IPPF International Planned Parenthood Federation

Quality of Care

Quality of Care Newsletter

IPPF working for clients' rights

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

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Special Issue

"The quality of care process is a beginning, not an end"

Introduction

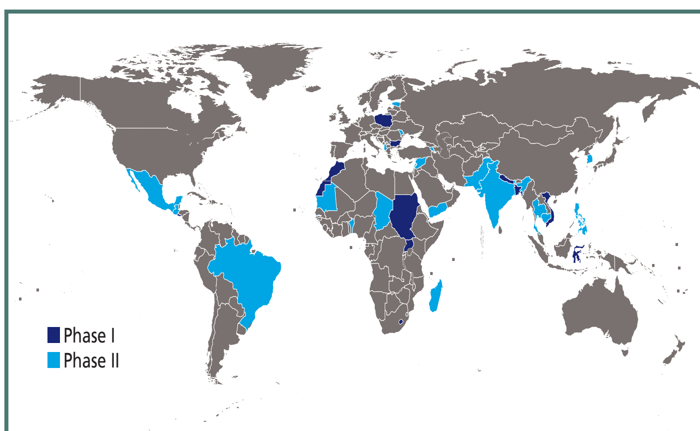
The IPPF Strengthening the Quality of Reproductive Health Care programme (the QOC programme) was launched in 2001 as a five year, multi-country initiative to improve the quality of sexual and reproductive health services that are provided by IPPF service delivery points around the world. The programme arose from the finding that, while many Member Associations have long delivered very high-quality service standards, no uniform quality assurance system existed to guide the Federation, and many Associations were keen to have assistance in this area.

The broad aim of the programme was to define a standard of care to which all Associations could aspire. The overall approach was this: to identify and nurture a systems approach among health providers and managers to routinely apply improvement tools and techniques aided by a supportive organizational culture that values change and integrates service improvement into its daily life. The specific objectives of the initiative were three-fold:

1 to develop a system of quality improvement based on essential quality standards;
2 to improve the medical and technical training provided for service providers; and
3 to improve the quality and availability of technical information related to sexual and reproductive health care.

Thirty four Member Associations from across IPPF's six regions were involved in the programme, which was rolled out in two phases: 12 Associations "pioneered" the process in 2002, followed by 22 Associations in 2003/2004.

Countries participating in the QOC programe 2001-2006



Region	Phase i	Phase ii
Africa	Uganda Lesotho	Benin Chad The Gambia Madagascar
Arab world	Sudan Morocco	Lebanon* Mauritania Syria Yemen
European network	Poland Bulgaria	Albania Armenia Estonia Moldova*
East / South-East Asia and Oceania	Vietnam Indonesia	Cambodia DPRK Philippines Thailand
South Asia	Nepal Bangladesh	India Pakistan
Western Hemisphere	El Salvador Trinidad & Tobago	Brazil Guatemala Mexico Venezuela

* Programme terminated in 2005/06 due to broader governance issues

Needs Analysis: gaps in quality of care

At the outset, these areas of improvement in quality of care – though by no means present in every case – were identified, based on initial need assessments in 2001/2, on self-assessment exercises, and on preliminary monitoring visits:

- supervision visits to service delivery points were inadequate
- there was a need for a rights -based approach to service provision
- physical conditions, infrastructure, and equipment at service points needed replacement and upgrading
- infection prevention procedures required standardisation
- logistics management systems required improvement
- staff morale was low and more training was identified as an urgent need
- effective mechanisms to monitor and improve quality of care were lacking
- referral systems were weak and client follow-up needed to be reviewed
- communication channels between headquarters and clinics called for greater effectiveness
- systems for dissemination of technical information needed upgrading
- translation of information materials for clients was not done due to high costs

Programme funding structure	
Total grant:	US$ 8,865,000
Central Office	US$ 2,875,200
Regional Office (6)	US$ 2,911,800
Each Regional Office	US$ 485,300
Members Associations (36)*	US$ 3,096,000
Each Members Association	US$ 86,000 (average)

*34 Associations eventually took part in the programme.
Average funds per Association adjusted for the four Associations in the South Asian region.

Strategies for improvement

1 The quality improvement process: from self-assessment to action plan

At the heart of the QOC programme is the IPPF Rights Charter which encompasses the rights of clients and needs of providers to ensure comprehensive clients-based programming. This framework lists ten elements required by service providers to deliver high quality services that respect clients' rights (Panel 1).

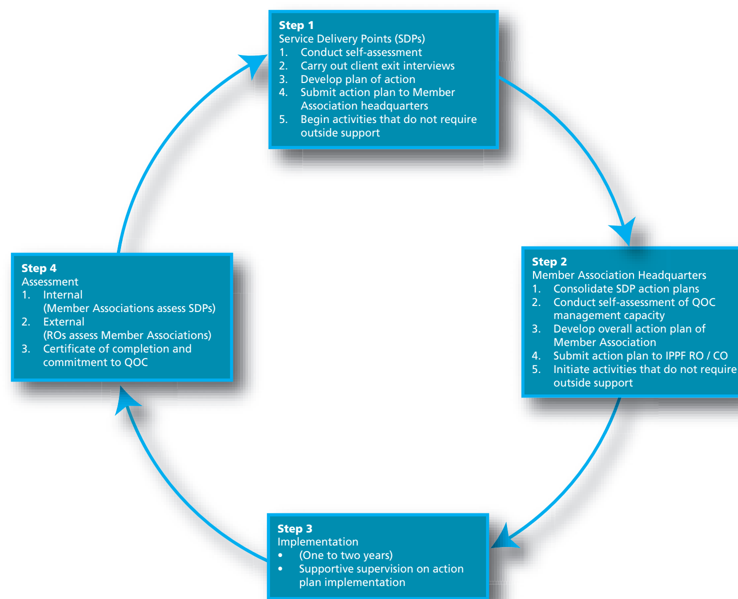
Client's rights SRH clients have the right to	Providers' needs Service providers need
Information	Training
Access	Information
Choice	Good infrastructure
Safety	Supplies
Privacy	Guidance
Confidentiality	Back-up
Dignity	Respect
Comfort	Encouragement
Continuity of services	Feedback
Opinion	Opinion

PANEL 1

Building on the Rights Charter, four core tools were developed to guide the quality improvement process: 1) essential quality of care standards; 2) self-assessment questionnaires for service providers and managers; 3) client exit interview questionnaires; and 4) monitoring and evaluation tools.

