

**Review of the Results of the Multi-  
Country Field Test of Quality of  
Care Indicators in Clinic-Based  
Family Planning Programs**

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**Minutes from meeting**

**April 23, 1999  
Arlington, VA**



**MEASURE Evaluation  
July 1999**



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## Executive Summary

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There has been a growing interest in developing a means to routinely monitor quality of care (QC) in Family Planning (FP) and Reproductive Health (RH). The USAID Office of Population has been strongly committed to developing ways to measure quality of care. In early 1998, the MEASURE Evaluation Project was asked to develop a “low-cost and practical” methodology that could be used on a regular basis to monitor quality of care in clinic-based family planning programs. To contribute to this effort, USAID also encouraged the formation of the Monitoring and Evaluation (M&E) Subcommittee of the MAQ Initiative (Maximizing Access to Quality).

To this end, a short list of quality of care indicators was derived through expert opinion. The 24 indicators on this list may be measured through the use of three instruments: observation of client-provider interaction (CPI), client exit interview, and the facility audit with interview of the manager. To date, the field test has been implemented in a total of four countries (Ecuador, Turkey, Uganda, and Zimbabwe); modified versions have been used in Paraguay and Mozambique; it is planned for implementation in Kenya and Morocco.

The meeting held on April 23, 1999 was a culmination of a four day meeting of the core group<sup>1</sup> to review field test experiences, discuss results, and identify improvements needed in the instruments. During the April 23, 1999 meeting, specific results from four countries (Ecuador, Turkey, Uganda, and Zimbabwe) were presented and limitations and constraints of the methodology were discussed.<sup>2</sup> Participants were asked to give their recommendations on how to further improve the methodology and to assess whether it was a low-cost and practical means of measuring quality of care. Finally, next steps for disseminating the methodology more widely were discussed.

The presentation of findings from the multi-country field test demonstrated the different uses of the data which included the following: to describe the strengths and weaknesses of a network of facilities on selected QC indicators, to contrast the performance in intervention and non-intervention areas, to compare performance on two types of service providers, and to compare the quality of care in different types of facilities. Comparability of the observation and the client exit interview was assessed to determine if the two instruments yielded similar results on the same indicators. For the most part the results were quite consistent across the two instruments. Two countries involved in the field test adapted the instruments to areas beyond family planning: In Uganda the instruments were adapted to assess QC in antenatal care services, and in Turkey

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<sup>1</sup> Members of the core group are involved in the final design of the instruments and, in some cases, data collection at the field level.

<sup>2</sup> See Appendix A for the list of participants. Presentations are available on-line at [www.cpc.unc.edu/measure/publications/workshops/](http://www.cpc.unc.edu/measure/publications/workshops/) or by request from MEASURE Evaluation.

to monitor post-abortion and post-partum clients. The results show that these instruments may easily be adapted to measure QC in other reproductive health services.

The sampling strategy (selection of facilities) was not uniform across all of the field test countries because the objectives of the monitoring and evaluation exercise differed by country. While in some cases it may be desirable to draw a representative sample of facilities, in others it may be more useful to survey a census of a given type of facility, e.g., a particular network of NGO facilities. Obtaining informed consent from both the client and the provider was discussed. The importance of developing protocols to determine how forms will be stored and what to do if service providers commit potentially life-threatening errors while under observation was also discussed.

Criteria used to determine if this exercise is low-cost and practical included sample size/geographical distribution of facilities, time, personnel and cost. While researchers tended to view it as low-cost and practical, service providers found the costs high. This issue was not fully resolved.

There were many lessons learned and issues identified with regard to this methodology. In the observation, training for inter-rater reliability is extremely important, and in future studies observers should be sure to follow the client through all phases of the client visit. Results for this instrument need to be interpreted with caution due to the Hawthorne Effect.<sup>3</sup> In the client exit interview, it is important to realize that this instrument measures what the client perceived, regardless of the quality of services she actually received. Results of the client exit interview should be interpreted with caution due to recall and courtesy bias. In the facility audit all equipment and supplies in working order are counted. This activity would be less time consuming and adequate information could be obtained by simply determining if there is at least one of each item in working order. One positive aspect of this instrument is that it measures if job aids, such as wall charts, are used by the provider to explain a method, which is an important component of informed consent under the Tiarht Amendment.<sup>4</sup>

In the post-Cairo period, it is necessary to move beyond family planning to a wider range of reproductive health services. The QC field test methodology may be adapted to other RH services as demonstrated in Uganda and Turkey. However, as each new topic is added, the instruments and the methodology become increasingly complex and decreasingly low-cost and practical.

