	90	1	90.00
Giving set (fluid administration apparatus)	1	200	1	200.00
Nasal gastric tube (for suction)	1	720	1	720.00
Urinary bag	1	248	1	248.00
Catheter	1	140	1	140.00
Total cost of supplies				**12255.80**

Worksheet 3: Part 3
Total Direct Variable Costs

Total cost of staff time	**3395.83**
Total cost of supplies	**12255.80**
Total cost of laboratory tests (add only costs that are not already included above)	
Total daily inpatient costs (staff time, food for patients, etc.) (Cost per day, __x__ number of days)	
Other (describe):	
TOTAL DIRECT VARIABLE COSTS	**15651.63**

Session F

Involving Staff in the QI Process:
Community COPE®

Essential Ideas to Convey

❏ Community COPE® is an extension of COPE® and is based on the same principles as other QI initiatives. It is also based on the same framework of clients' rights and staff needs.

❏ Community COPE tools help supervisors and staff to:

➤ Learn how community members feel about the services the facility provides

➤ Gather community members' recommendations for improving the quality of services

➤ Determine ways to encourage community members to participate in and to take owner-ship of QI efforts, both at the site level and at the community level

❏ Community activities should take place after staff members are acquainted and comfortable with the COPE process and have started to see some results from implementation of the COPE action plan.

Objectives

By the end of this session, the participants will be able to:

• Describe the tools of Community COPE

• Explain how to conduct Community COPE activities

• Conduct a mapping exercise

• Teach staff to involve the community in the QI process

Time

1 hour

Materials

• PowerPoint presentation for Appendix F, Session F

• EngenderHealth. 2002. *Community COPE: Building Partnership with the Community to Improve Health Services*. New York.

• Participant Handout F-1: Mapping Exercise

• Flipchart paper and markers

Advance Preparation

Make enough copies of Participant Handout F-1 for distribution to all participants.

Appendix F

Training Steps

1. Ask the participants whether their clinics work with the communities they serve.

2. Ask for 1–2 volunteers to share their experiences in working with communities.

3. Tell the participants that now the group will conduct an exercise that might prove useful for them in assessing community needs and perspectives and in bringing new resources for improving the quality of services a site provides.

4. Divide the participants into two groups.

5. Distribute Participant Handout F-1 and give both groups instructions on how to use it. Explain that the exercise is called a mapping exercise. (Explain what the word "mapping" means in this case.)

6. Assign the following tasks to the groups: One group is to represent a marginalized group of community members and the second group is to represent service providers.

7. Tell the participants that for 15 minutes they are to work in groups. They should use flipchart paper and markers to draw the results of their discussion.

➻ **Training Tip**

While the participants are working on their tasks, walk around and listen to the discussion. Sometimes, they may need some help to start expressing their ideas through drawings.

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8. After the groups have completed their work, invite each group to present their drawing.

9. Lead a discussion with an entire group.

10. Thank the participants for their creative work.

11. Start a PowerPoint presentation.

12. Show Slide 2 and remind the participants about the EngenderHealth QI package.

13. Distribute copies of *Community COPE Handbook* to the participants.

14. Use slides 3–5 to explain the goals of the Community COPE activities.

15. Reveal Slide 6 and describe Community COPE activities.

16. Describe the Community COPE process, using slides 7 and 8.

> ➠ **Training Tip**
>
> Slide 8 shows where the process can take one of two directions—either a greater level of community involvement in more steps of the process (by conducting action planning with the community) or less community involvement. In either case, community members volunteer to serve as representatives on the health facility's QI committee.
>
> The last step in the process is monitoring and evaluation.
>
> Also, note that the Community COPE process is meant to be continuous: It should repeat by going back to the step of identifying groups for the next set of activities. (This may or may not require seeking local leaders' support again.)

17. Reveal slides 9–11 and comment on them.

18. Use slides 12–14 to describe experiences and lessons learned from the countries where Community COPE has been used.

19. Describe the benefits for the facilities of involving their community in the QI process.

20. Describe the format of the *Community COPE Handbook*.

21. Show Slide 15 and remind the participants of the diagram of the QI process. Tell them that use of the Community COPE tools is another way to gather information to assess the quality of services and to develop solutions that help to solve problems identified through the assessment process.

Participant Handout F-1: Mapping Exercise

Group I

Participatory mapping is an activity in which the participants draw maps, diagrams, or pictures of their community or their social relationships in order to show the spatial relationships and relative importance of the various places and members in the community. Mapping allows community members to see their community as a whole in order to examine where services and resources are located and how they are distributed. Participatory mapping can help staff members learn what the barriers are that may be preventing community members from using particular services, so they can find ways to overcome the barriers.

