

Appendix A

Sample Medical Monitoring Checklists

Counseling Skills Observation Guide¹

Instructions: This observation guide was developed for use by supervisors and staff to regularly observe family planning (FP) counselors in their program and provide ongoing support. It is based on the REDI counseling framework. The supervisor marks the following scores according to the performance level for each client-provider interaction observed:

2 = Competently performed (step performed correctly)

1 = Needs improvement (step performed partially or incorrectly)

0 = Step omitted (step not done)

NA = Not applicable

Any area that is scored less than 2 needs improvement (except when it is not applicable).

Name: _____

Service Site: _____

Supervisor: _____

Date(s): _____

REDI: TASKS DURING CLIENT/PROVIDER INTERACTION	Clients/Rating		
	1	2	3
<i>Rapport Building</i> (Items 3, 5, 6, 7, and 8 should be observed during all phases of REDI. Please mark scores for them only after observing the entire counseling session.)			
1. Did the provider greet the client politely, according to local custom?			
2. Did the provider offer the client a seat?			
3. Did the provider ensure privacy throughout the session, with no interruptions?			
4. Did the provider explain that he or she asks personal and sometimes embarrassing questions of all clients to better help them select and use FP and stress that everything is confidential (i.e., that no one outside the counseling room will learn what is discussed)?			
5. Did the provider ask open-ended questions to encourage the client to speak?			
6. Did the provider listen to the client without interruptions?			
7. Did the provider give correct information to the client, using clear and simple language to ensure informed choice ?			
8. Did the provider use visual aids (brochures, flipcharts, contraceptive samples, posters, etc.)?			

¹This counseling skills observation guide is adapted from one appearing in: The ACQUIRE Project. 2008. *Counseling for effective use of family planning: Trainer's manual*. New York: EngenderHealth.

Counseling Skills Observation Guide (*cont.*)

REDI: TASKS DURING CLIENT/PROVIDER INTERACTION	Clients/Rating		
	1	2	3
Exploration			
9. Did the provider ask the client questions to identify the type of visit? (<i>Circle type of client and go to the appropriate category of client below.</i>) <ul style="list-style-type: none"> • New client with a method in mind • New client with no method in mind • Satisfied return client with no problems (routine follow-up visit or resupply) • Dissatisfied return client/client with problem/side effects/concerns 			
FOR NEW CLIENTS ONLY: If return client, skip to ⇒⇒⇒ 15			
10. Did the provider ask about the client's past experience with FP and assess the client's knowledge about FP?			
11. Did the provider ask questions about: <ul style="list-style-type: none"> • The client's sexual relationship(s) and habits? • Communication with partner(s) about sex, FP, and sexually transmitted infections (STIs), including HIV and AIDS? • Support from partner and family to use FP? • Possible domestic violence? • Socioeconomic circumstances? 			
12. Did the provider explain STI/HIV prevention and help the client perceive his or her risks for STI/HIV transmission?			
13. Did the provider give appropriate information to the client based on the client's needs (i.e., tailored to the need of the client)?			
14. Did the provider screen client for FP use according to standard (medical conditions and history)?			
FOR RETURN CLIENTS ONLY: If new client, skip to ⇒⇒⇒ 18			
15. Did the provider ask if the client has any problems or concerns with the method?			
16. Did the provider ask about possible changes in client's life ? <ul style="list-style-type: none"> • New health-related problems or concerns • New partner(s)/possible exposure to STIs/HIV • Change in fertility plans 			
FOR DISSATISFIED RETURN CLIENTS ONLY: If satisfied return client, skip to ⇒⇒⇒ 18			
17. Did the provider appropriately address the concerns or problems raised by the client and help the client to develop possible solutions?			

Counseling Skills Observation Guide (*cont.*)

REDI: TASKS DURING CLIENT/PROVIDER INTERACTION	Clients/Rating		
	1	2	3
Decision Making			
18. Did the provider help the client consider his or her different options or reconfirm his or her choice? • Select an FP method based on correct knowledge about side effects, health benefits, and health risks of suitable methods, considering her/his preferences and needs for FP and STI/HIV prevention (new client with no method in mind) • Reconfirm her choice of method based on correct knowledge about its side effects, health benefits, and health risks, including the level of STI/HIV protection it offers (new client with a method in mind AND satisfied return client) • Options related to discontinuation and method switching (dissatisfied return client)			
Implementing the Decision (the provider often does not need to cover all of these tasks with satisfied return clients)			
19. Did the provider help the client make a plan for implementing the decision by asking about next steps and the timeline for implementation?			
20. Did the provider help the client consider ways to overcome potential barriers to implement his or her decision(s)?			
21. Did the provider ensure that the client has adequate knowledge and skills to implement the decision(s) (e.g., how to use the method, condom demonstration/practice, communication and negotiation skills, provision of information about safer sex practices)?			
22. Did the provider ensure that the client understands what follow-up is required (return visits, referral, and/or resupply)?			
23. Did the provider ensure that the client understands what the possible side effects of the method are and what to do about side effects?			
24. Did the provider ensure that the client knows the warning signs of the method and that he or she needs to return to the facility immediately if he or she experiences warning signs?			
25. Did the provider assure the client that he or she is welcome to return to the facility any time that he or she has concerns or problems or thinks he or she might prefer to switch to another method?			
TOTAL			
Additional comments:			

Counseling Skills Observation Guide

Instructions: This observation guide was developed for use by supervisors and staff to regularly observe family planning (FP) counselors in their program and provide ongoing support. It is based on the GATHER counseling framework.

Observation Guide				
<p><i>Instructions:</i> Evaluate the performance of the provider in implementing each task or activity, using the following codes:</p> <p>1 = Needs improvement 2 = Adequate 3 = Competent N = Not applicable</p>				
Name: _____		Service Site: _____		
Supervisor: _____		Date(s): _____		
Task/Activity	Rating per client-provider interaction			
General skills and establishment of positive client-provider interaction				
Demonstrates respect for the client; does not judge the client				
Shows friendliness by smiling				
Ensures privacy in the consultation room				
Uses simple and clear language				
Asks open-ended questions				
Asks the client to paraphrase, as necessary, to ensure that the client understands his or her questions and explanations				
Encourages the client to ask question and express concerns				
Answers all of the client's questions				
Indicates throughout the consultation that he or she is listening to the client				
Paraphrases the client to ensure understanding of the client's message				
Does not interrupt the client unless absolutely necessary				
Greets the client with respect and kindness, introduces himself or herself, and offers the client a seat				
Asks what he or she can do for the client; determines the purpose of the visit				
Explains what will happen during the visit				
Assures the client of the confidentiality of all information that is shared				
Encourages and responds to the client's questions				

Observation Guide (*cont.*)

Task/Activity	Rating per client-provider interaction			
Asks the client about himself/herself and his or her concerns				
Assists the client in:				
• Clarifying his or her reproductive health needs, concerns, and problems				
• Asking questions				
• Determining decisions or actions that the client needs or wants to make during this visit				
Obtains the client’s medical and social history (as appropriate to the client’s needs and concerns, using the checklist for the corresponding service):				
• Asks simple and brief questions				
• Explains terms as need				
• Explains the routine nature and purpose of risk-assessment questions regarding pregnancy, sexually transmitted infections (STIs), and HIV or AIDS, among others				
Asks about the client’s:				
• Reproductive health plans (desired number of children, spacing of births, etc.)				
• Perception of risk (regarding pregnancy or STIs, and HIV and AIDS)				
• Risk behaviors as pertinent to the client’s concerns (e.g., pregnancy and STIs and HIV)				
• Other health, interpersonal, or social concerns				
• Feelings about his or her concerns, risks, etc. (as appropriate)				
Explains the purpose of the questions (as appropriate)				
Looks at the client while the client or service provider speaks				
Encourages and responds to the client’s questions				
Tells the client information appropriate to his or her sexual and reproductive health (SRH) needs and knowledge				
Begins the discussion with the client’s preference or most urgent need				
Asks what the client already understand about his or her SRH situation and desired course of action				
Tailors information to the client’s needs, knowledge, and personal situation				
Uses words familiar to the client				
Uses appropriate information, education, and communication materials in an effective manner				
Asks open-ended questions to verify client’s understanding of important information				
Encourages and responds to the client’s questions				
Corrects false information and rumors, as needed				

Observation Guide (*cont.*)

Task/Activity	Rating per client-provider interaction			
Helps client to make decisions to meet his or her SRH needs				
Through active listening, including asking open-ended questions, helps the client:				
• Take “ownership” of his or her problem and responsibility for his or her decisions				
• Identity options and the pros and cons of each				
• Make decisions based on weighing pros and cons of all options (including side effects and the possibility of complications), relative to the client’s values and social context				
• Act on decisions taken:				
➤ By asking concrete, specific questions about steps to be taken				
➤ By encouraging the client in terms of steps taken				
Confirms the client’s decision				
Assists the client to identity:				
• Possible barriers to implementing the decision				
• Ways to overcome these barriers				
Helps the client practice skills (e.g., communication skills) to overcome barriers (if appropriate)				
For the client who declines treatment or chooses not to practice any behavior change:				
• Explains possible complications or consequences of unmanaged condition or unchanged behavior				
• Offers his or her services if the client wishes to use them later				
Explains instructions for managing SRH problems/implementing decisions				
Explains how to use the chosen method or treatment option				
Reviews common side effects, the warning signs or symptoms of more serious complications, and what to do if they occur				
Provides written instructions and reviews them with the client				
Asks open-ended questions to verify the client’s understanding of important information				
Encourages and responds to the client’s questions				
Return visit/referral				
Sets up follow-up visit, as needed				
Invites the client to come back at any time for any reason				
Refers the client for needed or requested services unavailable onsite				
Thanks the client for coming				

Strengthening Long-Acting and Permanent Family Planning and Selected Maternal Health Services

Facilitative Supervisory (FS) Visit Checklist

Identification:

1. Name of Health Center: _____
District: _____
2. Date of Visit: _____
3. Visiting Team Members:
 1. Name and signature: _____
Organization: _____
 2. Name and signature: _____
Organization: _____
4. Name of the SITE Providers with training status: (Please circle the responses as appropriate):

