

The International Planned Parenthood Federation is the world's largest voluntary organization in sexual and reproductive health and rights

## Introduction

2003 has marked the midway point of the Strengthening the Quality of Reproductive Health Care programme (QOC); IPPF's five-year initiative to improve the quality of sexual and reproductive health (SRH) care provided by IPPF member associations. This has provided a fitting opportunity to take stock of achievements to date, evaluate progress made, and to make adjustments where required. Toward this end, a mid-term evaluation of the programme, conducted by four external experts in the field of SRH, was carried out between May-October 2003, with the major activities occurring in July-August. Members of the evaluation team were: Barbara Pillsbury, Halida Akhter, Philip Corfman, and Mark Okunnu. Their aim was to critically assess the status of implementation, performance and achievements made and produce recommendations to improve the potential for achieving the specified outcomes and expanding the system of quality improvement throughout the Federation.

Overall, the evaluation has shown that much progress is being achieved in the QOC programme. Importantly, the evaluation concluded that the programme is laying a strong foundation for improving the quality of care clients receive. Feedback from member associations during the evaluation also reveals the positive impact of the programme with its unique emphasis on participation, capacity building and self-assessment. In the words of one Regional QOC Adviser, the QOC process has led to a sort of "transformation" in staff relations and teamwork at the membership association levels. Of course, further improvements can always be made, and the evaluation also suggests priority areas where focus now needs to turn in the programme's final two years.

In terms of programme implementation, the quality improvement process continues at all levels. A total of 34 member associations representing all six of IPPF's regions are participating in the programme (Figure 1). Nine of the first 12 that joined in 2002 continue to implement their QOC action plans while member associations that joined in early 2003 are now participating in training on QOC and developing their own action plans for quality improvement.

As you will read in the newsletter, in all participating member associations, the programme is making significant strides in improving quality of care and making the goal of meeting clients' rights a reality.

**Carlos Huezto-Toledo**  
**Medical Director**  
**QOC Programme Coordinator**

## Main findings midway through

The mid-term evaluation provided the opportunity to comprehensively assess all aspects of the QOC programme midway through its implementation. Data was gathered using



a variety of methods, including document review, interviews, field visits and a survey among the first 12 member associations participating in the programme. Interviews with staff from Central and Regional offices, including Regional Directors and QOC Advisers, were complemented by field visits to three participating member associations (Bangladesh, Poland, and Uganda). During these trips, the evaluation team visited and interviewed membership association staff and volunteers as well as service providers and clients at a sample number of service delivery points (SDPs). Here below is a summary of key evaluation outcomes and findings.

### Design: "Making clients' rights a reality"

A broad goal of the QOC programme has been to develop a systematized and empowering process to quality improvement applicable to all member associations across the Federation. Toward this end, the programme adopted a rights-based approach to quality improvement, drawing on IPPF's Rights of the Client and Needs of the Service Provider Framework. Its design also applies a methodology based on participation, teamwork and self-assessment with the view that local staff know best how to improve the quality of care in their local settings.

Results of the evaluation show that this unique design and structure have proved to be a successful model for IPPF's vast network of member associations and for improving quality of care. Indeed, the evaluation notes that the design and structure are "excellent" and finds that "a system approach was needed if significant improvements were to be achieved".

Importantly, the self-assessment tools, so fundamental to the programme's philosophy, are judged as being particularly impressive. The evaluation notes, for example, that the "QOC self-assessment is a revolutionary tool that brings together all clinic personnel from the top manager to the sweeper - to assess their own needs ... this is immensely empowering and has created valuable team spirit dedicated to improving quality".



The emphasis on self-assessment is also ensuring that client rights are becoming a reality. As the evaluation notes:

"The design seeks to create an awareness of client rights and to make clients' rights meaningful rather than just a listing in a brochure or in a poster on a wall. This appears to be successful because it is not externally imposed from above or outside but is realized through a process of self-assessment"

**Implementation: "The QOC programme has been effectively rolled out"**

Despite initial start-up delays, the evaluation finds that much progress towards the three key programme objectives (QOC standards and processes, training and improved technical information) has been achieved in the first two years.