The approach to quality improvement is based on self-assessment. The self-assessment process enables Member Associations to appraise their own services and management practices and effectively decide an action plan that will best address any gaps identified in the quality of services. In other words, it is local staff who identify the areas that require improvement and decide what needs to be done, why, how, when and by whom.

The key steps in the quality improvement process are described in graph 1.



Graph1 The IPPF quality improvement process

In total, over 450 service delivery points undertook a self-assessment exercise and developed an action plan for quality improvement.

2 Emphasis on participation, motivation and teamwork

Participation, motivation and teamwork are key components of the quality improvement process. The full and meaningful involvement of all staff who are part of the day-to-day running of clinics and Member Associations is a critical aspect.

This might include, for example, doctors, managers, nurses, midwives, cleaners, supervisors, drivers, and accountants. Thus, all personnel – regardless of position or rank – participate in the identification of quality of care issues and in the implementation of solutions. Participation also includes clients, who contribute through client exit interviews and other feedback mechanisms. In practice, the approach provides a unique opportunity for staff to come together, discuss ideas, share suggestions and work out solutions for gaps in service delivery and management.

Encouraging a sense of commitment and motivation for the programme among health providers and managers is essential if quality of care is to be sustained over the long term. As such, the training programme and self-assessment exercises are designed not only to increase participants' knowledge and skills related to quality of care, but also to strengthen their motivation for the quality improvement process. Often, these activities bring staff members together for the first time: managers and drivers, service providers and accountants. This interaction helps to change people's behaviour towards each other and challenge traditional hierarchies.

3 Focus on providers

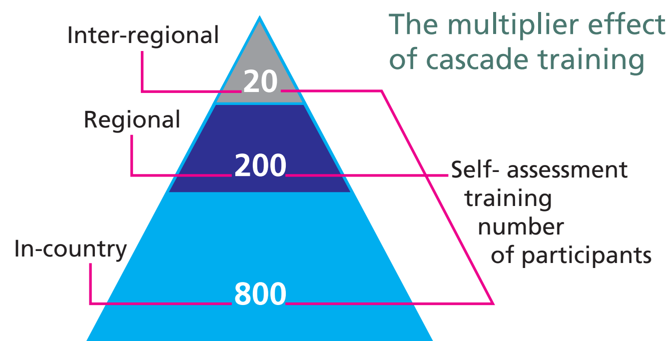
Improving training for service providers and Member Association staff is a key strategy to improve the quality of services. Training sessions aim to pass on specific knowledge about quality of care, such as interpersonal communication and prevention of infection techniques, as well as new skills in training and facilitation techniques. Ultimately, the aim is to enable Member Association and clinic staff to become local experts in this capacity. Thus, the training methodology follows the "cascade model", whereby core groups are instructed in functional skills

(including training techniques) and these master trainers train more staff in a cascade fashion. Typically, the process began with inter-regional training and then cascaded to the regional and in-country levels.

Core training topics were identified and training packages developed accordingly, covering a number of ideas, some of which were:

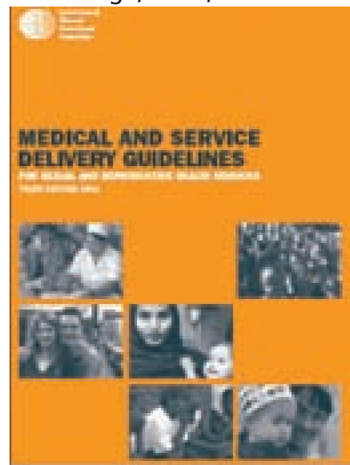
- Quality of care, self-assessment and facilitation skills
- Supportive supervision
- Implementation and dissemination of the IPPF Medical and Service Delivery Guidelines
- Counseling and interpersonal communication (in association with WHO and the WHO Decision-making tool for family planning- DMT)

In addition to these programme-driven trainings, the self-assessment process led Member Associations to undertake other training needs that were specific to their Member Association or to service points. Trainings covered the full range of sexual and reproductive health issues, revealing the comprehensive nature of Member Association services. Thus, trainings were provided on emergency contraception, youth-friendly services, STIs, HIV, and AIDS, cervical cancer screening, gender-based violence, implant insertion and removal, to name but a few topics.



4 Evidence based guidelines

To accompany the quality improvement process, IPPF developed updated medical and service delivery guidelines to improve the knowledge, skills, and confidence of clinic staff in delivering high quality services. Based on a clients' rights approach, the IPPF *Medical and Service Delivery Guidelines for Sexual and Reproductive Health Care (2004)* provides up-to-date and evidence-based guidelines on a range of sexual and reproductive health care issues. The guidelines were made consistent with the WHO *Medical Eligibility Criteria for Contraceptive Use* and *Selected Practice Recommendations for Contraceptive Use.* As with past editions, the Guidelines draw on the technical expertise of IPPF's International Medical Advisory Panel (IMAP).



To strengthen implementation of the Guidelines at the field level, a training curriculum on the dissemination and utilization of the Guidelines was also developed, and implemented, again, using the cascade approach. The training's focus covers both the technical updates provided for in the Guidelines as well as dissemination strategies designed to improve the likelihood that the Guidelines will be put into practice. This trained more than 500 participants.