Physical Facilities, Equipment, and Supplies			
1. Site has minimum standard space for:			
• Waiting area	Yes	No	NA
• Toilet facilities	Yes	No	NA
• Private space for counseling	Yes	No	NA
• Private space for physical examination	Yes	No	NA
2. All spaces are clean and well maintained.	Yes	No	NA
3. Appropriate manuals and behavior change communication (BCC) materials/job aids are available and are displayed in the provider's room/waiting place, such as:			
• Family planning (FP) manual	Yes	No	NA
• Flipchart on FP methods	Yes	No	NA
• Comprehensive FP chart/Tiaht poster	Yes	No	NA
• Contraceptive display board and tray	Yes	No	NA
• Informed consent form for sterilization	Yes	No	NA
• Appropriate forms, cards, and registers	Yes	No	NA
4. Adequate and functioning equipment for screening:			
• Blood pressure instrument	Yes	No	NA
• Stethoscope	Yes	No	NA
• Thermometer	Yes	No	NA
• Measuring tape/scale for measuring height	Yes	No	NA
• Weighing scale	Yes	No	NA
• Flashlight/torchlight	Yes	No	NA
• Examination table	Yes	No	NA
• IUD steam sterilizer	Yes	No	NA
• Autoclave machine or boiling equipment, as per guideline	Yes	No	NA

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Strengthening Long-Acting and Permanent Family Planning and Selected Maternal Health Services

Facilitative Supervisory (FS) Visit Checklist (*cont.*)

5. Adequate supplies of contraceptives:			
• Short-term (condoms, oral contraceptives, and injectables)	Yes	No	NA
• IUD	Yes	No	NA
• Norplant implant	Yes	No	NA
6. Procedure room is clean, organized, and equipped with:			
• Proper procedure table (with handrest for Norplant services)	Yes	No	NA
• Stainless steel nonmagnetic instrument trolley	Yes	No	NA
• At least three sets of IUDs and 10 Norplant instruments for insertion and removal	Yes	No	NA
• Spotlight/emergency light/flashlight with battery	Yes	No	NA
• Supplies required for IUD services	Yes	No	NA
7. Restricted area for providing no-scalpel vasectomy (NSV) and tubectomy, including:			
• Clearly demarcated area for procedure	Yes	No	NA
• Changing room/space with clothes hangers, masks, caps, operating theater sandals	Yes	No	NA
• Scrubbing basin with running water, elbow tap, antiseptic soap, nailbrush	Yes	No	NA
• Instrument processing area with basin/bowl, table/drying rack, gloves hanger, autoclave/sterilizer/boiling pot, and heating source (stove/electricity)	Yes	No	NA
• Operating theater with closed ventilators and windows	Yes	No	NA
• Stainless steel nonmagnetic instrument trolley	Yes	No	NA
• Operating theater light/spot light and emergency light/flashlight with battery	Yes	No	NA
• Wall clock in the operating theater	Yes	No	NA
• Adequate sterile supplies (linen, NSV, tubectomy instruments)	Yes	No	NA
• Buckets for decontamination solution	Yes	No	NA
8. Required supplies of emergency drugs:			
• Injectable Naloxone	Yes	No	NA
• Funds available for procuring emergency drugs (injectable promethazine, injectable atropine sulphate, injectable adrenaline (1:1000), injectable hydrocortisone, intravenous (IV) fluid (5% DNS and 5% DA) with IV sets, atraumatic catgut)	Yes	No	NA
9. Functioning emergency equipment:			
• Ambubag with airway tube	Yes	No	NA
• Oxygen therapy unit	Yes	No	NA
• Suction unit	Yes	No	NA
• Foley's catheter	Yes	No	NA

Strengthening Long-Acting and Permanent Family Planning and Selected Maternal Health Services

Facilitative Supervisory (FS) Visit Checklist (*cont.*)

10. Preoperative/postoperative room is clean and organized.	Yes	No	NA
11. The following supplies required for decontamination are available:			
• Red, blue, and green plastic buckets	Yes	No	NA
• Strainer and mug (plastic)	Yes	No	NA
• Bleach, container, spoon and measuring pot	Yes	No	NA
• Sturdy gloves (utility gloves)	Yes	No	NA
Logistics Management			
1. Store is organized and clean.	Yes	No	NA
2. Ensure first-in, first-out arrangement (known as FIFO).	Yes	No	NA
3. Look for stockouts (contraceptives and other commodities should be in regular supply and in condition with no disruption in stock).	Yes	No	NA
4. Ensure management of equipment repair, replacement, etc.	Yes	No	NA
Comments:			

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Facilitative Supervisory (FS) Visit Checklist

Identification:

1. Name of Health Center: _____
District: _____
2. Date of Visit: _____
3. Visiting Team Members:
 1. Name and signature: _____
Organization: _____
 2. Name and signature: _____
Organization: _____
4. Name of the SITE Providers with training status: (Please circle the responses as appropriate):

Infection Prevention Practices			
1. Hand washing:			
• Provider washes hands properly using soap and water before and after examining each client	Yes	No	NA
• Provider washes hands if touching body fluids, mucous membrane, and broken skin	Yes	No	NA
• Provider washes hands after removing gloves	Yes	No	NA
• Provider washes hands after handling soiled items/wastes	Yes	No	NA
• Provider performs surgical hand-scrubbing properly before performing surgical procedures	Yes	No	NA
Comments:			
2. Using gloves:			
• Provider demonstrates how to wear gloves properly	Yes	No	NA
• Provider uses examination gloves for patient examination	Yes	No	NA
• Provider uses sterile gloves during IUD, Norplant, NSV and tubectomy procedures	Yes	No	NA
• Provider uses utility gloves for instrument processing, waste disposal, etc	Yes	No	NA
• Provider decontaminates gloves before removal	Yes	No	NA
Comments:			
3. Provider knows how to decontaminate and clean instruments and other items, as per guidelines:			
• Wears protective attire (masks, utility gloves) during instrument processing	Yes	No	NA
• Soaks all used items in 0.5% chlorine solution for 10 minutes immediately after use	Yes	No	NA
• Clean items using detergent powder and toothbrush and submerge instruments under water during cleaning	Yes	No	NA
• Rinse items thoroughly in running water and dry them before sterilization/high-level decontamination	Yes	No	NA
Comments:			

Strengthening Long-Acting and Permanent Family Planning and Selected Maternal Health Services

Facilitative Supervisory (FS) Visit Checklist (*cont.*)

4. Provider demonstrates correct use of IUD steam sterilizer for sterilizing instruments, gloves, and cotton, as per guideline	Yes	No	NA
5. Provider demonstrates correct use of autoclave for sterilizing instruments and other items:			
• Opens and unlocks all jointed instruments and wraps the sharps with gauze/cotton	Yes	No	NA
• Does not pack the drum/tray tightly	Yes	No	NA
• Keeps the steam control valve open for 4 minutes after the hissing sound	Yes	No	NA
• Starts timer after pressure reaches a pressure of 15 lbs or a temperature 121° Celsius	Yes	No	NA
• Maintains pressure at 17-19 pounds or 1.20-1.35 kg for 30 or 20 minutes, depending on the items being autoclaved	Yes	No	NA
• Dries instruments/items before removing them from the autoclave	Yes	No	NA
• Cools items at room temperature before storing them	Yes	No	NA
• Keeps the autoclave dry when it is not in use	Yes	No	NA
Comments:			
6. Provider demonstrates correct technique of boiling (where applicable) of instruments and other items:			
• Opens and unlocks all jointed instruments before submerging them	Yes	No	NA
• Completely submerges all objects to be boiled, keeping at least 2.5 cm/1 inch of water above the instruments	Yes	No	NA
• Starts timer after water reaches the boiling point and boils instruments for 30 minutes	Yes	No	NA
• Does not add or remove any object or water after timing starts	Yes	No	NA
• Immediately after 30 minutes, removes all instruments and stores them in previously sterile container	Yes	No	NA
Comments:			
7. Provider demonstrates compliance with waste disposal standards:			
• Sharp objects are disposed of in nonpenetrable container	Yes	No	NA
• Uses utility gloves during handling of contaminated wastes	Yes	No	NA
• Pours liquid waste (0.5% chlorine solution, 5% savlon solution, etc.) down a utility drain or nonseptic toilet	Yes	No	NA
• Burns contaminated waste daily/on alternate days (or when 3/4 full) in the incinerator or burns and buries in pit	Yes	No	NA
Comments:			

Appendix A

Guide for Discussion with Facility Managers (such as head of department, head nurse, etc.)

Question/inquiry	Information obtained
1. Provide positive feedback; mention appropriate processes; build on things well done.	
2. In a facilitative manner, review status of problems still prevailing at the facility that are hindering provision of quality sterilization and other clinical family planning (FP) services.	
3. Get the statistical report of FP services and talk to the services provider; if the numbers are low, find out why they think this is happening, if numbers are appropriate for the facility size, community served, etc.	
<p>4. Ask if there have been any complications at the facility related to clinical FP services during the past year? If yes, what types? How were they managed?</p> <p>(Recognizing that complications occur and are to be expected, ask about the number of complications at the facility, ask to see the records and discuss them with providers. In a facilitative manner, discuss good management and proposed alternatives for inappropriate management. Discuss possible reasons for complications, ask for information about what they have done to avoid a repetition of complications, and provide suggestions on management, as appropriate.)</p>	<p>Number and types of complications:</p> <p>Possible reasons for complications:</p> <p>Management of complications:</p> <p>Steps taken to avoid repetition of complications:</p>
<p>5. Ask for recommendations on how to further strengthen long-term and permanent FP services at the facility.</p> <p>(There is always room for continuing improvement; build in their positive suggestions on ways to continue the quality improvement process.)</p>	If yes, specify:

Strengthening Long-Acting and Permanent Family Planning and Selected Maternal Health Services

Facilitative Supervisory (FS) Visit Checklist

Identification:

1. Name of Health Center: _____
District: _____
2. Date of Visit: _____
3. Visiting Team Members:
 1. Name and signature: _____
Organization: _____
 2. Name and signature: _____
Organization: _____
4. Name of the SITE Providers with training status: (Please circle the responses as appropriate):