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<sup>3</sup> The bias produced due to the presence of an observer is referred to as the Hawthorne Effect.

<sup>4</sup> An amendment to a U.S. House of Representatives 1999 appropriations bill that makes funds available only to "voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning services."

Sampling issues were discussed during the course of the meetings. One issue is whether the facility or the client is the unit of analysis. Whichever unit is used, weights need to be applied to obtain valid results for the other. Low prevalence countries represent a special case where it may be desirable to stratify by low and high volume facilities in order to address the issue of “no clients” more efficiently. For studies that cover multiple types of RH services, sampling becomes more complicated. If client volume differs by type of service, it is necessary to apply the appropriate weights to each type of service monitored.

Several next steps were identified. First, the data needs to be further analyzed to determine anomalies or inconsistencies in the results for specific countries. Subsequently, it will be important to analyze consistency of responses across instruments and identify cross-national patterns. The sampling guidelines also need to be revised to address the different potential uses of the instruments.

Finally, a user’s package for organizations interested in monitoring quality of care in FP will be developed and include the following: the short list of indicators, sampling guidelines, instruments for data collection, field guides for supervisors, plan of analysis, and illustrative presentation formats for the data. In addition, a packet of country reports including country specific protocols, results, and lessons learned will be compiled and distributed. Complete documentation, including instruments used in the local language, field work manuals, sampling information, and related material, will also be available through the MEASURE Evaluation Project.

## **1.0 Background of Field Test of Quality of Care Indicators**

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In recent years the USAID Office of Population has been strongly committed to improving the quality of family planning services in developing countries worldwide. The primary mechanism for this effort has been the MAQ Initiative (Maximizing Access and Quality), implemented by USAID's cooperating agencies (CAs). Considerable progress has been made in clarifying clinical guidelines, reducing medical barriers, training service providers in counseling and improved clinical procedures, and establishing norms for improved client-provider interaction.

Despite progress in these other areas of quality, the field has lacked a means of routinely monitoring quality of care (QC) to ascertain if efforts to improve quality have in fact resulted in measurable improvements and to communicate the importance of quality to service providers in the system. In short, there remains a need for a low-cost and practical methodology that can be used to monitor QC on a regular basis (every 1-2 years). To this end, the USAID Office of Population asked the MEASURE Evaluation Project to coordinate this initiative and encouraged the formation of the Monitoring and Evaluation (M&E) Subcommittee of the MAQ to contribute to this effort.

In May 1998, several groups of experts on quality of care and evaluation were surveyed to identify the factors most important to achieving quality outcomes. A short list of QC indicators (see Appendix B) was derived from this expert group. Subsequently, three instruments were identified as the minimum number needed to measure the indicators on the short list. These instruments are (1) observation of client-provider interaction and selected clinical procedures, (2) exit interviews with clients departing from the facility and previously observed, and (3) inventory of key items in the facility, with selected questions to the program manager. Drafts have been developed for all three instruments, along with guidelines for field personnel and a plan of analysis.

In September 1998, local researchers from selected countries met to finalize the instruments and guidelines. The field test of the QC instruments has since been conducted in Ecuador, Turkey, Uganda, and Zimbabwe. It is planned in Kenya and Morocco, and a modified version of the study was carried out in Paraguay and Mozambique. Data have been entered in Epi-Info, and data analysis is ongoing.

## **2.0 Objectives of the Meeting**

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The objectives of this meeting were

1. To share specific results from four countries involved in the multi-country field test of quality of care indicators, and to discuss constraints of the methodology with members of the M&E Subcommittee of the MAQ and other interested members of the CA community.
2. To obtain recommendations from participants on means of further improving the methodology used, based on information presented and their own background.
3. To assess whether the methodology used in the field constitutes a low-cost, practical means of monitoring quality.
4. To identify next steps (after revising methodology) for disseminating findings and results more widely to USAID missions, the CA community, and other interested parties.

The meeting was attended by members of the M&E Subcommittee of the MAQ and other members of the CA community interested in monitoring quality of care in family planning programs.

