



# IPPF Medical Bulletin

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## Strengthening the quality of reproductive health care: IPPF's quality improvement programme

*Carlos Huezco*

In the mid and late 1980s IPPF conducted a large prospective multicentre study to identify factors that influence the choice and use-continuation of contraceptive methods. The results indicated that the most important factors were related to the quality of the services provided, including that of counselling.<sup>1</sup> This study offered deep insights into issues related to quality of care (QOC) and the results have helped IPPF to develop practical strategies for improvement.

High quality in the delivery of sexual and reproductive health services is a top priority for IPPF and its worldwide network of family planning associations (FPAs). It ensures that clients receive services that respect their rights to make informed, confidential, and timely decisions about their sexual and reproductive health. It also means that service providers, in their turn, gain the support, knowledge, skills, attitudes, and facilities necessary to fulfil those rights. Enhancement of QOC demands changes in the behaviour not only of individuals but also of institutions. Without systematic changes it can be little more than a distant dream.

In this article, I trace IPPF's efforts to move the concepts of QOC into practice. I highlight, in particular, IPPF's Strengthening the Quality of Reproductive Health Care Programme, a five-year initiative to achieve systematic improvements in the quality of care provided by FPAs across the Federation. This programme builds on IPPF's past efforts and experiences which I discuss together with present activities and a vision for the future.

### Evolution of the QOC concept

Key quality-of-care concepts were defined in 1989 and the early 1990s by Judith Bruce and Anrudh Jain, two researchers for the Population Council.<sup>2</sup> The Bruce-Jain framework, which included six elements of quality largely pertaining to clinical services, prompted the development of numerous useful tools and procedures for assessment and improvement of QOC. However, it soon became obvious to IPPF that something more was required: in particular, quality was unlikely to improve unless the strategy enhanced the motivation of service providers and managers and gave them a sense of "ownership" of the programme; they needed a supportive and trusting environment.

The argument for high-quality care can be made from two perspectives – that of the service provider and that of the client. Clearly, the service providers will be happy to see clients

appreciating the service more and coming in greater numbers, and this will enhance their job satisfaction. The clients, in turn, will look for high-quality care encompassing respect for their rights and dignity. It was from this second principle that IPPF developed the framework entitled *Rights of the Client*, first published in 1992,<sup>3</sup> specifying ten entitlements for clients receiving sexual and reproductive health services (Panel 1). This publication was followed later that year by distribution of a poster with the same name – a highly popular resource that can be seen in FPAs and service delivery points around the world, translated into numerous languages.

The *Rights of the Client* framework was important in developing awareness of QOC and new perspectives on how to achieve it. It became clear, however, that service providers have their own set of needs if they are to fulfil those rights. Thus, IPPF developed the *Needs of the Service Provider* framework to complement the *Rights of the Client*. This lists ten elements required by service providers to deliver high-quality services that respect clients' rights (Panel 1).<sup>4</sup>

PANEL 1: Clients' rights and providers' needs

Clients' rights SRH clients have the right to:	Providers' needs Service providers need:
Information	Training
Access	Information
Choice	Good infrastructure
Safety	Supplies
Privacy	Guidance
Confidentiality	Back-up
Dignity	Respect
Comfort	Encouragement
Continuity of services	Feedback
Opinion	Opinion

In 1995 an article published in the *IPPF Medical Bulletin* suggested that motivation to perform well is affected not only by what individuals desire or expect for themselves, but also by altruism – a desire to do something for the benefit of others.<sup>5</sup> The article proposed that motivation to perform well is strongest when providers are fully aware of the importance of what they do for other people, when they feel that they are part of the service and not just employees, when they are supported by proper training, supervision, guidance and supplies, when their opinion counts, and when their work is recognised and respected. Subsequent research conducted by IPPF in collaboration with GTZ yielded results consistent with these concepts.<sup>6</sup>

In 1999, an evaluation of the medical and technical function at IPPF showed that, although international organisations, including IPPF, were developing useful concepts and tools to enhance QOC, these advances were not always reflected by improvements in actual practice.<sup>7</sup> The evaluation revealed, for instance, that medical and technical advice and information generated at IPPF central office often failed to reach those who most needed them – service providers in the field. The recommendations from this evaluation led to development of the programme described below.

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## The QOC programme

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The Strengthening the Quality of Reproductive Health Care Programme (QOC Programme) is a five-year initiative funded by the Bill and Melinda Gates Foundation which aims to achieve systematic improvements in the quality of care provided by FPAs. Now at half-way point, it currently involves 34 FPAs from across the six IPPF regions. At the heart of the programme is the conceptual framework defined in *Rights of the Client* and *Needs of the Service Provider*, with its emphasis on motivation, participation, good communication, collaboration, teamwork, and trust. From this has been developed a process to help participating FPAs improve the quality of care they provide.