Competence of Service Provider			
1. Compliance with counseling standards:			
• Greets client respectfully according to local norms	Yes	No	NA
• Maintains auditory and visual privacy	Yes	No	NA
• Gives sufficient key information to clients about requested services	Yes	No	NA
• Allows client to talk and listens to client's concern, responds to questions, and assesses need for other services	Yes	No	NA
• Uses service-specific job aids and behavior change communication (BCC) materials during counseling	Yes	No	NA
• Uses Tiahrt chart as a BCC material	Yes	No	NA
• Ensures customer's eligibility, ensures voluntarism and informed choice, and gets informed consent	Yes	No	NA
• Review of records shows consent was given before the procedure	Yes	No	NA
Comments:			

(continued)

Appendix A

Strengthening Long-Acting and Permanent Family Planning and Selected Maternal Health Services

Facilitative Supervisory (FS) Visit Checklist (*cont.*)

2. IUD (Copper-T) Services: (If client is available)			
• Provider demonstrates correct procedure for inserting IUD, according to guidelines			
➤ Uses sterile sponge holding forceps and three cotton balls for vulvae wash and does not give internal wash	Yes	No	NA
➤ Uses sterile speculum properly to inspect cervix and vagina for any discharge/ulcer/friability	Yes	No	NA
➤ Properly does a bimanual examination to assess uterus size and to exclude any abnormal finding	Yes	No	NA
➤ If customer is fit for IUD, reinserts speculum and cleans cervix using three cotton balls soaked in antiseptic	Yes	No	NA
➤ Grasps the cervix properly at 2 o'clock and 10 o'clock position using sterile tenaculum	Yes	No	NA
➤ Inserts the sterile uterine sound properly and determines depth and direction of the uterus	Yes	No	NA
➤ Loads the IUD into the inserter properly, following no-touch technique, and adjusts guard	Yes	No	NA
➤ Wears new pair of sterile gloves on both hands	Yes	No	NA
➤ Inserts IUD using withdrawal technique and ensures no-touch technique	Yes	No	NA
➤ After insertion, pushes the IUD upward for proper fundal placement	Yes	No	NA
➤ Cuts the thread keeping 3–4 cm long	Yes	No	NA
➤ Checks for bleeding	Yes	No	NA
➤ Properly decontaminates all used items in 0.5% chlorine solution	Yes	No	NA
➤ Provides postprocedure advice about IUD	Yes	No	NA
Comments:			
3. Hormonal Implant Services: (If client is available)			
• Provider obtains informed consent from the client	Yes	No	NA
• Provider correctly demonstrates following steps while providing implant services:			
➤ Properly selects site and cleans with antiseptic solution	Yes	No	NA
➤ Administers local anesthesia (1% lidocaine) appropriately in a fan shape	Yes	No	NA
➤ Introduces tip of the trocar properly beneath the skin, keeping its tip upward, and loads implant properly	Yes	No	NA
➤ Carefully places implants into position, one by one, using withdrawal technique	Yes	No	NA
➤ Ensures bleeding stops and dresses incision properly	Yes	No	NA
➤ Properly decontaminates all used items in 0.5% chlorine solution	Yes	No	NA
➤ Provides postprocedure advice about implant	Yes	No	NA
Comments:			

Strengthening Long-Acting and Permanent Family Planning and Selected Maternal Health Services

Facilitative Supervisory (FS) Visit Checklist (*cont.*)

4. Sterilization Services: (If services is available)			
• Provider obtains informed consent from the client	Yes	No	NA
• Provider correctly demonstrates following steps while performing procedure:			
➤ Properly cleans the procedure site with antiseptic solution and drapes	Yes	No	NA
➤ Ensures hemostatis and gives dressing properly	Yes	No	NA
➤ Properly decontaminates all used items in 0.5% chlorine solution	Yes	No	NA
➤ Provides postprocedure advice to client	Yes	No	NA
4a. No-Scalpel Vasectomy (NSV) Procedure: (If client is available)			
• Using the three-finger approach: Identifies, isolates, and fixes vas deferens under the median raphe at the junction of the upper and middle third of the scrotum	Yes	No	NA
• Administers local anesthesia (1% lidocaine) and makes perivascular block appropriately	Yes	No	NA
• Uses the ringed clamp properly for holding the vas and the dissecting forceps for piercing the skin and delivering the vas	Yes	No	NA
• Occludes the vas using fine silk	Yes	No	NA
• Performs fascial interposition properly	Yes	No	NA
• Tells client about the need to use condom or some other method for three months, and demonstrates correct use of condom	Yes	No	NA
4b. Minilaparotomy/Tubectomy Procedure: (If client is available)			
• Gives 10 mg diazepam orally with sips of water 45 minutes before the procedure	Yes	No	NA
• Ensures that client evacuates bladder before entering the operating theater	Yes	No	NA
• Selects site of incision 1 inch below the fundus properly (1 inch above the symphysis pubis for interval cases, just below the umbilicus for immediate postpartum cases)	Yes	No	NA
• Administers local anesthesia (1% lidocaine) layer by layer in the skin, rectus sheath, and peritoneum	Yes	No	NA
• Makes appropriate incision by layers until reaching the peritoneum	Yes	No	NA
• Before incising the peritoneum, ensures that the bladder and bowel are not trapped in it	Yes	No	NA
• Confirms the fallopian tubes before ligation by identifying the fimbriae	Yes	No	NA
Comments:			

Client Follow-Up and Referral:			
1. Follow-up is recorded in the cards, forms, and registers.	Yes	No	NA
2. Review of records shows recording of side effects and complications and their management in the history form and register.	Yes	No	NA
3. Comments	Yes	No	NA

Emergency Obstetric Care (EmOC) Services

What to Assess: The Walk-Through with Staff

<p>Instructions:</p> <p>(1) <i>Where to go:</i> The walk-through of the facility should include all client care and ancillary areas involved in providing EmOC services.</p> <p>(2) <i>What to do:</i> During the walk-through, focus on observation, talking to clients and all levels of staff, providing on-the-spot technical assistance training, and examining records.</p> <p>(3) <i>How to use this table:</i> During the walk-through, the following broad categories in this table should be kept in mind, but not used as a checklist. This way, the monitor is free to observe, teach, and discuss.</p> <p><i>Note:</i> The monitor may choose to do a Case Review with the staff to assess the following categories, especially if emergency cases are not present.</p>		
Service Category	How to Assess	What to Look For (Examples)
Facility	<ul style="list-style-type: none"> • Walk-through <ul style="list-style-type: none"> ➤ Client areas (waiting areas, latrines, exam areas, wards, procedure areas) ➤ Nonclient areas (instrument processing area, waste-disposal site, stores, blood bank) • Observe structure. • Discuss with staff the functioning of these areas. 	<ul style="list-style-type: none"> • Is each area clean and structurally sound? • Is there running water? • Is there functional electricity? • Is there a back-up system for electricity and water? • How frequently have services been interrupted for lack of water or electricity lately?
Emergency readiness	<ul style="list-style-type: none"> • Observe an emergency case, if possible • Ask staff about the last emergency case, how it was handled, what went well, and what needs improvement. • Ask about existing emergency protocols. 	<ul style="list-style-type: none"> • Are skilled staff available 24 hours a day who know how to: <ul style="list-style-type: none"> ➤ Recognize signs of complications ➤ Initiate emergency management ➤ Manage complications ➤ Perform cardiopulmonary resuscitation (CPR) ➤ Locate the nearest emergency trolley • Is a complete emergency trolley with emergency equipment, supplies, and drugs available? • Are oxygen/ambubag/face masks/suction apparatus in all client care areas, including the operating theater? • Are clients monitored for vital signs and bleeding before, during, and after care? • Are transportation (car, drive, fuel) and a referral facility available for complications that the facility cannot handle? • Are clients stabilized before transport?

(continued)

Emergency Obstetric Care (EmOC) Services

What to Assess: The Walk-Through with Staff (*cont.*)

Service Category	How to Assess	What to Look For (Examples)
Staffing	<ul style="list-style-type: none"> • Observe the availability of staff. • Review current duty roster for 24-hour duty assignments. • Contact the provider on duty now, make trial call. <p>Ask staff about:</p> <ul style="list-style-type: none"> • Experiences with getting providers during the night and holidays • If staffing is adequate and functional 	<ul style="list-style-type: none"> • Is a current duty roster with names and contact information posted in client care areas and nursing areas? • Are staff available on-site who can: <ul style="list-style-type: none"> ➤ Take care of normal labor and delivery ➤ Manage a complication (such as eclampsia, hemorrhage, infection) ➤ Perform uterine evacuation, cesarean section, assisted delivery ➤ Provide anesthesia
Equipment/supplies/drugs	<p>In each room, look at equipment, supplies, and drugs, and discuss the following with staff.</p> <p>Check the availability and functionality of equipment, such as:</p> <ul style="list-style-type: none"> • Oxygen tank • Anesthesia machine • Instrument sterilizer • Suction machine • Refrigerator <p>Review the contents of :</p> <ul style="list-style-type: none"> • Supply cabinets • Drug trays • Emergency trolley • Instrument kits, such as cesarean section kit, manual vacuum aspiration kits • Linen sets 	<p><i>For equipment:</i></p> <ul style="list-style-type: none"> • Is each piece of equipment available where it should be? • Is it functional? Can staff demonstrate its function now? • Is there a functional repair and maintenance system? • Are cesarean section kits complete? <p><i>For supplies and drugs:</i></p> <p>Adequacy:</p> <ul style="list-style-type: none"> • Are supplies adequate for the client load? Do staff run out of supplies? • Are drugs adequate for the client load? Do staff run out of drugs? <p>Storage:</p> <ul style="list-style-type: none"> • Do staff use the “first-in, first-out” (FIFO) system? • Are supplies and drugs stored in a dry, safe place? • Are drugs within their expiry date? • Is a chlorine supply available? <p>For the emergency trolley:</p> <ul style="list-style-type: none"> • Are there complete emergency drug trays in each client care area? • Are there complete emergency trolley(s) in client care areas?