Translation of the Guidelines into IPPF's official languages was also a priority. As of 2006 the Guidelines are available in English, Arabic, French, and Spanish. Finally, to complement the Guidelines, a range of other medical and technical publications were produced (see page 8).

5 Instituting supportive supervision

A supportive supervisory system is essential to ensure that standards are maintained for service delivery. Supportive supervision encourages and facilitates the participation that is needed to identify quality of care gaps and areas for improvement, and emphasizes teamwork, coaching, and motivation. Supportive supervision should transform the 'controlling' or 'policing' style of supervision into a continuous process of empowerment, one that assists staff in improving the quality of their work and personal performance.

Within supportive supervision, individual performance is emphasized only as it relates to the ability of the team to achieve common goals. This approach has a forward focus; it looks at systems, processes and team productivity more than the shortcomings of individuals. Within the context of the quality of care programme, supportive supervision encourages the whole team to:

- become knowledgeable about quality of care standards and ensurethat the standards are met
- find out what is assisting or hindering implementation of the quality of care action plan
- identify and implement ways to improve quality
- monitor progress towards implementation.

6 Assessing and certifying quality improvements

Assessing and recognizing the efforts of Member Associations who successfully improved the quality of their services is the last step in the improvement cycle. This is provided in part by awarding a "Quality of Care Certificate" from IPPF. The process takes place at individual service delivery points and the overall management level and is based on an assessment of the extent to which the Member Association has implemented its action plan and meets the essential QOC standards and criteria defined in the programme. The process is guided by comprehensive assessment tools based on the Rights / Needs Framework.

Following a successful assessment (at least 85% of standards met), Member Associations are eligible to receive a "Quality of Care Certificate" to affirm their commitment to quality sexual and reproductive health services. Perhaps more importantly, the certification event is an opportunity for staff to celebrate and take pride in their achievements and to raise awareness in the wider community about their services.

Regional profiles

This section provides a highlight of programme implementation and results from the assessment process across the six IPPF Regions.

Africa Region (AR)

In Africa Region, the QOC programme was launched in two Anglophone Member Associations: **Uganda** and **Lesotho** in 2002. It was then expanded in 2003 to the Gambia and three Francophone Associations: **Chad, Benin,** and **Madagascar**. About 40 service delivery points participated in the initiative. Clinics and Member Association headquarters undertook self-assessment exercises and developed an overall action plan for quality improvement.

While Member Associations differed in terms of specific quality gaps, common challenges in the region included: poor clinic infrastructure, outdated and worn out equipment, low staff morale and high workload, inadequate updated information materials for clients and providers, weak supervision systems, poor attention to clients' confidentiality, privacy and comfort. To address these gaps, action plans were developed and implemented over a period of two years.

Meeting provider needs:

Fianakaviana Sambatra (FISA) Madagascar

The activities listed below provide examples of interventions identified by FISA to meet providers' needs.

QOC Standard	QOC intervention
Need for training	• organized provider trainings in SRH topics; developed monitoring plan to follow-up on training activities; collaborated with partner agencies to provide training
Need for information	• provided clinics with information on the Member Association's goals and objectives; updated job descriptions; updated publication mailing lists
Need for infrastructure	• carried out clinic renovations in selected clinics; replaced old furniture and equipment
Need for supplies	• established contracts with suppliers to ensure regular maintenance of clinic equipment; ensured commodity supplies
Need for guidance, back-up and support	• organized regular information sharing meetings; routinely collected client feedback.
Need for respect and encouragement	• provided feedback to staff via regular staff meetings and appraisals; organized "staff recreation days" once per year
Need for feedback	• trained supervisors in supportive supervision; analyzed and discussed service statistics in each clinic; provided regular feedback.
Need for self-expression	• organized monthly staff meetings in all clinics; carried out regular self-assessment on an annual basis

External assessments were undertaken in AR in 2005/2006. The results showed that Member Associations made significant improvements to the quality of care provided. Certificate events have been planned in five Associations.

Results of the external assessment

Association	Achievement of QOC standards
Benin	**87.3%**
Chad	**82%**
Lesotho	**95.8%**
Madagascar	**85%**
The Gambia	**98.6%**
Uganda	**98.6%**

Profile: External assessment in Lesotho

"QOC has been an eye opener to us; before we were offering services and thinking that they we were doing very well. But after the QOC programme, we realised that we were not doing justice to the clients, in particular in relation to their rights; now you can see how we feel satisfied and proud of ourselves…."

Senior nurse at the Mohale Hoek service point Lesotho Planned Parenthood Association

The Planned Parenthood Association of Lesotho (LPPA) began programme activities in eight clinics in 2002. Following two years of implementation, an external assessment of LPPA took place in September 2005. The assessment involved site visits to three clinics, in depth review of programme reports and service statistics, and interviews with staff, providers and clients.

A significant outcome noted by the assessment team was the change in management's attitude towards staff. The result was an increase in staff motivation and a sense of belonging to the organization. The external report states that:

"The programme has increased management's respect towards service providers; service providers and others are called to headquarters for meetings. The support staff is also involved and better understands the work of the SDPs. The cleaners are now permanent employees and the clinics are very clean. The cleaners are motivated and neat because they have uniforms. In the Maseru clinic, the cleaner is applying quality of care in her work; she can state the services being provided and knows that the facility should be clean and ensures that clients are comfortable. She has received training on how to use condoms both female and male and on infection prevention such as the use of gloves and garbage disposal; she can conduct health talks on condoms use."