12 FPAs participated in phase I of the programme, beginning in 2002, and in 2003 an additional 22 were added for phase II. At FPA level the quality improvement process involves the following broad steps:

- *Step 1* – FPA service delivery points (SDPs) conduct self-assessment of the quality of the services they provide. At the same time, clients are interviewed to obtain their views on services they receive. Thereafter, SDPs develop and submit to the FPA headquarters an action plan which addresses deficiencies in QOC
- *Step 2* – FPA headquarters consolidate all SDP action plans and assess the quality of their own management practices. They then develop an overall FPA action plan that deals with deficiencies in quality identified at both SDP and headquarters levels. This plan is submitted to IPPF for funding
- *Step 3* – FPAs implement their action plans with financial assistance not only from IPPF but also, in many instances, from the community, other donors, and their own funds
- *Step 4* – Once an action plan is completed, the FPA is eligible to receive a QOC award to recognize and honour the achievement of a high quality of care, as determined by an external evaluation team.

### Self-assessment

With its reliance on self-assessment, the programme is very different from conventional approaches to evaluation of reproductive health care and services. In the past, evaluations were often conducted primarily by “outsiders” such as supervisors or technical assistance agencies, with the service providers having little influence on either the content or the method. In these circumstances external assessment tends to be seen by service providers as a threatening event, and it does little to improve motivation or enhance the quality of care.

The QOC Programme builds on the self-assessment methodology known as COPE (client-oriented, provider-efficient) developed by AVSC International, now EngenderHealth.<sup>8,9</sup> Adopting the self-assessment approach, IPPF developed tools and procedures that enable FPA staff to appraise their own services and management practices and decide for themselves on the action plan that will best address any gaps identified in the quality of services. In this context the term “staff” includes any person involved in the day-to-day running of SDPs or FPAs, including doctors, managers, nurses, midwives, cleaners, supervisors, drivers, and accountants; thus, all kinds of personnel participate in the identification of QOC problems and implementation of solutions. The programme represents a move away from the culture of blaming individuals for negative aspects of their work. Instead, it starts from the principle that, if something is below the required standard, the reason is not that people wish to perform poorly but that they lack the tools necessary to perform well; they may lack training, infrastructure, supplies, or motivation – all elements that can be improved.

In early 2003, 9 out of the first 12 participating FPAs completed their self-assessments and began implementing their action plans for improving quality of care in their organisations. 160 SDPs were participating at this stage. Sometimes the self-assessment exercises in SDPs have led to improvements at little or no financial cost – for example, extension of service hours to better accommodate the needs of young people and working women, or rearrangement of clinic space to give clients more privacy. Several FPAs have made contributions from their own funds or secured additional resources from their communities. Staff at all levels have made valuable contributions to the quality improvement process. An example is the cleaner who drew attention to the poor state of the client rest-room – which most of the service providers had not noticed because they never used it.

### Training

Complementing the self-assessment and action plan development process is a comprehensive training curriculum which aims to build FPA expertise in specially identified topics essential for QOC. Training topics in the QOC programme include: introduction to QOC and self-assessment, supportive supervision, IPPF *Medical and Service Delivery Guidelines*, infection prevention, interpersonal communication, and counselling.

Training activities are built on the “cascade” model, designed to transfer knowledge and skills in an ever widening network. It begins with training of a core group of regional and central office IPPF staff who then train groups at regional level, who train groups at FPAs, who train groups at SDP level. Importantly, the sessions pass on not only specific knowledge about QOC but also new hard skills in training and facilitation techniques. The aim is to enable FPAs and SDPs to become local experts in a given subject, thus helping to ensure the long-term sustainability of the programme. A *QOC Training Manual* and a *Reference Manual* on training and facilitation skills were developed, and 24 in-country, 13 regional, and 2 inter-regional training sessions had been conducted up to August 2003. At FPA level, more than 400 individuals had been trained in self-assessment. Training on supportive supervision is now underway among the first FPAs, while those FPAs that joined in 2003 are themselves being trained in QOC and self-assessment.

Early experience indicates that the cascade model of training works well. Several of the FPAs that participated in phase I are now taking a lead role in training the new FPAs that joined the programme in 2003. Several FPAs are also planning to “sell” the quality improvement process to other organisations and health clinics in their home countries, once they have completed the process.

### Motivation

As indicated earlier, motivation is seen as a key part of the QOC programme, essential to the development of a quality-of-care culture. The involvement of senior management is particularly important if the programme is to be successful and for the benefits to be maintained. Experiences with the first 9 FPAs indicate that, once staff understand the centrality of their opinions and recommendations, motivation and support for the quality improvement process improve substantially. It is noteworthy that half the questions on the SDP self-assessment questionnaire deal with providers’ needs; this ensures that important issues such as training, feedback on performance, respect, and encouragement are properly discussed and addressed in SDP and FPA action plans.