(continued)

Emergency Obstetric Care (EmOC) Services

What to Assess: The Walk-Through with Staff (*cont.*)

Service Category	How to Assess	What to Look For (Examples)
Clinical technique	<ul style="list-style-type: none"> • Observe as many procedures as possible (evaluation, labor exam, delivery, assisted delivery, repair of lacerations, manual removal of placenta, cesarean section, etc.). • Observe management of as many complicated cases as possible. • If observation is not possible, conduct case review of a complicated case. 	<p>For each client observed, note</p> <ul style="list-style-type: none"> • Was evaluation and management prompt (within 15 minutes of arrival for emergency cases)? • Was the client managed correctly? • Did the staff use the correct procedural technique? • If the client was unstable, was stabilizing treatment (i.e., intravenous fluids, MgSO₄ or diazepam, oxytocin) provided promptly? • Did staff follow correct infection prevention practices?
Anesthesia	<ul style="list-style-type: none"> • Observe the use of anesthesia. • Ask the anesthetist what he or she uses for a cesarean section and how. • Observe the anesthesia equipment. • Review the emergency protocols for managing anesthetic complications. 	<ul style="list-style-type: none"> • Is the client monitored during premedication, the procedure, and postprocedure? • Is local anesthesia used when possible, such as for uterine evacuation? • Is the client's pain controlled? • Are staff available who are trained in the safe use of anesthesia? • Are staff available who are trained to recognize anesthetic complications and resuscitate (staff knowledge of CPR and emergency procedures)?
Infection prevention	<ul style="list-style-type: none"> • Observe practices before, during, and after client care (i.e., exams, procedures, surgery). • Observe or ask staff to describe how instruments are processed. • Observe how medical waste (i.e., placenta, sharps) is processed and disposed of (i.e., burying, burning). 	<ul style="list-style-type: none"> • Do providers wear sterile gloves and gowns for surgery and delivery? • Is a sterile field maintained? • Is asepsis maintained in all procedures (restricted/semi-restricted zones, separation of clean from dirty)? • For decontamination, are instruments placed in 0.5% chlorine solution for 10 minutes before processing? • Are sharps disposed of in puncture-proof containers? • Is the chlorine supply adequate, and is it stored appropriately? • Are instruments sterilized and packed properly? • Is the waste-disposal site maintained properly (protected from public access, free from animals)?

(continued)

Emergency Obstetric Care (EmOC) Services

What to Assess: The Walk-Through with Staff (*cont.*)

Service Category	How to Assess	What to Look For (Examples)
Client-provider interaction	<ul style="list-style-type: none"> Observe any interaction between providers and: <ul style="list-style-type: none"> Clients Family members or other accompanying persons, such as traditional birth attendants 	<ul style="list-style-type: none"> Are clients and others treated with: <ul style="list-style-type: none"> Respect? Kindness and empathy? Privacy and confidentiality? Is appropriate information provided?
Postservice care	<ul style="list-style-type: none"> Observe the recovery room. Observe outpatient services for follow-up. Speak with staff. 	<ul style="list-style-type: none"> Are clients monitored after procedures and delivery for vital signs and bleeding: <ul style="list-style-type: none"> After premedication? During surgery? After surgery? Is a place available with skilled care 24 hours a day for clients returning in an emergency? Do all postsurgical/complications clients receive routine follow-up, either at a facility or in the community.
Discharge counseling	<ul style="list-style-type: none"> Observe discharge counseling. 	<ul style="list-style-type: none"> Do staff provide information (oral and written) on routine care, warning signs, and where to come for an emergency 24 hours a day? Do staff provide pain control, as needed? Is reproductive health counseling provided, as appropriate (e.g., referral to additional reproductive health services; family planning counseling and services)? For postabortion complications or clients with poor neonatal outcomes, is emotional support provided? Is follow-up undertaken in the facility or community?
Registers	Review 20 to 30 client entries in <i>facility registers</i> , such as: <ul style="list-style-type: none"> Labor and delivery Operating room Maternity ward 	<ul style="list-style-type: none"> Are facility registers always completed? Is there a column for complications, and is it always filled out? Is there a column for procedures, and is it always filled out? Is there a column for the outcome of the mother and baby? Is the reason for a cesarean delivery noted?

Appendix B

PowerPoint Presentations

PowerPoint Presentations

This curriculum utilizes a number of PowerPoint presentations; these presentations are all available on this CD-ROM. You can access them by clicking the highlighted titles below.

Module 2: Ensuring the Fundamentals of Care in Family Planning and Reproductive Health Services

Module 3: A New Approach to Supervision

Module 4: Ensuring Informed and Voluntary Decision Making

Module 5: Assuring Safety for Clinical Techniques and Procedures

Module 7: Leading Staff through Change: Links to the Larger System

Appendix F

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

Session B: Introducing QI Tools and Approaches—COPE®

Session C: Introducing QI Tools and Approaches—Whole-Site Training Approach

Session D: Introducing QI Tools and Approaches—The Quality Measuring Tool

Session E: Introducing QI Tools and Approaches—Cost-Analysis Tool

Session F: Introducing QI Tools and Approaches—Community COPE®

Session G: Introducing QI Tools and Approaches—Taking QI and PI Approaches and Tools to Scale

Session H: The Helms Amendment and The Mexico City Policy

Session H: Informed Choice and the Tiahrt Amendment

If you do not have access to an LCD projector, you can print selected PowerPoint slides onto transparencies and present them during the training using an overhead projector. If an overhead projector is not available, or if electrical supply is a problem during the training period, the PowerPoint files can be printed onto paper, duplicated, and passed out to the providers before the session. Alternatively, you can transcribe important information from the PowerPoint slides onto pieces of flipchart paper and display these at relevant points during the training.

Appendix C

Sample Forms for Monitoring the Learning Process: Reflection of the Day and Evaluation of the Training

REFLECTION OF THE DAY
Facilitative Supervision for Quality Improvement

Date:

1. The one thing that I learned today that I do not want to forget is:

2. The information or activity that I found most interesting and useful today was:

3. The one suggestion I have for improving today's session is:

4. Additional comments

REFLECTION OF THE DAY
Facilitative Supervision for Quality Improvement

Date:

List the five most valuable things you learned from today's sessions:

1. _____

2. _____

3. _____

4. _____

5. _____

EVALUATION OF THE TRAINING

Facilitative Supervision for Quality Improvement

1. The objectives of the training were:

- ☐ Very clear
- ☐ Clear
- ☐ Not clear

Comments:

2. The objectives of the training were:

- ☐ Completely met
- ☐ Mostly met
- ☐ Unmet

Comments:

3. The length of the training was:

- ☐ Adequate
- ☐ Too short
- ☐ Too long

Comments:

4. The workshop content maintained my interest:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time

Comments:

5. The materials presented in the course were?

- ☐ Almost all new to me
- ☐ Mostly new to me
- ☐ Not new to me

Comments:

(continued)

EVALUATION OF THE TRAINING
Facilitative Supervision for Quality Improvement (*cont.*)

6. The training techniques used in the course were?

- ☐ Most appropriate
- ☐ Appropriate
- ☐ Not appropriate

Comments:

7. The skills I acquired are:

- ☐ Directly applicable to my everyday work
- ☐ Somewhat applicable to my everyday work
- ☐ Not applicable

Comments:

8. The training facilities were:

- ☐ Very satisfactory
- ☐ Somewhat satisfactory
- ☐ Unsatisfactory

Comments:

9. The logistical arrangements (transportation, lodging, etc) were:

- ☐ Very satisfactory
- ☐ Somewhat satisfactory
- ☐ Unsatisfactory

Comments:

EVALUATION OF THE TRAINING
Facilitative Supervision for Quality Improvement (*cont.*)

10. Which topics or activities did you find MOST useful?

11. Which topics or activities did you find LEAST useful?

12. In future workshops, to which topics or activities would you dedicate more time?

13. What additional suggestions do you have for improving this course?

Appendix D

Sample Training Agendas

Agenda for Orientation to the Quality Improvement and Facilitative Supervision: One Day

Day/Time	Session	Time
Morning	1. Welcome and Introduction	40 min.
	2. Defining Quality Services: Fundamentals of Care	1 hour, 20 min.
	3. A New Approach to Supervision; Roles, Tasks, and Characteristics of Facilitative Supervisors; Basic Skills Needed: Communication Techniques; Mentoring and Coaching; Giving Constructive Feedback	1 hour, 45 min.
	Total time	4 hours²
Lunch Break		
Afternoon	4. Warm-Up	10 min.
	5. Basic Skills Needed (continued): Leadership Skills Building	35 min.
	6. Supervision and System Support for Quality Services	40 min.
	7. The Role of Supervisors in Assuring Safety of Clinical Techniques and Procedures: Conducting Medical Monitoring	1 hour, 20 min.
	8. Providing a Mechanism for Ongoing Quality Assurance; Making the Change in Quality Sustainable	45 min.
	9. Evaluation and Closing	25 min.
	Total time	3 hours

²All “total times” include times for a 10–15 minute break. Trainers will decide when to schedule these breaks, based on local preferences and needs of the training process.

Agenda for Three-Day Training Course

Day 1		
Day/Time	Length of activity	Activity
8:30–9:55	1 hour, 25 min.	Introduction: Opening remarks Introduction of participants and trainers: work in pairs Ground rules; Expectations; Goals and objective for the course; Logistics, Precourse assessment.
9:55–10:30	35 min.	Defining quality services, exercise
10:30–10:45	15 min.	Tea break
10:45–11:25	40 min.	A new approach to supervision
11:25–12:00	35 min.	Fundamentals of care; use of the Fundamentals of Care Resource Package
12:00–1:00	1 hour	The roles of supervisors in ensuring informed and voluntary decision making
1:00–2:00	1 hour	Lunch
2:00–2:10	10 min.	Warm-up
2:10–3:30	1 hour, 20 min.	Assuring safety for clinical techniques and procedures; the role of supervisors
3:30–3:45	15 min.	Tea break
3:45–4:40	1 hour, 15 min.	Assuring safety for clinical techniques and procedures; the role of supervisors (<i>cont.</i>)
4:40–4:50	10 min.	Overview of day's activities
4:50–5:00	10 min.	Reflection of the day
Day 2		
8:30–8:45	15 min.	Reflections from Day 1; Questions and answers
8:45–9:30	45 min.	Supervisors' use of data for decision making
9:30–10:30	1 hour	Leadership; leadership styles; facilitative supervisors build vision and trust
10:30–10:45	15 min.	Tea break
10:45–12:15	1 hour, 30 min.	Building leadership skills: recognition, motivation, work climate, tips for leading staff
12:15–1:00	45 min.	Leading staff through change; characteristics of effective and successful facilitative supervisor
1:00–2:00	1 hour	Lunch
2:00–2:10	10 min.	Warm-up
2:10–3:00	50 min.	Supervision and system support for quality services
3:00–3:15	15 min.	Introduction to communication skills for effective supervision
3:15–3:30	15 min.	Tea break
3:30–4:40	1 hour, 10 min.	Communication skills (<i>cont.</i>)
4:40–4:50	10 min.	Overview of day's activities
4:50–5:00	10 min.	Reflection of the day