By far the greatest progress has been in the area of standards and systems, which include development of the Quality of Care Standards and Criteria, self-assessment tools and the action plan forms. The evaluation notes, for instance, that:

"the package of standards, tools and processes developed by the QOC team for transmitting and institutionalizing systems for ongoing quality improvement in the SDPs is outstanding. It is appropriate to IPPF's far-flung system, paving the way for standardization and high standards throughout the Federation while also allowing for adaptation to local needs and differences. It is practical and user-friendly and is meeting with enthusiastic acclaim from users at all levels. The package developed by the QOC team comes across as truly inspired"

In the area of training, the evaluation reveals that the 'cascade model' is effectively transferring knowledge and practical skills through all levels of the Federation, from the Central Office to Regional Offices to member associations and to SDPs. The methods used for training, which include a combination of group work, mini-presentations, and role plays are also found

to be "facilitatory and egalitarian" and "motivating staff at all levels".

Yet further progress in the area of training is needed if the programme is to be successful. In particular, the evaluation stresses the critical importance of conducting training to introduce the IPPF Medical and Service Delivery Guidelines, and following through with training on inter-personal communication and counselling, as originally planned for. Since the time of the evaluation, inter-regional training on the Guidelines has taken place and in 2004, the training will move to the regional and in-country levels.

Finally, in the area of improved technical information, the evaluation notes that this is perhaps the most challenging aspect of the programme, given the diversity of needs and priorities of IPPF's extended network of member associations. Based on field visits, the evaluation notes that there is still a paucity of technical information materials available to service providers and recommends that focus should be given to this component over the next two years. The programme will therefore be implementing an information dissemination strategy in 2004 to address this objective.

**Feedback from the field**

As mentioned above, the evaluation included a questionnaire sent to the first 12 member associations participating in the programme. Its aim was to receive their feedback on the relevance of the QOC programme in their organizations and on implementation of the programme in general.

Responses received from all 12 member associations illustrate overall satisfaction and approval of the QOC initiative in their organizations. Moreover, responses reveal a high degree of motivation and commitment to the programme.

In addition, when asked about the relevance of the QOC programme to the mission, goals and objectives of the member association, 12/12 member associations stated that



the programme was indeed very relevant. 12/12 associations also stated that staff were committed to the programme and 10/12 saw the programme as sustainable in the long term.

This feedback correlates well with the findings of the mid-term evaluation. Table 1 provides further details of responses received from member associations.

Table 1	Responses*		
	1	2	3
<b>1. Importance of the QOC programme in:</b>			
Providing guidance in developing new effective sustainable quality improvement system	12		
Improving QOC at SDPs	11	1	
<b>2. Rating the QOC tools and procedures</b>			
QOC Standards and Criteria	11	1	
QOC improvement process	12		
Self-assessment tools	12		
Training materials	11	1	
Training methodology	12		
Action plans revision and approval	10	2	
Remittance of funds	10	2	
Financial and reporting procedures	10	2	

\* Twelve member associations were asked to rate their responses on a scale from 1-3, with 1 being the highest.

**Potential for impact: Many important improvements are immediately apparent in the SDPs"**

Midway through the programme, the evaluation shows that quality of care improvements are taking place at the SDP level. As the evaluation notes, "the ultimate goal of the programme – improvements in QOC at SDPs – was readily apparent during the site visits to three member associations". Moreover, the evaluation shows that many SDPs launched into making improvements even before they received funds

for their action plans. Improvements noted among phase 1 associations include: improved physical facilities, increase in staff pride and attitudes toward quality improvement, improved staff interaction among themselves and in the treatment of clients.

For example, the following improvements were clearly visible during the site evaluation visit to **Bangladesh**:

- Improved public signing
- Improved physical facilities and more client-friendly accommodation
- Translation and posting of Clients' Rights and Providers' Needs poster
- Improved equipment: including better surgical tables, a new or repaired autoclave, improved lighting for surgical procedures
- Improved staff relations and interaction
- Increased client and staff satisfaction

Similar improvements are taking place at all participating member associations, as illustrated below. Importantly, many improvements have required little or no financial investments.