Another noteworthy finding was that the quality of care approach has been mainstreamed in the operating procedures of the Association. The team found that "*QOC has helped to set standards and work procedures and to change providers' mindsets to appreciate quality*". As a result:

- supportive supervision is applied in all projects and conducted on a regular (quarterly) basis
- action plans are used for all other projects
- action plan forms are used to plan routine activities in the clinics
- the project design in clinical access programmes facilitates continuity with core activities
- regular client exit interviews and analysis of findings from the suggestions boxes are undertaken

Overall, the assessment team found that the 68 out of the 71 quality of care criteria were met (96 percent). Out of the 31 planned interventions, 26 were accomplished, 1 is in progress and 4 were not addressed. In total, 85.5 percent of the planned activities were implemented.

Service provider at Fianakaviana Sambatra (FISA), Madagascar

Arab World Region (AWR)

In the Arab World Region, Member Associations in **Lebanon**[1], **Mauritania, Morocco, Sudan, Syria,** and **Yemen** took part in the initiative. This involved the participation of 51 service delivery points.

While each Member Association had unique concerns, the self-assessment exercises revealed common priority areas for improvement. These were: introducing clinic guidelines, updating providers' knowledge and skills and increasing their motivation, improving clinic infrastructure and logistic management systems, and introducing mechanisms to measure client satisfaction and feedback.

When initiating the programme, Member Associations were encouraged to integrate activities from other projects into the quality improvement action plan and to seek funds from other donors to support quality of care activities. A number successfully did so. Thus, the quality improvement process was integrated, from the start, into Member Associations' broader plans, rather than it being treated as a stand alone project. At the Sudan Family Planning Association (SFPA), for example, the quality of care programme operated in the context of an established IPPF Vision 2000 project which runs 12 community health centers. The assessment tools were used to assess quality of care gaps and identify interventions in order to strengthen the quality of the care provided at these health centres.

Member Associations were also able to mobilize additional funds to support the quality of care interventions identified during the self-assessment exercises. For instance, the Global Fund supported the introduction of voluntary testing and counseling (VCT) services in the Port Sudan clinic of SFPA, and funding from WHO and UNICEF supported training activities identified by the Syrian Family Planning Association.

An impressive outcome in the Arab World Region is that self-assessment served as a catalyst to expand the range of services offered by Member Associations. Clinics are able to offer services that are more comprehensive and responsive to clients' needs. **For example:**

- the management of sexually transmitted infections (STIs) was integrated in six Member Associations
- voluntary testing and counseling services (VCT) were integrated in three Associations (Sudan, Lebanon and Syria)
- youth-friendly services were integrated into four Associations (Morocco, Sudan, Mauritania, and Lebanon)

Quality of care training at the Family Planning Association of Sudan

External assessments were undertaken in all Member Associations in Arab World Region in 2005/2006. All Member Associations demonstrated evidence of action plan implementation and accomplishment with the QOC standards and criteria, and have received the QOC Certification.

[1]Programme terminated in 2006 due to broader governance issues.

Results of the external assessments in AWR

Association	Achievement of QOC standards
Mauritania	93%
Monocco	96%
Sudan, Syria, Yemen	92%

European Network (EN)

Member Associations in **Albania**, **Armenia**, **Bulgaria**, **Estonia**, **Moldova**[2] and **Poland** participated in the QOC programme. The EN distinguished itself by undertaking two rounds of self-assessment among its Member Associations. Follow-up action plans were submitted by four Member Associations. In practice, the approach provided an excellent opportunity to take stock of achievements mid way through implementation, to make adjustments, and to reorient priorities as needed. A total of 36 service delivery points improved their quality of care under the QOC programme.

Major changes before and after the QOC programme among participating service points can be summarized as follows:

Before	After
• few or no services available • low supply of free contraceptives and services • little support from MA headquarters • QOC standards not up-to-date • poor team spirit	• wide range of services provided by SDPs • free contraception and services are readily available • supportive supervision and trainings from Member Association headquarters • up-to-date standards on high quality SRH care • enthusiastic team members

External assessments were completed in 2005 and showed that all five Member Associations met the quality of care standards and were eligible for certification.

Results of the external assessments in EN

Association	Achievement of QOC standards
Albania	98%
Armenia	96%
Bulgaria	97%
Estonia	96%
Poland	94%

[2]Programme implementation in Moldova ended in 2005 due to reforms in the national health sector and Association governance issues.

Profile: Supportive supervision in Bulgaria

The Bulgarian Family Planning and Sexual Health Association (BFPA) was among the first in the European Network to initiate the QOC programme in 2002. The programme provided the necessary tools for the Association to meet the essential needs of seven service sites for clinical equipment, training and medical commodities.

The supportive supervision approach was particularly appreciated and noted as "*fundamental*" to the achievement of the quality improvement process. According to the Association, the supportive supervision approach:

- improved interaction and feedback between the member association headquarters and service delivery points
- strengthened monitoring and internal evaluation within the association
- played a significant role in the proper implementation of the Association's working plans and in strengthening its organizational capacity; and
- will persist as an important part of the Association's work in future.

High quality standards at Towarzystwo Rozwoju Rodziny (TRR), Poland

East & South East Asia and Oceana Region (ESEAOR)

Member Associations in **Vietnam, Indonesia, Philippines, Cambodia, Thailand** and the **Democratic Peoples Republic of North Korea** participated, including a total of 100 service points.

Geography, language barriers, and the large size of three Member Associations were significant hurdles that ESEAOR worked hard to overcome. The number of service sites in the Associations in Philippines and Indonesia, for example, meant that the funding available per clinic was is some cases insufficient to meet all of the initial gaps identified. As in other regions, prioritization and additional fundraising was required to meet the identified needs. However, all Associations worked diligently to implement their action plans in order to meet the QOC standards required to achieve certification.

Meeting Clients' Rights

The activities initiated by the Family Planning Organization of Philippines (FPOP) demonstrate some of the relatively straightforward measures that can be implemented to meet clients' rights and improve quality of care.