Mapping may be used for different purposes. Clients may create maps of the:

❏ Various health care services they use in the community

❏ Other types of facilities in the community, such as schools, stores, or factories

❏ Location of traditional birth attendants' or midwives' households

❏ Barriers/problems they need to overcome to get to your site or that they encounter once they arrive at the site

❏ Changes occurring in the community over time—both how things have changed in the past and how community members would like things to look in the future

Task for Group I

Imagine yourself to be a group of marginalized women, typical of those most in need. Please draw a map of your community as you see it, marking on the map the places where you seek advice or services. (It might be traditional healer, a pharmacist, or some other type of person not associated with facility-based services.) The map might show where roads, shops, houses, landmarks, and/or health services are located, and the different barriers that may be preventing these community members from using particular services.

Take 15 minutes to prepare your drawing. A representative of your group should then take about three minutes to present the diagram.

Group II

Participatory mapping is an activity in which the participants draw maps, diagrams, or pictures of their community or their social relationships in order to show the spatial relationships and relative importance of the various places and members in the community. Mapping allows community members to see their community as a whole in order to examine where services and resources are located and how they are distributed. Participatory mapping can help staff members learn what the barriers are that may be preventing community members from using particular services, so they can find ways to overcome the barriers.

Mapping may be used for different purposes. Clients may create maps of the:

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❏   Location of traditional birth attendants' or midwives' households

❏   Barriers/problems they need to overcome to get to your site or that they encounter once they arrive at the site

❏   Changes occurring in the community over time—both how things have changed in the past and how community members would like things to look in the future

Task for Group II

Imagine yourself to be a staff member of a clinic that serves a community. Please draw a map of your site showing the relationship between the health system and the community. Discuss and reflect on your perceptions of the problems and barriers faced by current and potential clients, as well as the places where you think community members seek services in addition to your site.

Take 15 minutes to prepare your drawing. A representative of your group should then take about three minutes to present the diagram.

Session G

Making the QI Process Sustainable: Taking QI/PI Approaches and Tools to Scale

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Essential Ideas to Convey

❑ Taking QI/PI approaches and tools to scale is a process of planning, implementation, and evaluation of strategies and activities.

❑ Strategies and activities must be designed to *increase* and *expand* the use of QI/PI approaches and tools.

❑ The goal of the process is *institutionalization* of the use of these approaches and tools.

❑ Facilitative supervisors are catalysts for change.

Objectives

By the end of this session, the participants will be able to:

• Describe a process of taking QI/PI approaches to scale

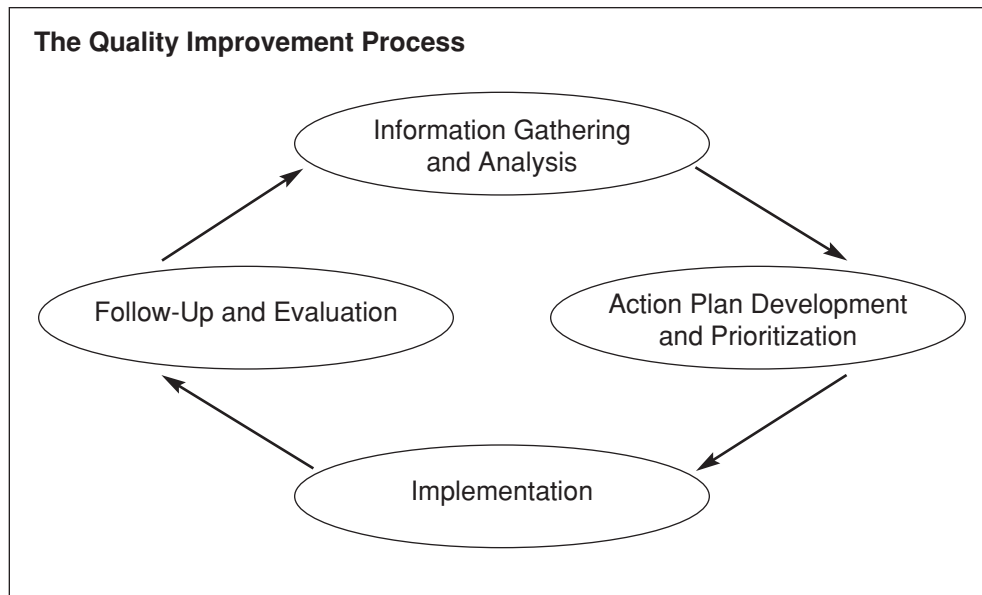• Analyze what support systems need to be in place to make changes sustainable