**"Low cost, but high gains in quality"**

IPPF member associations and SDPs are improving quality of care through multiple low-cost interventions based on gaps in services they identified through self-assessment.

**El Salvador**

Improved seating arrangements for clients at all SDPs  
Increased client comfort and privacy by adding partitions between rooms

**Indonesia**

Upgraded physical look of clinics  
Improved/repaired equipment

**Lesotho**

Reprinted existing pamphlets on key SRH topics  
Integrated quarterly supportive supervision at all SDPs

**Nepal**

Privacy curtains added between rooms  
Purchase of proper blankets for clients

**Bangladesh**

See above

**Poland**

Play area for clients' children created. Toys brought in from home and clients

Organized a meeting with all clinic managers to strengthen teamwork

**Vietnam**

Extension of clinic hours and additional doctor sessions  
Staff contributed books for the clinic resource centres

**Trinidad and Tobago**

Involvement of support staff in technical meetings  
Organized staff capacity building sessions

**Uganda**

Translation of clients' rights poster into local languages  
Taking extra time to counsel clients about privacy and confidentiality

Regional QOC training in Guatemala May 2003



**Participation, motivation, commitment: "The programme has introduced a new culture of participation and team spirit"**

Site visits to the three participating member associations provided the evaluation team with first-hand insight into local perceptions and interest in the programme. The visits revealed that the programme is having an extremely positive impact at the local level and that participation, motivation and commitment to the programme is high in all clinics. The evaluation notes, for example that, "the programme has introduced a new culture of participation and team spirit. This has greatly enhanced commitment of the member associations and especially the SDPs to the programme, to the clients and to meeting their own needs". In the area of motivation, the evaluation states that:

"in the three countries visited, the evaluation team found impressive enthusiasm about the QOC programme and evidence of high motivation and commitment to carrying out quality improvements through the action plans that are now underway".

**Sustainability**

When looking toward the future, the evaluation finds that prospects for sustainability look good given the design and structures built into the programme (the conceptual framework, the standardized tools and processes, self-assessment and its emphasis on participation, motivation and capacity building). However, given that improving quality of care is a long-term process, the evaluation recommends further steps to ensure the significant improvements now visible in the QOC programme continue. The evaluation notes, for example, that:

"a wonderful foundation is being laid, but vigorous, effective follow-up through the remaining two years will be crucial, essential both for maximizing results under the current grant for achieving lasting impacts"

Potential activities include additional fundraising, incorporating self-assessment into other programmes, and expansion of the programme. Ensuring programme sustainability will be a key focus in 2004.



**Other QOC activities from June-November**

In the time since the last newsletter in June 2003, many activities have taken place in all areas and at all levels of the programme. Significant activities in the time period include:

**June 2003**

- Second regional training on QOC and self-assessment in, Cambodia, India, Pakistan, Philippines and Thailand
- In-country training on QOC and self-assessment in India, Estonia and Armenia

**July 2003**

- Visit by IPPF Director-General Steven Sinding to the Family Planning Association of Vietnam, a QOC participating member association
- In-country training on QOC and self-assessment in Brazil, Lebanon and Moldova

**August 2003**

- In-country training on QOC and self-assessment in Guatemala, Mauritania and Syria
- Francophone regional training on QOC and self-assessment in Benin, Chad, Madagascar and Mali
- Self-assessment and action plan development and consolidation in Estonia and Armenia
- Self-assessment exercise in Brazil

**September 2003**

- In-country training on QOC and self-assessment in Benin, Cambodia, Cambodia, the Philippines, Sudan and Venezuela
- Regional training on supportive supervision for six member associations in the European Network

**October 2003**

- Regional Training on Supportive Supervision in South Asia Region for four member associations
- Finalization of 15 SDP Action Plans in Guatemala
- Management self-assessment in Guatemala
- Self-assessment and consolidation of action plans in Moldova
- In-country training on QOC and self-assessment in Yemen, Mexico and Morocco

**November 2003**

- 6th Inter-regional consultation between QOC Central and Regional Office staff
- Inter-regional training on the IPPF Medical and Service Delivery Guidelines and Infection Prevention coordinated and facilitated by two Regional QOC advisors: Dr. Magdy Khaled from Arab World Region and Ilka Maria Rondinelli from Western Hemisphere Region, and Carlos Huezco from IPPF central office.
- Overall action plan developed in Venezuela
- Management self-assessment in the Philippines
- Finalization of the Gambia's Action Plan

## Next steps

In 2004, the focus of the programme will turn to implementing key recommendations from the mid-term evaluation. Following through on all training activities and improving the dissemination of technical information to member associations will be of special priority. In addition, steps to ensure programme sustainability and expansion beyond the current five-year grant will also be taken.