Quality of Care Standard	Quality of Care interventions
Rights to information	• IEC materials developed, produced and distributed to 33 clinics • other IEC materials from partner agencies collected, printed and distributed
Rights to information	• "Rights of the Client" poster printed, translated into 7 local dialects and distributed
Rights to access	• new sign posts and list of services and working hours prominently displayed at all clinics
Rights to choice	• service providers trained on counseling using the WHO DMT • copies of DMT distributed and in use at all clinics
Rights to safety	• infection prevention techniques integrated in the training on the IPPF Guidelines • laminated infection prevention procedures displayed and monitored by supervisors • equipment purchased, including autoclave, sterilizers, IUD insertion kits and new speculums
Rights to privacy	• all clinics either rearranged and/or renovated to ensure client privacy • five clinics provided separate rooms for counseling
Rights to continuity of care	• database of client contact numbers being developed for follow up • referral system strengthened
Rights to cofidentiality	• client records kept in locked cabinets in all clinics
Rights to comfort	• water dispensers purchased and placed in client reception areas • "kiddie corners" set up at all clinics • toilet facilities repaired
Rights to opinion	• suggestion boxes set up • client exit interviews initiated and feedback used to improve services

Results of the external assessment process in ESEAOR

Phase	Year of initiation	No. of SDPs	Level of action plan implementation	Achievment of QOC standards
Phase 1 Vietnam	August 2003	19	100%	96%
Phase 1 Indonesia	August 2003	20	100%	94%
Phase 2 Philippines	January 2004	33	85%	89%
Phase 2 Thailand	April 2004	9	100%	95%
Phase 2 DPRK	April 2004	10	85%	96%
Phase 2 RHAC	April 2004	9	90%	97%

Clients at a clinic of the Korean Family Planning & Maternal Child Health Association of DPRK

South Asia Region (SAR)

Compared to other regions, four Member Associations participated in the QOC programme in the South Asia Region. These were **Bangladesh, Nepal, India** and **Pakistan**. However, the size of the Associations in India, Nepal and Bangladesh meant that a full 116 service delivery points undertook self-assessment and developed action plans for quality improvement. External assessment of all four Associations was carried out in 2005/ 2006. Certification in SAR will be provided after sustainability has been monitored for another year.

Priority attention in the quality improvement process was paid to investment in infrastructure and systems improvement, particularly in relation to clients' rights to privacy, safety and information. Strengthening providers' skills and expertise was also a priority intervention. Key actions included:

- improved clinic infrastructure:
  - separate rooms and client waiting areas
  - new / repaired equipment (autoclaves, anatomical models)
  - electricity back up
  - waste disposal
  - water supply
  - sign boards for the clinic and for service areas
- improved the availability and quality of IEC materials for clients and service providers
  - translation of "Clients' Rights" posters in local languages
  - translation and dissemination of IPPF Guidelines (in Urdu and Nepali)
  - translation and implementation of WHO Decision-making tool for family planning (translated in Nepali, Bengla, Urdu and Hindi, Kannada, Tamil, Marathi)
- Instituted internal assessment and supervision
- Initiated cascade training for providers (see table on page 7).

Numbers trained in programme-initiated training activities

Types Of Training	Master Trainers Trained in Regional Trainings				Service Providers/Supervisors trained in Member Associations			
	FPAB	FPAN	FPAI	FPAP	FPAB	FPAN	FPAI	FPAP
Self-Assessment and Motivation	5	5	10	8	52	51	54	35
Supportive Supervision	6	4	6	4	35	35	49	28
Utilization of Guidelines	6	5	6	4	116	101	65	50
Counseling and use of DMT	8	4	6	4	124	58	62	22

Profile: Family Planning Association of Pakistan (FPAP)

FPAP's action plan focussed on the strengthening of infrastructure, purchase of equipment & instruments, and development of IEC materials and training materials in local languages. Training was also a major focus. The cascade trainings incorporated into the IPPF QOC Programme took place in batches to cover all of the service providers and supervisors. In addition, training in HIV/AIDS and emergency contraception took place in response to self-assessment. The achievements highlighted by FPAP, and the observations of the external assessment team, were as follows:

- Improved quality of services – quality of care funds were used to organize a number of technical/skills building sessions to upgrade the skills of medical officers and para-medical staff.
- Improvement in general administration and communication between regional offices and headquarters, especially on service delivery matters.
- Clients' feedback – solicitation of client feedback on cleanliness of the hospital, attitude of staff, client satisfaction with medical treatment, and service charges.
- Quality consciousness of service providers – hospital staff expressed the view that quality of care tools had generated quality consciousness in the delivery of services, including in interaction with clients.
- Dilution in the hierarchical structure within the hospital – monthly staff meetings and self-assessment tools gave an opportunity to all staff to interact with different levels of service providers and share their views.
- Translation of the IPPF Service Delivery Guidelines into Urdu which will be implemented across FPAP.
- Increase in IEC materials – under the Quality of care programme, FPAP produced a number of IEC material on STI/HIV/AIDS and reproductive health, and anatomical models.

Service provider at the Family Planning Association of India (FPAI)

Western Hemisphere Region (WHR)

Member Associations in **Brazil, El Salvador, Guatemala, Mexico, Trinidad and Tobago**, and **Venezuela** participated in the QOC programme. A total of 100 service delivery sites benefited from the initiative and are now better equipped to provide quality services.