## **3.0 Overview of the Field Test**

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### **3.1 Participating Countries and Instruments Used**

The three instruments were chosen to measure all QC indicators on the short list. In the observation, a person with clinical training follows the client and evaluates the performance of the provider during counseling and clinical sessions, thereby collecting information on counseling skills and clinical procedures, including some items the client might not be able to judge. The client exit interview collects information about the client's experience at a given health facility. This instrument is particularly important because it provides information about the quality of services received from the client's perspective. The facility audit is used to determine the readiness of each facility to serve the client. Information is collected about types of services provided, types and amounts of supplies in stock, the condition of the facility, and the types of records kept.

When used together, all three instruments measure the short list of QC indicators, in addition to other optional variables. While the field test countries were encouraged to retain the same core questions in order to measure all items on the short list, they did have the option to adapt or add items to the instruments as appropriate to the local conditions.

### **3.2 Sampling**

Local circumstances dictated the universe of facilities and the approach to sampling them. Consequently, Ecuador used the census of facilities in two NGOs; Turkey sampled government facilities in the province of Istanbul; Uganda sampled from ten intervention (DISH) and three non-intervention (non-DISH) districts; and Zimbabwe used a census of facilities that collaborate with the SEATS project. The upcoming field test in Morocco will use a random sample of clinic facilities in the Ministry of Health system. It is important to note that the objective of the field test has **not** been to compare quality of services across countries; rather, the field test was conducted to determine how specific indicators work in different settings and to draw inferences regarding quality in those service delivery systems.

### **3.3 Expansion of Instruments beyond Family Planning**

In the field tests, it was found that these instruments could easily be expanded into other areas of reproductive health and used in tandem with the FP instruments. Countries with relatively low FP client flow are particularly well suited for this activity because the fieldwork can easily be combined which keeps the field workers occupied and drives down cost relative to the amount of information collected. However, collecting data for both FP and other RH services is more cumbersome and may not be possible in areas where there is high client flow. In Uganda, the instruments were adapted to measure quality of



antenatal services, and in Turkey they were adapted to assess post-abortion and post-partum care. In some cases the indicators could be measured with the same items as those on the FP instruments; in others, items were changed to better capture the key quality aspects of those services.

### **3.4 Uses of Results**

The quality of care tools developed for the field test can serve many functions, depending on local needs. The instruments may be used to describe the strengths and weaknesses of a network of facilities on selected QC indicators (all countries), to contrast performance in intervention and non-intervention areas (Uganda), to compare the performance of two types of service providers on key indicators (Ecuador), to compare QC in different types of facilities (Turkey), and to compare a given set of facilities over time (planned for Turkey). Whereas the current protocol was developed with the idea of first refining the instruments for family planning, the instruments may be adapted for use in other areas of reproductive health as demonstrated in Uganda and Turkey.

## **4.0 Summary of Meeting Presentations**

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Illustrative findings from a specific country were presented for each instrument. Results on the consistency of findings across instruments were also presented, as well as results beyond family planning. Presenters' names are in parentheses. The complete meeting presentations are available on-line at [www.cpc.unc.edu/measure/publications/workshops/](http://www.cpc.unc.edu/measure/publications/workshops/) or by request from MEASURE Evaluation.

### **4.1 Highlights of Results**

#### **Observation of Client-Provider Interaction (CPI): Ecuador (Amparo Gordillo and Ernesto Pinto)**

The results of the observation in Ecuador were presented for 584 observations in 21 provinces using a census of 43 clinics in two NGOs (CEMOPLAF and APROFE). In Ecuador, one of the objectives of the field test was to compare service provided by doctors to that provided by *obsteriz* (a type of physician's assistant). Overall, both types of practitioner scored well on the indicators "demonstrates good counseling skills," "treats client with respect," "follows infection control procedures for injectables," and "performs clinical procedures according to guidelines." Neither practitioner type scored as well on "asks client about reproductive intentions" or "gives accurate information on the method." In general the comparison between the two types of providers showed that there was not much variation between them with regard to the quality of services provided, and that overall the quality given through this network of clinics was high.

#### **Client Exit Interview: Zimbabwe (William Sambisa)**

The results of the client exit interview were presented for Zimbabwe (n=742). These results focused on demonstrating the strengths and weaknesses in the network of clinics collaborating with the SEATS project. It was found that the majority of providers "discuss with client which method she prefers," "tailor key information to the particular needs of the client," "give instructions on when to return," and "treat client with respect." Providers did not score as well on "mentions HIV/AIDS or responds to questions on HIV/AIDS" nor on "promotes dual method use." These findings are particularly worrisome considering the high prevalence of HIV/AIDS in Zimbabwe.