In the upcoming year, the programme also looks forward to the first external assessments among member associations who feel they have attained all quality of care standards and criteria through the implementation of their action plan. Hopefully, the June 2004 Newsletter will provide further details about the first awards.

## Word of appreciation and thanks

The QOC team wishes to acknowledge and thank Dr. Carlos Huezo for his tremendous work for the QOC programme on the occasion of his leaving IPPF. Carlos was instrumental in developing IPPF's Rights of the Client and Needs of the Provider Framework,. His vision and knowledge of quality of care have shaped and driven the programme since its inception. He will be greatly missed. Dr. Thierno Mariama Barry, QOC Monitoring and Standards Specialist, will be taking over as interim Programme Coordinator.

QOC training in Mauritania, August 2003



## Core staff of the IPPF QOC Programme

### Central Office:

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IPPF is incorporated by UK Act of Parliament and is a UK Registered Charity  
No: 229476

Figure 1

## Africa Region

- Uganda:** Family Planning Association of Uganda (FPAU)
- Lesotho:** Lesotho Planned Parenthood Association (LPPA)
- Gambia:** Gambia Family Planning Association (GFPA)
- Benin:** Association Béninoise pour la Promotion de la Famille (ABPF)
- Madagascar:** Fianakaviana Sambatra (FISA)
- Chad:** Association Tchadienne pour le Bien-Etre Familial (ASTBEF)

## Arab World Region

- Sudan:** Sudan Family Planning Association (SFPA)
- Yemen:** Yemen Family Care Association (YFCA)
- Mauritania:** Association Mauritanienne pour la Promotion de la Famille (AMPF)
- Syria:** Syrian Family Planning Association (SFPA)
- Lebanon:** Lebanon Family Planning Association (LFPA)
- Morocco:** Association Marocaine de Planification Familiale (AMPF)

## ESEAOR

- Vietnam:** Vietnam Family Planning Association (VINAFPA)
- Indonesia:** The Indonesian Planned Parenthood Association (IPPA)
- Cambodia:** Reproductive Health Association of Cambodia (RHAC)

## Democratic People's Republic of Korea:

Korean Family Planning & Maternal Child Health Association of DPRK

- Philippines:** Family Planning Organization of the Philippines (FPOP)
- Thailand:** Planned Parenthood Association of Thailand (PPAT)