The primary changes "**before**" and "**after**" programme implementation in WHR are summarized as follows:

Before	After
• no QOC standards in place • lack of effective mechanisms to monitor and improve QOC • insufficient training plans to improve knowledge, skills and attitudes of service providers • procedures and protocols for service delivery not consistent with international guidelines • lack of effective communication channels between managers and service delivery sites. • low motivation at service delivery level	• QOC standards and criteria implemented and institutionalized at all levels • quality improvement process successfully implemented and institutionalized at the 6 Associations • providers trained, enabled, committed and motivated at service delivery level • Service Delivery Guidelines updated, distributed and disseminated • The quality improvement process enhanced communication and the capacity to solve problems • decision power decentralized • supportive supervision process established • infection prevention procedures standardized

Profile: Interventions to improve quality of care in MEXFAM (Mexico)

Mexfam began programme activities in 2004. Key quality of care interventions that were identified and implemented were as follows:

Activities/Interventions	Comments
1. QOC and self-assessment training	38 participants trained
2. Self-assessment and action plan development at 18 MEXFAM's clinics	18 MEXFAM's clinics applied the QOC self-assessment manual and developed and implemented QOC action plans
3. Training in counseling Skills and Use of WHO DMT	24 participants (physicians and nurses from MEXFAM clinics nationwide)
4. Supportive Supervision training	20 participants – District Supervisors and Clinic Supervisors
5. Training in Infection and Prevention	24 participants (physicians and nurses from MEXFAM's clinics)
6. Renovations at MEXFAM clinical facilities	4 clinics renovated
7. Equipment	3 Autoclaves, 2 Crio Surgical Equipment , 3 PowerPoint equipment
8. Update of administration manual	Distributed to all clinics
9. Update of job descriptions	All staff have updated job descriptions
10. Internal dissemination of MEXFAM mission and objectives	36 clinics
11. Internal dissemination of Technical publication	Libraries created at 36 clinics to facilitate access to technical publications for clinical staff
12. Client satisfaction surveys, suggestions box	Client's suggestion boxes available at all SDPs-monthly analysis and discussion with service providers

Mainstreaming the quality of care approach has been an integral component of the WHR programme strategy. The Region has developed a comprehensive sustainability and expansion plan beyond the end of the current funding. As a reflection of this commitment, in 2005 the Region used its own funds to support additional interventions (in the amount of US$163,000). Key aspects of the strategy are:

- Developing a "**South-South**" technical assistance strategy whereby Member Associations involved in the current programme lend their skills and expertise to other Associations
- Expanding the programme to new Member Associations: since 2005, Associations in Belize, Bolivia, Paraguay and Puerto Rico have begun the quality improvement process based on the South-South technical assistance strategy
- Strategically selecting components of the process to implement in other Member Associations. For example, training on the Guidelines was adapted for a training focused on infection prevention and control for Caribbean Associations, in order to standardize and implement effective procedures at their service delivery sites.

All Member Associations demonstrated evidence of action plan implementation and accomplishment in accordance with the QOC standards and have received the QOC certification.

Association	Action plan implementation	Achievement of QOC standards
(ADS) EL Salvador	90%	94%
(BEMFAM) Brazil	100%	98%
(APROFAM) Guatemala	89%	92%
(MEXFAM) Mexico	97%	93%
(PLAFAM) Venezuela	97%	98%
(FPATT) Trinidad and Tobago	96%	90%

Technical information materials

Quality of care newsletter (English, French, and Spanish)

Produced bi-annually since December 2002, the QOC newsletter has been the key information tool to disseminate progress and news of programme implementation. The newsletter has chartered programme activities from the early days of self-assessment, action plan implementation, development of tools, and results of the assessments process.

Directory of Hormonal Contraceptives available in English, French and Spanish

Launched in October 2002, The Directory is the first searchable worldwide on-line database of hormonal contraceptives. It allows users to search by brand, composition, country, manufacturer, and type. Access is free. In 2005, the Directory was extensively updated based on the latest information received from Member Associations and pharmaceutical companies. To learn which hormonal methods are available in your country, log on to http://contraceptive.ippf.org/

IPPF Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services (2004)

Available from IPPF Central office in English, French, Spanish, Arabic (see page 03).

Statements of the International Medical Advisory Panel (IMAP)

- Statement on Infertility (forthcoming 2006)
- Statement on Contraception for Adolescents/ young people in an era of HIV and AIDS (June 2006)
- Statement on HIV/AIDS: an overview (June 2005)
- Statement on the Management of HIV infection within SRH Service (March 2005)
- Statement on Emergency Contraception (March 2004)
- Statement on Intrauterine Devices (January 2003)
- Statement on hormonal Methods (May 2002)
- Statement on Female Genital Mutilation (May 2001)
- Statement on Barrier Methods (May 2001)

All resources are available at: www.ippf.org or by contacting medtech@ippf.org

IPPF Medical Bulletin

The Medical Bulletin is IPPF's long-running (over 35 years) medical newsletter. It provides up-to-date information on the clinical, service delivery, managerial and programmatic aspects of a range of sexual and reproductive health topics. Produced on a quarterly basis and distributed free of charge, the Bulletin is available in English, French and Spanish. Recent articles in the Bulletin include:

- Progestogen-only injectable contraceptives and bone health, Nuriye Ortayli
- The herpes-HIV link, Sinead Delany
- Ortho Evra contraceptive patch, Edith Weisberg
- IPPF guidelines on protection against HIV infection, including post-exposure prophylaxis, in the service setting
- Carcinogenicity of combined hormonal contraceptives
- Use of the male condom within marriage, John Cleland
- NuvaRing, Edith Weisberg

Increasing access to the IPPF Medical and Service Delivery Guidelines

IPPF European Network has translated the IPPF Guidelines into Russian, the common language of most former Soviet countries. The translated version will benefit Member Associations and partner organizations in more than ten countries.

Member Associations in Armenia, Bulgaria and Poland also translated the Guidelines into their national languages.