Time

40 minutes

Materials

• PowerPoint presentation for Appendix F, Session G

• Flipchart paper and markers

Advance Preparation

1. Make enough copies of the PowerPoint presentation slides for distribution to all participants.

2. Prepare a flipchart showing a graphic representation of the QI process (below, and Flipchart 2C, from Session 2).

Appendix F

The Quality Improvement Process

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           ┌─────────────────────────────┐
           │   Information Gathering      │
           │       and Analysis           │
           └─────────────────────────────┘
      ↗                                      ↘
┌──────────────────────┐        ┌──────────────────────────┐
│ Follow-Up and        │        │  Action Plan Development │
│ Evaluation           │        │   and Prioritization     │
└──────────────────────┘        └──────────────────────────┘
      ↖                                      ↙
           ┌─────────────────────────────┐
           │       Implementation         │
           └─────────────────────────────┘
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Training Steps

1. Tell the participants that in the QI and PI process, the goal of facilitative supervisors is to make this process sustainable by establishing support systems.

2. Start a PowerPoint presentation.

3. Ask the participants to list the steps in the QI process. After they have responded, reveal slides 2–4 and comment on them, reinforcing the knowledge that the participants have acquired during previous training sessions.

4. Ask the participants how they would describe the process of taking approaches or tools to scale.

5. After the participants responded, reveal the prepared flipchart and comment on it. Reveal slides 6–7. Tell the participants that for the scaling up process to be implemented successfully, the support system should be established, and facilitative supervisors play a crucial role in that process.

6. Continue the PowerPoint presentation by showing slides 8–14.

7. Reveal Slide 15 and ask the participants to give examples and describe the importance of each level of support. Discuss the role of supervisors in the process of building support and providing leadership.

8. Use Slide 16 to describe how the environment can affect the process of change.

9. Use slides 17–18 to present an example of COPE and the specific systems that support the use of COPE.

10. Tell the participants that the goal of taking QI/PI approaches to scale is institutionalizing that approach, because it makes the QI process sustainable.

11. Reinforce the message about the role of supervisors and about the importance of involving staff in the QI process.

Session H

Informed Choice and the Tiahrt Amendment, and the Helms Amendment

Objectives

By the end of this session, the participants will be able to:

- Identify the five requirements of the Tiahrt Amendment
- Explain what the Tiahrt Amendment applies to
- Describe the Mexico City Policy and the Helms Amendment

Time

1 hour, 10 minutes

Materials

- PowerPoint presentation for Appendix F, Session H
- Flipchart paper, markers, and masking tape

Advance Preparation

No advance preparation required

Activity A: Overview of the Tiahrt Amendment (40 minutes)

1. Tell the participants that during this session, they will be oriented to the policy require-
   ments applicable to reproductive health– and family planning–related activities if the
   programs are funded by the U.S. Agency for International Development (USAID). This
   session will help to build the participants' capacity to program for, monitor, and manage
   issues related to informed choice and compliance with the Tiahrt Amendment, the
   Mexico City Policy, and the Helms Amendment. Supervisors need to be aware of these
   requirements

2. Start the PowerPoint presentation on the Tiahrt Amendment. Follow the information
   given in the slide notes pages. Explain the background of the Tiahrt Amendment and the
   context of voluntarism and informed choice in USAID-funded activities.

3. Discuss the five key aspects of the Tiahrt Amendment:

   - No quotas or targets are permitted.
   - No incentives, bribes, gratuities, or financial rewards are to be offered to clients or
     program staff.

- No one is to be denied rights or benefits for not accepting family planning services.

- Comprehensive information is to be provided on the health benefits and risks of the chosen method, in addition to information on inadvisable conditions and adverse side effects.

- There is to be full disclosure to clients about any experimental contraceptive methods and procedures being offered.

4. Use slides 21–24 to facilitate a discussion with the entire group on the cases from the slides. Allow the participants to decide for each case whether there is a vulnerability or a violation under Tiahrt.

Activity B: Overview of the Helms Amendment and the Mexico City Policy (30 minutes)

1. Start the PowerPoint presentation on the Helms Amendment. Follow the slides to explain what the restrictions are on funding for abortion and involuntary sterilization. Explain the terminology (slides 5–9), the responsibilities, and the consequences of violating the Mexico City Policy.

2. Facilitate a discussion using the following trigger questions:

- Who are the implementing partners in their cases? To which of them do these policies apply?

- What is the nature of your relationship with these partners? What is the nature of your support?

- What are some existing or potential concerns, problems, vulnerabilities, or questions with regard to compliance with these policies?

3. Explain to the participants that issues related to the Helms Amendment and the Mexico City Policy are unique to the context of each given country. They need to remember to make sure that they:

- Understand the kind of relationship between the donor and the recipient, and between the recipient and the subrecipient

- Understand the kind of technical assistance provided to the subrecipient

- Seek clarification from in-country partners (USAID, cooperating agencies, and counterparts)

- Seek clarification from existing materials