## Next steps

In the coming months, most of the phase II FPAs are expected to complete their self-assessments and begin implementation of their action plans. Phase I FPAs continue to implement their action plans and several will be ready to be assessed for a QOC Award in the first half of 2004. Meanwhile, training at all levels continues. The next inter-regional training, for example, is scheduled for November 2003, and will focus on IPPF's *Medical and Technical Guidelines* and infection prevention techniques. Regional and in-country training sessions will follow.

## Conclusion

Initial experience with the QOC programme supports the idea that self-assessment is a simple, cost-effective, and appropriate way to identify areas where quality of care should be improved. The use of self-assessment has also helped increase staff motivation and improve relations between service providers and managers. As one regional QOC advisor described the effects of the self-assessment: "[staff] now look at themselves as a team... there has been a kind of *transformation*". In addition, the targeted training activities have been successful in transferring skills from level to level. The achievement of high-quality care is a long-term process and these are early days, but the results suggest that the first steps towards a QOC culture have been taken.

## The Standard Days Method for family planning

Victoria H Jennings, Marcos Arevalo

Millions of women around the world – as many as 1 in 4 fertile women in some countries – try to avoid pregnancy by periodic abstinence from sexual intercourse. Their rate of unplanned pregnancy is high, because few can accurately identify the days of their cycles when they are likely to become pregnant. A way to meet this need, at least in part, is offered by the Standard Days Method (SDM), developed at the Institute for Reproductive Health, Georgetown University, Washington, DC, USA. The SDM is a fertility-awareness-based method appropriate for women with regular menstrual cycles between 26 and 32 days long. It identifies days 8 through 19 of the menstrual cycle as the "fertile window" – the days when pregnancy is very likely. To prevent pregnancy, the couple avoids unprotected intercourse during the 12-day fertile window, by using a barrier method or by not having sex.

In a multisite prospective study of 478 women, the SDM had a one-year failure rate of 4.8 % when used correctly.<sup>1</sup> When all pregnancies were considered – those in which couples avoided unprotected intercourse on days 8-19 and those in which they did not - the failure rate was 11.9%. This compares well with the results of several user-dependent methods offered by family planning programmes (Panel 1). The method was used correctly in about 97% of cycles. Similar typical-use

PANEL 1: Comparison of SDM with other methods. Adapted from *Contraceptive Technology*, 17th edition 1998

	Percentage of women pregnant in 1st year of use	
	Correct use	Typical use
Chance	85	85
Periodic abstinence	1-9	25
Spermicides	6	26
Diaphragm	6	20
Female condom	5	21
Male condom	3	14
SDM	5	12
Pill	0.1	5

*Acknowledgment* I thank Susanne Hamm for editorial assistance

*Dr Carlos Huezo is Medical Director, IPPF, Regent's College, Inner Circle, Regent's Park, London NW1 4NS, UK. E-mail: huezo@ippf.org*

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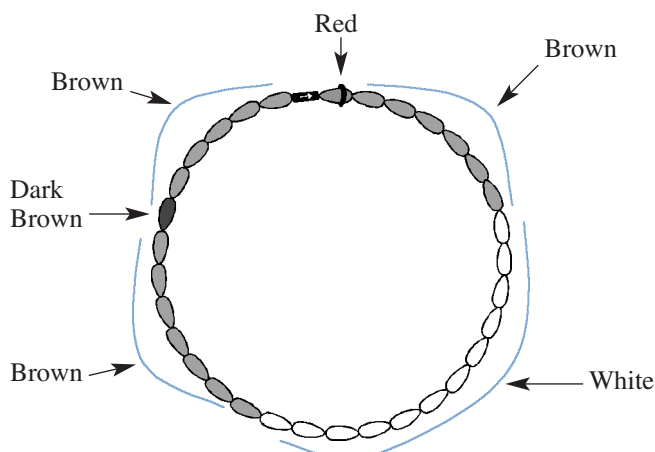
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failure rates have been reported in further studies conducted in several countries ([www.measuredhs.com/countries.start.cfm](http://www.measuredhs.com/countries.start.cfm)).

## The method

CycleBeads (Figure 1) are a tool to help couples learn and use the SDM. They help a woman keep track of her cycle days and know when she is fertile. Each bead represents a day of the cycle. On the first day of her menstrual period, she puts the black ring on the red bead. She moves it forward one bead each day. When the ring is on any of the brown beads, pregnancy is very unlikely. When it is on any of the white beads, she has a significant probability of pregnancy and should avoid unprotected intercourse. CycleBeads also help her monitor her cycle length. If she starts her period before she moves the ring to the dark brown bead, her cycle is less than 26 days long. If she moves the ring to the last bead and does not start her period by the next day, her cycle is longer than 32 days. If either of these occur more than once in twelve months, she should consider another method because the SDM will not be as effective for her as for women with cycles within the 26-32 day range. Studies in several countries around the world indicate that 70-75% of women have one or fewer cycles outside that range in a year.<sup>2</sup>

FIGURE 1: CYCLEBEADS



## Reasons for inclusion in family planning programmes

### Demand

As indicated above, many women now use natural methods that are highly unreliable. In addition, vast numbers worldwide use no method of family planning despite a wish not to become pregnant. The SDM is an option for both these groups, and it also has attractions for the many women who wish to determine the interval before their next birth. Worldwide, more than half the unmet need for family planning is in women who wish to space their pregnancies.<sup>3</sup> This is particularly true for younger and lower parity women.