Youth group at BEMFAM, Brazil

Certification events

Certification events were organized by 22 Member Associations in five regions in 2005/ 06. The events served as an excellent opportunity for Member Associations to showcase their achievements and commitment to quality of care to their communities. In most cases, the celebrations were attended by Government officials, national and international donors, partner organizations, and local leaders, as well as the Association's board members, staff and service providers. Many Associations decided to provide similar quality of care certificates to their clinics in order to recognize the efforts in the programme.

THAILAND (PPAT)

The certification ceremony was held for PPAT on March 15, 2006. Dr Raj Karim, Regional Director of IPPF ESEAOR presented the certificate to the President of PPAT. The Deputy Permanent Secretary of the Ministry of Health of Thailand, as guest of honour, gave a speech on the actions and responses of the government in reproductive health promotion in the country after the ICPD.

Eight clinic managers of PPAT received the PPAT QOC certificate from its President. An exhibition on various projects of PPAT was held, highlighting successful stories of the Association.

MOROCCO (AMPF)

The certificate presentation was a very big event, with extensive media coverage attended by representatives from the concerned ministries, embassy, international organizations, and board members. Dr Mohammed Kamel, Regional Director of AWR presented the certificate to AMPF's President and Executive Director. The Member Association awarded QOC certificates to the branch managers at the same event.

MEXICO (MEXFAM)

The certificate event in Mexico took place on April 26, 2005 in coordination with the Association's annual Assembly. Board members, volunteers, department coordinators and staff were present.

The certificate was presented by Ilka Rondinelli, Senior Quality of Care advisor for the Western Hemisphere Region.

BULGARIA (BFPA)

Bulgaria's certificate was presented by Regional Director for the EN, Vicky Claeys, at an event that was reported on by four media channels. Representatives of the Ministry of Health, service delivery points and management attended.

Outcomes of the quality improvement process

The outcomes of the quality improvement process using the self-assessment approach are evident at various levels; from individual service providers to the community at large. The outcomes illustrate the relevance and usefulness of self-assessment to achieve relevant and effective solutions to improve quality of care. The common results of quality improvement, as reported by Member Associations, include:

Providers

- strengthened competency in sexual and reproductive health
- greater appreciation and awareness of clients' rights
- greater observation of infection prevention measures
- use of supportive supervision and annual appraisals
- improved access to information and feedback
- increased sense of teamwork and purpose, beyond simple employment
- identification of clients as the focus of services and of the need to provide "**the best**"
- more conducive skills, knowledge and attitude for quality services
- improved motivation, commitment and morale

Service delivery points

- improved quality of services
- more integrated and comprehensive services
- improved infrastructure, equipment, and supplies
- adequate supply of IEC materials (radio cassettes, posters, pelvic models, etc)
- increased organizational capacity
- greater client load
- improved relations between headquarters, branches and SDPs
- more detailed analysis of service statistics used for planning

Clients

- improved access to information on a range of SRH topics (posters, pamphlets, etc)
- greater opportunity to provide feedback and participate in decision-making
- ability to make more informed choices from the range of services provided
- increased satisfaction with services

Self-assessment exercise in Benin

Increased client satisfaction: Family Planning Association of Uganda

	2003 (compared to 2002)	2004 (compared to 2003)	2005 (compared to 2004)	2006 (compared to 2005)
Client load	+20%	+40%	+45%	+45%

Member Association headquarters

- establishment of quality of care standards and system
- initiation and regular monitoring of quality assessment
- better and more regular communication with service points and branches
- more acute awareness of roles as supervisors and motivators of the service providers
- provision of regular supportive supervision
- improved quality and quantity of IEC materials
- improved organizational and administrative systems, including personnel policies, logistics, procurement, and information dissemination

Community level

1. greater visibility and credibility of Member Associations and their clinics
2. strengthened partnerships with other organizations; for example, the Maseru clinic in Lesotho has become a referral center for clients attending the Government ARV center
3. improved funding opportunities; for example, the Mityana clinic of the Family Planning Association of Uganda attracted other donors to renovate and equip their laboratory; and the Port Novo clinic of the Benin Family Planning Association received HIV and AIDS kits from the national AIDS Council.

A number of Member Associations have become "**local leaders**" in quality of care and are using the expertise gained in the programme as an income-earning activity. For example, the Polish Association "Towarzystwo Rozwoju Rodziny (TRR)" now offers a training course on "clients' rights and quality of care" to local medical students.

Other Member Associations have seen their **relations with the Ministry of Health** strengthened after implementation of the programme. For example, the Moroccan Family Planning Association has become a reference center for QOC in sexual and reproductive health and was asked to assist the Ministry of Health to implement a quality improvement system.

In Brazil, BEMFAM was asked to carry out training in quality of care in 1500 local municipalities. Among other success stories, PROFAMILIA Colombia is offering national training on the IPPF Medical and Service Delivery Guidelines to the Ministry of Health, and the Lesotho Planned Parenthood Association has been contracted by the Government to provide VCT services countrywide.

Constraints and challenges

An inherent limitation to the programme was its focus on static clinics. Community based services such as mobile health units, outreach activities, and home based visits were not included in the programme design. In order to ensure quality of care at all levels of service provision, it is anticipated that attention will turn to this level of care. The valuable experience, lessons learned and expertise gained thus far will provide the building blocks to adapt the quality improvement tools to these community based services.

Challenges encountered in programme implementation were as follows:

- **Implementation in large Member Associations** (> 20 clinics) was a challenge in many cases because of insufficient funding and time to effectively carry out the process. In particular, providing supportive supervision visits in large Member Associations such as Indonesia and Bangladesh was challenging in terms of financial and human resources, and additional support from RO budgets was required to facilitate the process.

- **Infrastructure constraints**. In some cases, clinics were unable to meet all the quality of care standards because some required changes to physical structures which were too costly or simply unviable particularly where the premises are rented. In such cases, the programme clearly revealed the need for Member Associations to seriously consider purchasing their own facilities.