#### **Facility Audit with Interview of Manager: Turkey (Ersin Topcuoglu)**

In Turkey, a total of 128 facilities were surveyed. Here, the results were used to compare different types of facilities: public hospitals, private hospitals, MCH/FP centers, and health centers. The private hospitals scored better than the other types of facilities on the "availability of privacy," while the MCH/FP centers scored the best on "receiving supervision" and the summary quality index.

Health centers scored consistently lower on all indicators. All of the facility types scored well on “adequate storage conditions” and none did well on the index of “availability of Information, Education, Communication (IEC) materials.” It is important to note the results for the indices should be interpreted with caution since an all-or-nothing approach was used to determine these. (A certain standard was set for items that needed to be available, and if any were lacking, the facility scored “0”.)

### **Comparability across Instruments on Selected Indicators (Ruth Bessinger)**

The comparison of selected indicators across the client exit interview and the observation was presented for Ecuador, Uganda, and Zimbabwe. This comparison of indicators across instruments is useful because it provides information about the comparability of the methodologies and the reliability of the instruments. The results show that there is good comparability across the instruments on almost all of the selected variables. Of the results presented, only a few indicators had notable discrepancies (greater than a 10 percentage point difference) across the instruments in any of the three countries. These indicators included the following: “provider mentioned HIV/AIDS,” “provider promoted dual method use,” and “provider discussed method preference.”

Differences on a given indicator may be due to the fact that items were phrased slightly differently on each of the instruments. For example on the client-provider observation the observer determines if the provider “treats client with respect,” whereas on the client exit interview, the client is asked: “During your visit to the clinic, how were you treated by the provider?” Here two different phenomena are being measured, and thus the results should be interpreted with caution. There also may be differences due to observer subjectivity and poor recall of events by the client. On the balance, however, the level of consistency was higher than expected, based on the experience of Situation Analysis.

### **Expanding Measurement of QC beyond Family Planning (Charles Katende)**

Uganda and Turkey expanded the measurement of QC beyond FP. In Uganda, the quality of care instruments were adapted to measure QC in antenatal care clients. In Turkey, the instruments were adapted to measure QC in post-abortion and post-partum clients. Researchers found that some items on the instruments could be used as they are when applied to the following reproductive health services: client satisfaction, general counseling skills, and infection control procedures. Other items on the instruments had to be adapted to the specific RH context: information provided, clinical guidelines, and services and supplies provided. A set of new items had to be added to measure “tailoring information to clients needs.” Generally, the level of quality was found to be consistent across types of services on a number of variables in both countries.

## **4.2 Methodological Issues**

### **Sampling (Marilyn Wilkinson)**

The selection of facilities depends upon the objectives of the monitoring exercise. There are some logistical concerns such as the availability of a complete list of facilities. While in some cases it may be desirable to draw a representative sample of facilities, in other instances it may be sufficient and desirable to conduct a study using a census of clinics. For example, Turkey used a representative sample of facilities in the province of Istanbul, whereas Ecuador used the census of APROFE and CEMOPLAF clinics. It is important to stress that, if a subsample of facilities such as NGO clinics is used, the results will only be representative of the NGO clinics not the overall FP services provided in a given country. Low prevalence countries represent a special case where it may be necessary to stratify by low volume and high volume facilities in order to address the issue of “no clients” more efficiently.

### **Informed Consent and IRB Review (Sian Curtis)**

There are several relevant ethical issues that need to be considered when planning a study. The federal agencies in the U.S. adopted the Common Federal Policy for the Protection of Human Subjects that describes appropriate ways in which to conduct research involving human subjects. Any study that involves human subjects must be reviewed and approved by an Institutional Review Board (IRB) before the study can be implemented in the field. In the past, survey research was not required to undergo this process; the IRB process was geared more toward clinical research involving human subjects. Today, survey research is subject to review because surveys may be used in vulnerable populations such as children, they may include sensitive topics such as HIV/AIDS, or the protocols may involve the observation of confidential issues. The IRB must know the purpose of the study, any procedures involved, and any risks or benefits to those participating in the study.