Agenda for Three-Day Training Course (*cont.*)

Day 3		
Day/Time	Length of activity	Activity
8:30–8:45	15 min.	Reflection from Day 2; Questions and answers
8:45–9:25	40 min.	Working effectively with staff: stages of group development, characteristics of effective groups; building the team
9:25–10:45	1 hour, 20 min.	Team building and mentoring skills: types of feedback; giving/receiving constructive feedback
10:45–11:00	15 min.	Break
11:00–11:15	15 min.	Team building and mentoring skills: transferring skills; coaching the staff
11:15–1:00	1 hour, 45 min.	Involving all staff in the QI process: introduction to COPE (mock exercise)
1:00–2:00	1 hour	Lunch
2:00–2:10	10 min.	Warm-up
2:10–3:15	1 hour, 5 min.	Developing future plans for supporting quality family planning services (including long-acting and permanent methods); presentation of the plans
3:15–3:30	15 min.	Tea break
3:30–3:50	20 min.	Review of the course
3:50–4:05	15 min.	Course evaluation
4:05–4:35	30 min.	Closing ceremony, awarding of certificates

Agenda for Five-Day Training Course (includes practice supervisory visit)

Day 1		
Day/Time	Length of activity	Activity
9:00–10:25	1 hour, 25 min.	Introduction: Opening remarks Introduction of participants and trainers: work in pairs Ground rules; expectations; goals and objectives for the course; logistics; precourse knowledge and needs assessment
10:25–11:00	35 min.	Defining quality services
11:00–11:15	15 min.	Tea break
11:15–11:45	30 min.	A new approach to supervision
11:45–12:10	25 min.	The fundamentals of care
12:10–1:00	50 min.	Fundamentals of care: Use of Fundamentals of Care Resource Package
1:00–2:00	1 hour	Lunch
2:00–2:10	10 min.	Warm-up
2:10–3:30	1 hour, 20 min.	Ensuring informed and voluntary decision making
3:30–3:45	15 min.	Tea break
3:45–4:40	55 min.	Assuring safety for clinical techniques and procedures
4:40–4:50	10 min.	Overview of day's activities
4:50–5:00	10 min.	Reflection of the day
Day 2		
8:30–8:45	15 min.	Reflections on Day 1; questions and answers
8:45–10:30	1 hour, 45 min.	Assuring safety for clinical techniques and procedures (<i>continued</i>)
10:30–10:45	15 min.	Tea break
10:45–12:00	1 hour, 15 min.	Using data to assure the quality of medical services
12:00–1:00	1 hour	Building leadership skills: Leadership styles
1:00–2:00	1 hour	Lunch
2:00–2:10	10 min.	Warm-up
2:10–3:00	50 min.	Leadership skills: Building vision and trust
3:00–3:15	15 min.	Tea break
3:15–4:10	55 min.	Leadership skills: Recognition and motivation: tips for leading staff
4:10–4:50	40 min.	Supervisors influence the work climate
4:50–4:55	5 min.	Overview of day's activities
4:55–5:00	5 min.	Reflection of the day

(continued)

Agenda for Five-Day Training Course (cont,)

Day 3		
Day/Time	Length of activity	Activity
8:30–8:45	15 min.	Reflections on Day 2; questions and answers
8:45–9:35	50 min.	Leading staff through change; links to the larger system, and the roles of supervisors
9:35–10:30	55 min.	Supervision and system support for quality services
10:30–10:45	15 min.	Tea break
10:45–11:00	15 min.	Supervision and system support for quality services (<i>continued</i>)
11:00–12:30	1 hour, 30 min.	Building communication skills
12:30–1:00	30 min.	Team building and mentoring skills: Stages of group development; Characteristics of effective groups; Building a team
1:00–2:00	1 hour	Lunch
2:00–2:10	10 min.	Warm-up
2:10–2:40	30 min.	Team building and mentoring skills: Building a team (<i>continued</i>)
2:40–3:15	35 min.	Team building and mentoring skills (<i>continued</i>): Giving constructive feedback
3:15–3:30	15 min.	Tea break
3:30–4:30	1 hour	Team building and mentoring skills (<i>continued</i>): Giving constructive feedback
4:30–4:55	25 min.	Orientation to a practice supervisory visit
4:55–5:00	5 min.	Reflection of the day
Day 4		
Morning Session: Participants are divided into two groups. Groups conduct practice supervisory visits at two facilities.		
Afternoon Session: Participants are back in the training room		
3:00–4:45	1 hour, 45 min.	Participants discuss in their groups the results of the practice visit; each group prepares a report and an action plan on a practice supervisory visit. Groups present results and engage in group discussion.
4:45–5:00	15 min.	Reflections of the day

(continued)

Agenda for Five-Day Training Course (*cont.*)

Day 5		
Day/Time	Length of activity	Activity
8:30–8:45	15 min.	Reflections on Day 4
8:45–9:40	55 min.	Team building and mentoring skills (<i>continued</i>): Encouraging people to work together; Dealing with personalities and solving conflicts
9:40–10:15	30 min.	Team building and mentoring skills (<i>continued</i>): Mentoring and coaching skills
10:15–10:30	15 min.	Tea break
10:30–10:45	15 min.	Planning and conducting meetings
10:45–12:30	1 hour, 45 min.	Developing future plans
12:30–1:00	30 min.	Review of the course
1:00–1:15	15 min.	Postcourse assessment
1:15–1:30	15 min.	Course evaluation
1:30–2:30	1 hour	Lunch

Appendix E

Trainee Follow-Up Forms

Follow-Up on Facilitative Supervision Trainees—Offsite Supervisors Checklist

Date: _____

District: _____

Supervisor name and position: _____

Interviewer name: _____

Instructions for interviewers: Use only one form per supervisor. Please note that it is ESSENTIAL to answer questions 17, 18, and 19.

Question	Yes	No	Supervisor's Response	Interviewer's Comments
1. Do you supervise any sites If yes, how many sites do you supervise? IF NO, STOP THE INTERVIEW.				
2. Do you have supervision guidelines?				
3. Do you have your job description?				
4. Have you developed a schedule for supervisory visits? If yes, ask to see the schedule.				
5. Are you able to follow the schedule? If no, why not?				

(continued)

Follow-Up on Facilitative Supervision Trainees—Offsite Supervisors Checklist (*cont.*)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
6. In the past six months, did you visit all of your assigned sites? If yes , on average, how many times did you visit each site during those six months?				
7. Do you have a regular scope of work for the supervisory visits that you usually conduct? If yes , please describe it.				
Prior to your arrival at the site, do you:				
8. Review the previous visit's report and action plan before the visit?				
9. Inform the site's supervisors about your visit?				
10. Communicate the purpose of the visit to the site's supervisor? During the supervisory visit, do you:				
11. Discuss the agenda of the visit with the site's supervisor? If yes , please describe a typical agenda.				

(continued)

Follow-Up on Facilitative Supervision Trainees—Offsite Supervisors Checklist (cont.)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
12. Do you discuss the status of the action plan developed during the last visit with the staff? If yes , please describe what is typically discussed.				
13. Do you use any tools during your supervisory visits that help you to assess service provision at the site? If yes , list them.				
14. Do you use the checklists that were distributed during the facilitative supervision training? If yes , have you adapted the checklists' questions or do you use the original version of the checklists? If changes have been made, describe these changes . If no , what are the reasons that you did not use the checklists?				
15. Do you typically assess the readiness of the site to provide services? If yes , give example of findings from a typical visit.				

(continued)

Follow-Up on Facilitative Supervision Trainees—Offsite Supervisors Checklist (*cont.*)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
16. Do you review site records during your supervisory visit? If yes , describe typical findings from client records or other onsite records				
17. In the past three months, has it been usual for you to observe staff providing services to clients? If yes , list the services that you have typically observed.				
18. At the end of your supervisory visit, do you usually meet with staff to discuss your findings? If yes , describe a typical meeting discussion.				
19. Do you record the findings of your visit in the site's supervisory journal?				
20. Do you use supervision visits as an opportunity to coach providers onsite, if needed? If yes , give examples from a typical visit.				

(continued)

Follow-Up on Facilitative Supervision Trainees—Offsite Supervisors Checklist (*cont.*)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
21. Do you update staff on the newest developments in family planning and reproductive health and/or changes in national standards and guidelines?				
22. Do you provide onsite supervisors and staff with copies of updated guidelines or protocols for procedures and techniques?				
23. Do you discuss changes in the service statistics with the site staff? If yes , give examples of how you used service statistics to make decisions.				
24. Do you help the site supervisors and the staff to assess the site's learning needs? If yes , describe how.				
25. Do you recognize staff's achievements in providing quality services? If yes , describe how.				
26. Do you motivate staff to improve the quality of services they provide? If yes , describe how.				

(continued)

Follow-Up on Facilitative Supervision Trainees—Offsite Supervisors Checklist (*cont.*)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
27. Do you discuss the possible solutions for the problems identified with the staff during the supervisory visit? If yes , give examples.				
28. Do you usually offer help to staff to solve problems that they could not solve alone? If yes , give examples.				
After the visit, do you:				
29. Write reports about your visit? If yes , request to see the reports.				
30. Send a copy of the report to the site?				
31. Integrate the findings of the visit into your supervisory ongoing action plan? If yes , give examples and request to see the plan.				
32. Follow up with site staff to ensure that the site's action plan was implemented? If yes , give examples.				

(continued)

Follow-Up on Facilitative Supervision Trainees—Offsite Supervisors Checklist (*cont.*)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
After the visit, do you:				
33. Evaluate the quality of services provided by the site? If yes, please describe. What tools and indicators do you use to evaluate the quality of services?				
34. Need support to perform your work as a supervisor effectively? If yes, please describe the type of support that you need.				
35. Has the facilitative supervision training affected your work as an offsite supervisor? If yes, describe any changes you have made in your work as a result of the training.				