## European Network

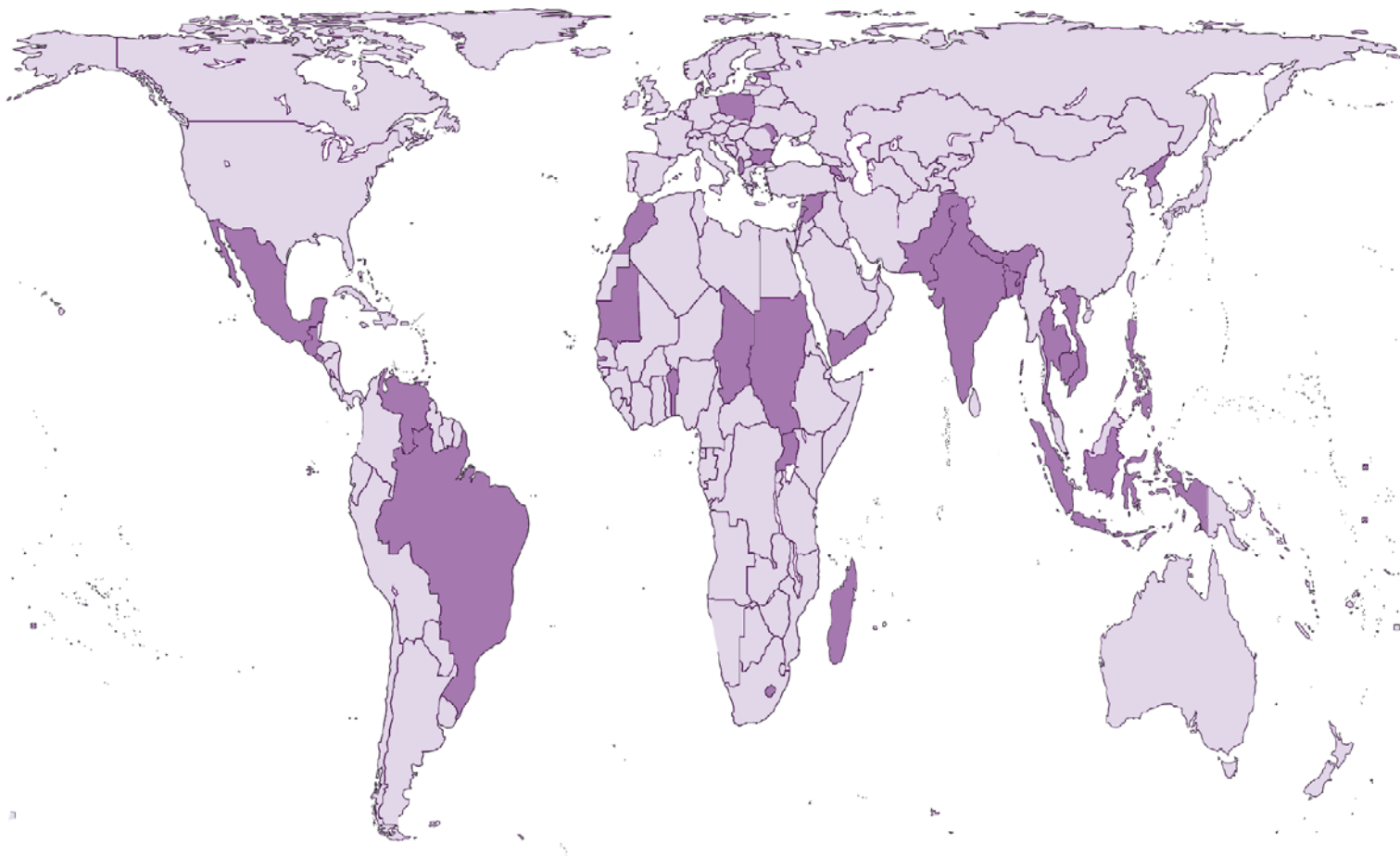
- Poland:** Towarzystwo Rozwoju Rodziny (TRR)
- Bulgaria:** Bulgarian Family Planning and Sexual Health Association (BFPA)
- Albania:** Shoqata Shqiptare e Planifikimit Familjar/ Albanian Family Planning Association (AFPA)
- Armenia:** Armenian 'For Family and Health' Association (AFHA)
- Estonia:** Eesti Pereplaneerimise Liit (EPPL)
- Moldova:** Societatea de Planificare a Familiei din Moldova (SPFM)

## South Asia Region

- Bangladesh:** Family Planning Association of Bangladesh (FPAB)
- Nepal:** Family Planning Association of Nepal (FPAN)
- India:** Family Planning Association of India (FPAI)
- Pakistan:** Family Planning Association of Pakistan (FPAP)

## Western Hemisphere Region:

- El Salvador:** Asociación Demográfica Salvadoreña (ADS)
- Trinidad and Tobago:** Family Planning Association of Trinidad and Tobago (FPATT)
- Brazil:** Sociedade Civil Bem-Estar Familiar no Brasil (BEMFAM)
- Guatemala:** Asociación Pro-Bienestar de la Familia de Guatemala (APROFAM)
- Venezuela:** Asociación Civil de Planificación Familiar (PLAFAM)
- Mexico:** Fundación Mexicana para la Planeación Familiar, A.C. (MEXFAM)\*



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