Informed consent is one way in which subjects are protected. Clients should be asked for their informed consent before they are observed and before they are interviewed in the client exit interview. Providers also should be asked for their consent before they are observed. Participants need to be aware of any risks and/or benefits of the study. They must be informed that they do not have to participate in the study and that if they choose not to participate, it will not affect their care at the facility in any way. In addition, clients must be assured that the information collected will be kept confidential. This informed consent may be administered verbally, or the client or provider may read it.

In addition to informed consent, protocols must be developed to determine how forms will be stored to preserve confidentiality and how observers should react if they witness improper, especially life-threatening, clinical procedures. In the latter case there is a delicate balance between protecting the safety of the client and jeopardizing future research at that site.

Some feel that the informed consent forms required in the United States are too lengthy and verbose to use in a developing country context. Informed consent forms might discourage people from participating in the study (although there was evidence to the contrary in the Uganda study). One solution around this issue is to use the local IRB of the facilities or institutions where the study will be taking place, since the requirements may be more acceptable by local standards. However, few developing country institutions have their own IRBs.

#### **4.3 Use of Data for Programmatic Purposes (Gabriel Ojeda)**

Before starting a monitoring and evaluation exercise, researchers should ensure that the information obtained will be welcomed, or at least anticipated, and used appropriately. To this end, it is important to try to involve those within the organization from the beginning. Program administrators and managers should be included so that they can have input in establishing the standards by which their services will be judged. Once the results become available, administrators and managers can identify problems and solutions, as well as a timetable for solving them. To ensure greater cooperation and collaboration with local institutions, the monitoring and evaluation exercise may be integrated with other types of M&E tools already in use at facilities, e.g., self-assessment forms, supervisory checklists, guidelines.

Service providers also need to be informed of the results of an evaluation. Service providers are well placed in terms of identifying the root of problems and suggesting possible solutions. Too often providers are simply told that they are undergoing another training, but they are not aware of the standard by which they have been judged and have not been consulted for their opinions. By disseminating results throughout the system, there is greater local ownership and it encourages all parties to collaborate to improve services.

Not only is it important to involve all parties in the improvement of the service delivery system, it is equally important to present data in a very clear, understandable and timely manner. Results may be presented in different formats to policy makers, program managers and providers. In terms of donor agencies, timing may be important, e.g., present positive results before the next funding cycle.

#### **4.4 Is the Methodology “Low-Cost and Practical?” (Tim Williams)**

To determine if this exercise is low-cost and practical, data were presented on sample size/geographic distribution, time, personnel, and cost. The sample size/geographic distribution of the study varied by country, depending on the objectives of the specific field tests. The number of service delivery points (SDPs) visited ranged from nine in Mozambique to 128 in Turkey. The

resources required for each field test also varied by country with an average of one week of training, four and a half weeks of data collection, using approximately nine research teams, and almost five weeks for data entry and preliminary analysis. The average cost of the fieldwork was \$31,000 (\$486 per SDP) excluding the cost of technical assistance and local dissemination costs. A key determinant of total cost was number of person-days, and the amount and distance of travel. Person-days are affected not only by the amount of travel required, but also by the number of instruments used. In general, the size of the research team increases as the number of instruments used increases.

While these findings do provide important information about the cost of monitoring quality of care, a key question remains: Do improved services lead to better outcomes such as longer continuation rates, fewer complications, and greater achievement of reproductive intentions? FRONTIERS is currently looking into this issue with their global agenda, and the Population Council is also conducting a set of studies to document the impact of quality on women's reproductive health. Although the empirical evidence to link quality of care to client outcomes has been elusive, more effective programs tend to have a commitment to quality. In addition, conducting research on QC can influence how service providers deliver services by spotlighting the importance of quality within the organization. As a second phase of the QC field test, an attempt will be made to conduct 12-month follow-up visits to new users in the fall of 1999 to measure continuation rates, as well as other outcomes, and then link them to the quality of care at their FP facility.

## **5.0 Lessons Learned and Issues to be Resolved**

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### **5.1 Client-Provider Observation**

The presence of an observer may produce a Hawthorne Effect in the client-provider observation. The provider may be more likely to adhere to clinic guidelines when there is an observer in the room. Consequently, the results may show a higher quality of care than what is typical. One way to overcome the Hawthorne Effect is to have the research team at a facility for a few days before they start observations. A more practical solution may be the use of a mystery client, although this methodology has its own limitations.