Follow-Up on Facilitative Supervision Trainees—On-Site Supervisors Checklist

Date: _____

Facility: _____

Supervisor name: _____

Interviewer name: _____

Instructions for interviewers: Use only one form per supervisor. Please note that it is ESSENTIAL to answer numbers 9 and 27.

Question	Yes	No	Supervisor's Response	Interviewer's Comments
1. Do you have your job description?				
2. Do you have your personal work plan as a supervisor? If yes , ask to see the plan. What items are included in that plan?				
3. Have you conducted medical monitoring activities within the past six months? If yes , on average, how many times did you activities in the past six months?				
4. Do you use any tools during medical monitoring activities? If yes , list them.				

(continued)

Follow-Up on Facilitative Supervision Trainees—On-Site Supervisors Checklist (*cont.*)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
5. Do you use the checklists that were distributed during the facilitative supervision training? If no , why not? If yes , have you adapted the checklists' questions or do you use the original version of the checklists? If adaptations were made, describe the changes made to the checklists.				
6. Do you involve staff in medical monitoring activities? If yes , please describe how.				
7. Do you regularly assess the readiness of the site to provide services (i.e., conduct a facility audit)? If yes , describe how, and give example(s) of findings.				
8. Do you review client records? If yes , what were the common findings 1) from the client records, and 2) from other records kept at the site?				
9. In the past three months, has it been usual for you to observe staff providing services to clients? If yes , list the services that you typically observed. What were some typical findings?				

(continued)

Follow-Up on Facilitative Supervision Trainees—On-Site Supervisors Checklist (cont.)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
10. Do you keep records of the findings from the medical monitoring activities? If yes , ask to see the records.				
11. Do you teach staff how to use medical monitoring checklists?				
12. Do you encourage staff to use the medical monitoring checklists for a self-assessment or a peer assessment? If yes , please describe how.				
13. Do you use the findings from medical monitoring activities? If yes , what do you do with the findings? Please describe. Give examples of findings. (Possible responses: Share with the staff; develop a plan with solutions by him/herself; involve staff in developing an action plan to solve the problems; inform off-site supervisor and ask for his/her help on the issues that staff cannot solve on their own.)				
14. Do you regularly have staff meetings? If yes , how often did you have staff meetings in the past six months?				

(continued)

Follow-Up on Facilitative Supervision Trainees—On-Site Supervisors Checklist (*cont.*)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
15. Do you discuss with the staff the status of the current action plan on a regular basis? If yes , please describe a typical discussion.				
16. Do you use an opportunity to coach providers on the job, if needed? If yes , give examples.				
17. Do you update staff on the newest developments in family planning and reproductive health (FP/RH) and on changes in national standards and guidelines?				
18. Do you make updated guidelines/protocols/standards for FP/RH service provision available for the staff to use?				
19. Do you discuss with the site staff the site's/district's/country's FP/RH service statistics? If yes , describe how, if at all, you use that information.				
20. Do you involve staff in assessing the site's learning needs? If yes , describe how and what you do to address those needs.				

(continued)

Follow-Up on Facilitative Supervision Trainees—On-Site Supervisors Checklist (*cont.*)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
21. Does your site have a staff development plan? If yes , ask to see the plan.				
22. Do all staff follow the updated guidelines and protocols for FP/RH services needed to perform their duties according to standards?				
23. Do all staff have job descriptions?				
24. Do you discuss job expectations with your staff? If yes , please give examples of what you discuss in a typical meeting.				
25. Is there a system in place to appraise staff performance at your site? If yes , please describe the system.				
26. Do you motivate staff (e.g. by recognizing achievements, etc.)? If yes , describe how.				
27. Do you have a supervisory journal in which the off-site supervisor can record the findings from his/her supervisory visit to your site?				
28. Do you receive copies of the supervisory visit reports from your off-site supervisor?				

(continued)

Follow-Up on Facilitative Supervision Trainees—On-Site Supervisors Checklist (cont.)

Question	Yes	No	Supervisor's Response	Interviewer's Comments
29. Do you evaluate the quality of services provided by your facility? If yes , describe how you evaluate the services. What tools and indicators do you use to evaluate services?				
30. Do you involve staff in the quality improvement process? If yes , describe how and what tools you use.				
31. Do you need any support (from district/national supervisors, from community, donors, and counterparts) to be an effective supervisor? If yes , describe the type of support that you need.				
32. Has the facilitative supervision training affected your work as an on-site supervisor? If yes , describe how, especially what changes you have made in your work as the result of the training (if any)?				

Appendix F

Optional Training Sessions

Session A

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

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



USAID
FROM THE AMERICAN PEOPLE

the **ACQUIRE** project

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

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

Executive Summary

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.

³See 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).

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- 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 COPE⁴; 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.

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

This document includes:

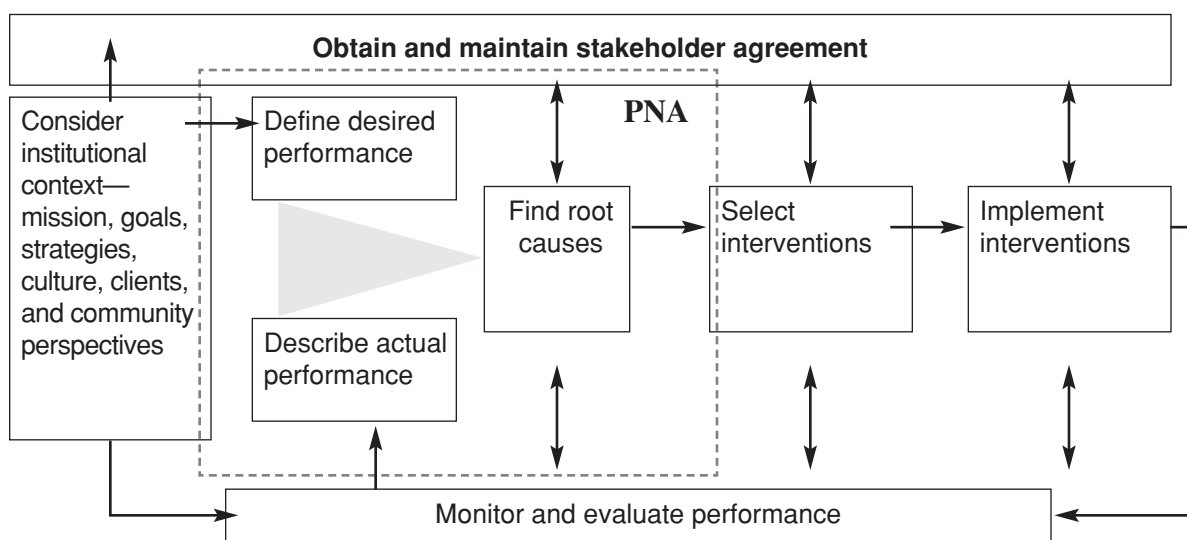
- A brief overview of approaches and tools
- A discussion of similarities and differences
- An explanation of how these approaches and tools can be used together to maximize benefits
- A summary and recommendations
- A resource section, including references for materials containing in-depth information 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?

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- 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

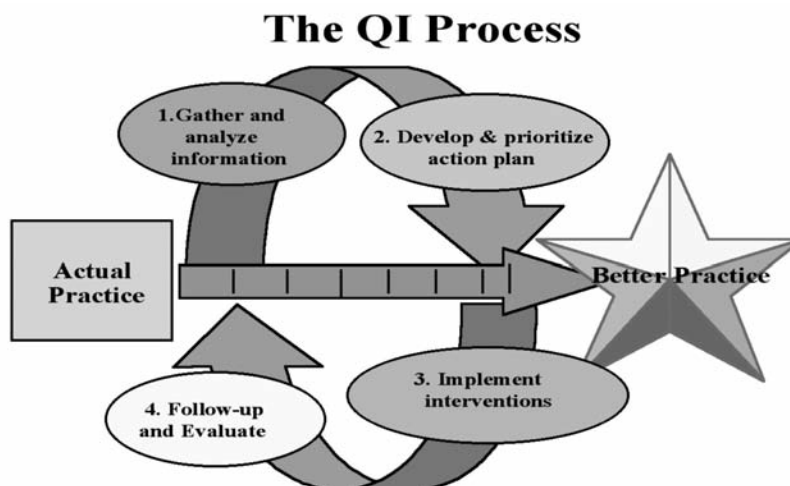
- Interviews with providers/staff (including supervisors and managers)
- Observation of client-provider interactions
- Facility audits/assessments
- Review of service statistics
- Client interviews
- Group discussions in the community

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



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.
- **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.

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

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
<ul style="list-style-type: none"> • Client interviews • Provider self-assessment guides • Record-review checklist • Client-flow analysis 	<ul style="list-style-type: none"> • Individual interviews • Focus-group discussions • Mapping exercises • 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

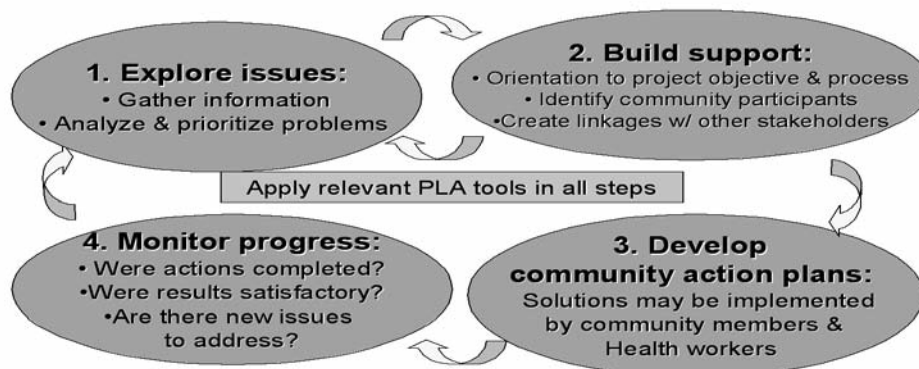
Definition of PLA

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



The first two steps of the PLA process (exploring issues and building support) tend to be interchangeable, 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 project'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 contexts. Figure 5 does not represent an exhaustive list of tools.