- **Provision of services through partner organizations.** Several Associations (notably in the EN) do not have their own service sites and work in partnership with other clinics to provide services. In a number of cases, this posed a challenge to initiating changes to improve quality, decision-making and sustainability. The situation also made Member Associations vulnerable to restructuring of the health system, as occurred in Moldova where the programme was subsequently halted due to the restructuring.

- **Staff turnover.** IPPF Member Associations, not unlike other health providers in the 'Global South', face a serious challenge in recruiting and retaining well qualified health professionals. The impact in terms of sustaining training knowledge, programme gains, and the experience retained by Member Associations is immense. While the QOC programme has made good progress in this area by its emphasis on providers' needs, additional strategies to retain skilled staff are required.

- **Effective referral systems.** While many Member Associations have a basic system for referring clients for further care, developing an effective cross-referral system has been a real challenge. This is often due to the lack of strong partner organizations with whom to build such links, and a need for capacity building and guidance to improve skills in this area.

- **Follow-up with drop out clients.** As in the case of referrals, establishing effective systems to contact defaulters and drop-out clients requires further attention.

Lessons learned . . .

The self-assessment process:

1. is a powerful non threatening method that brings a sense of local ownership of the quality improvement process.
2. recognizes the vital knowledge and skills of local staff in identifying solutions to gaps in quality of care, something that is not only new to many staff, but also very encouraging and motivating.
3. is effective in generating a range of achievable, low-cost, innovative, and appropriate solutions to improve quality of care.
4. allows Member Associations to identify a wide range of training needs and gaps beyond those included in the programme itself.
5. is highly valued by Member Associations and service delivery teams. Associations have found the self-assessment approach empowering, motivating and "**revolutionary**".
6. is self-sustaining: this includes performing regular self-assessments, conducting client exit interviews, and using the internal assessment tools.

The cascade training approach:

1. is a useful training methodology to maximize the impact of limited resources. Programme training targets were exceeded due to the strategic decision to use this approach.
2. requires regular supervision and monitoring to ensure skills retention and application.
3. created a critical mass of master trainers and managers who are able to reproduce the training to others.
4. was greatly appreciated by service providers: ensuring regular staff training updates can be a mechanism to enhance staff retention and recruitment.

On quality improvement:

1. gains in quality can be achieved with little or no financial support. Many Member Associations and service points initiated improvements before receiving funds for their action plans. Small scale and low-cost changes can make a world of difference in terms of quality.
2. all staff (cleaners, drivers, nurses, doctors, managers, etc) can make valuable contributions to the identification of quality of care gaps and their solutions.
3. quality improvement strategies require the commitment and support of management and senior volunteers.
4. regular internal follow up through supportive supervision significantly promotes the commitment of service staff and encourages them to provide high quality services.
5. processes need not be complex to be effective. Relatively simple and straightforward approaches may be more applicable and transferable to in-country settings.
6. the certification process, involving internal and external assessment, has provided Member Associations with a solid framework with which to monitor and provide recommendations on quality of care issues at the service delivery level. Associations have welcomed these tools as a means to guide their supportive supervision visits. At the same time, clinic staff have appreciated the assessments for the technical feedback and practical recommendations generated by the visits. The assessment process has motivated staff to complete all aspects of their action plans.
7. quality improvement is a long term, continuous process that requires a commitment to quality in all aspects of service delivery and management.

Service providers at the Bogura branch of the Family Planning Association of Bangladesh

Sustaining the momentum

There are many indicators showing that quality of care, as a core principle and mindset, has been integrated as part of regular activities across the Federation at multiple levels. Across all Regions, Member Associations have begun conducting annual self-assessment and using the results to guide development of their annual work plans. Other components of the process have also been integrated as part of standard practice. This includes regular client exit interviews, supportive supervision and internal assessment of service delivery points. In Member Associations where all service points did not participate in the programme, the process is now being expanded to include them (e.g. Indonesia, Guatemala and Morocco).

A number of Regional offices have taken the quality of care process forward by launching the programme in new Member Associations. As noted, this has taken place in WHR, but also in ARO, where additional funds were secured by DANIDA to train Member Associations in Guinea Bissau, Angola, Guinea Conakry and Sao Tome and Principe in quality of care. From 2006, ARO will include quality improvement activities in its annual work plan to support selected Associations each year, starting with Rwanda, Burundi, Congo Brazzaville and Cameroon. Programme "Lessons learned workshops" in EN, SARO, ESEAOR and AWR were organized in March-June 2006 to initiate discussions on mainstreaming the programme.

The quality of care model is being applied to other programmes that address the IPPF strategic priorities. The EN has adapted the self-assessment tools to youth friendly services and for assessing safe abortion services. Based on the QOC model, WHR developed a gender, rights and sexuality guided self-assessment module on clients' rights and providers' needs. The region also adapted the self-assessment questionnaire into a monitoring tool for regional country desk officers as a means to ensure continuous follow-up to quality improvement initiatives.

At the central level, IPPF is committed to maintaining the momentum generated by the programme. Quality of care has been integrated as part of the core work under the strategic priority of "**Access**". Future activities will include updating the complete package of the quality improvement process to integrate IPPF's Five A's, and adapting and applying the tools for community based services. Watch for future editions of the QOC Newsletter for further information on quality of care initiatives in the Federation.

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Certificate event of PLAFAM, Venezuela

Certificate event of RHAC, Cambodia

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The International Planned Parenthood Federation (IPPF) is the strongest global voice safeguarding sexual and reproductive health and the rights for people everywhere.
Today, as these important choices and freedoms are serously threatened, we are needed more than ever.

We would like to sincerely thank the Bill and Melinda Gates Foundation for their generous and continued support of this important IPPF initiative. With their assistance we have made real improvements to the services we offer, significantly enhancing the quality of care that our clients receive.