It is important to capture the **entire** client-provider interaction. In CEMOPLAF and APROFE, the two NGOs surveyed in Ecuador, there are two phases to a clinic visit. First, there is a one-on-one session with a counselor. Immediately following this counseling session, the client moves to the exam room to be examined and further counseled by the provider. During the field test, the observer was stationed in the provider's office and as a result did not observe the counseling that occurred before the client entered the exam room. Consequently, the scores on the observation in Ecuador were consistently lower than those on the client exit interview for the same indicators. In the future, it is advised that the field team collect information about the client flow before starting data collection in a given facility so that all aspects of the client-provider interaction are recorded.

Training is also an important issue in the observation of the client-provider interaction. Although all countries involved in the field test had observers watch the same session and compare results during training to check for inter-rater reliability, some countries put more time into this training technique than others. Also, because an observation does not follow a particular sequence, some observers had trouble marking all of the items. Therefore, it is extremely important to spend extra time training observers in order to improve their skills in using the instrument and to increase inter-rater reliability. Taking extra time to train observers will increase the accuracy of the results.

### **5.2 Client Exit Interview**

With any type of client exit interview there is always the fear of courtesy bias. This set of tools was designed to address this problem in part by asking questions about specific actions performed, or not performed, by the provider. For example, "Did the provider show you how to use the method?" can be compared to a more specific question such as, "How do you take the pill?" In some cases two questions such as these showed a much different picture of quality. It is important to note that a client really may have felt that she received quality services, even though there is evidence to the contrary. Clients may not be in a position to evaluate quality of care in areas where they have little

knowledge, e.g., clinical procedures and guidelines. This issue highlights why it is important to conduct both the observation of the client-provider interaction and the client exit interview. The results from both instruments form a more complete picture of the quality of services received than does either one by itself.

### **5.3 Facility Audit with Interview of Manager**

Currently, the facility audit requires that **all** of the equipment and supplies listed on the form be counted. However, counting equipment and supplies is extremely time consuming and not necessary to get a summary measure of quality. Much time can be saved and important information can still be collected by simply determining if there is at least one of each item in working order. Overall, data collection time for the facility audit used in this field test takes less time (about 20 minutes on the average) than for the other methodologies. This methodology could be further improved by using palmtops, thus eliminating the need for separate data entry for this instrument.

One positive aspect of this instrument is that it collects information on job aids, such as wall charts, which is one way programs can comply with the Tiarht Amendment. By collecting information about the presence of job aids at a given facility, it is possible to demonstrate that clients are choosing methods with informed consent.

### **5.4 Expansion of Instruments into Other Areas of Reproductive Health**

In the post-Cairo period, it is necessary to move beyond family planning to a wider range of RH services, and this set of instruments needs to reflect this expansion. However, as each new reproductive health topic is added, the instrument becomes increasingly complex and increasingly less "low-cost and practical."

### **5.5 Sampling**

One basic decision that needs to be made in future applications of these instruments is whether to use the client or the facility as the unit of analysis. If the facility is the unit of analysis, the results will reflect the experience of clients in the average facility. If the client is used as the unit of analysis, the results will reflect the experience of the average client in the network of facilities. Whichever unit is used, weights will need to be applied for the other. In the QC field test, the client was used as the unit of analysis since many of the indicators try to capture the client-provider experience.

Low prevalence countries present a special case where it may be desirable to stratify by low and high volume facilities in order to address the issue of "no clients" in certain facilities and to improve the efficiency of sampling.



When multiple types of RH services are involved in a single study, sampling becomes complex very quickly. Because the client volume for FP clients, post-abortion, MCH or RTI/STD services may be quite different, it is important to determine appropriate weights when all are included in a given study.

Where the sample of facilities is not representative at the national level because it includes only certain geographical regions or only NGO facilities, for instance, it is important to stress this in the write-up of the results.

## **5.6 Other**

This methodology is limited because it does not reflect the experience of the individuals who did not receive services on the day of the visit, stayed away from the clinic, or never came back. Information needs to be collected on women who never make it to the facility to determine if, and why, women are denied access or leave facilities before they see a provider. Additional types of data collection will have to be used to reach these audiences, e.g., focus groups, follow-up home visits to dropouts, household surveys.

Some programs have combined results from several variables to create a standard such as the five types of IEC materials that should be available. A complete picture of the results includes both the percent achieving the standard, and the percent on each variable that comprises the index. It is recommended that both be presented. One benefit of presenting information both ways is that policy makers will not be overwhelmed by the detail, and the detailed information presented to program managers can be used to refine supervision and conduct future training.