Figure 5. Tools for use in the PLA proces

<ul style="list-style-type: none"> • Social mapping • FP or sex census mapping • Transect walks • Venn diagrams (Human resource and community organization, Social networks and sources of information, Household relations/decision making) • Matrix ranking (e.g., choice of caregiver by type of maternal health and RH need) • Trend analysis (e.g., reproductive life-line) • Ranking and scoring (e.g., contraceptive preference) • Causal-impact analysis (flow diagrams) 	<ul style="list-style-type: none"> • Pocket chart (situational assessment/analysis) • Three-pile sorting • Picture stories/cartooning • Drama (open-ended/closed-ended) and role plays • Critical incident analysis using visuals • Flexi-flans as creative materials • Unserialized posters • Carts and rocks (analysis of resources and constraints) • Two-circles exercise • Semi-structured interviews • Focus-group discussions • Case studies, stories, portraits
<p>Note: This list shows selected PLA tools applicable to RH issues, adapted from CARE, 1999.</p>	

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 evaluation. This continuous process builds capacity and empowers communities to undertake ongoing 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 feasibly use PLA tools to get community input, participation, and buy-in during start-up and

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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:

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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.

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- ***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.

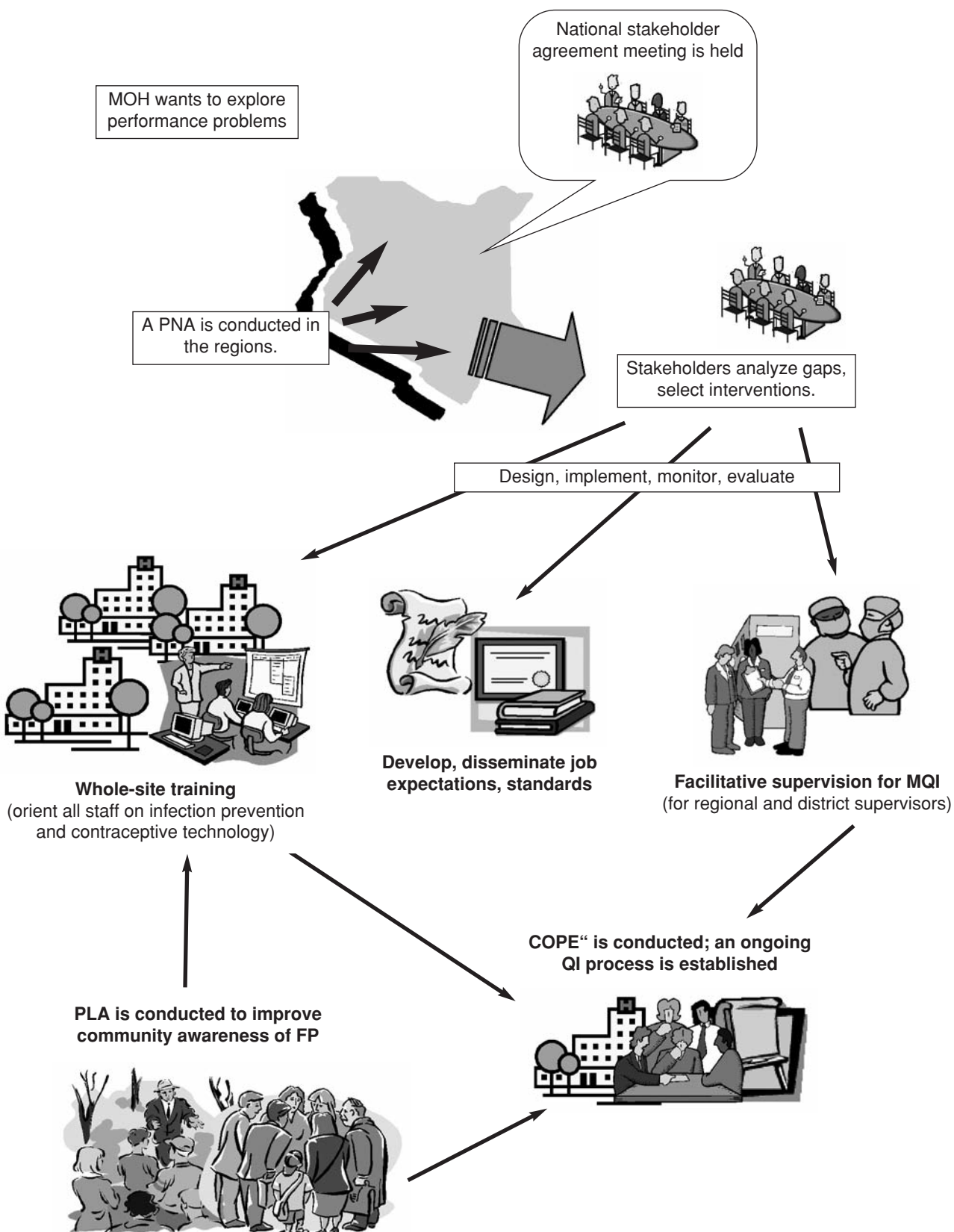
The following two descriptions and illustrations depict scenarios where the three approaches are successfully integrated.

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**



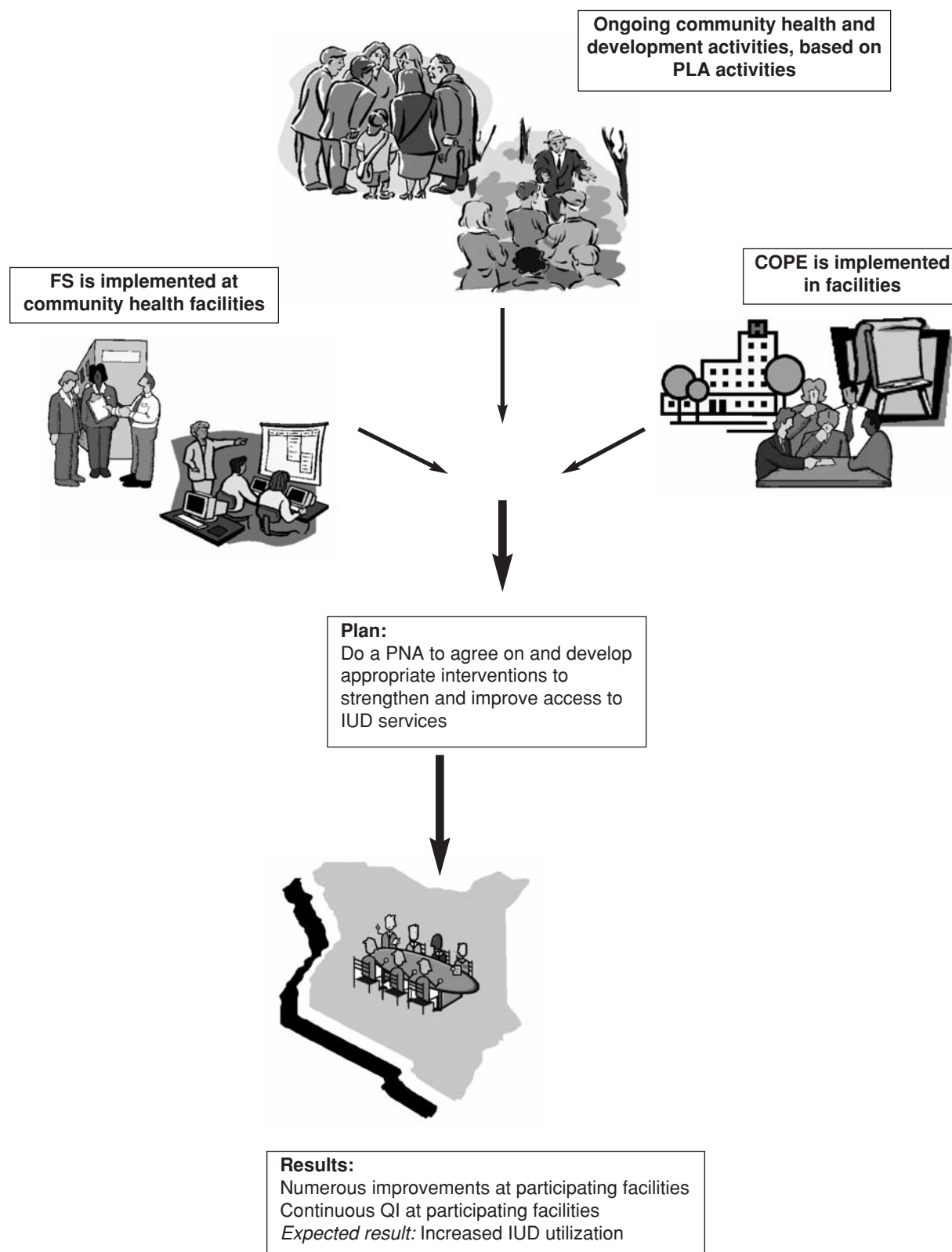
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Continued monitoring and evaluation illustrated that using the approaches in this way improved FP service delivery at the facilities and regions involved in the PI and QI efforts.

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**



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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 toolbox 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.

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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. *Tools 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.

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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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References

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.

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* toolbox 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.

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* toolbox 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* toolbox.

➤ 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* toolkit.

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

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: _____ _____ _____ _____											

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Surgical Record-Review Checklist

(See the *COPE for Reproductive Health Services* toolbox 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: <ul style="list-style-type: none"> • 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.

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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
	Provide training to all newly hired staff responsible for processing reusable instruments	Refresher training on IP	At the trainees' site	Dr. Y	For all newly hired nurses and cleaning staff	IP guides Chlorine
		Skills training in preparing 0.5% chlorine solution	At the trainees' site	Nurse Z	For all newly hired nurses and cleaning staff	IP guides Chlorine
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 instruments; 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
<ul style="list-style-type: none"> • Facilitative supervision • Medical quality improvement • Whole-site training 	<ul style="list-style-type: none"> • COPE® • Community COPE® • Quality measuring tool • Cost analysis tool • Medical monitoring

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

<ul style="list-style-type: none"> <input type="checkbox"/> Customer mindset <input type="checkbox"/> Staff involvement and ownership <input type="checkbox"/> Cost consciousness and efficiency 	<ul style="list-style-type: none"> <input type="checkbox"/> Focus on systems and processes <input type="checkbox"/> Staff development and capacity building <input type="checkbox"/> Continuous quality improvement
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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.