### Feasibility

Most family planning programmes do not offer a natural method to their clients, primarily because the methods previously available are time-consuming and difficult for both providers and clients. Programme managers lack confidence in their effectiveness or feasibility under these circumstances. In contrast, only a few hours of training are needed for providers to learn how to counsel clients in the SDM, and clients can learn to use the method in a single counselling session of about 20 minutes (though continuation rates and successful use are improved by a follow-up session). The SDM requires no clinical examinations or procedures, and clients do not need to return to the clinic for resupply.

### Expansion of options

Most SDM users are “new” to family planning. In studies conducted in several countries, 50 – 80 % of women who chose the SDM had never used family planning before: Ecuador 60%, Honduras 50%, Peru 88%, Jordan/Benin 48%.<sup>4</sup> Because of its special characteristics, the SDM tends to reach couples with unmet need rather than substituting for established methods.

### Male participation

The importance of including men in family planning and reproductive health has been shown in programmes around the world.<sup>5</sup> Because the SDM requires a change in the couple's behaviour, it necessarily involves the male partner. Studies in rural communities and urban settings indicate that, when men are given information on SDM, correct use increases and pregnancy rates are lower.<sup>6</sup> Successful strategies include reaching men directly through home visits and community-based meetings as well as through the media, and providing women with materials and skills to communicate with their partners about the method.

## Strategies for programme managers

### Provide information on the method

Traditionally, women have learned about family planning methods primarily from relatives, neighbours, or friends. But in the case of the SDM, programmes need to start the flow of information and ensure its accuracy. In addition, research shows that potential family planning users often seek services already knowing which method they want, and that they are likely to use their method longer if they receive the one they initially wanted.<sup>7</sup> So, provision of information about the SDM is an important step in expanding use.

### Include men

With all methods of family planning, male-friendly services, community education, and helping women communicate with their partners can increase satisfaction and correct use.<sup>8</sup> This is particularly true for the SDM. Correct method use relies on both members of the couple, because they need to abstain or use a barrier method for 12 consecutive days each cycle. Experience in a wide variety of settings shows that men can support SDM use in several ways – from assisting their partners with CycleBeads to the use of condoms on fertile days.

### Avoid provider bias

When all methods are offered in an atmosphere of true informed choice, clients receive the method that best meets their individual needs and preferences. Provider bias is a factor in family planning programmes around the world, and many providers are reluctant to offer the SDM if they lack experience with it or are uncertain about its efficacy. Studies in Honduras and Ecuador showed that, although provider training reduced bias against the SDM, supportive supervision was necessary to ensure that the method was offered equally with other methods.<sup>9,10</sup>

### Include the SDM in management information systems

Management information systems are a key source of data on programme performance, so it is important for managers to know how the addition of the SDM affects the method mix and number of clients. Programmes that calculate couple years of protection (CYPs) from their system data can attribute *two* CYPs for each new SDM client. As programmes are beginning to offer the SDM on a wide scale, studies are underway to assess its impact on contraceptive prevalence, methods mix, and attitudes in the community.

### Resources

The Institute for Reproductive Health can supply training manuals, provider job aids, and descriptions of programme experience in many countries ([www.irh.org](http://www.irh.org)). Information on CycleBeads is available from [www.cyclebeads.com](http://www.cyclebeads.com). A CD-ROM on the SDM is available from JHPIEGO as part of its ReproLearn Tutorial series at [JHPIEGO.org/pubs/index.asp](http://JHPIEGO.org/pubs/index.asp). The Institute for Reproductive Health also provides training and technical assistance to selected programmes. Additional information about the method is available in *Contraceptive Technology*, and in the World Health Organization's *Medical Eligibility Criteria for Contraceptive Use and Selected Practice Recommendations for Contraceptive Use*.

*Dr Victoria Jennings is Director, Institute for Reproductive Health, Georgetown University Medical Center, 4301 Connecticut Avenue NW, Suite 310, Georgetown, Washington, DC 20008, USA (e-mail: [irhinfo@georgetown.edu](mailto:irhinfo@georgetown.edu)). Dr Marcos Arevalo is Director of Biomedical Research at the Institute.*

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