## 6.0 Next Steps

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Several next steps were identified. First, the data need to be further analyzed to determine anomalies or inconsistencies in the results for specific countries. Subsequently, it will be important to analyze consistency of responses across instruments and identify cross-national patterns. The sampling guidelines also need to be revised to address the different potential uses of the instruments such as whether the sample is representative of clients or facilities, and for special situations such as low-volume facilities or multiple types of service in a single survey.

A user's package for organizations interested in monitoring quality of care in FP will be developed. The packet will include the short list of indicators, sampling guidelines, instruments for data collection, field guides for supervisors, plan of analysis, and illustrative presentation formats for the data. In addition, a packet of country reports including country-specific protocols, results, and lessons learned will be compiled and distributed to appropriate audiences both in-country, such as policy makers, program managers, evaluators, and providers, and within the larger international RH community which includes CAs and other technical agencies. Complete documentation, including instruments used in the local language, field work manuals, sampling information, and related material will also be available through the MEASURE Evaluation Project for interested parties.

Additional analysis is needed to better understand how well the instruments performed. The descriptive analysis performed at the country level may be used to determine if any variables yield improbable results. There is also a need for further exploration of the consistency across instruments for a given indicator by matching results across instruments by case and identifying patterns or systematic bias. Correlations among variables need to be analyzed to determine redundancy among the QC items, consistency of correlations among the QC variables for the different countries, and whether it is necessary to further shorten the short list of indicators. Lastly, the differences in information covered during counseling for new users versus continuing users need to be explored. This exploration should take place in an effort to make recommendations for including just new users versus all users in future applications of this methodology and to contribute to the dialogue on what should constitute good counseling for continuing users. These next steps will be undertaken by the MEASURE Evaluation Project with input from the core group and members of the M&E Subcommittee of the MAQ.

## **APPENDIX A**

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### **Participant List**

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## **APPENDIX B**

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### **Short List of QC Indicators Matched with QC Instruments**

**Draft Version: April 22, 1999**

Indicator Number	Indicator	Client Exit Interview	Observation	Facility Audit
	<b>PROVIDER</b>			
I-1	Demonstrates good counseling skills (composite)	✓	✓	
I-2	• Assures client of confidentiality			
I-3	• Asks client about reproductive intentions (more children? When?)	✓	✓	
I-4	• Discusses with client which method she would prefer	✓	✓	
I-5	• Mentions HIV/AIDS or responds to questions about HIV/AIDS	✓	✓	
I-6	• Promotes dual method use	✓	✓	
I-7	• Tries to make interaction respectful	✓	✓	
I-8	• Tailors key information to the particular needs of the specific client	✓		
I-9	• Gives instructions on when to return	✓	✓	
I-10	• Gives accurate information on the method accepted (how to use, advantages, disadvantages, side effects, complications)	✓	✓	
I-11	Follows infection control procedures outlined in guidelines		✓	
I-12	Recognizes/identifies contraindication consistent with guidelines		✓	
I-13	Performs clinical procedures according to guidelines		✓	
	<b>STAFF (other than provider)</b>			
I-14	Treat clients with dignity and respect	✓		
	<b>CLIENT</b>			
I-15	Participates actively in discussion and selection of method (is “empowered”)	✓	✓	
I-16	Receives her (his) method of choice	✓	✓	
I-17	Client believes the provider will keep her information confidential	✓		

<b>Indicator Number</b>	<b>Indicator</b>	<b>Client Exit Interview</b>	<b>Observation</b>	<b>Facility Audit</b>
<b>I-18</b>	Has all (approved) methods available; no stockouts			✓
	<b>FACILITY</b>			
<b>I-19</b>	Has basic items needed for delivery methods available through SDP (sterilizing equipment, gloves, blood pressure cuff, specula, adequate lighting, water)			✓
<b>I-20</b>	Offers privacy for pelvic exam/IUD insertion (no one can see)	✓	✓	✓
<b>I-21</b>	Has mechanisms to make programmatic changes based on client feedback			✓
<b>I-22</b>	Has received a supervisory visit in past __ months			✓
<b>I-23</b>	Adequate storage of contraceptives and medicines (away from water, heat, direct sunlight) is on premises			✓
<b>I-24</b>	Has state-of-the-art clinical guidelines			✓