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- **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 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

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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

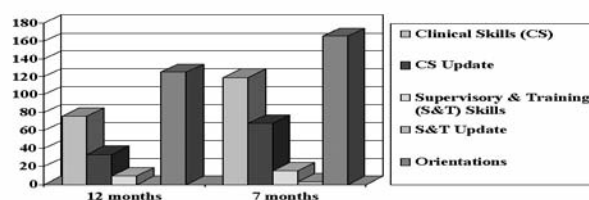
EngenderHealth has been working to improve family planning services in Tanzania since 1988, in collaboration with the Ministry of Health of Tanzania, UMATI (the Family Planning Association of Tanzania), and Marie Stopes International and with support from the U.S. Agency for International Development (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



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.

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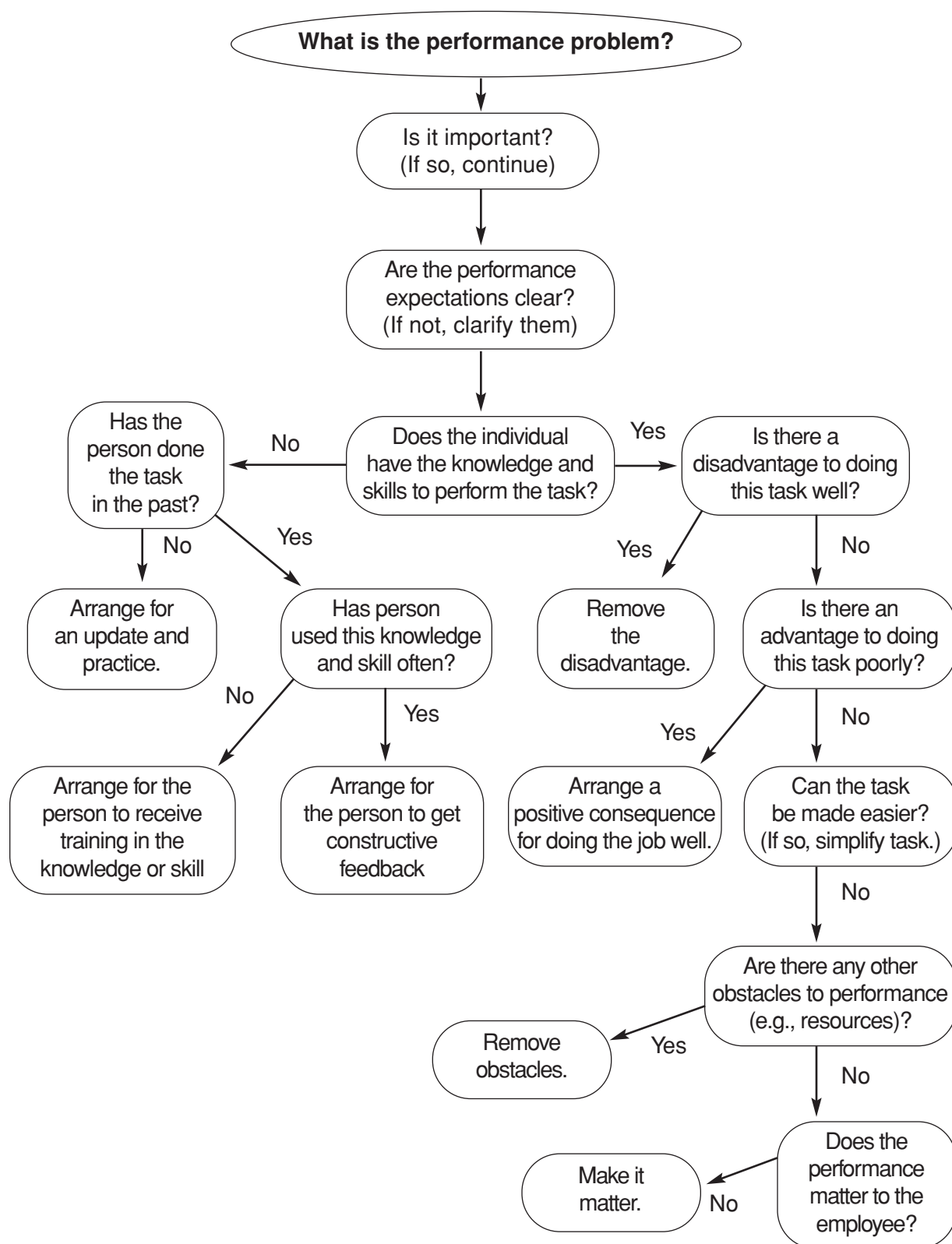
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Participant Handout C-3: Is Training the Answer? (Optional)



⁵Adapted from: Mager, R. F. and Pipe, P. 1984.
Analyzing performance problems. Belmont, CA: Lake Publishing Co.

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 ($A/C \times 100$).

QMT SECTION (Client Right or Staff Need)	A Total Yes	B Total No	C Total Yes+ No (A+B)	D Score (% Yes) $A/C \times 100$
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				

Appendix F

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 funders		

Trainer's Resource: Communicating about Your Successes—Answers

Audience	Messages	Ways to Communicate
Clients and community members	<ul style="list-style-type: none"> • 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! 	<ul style="list-style-type: none"> • Interpersonal communication • Posters • Bulletin board • Community meetings
Site staff	<ul style="list-style-type: none"> • Where we are with our current action plan. • What we have 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! 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • What accomplishments have been made • What clients say about services • What problems are recurring or system-wide and require support from higher levels 	<ul style="list-style-type: none"> • Meetings • Site visits by upper managers • Reports
Other sites and organizations	<ul style="list-style-type: none"> • Examples of creative solutions to common problems • Opportunities for working together to solve problems (with community members, local organizations, etc.) 	<ul style="list-style-type: none"> • Meetings • Site visits • Reports
Donors and other funders	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

Appendix F

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 can 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.

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.

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 Worksheet 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**

Service or Clinical Procedure: <u>Laparotomy</u>			
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 (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

<i>Service or Clinical Procedure</i> _____			
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 (<u>20</u> minutes for <u>10</u> 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 <u>60</u> minutes each procedure and <u>5</u> minutes between clients for cleaning and preparation (total <u>5</u> minutes)	Physician	65
		OR nurse	65
		Runner nurse	65
		Support staff	65
	Clean up procedure room (<u>480</u> minutes weekly for <u>40</u> clients)	Support staff	12
		Nurse	12
Postprocedure Care			
	Rest in recovery room (<u>300</u> minutes for <u>10</u> 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 (<u>10</u> minutes daily for <u>10</u> clients)	Nurse	
		Supervisor	1
	Overall staff supervision	Support staff	30

Worksheet 1: Part 1

Calculation of Staff Time for Clinical Procedures

<i>Service or Clinical Procedure</i> _____			
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	B	C	D
	Amount in unit	Unit cost	Amount used per client	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	B	C	D
	Amount in unit	Unit cost	Amount used per client	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	

Appendix F

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 Worksheet 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: <u>Laparotomy</u>			
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 (<u>10</u> minutes for <u>10</u> clients)	Support staff	6
		Nurse	
	Clean and prepare examination equipment (<u>120</u> minutes for <u>10</u> clients)	Support staff	
		Nurse	12
	Clean room at the end of the day (<u>120</u> minutes for <u>10</u> 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

<i>Service or Clinical Procedure</i> _____			
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 (<u> 20 </u> minutes for <u> 10 </u> 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 <u> 60 </u> minutes each procedure and <u> 5 </u> minutes between clients for cleaning and preparation (total <u> 5 </u> minutes)	Physician	65
		OR nurse	65
		Runner nurse	65
		Support staff	65
	Clean up procedure room (<u> 480 </u> minutes weekly for <u> 40 </u> clients)	Support staff	12
		Nurse	12
Postprocedure Care			
	Rest in recovery room (<u> 300 </u> minutes for <u> 10 </u> 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 (<u> 10 </u> minutes daily for <u> 10 </u> clients)	Nurse	
		Supervisor	1
	Overall staff supervision	Support staff	30

Worksheet One, Part I

Calculation of Staff Time for Clinical Procedures

<i>Service or Clinical Procedure</i> _____			
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 (<u> 10 </u> minutes daily for <u> 10 </u> 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 (<u> </u> minutes daily for <u> </u> 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	B	C
	Time spent per client	Cost per minute	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	B	C	D
	Amount in unit	Unit cost	Amount used per client	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	B	C	D
	Amount in unit	Unit cost	Amount used per client	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 ownership 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.

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.

Appendix F

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:

- ☐ 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 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

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

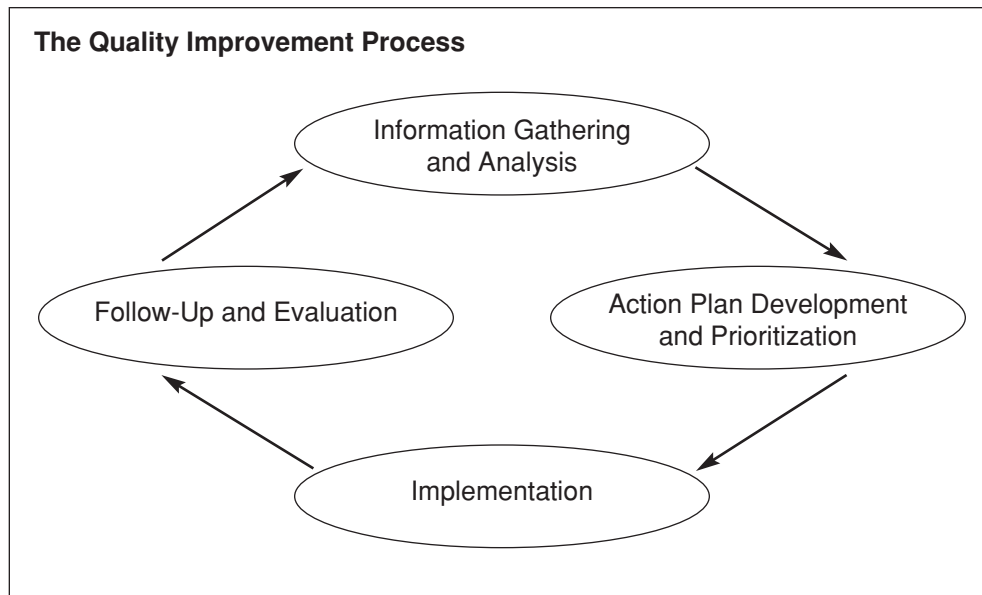
40 minutes

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).



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 requirements 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.

Appendix F

- 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